LEARNING OBJECTIVES

After reading this chapter and completing the activities, you will be able to:

- discuss the historical foundations of healthcare in Australia and their impact on current healthcare provision
- describe the different frameworks for healthcare in Australia
- evaluate the political and policy drivers for healthcare provision in Australia
- critically examine the impact of socio-economics in relation to both accessing health services and the delivery of health services.

KEY TERMS

Frameworks for healthcare
Liberal individualist
Health policy
Person-centred care

Social determinants of health
Socio-economics
Social gradient

Social liberal
Universal healthcare
Introduction

When asked to describe the healthcare environment, many people will begin to describe a physical environment: a hospital, or a doctor’s surgery or another of the many places that people can go to receive care.

However, this chapter will consider the healthcare environment as a combination of elements. These elements have shaped healthcare in Australia and continue to shape healthcare now and into the future. Healthcare is such a broad term that, aside from numerous definitions, we all have our own unique way of defining healthcare. Take a moment to consider a more personal definition of healthcare. Now think about people studying at university, and people in shopping centres on the weekend and a group of friends at the football: do they all have the same definition as everyone else? They probably don’t.

Just like our understanding of health, people have many different definitions of healthcare. These many different beliefs, views, ideologies and definitions create a very unique healthcare environment in Australia.

In this chapter, the elements that shape the healthcare environment will be explored, including the historical foundations, political ideologies, political and policy drivers, the impact of socio-economics, and models and frameworks.

Political ideologies

To truly understand the healthcare environment in Australia, it is important to gain some insight into the ideological differences that have long existed between the two most prominent political parties in this country: the Liberal Party—or, in some periods, the Liberal/National Coalition—and the Australian Labor Party. The Liberal Party and the Coalition partnership with the National Party have often taken a liberal individualist approach towards the provision of healthcare (Gray 2005).

This approach favours minimal government intervention in health policy, and increased roles for private medicine and private health insurance. On the other hand, the Australian Labor Party has often taken a social liberal approach, suggesting that health should be publicly funded to ensure access and equity to all citizens. The result of these differences is a continual movement in Australia between public and private health insurance systems (Gray 2005).

How health is delivered or how a healthcare system is structured is individual to the needs of the community. There are a number of different healthcare systems; some are primarily government funded through tax systems, while others are primarily funded by the individual (pay-for-service). This continued movement between public and private approaches is unique to Australia, especially when compared to other OECD (Organization for Economic Co-operation and Development) countries (Gray 2005). This unique relationship between public and private sectors extends beyond the underlying politics of healthcare, reaching into everyday healthcare
practice and resulting in both positive and negative outcomes. Given the politics of healthcare and the link between healthcare consumer/professional interaction, communication, health outcomes and perceptions of healthcare quality (Asnani 2009; Clark 2003; Wanzer et al. 2004), a deeper understanding of the origins, inner workings and future directions of healthcare should result in improved interactions, improved health outcomes and improved quality perceptions.

Universal healthcare in Australia

Australia’s current universal healthcare system is recent; however the history of its development and introduction is complex. Medicare, as we know it today, has only been in place since 1984, after being introduced by Labor Prime Minister Bob Hawke. The Hawke Government, although credited with the introduction of a long-term, stable universal healthcare system, cannot be credited with the inception of national universal healthcare in Australia. The movement towards national universal healthcare came almost 40 years before the introduction of Medicare.

In 1945, when the Chifley Labor Government came to power, a number of social reforms around health and pharmaceuticals began to take shape, as the government focused on shifting from a wartime economy (Swan 2009). Among the social reforms were changes to the constitution that gave the federal government more power over health matters. Prior to these changes in 1946, federal administration relating to health was limited to quarantine matters (Duckett & Wilcox 2011). This period was the beginning of a movement towards universal healthcare in Australia.

However, this movement towards universal healthcare was short lived. In 1949, the Menzies Liberal/Country Party Government came to power and modified the plans for national healthcare set in place by the Chifley Government. The Menzies Government opted for a health scheme that would provide free healthcare for those who couldn’t afford it, and required the rest of the population to purchase private health insurance. This approach to healthcare required means testing, resulting in the very disadvantaged having access to free healthcare and the wealthy having private cover (Willis et al. 2009). However, means testing has a tendency to disadvantage those who fall between very disadvantaged and wealthy, as they are unable to access free healthcare but unable to afford private cover. This is exactly the scenario experienced in Australia during the 1960s, resulting from a two-tiered system of healthcare provision, leaving approximately 17 per cent of the population without any health cover at all (Willis et al. 2009).

The Menzies Government remained in power from 1949–1966 (NAA 2014). Sir Robert Menzies retired as prime minister in 1966, but the Liberal/Country Party coalition continued in power until 1972, when the Whitlam Labor Government came to power. By this stage, public dissatisfaction with the healthcare system was

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**Universal healthcare**

All citizens are provided with required healthcare services and protection from financial burden when accessing healthcare services.
evident and the Whitlam Government seized the opportunity to introduce a new healthcare system similar to that proposed by the Chifley Government (Biggs 2004).

In July 1975, the Whitlam Government introduced Medibank (although credit for the Medibank concept should go to health economists John Deeble and Richard Scotton). However, the Whitlam Government was short lived, being dismissed by the Governor-General; as a result, Medibank failed to provide a long-term universal healthcare system. The Fraser Liberal/Country Party coalition came to power in November 1975 and quickly moved to modify the Medibank system. Medibank Mark II was introduced in 1976. Medibank Mark II attracted a 2.5 per cent levy on income, with the option of taking out private health cover to avoid the levy (Biggs 2004). In later years, the Fraser Government would enact a number of changes to the Medibank system, leaving it somewhat unrecognisable as a universal healthcare system.

It took until 1984 and the Hawke Labor Government for the introduction of a stable, long-term, universal healthcare system. Much like the original 1975 Medibank, the new system would undergo a name change along with changes to financing, including amendments to the Health Insurance Act 1973, the National Health Act 1953 and the Health Insurance Commission Act 1973 in an attempt to ensure its longevity.

The provision and arrangements for healthcare in any country present a number of challenges, one of the most noticeable being funding. Healthcare is expensive and needs to be financed somehow. Government-funded universal healthcare is usually funded by government income, such as taxes; however, as populations grow, the costs of healthcare also grow.

**TABLE 1.1 Universal healthcare in Australia**

<table>
<thead>
<tr>
<th>Year</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1945:</td>
<td>Chifley Labor Government introduces social and health reforms.</td>
</tr>
<tr>
<td>1946:</td>
<td>Changes to the constitution to allow Commonwealth powers over healthcare.</td>
</tr>
<tr>
<td>1949:</td>
<td>Menzies Liberal/Country Party Government provides means-tested healthcare:</td>
</tr>
<tr>
<td></td>
<td>very disadvantaged receive government-funded healthcare; all others must have</td>
</tr>
<tr>
<td></td>
<td>private health cover.</td>
</tr>
<tr>
<td>1975:</td>
<td>Whitlam Labor Government introduces the Medibank medical insurance scheme.</td>
</tr>
<tr>
<td>1976:</td>
<td>Fraser Liberal Coalition Government restructures Medibank, introduces Medibank</td>
</tr>
<tr>
<td></td>
<td>Mark II.</td>
</tr>
<tr>
<td>1984:</td>
<td>Hawke Labor Government introduces Medicare on 2 February 1984 as a long-term,</td>
</tr>
<tr>
<td></td>
<td>universal healthcare system in Australia.</td>
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</tbody>
</table>
Continued change

The differing ideologies regarding the provision and financing of health services in Australia has led to a system of constant change. However, many of the basic principles first introduced by the Whitlam Government remain in place, creating what appears to be a stable, long-term, universal healthcare system. Although stability in healthcare provision appears to be a desired outcome, change is inevitable, as Australia’s population profile has dramatically changed since the 1975 introduction of Medibank. In 1975, Australia’s population was around 14 million people (ABS 2001), and in 2014 the estimated population was around 23.5 million people. The dramatic increase in numbers is not the only change in the population profile. Increases in life expectancy, changes in disease and illness—with decreases in infectious disease and increases in chronic disease—fluctuations in fertility rates, unemployment, home ownership, interest rates and inflation, have all had an impact on the transition of a population, leading to changing demands for healthcare. These changes are not just in consumption of healthcare, but in demands for its provision and funding.

The Australian health expenditure report (AIHW 2013) estimated health spending in Australia 2011–2012 at $140.2 billion, compared to an estimated $72.2 billion in 2002–2003 (AIHW 2004). In this short period of time, total health expenditure had almost doubled. The amount spent on health can increase for a number of reasons, such as increasing population demands, increasing costs of goods, new technologies or changes in the use of technology; even the social and economic structure of a population can influence how much is spent on health. Given the propensity of populations to change, it is easy to see why healthcare provision and consumption are so dynamic in nature. The ever-increasing cost of healthcare is quite often a political tug of war, with one side believing that, regardless of cost, universal healthcare should remain relatively unchanged, while the other believes that significant changes must be introduced to ensure the longevity of universal healthcare in Australia. Regardless of these opposing viewpoints, healthcare costs continue to rise and at some point someone will need to pay for the increases.

The dynamic nature of the healthcare environment also creates a continually evolving client–professional relationship that requires constant attention from all parties. Political influence and healthcare funding, pay-for-service arrangements, access to health information, social media and changing health needs all create a client–professional relationship that demands continual evolution. The healthcare environment is one of few sectors where macro and micro components, communication and influences combine to alter the interaction and communication between client and professional.
Since the introduction of universal healthcare in Australia there have been many changes associated with health and healthcare. The needs of populations have changed, and access to information about health and healthcare needs has changed dramatically, too. This access to information—although more evident in some sub-populations and specific age groups comfortable with technology and social media—has influenced the way that people access healthcare, communicate healthcare needs and consume healthcare. The introduction of the internet has enabled easy access to substantial amounts of health information (Hesse, Nelson, Kreps et al. 2005). The presence of this information, our understanding of health, what health means to us, and our ideologies regarding the provision of healthcare help to create our own individual model of healthcare. This information has also bought about a shift in the balance of power in health needs communication.

Since Australia’s settlement, there has been a continued shift in communication of healthcare needs. From a macro perspective, government organisations traditionally communicated the needs to the people. However, communication has evolved, resulting in a move away from government and private organisations communicating what individuals and communities require, to individuals and
communities directing the communication about their specific healthcare needs. From a micro perspective, individual–health professional interactions have also evolved in favour of the individual, allowing for far greater communication of needs. The greater access to information, the greater the shift in both micro and macro communications.

Consider your own model of healthcare.
- What does health mean to you?
- What does healthcare provision mean to you?
- Consider how you established your understanding of health.
  - Where do your ideologies stem from?
  - Who influenced you?
  - What information influenced you?
- Now think about how other people (clients or patients) might see health or the provision of healthcare.
  - As a health professional, it is likely that your ideologies will differ from those of your clients or patients. How might this impact on your interaction with them?

Without really knowing it, we create our own healthcare model to suit our own individual ideologies; this conceptualisation can then be expanded to the community around us. What we create individually or as a community can be referred to as a model or framework for healthcare. Frameworks for healthcare generally reflect how health is conceptualised by individuals or communities (Taylor et al. 2008), and can be seen as the way in which healthcare is approached. However, it is unlikely that any two people will conceptualise the exact same framework, nor will any two communities. Like many aspects of health and healthcare, this is not a one-size-fits-all process.

Frameworks for healthcare

How health is conceptualised is reflected in the way that individuals, communities, government or private organisations approach healthcare.

So why are frameworks for healthcare necessary when governments and experts can tell us what healthcare needs to be delivered? Frameworks for healthcare actually guide health policy and the delivery of health services. We should really consider health frameworks as continually evolving concepts that can be shaped, adjusted or reinvented as the populations change and new evidence is introduced. As with different individual conceptualisations and different communities, the diversity of health practice areas, health-related sectors, and even the practitioners’ ideologies, create the need for a large array of frameworks. A simple internet search
will demonstrate the diversity of healthcare frameworks. In this chapter we will focus on four primary frameworks:

- biomedical
- bio-psychosocial
- International Classification of Functioning (ICF)
- socio-ecological framework.

The biomedical model

The biomedical model is a model that people are most likely familiar with and, although they may not know it by name, it has most likely influenced health and healthcare beliefs of individuals and communities. The biomedical model has for a very long time provided the basis for healthcare, based on the premise that health is the absence of disease (Taylor et al. 2008; Wade & Halligan 2004). The biomedical model is entrenched in scientific understanding, suggesting that scientific processes can explain health and illness as the cause of disease; it is limited to biological causes, somewhat dismissing any causation related to psychological factors. As we learn more about health and wellbeing, it may seem easy to dismiss a model of care that only really considers the biological aspects of health or illness. However, the biomedical model still underpins a great deal of our medical understanding; it is the model we use to educate health professionals, and it still has a place in some health settings. The biomedical approach is somewhat limited regarding rehabilitation medicine, as the scientific nature of the model suggests that knowledge lies with the practitioner, creating barriers to effective therapeutic communication.

As mentioned earlier, the models or frameworks for healthcare are reflected in health policy and, to some extent, health spending. The biomedical model is quite clearly reflected in health spending. In 2008/2009 the proportion of public health spending to total recurrent government health spending was 2.8 per cent (AIHW 2011), and although this amount was an increase from previous years, it still remains a small proportion of total government recurrent spending, reflecting the focus of the biomedical model on physiological outcomes. However, the total amount spent on health is not necessarily a reflection of health outcomes, as the proportion of public health spending is more important regarding health outcomes (Baum 2011). The US provides a good example, as it has one of the highest health expenditures in the world while at the same time infant mortality remains higher than the average of the top ten OECD nations (Baum 2011). Although health spending would appear to be concerned with the macro level of health, the micro level is also impacted through resource allocation and utilisation. Resources in health can be physical, human or time, and their allocation and utilisation can influence client–professional interaction, health outcomes and perceptions of quality. A biomedical approach emphasising physiological outcomes may force resource allocation away from interventions or approaches that foster client-centred outcomes.
The bio-psychosocial model

The bio-psychosocial model accommodates psychological and social contexts; however, it also encompasses a number of elements of the biomedical model. The bio-psychosocial model provides an example of the evolution of models or frameworks in response to changing needs and understanding about health and illness. The bio-psychosocial model evolved from the biomedical model in response to claims that the biomedical model was too narrow in its focus (Borrell-Carrio et al., 2004).

The bio-psychosocial model takes a holistic approach that considers the molecular and also the social context of disease (Borrell-Carrio et al. 2004; Taylor et al. 2008). However, given its origins are entrenched in the biomedical approach to health and illness, there is significant conflict regarding treatment and the balance of power between the health professional and the patient. Recognising the social context to health, barriers to therapeutic communication resulting from the biomedical component are slightly reduced under this model. These barriers can be further reduced when health practitioners acknowledge the existence of power relationships.

The impact of power relations on communication and interaction can be further reduced—or in some cases exacerbated—through individual–health professional terminology. For example, the term ‘patient’ traditionally demonstrates an imbalance in power, as the patient generally receives treatment or is acted upon. Although ‘patient’ may not carry the same meaning for everyone, it does carry an element of power shifting towards the health professional. On the other hand, the

**TABLE 1.2 Biomedical model of health and illness**

<table>
<thead>
<tr>
<th>Description</th>
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<tbody>
<tr>
<td>Health and illness is physiological: the presence or absence of disease.</td>
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<tr>
<td>The aetiology of a disease is physiological and has a physiological or biological cause with the host body.</td>
</tr>
<tr>
<td>Balance of power in the relationship is significantly shifted towards the practitioner, who is the only expert in the equation.</td>
</tr>
<tr>
<td>Disease is curable and the systems are restorable as a result of medical intervention and cure.</td>
</tr>
<tr>
<td>Life experiences, psychological trauma and socio-economics are not considered contributing factors in the disease process.</td>
</tr>
<tr>
<td>Functioning of systems can be considered normal or abnormal; abnormal indicates some form of malfunctioning in the synchronisation of body systems.</td>
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</tbody>
</table>

Adapted from Taylor et al. 2008
terms ‘client’ or ‘consumer’ reset the balance of power, suggesting that the client or consumer is now acquiring services for their own personal needs; there is an element of control in the hands of the receiver. The use of different terminology proposes an underlying framework or belief from either party, which may result in either negative or positive communication outcomes.

**TABLE 1.3 Bio-psychosocial model**

<table>
<thead>
<tr>
<th>Description</th>
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<tbody>
<tr>
<td>Encompasses a worldview of health, and recognises the relationship between physical, psychological and social wellbeing.</td>
</tr>
<tr>
<td>Physical components of health, illness and function can be considered normal or abnormal; abnormal indicates some form of malfunctioning in the synchronisation of body systems.</td>
</tr>
<tr>
<td>Curative approach to physical systems.</td>
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<tr>
<td>Balance of power remains with the practitioner as the expert; the patient requires a curative approach to restore system functions.</td>
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<tr>
<td>Presenting symptoms approach: focus on the individual.</td>
</tr>
<tr>
<td>Recognises a relationship exists between physiological, psychological and social determinants of health; able to take a holistic approach to intervention.</td>
</tr>
</tbody>
</table>

Adapted from Taylor et al. 2008

**International Classification of Functioning, Disability and Health (ICF)**

The biomedical and the bio-psychosocial models provide a basis to drive health policy in a direction that considers more than just the physiological components of health and illness. However, as health and medical research continues to provide greater insight into the mechanisms of wellness it becomes evident that the previous models have limitations.

Health or wellness is far more than just physical and social contexts; it is individual and continually evolving via multiple inputs that include physical and social inputs, as well as environmental inputs, experiences, and much more. In 2001, the World Health Assembly (WHA), along with many governing bodies, adopted a new framework for healthcare: the International Classification of Functioning, Disability and Health (ICF) (Taylor et al. 2008). Although referred to as a new framework, it is an earlier framework redesigned to incorporate the changing needs of and understandings about health and wellness. The ICF actually