

HEALTHCARE IN AUSTRALIA AND NEW ZEALAND OVER RECENT DECADES
PART B – AUSTRALIA

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ABSTRACT

Often policy and institutional reform proposals, developed through experience and learning transfers from other jurisdictions, encounter many veto points/players before they can be implemented. When New Zealand elected members by a first-past-the post voting system in single member electorates to a unicameral parliament it was relatively easy for the majority party to legislate their reform proposals. However, if reform legislation is not supported by the electorate it can be reversed just as easily by an incoming government of a different ideological persuasion. The situation is different in Australia because it is a federation and restricted by its constitution. It also has a bicameral parliamentary system that makes it easy for veto players, with ideologies opposed to that of the government, to reject policy reform proposals before they can be legislated into law. Despite these difficulties, some significant health care policy reforms have been enacted in both Australia and New Zealand during recent decades.

Keywords: partisan ideology, bicameral, unicameral, reform veto players, health reform policies, Australia, New Zealand

Introduction

This paper argues that when health sector reforms are undertaken at different time periods or in countries with differing electoral systems, the nature of the reforms reflect the dominant ideology of the government concerned. This paper is in two parts aiming to undertake case studies of health reforms in two countries, New Zealand and Australia. Each has a Westminster style of government but with different electoral and parliamentary systems. Part A involved a literature examination of reform processes followed by a case study of health care reform in New Zealand. Part B, examines the differences in electoral systems in the two countries and also the unicameral parliamentary system in New Zealand and bicameral system in Australia. It then proceeds to a case study of health reform in Australia.

The first paper examined various policy reform theories including 'triggering' and 'structuring' causes of policy reform (Dretske, 1991; Starke, 2008, 2010); socioeconomic demand-side factors (Harris, 2011) and political ideology (Potrafke, 2010). The case study on health policy reform in New Zealand indicated that partisan ideology was a major driver of specific reform measures. Prior to 1996 New Zealand had first-past-the-post voting in single member electorates to select members to a unicameral parliament. Usually these elections ensured that one or other of the two major parties

held a majority of parliamentary seats in its own right. One of these parties, the Labour Party, adhered to a social democratic ideology whilst the other, the National Party, held a conservative ideology that promoted the 'free market' and small government. In the system operating before 1996 it was relatively easy for a government to obtain the support of the legislature for its own ideological reform proposals. However, if a party loses favour with the electorate it is just as easy for the other party to legislate to reverse these reforms and impose others that conform to its own ideological position. The change to multi-member electorates and proportional representation ensured that the party with the most seats had to govern in coalition with another party or form a minority government with the support of one or more of the minor parties. As these parties did not adhere entirely to the government's ideology, legislating reforms became more difficult and usually involved lengthy negotiations to establish a compromise position.

The second paper examines the differences between electoral systems in the two countries, the unicameral parliamentary system in New Zealand and the bicameral system in Australia. It then proceeds to a case study of health reform in Australia and argues that the bicameral systems usually involves extensive negotiations and compromise if the government's reform proposals are to obtain the approval of the legislature.

Some Organizational Differences Between Australia and New Zealand

One of the main differences between the two countries is in the very nature of their parliaments (c.f. Lijphart, 1999). New Zealand changed to a unicameral parliament in 1951 (c.f. Cox, 2001; Johnson, 1938; Longley & Olsen, 1991; Lord Cooke of Thorndon, 1999; Morris & Malone, 2004; Norris, 1935) as adopted by Sweden (von Sydow, 1991) and a number of other countries. Unicameralism in conjunction with a first-past-the-post electoral system ensured an easy road for the ruling party until 1996 when New Zealand introduced MMPs (c.f. Aroney, 2011). On the other hand Australia is a federation with the Federal Government and five of the six State Governments having bicameral parliaments (c.f. Barnett, 1915; Cutrone & McCarty, 2011; Diermeier & Myerson, 1999; Druckman & Thies, 2002; Longley & Oleszek, 1989; Riker, 1992a, 1992b; Rockow, 1928; Rogers, 1998, 2011; Tsebelis & Money, 1997). Queensland abolished its upper house of parliament in 1922

(c.f. Solomon, 1998), and so Queensland, the Australian Capital Territory and the Northern Territory, became the only Australian parliaments with an unicameral system. A bicameral system often causes problems both for the formation of a government and the duration of its term of governance, such as when the majority party in one house is of a different ideological persuasion to the majority of members in the other house (c.f. Diermeier, Eraslan, & Merio, 2003). This can also occur in an unicameral system, particularly under a system of proportional representation, as in New Zealand since 1996, when the major party does not have a majority in parliament at all (c.f. Heller, 2001). Hung parliaments with minority governments (c.f. Paun et al., 2010; Vowles, 2010) are not unique to unicameral systems, for instance, the Australian Federal Government since August 2010. Additionally, the approval of legislation often requires compromise through political bargaining and granting minority groups certain proposal and veto rights (McCarty, 2000). In both systems, in which the ruling party does not have the support of the upper house or even of the lower house, there is a potential to impact upon government spending and its control of budget deficits (c.f. Heller, 1997).

Another significant difference between the two countries is in the way their parliaments are elected. Before 1996, New Zealand had single member electorates where the candidate with the most votes is elected whether or not he/she is supported by an absolute majority of the electors. Since 1996, in a unicameral system, members are elected in accordance with the proportion of votes they receive in mixed member electorates (c.f. Johnston & Pattie, 2002). On the other hand, Australia only became a federation on certain conditions or principles including the stipulation that:

the Parliament of the Commonwealth would be of two houses, one representing the people as a whole and one representing the people voting for their states, and the consent of both houses would be necessary for the passing of laws (Parliament of Australia, 2010, p.2).

As Australia is a federation, like the United States, and like the US Congress, the Commonwealth Parliament's legislative powers are restricted by the constitution. This is not the case for New Zealand and the British Parliaments both of which, in theory, are not prevented from passing any desirable laws they consider necessary and for which they have majority support of the parliamentary members (Parliament of Australia, 2010, p.3). As Australia has a bicameral system the framers of the constitution

(c.f. Australasian Federal Convention, 1898; Craven, 1986) desired that each house would be elected on a different basis so as to secure all of Australia's characteristics. Thus the lower house, the House of Representatives, reflects the wishes of the people and is elected in single member electorates by preferential voting. The upper house, the Senate, reflects the wishes of the states as determined by electors of each state voting in a single state electorate by proportional representation. Each State elects 12 senators irrespective of the size of the state and there are two senators elected from each of the two major territories. The framers of the constitution believed that true representation is only possible through a bicameral system and their rationale was guided by the essays of Alexander Hamilton, James Madison and John Jay (Hamilton, Madison, & Jay, 1898) in *The Federalist* (c.f. Carey, 1989; Dietze, 1960; Epstein, 1984; Kesler, 1987; Meyerson, 2008). Hamilton, Madison and Jay's argument about bicameralism adopts the theory of the French Philosopher, Baron Charles-Louis de Secondat Montesquieu (1773, 1949) who proposed that "[t]he legislative body being composed of two parts,, they check one another by the mutual privilege of rejecting" (Montesquieu, 1949, p.160; cited in Parliament of Australia, 2010, p.5). Montesquieu also argued against the Westminster, or British, type of government in which the members of the executive are also elected members of the legislature. Whereas the United States has a bicameral system, with the executive not being part of the legislature, Australia, also with a bicameral system, follows the Westminster system in which the executive arm of government is derived from the parliamentary legislature. In this respect Australia is like New Zealand as well as Britain. The English philosopher, John Stuart Mill (c.f. Capaldi, 2004; Carey, 2002; Packe, 1954), saw dangers in the way in which single member electorates placed limits upon representation and shared the arguments of *The Federalist*, and of Montesquieu, that two Houses of Parliament are desirable because of their ability to keep checks on each other (c.f. Maartensz, 2006; Mill, 1904, 1910, 1962; Parliament of Australia, 2010, p.6).

Reform of the Australian Health Care System

In the twentieth century there were some deep political and ideological divides between a social democratic government and wealthy doctors supported by conservative senators in a bicameral system of government, thus frustrating efforts to legislate health care reform proposals. For instance,

the resistance of the medical profession to socialised healthcare delayed the proclamation of the Pharmaceutical Benefits Act enacted by the Chifley Labor Government. A successful constitutional challenge (c.f. Blackshield & Williams, 2002; Craven, 2004; Quick & Garran, 1995; Zines, 1997), in the High Court of Australia, by the conservative Victorian Government and the British Medical Association, also placed a number of other social welfare provisions at risk (c.f. De Voe, 2003, p.86; Hunter, 1980; Palmer, 1978). The Australian electors' support for the Chifley Labor Government in its constitutional difficulties were resolved by referendum in 1946. Thus the Chifley Labor Government was able to legislate to provide for pharmaceutical, sickness and hospital benefits and for the delivery of medical and dental services as part of a range of social welfare benefits (Dickey, 1980, p.182).

The election of a conservative government in 1949 enabled the medical professional contumacy to scuttle Labor's efforts to provide universal free medical care. Thus health care remained a personal responsibility during the 23 years the Liberal and Country Parties were in power (Dickey, 1977, p.62). Whilst it was the conservative government's policy to promote growth and development, the government still sought to protect the dominance of ruling medical professionals against any threats from the bulk of the population. However, at elections political necessity brought some incremental increases in benefits for pensioners, and for medical, hospital and pharmaceutical services (Dickey, 1977; Kewley, 1973, chs. 18 and 24).

Concerns about health insurance and unemployment ensured the election of a social democratic government in December 1972 (Gardner, 1989), and enabled the incoming Whitlam Government to challenge a number of structures of the coalition government. Two bills to establish Medibank were opposed strongly by the Australian Medical Association and the conservative majority in the Senate, the upper house in a bicameral parliament (Parliament of Australia, 2010). The matter was resolved when after a double dissolution election in 1974 the Labor Party, with 51% of the seats in the House of Representatives and only 48.3% of the seats in the Senate (Parliament of Australia, 2010, p.24), was still able to have Medibank passed into law but only after a joint sitting of the two houses. However, the Whitlam Government still lacked an absolute majority in the Senate comprising ten members from each of the States, regardless of size, that produced consequences of

crisis proportions (c.f. Lee & Oppenheimer, 1999). Thus partisan ideologies enabled opposition parties to continue to obstruct the will of the majority party in the House of Representatives and after a lengthy impasse on the supply of funds for the operation of government, the Governor General, Sir William Kerr (Kerr, 1978), dismissed the Whitlam Government on 11 November 1975 (c.f. Evans, 1977; Hocking, 2008; Hocking & Nolan, 2005; Horne, 1976; Kelly, 1976, 1983, 1995; Kerr, 1978; Lloyd & Clark, 1976; Murphy, 1980; Reid, 1976; Smith, 1997; Whitlam, 1975, 1985). One outcome of the political crisis was to stimulate academic debate and some scholars have argued the case for an alternative parliamentary system to the 1975 system. To a large extent the debate still continues. For instance, David Solomon argues for an unicameral parliament (Solomon, 2000) and for the Governor-General to be elected (Solomon, 1976) and Leigh Gollop (2005) argues for the maintenance of a strong bicameral system but with the Upper House being replaced by a People's Deliberative Assembly comprised of 300 to 500 randomly selected citizens (see also Gollop, 2002; Maddox, 2005; Sharman, 1999; Uhr, 1993, 1995)

Although the new Prime Minister, Malcolm Fraser, stated he would not dispense with Medibank (Siedlecky, 2005) his coalition government did so progressively over the next five years. However, in 1982 the Leader of the Opposition, Bill Hayden (Hayden, 1996; Murphy, 1980; Stubbs, 1989), advocated that a revised Medibank termed Medicare be reintroduced.. His scheme was supported by the Doctors Reform Society (DRS) National Conference in Brisbane in 1982 (Siedlecky, 2005, p.10). This support helped the new Labor Party leader, Bob Hawke (Anson, 1991; Blewett, 2000; D'Alpuget, 1982; Hawke, 1994; Hurst, 1983), win the 1983 election (see Scotton, 2000). Whereas the Medibank of the Whitlam years was obtained partly by employing a "*crash or crash through*" motto and obtaining consensus "*by ramming it through, and then people finding out it was right*", Hawke's approach was one of consensus which takes longer (De Voe & Short, 2003, pp.350-351). De Voe and Short (p.351) cite Day and Klein's (Day & Klein, 1992, p.462) claims that debates about national health insurance questioned "*the structure of the health care system itself [and] the way in which it should be organized and run*". Also the Medibank proposals in disputing "*the structure of the decision-making process [and] the rights of various actors to participate in the health care policy*

arena” changed the policy landscape (see also Kelly, 1992; Mills, 1993; Richardson, 1994; Ryan & Bramston, 2003).

In December 1991, the Labor Party Caucus replaced Bob Hawke, as Parliamentary Leader and Paul Keating (Carew, 1992; Edwards, 1996; Gordon, 1993, 1996; Love, 2008; Watson, 2002) became Prime Minister. Under Keating the Labor Party retained power at the 1993 election but lost to the conservatives in March 1996. The Keating Government continued the reform agenda advanced when Hawke was Prime Minister and Keating was the Treasurer. The liberalization of Dental Care was a major health care initiative of the Keating Government.

The 1996 election returned the conservatives to power with John Howard (Errington & Van Onselen, 2007; Grattan, 2000; Kelly, 1994) as Prime Minister. He was to remain in power until the coalition was defeated and he lost his seat of Bennelong in November 2007. Despite promising not to dismantle Medicare, the Howard Government altered it so it no longer conformed to the original intention for it to be an universal system. Howard argued that it was never universal because of the Victorian Government’s and the British Medical Association’s (BMA) successful High Court challenge to the Chifley Labor Government’s Health Care Legislation. The coalition introduced a system of co-payments for medical services despite strong opposition from the Doctors Reform Society (Gunn, 2003; Leeder, 2003; Shrader, 2003a, 2003b) and the Labor Opposition (Crean & Smith, 2003). Other commentators (for instance Gunn, 2003; Shrader, 2003b) argued against it on equity grounds as co-payments ensure a financial advantage for the wealthy and the doctors .

Liberal Party ideology is based on choice and consequentially is similar to the ideology of those who advocate small government. Adhering to the Liberal Party’s ideology of choice, the Howard Government encouraged people to insure themselves against illness with private health funds. This was achieved by requiring the taxpayers to provide a 30% subsidy on premiums and levying wealthy non-insurers. Norton (2006, p.19) claims that the “*proportion of people with private health insurance increased from 30.6% in 1999 (when the rebate started) to 42.9% in 2005. Rebate expenditure in 2004-05 was just under \$3 billion*” (see Australian Bureau of Statistics (ABS), 2006, p.61; Australian Institute of Health and Welfare, 2006, p.33). Although the rebate may have reduced public hospital

usage and expenditure, nevertheless it paid some people to continue their existing private health insurance practices. The rebate also subsidised health fund premiums for services that were not then eligible for Commonwealth subsidies. This was inequitable because the Commonwealth government did not reintroduce subsidies for dental treatment of the financially disadvantaged. Where such provisions existed it remained the domain of the States and incurred very lengthy waiting times for treatment. The concept of subsidising high income earners also involved increasing subsidies to private schools and impacting the Commonwealth budget accordingly. Norton argues that these *“private health and education spending increases were matters of policy choice, not political necessity”* (p.19).

Although concerns over the Howard Government's industrial relations 'reforms' (Work Choices) were, arguably, the main cause of the coalition's defeat in the 2007 election, health care and education figure prominently in the minds of the electors. The incoming Prime Minister, Kevin Rudd (see Macklin, 2007; Stuart, 2007), as well as reversing what he perceived as 'obnoxious' Work Choices provisions, implemented promised reforms in many other areas including health and education (c.f. Hartcher, 2009). Although processes of instituting some of these reforms were established in early 2008 the onset of the 2008-2009 global financial crisis called for a reassessment of financial priorities and a realignment of economic values in many Western Countries.

Some political commentators claim that there is a clash of values between liberal and social democratic ideologies. For instance, liberals such as Locke (2006) and Sirico (2000), tend to blame the victims for their plight. Such a clash in values may be described as a clash between market fundamentalism and altruism (Marsland, 2001), or as Rudd (2006) describes it, a battle between social democratic beliefs and market fundamentalism. In the midst of the 2008-2009 global financial crisis Rudd (2009) attributed the crisis to greed and extreme capitalism and reaffirmed his belief that the clash is between social democratic ideologies and the market fundamentalism of neo-liberalism. Even in times of financial crisis there still exists a clash of values with some, for instance Henderson (2009), opposed to the enacted government policies even if there is widespread scholarly and popular support for such remedial actions (see Gittins, 2009). Market fundamentalists see the clash as being between

virtue and socialism (c.f. Marsland, 2001; Shils, 1997). Others argue for government intervention to ensure a more equitable distribution of wealth between individuals, communities and nations (c.f. Gates & Steane 2007, pp.344-347; Sepulveda & Martinez-Vazquez, 2011; Soros, 1997). It was the intervention of the Rudd Government's stimulus package that delayed efforts to institute reforms in the Australia Health Care System.

Rudd had sought to have the blame-game removed from the Australian health care psyche right from the first question time after he was elected Leader of the Opposition in 2006. There have been progressive health care initiatives from 2007 to the present time (c.f. Department of Health and Ageing, 2009; Gregory, 2010; National Rural Health Alliance, 2010).

In an historic 29th meeting of the Council of Australian Governments (COAG) agreement was reached "*on health and hospitals reform – the establishment of a National Health and Hospitals Network*" (COAG, 2010, p.1). The reforms are designed to help patients receive care as and when required through all health care sectors; institute high-performance standards by local clinicians and so improve the quality of health care; and to provide "*a secure funding base for health and hospitals into the future*" (COAG, 2010, p.1). The \$5.4 billion health reform package provides recurrent funding for about 22,000 new elective surgery operations in 2013-14; funding to reduce the waiting time in hospital emergency departments to a maximum of four hours; personalised flexible care for patients with chronic diseases such as diabetes; an additional 1,375 general practitioners practising by 2013 (5,500 in the next decade); 680 more specialists in the next decade; about 5,000 aged care places over four years; 1,316 new sub-acute beds by 2013-14; and 1,200 sub-acute care packages over four years (COAG, 2010, p.1). With the exception of Western Australia, COAG agreed that the Commonwealth "*will fund 60 percent of the national efficient price of public hospital services delivered to public patients*". The Commonwealth is to be responsible "*for absorbing the majority of cost growth in the health and hospital system*" (COAG, 2010, p.3; c.f. Davis, 2010; Gregory, 2010).

Due to a slump in the opinion polls and some organizational issues the Labor Caucus removed Kevin Rudd from the Prime Ministership in June 2010. Although, the new Prime Minister, Julia Gillard (c.f. Kent, 2010) endeavours to obtain a more consensual approach the need to negotiate with

cross bench members in a hung parliament following the August 2010 election, on a range of policy issues, has supported arguments that reform is not easily achieved in a bicameral federal system of government. This task has not been made easier by the election of conservative governments in Victoria (November 2010) and New South Wales (March 2011) that have called for a review of the arrangements accepted in April 2010. This highlights the part partisan ideology plays in the health reform process.

Conclusion

From the early twentieth century to the present day, there have been many developments in healthcare. Some significant policy reforms have been achieved amidst ideologically based controversies in both New Zealand and Australia. Although reforming governments have encountered many veto points and veto players who hinder their reform agendas they have been able to learn from reformers in other countries about what reforms to propose and about strategies to be employed in implementing desired changes.

Legislating reform is never easy when partisan ideologies and self-interested veto players vehemently oppose the reform proposals. Legislating reform policies are relatively easy in a unicameral parliamentary system like that of New Zealand but, unless they win the support of the electors, these reforms can just as easily be reversed by a subsequent majority government with a different ideological viewpoint. In a bicameral system and a federation, like that of Australia, legislating reforms are more difficult because the checks and balances are in the Houses of Parliament themselves. In a bicameral system the house, in which government is formed, is elected under a different system from that of the other house. This usually ensures that the ruling party will not have an absolute majority in the other house. Thus governments need to negotiate and compromise with members holding ideologies that are reasonably close to their own, to achieve their reform goals. Where governments are elected in a single electoral first-past-the-post electoral system to a unicameral parliament one political party frequently wins sufficient seats to form a majority government in its own right. This was the case in New Zealand where one or other of two ideologically opposed parties

formed the government prior to the 1996 election. In these circumstances reform proposals could be legislated easily but if they were not approved by the electorate at large at the next election an incoming government of a different ideology could reverse the reform legislation just as easily. At the 1996 election the introduction of Multi-Member Proportional electorates ensured that as neither major party obtained an absolute majority the party with the greater number of seats had to rely on support from one or more of the minor parties to pass any of their reform proposals.

Australia, with a bicameral system of parliament and the restrictions of a constitution in a federation, needs to take a different route to legislate their reform proposals. In the lower house members represent 150 individual electorates through a preferential voting system. On the other hand the upper house represents the interests of the states and, through a proportional voting system, elects twelve senators from each state for a six year term in electorates comprising each state as a whole, irrespective of population. There are also two senators elected proportionally in each of the two major territories. In such a system a majority party in the House of Representatives usually does not have majority support in the Senate for contentious policy reforms. In such circumstances and when there is a hung lower house, the government negotiates a compromise position to achieve an acceptable reform. When the two houses fail to agree the issues can be resolved by a double dissolution, a practice that has been followed on a number of occasions by social democratic governments to have health care reforms passed into law. A significant cause for having a double dissolution has been uncompromising ideological partisanship. The 1974 double dissolution elected 29 Labor Party and 29 coalition Senators plus a Liberal Movement Senator and an Independent Senator from Tasmania, Michael Townley. In February 1975 Senator Townley joined the Liberal Party, thus increasing the number of Coalition Senators to 30. On 3 September 1975, Albert Patrick Field was selected under Section 15 of the Constitution by the Conservative Government of Queensland to fill the casual vacancy caused by the death of a Labor Party Senator. Thus the coalition parties were in a position to withhold supply for the running of government and, rightly or wrongly, the Governor-General, Sir John Kerr, dissolved parliament on 11 November 1975. As well as supporting our argument that in a bicameral system ideological partisanship contributed to the rejection of policy reform proposals, the

rejection of supply brought to an end the Whitlam Government and, ironically, Albert Field's 70 day term as a Senator for Queensland.

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