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THE CHALLENGE OF ETHICAL HEALTH CARE DELIVERY IN THE CURRENT ECONOMIC CLIMATE

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It is clear that we are in a time of constantly balancing the provision, maintenance and management of the Australian Health and Aged Care system. It has to be accepted that this 'white water' will be an ongoing phenomena of an exceptionally complex system that is a fundamental of the fabric of our society in this country at this time. Any sense of managing through this environment to some sort of end point, needs to be replaced with a thinking that, at best, relates to achieving and passing a series of milestones well into the next millennium.

A fundamental, or even a safe guard, principle to operate in this climate and context is to underpin our individual and collective contributions and influences on this system within an established, accepted and emerging ethical framework or series of moral principles. The moral expression for the health system is fundamental both in terms of supporting and answering a need of the individual whole person, as well as in providing a series of rules or standards of behaviour to mark out a direction or context, and to be uplifting and supportive in the articulation and delivery of these milestones for Australians.

The Australian health system has not been immune from any of the western world and Australian environmental change issues over the last decade. Necessity, expectations and viability requirements in respect to enhancements in quality, issues of accountability, utilisation and productivity, have been very much part of the system's agenda for the last twenty years. In retrospect, the main issues are whether the determinant, application and outcome have been the most appropriate and successful for the health system and the Australian community. In the 1970s the divergent impact of performance change for the health system with rising costs, technological change and clinical outcome alternatives through overseas and local research, were fused against health and welfare policy changes in terms of access, equity and system delivery changes. In terms of the management of such a delivery system, this period was quite a shock to the Australian health system in terms of the need for inherent management and change skills necessary to respond to those growing divergent pressures from political, community, professional and program inherent pressures. The 1980s were marked by a continuation of these tensions, clinical practice and service based changes effecting utilisation of the health system, as well as a growing number of tools for intervention into the overall operation of the health and aged system.

Patterned or overlaid across the health system, either at macro or micro level, are in effect a series of ethical norms or framework that we base, deliver and operate the health care system from. Peculiar to the health system of course is the bioethical perspective for context, issues or problem base response in the health system. Issues of life and death - quality of life; determination of life and death; prolongation of life; suicide; euthanasia; organ donation; scientific and applied research etc., are a range of profound event and daily health service delivery responsibility issues. Pastoral behaviour - spiritual; existential well being; characteristics of humanity or humanhood; guidance by the Spirit etc., are fundamentals for the essence of the caring profession that with the science and the craft, then compound to a holistic interplay in the system. Individual or personal context - life satisfaction; physical well being; care and protection etc., are main preoccupations for the human community, and therefore mark out existing and continually changing rules for behaviour. Social and welfare context - social, economic and environmental well being have direct translation into the tension between health and ill health. Systematic or business standards of behaviour and approach - operation and management of the health system; care, well being and support for the caring workforce; corporate citizen; role model etc., are issues of behaviour responsibility for the vehicle or delivery system in its own right and its impact on direct and indirect care to individuals.

There are approximately seven hundred (700) public acute hospitals; three hundred and thirty (330) private acute hospitals; thirty (30) public psychiatric hospitals; one thousand four hundred and sixty (1,460) aged care nursing homes; and one thousand three hundred and sixty-five (1,365) hostel facilities operating throughout Australia at this time. These numbers, with the exception of the public psychiatric facilities, have remained fairly constant over the last 10 years. Within these figures that represent the system size in terms of facility numbers, there are approximately sixty (60) public and private acute care Catholic hospital facilities, and in excess of six hundred (600) aged care facilities owned by Catholic health and aged care providers. An analysis of the number of institutions providing care throughout the country are not good indicators in themselves regarding the supply facilities, as many institutions differ in size and the scope of services that they may provide. There are approximately 3.2 public acute hospital beds; 1.2 private acute hospital beds; 0.3 public psychiatric beds; 53.2 aged nursing home beds; and 39.5 hostel beds per 1,000 population.

Generally, there are higher ratios of beds per population in the non metropolitan areas of Australia, with a higher proportion of public hospital beds in non metropolitan areas compared to metropolitan areas which is partly off set by a lower ratio for private hospitals in the non metropolitan areas. People in non metropolitan areas generally have limited access to some specialities and to intensive care beds. The teaching or tertiary hospitals are located in the major urban area with greater specialisation in major urban area seen as essential to maintain skill levels and quality of care. This, and the population settlement to the vast geography of the country, means that rural and non capital city residents are more likely to require inter hospital transfers than people living in the larger urban centres.

Some five hundred and eighty-five thousand (585,000) people are employed in the Australian health industry. In the preceding five year period to 1995, there was an increase of 9% in the health care system employment overall in that period, and this was greater than the 6.4% increase which occurred in the total number of employed persons in the country for the same period. These figures represent approximately 7% to 8% of total employment in this country. The health industry is a major employer of women, providing 13% of national female employment but only 3% of male employment. The females constitute 76% of those employed in the health industry, and the proportion has remained stable from the late 1980s onwards. The occupation with the highest proportion of females is the nursing profession with approximately 93% of the registered nurses are women. In the professional diagnosis and treatment occupations, the portion of females has fluctuated in the 40% range.

Commonwealth, State and Local Government as well as Private Sector expenditure on health currently accounts for approximately \$33 billion each year. Over the last 10 years, this has represented a growth rate annually of about 3%.

Australia spends 8.5% of its Gross Domestic Product (GDP) on health care expenditure. The Organisation for Economic Co-operation and Development (OECD) comparison of this figure to other selected western countries places Australia about equally with the averaged expenditure for Canada, France, Germany, Japan, New Zealand, Sweden and the United Kingdom, and approximately 1%

less when compared with that same group but including the United States of America. The United Kingdom generally expends a lower figure in the 7% range, and the United States a higher figure in the 14% range. In our country, percentage expenditure of GDP has risen from 5.2% in 1970 through to 7.4% in 1980 and then 7.8% in 1990. While comparative with the expenditure of the other developed nation as a percentage, the growing pace of many elements of the Australian health care budget and the particular elements and proportion of those elements of the health system costs, there are growing concerns regarding health care expenditure. As an example, the Federal Health Minister, Dr. Michael Wooldridge, recently commented:

(On the Pharmaceutical Benefits Scheme) "... (upon taking up office) I was faced with a pharmaceutical benefits system that was doubling every four years off a base that was one and a half times the size of the budget of the state of Tasmania ... it was growing at a compound rate of about 15 per cent per annum. That meant that by 2001 we could expect the PBS to be roughly the size of the budget of South Australia "

The main policy debates in Australia for the last thirty years have certainly been concerned with the issues of financing and infrastructure organisation for the health system. In the last decade, this has been overlaid with issues of the organisation of health services (e.g. regionalisation, area health networks, networks etc), remuneration and training opportunities for general and specialist medical practitioners; and the provision of sustained and growing quality of care. In June of last year, the Australian Health Ministers' Advisory Council issued its final report of the 'Task Force on Quality in Australian Health Care'. This direction is articulating a vision emerging at senior policy level over the last five years of ... "improving safety and quality of care...a central concern for all those in the health care system; policy makers, managers and health practitioners alike. The current drive for efficiency must be matched by a drive for safety and quality. This involves redesign of processes and systems, both within institutions and across the spectrum of health care that consumers receive". This focusing and drawing together the issues of an expensive system to the demands and expectations of a high quality service focused on consumers needs is of course difficult.

The unfolding of review, analysis and systematic changes to our health delivery system is consistent with most western countries. In Australia in 1927, a Royal Commission on national insurance was established and this led ultimately to the enacting of the National Health and Pensions Act in 1938.

The Pharmaceutical Benefits Act was legislated in 1944; the Pharmaceutical Benefits Scheme was established in 1950 and of course major reforms to the Health Insurance Scheme in 1972 with the establishment of Medibank (now Medicare). Consistent with our Commonwealth and State Government systems of tax collection at the Federal level with Constitutional allocation of funds to States, the Commonwealth provides the Medicare Insurance Scheme, Pharmaceutical Benefits Scheme, Pensioner Medical Scheme and Nursing Home Benefits Scheme (changes to occur on October 1, 1997) with State Government responsible for the direct provision of public health and hospital services, where up to 25% of state budgets will be framed in this responsibility.

This brief overview should give a hint to at least some of the major issues and challenges associated with providing health care at this time. The issues themselves present in their own right, than again and again, with a number of perspectives or implications binding with these singular issues that produces the complex and important dilemmas faced on a daily basis.

The whole issue of resource allocation against the needs of the community is an ongoing delivery responsibility that provides daily tension at the micro level, inside organisations and ambulatory services, and at the macro level at Government and Private Sector level. This responsibility, directly or indirectly, effects people working in the health system delivery sector. By our own standards and comparison to overseas health systems, the Australian health program is of a high stature. This has been achieved through fundamental commitment in the caring profession; through education and training of Australian health professionals and support staff; national and state policy; as well as a combination of expectations set within Australian culture and the relatively world medium size of the service that enabled the detection of need and relatively straight application of solutions. Australia's health status is generally improving, single or multi dimensional measures of health for the Australian population show improvement, although much more needs to be done for vulnerable groups within the Australian community.

Australia is now entering a time when four generation families will exist. The aging of the Australian population represents great goodness in respect to life expectancy, wellness and well being. An older population also presents a combination of new challenges for a health and aged care sector to

response. Recognition of the independence in Australian society presents the need for a wider range, choice and volume of residential opportunities for older Australians. Provision of acute care becomes more complex as health problems don't necessarily relate to the aging process, but rather the issue of ill health in the older person. Australians generally consume the greatest amount of health care resources in their last year of life. Clinical decisions and bioethical issues become more complex in respect to providing the right depth of care in such a way that does not become burdensome but rather to enhance quality of life for the individual and still be cognisant of the cost of resources that are available.

Private health insurance funds are facing difficulties with the decline in memberships, particularly younger members of the community who have made contributions to the community insurance fund, but have limited claims to benefit entitlements. The process of community rating equity, where insurance fund pools are supported by a larger group of members making limited claims to funds that enable members who have high cost episodes of care claims, those with chronic illness claims and the older members of the community to be supported by the pool, becomes stretched.

Recognition of the special needs of an older patient community in the acute care setting is important. In my own hospitals at present, some 6%-10% of the adult patient population at any one time can be older people who have moved past the acute care treatment phase of illness and are in need of establishing or re-establishing appropriate longer term residential care and support. Strengthening the continuum of care between acute care facility and aged care assessment and residential care will be an important feature of the health delivery system over the coming decade.

The situation that is developing where acute care health facilities are decreasing length of time patients remain in hospitals because of technological improvements and changes in the model or approaches of care used, means that there is an emerging health environment that will not be necessarily conducive to the older patient in the sub acute or recovery phase. Many hospitals and aged care facilities are recognising the need to more tightly link to improve the transfer for people in these circumstances. Catholic health and aged care facilities are in an ideal position to build those approaches, because of the decades of experience in understanding the particular need of the

individual people at these various phases of their lives. Operating public, private and residential facilities in the 'not for profit' sector, provides a strong motivational base to articulate action in this continuum of care in many parts of the country.

In the acute care sector of the health system, staffing costs continue to amount to approximately 75% of recurrent expenditure. Despite this situation, the development and growth of technology in the health system is an important aspect that provides many ethical challenges. In technology, we mean diagnostic capabilities such as high cost bio-medical equipment, software development and laboratory testing; drug therapies; invasive and non-invasive monitoring of patients; and the emergence of new techniques or procedures that might use a number of these technological modalities. Hospitals are faced with two important aspects of technological development. Firstly, there is the affordability of the new technology and its progressive upgrades or redevelopment. Examples of this are the high cost scanning equipment that provides non-invasive diagnosis for patients that are high cost in capital acquisition because of inherent research and development costs and a relative limited market in this country. Secondly, there is the recurrent operating costs associated with the introduction of the technology. Examples include, single or multiple drug therapy that provide a regime of care for patients.

Introduction of the technology and its maintenance within the system provides challenges in terms of balancing resources available, as well as having to address the issue of while being able to care and treat patients in a better way to achieve health gain, the system is faced with a growing demand for those results.

There is stronger use of more formal outcomes for evidenced based practice in the system to validate both patient benefit and cost benefit use of these technologies. Such approaches have always been inherent in clinical practice, but more formal, rigorous and open evaluations are now needed to involve a wider spectrum of people in the decision making processes about the value of these emerging technologies.

Research and development for ongoing contribution to the sciences is a hallmark of any profession. While scientific or laboratory based research may be focused on larger centres because of the need to pool expertise, funding and collaborative research effort, many parts of the health care system routinely engage in research and development in various aspects of treatment, models of care and therapy approaches.

Research protocols and approaches are well defined within the health system, and significant contribution has been made by the National Health and Medical Research Council, in terms of developing resources and policies in this regard. Research, development and education, of course, are promoted within the health system as a fundamental to ongoing contribution of professional development and clinical practice.

Two particular areas of challenge that emerge in the research context are the issues of being in a position to offer care for more people and the commitment to ongoing funding for new technology.

Over the last twenty years, there has been an increase in delivery for drug therapy options to the health care provider. Many centres nationally and internationally now collaborate on a growing number of drug trials as part of the evidence based and effectiveness research into these therapies. Many of these trials are funded by manufacturers as part of their research and development responsibility to the new therapies. Trials established in hospitals with patient's consent provide the therapy at no cost in exchange for scientific and performance measurement reports and results for the new therapy. The health system becomes dependent on having to continue to provide patients with drug therapy after subsidised trials are completed. The issues of equity and fairness in clinical priority setting of these circumstances against potentially denying patients effective drug therapy that was previously provided at no cost. Hospitals are increasingly incorporating the need for discipline and decision making in this regard as part of the research protocol prior to the establishment of studies. These situations have reinforced the need for a more stronger and complete use of established research and ethical reviews, as well as inclusive debate concerning cost benefit and cost effectiveness of such therapies.

Public and private sector health facilities in this country have been quite progressive in terms of establishing and financing research into alternative models or approaches of care delivery. Examples such as greater use of day only surgical and medical diagnostic techniques; community care for patients in the home; outreach rehabilitation programs; and integrated delivery systems have had profound impact on the needs and ways in which hospitals provide care to patients. The Australian health care system is certainly a leader in this regard on the international scene. The concept of developing system and service seeding capital to facilitate change in processes has achieved results in our system. Difficulties arise when changes to systems or models of care enable shorter length of stay and a reduction in the need for access to services that then can cause greater demand to the system because of the now evident capacity to treat and care for more people.

Again, this environment necessitates reorganisation of services to accommodate these facilitated changes, as well as the discipline of realising at an early stage what is the potential outcomes of the research and development work being undertaken or envisaged in these circumstances. Strong linkage to research protocol and the moral expression framework are imperatives.

While Australia is one of the healthiest countries in the world and the health status of Australians generally continues to grow, there are a number of vulnerable groups within the community. There has been sustained and productive development work at national and state levels regarding research and articulation of national health goals and targets. Particular special groups such as Aboriginal and Torres Strait Islanders or those with mental illness, together with people exposed to risk factors such as alcohol and those attributed to cardiovascular disease, need to become people who receive help both through the health care system as well as in general community risk factor management. Refocussing of the health system on improving outcome well being for these people is a responsibility of all levels of the health care system.

The issues of equity and access as well as response to changing community need are areas of great importance. It is difficult in the health system to obtain rapid outcome measures of any direct or indirect interventions in these areas. The health system cannot operate alone in these

environments. It is a very difficult task at any level in the system to balance curative or interventional resourcing against preventative resourcing.

These are areas for further application of outcomes based research to enable the structuring and establishment of dedicated performance programs, but also they are areas of formal and informal debate and participation by community, professional groups and public and private sector involvement. Generally I believe there is a growing intolerance in the community regarding issues of access and equity to essential services such as health and aged care. The main elements here would seem to be the whole issue of the complexity, the questions at hand and the time and skill levels required to unbundle or unravel complex issues to enable a series of observations and possible strategies. Short term nature of the political process, the ability to articulate complex problems through media and the general complexity of life in a community, makes debate of the harder long term issues more difficult. The commitment of the Church for these fundamental social issues provides an important and credible vehicle to undertake these debates on a consistent and long term basis. The need for the continued use of this facility within the modern Church are equally important now in our modern society as over the last century.

One of the most important and difficult dilemmas in the health system at present is the position of the health profession to have to make difficult decisions and choices in this challenging health care environment. Commitment to the profession and training in the discipline certainly equips individual and groups to take on that responsibility that is consistent with being part of the caring profession. What is particularly difficult, and at times unfair, is the ultimate position of responsibility that health care professionals can find themselves in having to accept health outcome and resourcing decision have implications beyond the immediate care for the individual patient or client.

This is a particular area with issues such as resource allocation, support and advocacy for vulnerable groups in the community, as well as being a voice or an advocate for the wider community. Tolerance and support for people in the caring profession is deserved. Participation by the wider community and a deeper appreciation for the complexities and the delivery of care, is more than justified. Conviction to the issues of social response by Catholic health and welfare is an enormous

responsibility and contribution that our system can make in the discernment and debate process for the benefit of individuals and the wider community.

Finally, I believe that the issue of leadership is an area of palpable need throughout our communities. I hope I have been able to demonstrate some issues of the size and complexity of the health delivery responsibility at this time, as well as some of the successes and opportunity that exist for the formal and informal leadership that is enabled through the Catholic health and aged care system. If I am allowed to use this opportunity to ask for help and assistance in this community welfare task, then it would be to make a call for involvement of everyone in the health system. This of course can be by being informed; by being an advocate to stimulate debate in the community; by direct gifting of talents and skills to the system; by taking on any number of roles or tasks within the system. As the complexity of the system and society generally grow, there is a proportionate growth in the need for a strong leadership presence in this very viable and vital health and aged care system.

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