The health system: what should our priorities be?

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Introduction

Although Australia’s health system is one of the best in the world, it is unable to deliver improved health outcomes to all people. The disparities between the health of Indigenous and non-Indigenous people, for example, are vast. Slow, or in some cases no, progress has been made over the past decade despite governments attending more closely to this problem. This in part reflects the important effects of the wider social determinants of health, such as employment, education and income on health outcomes, but also reflects a health system that is focused on treatment of health problems rather than their prevention and early intervention.

The care of people with acute illness and serious injury in Australia is of high standard, well regarded, and comparable with the best international experience. There are problems of access in specialties, and the tyranny of distance is a particular problem for people living in the country and outer metropolitan areas. But by world standards, these services are well provided. It is in relation to serious and continuing illness – both its prevention and its continuing care and support – that the system is least adequate and where considerable reform is needed to provide both an effective and efficient service.

Abstract

Issue Addressed: The way the health system is organised is a critically important social determinant of health. Australia’s current health system funding arrangements contain serious barriers to effective health promotion and chronic disease management. The consequences are most evident among disadvantaged people. Major health system reform is needed in Australia to rectify this problem.

Methods: This paper describes current mechanisms for funding health care in Australia and examines a recent reform experiment, the Co-ordinated Care Trials. It discusses why the trials were unsuccessful and identifies key criteria for future success. Three existing proposals for health system reform are assessed against these criteria – managed competition, a Commonwealth takeover of health and medical saving accounts.

Results: Successful reform of Australia’s health system will need to ensure that more flexible services are delivered, changes are made on a large scale to affect demand and strong incentives to use cost-effective services are put in place. Of the models considered, managed competition best meets these criteria and is most likely to reduce health disparities and improve health promotion and disease prevention. A Commonwealth takeover of health funding is a less ambitious alternative but because of this, it is also likely to have less impact. It is doubtful whether medical savings accounts meet any of the criteria for success and they would also require a fundamental change in the values that underpin the Australian health system.

Conclusion: Recent reforms of Australia’s health system have been too small and have had little impact. Although radical reform of the health system is politically unpalatable and extremely rare, it may be the only way Australia will be able to meet the health challenges of the 21st Century.

Keywords: Health system, reform, health funding and financing, Australia, chronic disease.

So what?

Health professionals and policy makers wanting to ensure health outcomes improve for all Australians should attend diligently to the way health care is financed. Because of the major impact of health care on health outcomes, this particular social determinant of health deserves priority action.
In searching for alternative proposals for how our health system should be organised, we heed lessons from the recent Coordinated Care Trials (CCTs) and identify three essential criteria for successful reform. We then describe and review three proposals for structural reform of Australia’s health system and analyse how likely it is that they will be able to facilitate effective disease prevention and health promotion.

The Australian health insurance model and health financing – barriers to health promotion

Fee-for-service medical insurance

Australia does not have a system of health care financing that facilitates disease prevention, nor is it well equipped to provide the systematic support required by people with serious and continuing illnesses. There is nothing within private health insurance that achieves these goals, perhaps in part because it is so heavily publicly funded and regulated and because to date it has covered virtually nothing other than care in a private hospital. This is about to change. Within Medicare, there is nothing that makes the heart (or any other organ that might benefit from a healthy lifestyle) sing about prevention or long-term care either. This is because it privileges curative and hospital-based treatment over preventive and community-based care, including that required by individuals with serious and continuing illnesses.

Medicare funding for out-of-hospital medical services in Australia is provided through the Medical Benefit Scheme (MBS), which subsidises the cost of the services of general practitioners (GPs) on a fee-for-service basis. Most of the services provided by GPs are curative or supportive. Most preventive or health promotion services (for example, weight loss, education-based smoking cessation and exercise programs that require extended support) are not funded through Medicare, but instead are provided by allied health professionals working in public hospitals, community health centres or the private sector, co-ordinating patient management is a difficult task. Providing GPs with incentives to take responsibility for it is only a partial solution, especially if there is no attempt to improve skills in management and communication that are pertinent to multi-disciplinary care.

Hospital funding through Australian Health Care Agreements

The Medicare financing system covers public hospital care as well as medical services in the community. Medicare funds for hospital care are distributed to State and Territory governments through the Australian Health Care (formerly Medicare) Agreements (AHCas). State and Territory governments, which are responsible for managing and running public hospitals, contribute equal funds. Hospital care, however, is very expensive. In 2002/03, public hospitals consumed 35.1% of total health expenditure in Australia. Together, hospitals, medical services (17.2%) and pharmaceuticals (14.3%) – the mainstay of curative and supportive health services – accounted for more than two-thirds of total health expenditure. In contrast, only 1.7% of total health expenditure went towards public health in 2002/03 and 4.8% was spent on community health centres.

This maldistribution of funding between the hospital and community sectors has led commentators such as Andrew Podger, former Secretary of the Commonwealth Department of Health and Ageing, to draw attention to the high cost of allocative inefficiency in Australia’s health system. He explains that health system funding is suboptimal because some areas are getting too much and some are getting too little. Instead of rectifying this major problem, we expend billions of kilojoules obsessing about achieving greater technical efficiency (how well we run things inside one component of the system) in our hospitals, which can only ever make a marginal difference to the overall efficiency of the complete health service.

The principal decision-making mechanism for funding hospitals – AHCAs – needs to be revised. AHCAs are made for a five-year period according to a complex formula that considers population and hospital separations (or casemix) data, with additional payments for mental health, palliative care and safety and quality (see footnote 1). AHCAs are evaluated according to hospital patient numbers, average cost per episode of treatment and funded five allied health services per year for patients with a chronic disease. This was a positive move, but falls well short of the needs of many patients.

In 2005, further Medicare reforms were introduced that aimed to improve chronic disease management within the existing system. New MBS items provided GPs with rebates for preparing and reviewing management plans for patients with a chronic disease. These initiatives, like the EPC items, are positive but have a limited capacity alone to overcome the underlying problem, which is that the fee-for-service general practice model constrains the ability of GPs to integrate easily with the rest of the health system. With much of the multi-disciplinary care provided by allied health professionals working in public hospitals, community health centres or the private sector, coordinating patient management is a difficult task. Providing GPs with incentives to take responsibility for it is only a partial solution, especially if there is no attempt to improve skills in management and communication that are pertinent to multi-disciplinary care.
Reform of Australia’s health system

Given the heavy burden of chronic disease (as well as its precursors such as overweight and obesity) and the limited success of the health system in dealing with these problems, there is a clear need for more energetic action in prevention and promotion and in organised care for patients in the community with serious and continuing illnesses. Health system reforms are needed that prioritise prevention and community-based care and use financing models that reward the use of efficient and effective health services.

In recent years, several small-scale reforms have been trialled. They include the Council of Australian Governments’ Co-ordinated Care Trials (CCTs), the Enhanced Primary Care Program (EPC), Chronic Disease Self-Management Program, and new provisions within the Health Care Agreements that allow substitution of state hospital, Medical Benefits Scheme (MBS) and Pharmaceutical Benefits (PBS) funds for programs that demonstrate efficiency gains. The CCTs, which were designed to improve management of chronic diseases, have been the most ambitious of these experiments.

Between 1997 and 1999, the Commonwealth Government funded nine general and four Aboriginal CCTs across the nation. Each CCT was required to design an innovative model for health service delivery and funding based on local needs. Each needed to have a single focus of responsibility for the management of pooled funds, a variety of providers from whom services could be purchased, as well as care planning and co-ordination. The aim of each CCT was to test whether it was possible to achieve better co-ordinated care for patients with high health needs. The challenge was to achieve this using funds pooled from a number of Commonwealth and State programs, and be cost neutral. Overall, results were mixed.

The Illawarra CCT (Care Net) did not lead to improved health outcomes for patients using multiple services and it ran over budget. According to the Wollongong University academics who evaluated Care Net, some of the reasons it failed to deliver were that:

- Fund pooling arrangements did not encourage public sector service providers to deliver services in a more flexible way.
- The scale of the trial was not large enough to change the existing pattern of demand.
- The philosophy of the trial did not change deeply held values by service providers about giving priority to patients in greatest need.

Results of the Australian Capital Territory (ACT) CCT were equally disappointing, with no reported impact on health outcomes for patients enrolled. In a qualitative analysis of the reasons for its failure, Gardner and Sibthorpe from the National Centre for Epidemiology and Population Health said that barriers at the local level prevented success. They found that:

- There was a reluctance by stakeholders to endorse the trial’s goals and strategies.
- GPs did not become effective purchasers of outside services.
- The need for increased gate-keeping was never fully realised.
- Cost-saving strategies were never fully taken up.
- Improvements in continuity of care were impeded by limited provider networks and GPs’ reluctance to collaborate with other service providers.

Not all trials were unsuccessful. One rural South Australian CCT, for example, that focused specifically on outcomes for patients with type II diabetes produced results showing that many patients had improved health outcomes and that hospital and medical expenses reduced as a result of changes that developed out of the trial. Overall, however, the CCTs had little impact because of their small scale, limited resources and restricted role for private sector providers. These limitations meant that real structural reforms that were hoped for did not materialise.

What have we learnt so far?

The Australian health system faces a difficult problem. It is failing in key areas, and the only major reform experiment for nearly two decades has produced disappointing results. To reshape the health system and work out new priorities for the future, we need to heed the lessons of the failed CCTs and ensure new proposals meet three criteria. They need to:

1. Offer flexible delivery of services.
2. Implement changes on a scale large enough to change demand for health services.
3. Provide strong incentives for the use of cost-effective services.

Successful health system reform will need to do far more than meet these criteria. It will also need to overcome bureaucratic resistance, interest group opposition and the complexities of our constitutional arrangements for health. It will depend heavily on the attitudes, values and support of health service providers.

Footnotes:

Despite the many obstacles, some reform proposals for the Australian health system already exist. They are considered below.

**Proposals for a new health system**

This section briefly describes three proposals and evaluates them according to the three criteria for success (discussed above). We argue that a new model for our health system that is able to deliver more flexible, cost-effective services and reduce overall demand will create better conditions for effective health promotion and reduce disparities in health outcomes. This argument is justified on the basis of two assumptions:

1. That a new system would remove the current barriers to effective disease prevention and management of chronic illnesses (the insurance model and unresponsive AHCAs).
2. Cost-effectiveness in the long term depends on successful disease prevention and management and reducing disparities in overall health outcomes (see footnote 3).

The three major proposals considered in this paper are:
- Managed competition – the Scotton model.
- A Commonwealth takeover of health – the Podger model.
- Medical Saving Accounts.

**Managed competition**

The Australian version of managed competition has been developed and advocated by Dr Richard Scotton, formerly of Monash University and co-architect of Australia’s original public health insurance scheme, Medibank. Scotton’s managed competition model proposes major structural reforms to the financing and delivery of health services in Australia. It involves consolidating all health programs into one (including Medicare, public hospitals, the Pharmaceutical Benefits Scheme, nursing home benefits, mental health, community health and other programs), and depends on the Federal Government assuming responsibility for the overall health system as well as legislating and regulating access to services.

Under the managed competition model, funding would continue to come through the taxation system, a health insurance levy and co-payments, but would more fully integrate the private sector. Funds would be distributed to health regions by the Federal Government rather than to States and Territories. Each region would have a unique risk-adjusted rating, calculated using health outcome data for its own population. Regional budget holders would receive grants and, in return, would fund all health services for their registered enrollees. Competition between providers is a fundamental feature of the model. Citizens within each region would be able to choose between public and private budget holders. It is hypothesised that competition between budget holders and service providers would stimulate efficiency and delivery of services more appropriate for the needs of enrollees.

**Commonwealth takeover of health care: the Podger model**

Andrew Podger, former head of the Commonwealth Department of Health and Ageing, has proposed a model for the structural reform of the health system whereby the Federal Government assumes total responsibility for the funding and delivery of all publicly funded health services. It shares many features with the Scotton model, with regional purchasing units and regional risk profiles as the centrepieces. The model differs from Scotton’s in that it does not depend on competition between regional budget holders. Instead, budget holders would be allocated a ‘soft-capped’ budget, determined according to regional risk profile. Over time, regions would be expected to develop increasingly sophisticated approaches to managing the risks of their population. If they over-ran their budgets, health authorities would conduct a performance review rather than impose financial penalties.

Health service provider arrangements under this model would not differ substantially from present arrangements except that hospitals would be funded more directly according to casemix data. Podger states that this change would probably prompt hospitals to contract out particular services and establish centres of excellence so as to improve efficiency, improve co-operation between providers and reduce the need for hospital care.

In addition to changes in the public sector, the Podger model would allow an expanded role for the private sector. It proposes that private health insurance funds be allowed for use in either public or private hospitals, according to contracting arrangements.

**Evaluation**

Managed competition has been introduced into health systems in the United States (US), Colombia, Israel, the United Kingdom and New Zealand. Because the health systems in each of these countries differ considerably, it is not possible to provide a concise overview of the effectiveness of managed competition. Instead, a preliminary analysis of the potential effectiveness of managed competition in Australia is made using the criteria for successful reform discussed previously.

The scope of proposed reform is certainly large enough to affect demand but because markets in health care are not always predictable, it is difficult to be certain that demand would decrease. Because regional budget holders would have substantial autonomy and competitive markets would operate within each region, it is likely that managed competition would bring a greater diversity and more flexible service delivery. It would likely enable the delivery of more appropriate services within regions because of the links between funding and health outcome data. If regional markets were properly regulated, managed competition may also ultimately lead to efficiency gains. This notion has been contested, however, by some participants in a Productivity Commission workshop that considered the model. They argued that it would be difficult to ensure that viable markets operated in some places, particularly regional and remote areas.

Footnote:

Evaluation
Podger’s model is similar to Scotton’s and therefore its capacity to improve health promotion and reduce disparities is similar. The model would reduce demand for health services if it were implemented across the spectrum of health areas. Podger sees that one advantage of the model is that it could be implemented incrementally by restricting reforms to particular areas (such as aged or primary care). This, however, is likely to limit its capacity to reduce demand. As in the Scotton model, the autonomy given to regional budget holders would probably lead to the delivery of more flexible services. Its impact on efficiency is more uncertain as it is highly dependent on the effectiveness of ‘soft-capped’ budgets and performance reviews as incentives for cost control. These tools have yet to be tested in Australia.

Medical Saving Accounts
The Medical Saving Accounts (MSAs) idea has been discussed in the past decade, and in Australia has been advocated by Paul Gross from the Institute of Health Economics and Technology Assessment. MSAs are like personal banking accounts, or perhaps self-insurance, with the saved funds being earmarked for health care expenses. Individuals contribute a portion of their income into MSAs over time. Sometimes employers and the government also make contributions to an individual’s (or family’s) account. The essential feature of an MSA, however, is that a private citizen holds his or her own account, rather than the government or insurance organisation, and he or she controls the money. Account holders are able to determine when, and what, medical services are purchased and can use services from the public or private sector. Account holders also bear the risk of ill-health alone, unlike in insurance systems where risk is spread across the community. Cost savings are thought to arise from MSAs because consumers become more sensitive to price and therefore use fewer unnecessary and more cost-effective and preventive services.

Evaluation
Some international evidence on MSAs is available because they already operate in Singapore (the only nationwide, compulsory MSA system) and China, the US and South Africa (countries that have experimented with smaller-scale voluntary systems). Most evidence on MSAs concerns their ability to change consumer behaviour and improve cost-effectiveness because this is the main claim for them. Although international evidence may not be directly transferable to Australia, it is likely to be relevant because consumers of health services behave similarly across nations.

Economists are divided over MSAs’ capacity to deliver efficiencies. In a 2002 study addressing this issue, Shortt argued that in China, Singapore and the US, MSAs did not in themselves lead to cost control. In another study, Byrne and Rathwell acknowledged that some MSAs had achieved cost savings, but they had been in systems where they were compulsory, that also provided special assistance to some groups (for example, the poor, unemployed and those who have catastrophic illnesses), and imposed some supply-side controls and had government stewardship. It is likely, then, that to achieve efficiency in Australia, MSAs would also need to be strongly regulated and serve as a channel for government subsidies to disadvantaged groups.

MSAs work by influencing the demand rather than the supply side of the health market. They aim to make health consumers more price sensitive. It is well recognised, however, that many of the central principles in economic theory do not operate in health care and consumers frequently behave in ways that are considered ‘non-rational’. As a result, it remains unclear whether MSAs can reduce demand for health services (this would be particularly true for catastrophic illness where non-rational decision-making is most likely).

In a recent article on health funding in the US, journalist Malcolm Gladwell, author of the best-selling book The Tipping Point, claims that the idea for MSAs results from an exaggerated concern about the problems of moral hazard in insurance. Moral hazard refers to the incentive to overuse services if they are covered by insurance and where the premium stays the same whether one uses the insurance or not. He cites the argument of Princeton economist Uwe Reinhardt, who claims the moral hazard argument makes no sense because people do not consume health services in the same way as other goods or services that confer pleasure.

Gladwell then points to the main problems with MSAs in the US – that they almost completely ignore the impact of poverty on health and dispense with the notion of cross-subsidisation in health (that is, that the well-off and healthy contribute towards the cost of treating the poor and sick). A certain level of financial competence is required of an MSA holder, and this may exceed the abilities of many. MSAs favour the rich and ask nothing of them for the care of fellow citizens.

The ability of MSAs to change demand in a way that promotes health – particularly for the poor – is questionable. This is especially concerning given the strong evidence for the existence of a social gradient in health. Because MSAs are a demand side reform, it is also uncertain how effective they would be in inducing supply side changes in the health market, such as more flexible delivery of services.

If MSAs were implemented in Australia as a compulsory program nationally, as in Singapore, it would certainly be a large-scale reform. This is unlikely, though, because most countries have introduced a more experimental version because of the administrative, legal, social and political barriers associated with a reform of this type on a large scale. Available evidence on MSAs therefore cast doubts on whether they meet many of the three criteria for successful reform.

Summary
Of the three options for health system reform considered in this paper, none is the magic bullet that some might hope for. The managed competition model, however, is the proposal most likely to improve Australia’s capacity to reduce disparities in health outcomes and deliver more effective health promotion services because it best meets the criteria for success – it could...
reduce overall demand for health services and lead to the
delivery of more cost efficient, flexible and appropriate services.
The Podger model is similar, but more tentative in its approach.
It is this more cautious and incremental approach that is also
likely to prevent it from making a significant difference to service
delivery, overall demand and cost efficiency.

MSAs do not appear to meet the criteria established in this
paper for successful reform. To implement them in Australia, a
fundamental shift in the principles underpinning the health
system would also be required – a shift away from the principles
of redistribution and cross-subsidisation that exist in both public
and private health insurance to an individualistic system based
on an actuarial rather than a social insurance model. Some
collectors have dismissed the managed competition
model because it is too radical. The assumption is that
incremental reform is the only possibility in the real world of
politics. When it comes to the health system, however, this
conventional wisdom is not so helpful. The most radical reform
to the structure of Australia’s health system in our era was the
introduction of Medibank in 1975. The battle to introduce it
was long and bitter. Many assumed that the experiment had in
fact failed after it was abolished in 1981, but the introduction of
Medicare in 1984 put this argument to rest. Medicare was
another chapter in the last major reform of Australia’s health
system that started with Medibank. While it is now stressed
under the pressures of a changing burden of disease and new
preventive imperatives, its introduction demonstrates that radical
reform is possible and can be successfully achieved in Australia.
The analyses in this paper also suggest that reform is only likely
to be successful if the radical option is taken. Although a proposal
for incremental reform (such as the Podger model) has a much
greater chance of being adopted and advocated by a political
party, it is likely to falter unless it can stand up to the scrutiny of
the multitudes of commentators on Australia’s health system –
health advocates, the public, academics, economists, interest
groups and State and Territory governments to name a few –
who are well aware of the faults of the present system. Many of
these observers have watched all the tinkering around the edges
and seen it lead to only marginal improvements. They are now
concerned by the urgency of changing needs for health care
and health promotion and are demanding a remedy that will
bring demonstrable and substantial improvements in health outcomes.

Conclusion

Australia’s health system has served us well but its insurance
model and blunt mechanisms for financing care are struggling
to meet the challenges of the 21st Century – effective disease
prevention and chronic illness management. Previous initiatives
aimed at correcting these problems have been tentative, marginal and had too little impact. We need a new health system
if we want to make substantial improvements to the health of
Australians. There are various proposals and international
tests to inform our choice. The best of these seeks to achieve
higher level of allocative efficiency, which would reduce
disparities in health outcomes that result from the under-funding
of community-based care, and opens up incentives for regional
health authorities to engage in prevention and promotion. To
succeed in reforming our health system we need to heed the
lessons from our own experiments and our own history, which
suggests that only radical structural reform will bring success of
the order needed today. Although radical reform is politically
unpalatable and extremely rare, tentative and safe incremental
reforms have, and are likely to continue to have, only marginal
effects on the health of the nation. We deserve better than
marginal changes, however valuable marginal victories may be
to our political leaders.

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