Ben Chifley Memorial 'Light on the Hill' Dinner 20 September 2008

"The Light on the Hill: History Repeating"

It is an honour and a pleasure to be here tonight to deliver a speech in memory of one of the Labor Party's greatest leaders, and just as importantly, one of this country's greatest leaders.

When Ben Chifley spoke to the NSW ALP Conference in 1949 he uttered some words which have never been bettered in their clear description of the aim of the Labor movement:

> "a movement bringing something better to the people, better standards of living, greater happiness to the mass of the people. We have a great objective – the light on the hill – which we aim to reach by working the betterment of mankind not only here but anywhere we may give a helping hand. If it were not for that, the Labor movement would not be worth fighting for."

They are words which every Labor politician carries in their heart.

Tonight I want to talk to you about my passion for health, and why I believe that good health policy is at the heart of Chifley's vision of "bringing something better to the people".

Health has long been part of the labour movement. One of the reasons workers originally formed friendly societies – and in turn trade unions – was to provide themselves and their fellow workers with financial support and care if they were sick or injured.

Workers understood that good health was essential to an individual's ability to earn a living. And this remains just as true today – health has a direct impact on workplace participation, productivity, and national prosperity more generally.

Still today health status is one of the greatest markers of inequality in our society. And while there have been many amazing medical advances since Chifley's time, we now face a new set of challenges which threaten to entrench that inequality, while slowly destroying the health and prosperity of our community.

As you'll see, tackling this new set of challenges in order to address age old inequalities in health status has set me on a path not dissimilar to some of my Labor forebears – who faced determined resistance in their efforts to provide cheaper medicines and universal health care – elements of our health system which have come to seem like cricket, or the Aussie BBQ – part of the fabric of our nation.

But tonight I want to explain to you why I believe the changes we're pursuing – the next generation of health reform – will be just as important in strengthening our health system as the reforms Chifley embarked upon in pursuit of the Light on the Hill all those decades ago. And you'll see that in order to deliver those reforms, some of the battles Labor fought in the past may now have to be fought all over again.

PBS

Take the Pharmaceutical Benefits Scheme, or PBS – which today provides around 700 drugs and more than 3,000 brands, free or at little cost, for millions of Australians every week.

It was Ben Chifley, under John Curtin, who took the stance that the new wonder drug penicillin – discovered by an Australian scientist – should be made available to all Australians – and pressed ahead with a benefits scheme to subsidise it.

The British Medical Organisation – the precursor to today's Australian Medical Association – rose up in anger. Arguing that the Pharmaceutical Benefits Act was the first step towards a nationalised medical service, they took their opposition to the High Court, and won.

In the referendum that followed, voters agreed to give the Commonwealth powers to provide pharmaceutical, sickness and hospital benefits, and medical and dental services, with the proviso that this did not involve 'civil conscription'.

As you know, Australians don't like voting "yes" in referenda. Only 8 out of 44 have been successful.

In this case, the public ignored the caution of the medical profession, and voted to endorse access to cheaper medicines.

By the time the Pharmaceutical Benefits Scheme came into operation in 1948, it had been passed twice, overturned once; and had been the subject of a national referendum and a constitutional challenge.

In 2008, the PBS is the envy of many nations, and is supported by the Liberals and the AMA. But what now seems like the height of common sense, took a long, determined, and quite political fight by Labor to embed in Australian society.

And for that, we have Ben Chifley to thank.

Universal health care

Let's turn then to Medicare. Everyone knows that it was Labor's Gough Whitlam who achieved universal health care for Australians. But it was Chifley who put it on the national agenda. Much like the PBS, Chifley's plans for health met firm resistance.

The Australian Dictionary of Biography states that Chifley's attempt to introduce his health scheme "foundered on the intransigence of the British Medical Association in Australia".

In this instance, his plan for a "free, comprehensive" health system was not to be. It was not until the election of the Labor Government in 1972 that a proposal for universal health insurance was revived.

In just 3 years, the Whitlam Government changed the face of the country. Whitlam and his Ministers granted indigenous Australians self determination and land rights, made tertiary education accessible to all, and introduced equal opportunity laws for women.

These were all major reforms.

But ranking alongside any of them in its enduring impact on Australia was the Whitlam Government's introduction of a universal health insurance scheme – the precursor to Medicare.

From the beginning, Whitlam's proposal was met with strong opposition. As soon as his interest in a universal health insurance scheme became public, the Australian Medical Association voiced its disapproval.

Doctors' groups waged an intense propaganda campaign against universal health insurance, comparing the Whitlam Government to a Nazi regime. They even raised money for what they called a "Freedom Fund".

A set of bills to implement a universal health insurance scheme was drafted. Over the course of two years the bills were defeated by the Senate three times – the Liberals blocking their passage. Universal health insurance was among the measures on which the Governor-General granted the double dissolution of 1974.

It was only when Whitlam was returned with a victory, having campaigned heavily on health, that the bills were finally passed, on the thinnest of margins, at the first and only joint sitting of both Houses of Parliament.

The doctors didn't rest though. They established a campaign to "fight socialist medicine and protect the freedom of doctors and patients". They raised funds to lobby MPs. They mobilised their members.

But by this time the public was pretty determined in their support for universal health care, and by 1975, the Liberals were too afraid to try to remove it altogether.

They did try to trim back the proposal – but the election of the Hawke Government in 1983 reversed the tide once and for all with the introduction of Medicare to provide all

Australians with access to quality health care, regardless of their financial means. John Howard said at the time that Medicare was an "unmitigated disaster" which had "raped the poor" – a position his Government later reversed, claiming it was the "best friend that Medicare ever had!".

And so what we have seen, over time, is a clear cycle – Labor introduces a signature health reform; it is opposed by the conservatives, and by the medical profession; as it gathers public support, the fight is won;

and the Liberals are forced to accept that the reform has won community support and a firm place in Australian society.

Today, Medicare – and its goal of providing universal access to health services for all Australians – is no longer just a program. It is now central to our sense of our selves as a nation and as a people. Again, we have our Labor forebears to thank.

Crossroads

We now stand at a crossroads.

Both the PBS and Medicare are being challenged by demographic and economic trends. Without pursuing further reforms, the work that has been done by our forebears will quickly be eroded.

Without change, Australian Government spending on health is projected to almost double as a proportion of GDP over the next forty years, with spending on medicines projected to grow the fastest of all health factors.

At the same time, the invasion of our lives by chronic diseases like diabetes and heart disease – and the early death that they bring – threatens the sustainability of Medicare, and poses new challenges for the way we think about delivering health care.

Finally, in discussing the challenges facing Medicare, we must also confront the ways in which Medicare has failed us.

As part of considering how we design our health system to confront new challenges, it's time to accept that for all the benefits Medicare has delivered to millions of Australians, year in year out, there are still major health gaps we have yet to close.

We know that health is a major indicator of inequity.

If you want to judge how affluent a suburb is, you could check its tax returns – or you could look at its medical records. Rates of diabetes, of heart disease, early deaths, infant mortality, how many teeth a person has left – all are clear markers of socio-economic status.

We like to think that we left class back in the twentieth century, but inequality continues to stare us in the face.

To put it another way – Medicare has achieved a lot, but it has not achieved all we need it to.

Just one example of the vast differences in mortality from cardiovascular disease across socio-economic groups makes the point.

Dr Gavin Turrell, a senior research fellow at the Queensland University of Technology, found that over just two years, thousands of deaths would have been avoided if every area in Australia had the same mortality rates as the most advantaged 20 per cent of areas.

Among men aged 25 to 64, almost 20,000 died before their time – because they happened to live in the wrong suburb.

Similar contrasts can be discerned between rural and urban health – something that Chifley would certainly have turned his mind to.

For example, deaths from coronary heart disease and diabetes are higher in rural and remote areas. For prostate cancer, mortality in regional and rural areas is 21 per cent higher than in capital cities.

The sad fact is these facts won't shock any of you. We all know that people with less money will die earlier. We all know that if you are less educated, you are more likely to get sick.

These facts won't shock you – but they should.

And it is of course a vicious cycle. Poor health thrives on inequality, just as inequality thrives on poor health.

This has two lessons for health policy.

First, that health policy can't exist in a vacuum. As is most clearly demonstrated by our approach to Indigenous health, we know we must simultaneously work on improving housing, education, and employment.

Second, that investing just in hospitals can play only a very limited role in addressing disadvantage. It can do a great deal of good, but the chance at early intervention, and a better life, has been lost. It is the notorious ambulance at the bottom of the cliff – not the fence at the top that stops the fall in the first place.

This means that not only is prevention a key weapon in the arsenal of health; it must also be at the forefront of reform for social democratic governments across the world, as we strive to redress inequity.

It is not only a tool of health policy; it is a crucial aspect of our wider fight against disadvantage.

To intervene at a point that might actually make a difference, we must focus our efforts on prevention – teaching kids, no matter where they come from, healthy habits; educating young adults, as their bodies begin to slow, about what they can do to avoid diabetes; giving older adults the tools to prevent heart disease.

I'm passionate about this – because it will help turn around disadvantage and give people a real go at a fulfilling and productive life.

At the moment, though, Medicare and the PBS can't help us make that leap to prevention in our health system. Our workforce, the way we fund health, and much, much more will also need to be reshaped if we are to prevent, not just cure, the illness and accidents that can afflict us all.

This must be part of the next generation of health reforms, and it is the key to achieving Chifley's vision of bringing something better to the people.

Given the vast complexity of this agenda, I can't go through each of the early commitments we have made or each part of our strategy to bring about this change – whether it be our new $10 billion health infrastructure fund, incentives to get nurses back into our hospitals, or the work of the Health and Hospitals Reform Commission.

But having outlined our vision, for which we have Chifley to thank, I want also to explain part of the framework which will govern our approach to achieving Chifley's vision.

The Prime Minister has described our Government as occupying "the Reforming Centre".

That is, we believe neither in the primacy of the market – in the treatment of people as economic units – nor in Government as the source of all wisdom.

Instead, we must strike a balance between well-designed markets that encourage innovation, and government intervention that guarantees the basic services upon which we all depend.

We must move beyond old contests – like the fight against government intervention in health services. And we must move beyond false contests, too – like the imaginary trade-off between a greater role for nurses and safe, strong patient care; or the battle between public and private health; or the division between State and Commonwealth health responsibilities.

These false divisions – often the sites of dramatic political battle – have created significant problems in the way that health services in this country are delivered. They have led to government regulation which is often poorly matched to its alleged aims, and ensured that the health landscape is dotted with badly designed markets.

By leaving old contests and false contests behind, we can focus on real challenges instead – how can we make health care more accessible? How can we shift from a focus on hospitals to a focus on prevention? How can we use health policy to tackle disadvantage? How can we deliver health care that is better quality?

Ultimately, better outcomes are what is important – and I doubt they will come from leaving markets behind or arguing for full public ownership or nationalisation. Instead, we need to ask whether we can design

markets more effectively – and how we can strike the right balance between the market and government intervention to deliver the outcomes we need.

There are several areas I could use as examples of where existing markets are working ineffectively and inefficiently – to the cost of us all – and in which the balance between government and the market is currently askew.

The first area in which we must strike the right balance is in providing incentives for individuals to engage in prevention. Even when we have delivered the best health services we possibly can, we are fundamentally looking at an issue of cultural change – shifting behavioural patterns.

Government can and should help in providing the right settings, but we also need to develop ways of encouraging people to invest early, and effectively, in their own health – and getting these incentives right will be a tough challenge.

This is closely tied to the second question – how to use our health workforce effectively. If we can get this right, we can improve access to health care for people in rural and disadvantaged communities, help to tackle inequality, and make prevention far more central to our health system.

This is the next step in the evolution of health in this country.

Getting it right will involve us looking at how we pay which health professionals.

Right now, the market for doctors' services is free in many ways (with rural health often suffering as a result) yet highly regulated in others. GPs are paid for the number of patients they see or services they deliver – not for any health impact the intervention might deliver. The current Medicare structure means a GP will receive more money for seeing ten patients in an hour than they will for seeing three patients, each for longer periods.

In other words, there is a financial disincentive for GPs to provide the type of longer, intensive visit that prevention demands – like teaching somebody how to lose weight, keep fit, and avoid diabetes.

At the same time, a GP stands to benefit equally from providing care that demands their complex knowledge and training, and a simple act like refilling a prescription for, say, the birth control pill – an extremely economically inefficient proposition!

There is a longstanding historical anomaly here. Our health system, including funding for health services, is organised almost entirely around doctors, despite the fact that many services are now safely and ably provided by other health professionals – nurses, psychologists, physiotherapists, dieticians and others.

Of course, in considering any changes, patient safety and clinical quality must always remain absolutely paramount. Doctors must and will remain central to our health system. But to date, professional resistance and government funding have prevented the development of a health sector in which services are delivered not only by doctors, but by other health professionals who are safe, potentially cheaper, and most importantly, available.

In delivering change, pricing signals are likely to be needed. Doctors will need to be prepared to let go of some work that others can safely do. To ensure this transition, there needs to be an incentive for doctors to eschew less complex work, and focus on the work that does require their high level skills and expertise. Or if doctors don't want to let go of it, to accept being paid less for devoting their highly skilled and heavily trained selves to less complex tasks than they might.

With doctors weighed down by the urgent needs of acute care, as well as unnecessary administration, we need to consider how we can unburden them of some of this work where it is safe to do so, and whether it is possible for nurses or others to take on some of those burdens – and, if so, how we make this an attractive proposition.

And in doing so, we will not only be redressing the historical bias towards medical intervention and acute care, we will be redressing the historical bias against the traditionally female nursing workforce. A few good Labor principles all tied up in one set of reforms!

This is a long term aspiration of mine – not one that can be delivered in a single Budget or without great care. But it is also one that will need leadership within the professions, not just government.

Along with shifting our health system to focus on prevention, these sort of workforce changes are a key part of what I describe as the next generation of health reforms – and will be crucial in delivering better equity in health, as well as alleviating the threats to the sustainability of our system.

Reforms are needed in our hospitals as well – and this is the third area in which we see the potential for significant reform.

This may sound like heresy for a Labor Health Minister, but the truth is I am fundamentally agnostic about the division between public and private health. I believe the opposition between the two belongs firmly under the heading of "false contest".

The nub of the problem is not that we have privileged one over the other, but that we have failed to use the competitive tension a mixed health market should provide to deliver the results we all deserve – by acknowledging the ways in which private health and public health can and do interact.

In other words, we have ignored the potential of the health market that exists right under our noses.

What I want to do is look more closely at the health landscape and ensure we are using public investment wisely and private investment just as cleverly.

Let me explain how this should work.

At present, the Commonwealth simply provides block funding to the States – with little incentive for the States to adopt innovative, effective practices in exchange for this money. We want to change that model dramatically – to fund States based on a combination of outcomes, activities and quality.

This will achieve two things. First, as with any classic market, it offers incentives for results – which encourages innovation.

Second, it allows the Commonwealth to direct its funding to where it will get the biggest bang for its buck. If private hospitals prove particularly adept at, say, elective surgeries, then we could consider redirecting more funding for elective surgery to private hospitals. This then has a flow-on effect. As other actors in the market – in this case public hospitals – lose market share, and therefore funding, they are forced to compete, either by developing different specialties, or by delivering better services. And that in turn drives further quality or innovation.

Similarly, public hospitals should be rewarded appropriately for the kinds of care they provide more effectively than the private sector – such as highly complex trauma care.

And of course this does not just have to be competition between private and public – it can encourage competition between public services, or between private health providers. The competition, though, will not just be about price and activity – quality and access must also be central.

As you can see, I do not take the view that public is necessarily good and private is necessarily bad – in both cases, it ain't necessarily so.

But to have that debate properly, we need to be prepared to acknowledge the true nature of private health in Australia. The fact is, in health, the private sector is not a true private sector – it is massively publicly subsidised.

This means that the industry has a special responsibility to be aware of not just their commercial interest, but the public's interest too. To ensure the public gets something for its investment in private enterprise – for example, new ways of co-operating to provide services to those who are missing out will increasingly need to be explored.

In these three areas – prevention, workforce, and the provision of health services by both public and private providers – a confused combination of government regulation and badly designed markets can hamper our ability to deliver the health care that people deserve

Which means health inequalities are becoming entrenched in our community.

I know that some people will protest at the very idea that health is a market. In part, they are right – it is not just a market. It is also a cornerstone of our compassionate society. In fact, this is the balance that defines the reforming centre.

What these few examples show is that both the market and the government have key roles in health – but we must be prepared to ask if we have the mix of intervention, regulation, financial support and incentives right. And especially to be prepared to keep asking what mix will enable us to provide quality care across the community and close significant health gaps in the process.

Chifley's legacy – conclusion

This is very different, I know, to the language Ben Chifley would have used when talking about health. But the spirit is the same.

Chifley's reforms – from post-war reconstruction through to free hospital treatment – were attempts to reshape our country for the future, and to improve the welfare of the men and women of Australia. They were new answers for a new time.

But they did not come easily. In his endeavours to strike out for something new, for that light on the hill, Ben Chifley met with stiff and determined resistance.

In short, he knew what it was to govern.

The wonder of Ben Chifley was that he strode forward towards that light on the hill, whatever obstacles were placed in his path – and in doing so, he inspired the entire labour movement.

This is the first Light on the Hill speech since Labor was victorious at last year's federal election. It was a great victory. It is wonderful to be here when we sit on the correct side of the House.

But that victory, hard-fought as it was, is just the beginning.

There is now much to be done. If we are to tackle inequality in this country, then reshaping health is crucial. If we are to ensure that Medicare fills the potential that Whitlam dreamed of, then there is much work ahead of us. If we want our kids to live longer, not shorter lives than us, we can't afford to rest.

Like Chifley, we will meet opposition. But I firmly believe that it is the role of a politician not simply to allow the times to shape her, but to shape the times in which she lives.

It was George Bernard Shaw who said: "The reasonable man adapts himself to the world; the unreasonable one persists in trying to adapt the world to himself. Therefore all progress depends on the unreasonable man."

On that basis, Ben Chifley was an unreasonable man – he was in fact the best of unreasonable men.

I know that many of us politicians are called unreasonable from time to time. But if that is the price of change, then it is a small price to pay.