Caring for our future

A special report

CROAKEY HEALTH MEDIA
Introduction by Croakey: So much of our day-to-day attention is focused on the problems facing healthcare systems now. Lifting our gaze to envision the likely future challenges – say in 2050 – can help set a course forward.

In this special report, Croakey editor Jennifer Doggett gazes into a health policy crystal ball, providing advice to the policymakers of today around five key themes: health financing; workforce; technology; climate and planetary health; and patient and community involvement in healthcare.

This article is published in collaboration with cohealth, a not-for-profit community health organisation, as part of their Health Equity Champion membership of the Croakey Health Media funding consortium.

Jennifer Doggett writes:

For three years on the frontline of a global pandemic, our health system has been focused on meeting the short-term demands of this rapidly changing crisis.

Time and energy for long-term planning have been scarce, but this is critical now in order to set our health system up to meet the demands of the future.

It is impossible to predict exactly what these will be but we certainly know enough about key trends impacting our health system to make an educated guess about our future population health needs.
As well as planning for these predictable demands, we also need to ensure we are prepared for unlikely but potentially catastrophic events. The COVID-19 pandemic has demonstrated the importance of comprehensive disaster preparedness, which also means addressing health inequities and the social determinants of health.

Thinking about the sort of health system we will need in 2050 can help us make changes now to ensure we are able to meet these future health challenges.

This article draws on the expertise of three senior cohealth leaders: Dr Richard di Natale, cohealth public health adviser, GP and former leader of the Australian Greens; Research Chair, Professor Virginia Lewis; and Dr Kim Webber, former Executive Lead - Strategy, Impact & Development.

As they gaze into the health policy crystal ball, these health leaders make some predictions for the future and provide advice to the policymakers of today about in five key areas: health financing; workforce; technology; climate and planetary health; and patient and community involvement in healthcare.

**Financing**

In 2050 Medicare, if it still exists, will be almost 70. This would make it an exceptionally long lived government program but this is not unprecedented in the health sector (the Pharmaceutical Benefits Scheme was established in the 1940s and is still going strong).

Compared to the PBS, however, Medicare is a complex program that will be more challenging to evolve to ensure it keeps pace with Australian’s changing healthcare needs. While it remains popular with the community and (at least in name) has bipartisan political support, there are already clear signs that Medicare’s design is not ideal for our current needs.

The structural deficits within Medicare are likely to worsen as the burden of disease continues to tip towards chronic and complex conditions, which require a coordinated, long-term and multidisciplinary approaches to care.

These deficits will be compounded if future governments fail to adequately fund Medicare to deliver on its original vision as a universal health program.

Di Natale describes ongoing under-funding of Medicare as a reflection of a shift in political thinking of healthcare as an individual responsibility rather than governments having a central role. This, he says, risks resulting in a two tier United States-style health system. One example of this approach he cites is the public subsidy of private health insurance.

A challenge for the future will be to maintain the universality and equity of Medicare, and fund it adequately, while also introducing the needed reforms to ensure it keeps pace with changing community needs.

“Future proofing” Medicare, Di Natale suggests, should involve moving towards a single funder for healthcare which would increase efficiency of health spending and avoid incentives currently built into the system that encourage cost shifting between governments and services.

“If something in the health system costs tax payers more but costs one level of government less, they will still do it,” he says.

Di Natale and Webber both argue for a move away from a strictly activity-based, fee-for-service funding system for primary care, towards alternative approaches, including blended payments to incentivise outcomes such as quality of care, patient experience, prevention and health promotion.
Webber also stresses the need to address the geographic inequities inherent in Medicare, which she describes as a system where health financing is driven by the needs of the health workforce rather than those of patients.

“We need to put the dollars where the patients are – not where clinicians are, and this is difficult to do when the bulk of funding for primary healthcare is funnelled through private general practice,” she says.

Webber cites as evidence the failure of Primary Health Networks (PHNs) to make significant changes to the equitable distribution of health services.

Di Natale and Webber both recognise that while regionalised health funding and governance would be the most effective strategy for ensuring a fair allocation of healthcare resources and driving innovation, this will be difficult to achieve due to opposition from the medical profession.

All three experts also agree on the need for reform of health financing to incentivise quality care and outcomes, rather than process and services, but Lewis warns that it can be difficult to ensure incentive payments deliver better care.

“One problem is that for any given incentive program, there is a proportion of the medical profession who will take the payment without changing the service they provide,” she says.

“This means that an incentive might allow good GPs to improve their services but also enable ‘bad’ GPs to make more money without providing any additional care.”

Lewis also describes the complexity of measuring outcomes in primary healthcare, saying that overly simplistic approaches can ignore the factors in primary healthcare that deliver the most value.

“There is a risk in making things all about outcomes,” she says. “Outcomes-based models which work in hospitals are a disaster when applied to community health.”

Lewis explains how in a system with both public and private providers, incentives for particular patient groups or outcomes can lead to cherry-picking by private GPs.

This can leave public providers, such as community health services, to pick up the patients who have more complex needs and complicated circumstances which require more time, thus threatening the financial sustainability of services.

“It’s difficult to devise sensible ‘outcomes for core community health activities like health promotion, community development, community engagement, which then devalues them and can lead to funding being withdrawn or becoming so narrow and constrained that people can’t do their jobs,” said Lewis.

“But also it’s very hard to develop a KPI for the work associated with ‘doing’ inter-disciplinary, team-based care,” she said.

These concerns highlight the importance of developing more sophisticated mechanisms for measuring and incentivising quality care and health outcomes, particularly in primary healthcare.
**In summary**

If these reforms – single funder, regional funding, better ways of measuring outcomes – can be implemented between now and 2030, there is a good chance that Medicare will still exist in 2050 as an equitable and efficient funder of universal healthcare, which supports the provision of high quality, coordinated and multidisciplinary chronic disease prevention and management. Avoiding these issues and bowing to pressure from interest groups to resist reform will result in the further erosion of Medicare due to its ongoing inability to provide effective care for chronic and complex conditions. This in turn will lead to disillusionment within the community as the market provides alternative options for those with means, with Medicare remaining as a safety-net only for the most disadvantaged and ultimately one which is easy for governments to cut when budgets are tight.

**Workforce and roles**

As our healthcare needs change, so should our health workforce. In practice this has proved to be difficult as professional groups resist changes that they perceive will reduce their power or influence. This means that the way we educate, train and regulate our health workforce has changed little over the past 30 years, despite significant shifts in the burden of disease.

This failure to evolve is one factor contributing to current health workforce challenges, which include widespread workforce shortages, a maldistribution across geographic areas and the under-utilisation of many health professional groups, including nurses and allied health.

These problems have taken decades to develop and cannot be solved in the short-term. Therefore, we need to start planning now if we are to have a health workforce that can meet our needs in coming years.

Webber suggests that establishing a sustainable primary healthcare workforce should be the first goal for workforce reform.

Health financing changes, such as those outlined above, are important to change the current system, which allows specialists to charge increasingly higher fees while GPs remuneration lags behind. Webber says this has made general practice an unattractive career path for many medical students, leading to an overall shortage of GPs with particular impacts on rural, regional and disadvantaged urban areas.

Medicare reform to build more flexibility into primary healthcare funding would support a genuinely multidisciplinary approach and take the pressure off the general practice workforce, thus making this career choice a more attractive option for medical students.

Workforce reforms could also involve breaking down some longstanding professional divides within other health professions, such as between nurses and doctors, or between GPs and specialists.

Webber suggests that one option could be to focus on skills rather than qualifications within the health workforce, with a new approach to health and medical education that is focussed on core minimum level competencies across disciplines.

This would require a new credentialling and regulatory framework, based around competencies and experience rather than professional roles.
Lewis also sees some merit in this type of approach but both she and Webber suggest that the power of unions and professional groups is a barrier to making these changes.

One example Webber gives of changing primary healthcare teams is cohealth’s recent move towards making peer navigators a key role in healthcare teams.

“Peer navigators understand the system and speak the language of both consumers and providers. They are the key people to join up the system, a role we currently expect GPs to perform but which does not usually occur. We can learn how this works from Aboriginal Health Workers here – they are ten years ahead of the rest of the health system.”

Another bold suggestion from Di Natale is to review the way in which we allocate provider numbers, in order to increase the number of doctors in areas of need.

“Clearly, a system that allows for an oversupply of GPs in high income areas with huge gaps in other areas is not the right system,” he says.

Webber, Lewis and Di Natale all nominate the political power of the medical profession as a barrier to progressing workforce reforms like this that would provide more flexibility and better value for consumers, particularly important in rural and regional areas.

Di Natale says some health groups dress up their own self-interest in the guise of patient safety.

“We need to challenge some interest groups and allow sensible, evidence-based reforms that are in the interest of the community, for example, expanding the role of pharmacists to provide some vaccinations,” he says. “Without allowing health professionals to work to their full scope of practice, GPs will be unable meet the care needs of their community and many patients will miss out on services which could be provided safely and efficiently by other health professionals.”

Along with the power of vested interest groups, Di Natale identifies an overall lack of planning as one underlying reason for our current workforce problems, exacerbated by the abolition of Health Workforce Australia in 2014.
**In summary**

Australia clearly needs to establish a comprehensive health and aged care workforce planning process to set the foundation for a future health workforce that can meet our healthcare needs. Without robust planning and the political will to resist pressure from professional vested interest groups, the most likely scenario in 2030 will be a hyper-concentration of health professionals in areas of high income where they can generate supplier-induced demand. Meanwhile, many other areas, including disadvantaged communities and rural and regional areas, will have little or no access to healthcare.

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**Technology**

Technology has already transformed many areas of healthcare and promises to be an even more disruptive force over the next 30 years. Advances in digital and information technology are likely to change almost every aspect of healthcare, including how and where we access services, processes for the diagnosis and treatment of illness and the ability to personalise medicine based on individual genetic profiles.

Improving the use of technology offers opportunities for improving communications across providers and sectors, but can also present ethical challenges and risks widening existing health inequities across the Australian population.

Lewis suggests learning from our experience with e-health during the COVID-19 pandemic and ensuring we keep patient experience at the centre when introducing new technologies in the future.

“We need to make sure we preserve the human element of healthcare while implementing mobile health and e-health,” she says. “We need a good understanding of where something like remote monitoring works well and where personal contact and a face-to-face visit with a health professional is beneficial.”

Webber echoes this view, stressing the relational nature of healthcare and that this could be undermined if technological-driven reform is driven by clinician or business needs, rather than those of consumers.

Di Natale sees technology as driving a major shift in the clinician-led model of healthcare as entrepreneurs enter the market with tech-based solutions allowing consumers to monitor their own health and engage with health providers in non-traditional ways. This, he says, comes with both potential benefits and risks, and it is important that we plan for both.

“In 50 years people will be using technologies that today we can’t conceive of,” he says. “Policymakers need to make sure we have a rigorous framework to evaluate them so that governments can take advantage of technologies which are good for patients and deliver good value. We currently have a framework for evaluating medicines and technologies but it’s not built for the emerging individual healthcare technologies – we need to move quickly, otherwise these will get away from us.”

Di Natale cites a lack of understanding of new technologies within government as one of the barriers to an effective system of regulation and evaluation.

“Often the people who hold institutional power don’t understand new technologies,” he says.
Di Natale notes that it took a pandemic to accelerate uptake of existing technologies such as e-health, stating that ideally in the future we shouldn’t need external pressures such as this in order to progress evidence-based reforms.

He highlights the need for planned, evidence-based and value-driven approaches to adopting new technologies, coordinated across sectors and jurisdictions.

**In summary**

Continuing with our current ad hoc and piecemeal approaches will make it difficult for future governments to direct health spending into technologies that deliver maximum value to the community.

This could lead to increased spending on low value technologies or even those which have a harmful impact on community health. It could also mean that those who are already marginalised being further disadvantaged through unequal access to health technologies or through having their personal data used to discriminate against them in areas such as insurance or employment.

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**Climate and planetary health**

The World Health Organization has called climate change the **biggest single threat facing humanity** and we can expect climate disruption to increase over the next 30 years, even if we were to act immediately to significantly reduce our carbon emissions.

Di Natale nominates two main ways in which climate change will impact the health system of the future. Firstly, it will result in an increase in extreme weather events, leading to a greater demand for emergency response and acute healthcare services. Secondly, given that our health system is a huge consumer of resources, it will require us to focus on increasing overall health system sustainability.

He also suggests that the health impacts of climate change may force us to broaden the current narrow focus on health policies and programs to include environmental and other determinants of health, such as access to affordable energy, heat-resistant housing and green spaces in the community.

“We need to see the home and urban environment as part of health infrastructure. Currently the design of our houses and cities is determined more by developers than human health,” Di Natale says.

As with many other determinants of health, Webber also reminds us that climate change will have a disproportionate impact on those with the least resources.

“The quality of public housing is an issue,” she says. “People in high density, high rise apartments struggle to stay cool in the summers – sometimes air conditioning is only available in the common rooms. People who are sleeping rough are also impacted adversely.”

Webber suggests a need for more public messaging around heat to educate the community about how to reduce its health impacts. She also warns health services to prepare for increasing numbers of climate refugees, who are likely to have high healthcare needs and, unless policies change, will not be eligible for Medicare.
In summary

Even if we step up adaptation and mitigation efforts, the impact of climate change will still be devastating. However, investing in our emergency response capacity now will ensure we are in a better position to protect communities from the worst climate-fuelled natural disasters in the future. Resourcing the community health and social services sectors will ensure they can identify people at risk and put measures in place to reduce the inequitable impact of climate events on the most vulnerable.

These changes need to go beyond the health system to include improved urban design, including more climate-resilient housing, public transport and green spaces. Dealing with the problems of housing affordability and renters’ rights will also help reduce future high rates of housing instability, which exacerbates the adverse impacts of climate change.

If we fail to take these actions, our health system will become increasingly overwhelmed by the impacts of climate change.

At the community health level, this would mean higher rates of acute problems relating to extreme heat as well as a range of chronic conditions, such as heart disease, asthma and mental illnesses. Without an increase in resources to meet these demands, there will be more preventable deaths among those at higher risk, including the elderly, people with chronic conditions and disabilities and those with other disadvantages.

Patient and community involvement

The role of patients and the community in our health system has changed dramatically over the past 30 years and this trend promises to continue into the future in ways that could fundamentally change the relationship between consumers and providers.

Di Natale has noticed this change over the course of his career and can see both positives and negatives in increased access to information. On the positive side, he agrees it supports consumers to take more responsibility for their own health but on the negative side he says misinformation is rife and for some consumers it can heighten anxiety.

He sees this ongoing trend as leaving behind the old model of consumers handing over all responsibility for care to their doctor towards a new approach with a doctor in more of a consultant role, working with patients to discuss options and jointly develop treatment plans.

Di Natale warns that inequitable access to health information will reinforce existing patterns of privilege and disadvantage. He cites research showing that currently information about basic health issues, such as nutrition, varies significantly with socioeconomic status. He argues that this inequity is likely to increase as technologies available in the future to monitor and diagnose health conditions are not shared equally across the community.

Lewis suggests that a high priority for improving patient and community engagement in healthcare should be to become more skilled at sharing the power appropriately between health services and consumers, a relatively new concept for our health system, which she says we are still navigating.

“It’s important that we work out the complexities of this relationship in order to maintain autonomy for each party, while recognising their different skills and experiences,” Lewis said.
“Our current approaches lack subtlety and are not always effective but hopefully in 30 years we will have worked out how to share power and have a more sophisticated approach to co-designing services, which recognises differences in power and differences in what parties bring to the partnership.”

**In summary**

If we fail to transform these dynamics, the promising trend of increasing patient and community engagement may fizzle out after not being successful in delivering what either group wants. This will be a missed opportunity for achieving the benefits that come from moving away from a provider-centric approach to healthcare.

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**Facing the future**

Our health system of 2050 will have to address some “known knowns” such as climate change, an ageing population and increased rates of chronic disease. It will also face “known unknowns” such as technological advances and changing community preferences – and no doubt some “unknown unknowns” as well.

As we prepare for these future challenges, it is worth asking what the role of the community health sector will – or potentially could – be.

The community health sector once played a major role in the provision of primary healthcare in Australia but since the 1970s this role has dwindled. Will this trend continue or will 2050 see a return to the centrality of community health centres as providers of integrated, place-based primary healthcare?

A strengthened and expanded community health sector would have the potential to address many of the health challenges expected in the future. Community health centres already have expertise in delivering the type of multidisciplinary and coordinated care required for the effective prevention and management of chronic disease and, as outlined above, they would have the ability to implement many reforms that are difficult to achieve within traditional general practice due to opposition from the medical profession.
One pre-requisite for an expanded role for Community Health Centres is increased awareness of this sector at the federal level among politicians and policymakers. Because Victoria is the only state with a generalist community health sector, there isn’t an awareness among policymakers in Canberra of the potential of community health as a scaled up model.

That may be about to change, as the recent Strengthening Medicare Taskforce recommended a move away from episodic care delivered by GPs towards a multidisciplinary, team-based approach, mirroring the community health model of care.

Successful advocacy by the community health sector to decision makers at the federal level could see a health system in 2050 which, in addition to having Aboriginal Community Controlled Health Organisations or ACCHOs, has a national generalist community health sector that runs on the principles of community involvement in governance, and which provides interdisciplinary care, and is successfully advocating for greater action on the social determinants of health.

However, without such advocacy to policymakers, existing community health services risk becoming further marginalised, providing only niche services in specific areas with little broader awareness of their role or potential.

In this scenario, we will continue to see policymakers still making futile efforts to make a private general practice sector based upon fee-for-service address increasingly complex health and social problems. This will prove ineffective and inefficient, and ultimately will be damaging for the health and wellbeing of Australians and for our social fabric.

This report is published in collaboration with cohealth as part of their Health Equity Champion membership of the Croakey Health Media funding consortium. The article was researched and written by Jennifer Doggett, and edited by Dr Melissa Sweet and cohealth. Layout and design by Mitchell Ward.

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