Hayden

NATIONAL HEALTH

The ALP programme

Australian Fabians.

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NATIONAL HEALTH – The A.L.P. Programme is based on an address delivered by Mr Hayden. M.H.R. for Oxley and A.L.P. spokesman on Health and Social Services, to the Victorian Branch of the Australian Medical Association in November 1971.

Mr Hayden shows how the Commonwealth's financial role, as a proportion of total health expenditure, has actually decreased over the past five years. Australia is not spending sufficient on its Health Services, nor is the expenditure effective. There is the need for greater Commonwealth initiatives.

The costly and inadequate nature of the so-called "voluntary health service" is analysed. The A.L.P. alternative, namely a Universal Health Insurance Scheme, is described and the Canadian experience with a similar scheme noted.

But the A.L.P. proposals do not stop with the provision of comprehensive health insurance. Health Services at the moment are "sickness oriented". An outline is given of a new positive approach which recognizes the equivalent importance of social, preventive, and rehabilitative services. A concept based on treating the total man in the setting of his entire community. Consideration is given to the re-organization such an innovative approach would involve in the areas of hospital administration, the structure of institutionalized service, nursing homes and psychiatric health services.

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The task of providing adequate health services in an advanced society is an expensive undertaking.

In fact health services are one of the larger expenditure items and one of the greater absorbers of manpower in the economy.

Personal consumption and net current Public Authorities expenditures in this area, identifiable in the Bureau of Census and Statistics publication "Australian National Accounts" were of the order of $I,594M in 1969-70. That is, about 5.3% of G.N.P. For the year just completed the figure would be of the order of $I,800M. Additionally about one quarter-million people in our total civilian workforce of $5.6M are employed by health and hospital services; that is 4.5% of the workforce compared to 3.7% of the workforce so employed in the U.S.A.[I]

Two questions immediately rise; are we spending enough and do we spend wisely?[2]

Our expenditure as a nation on health services expressed as a percentage of G.N.P. indicates that we are not mean, though it is fair to observe that international comparisons suggest that it would be no great strain to our economy to allocate a greater proportion of our total spending for this purpose. (See Table I).

However, G.N.P. percentages tell us nothing about the quality, adequacy or distribution of resources. Those who have seen the Swedish health services will realise just what can be provided with proper planning, the provision of relatively adequate resources and the will to get the job done.

Given the fact that in Australia nearly 83% of public revenue raising is controlled by the Commonwealth and it is therefore in the pre-eminent position to fund public services the role of Commonwealth expenditures in supporting health services is unimpressive.

A dissection of health expenditures in the G.N.P. shows that the Commonwealth's financial role, as a proportion of total health expenditure, rather than increasing as one would hopefully expect, given needs and the Commonwealth's financial power, has been falling steadily over the five years to 1969-70. There was a slight improvement in 1969-70 on the preceding two years but the proportionate level was still below that of 1965-66.

These trends are clearly shown in Table II.

One does not have to search far to see evidence of neglect and want in our public health services, and accordingly to see a case for greater Commonwealth initiatives.

The unevenness with which resources are allocated between different sections,

viz. Repatriation Hospitals as against Mental Hospital services, the appalling neglect of Aboriginal health so that tuberculosis notification rates in the Northern Territory are four times higher than the Australian national rate, or infant mortality rates of 132 per 1,000 for Aboriginals in the Northern Territory compared to a national rate of about 19.06 in 1964[2], grave unmet needs leading to reports of ambulances in Melbourne on busy nights hawking accident victims about overtaxed casualty wards seeking a hospital that can admit the victim.[3]

On the basis of what I can see of our health services we are neither spending enough nor are we ensuring maximum return to the public for every dollar of theirs which we spend in this essential field.

The first priority is to develop ways that ensure maximum efficiency, consistent with guaranteeing peoples' rights, in the way in which we put the public's money to use in the health field.

Accounting and Administration in the Health Field – How Adequate?

Given this, it is extremely perplexing to find that until fairly recently little effort has been made to develop some sort of accounting of these services. Planning and co-ordination of the various services has been minimal, disjointed, and not according to any national programme. Evaluation of the performance of the services, individually and overall, still seems non-existent in spite of the relative scarcity of resources available in the economy, the opportunity costs their use represents, and the essential need to maximise return from every dollar of the public's which is spent.

Professor Palmer of the N.S.W. University School of Health Administration has pointed out the possible benefits of "operations research" methods, e.g. inventory analysis, queueing theory, linear programming, replacement theory and scheduling in evaluating performance.[4] One could add "Systems Analysis". Commonwealth funding of research into the possibilities of these and similar possibilities would be a worthy venture.

Perhaps modern medicine has held the mystique for the bulk of people, and has been given accordingly the unquerying deference, that the practice of medicine men in some earlier societies attracted. If so, this might partly explain why a profession, highly skilled in its field, ipso facto has been expected to be equally qualified and skilled as administrators of large enterprises and planners in a field which demands a multi-disciplinary approach.

This is not to deny that there have been many outstanding medical administrators and planners in the past who based their expertise on practical experience. The argument is that the approach to this area of health services support, unlike the medical practice side, has been pretty much left to chance and in turn has thrust unreasonable burdens on to many medical people.

Unfortunately health administration, until quite recently, has not been a highly regarded profession among non-medically qualified people. Thus the bulk of clerical administrative staff in the hospital service, at least in N.S.W. and Victoria, falls into an age structure very much above the distribution in other similar enterprises e.g. banking, insurance, accountancy.

On the face of evidence produced by Professor Griffith many who had 'dropped out' from other fields seemed to turn to the hospital service as a point on a tunnel of contracting opportunities for their skills and abilities.

Again under-qualification seems to have been a problem. Professor Griffith's 1968 survey showed only 3.5% of non-medical hospital administrative staff with a university degree, and an unimpressive average level of education generally for the demanding task of hospital administration.(5)

True, steps have been taken to overcome this deficiency with, for example, the expansion of an upgrading of courses at the Health Administration Faculty at the University of New South Wales and the initiation of a new course of study in this area at Monash University.

The fact is that the response is late and represents another case of a piecemeal approach to an area which badly needs a thorough analysis of its overall needs, of what it is supposed to be achieving, and how best to achieve that through balanced, co-ordinated development and operation, as an essential preliminary if worthwhile progress is to be made.

It has always seemed odd to me that there should be so much neglect of research into health services delivery systems, as distinct from medical research. One inspired estimate of our expenditures in this field places the level at about $50,000 a year $9M in Great Britain and $40M in the U.S.A. Yet it seems so obvious that efficient allocation of resources between, and use within, the various health service sectors is one of the most obvious ways to contain cost movements and to maximise return from money spent.

In having made these preliminary remarks I must now stress that a modern, adequate and efficient delivery system for health services has to be structured around an equally modern, adequate and efficient system of universal health insurance.

The Failure of Voluntary Health Insurance

You are of course, familiar with the system of what is called voluntary health insurance in this country.

The term voluntary is a strange and jarring misnomer in this context related as it so obviously is to the philosophy of a laissez-faire market place with consumer freedom of choice between competing offers on the market place.

The very complexity of medical technology and the esoteric nature of medical practice prohibits the

arrangement of the system by market forces. Indeed this is true of the major forces in our economic system. For instance, consider the logistics of the automobile industry –

> No one expects the ... motorist to assemble his own automobile – to go to the warehouse to select this manufacturer's fenders, and that manufacturer's fins, and this set of headlights, and that motor, and so on. By the same token we cannot expect the consumer, medically indigent or not, to go out and organise the medical care he needs from the highly specialised working parts available to him here and there in the present system.[6]

The market place has fulfilled an important role in our society, albeit far from perfectly, but it is not the milieu for providing and preserving basic human rights and needs such as health services.

In any case the present health insurance scheme collapses badly on the score of its adequacy of protection and efficiency of operation.

Additionally, if the cost of the pensioner medical and hospital benefits and local Repatriation medical officer services – services which would be covered by Labor's Universal Health Insurance programme – are added to the cost of operating the so called voluntary health insurance scheme the whole structure is revealed as an extremely expensive mechanism to operate.

Estimates for 1971-72, based on the performance of the voluntary health insurance funds in earlier years, indicate total outlays for these services will be around the level of $630M. (See Table III).

With spending of this order careful accounting is justified to establish whether in some other system the same volume of money can provide greater return to the public, who foot the bill in all respects in the final result.

This means that one dollar of every three spent last year on recurrent health expenses was spent in this area alone.

I assert categorically that the present system of health insurance, with the attendant system of benefits for pensioners, is neither adequate for the public's health needs, efficient in its operation, nor providing satisfaction in its operation.

On the last point the fact that proposals for a system of universal health insurance attracted about 30% more public support than the present scheme in the last public opinion poll on this topic is adequate testimony to my point.[7]

The structural defects of the present system are inherently wasteful, unnecessarily costly, and are incapable of anything but the most moderate reform.

Our motivation must be to constantly strive for standards of excellence in the health care system and must not be deflected by opposition derived from habit, fear, suspicion and reverence for the past.

Harvard economist John T. Dunlop could equally be talking about the situation in Australia when he says –

> The real function of the cost increases of the past decade, and those in process, should be to compel vast structural changes in the organisation of medical care. Nothing could be worse in our society today than to say we need another three to five billion for medical care, and then simply duplicate or multiply the arrangements that we now have. This would get us nowhere. It is the fundamental transformation in a variety of our arrangements that I think is signalled by these cost changes. The permanent problem is the need for more productivity ... brought about by structural changes in the practice and organisation of medicine.(8)

The major criticisms of the present system are that it –

- necessarily involves costly duplication of services,
- unavoidably involves high costs of operation,
- sterilises large amounts of contributors' money into reserves,
- wastes money on advertising,
- allocates too much to commission payments,
- involves too many branches,
- is not universal in cover,
- distributes its cost burden inequitably between income groups,
- will not improve merely by pouring more and more of the public's money into the system, as the government periodically does, in order to stave off collapse.

I now want to deal with these points.

Costly Duplicated Services

First the proliferation of insurance agencies runs counter to efficient use of the public's money; there are 75 medical and 85 hospital insurance organisations.

This proliferation leads to an unnecessary and excessive cost structure. This is wasteful. Every dollar misspent is a dollar doubly lost. It achieves nothing in the area of health services for which it has been provided while denying other areas of health services of sorely needed finance.

This waste is dramatically obvious in the high cost of operation these numerous schemes and their costly practice of accumulating reserves.

The cost of operation for these funds is inexcusably inflated.

No one has ever tried seriously to propose a rationale for the enormous accumulation of contributors' money held in reserves investments. At the end of last year these funds aggregate investments stood at nearly $148M.

This is a capital equivalent of eight 600 bed public hospitals of the size and style of the proposed Woden Valley Hospital, Canberra. To have this large amount of capital, provided for health services, used for the financial empire building of fund controllers at a time when the nation's health services are desperately in need of more finances, is scandalous.

The Report of the Commonwealth Committee of Inquiry into Health Insurance In 1969, the Nimmo Report, recommended that accumulated reserves should not exceed the equivalent of three months' contribution income. On the basis of this principle there is an excess of $90M held in reserves investments. Of that excess $70M is held in hospital fund reserves alone, which, incidentally, jumped by an unprecedented and thoroughly unjustified $20M last year.

The patchy performance of these funds is even more disturbing. The 'Big Three' funds in each of the States, between them hold more than 74% of all reserves held by medical funds and nearly 86% of all reserves held by hospital funds. Within this select, wealthy and powerful group only one hospital fund has reduced its reserves to the three months' contribution income equivalent level recommended by the Nimmo Report. Indeed, one such fund has reserves equivalent to more than two years' contribution income; a further five have reserves exceeding twelve months' contribution income equivalent; while another nine have reserves greater than six months' contribution income equivalent.

In the case of medical funds two have been successful in achieving this three months' limit, while eight, or nearly fifty per cent have reserves which are more than twice as great as this level.

There is room for a sixty per cent of a $90M reduction in reserves and this could be speedily achieved by substantial reductions in contribution rates.

The accumulation of these reserves, in such an uneven pattern between funds mind you, has been unnecessary, has deprived contributors of $90M worth of benefits as the money is sterilised away in non-benefit producing investments, has been accumulated at considerable expense to contributors, and cannot be justified.

Let me quote from a paper by a Liberal Party Study Group. The report, which obviously the Liberal Party never intended I should have, is headed "Report by Health Sub-Committee – Sydney Special Branch" and the committee had been convened by a Dr D.C. Gengos.

It says, inter alia, – "On the question of reserves it is doubtful if such reserves are necessary" and one of its blunt recommendations is, "The system of funds holding reserves should be abolished." This recommendation was made to the Liberal Party in late 1970 when that party was searching about, in the aftermath of its near-disaster at the 1969 election, for ways in which to improve its policies.

The incidence of unnecessary high costs is not restricted to reserves. For instance

last year it cost the funds $1 to pay every $4 benefits. That is an unreasonably high ratio and it is clear that the profoundly unsound structure of the system largely accounts for this cost problem.

Precisely because there is duplication, varying scales of operation, fierce competition at times, wasteful advertising and commission rates, uneven risk spreading between funds, plus the need for accumulating reserves, one cannot see the sorts of efficiencies being achieved, to the benefit of the paying public, that are so obviously available under a universal scheme.

In the case of operating costs, one dollar in a little over every three spent for this purpose is in fact spent on advertising and commission payments to agents.

Commission payments were seen by the Nimmo Committee as "one of the costs which is unduly building up the organisations' management expenses to unduly high levels".

The Senate Committee reported of advertising, that it "is undesirable and wasteful in a sphere which should be a matter of welfare rather than 'big business".

Overall the Senate Report concluded on the level of operating costs that it found "the existing situation to be most unsatisfactory and wasteful of contributors' funds".

Yet these costly defects, which are exclusively a drain on funds made available for health services without in any way improving or expanding those services, are inherent in an insurance system based on numerous competing units.

Although hamstrung by the federal government imposed terms of reference binding any conclusions to the present structure of health insurance, the Nimmo Committee nonetheless went as far as it could in pointing out the crucial nature of this defect in aggravating management costs. The committee accordingly recommended the elimination of duplicatory servicing and urged the rationalisation of the activities of 'open funds', limiting the activities of one fund alone to any one region.

The Senate Committee was similarly impressed by the wasteful competition that had developed to the point of causing open hostility between funds, a trait, the committee felt, not in the public interest given the nature of the service involved. The committee thus proposed limiting branches of any organisation on a ratio of one branch to 50,000 contributors.

In fact of the 347 branches in operation throughout Australia fewer than one in six meet this requirement. Even worse, four out of five branches hold a ratio less than half the recommended 50,000 contributors.[9]

This gives some conception of the costly wastefulness that plagues the ailing health insurance industry.

All of this is token to a highly inefficient structure for financing health services. It means that there is considerable unnecessary wastage of the public's money in supporting the system. On the basis of expected levels of improvement which the scheme just might achieve, under enough pressure to improve its performance, the benefits to the public would be comparatively marginal and certainly shape up poorly alongside a universal system of health insurance. This is a point I will come back to.

Perhaps if articulate contributor representation were allowed to be democratically elected to the bodies which control the open funds this inexcusable dissipation of the public's money might have been brought into check long since.

Significantly, however, the large open funds with the assistance of the federal government which subsidied their operation with more than $190M of taxpayers' cash last year, has effectively prevented any such representation. The government is in connivance with the funds for it steadfastly resists requests to have these funds – which cannot operate without government financial support and which are subject to regulatory controls by the federal government – produce for public perusal their articles of association.

Dr R. Klugman M.H.R. (Prospect N.S.W.) has been singularly successful in exposing how one large open fund has set itself up and conducts its affairs like a self-perpetuating autocratic council of feudal overlords.

The Medical Benefits Fund of Australia has a Council of twenty-three which controls its affairs. The rules require there should be a majority of medical members on the council. Those open to selection are a select few for there are only one hundred eligible medical members. These medical members are the only members of the fund eligible to vote members on to the council. In tum, the medical members are selected by the council. What an incredible racket by these mutual beneficiaries of this organisation which regards itself as a mutual benefit fund. Contributors to this fund, by fund regulation, are not entitled to vote, attend or be notified of Council general meetings. They are mutually excluded.

Contributors to medical and hospital insurance with this one fund in each case exceed one million persons and in 1970/71 total contributions exceeded $66M. This is a big business by faceless men in remote board rooms.

Indeed, the whole system of so called voluntary health insurance needs to be approached in the light of its being big business; very big business indeed!

Total funds handled in the voluntary health insurance system last year will exceed half a billion dollars or about 1.4% GNP.

That is, this industry controls a lot of resources within the economy. It would

be a very foolish public indeed that didn't want a rigorous, open accounting of the way in which such a large volume of its hard earned cash is used. It doesn't get this.

In 1970/71, the latest year for which official statistics are available, and consistent with its position of Big Business, voluntary health insurance funds held investments aggregating $148M of which 45% was in the private sector.

What is more significant is the enormously dominating position of the 'Big Three' funds in each of the States. This powerful group controls 82% of all investment, or four of every five dollars held in investments by all funds.

Of that total investment in the private sector they control 80% or an amount in excess of $54M.

Now the notable feature of all of this is that this dominant position within Big Business of the 'Big Three' funds of each State has been built up through the very understanding patronage of the federal government and at the expense of contributors who have supplied the funds for these enormous investments.

The community would be better served if fund administrators put as much energy into containing costs borne by contributors as they do into their investment activities.

I feel it not to be overstating the case by asserting that contributions to funds are in fact a tax. I put the proposition quite firmly that there is very little that is voluntary about the present system of health insurance.

Let me briefly develop this point.

Given the risk of ill health affecting us – a risk that worries most of us, especially those of us with children – it is scarcely credible to argue that there is a choice of reasonable alternatives open to us in the matter of health cover of either insuring or of foregoing that opportunity.

Ill health costs money. Serious ill health can be extremely costly. In some cases it can be financially disastrous. There would be few responsible people in the community not concerned about such a possibility afflicting them. In short, there is little choice in this matter. The risk is too great and the potential implications of risk taking too serious for choice to be exercised by most people. They see themselves with no alternative but to cover themselves with the only form of health insurance available to them; the government sponsored one.

In such a situation contributions are truthfully a tax.

This contribution tax is levied inversely to one's ability to pay so that the low and moderate income earners subsidise the relatively well off and the cost to contributors represents a savage tax slug.

For instance the estimated cost of contributions last year will represent a 15.5% increase in "Pay as you Earn" tax paid by contributors.

For contributors, total contributions are equivalent to a levy of 2.22% on their aggregate taxable income.

Inadequate Cover

On the score of population cover, it is of concern that at any time somewhere between one in seven and one in ten of the population is without any cover at all under the present scheme.[10]

This calculation allows for pensioners and those drawing on Repatriation benefits who are not included in that 10% to 15% uninsured.

On the evidence available those uninsured come overwhelmingly from income groups which would have greatest difficulty in meeting health services costs, and include non English speaking European migrants as a special risk group.[11]

There is, of course, a subsidised health insurance scheme for low income earners.

It doesn't work.

When it was introduced in 1970 the then Minister for Health announced it would benefit 184,000 low income families. In fact fewer than four families in every hundred entitled to do so have drawn on the programme. Only one out of five migrants and two out of five unemployment/sickness beneficiaries entitled to draw on the scheme have done so.

In any case those who draw on the scheme must have doubts about its benefits. Under the subsidised medical benefit scheme the beneficiary meets nearly one third of the total average cost of a service, in Victoria he meets more than one dollar in three of the cost of such a service. Members of the unsubsidised health insurance scheme meet less than one dollar in four of the average cost of such a service. That is, the needy pay more, a peculiar but not uncommon principle influencing the operation of this scheme.

The humiliating failure of this scheme to assist people with indisputable need is bad enough but the insouciance of the acting 'Minister' for Health a few weeks ago in the House of Representatives in asserting that eligible families would decrease from 184,000 to 125,000 and then interpreting this as evidence of advance in the fight against relative poverty in the community is a little rich.[12] The only reason eligible families will decline in number is because the income bands set for eligibility have been frozen in the face of fairly rapidly accelerating wage movements. Inflation, rather than welfare initiatives from the federal government, are responsible for this trend.

The failure of this programme is directly related to the imposition of another prying, degrading means test reminding the needy once again of their inadequacies and dependence. It is also connected with a complex double registering procedure requiring two separate and involved steps, first at a Commonwealth Department and then, if that step is negotiated successfully, at a voluntary insurance fund.

Complex procedures such as this imposed on the socio-economically deprived are doomed to failure. They ignore the serious cultural disadvantages of these people which hinder their ability to exercise their rights in society.

A special case of this cultural inadequacy concerns the 6,000 to 7,000 detribalised, fringe-dwelling Aborigines in the South-West of Western Australia. Prior to the introduction of the Subsidised Health Insurance Scheme the health of these Aborigines was cared for by local medical practitioners remunerated from a $20,000 grant from the W.A. Government to the W.A. branch of the A.M.A. which made the necessary distributions. Upon introduction of this scheme the W.A. Government ended its grant support in favour of this programme. Unfortunately, this programme has proved a spectacular flop with these Aborigines. Strenuous efforts to have these people enrol under the scheme resulted in a maximum of 1,00O people being covered. Informed opinion is that it is impossible to enrol a higher figure because of cultural and educational deficiencies among these Aborigines.(13)

Inequitable Cost Burden

Finally, in this list of defects in the system of voluntary health insurance, the subject of an inequitably distributed cost burden as between incomes arises. Rather than payments being geared to one's capacity to pay a flat rate or poll tax is levied on contributors. Because of the way in which the marginal tax rate works, cost of contribution works out cheaper for higher incomes after tax deductions are claimed. Even worse, because of this factor low and moderate income earners pay more for cheaper forms of insurance than do high income earners who choose more expensive protection.

Thus, a man supporting a wife and two children in Victoria on $3,000 a year pays $ 1.05 a week net for public ward and medical insurance cover. If he earned $10,000 a year, he would pay only $0.91 a week net for private ward and medical protection. For this sort of cover, if his salary was $20,000, he would pay only $O.6O a week net.(14)

It is worth noting here that the daily bed cost for private ward accommodation in Victorian public hospitals is twice as dear as the daily bed cost in a public ward.

Money is no Panacea – A New System is Required

Whenever the voluntary health insurance system is under challenge because of its obvious inadequacies the government's response is to pour more money into the system; more taxpayers' money and more contributors' money.

But money is no panacea for problems caused by the inherent structural defects of the present system. Nimmo saw these defects when he stressed the need to rationalise fund activity through regionalisation of the funds. The Senate Committee were equally alert to this problem when they discreetly mentioned the need to reduce fund representation

by curtailing branch activity. These sorts of proposals do not cost money, in fact they cut back on costs. This was their essential aim.

In this matter the government's response is to tinker with a model T Ford system in an effort to have it meet the pace and demands of the space age.

Tinkering with the spark plugs, or fiddling with the motor of this museum piece proves inordinately expensive, and provides only marginal, short term, and quite unsatisfactory improvement in performance. As a vintage show piece model 'T's' have their place of interest, but in their proper setting, a museum where they may quietly, harmlessly, and inexpensively blend into the past.

The ALP's Solution – A Universal Health Insurance Scheme

The Australian Labor Party's proposal is to introduce a Universal Health Insurance Scheme. It will use about the same volume of money, in total, required by the present system. In doing this it will draw together the same sources for pooling finances for health services currently used; viz. tax financed services and subsidies, compulsory insurance through workers' compensation and third party motor vehicle accident insurance, and personal contribution earmarked for health insurance.

The difference is that the current inefficient structure for the administration and distribution of these pooled funds will be replaced by a single national authority which can and will introduce valuable economies of operation, the savings from which will be passed on to the community in the form of improved benefits.

These qualities are the essence of what has been built into Labor's proposals for a Universal Health Insurance Scheme.

The principal elements of Labor's proposal are –

- Universal cover
- Universal contributions
- Contributions geared to one's ability to pay and levied at 1.35% of taxable income
- A Commonwealth subsidy
- A levy on third party and workers' compensation insurers
- Provision of a general subsidy and a special grant to public hospitals

General subsidy would be about $13.00 per occupied bed day this year. This would cover the average occupied bed day cost now being met by Commonwealth occupied bed day subsidy including pensioner bed days and patient fees charged for public or standard ward treatment. This subsidy would grow with cost movements unlike the present one which has fallen from 56% to 13% of public ward charges between 1958 and the end of last year.

Special grants would be made to allow for the payment, inter alia, of staff now classified as honorary, on a salaried or sessional basis. This year this grant would be approximately $20 million.

- Where a patient chooses private ward hospital accommodation he would have a right to the occupied bed day subsidy as a credit towards his account. He could privately insure himself for any additional cost above the occupied bed day subsidy.

- Medical practitioner services provided from the present system of private practice and remunerated on the fee for service system.

- Medical practitioners may charge in either of two ways. By directly billing the patient who subsequently can receive 85% settlement of the cost from the national health insurance authority. Alternatively the medical practitioner may bulk bill the insurance authority regularly, accepting 85% of the total cost in settlement. Experience in Saskatchewan, Canada, establishes clear economies through the latter practice, viz. lower overheads, debt chasing, bad debts, etc. There all but 4% of medical practitioners prefer this latter system.[15]

- Maximum cost met by a patient for a service of $5.

- Pensioner patients will be paid for at the negotiated schedule rate, however they will not be required to make any personal payment.

- Low income earners supporting one or more dependent children will be automatically covered at public expense. This exemption commences at a gross income of $2,678 for a man supporting a wife and one child. Additional income of $156 yearly will be allowed for each child so that exemption income levels are struck on a sliding scale to make proper allowance for large families.

- A participating doctor scheme which guarantees for doctors who wish to practise outside of the scheme the right to do so.

- Surgical prostheses supplied as a separate welfare benefit.

The expanded benefits of this scheme are considerably more attractive and advantageous to the public than is offered by the current one. Considerable savings are achieved through the more efficient scale of operation and the elimination of reserve funds which are pretty much dead money carried by the contributors.

For instance additions to reserves by voluntary health insurance schemes were nearly $20M and management costs were approximately $27M in 1970/71. Under the proposed universal scheme the $20M allocated to reserves and $11M saved on administration costs would be available for payment of services for the public.

In making these claims of economies of operation one does not do so on a purely speculative basis. The experience of, for instance, Canada is instructive in this respect.

In a publication on the Federal Medical Care Program, published 1969 by Department of National Health and Welfare, Canada, the following observation is made –

> The experiences of the commercial insurance industry and of the governmental plan in Saskatchewan clearly indicate the definite economies of scale and of uniformity of coverage, the subscriber in Saskatchewan having had to pay much less in order to receive each dollar of benefits ...

The Canadian experience was that return in services supported from each dollar contributed to schemes outside of Saskatchewan varied from between 54 cents and 87 cents. In Saskatchewan the return was nearly 95 cents.[16]

Nor is there evidence from the Canadian experience to support a contention that Universal Health Insurance accelerates costs faster than in a system where there is so called Voluntary Insurance available from a number of organisations.

In 1967, ten years after the introduction of Universal Health Insurance in Canada the average cost of hospital care had increased nine comparable dollars to an increase of seventeen comparable dollars in the U.S.[17] The Canadian scheme provided universal cover while the U.S. system gave no protection at all to millions of its citizens.

The introduction of salaried and sessional specialist staff, apart from providing a more satisfying professional milieu, will also provide very tangible improvements in efficiency and, accordingly, savings.

The report of Professor R.A. Joske, Professor of Medicine at the University of Western Australia is informative in this respect. He points out that after sessional physicians were appointed at the Royal Perth Hospital in November 1958 the following savings were achieved –

- without extra beds monthly admissions increased from 1,600 to 2,000.
- average bed stay fell by 2 days, equivalent to an increase of 225 beds with a present capital cost exceeding 5.5M.
- each bed accommodates eight additional patients a year allowing an extra 5,000 admissions a year without increased resident or nursing staff.
- the cost of all of this was $50,000 a year salaries to visiting physicians and about half of this was clawed back by the taxman.

Professor Joske asserted –

> It is honorary service which the community cannot afford, not sessional payment.[18]

The guaranteed prompt payment of fees due for third party and workers' compensation insurance covered services will similarly strengthen the financial situation of hospitals. About one third of outstanding monies due to a hospital fall into this area. Under the proposed Universal Health Insurance Scheme a levy charged on third party and workers' compensation insurers will ensure regular payments from this source.

Taken in conjunction with the proposed generous financing of standard ward service the burden of writing off bad debts, which I conservatively estimate at more than $I0M for Australia's public hospitals in 1969/70[19] and late fee payment, will be virtually eliminated.

Labor's Proposals and The General Practitioner

In so far as general practitioner medical services are concerned Labor's scheme is based on the fee-for-service principal; private practice; freedom of patient to select his own private practitioner; and preservation of doctor/patient relationship.

That is, on these matters, there is no disturbance of present practices.

It is sheer fantasy to draw an analogy between Labor's proposals and the comprehensive British National Health Service.

The British National Health Service, in so far as medical services are concerned, is based on per capita payments according to the number of patients registered with a medical practitioner. There is a ceiling on the number of registrations permissible.

This payment system is historically based in the Workmens' Lodge subscription system developed in the last century.

The National Health Insurance Act of 1911 , enacted by Lloyd George, formalised this arrangement and provided for a subsidy from the Exchequer to the employer/employee contribution covering all manual workers and other low income workers.

By 1938 90% of all G.P.'s had accepted a panel (list) of patients with national insurance and the basic system and principals on which the British N.H.S. of today is firmly based was by then well established and widely accepted by the British public and medical profession. The National Health Service of 1945 represented the culmination of an historical development of a system evolving from the previous century.

The Australian situation is entirely different. The tradition of general practice medical service is private practice based on fee-for-service.

Apart from any other consideration there is a constitutional barrier which imposes very real limitations on what can be done in the development of medical services.

Section 51, placetem (xxiiiA) clearly states –

> The Parliament shall, subject to this Constitution, have power to make laws for the peace, order and good government of the Commonwealth with respect to – inter alia – ... medical and dental services (but not so as to authorise any form of civil conscription ...

Now it is true that the A.L.P. platform states as a policy objective –

> The provision of general practitioner medical services staffed by salaried medical practitioners willing to join and available without charge and without means test to persons who choose to use such services.

The section of the Constitution quoted ensures that this salaried service is staffed only by those prepared to *voluntarily* serve within it.

The simple fact is that if we are going to talk about a National Health Insurance Scheme providing universal cover through adequate health services, including general practitioner services, then we have to work with the tools that are, and are likely to become, available.

In a nutshell, Labor has to base its scheme on fee-for-service private practice. There can be no threat to this long-standing traditional delivery system; the Constitution makes that clear. To the extent there is any variation or change it has to be voluntarily accepted and supported by members of the medical profession.

Confronted by these clear, unassailable facts, talk of nationalising the medical profession or destroying private practice, or any of the numerous other horrendous predictions of what Labor's Health Insurance proposals would involve are sheer nonsense.

The Labor Party is certainly based on democratic socialist values but the ideological ends sought by a party, such as ours, working in a democratic system are tempered by our acceptance of the democratic responsibility of persuading the public to support any case for change. There are very clear limitations on what can be achieved in this way; limitations imposed by public attitudes. The public is dearly opposed to anything remotely smacking of nationalising the medical profession.

What it does want is a simpler financing system supporting health services which expands benefits for any given outlay compared with the present system.

This is what Labor is talking about! The most effective way of using the public's money.

The choice is between proposals which involve on the one hand extremely slow progress in improving health services by the very gradual development of salaried services or the extremely doubtful gamble of achieving a constitutional change. On the other hand considerable improvement can be achieved fairly

quickly by reform proposals along the lines suggested by Labor. The needs of the community are too great in this field and the opportunity of satisfying them so relatively simple and expeditious to allow the frittering away of time and opportunity on highly speculative ventures.

It is a measure of the considerable conservatism of many people in Australia that they should be alarmed by the "radicalness" of a system, such as the one proposed by Labor, which is essentially similar to the health insurance principles embodied in the health insurance laws of a very cautious, non-socialist German Chancellor, Bismarck, in the 1880's. In short, the debate on principals behind social security programmes in this country is up to a century behind advanced countries of Europe.

The Costing of Labor's Proposals

The next obligation is to produce a costing of the proposed scheme.

At the personal level contributions prove cheaper for four out of five taxpayers than is currently possible under the government sponsored voluntary insurance scheme.

Contributions would be, as I mentioned earlier, levied at the rate of 1.35% of taxable income. However, they would reach a ceiling at three times average weekly earnings. For all incomes at and above this level they would be levied at a flat money rate. This rate would be equivalent to the 1.35% contribution levy on the ceiling income of three times average weekly earnings.

Contribution rates for the two schemes are compared in Table IV.

A provisional costing of the two schemes; the current one and Labor's proposal shows total costs under the present one at around $672M in 1969/70 and at around $596M for the Universal scheme.

The break up of costs is shown in Table V.

There is an additional cost for an aspect of our scheme which will be borne by the government. This is the cost of meeting contributions for low income earners.

The total cost in 1971/72 would have been about $5M. This is a bagatelle in terms of national expenditure. In terms of a very urgent, and in many cases, distressing need the outlay is well justified.

Our proposal would mean a family with one or more children on $1,890 taxable income would be automatically protected. There would be no prying means testing. The employer, who would make collections for this scheme much on the basis of pay as you earn tax collections, would know from his table that an employee with a taxable income below this level would not have subventions made from his pay.

This scheme would cover about 325,000 low income families.

The government proposal cost $7M in 1970/71. If it had been successful instead of a monumental flop it would have cost more than $14m, not allowing for Commonwealth Medical and Hospital subsidies but including patient fees and contributions from ‘B’ and ‘C’ category beneficiaries.

In practical terms our proposition would mean a man supporting a wife and one child on an income of $2,678 would be fully covered at public expense. An allowance of $156 a year additional actual income would be allowed for each additional child.

The effect of this, and a comparison with the government scheme is seen in Table VI.

Universal health insurance is a better proposition all round for the community.

Our scheme has been costed, the costing subjected to intense scrutiny, and not a little misrepresentation from some government spokesmen. Doctor Forbes as Minister for Health made the casual error of understating taxable income and accordingly seriously underestimating collections from the levy on this income. This conveniently allowed him to mount a criticism of the proposal which was built around his own error.

But then the government has a consistent record of underestimating its own costs and overstating those of its opponents.

You will remember that in the 1969 election, changes to the voluntary health insurance scheme were to cost $16M when detailed by the then Prime Minister. Within three months of the election they were estimated to cost another $I3.5M and at the end of the full year they in fact cost more again; $32M! The Minister was 100% out with his calculation.

More recently we experienced a fictitious government cost estimate of our proposals to provide contraceptives free on a doctor’s prescription. The current Minister for Health produced costings based on retail pricing. It is hard to conceive anything more unreal than a government providing free goods or services and then charging itself 27.5% sales tax on the goods or services.

Similarly, this same Minister, concurrent with his fictitious costing of our proposals on contraceptives gave an estimate of our health insurance proposals at $420M and the government supported voluntary health insurance scheme at $250M. I have earlier indicated the true cost of the government scheme at more than twice this level. What the Minister forgot to include were fund members’ contributions. He did not neglect to do that in relation to our proposal however. Where he did go astray was to give a costing of our scheme some years out of date.

But then, costing programmes has never been a strong point with the government. Even a simple sheep farmer knows that.

Health Services – Towards the View of Treating the Total Man in the Setting of his Entire Community

I have dealt at some length with the finance side of our programme. This is necessary as this seems the side which attracts most attention and concerning which most queries arise.

I mentioned in my opening remarks the need for adequate and efficient delivery systems.

In fact I see no great problems introducing and having successfully operated our Universal Health Insurance proposals. This task will represent nowhere near the challenge, and in the final result, the far more important responsibility, of upgrading, expanding, and constantly improving and evolving our delivery system.

The question is what sort of delivery system?

As things stand now what is offered is pretty much sickness oriented.

What is needed is an approach which recognises the equivalent importance of social, preventive, and rehabilitative services. A concept based on treating the total man in the setting of his entire community.

The Report of the U.S. National Commission on Community Health Services, *Health is a Community Affair* put the point nicely –

Communities must look beyond the person who is sick in bed. Each of us needs continuing health services, beginning with birth and lasting throughout our lives. Health Services should be brought to bear on the person when he is well, from the moment of birth, and the efforts of that service should be concentrated on keeping him healthy as well as on treating him when ill.

In aiming at this sort of achievement the Labor Party will set up an Australian Hospital and Public Health Services Commission to promote the modernisation and regionalisation of hospitals. In practice the Commission will be concerned with more than merely hospital services. Its interest and support will extend into the development of community based health services and sponsoring preventive health programmes as well as therapeutic services.

The Commission would work in conjunction with public health authorities in the States developing acceptable planning and evaluative systems. According to the criteria developed for these systems priorities would be identified in public health services needs. The Commonwealth would then set about a programme of financial assistance for the development of these services.

Broadly stated, our aim is at a rational, integrated system of health services where the key stress is placed on the role of the community day care centre from which primary medical, paramedical and related welfare services will be provided.

The aim, initially would be to rationalise and augment the operation of public

health services by fostering the development of a community based concept of these services focused on a fairly large central hospital.

Because of the expensive nature of some forms of treatment and of some resources and the fact that they can only be used in large hospitals with fairly large catchment areas the aim would be to encourage the appointment of those services and facilities at these large centres. In metropolitan areas there would most likely be teaching hospitals.

The more regularly used type of service can be located at smaller district hospitals where their presence can be economically utilised.

Smaller convalescent units, perhaps of a hundred beds, would serve the two larger hospitals services to relieve acute bed usage. If overseas surveys are any guide considerable waste in resources occurs because costly acute beds are unnecessarily occupied. The New York Governor's Committee on Hospital Costs reported that on any given day 10% of patients occupying acute beds in general hospitals did not need to be there;[20] a Birmingham study in 1959 by Crombie and Cross estimated that 25% of patients had no need for acute bed in-patient services; Forsyth and Logan in a 1960 survey of acute beds at Barrow concluded that 25% of men and 40% of women had no need of this sort of expensive in-patient treatment on clinical grounds.[21]

Part of this structure of services would be the development of Commonwealth sponsored public nursing homes. The purpose in developing public nursing homes is to apply market pressures on the private sector so that charges are contained, excessive profiteering eliminated, and quality of service and facilities maintained at a high level.

Nonetheless, it is preferable to keep aged people out of institutions who are able to care for themselves at home with domiciliary help. Unnecessary institutionalising leads to mental and physical deterioration. Consequently there will be a concurrent development of domiciliary and community services to provide the necessary support for those aged people wishing to retain their independence by remaining outside of an institution, but unable to achieve this without such support.

The cost of developing this sort of integrated service will be outweighed by the savings which a more rational use of resources achieves. For instance, a U.S. report suggests that high quality chronic care units can be operated at 30% to 50% cheaper than acute hospital care[22], and one British report suggests a figure of about 30% saving by caring for geriatric patients with co-ordinated medical and para-medical services.[23]

The key to the whole system would be the development of Community day health centres. If anything is to rescue the disturbing trend away from general practice it will be the practical application of our proposals on these centres. Let me give a quick sketch of what we aim at.

From these centres, the development of which we will fund with special grants under Section 96 of the Constitution and in doing so acting on the advice of our Commission of course, medical practitioners will work in joint practice. They will have publicly employed para-medicals, such as a home visit nurse, social worker, and physiotherapist, supporting them but the concept is essentially one of team work. Not a situation of a leader and the led but rather of a co-ordinator who smoothly meshed into action the various cogs in the delivery system operating from the centre. Where centres are sufficiently large enough suitable laboratory and X-ray equipment should be provided as part of the centres so that quick front line results can be provided. These would be limited in their range of course but for many needs they will be sufficient and will be as cheap as centralised services.

If I can draw an analogy with the battle field. The general practitioner and his supporting professionals operating at the Community Day Care Centre are the front line people.

This is where our field casualties are handled. The hospitals are for the heavily wounded and I want to talk about their role in a few minutes. It is out in the community that the most important area of medical practice is taking place where the front line battle continues. Increasingly psycho-social stresses are going to make demands on the skills of the medical practitioner who, accordingly, must understand the community in which he works. The neuroses treated today is the suicide of tomorrow avoided. Less dramatically it is the ulcer, hypertension or broken home of the future avoided. In this respect the Community Day Care Centre plays a prominent role in applied social and preventive medicine.

Medical education will involve the Community Day Care Centre. Future medical practitioners will ideally have had considerable experience with community medical practice while undergraduates through their training at these centres. Qualified, experienced medical practitioners working from these centres could hold faculty appointments with affiliated medical schools. It would be part of their responsibility to educate and train undergraduates attached to their centre.

I am quite convinced that the institutional orientation, the hospital domination of medical training is showing itself to be a disastrous influence. We don’t need a community oversupplied with medical specialists and gravely short of general practitioners.

Yet this is the trend that is commencing to emerge.

We are graduating enough doctors. The problem is they are by-passing general practice.

A survey by the Victorian Government Statist and Actuary has shown in that State a worsening of the ratio of G.P.’s to population in the period 1964 to 1970, from 1:2026 to 1:2045. This is evidence of

an increasing fall out from general practice to specialities and also of an increasing average age for general practitioners.

Of course the 1970 principle whereby a differential rebate paid as between general practitioners and specialists has encouraged some of this movement. This differential, unfair to general practitioners in its application, would have no place in our proposals. If a medical practitioner was accredited to perform certain procedures or services then we would receive the standard rate of remuneration agreed upon.

The major influence on this trend away from general practice, however, is being seen as the hospital orientation of medical teaching and the sorts of values, outlook and expectations this tends to give medical undergraduates. Teaching hospitals are large institutions where the tendency is towards more and more specialisation and where the orientation is towards organic medicine.

In this sort of setting teaching of community medical practice is largely theoretical and obviously suffers serious handicaps. The sort of concepts we are putting forward will give more balance to the undergraduate's training, provide him with a better appreciation of what general practice in the community setting really involves, and offer a more attractive role for general practice.

Incidentally, we have been putting forward these proposals for nearly three years now and accordingly we were gratified this year when A.M.A. policy in this area was announced. It parallels with what we have been saying. We welcome the favourable accreditation of our policy by the A.M.A. study group which has just recommended a new concept of health delivery service, which as I just said exactly parallels our scheme and which the A.M.A. stresses must be developed if the drift from general practice is to be halted and reversed.

While these centres would have affiliations with Medical Faculties and Teaching Hospitals they would not be under the control of such bodies or indeed of hospitals.

I feel it would be unwise to start spelling out in too fine a detail planning criteria for the development of these services. In the first place, as I said, the initial development of hospital services will have to be based on a rationalisation and augmentation of present public hospital services. Overseas models are only confusing and in any event are quite likely to have been developed because of different sets of circumstances.

I feel this point particularly well taken in discussion of hospital bed size. One only gets confused by referring to overseas authorities. For instance McKeown talks of centres with 1,500 and 2,000 to 2,500 beds.[(24)] On the other hand Feldstein argues his research shows that optimum economic output occurs at between 300- 500 beds.[(25)] He claims to have discovered from an analysis of various input categories that some inputs, including diagnostic and therapeutic

equipment, have economies of scale, but other especially pure labour components, have economies of scale which cancel the economies out.

Again, some overseas authorities operate on bed ratios as low as 2.9 (Barlow) and 2.0 (Reading) per 1,000 population in Britain. [26] Because of our population dispersion there would be difficulty in achieving this sort of ratio. Nonetheless there is a worrying imbalance in the distribution of hospital beds between areas.

For instance, non-metropolitan areas of Victoria hold less than 30% of the State's population but they have more than 43% of the hospital beds. In New South Wales they have 39% of the population and nearly 50% of the beds.

Perhaps this imbalance explains what seems under-utilisation of very expensive acute beds. The report cited of the US National Commission on Community Health Services suggests optimum bed occupancy at 85%-90% and goes on to assert that empty beds can be up to three quarters as expensive as occupied ones. Public Wards in New South Wales are the only beds in Australia which achieve this level of use on an overall state average basis.

In sum then, my concept of the National Hospitals Commission is of a flexible, experimenting body which will foster the evolutionary development of high standard, comprehensive community health services peculiar to Australian needs.

Within the community concept of health services, psychiatric health services must be integrated too. The Stoller Report of several years back now suggested in a typical Australian community nearly 19% of the population suffered some sort of psychiatric disturbance. More recently it has been suggested that there might be a psychiatric base to 40% of work days lost.[27] In any event, the stresses, alienation and depersonalising influences of modern mass societies and their environments will undoubtedly aggravate this trend.

Our purpose would be to integrate psychiatric in-patient services as much as possible into public hospital services and to back these up with community psychiatric day centres with appropriate medical and para-medical services.

Finally, on this point of developing community health services the question of cost arises. How much will it cost?

The short, simple and correct answer is that I don't know and nor does anyone else. The Senate Committee of Inquiry Report on hospital and health costs, cited, after favourably quoting Dr L. Wienholt, Deputy Director-General, Department of Health, who claimed that there are "great savings and great benefits" from the development of community domiciliary services, went on to admit that because of the complexity of the subject and the numerous authorities involved they had been unable to make any estimate as to the possible cost of such a programme.

On the basis of what I can see of our health delivery system we are not using our resources as wisely as we should. On international comparisons we could justifiably make a greater expenditure effort and because of our considerable wealth as a nation we are easily capable of doing so. In the light of the 1969 disability survey conducted under the joint sponsorship of the New South Wales Department of Public Health and Council of Social Services, New South Wales, which found that nearly one in four of the civilian population of that State suffers from one or more chronic illnesses, injuries or impairments, and that nearly one in ten were limited in their activities by these conditions, suggests a deficiency in our system of health services delivery. On these bases I find it hard to believe that there would be any quibbling about a determined start in developing better and new structures in this field.

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TABLE I

Expenditure on Health Services as Per Centage of G.N.P. for Selected Countries

	1968-9
U.S.A.	7.0
Austria	7.0
Sweden	6.7
Germany F.R.	6.3
United Kingdom	5.3
Australia	5.2

Table II

National Expenditures of a Non-Capital* Nature on Health Services from 1965-66 to 1969-70

	1965-66 $M.	1966-67 $M.	1967-68 $M.	1968-69 $M.	1969-70 $M.
Personal Consumption Expenditure					
Chemist Goods	366	393	422	459	506
Medical Hospital	412	487	493	597	672
Total:	778	879	915	1,056	1,178
Net Currant Expenditure on Goods and Services: All Public Authorities					
Public health	258	287	322	365	416
(1) Total:	1,036	1 ,166	1 ,237	1 ,421	1,594
(2) G.N.P.	20,965	22,772	24,318	27,270	30,098
(A) Health Expenditure as %age of G.N.P.	5%	5.1%	5%	5.2%	5.3%
Cash Benefits to Persons: Commonwealth Government					
(3) Health	229	247	264	293	345
(B) Commonwealth Cash Benefits as %age of G.N.P.	1.1%	1.1%	1.09%	1.07%	1.15%
Net Current Expenditure on Goods and Services by the Commonwealth					
(4) Public Health	19	23	26	30	34
(C) Current Commonwealth Expenditure on Health Goods and Services as a %age of G.N.P.	.09%	.1%	.1%	.1%	.1%
Total Commonwealth Government Expenditure on Health as a %age of Total National Expenditure on Health Expenditure on Health	23.8%	23.6%	22.8%	22.5%	23.6%

Source: Australian National Accounts 1969-1970, Bureau Census and Statistics.
* "Australian National Accounts" do not identify private capital investment in Health Services.

Table III

Estimated Total Cost of Voluntary Health Insurance Funds 1971-1972

	Hospital $M.	Medical $M.	Total $M.
Commonwealth –			
Funds subsidies	67.5	123.2	190.7
Pensioner benefits	25.3	27.8	53.1
Repatriation L.M.O.	–	8.1	8.1
Fund Contributions	219.9	105.0	324.9
Patient fees	–	50.6	50.6
	312.7	314.7	627.4

TOTAL COST = $627M.

TABLE IV

Comparison of Government and Australian Labor Party's Alternative Scheme from the Contributor's Viewpoint

Gross Income		Australian Labor Party Proposal				Government Scheme				
				Contribution as a % of			Cost of Contribution		Net Contribution as a % of	
Annual	Weekly	Taxable Income (a)	Contribution (b)	Taxable Income	Gross Income	Taxable Income (c)	Gross (d)	Net (e)	Taxable Income	Gross Income
$	$ c	$	$ c	%	%	$ c	$ c	$ c	%	%
2210	42.50	1313	–	–	–	1313.00	–	–	–	–
2360	45.38	1448	–	–	–	1448.00	–	–	–	–
2520	48.46	1592	–	–	–	1563.23	28.77	24.52	1.57	0.97
2600	50.00	1664	22.46	1.35	0.86	1606.45	57.55	48.15	3.00	1.85
2860	55.00	1898	25.62	1.35	0.90	1811.68	86.32	71.06	3.92	2.48
3120	60.00	2132	28.78	1.35	0.92	2045.68	86.32	69.13	3.38	2.22
3380	65.00	2366	31.94	1.35	0.95	2255.76	110.24	88.26	3.91	2.61
3640	70.00	2600	35.10	1.35	0.96	2489.76	110.24	85.32	3.43	2.34
3900	75.00	2834	38.26	1.35	0.98	2723.76	110.24	84.53	3.10	2.17
4160	80.00	3068	41.42	1.35	1.00	2957.76	110.24	82.73	2.80	1.99
4420	85.00	3302	44.58	1.35	1.01	3191.76	110.24	80.32	2.52	1.82
4680	90.00	3536	47.74	1.35	1.02	3425.76	110.24	80.14	2.34	1.71
4940	95.00	3770	50.90	1.35	1.03	3659.76	110.24	77.77	2.13	1.57
5200	100.00	4004	54.05	1.35	1.04	3893.76	110.24	77.64	1.99	1.49
5460	105.00	4238	57.21	1.35	1.05	4127.76	110.24	74.27	1.80	1.36
5720	110.00	4472	60.37	1.35	1.06	4361.76	110.24	74.27	1.70	1.30
5980	115.00	4706	63.53	1.35	1.06	4595.76	110.24	74.27	1.62	1.24
6240	120.00	4940	66.69	1.35	1.07	4829.76	110.24	71.34	1.48	1.14
6500	125.00	5174	69.85	1.35	1.07	5063.76	110.24	71.34	1.41	1.10
6760	130.00	5408	73.01	1.35	1.08	5297.76	110.24	71.34	1.35	1.06

(a) Gross income *less* 10% (taxation concessions other than family concessions) and then less $676 (family taxation concessions, wife and 2 children)
(b) 1.35% of annual taxable income; incomes below $1600 are exempt under A.L.P. scheme
(c) Equals (a) above less the gross cost of tile contribution (see (d) following)
(d) Contribution as in new Government Health Insurance Scheme–
(i) 84 cents per week for medical benefits (N.S.W. only)
(ii) 82 cents per week for hospital benefits, public ward
(iii) $1.28 per week for hospital benefits, intermediate ward

Combined contribution – $86.32 for public ward scale
– $110.24 for intermediate ward scalerd

When income is –
$46.50 per week or less – No contribution
More than $46.50 per week and up to $49.50 per week – 1/3 of contribution payable = $28 .77
More than $49.50 per week and up to $52.50 per week – 2/3 of contribution payable = $57.55
(e) As the gross contribution is a taxation concession, the net cost to the contributor is his gross cost less taxation savings(based on appropriate taxation scales).
(Compiled at request by Commonwealth Parliamentary Library Legislative Research Service)

Table V

Payment for Hospital and Medical Care Estimates and Estimates for Proposed Universal Health Insurance Scheme 1971-72 est.

	$M Hospital	$M Medical	$M Total
PRESENT SCHEME			
Outlays –			
• Hospital Fees	266.1		266.1
• Doctors' Fees		301.0	301.0
• Administration Expenses of Benefit Funds	20.5	15.4	35.9
• Surpluses of Benefit Funds	26.1	-1.7	24.4
	312.7	314.7	627.4
Met by –			
• Net Patients' Fees	–	35.4	35.4
• Net Insurance Contributions	153.9	73.5	227.4
• Commonwealth Government Benefits	92.8	159.1	251.9
• Tax Concessions	66.0	46.7	112.7
	312.7	314.7	627.4
PROPOSED UNIVERSAL HEALTH INSURANCE SCHEME			
Outlays –			
• General Grants	261		261
• Payments to Honoraries	20		20
• Pensioner and Repatriation Patients		44	44
• Other Patients		255	255
• Administrative Expenses			16
			596
Met by –			
• Individual Contributions @ 1.35% taxable income, within limits			243
• Commonwealth Contribution			353
			596
NOTE:			
Present Government contributions –			
• Commonwealth Benefits	251.9		
• Tax Concessions –			
(i) Contributions to benefit funds	97.5		
(ii) Net medical expenses	15.2		
	364.6		

Table VI

Comparison of A.L.P. and Government Subsidised Health Insurance Schemes for Low Income Families Based on Year 1970-71.

	Annual Income		**Personal Contribution Rates**	
	Approx. Gross	Taxable	Labor Scheme	Govt . Scheme (a)
Family size – Man & Wife, plus –	$	$		$ a week
One child	$2678 ($51.50 a week app)	$1890	Nil	Nil
Two children	$2834 ($54.50 a week app)	$1890	Nil	$0.56
Three children	$2990 ($57.50 a week app)	$1890	Nil	$1.11
Four children	$3146 ($60.50 a week app)	$1890	Nil	$1.66
Five children	$3302 ($63.50 a week app)	$1890	Nil	$1.66
Six children	3458 ($66.50 a week app)	$1890	Nil	$1.66

(A) Based on N.S.W. medical and public ward weekly contribution rate of $1.66 a week.

ABOUT THE FABIAN SOCIETY ...

You are invited to join the Victorian Fabian Society, and play a part in restoring purpose to Australian politics.

The Fabian tradition is one of achieving social progress through research and education. Bernard Shaw and the Webbs began it, and generations of Fabians have placed its stamp on every facet of British society. British Labour leader, Harold Wilson, is a Fabian, as were Hugh Gaitskell and Clement Attlee. In 1947, Australian Fabians formed the Victorian Fabian Society, which has grown rapidly, and now includes among its members political, professional, trade union and academic figures.

In the second half of the 20th century Australians have still to make up their minds whether their country is a distant outpost of Europe, an isolated southern continent, or a neighbour of South-East Asia. Internally, a misallocation of economic resources, an education system inadequate to the point of irrelevance and continuous failure to face the problem of regional development give the lie to an official image of a society on the move. Throughout a crucial period in Australia's history, politics have oscillated between the trivial and the half-hearted, the short-sighted and the absurd.

The Victorian Fabian Society is an organization dedicated to the proposition that this need not be so. Its members are democratic socialists who believe that solutions exist to Australia's problems; and that, given the chance, responsible Australians will both define these solutions and find the politicians to implement them. From this it follows that the aim of the Society is to create informed, articulate public opinion, to restore purpose to Australian politics and vitality to Australian democracy. In furthering this aim, it both carries out and commissions research , publishes books, pamphlets and periodicals, and conducts forums, seminars, symposia and conferences.

The Society has no policy beyond that implied in a general commitment to democratic socialism, makes no political statement and issues its publications as the opinions of their authors and not of the organization. As a democratic socialist body, it maintains an informal relationship with Australia's democratic socialist party, the A.L.P., and does not admit members of parties other than the A.L.P.

If you believe that reason, education and ideas should play a larger part in Australian politics, if you care about the quality of the society we live in and the direction it is taking, and if you share the ethic of democratic socialism, the Victorian Fabian Society would like to number you among its members.

Membership of the Victorian Fabian Society is open to all Democratic Socialists

Write for particulars to
The Secretary Victorian Fabian Society
Box 2707X GPO
Melbourne 3001

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