

# **Designing the Structure for Australia's Health System**

*Jane Hall*

*Occasional Paper 1/2010*

**The Academy of the Social Sciences in Australia  
Canberra 2010**

© The Academy of the Social Sciences in Australia 2010  
ISSN 1323-7136

Requests and enquiries concerning reproduction rights should be addressed to the Academy of the Social Sciences in Australia, GPO Box 1956, Canberra 2601.  
Tel 02 6249 1788; Fax 02 6247 4335;  
Email [assa.secretariat@anu.edu.au](mailto:assa.secretariat@anu.edu.au).  
The Academy is not responsible, as a body, for the opinions expressed in any of its publications.

All essays appearing in the *Occasional Paper Series* are peer reviewed.

# Designing the Structure for Australia's Health System

*Jane Hall*

## Introduction

Public hospitals and their performance was the major health issue in the 2007 national election. The now Prime Minister, as Opposition leader, announced that he would develop a national reform plan 'designed to eliminate duplication and overlap between the States and the Commonwealth' and 'to move beyond the blame game'.<sup>1</sup> He also stated his intention to hold a national referendum to allow the Commonwealth to take over the running of public hospitals if reform could not be achieved cooperatively with the States by the middle of 2009.

The reform task, developing the long term plan for Australia's health care system, was given to the Health and Hospitals Reform Commission, a ten person committee under the chairmanship of a paediatrician, now working as the medical advisor for a large private insurer, with ex-politicians, medical practitioners, one nurse, and others with both corporate and public sector experience.<sup>2</sup> The Interim Report of the Commission was publicly released in February 2009<sup>3</sup> and the Final Report in June of the same year.<sup>4</sup> The Interim Report set out 116 reform directions, ranging from specific recommendations to aspirational goals. The Committee commented that the single most controversial issue it was called to address was the split of responsibilities between the Commonwealth and States and Territories, essentially the governance, funding and operating of public hospitals. The Interim Report was released for further discussion and consultation to assist in the development of the Final Report. The Institute of Public Administration Australia, with co-sponsorship from the Academy of Social Sciences, convened a Roundtable discussion in March 2009 as part of the wider discussion. Its focus was quite specifically on the governance issues, 'Designing the structure for Australia's national health system'. The Interim Report proposed three alternative structures: a continuation of current responsibilities with clearer funding mechanisms and accountability; a move to a regional health authority model; a move to social insurance with competing plans. Participants were drawn from the Commission, public and private administration, various interest groups including private insurers and the medical profession, and academia.

The aim of this paper is to provide the background to governance issues in the Australian health care system; an overview of health care financing issues; an outline of the international context; a summary of the discussions and views expressed at the Roundtable, and to offer a commentary on the recommendations of the Health and Hospitals Reform Commission.

## Background: Governance and financing in the Australian health care system

Australia spent 9.0 per cent of its GDP on health in 2006-07, an increase from 7.7 per cent GDP a decade earlier.<sup>5</sup> This is below the average for OECD countries.<sup>6</sup> Nonetheless, it represents an increasing share of national income and is expected to continue to grow, with an estimate of 12.4 per cent GDP by 2032-33.<sup>7</sup> Currently around two-thirds of total expenditure is contributed by government, mostly from general

revenue, although there is a small specific income tax levy, raising 7 per cent of total expenditure.<sup>8</sup> The demands on government are expected to increase, as emphasised in the Intergenerational Report, the Australian government contribution alone is expected to account for almost 8 per cent GDP by 2046-67, more than aged care, pensions, education or defence.<sup>9</sup>

A great deal of policy under the Howard government was focused on increasing private finance for health care expenditure, with the most significant strategies being the 30 per cent rebate for private health insurance premiums, and the introduction of age related health insurance premiums known as Lifetime Health Cover. Nonetheless, private health insurance raises around 7.2 per cent of total funds.<sup>10</sup> The private finance component of health care expenditure in Australia is predominantly individual out-of-pocket expenses (17.4 per cent of total expenditure), which is relatively high compared to other OECD countries, and growing more rapidly than other components of health expenditure. This has prompted a range of safety net arrangements to limit consumers' exposure to high costs.

The Australian Government provides subsidies for medical services, and a comprehensive range of pharmaceuticals at fixed copayments to consumers. Most providers are private and independent practitioners, charging fees according to services delivered. Public hospitals are owned and operated by the six State and two Territory governments. In short, not only does Australia have a very mixed system of public and private finance, as well as public and private delivery, it has government responsibilities split across government levels.

Australian health care delivery is a product of history, the development of a federal system of government. and advances in medical practice and health care delivery. The first medical staff arrived with the First Fleet as naval surgeons to care for the military and convicts.<sup>11</sup> The arrival of free settlers brought opportunities for private practice, and the establishment of fee for service medical care. The first hospitals were established by charitable institutions to provide care and shelter for the poor, with medical staff providing their services for free; and the well off were attended in their own homes – indeed, hospitals were dangerous places to be and avoided by those who had alternatives. This second phase was the result of the understanding of infection transmission and the increasing effectiveness of medical and nursing care. With the introduction of hygiene and antiseptics, hospitals became the focus of modern medical care, and so became places where the sick, not just the poor, were treated. Consequently, the costs of providing treatment increased. Those with the means paid, and the poor were treated free of charge. Senior medical staff continued to provide their services to hospital patients in an honorary capacity, and in return had the right to admit their private patients.<sup>12</sup>

The development of medical science and advances in health technology increased both the effectiveness and the costs of health care. By the early twentieth century, the charitable institutions operating hospitals turned to government – at that time State governments - for financial assistance. The growing contribution of governments was accompanied by increasing control, and many charitable institutions became public hospitals, although the charitable sector remained, and still remains, a significant owner and operator. By the 1930s, even the respectable could have trouble paying hospital bills and in 1932 hospitals established an insurance scheme, followed by the medical profession in 1945. Once the States had ceded the major tax base to the Commonwealth, they looked to the central government to financially support their

growing expenditure on public hospitals which it has done since 1945 through five yearly agreements.

The Commonwealth at the same time established the national Pharmaceutical Benefits Scheme (PBS), to provide effective medicines initially at no charge (but now with patient copayments). The Commonwealth took further responsibility for health care with its involvement in medical care through the provision of subsidies (still in the 1950s). This entrenched private health insurance with the following features: insurance was to be voluntary with no compulsion; medical care would be provided on a fee-for-service basis; and there would and should be patient copayments – hence government could not set or limit medical fees. Further, insurance premiums were to be community rated, and insurance could only be provided by non profit organisations, thus managing to avoid 'unhealthy competition'.<sup>13</sup>

The advent of Medicare in 1984, although a substantial reform, was grafted onto this basic structure. Public hospitals remained owned and operated by State and Territory governments, with substantial, but varying, cost sharing by the Commonwealth Government, negotiated via five yearly agreements. In return for higher Commonwealth payments, the States and Territories provide free hospital treatment for all Australians. The Commonwealth continued to subsidise medical services, but instead of channelling these through insurance funds, Medicare paid directly to either the medical provider, if there was no patient copayment, or directly to the patient. The PBS remained unchanged, although now it is generally encompassed by the term 'Australian Medicare'. These three programs remain the major areas of health care expenditure, contributing over 80 per cent of recurrent expenditure: hospitals, public and private account for 38.6 per cent of the total; medical services 19.3 per cent and pharmaceuticals 14.3 per cent.<sup>14</sup>

The development of these three separate funding streams reflects health care as it was, designed to focus on: acute, severe illness which required the resources and skill mix of a hospital: and minor often selflimiting illnesses which could be treated by a medical practitioner, working alone, with the ability to prescribe from a drug formulary. But contemporary health care has to deal with: illnesses which are chronic and continuing; an emergence of the problems of mental illness; an ageing population with problems of multiple chronic conditions and general frailty; smaller families and single person households with less capacity to provide support and care; a greater understanding of the precursors of illness; and new possibilities for screening and early detection. The attempt to address these has resulted in a myriad of programs which have been grafted onto this basic structure.

The other major Commonwealth-State funding arrangement is implemented via the Public Health Outcome Funding Agreements. In addition, there are a national mental health strategy, a national mens health strategy, a national womens health strategy, a national tobacco strategy, a national incontinence management strategy, and agreements on palliative care, cardiovascular disease, asthma, diabetes, cancer and the transition pathways for older people from hospital to home, just to name a few. Not surprisingly, this state of arrangements leads many people to ask is there an Australian health system? Or is there just a series of poorly connected programs?

The Commission's Review presented an opportunity to completely rethink the structure of the Australian health care system, and such an opportunity does not arise very often in this country. Indeed, the Commission's Chair has described their mission as 'to go

boldly where no Commission has been before' in contrast to the usual Australian approach of progressing by incrementalism.<sup>15</sup> The last major new thinking implemented in Australian health care was the introduction of Medibank/Medicare but even then new methods of finance were grafted onto existing Commonwealth and State responsibilities.<sup>16</sup> This is sharp contrast to developments in other countries, including New Zealand, where the last ten years have seen radical reform plans implemented, revised and replaced.<sup>17</sup>

## **Overview: Financing health care**

Health care financing is about the management of risk. Health care is typified by high levels of uncertainty; individuals do not know their future health status, and some treatments are extremely costly. Hence, without some form of insurance or risk pooling, they are exposed to high financial risk or may be denied appropriate treatment due to their inability to pay for it. However, in limiting the cost of health care at the point of delivery, risk pooling introduces moral hazard which results in more costly health services than if consumers were paying the full price. In addition, there are major asymmetries of information with health care consumers having to rely on professionals who both advise and provide health care, poor health is not completely random but associated with other social and economic disadvantage. Advances in medical technologies are rapidly increasing the range of available treatments – and driving costs higher, and the increasing prevalence of chronic disease, which is not cured, but ongoing. Since the goals of health care financing are to ensure that individuals are able to access health care in spite of their inability to pay; to restrain wasteful or inefficient spending; and to promote equity and possibly some form of social solidarity by providing universal access to services, while also allowing responsiveness to individual preferences.<sup>18</sup> As these are not compatible, financing of health care can be typified as a challenging exercise in compromise.<sup>19</sup>

Social health insurance was developed primarily in Europe. Known as the Bismarck model after the German nineteenth century Chancellor, it is a model of compulsory insurance, generally linked to employment, with contributions related to earnings, and often the fund to which an individual subscribes is determined by his/her field of employment. In this model, providers remain independent and autonomous, although there may be more government control and funding of hospitals.<sup>20</sup>

The UK National Health Service (NHS) established a new model with the government both raising the finance for health care through taxation, and operating health services. This is often termed the Beveridge model, after the post World War II Prime Minister who oversaw its introduction. The underlying premise of the NHS was that good health care should be accessible to all citizens, irrespective of their employment status and ability to pay; and that the nation would be better if all citizens were provided with the health care they needed. It is interesting to note that the founders of the NHS also believed that once the backlog of untreated illness was taken care of, the population's health status would improve and the costs of health service provision would decline. Under the NHS, the state owned and operated the hospitals, employed health service staff and contracted directly with medical providers.<sup>21</sup>

In the US, there has been much more reliance on private rather than government led initiatives. Private insurance developed, as in other countries, primarily as a response

to the problem of bad debts as health care was becoming both more effective and expensive. However, it was the wage controls imposed during World War II that boosted private insurance, as employers were able to provide health insurance as an additional fringe benefit, not subject to the new controls. After the controls were lifted, employer provided insurance remained attractive as it was not subject to income tax.<sup>22</sup> As employment based insurance left gaps in population coverage, Government schemes were developed to cover the elderly, Medicare, and the poor, Medicaid. Thus even in a private dominated system, government funds account for around 45 per cent total expenditure. However, major gaps in coverage remained for those in low paid jobs which did not offer insurance; those employed by small enterprises or the self-employed who could no longer afford rising premiums, and for the families of workers whose benefits did not cover their dependants.<sup>23</sup>

In all these models, insurance acted as an entitlement to use services and consequently insurance funds were channels for funds to pass from subscribers to providers. There were some restrictions, in the range of services available; for example, many schemes were limited to services deemed 'medically necessary' and excluded cosmetic surgery. Further restrictions were applied to price, with price schedules or reimbursement limits set by the insurers. Traditionally the purview of insurance was to ensure the legitimacy of claims; there was no concern with how well service provision matched the needs of the claimant; certainly no focus on gaps in service provision or access for those who did not use services; or coordination of a package of care rather than occasions of service.

By the 1970s, health care costs were rising exponentially. Although in developed countries, health status was improving, there seemed to be no end to the growth in community expectations and demand. This was the result of successful insurance which had provided comprehensive coverage with reduced or no price signals, coupled with major advances in medical technology. Unlike technological development in other fields, medical technology tends to drive cost increases; it provides new services which can be offered to a greater range of people, and its success is often in ameliorating disease and postponing death, which means a larger share of the population living with the sequelae of disease or into older age with more chronic disease and handicap. Although the NHS in the UK was the most successful in restricting the growth of the total health budget, health expenditure represented 4.6 per cent of its GDP in 1973.<sup>24</sup> There were concerns over poor outcomes, restricted use of new technologies, and long waiting lists. And even in the UK with its overtly egalitarianism, there were stark inequalities in access to services and health outcomes. In contrast, at the same time the US was spending 7.2 per cent of GDP on health care, with a growing proportion of the population uninsured or underinsured. Not surprisingly, many wondered whether the existing funds could be better spent, and better directed to meet the needs of the population.

### **The International Context: Reforms in other countries**

One line of reform has focussed on managing risk under insurance arrangements. Managed competition, associated most strongly with the name of Alain Enthoven, was the most significant basis for health care reform in the 1970's.<sup>25</sup> The Health Maintenance Organisations (HMOs) operating in the US with much lower per capita

costs had already attracted much attention.<sup>26</sup> This model integrated the financing and delivery of health care; by the HMO in return for the annual premium, ensuring the delivery of a comprehensive health care package for its enrollees. Enthoven's proposal was that having insurers bear all or at least most of the financial risk for their enrollees' health care, coupled with a competitive market for health insurance within strong government regulation, would drive greater efficiency in an economic sense, reducing costs while promoting responsiveness to consumer preferences, including for quality of care.<sup>27</sup> Although Enthoven's work is no longer recent, his ideas still form the intellectual basis for the competitive insurance approach that is being implemented in the Netherlands, and to a lesser extent in Switzerland, Germany and Israel, and actively considered in a range of other countries.<sup>28</sup> The essential components are these:

- there are freely competing insurers who can offer different insurance packages
- packages must provide comprehensive health cover, though they may compete on quality including the luxury aspects of health care (eg private hospital rooms)
- consumers are free to choose across insurers and packages.

Government plays a major role in regulating the market, by determining the basic package of care that must be covered; and in ensuring the solvency of insurers. In such a competitive market, the insurers must act to limit total health care costs, so are expected to coordinate the care for their enrollees, and purchase services from providers on a value for money basis. This should lead to selective contracting and preferred provider arrangements, but if one insurer attempts to limit access to providers too much, consumers will switch to other insurers with more attractive insurance packages. Insurers cannot shift costs of care to other parties as they are required to provide a comprehensive package. Insurers are thus turned into active purchasers of care, and this is termed managed care.

Government's role also extends to monitoring market efficiency and meeting any equity objectives. First, market efficiency requires that insurers compete on price and quality. However, insurers have a strong incentive to compete on risk selection; if an insurance firm can attract customers whose risk of using health care is low, then it can offer a generous insurance package at a low premium. Second, equity requires some cross-subsidisation from good risks to bad risks. Poor risks such as those with chronic conditions, or inherited conditions will require substantially more services. This will lead to large variability in premiums; for example van de Ven and Ellis estimate that unregulated premiums could be as high as 10 times or more than the average premium for high risk groups.<sup>29</sup> This is addressed by the use of a risk adjustment mechanism. Indeed the implementation of an appropriate risk adjustment mechanism is absolutely essential to the operation of managed competition. This allows a subsidy for insurance premiums which is related to risk class, so poor risks receive a higher subsidy, and expected profit is equivalent across risk classes.<sup>30</sup>

In the US, managed care is the term used to cover a variety of institutional arrangements, from the traditional HMO to selected contracting between insurers and providers. However, what they have in common is some restriction on the providers and services covered by the insurance plan. Enrolment in managed care plans has grown rapidly since the 1990s, and most Americans are covered by these plans.<sup>31</sup> While some stabilisation of the growth in health care expenditure was observed during the 1990s, it is by no means clear that this was due to managed care; and these plans were in general attracting better risks.

The managed care environment still falls short of the regulated market envisaged by Enthoven.<sup>32</sup> The escalation in expenditure growth had resumed by the early 2000s. Problems of lack of insurance coverage continue with around 15 per cent of the population with no insurance and not eligible for public programs, a situation made worse by the financial crisis – with rising unemployment and the loss of employer subsidised insurance, and the cut back on generous insurance policies. The election of Barack Obama has been heralded as a new opportunity for reform.

Enthoven's ideas also found a receptive environment in Thatcher's Britain.<sup>33</sup> Reforms in the 1990s attempted to use competitive forces, but among providers rather than developing a large private insurance market. This was implemented by separating the functions of purchasing care from provision and funding.<sup>34</sup> This strategy attempts to distinguish between the interests of providing services, ensuring efficient production but often also expanding services; and purchasing or commissioning, reviewing the needs of a defined population group and acting as an informed purchaser of the right mix of services. Local area health authorities became purchasers, and hospitals and other secondary providers were expected to compete for contracts. In parallel, general practitioners were also given some purchasing power for a limited range of primary care services. The change of government reversed the rhetoric of the market place, and competition was replaced by collaboration;<sup>35</sup> at least for a time.

Under the Blair government, there was a substantial investment in new spending on the NHS with particular attention to improving health outcomes and reducing waiting time. Expenditure which accounted for 5.2 per cent GDP in 1974 remained at less than 6 per cent until 1990, reached 6.9 per cent in 1995, 7.2 per cent in 2000, and 8.2 per cent in 2005.<sup>36</sup> The pace of reform has been unrelenting. The purchasing role of primary care has been expanded, with the development of Primary Care Trusts as budget holders for populations defined geographically; continuation of the purchaser-provider split; the development of independent public hospitals (Trust Hospitals); the National Institute of Clinical Excellence to assess new technologies and programs; new approaches to clinical governance and leadership; new programs to improve quality; and new contracting and incentive arrangements.

Managed competition also provided the basis for the reform process in the Netherlands where it has been implemented progressively over twenty years. Early attempts in the 1990s introduced risk adjustment capitation payments to competing insurers, and selective contracting between insurers and providers. The inadequacy of risk adjustment, collusive behaviour among insurers and providers, and the limited exposure of insurers to financial risk, limited the extent to which the plan was realised.<sup>37</sup> For a period there was a move away from these reforms, though there was continued investment in the underlying mechanisms, principally the development of a more sophisticated risk adjustment mechanism. Since the late 1990s, the reform along managed competition lines has been back on track, though as a recent commentary States: 'the first stage of the introduction of managed competition has now been completed. The development of the insurers' role as prudent purchasers of care is still work-in-progress'.<sup>38</sup> Similar reforms are developing in Switzerland, in Israel, and to a lesser extent in Germany. During the 1990s, New Zealand also embarked on a rapid and ambitious reform program. This was modelled more on the British reforms of the same period, retaining the universal, tax financed system and introducing the purchaser-provider split.

Another theme in reform has been focused on how to pay providers. Funders and purchasers of health care, whether in a private insurance, social insurance or government funded model, are increasingly interested in using payment mechanisms to influence provider performance. Early research and analysis of provider payment systems focused on the comparison of behaviour under one form of funding compared to another (eg fee-for-service versus capitation versus salary) and the effects on service provision.<sup>39</sup> Fee-for-service, the traditional means of paying independent providers such as medical providers, clearly sets incentives for increasing the number of services; this, coupled with insurance with little, or no price signals to the consumer at the point of service, will increase total expenditure. Capitation, while reducing the incentive to over service, has been criticised for encouraging fewer services than appropriate. Similarly, the payment of hospitals had traditionally been on a per diem rate with extras charged on an item by item basis, encouraging longer stays in hospital and greater use of individual services. Case-mix payment, that is paying hospitals for the number and type of cases treated, developed in the 1980s, and by the mid 1990s was a widely accepted means of using payment mechanisms to improve 'efficiency'. However, even with improvements such as price-volume contracts, or bundling payments based on an episode of care, there was insufficient focus on the appropriateness and effectiveness of the care provided, and what was actually achieved by health care.

Pay-for-performance (P4P) schemes attempt to directly reward better health outcomes, at least in principle. Incentives for the provision of appropriate and effective care have been widely applied in the UK, as the basis of the general practitioner contracts and the Quality and Outcomes Framework implemented since April 2004. Subsequently pay-for-performance approaches have now been widely trialed in the US; according to Rosenthal and Dudley<sup>40</sup> more than half of commercial HMOs as well as Medicare are now using it. Wider adoption of pay-for-performance has been advocated by the Institute of Medicine<sup>41</sup> and several other influential commentators.<sup>42</sup> In Australia, the Productivity Commission had previously recommended redesigning payment mechanisms to improve incentives;<sup>43</sup> and the approach has been supported by the Commission. Germany is similarly committed to implementing this approach.<sup>44</sup> Indeed, according to a recent editorial in the *New England Journal of Medicine*,<sup>45</sup> these ideas have already reached a 'tipping point'.

There are several problems with implementing pay-for-performance. Health outcomes for many episodes of care are difficult to observe; although death is an unequivocal state, many health services are aimed at making people feel better. The final outcome may be quite distant in time from the original service, and many other factors outside the control or even influence of the original provider may intervene. Another problem is measurement, some clinical conditions are far more amenable to measurement than others (contrast diabetes care with mental health care). This can introduce a bias towards what is readily measured with the unintended consequences of short termism, neglecting other effective care, and crowding out intrinsic motivation. This has meant that in practice the focus has moved from the patient-relevant outcome to the process of providing treatment for which there is evidence of a positive effect. Consequently, the incentives are then back to managing activity rather than outcome. A further consideration is the type and size of the incentive itself. Important considerations are the nature and size, the target (eg individual providers, provider groups, consumers), and contextual factors such as the information system, type of organisation, aspects of

its culture, and the current reward mechanisms. An incentive that is too small will not change provider behaviour; one that is too large will provide excessive rewards and even windfall gains. In the UK, general practice earnings increased by 30 per cent, largely due to higher levels of achievement of quality targets than had been anticipated.<sup>46</sup> It is likely that this does not represent any real improvement to patients but rather is an under estimate of existing performance or even gaming of the system.<sup>47</sup>

So any implementation of pay-for-performance is likely to involve a range of indicators, with a consequent requirement for more sophisticated and perhaps cumbersome information systems. The UK Framework is characterised by a large number of clinical and other indicators.<sup>48</sup> Any implementation must identify the target behaviour, and consider the nature and size of the incentive, the target group (eg, individual providers, provider groups, consumers), and contextual factors such as the appropriate outcome measures and information system, type of organisation, aspects of its culture, the current reward mechanisms, and the transaction costs associated with imposing another major administrative structure. This makes it difficult to reach general conclusions about effectiveness, or how such approaches should be adapted from context to context.<sup>49</sup> While the rationale is strong, there are practical difficulties in identifying the appropriate measures, and rewarding provider effort rather than good patient selection.

Although there has been a strong commitment to reform in Europe and to some extent in the US, the Australian system has been remarkably immune from reform. The most significant change, and most noted in international policy circles, has been the 30 per cent subsidy granted to private health insurance.

### **The National Health and Hospitals Reform Commission directions**

The Roundtable began with a presentation from the Commission Chair. Although the Commission's Report is wide ranging, it was the intent of the Roundtable to focus on the governance issues. Three alternative models were offered for consideration. Under each alternative, primary care is to become the responsibility of the Commonwealth. The Commonwealth already funds medical primary care, that is general practice, and this stays in place with fee for service funding through the Medical Benefits Schedule (MBS). However, other practitioners (these include dentists, physiotherapists, pharmacists, podiatrists, community nursing services) would also be funded by the Commonwealth using a mix of grants, capitation, and performance payments. It appears that, instead of remaining as independent and scattered service providers, these would be brought together into Comprehensive Primary Health Care Centres which can also include medical providers. So in discussing governance, the Commission is really asking who should fund, own and operate public hospitals.

The Commission identified several strengths of the current system, and it's approach is to build on those rather than design from 'the ground up'. The opening statement affirms the value of universal entitlement, with the choice provided by private health insurance. It goes on to declare the current mix of financing from taxation, private insurance, and out-of-pocket spending to be not just the right balance but a strength of the system. Further, it calls for individuals to take more personal responsibility for their own health in return for more empowerment, for individuals and communities.

Option A can be described as incremental change. The States and Territories would continue to own and operate public hospitals; but the Commonwealth would assume a greater funding role. For inpatients, this would be 'a significant portion of the efficient costs of inpatient treatment' funded as fee per episode (casemix payment).

Commonwealth hospital payments would be as open ended as medical services and pharmaceuticals. Outpatient and emergency services would be fully funded but through agreed activity based budgets.

Option B is the development of regional health authorities. These authorities would take over from the States and Territories the responsibility for planning and operating public health services, mostly hospitals but also community health, school health and ambulance services. The regions would be given annual budgets from the Commonwealth, with some risk sharing. The Commonwealth would have a policy role, planning and funding major capital projects, setting rules around user charges, and monitoring performance.

Option C is multiple, competing insurance plans, who become purchasers. It is social insurance in that basic comprehensive cover (yet to be defined) would be provided by a tax financed, risk adjusted capitation payment. Plans would be able to offer additional benefit packages. It is managed competition in that most, but not necessarily all, plan operators would be private insurers or other non government bodies.

Alongside these options, there are a number of other bodies recommended by the Commission:

- A national health promotion and prevention agency responsible for national leadership, building capacity and infrastructure to integrate prevention into all aspects of the health system;
- Divisions of Primary Care, evolving from or replacing existing Divisions of General Practice, to provide efficient and effective coordination for service coordination and population health planning;
- A National Aboriginal and Torres Strait Islander Health Authority as the purchaser of health care services for Aboriginal and Torres Strait Islander peoples;
- Services in addition to primary health care that include pre-conception, antenatal, child and family services;
- School nurses in all primary schools to promote and monitor children's health, development and well-being;
- Continuing the Health and Community Care program for aged care;
- Special arrangements for rural and remote communities which incorporate networks of primary care, outreach specialist services, telehealth and 24 hour advice arrangements;
- Community based services for screening young people for mental disorders and sexual health;
- Denticare, which provides universal access with tax based funding to dental services, but with an 'opt-out' option to allow individuals to take their entitlement to a private insurer;
- The National Clinical Education and Training Agency as a purchaser of clinical placements required for training health professionals;

- The National Institute of Clinical Studies to encourage innovation with an emphasis on high quality and safety;
- The Commission on Safety and Quality in Health Care should become a permanent and independent body, to develop appropriate measures and monitor the quality and safety of patient care.

### ***Discussion from the Roundtable***

#### *Principles of good governance*

Roundtable participants accepted that public sector management practice identifies the desirable characteristics of governance as accountability, transparency/openness, integrity and efficiency; further the principle of subsidiarity emphasises that decision-making should be at the most local level possible consistent with communities of shared interests. Translating this to health care means that while there is a clear need for national goal setting and performance monitoring, decisions should be made at local, regional levels, rather than nationally. In short, service delivery organisations, such as hospitals, should not be run from Canberra.

There are also issues which are specific to health care. There is a high level of government involvement which requires political accountability. As well as the health or human services department, central agencies such as Treasury, Finance and Cabinet have an interest. Health is an extremely personal service, and at its most extreme a matter of life and death, hence health care delivery and allocation of health care resources will always be political. There is increasing recognition of the need for responsiveness to consumer preferences, and that there is justifiable heterogeneity in individuals. Communities, as well as individuals, have a right to influence resource allocation within their area. Health care professionals have a major influence, as advisers and providers to consumers; professional groups fiercely protect professional autonomy and so the engagement of health care professionals in serving community as well as individual interests is a particular challenge.

Unfettered market forces do not achieve a distribution of resources and facilities that matches population distribution and needs. So there is a need for a proactive approach to defining and determining appropriate service delivery. There is a need for better co-ordinated care, to avoid duplication, overcome gaps, and ensure appropriate care. This, in turn, requires flexibility of funding and better information systems; so that, for example, diagnostic tests are not repeated as patients move from one provider to another. Health care delivery is a sector of rapid and often major change, so governance arrangements have to be able to deal with change, particularly around the dissemination of new technologies so as to ensure safety, effectiveness and efficiency. Not least, there is a need to stimulate organisational change and to monitor and evaluate the impact of reforms across all aspects of the system.

This consideration suggests several desiderata for health system governance:

- Clear political accountability;
- National performance and monitoring frameworks;
- Regional population focus;
- Funding arrangements that are population focused but with maximum flexibility;

- Separation of purchaser and provider functions, with a concomitant investment in commissioning capacity;
- Engagement of health care professionals;
- Development of better incentives;
- Consumer responsiveness and autonomy;
- Community engagement;
- Commitment to evaluation and learning across the system;
- Investment in personal electronic health records;
- Investment in data bases to support monitoring, research and evaluation.

### *Current problems in the system*

The discussion also examined existing problems in the system and identified public hospitals as a major pressure point. Public hospitals are funded by State and Territory governments and represent a large portion of their budgets. Unlike the MBS and the PBS entitlement schemes (which are open-ended), public hospital budgets can be capped quite effectively. Any fiscal constraint at the State or Territory level will have a major impact on hospital budgets. Although expenditure has been shared with the Commonwealth, the relative contributions have varied,<sup>50</sup> allowing both Commonwealth and States to blame the other for failing to make a fair contribution. Public hospitals have faced cost increases, as a result of an increasingly complex workload, due to the growing prevalence of chronic disease and patients with multiple conditions; and as a result of technological advances – the most 'high-tech' concentrated in the super-speciality teaching hospitals of the public system. Public hospitals are in many ways the last resort, with emergency departments providing 24/7 care to all comers. The hospitals have no control on who presents and, with the shortage of nursing homes, transition facilities, and community services, have little control on getting in-patients out. As one participant suggested 'maybe the States just can't afford public hospitals any more'. Or as the recent review into the NSW public hospital system put it:<sup>51</sup>

If I were to sum up my conclusions about the performance of our public hospitals following ten months investigation, I would describe our hospitals as good by world standards, in many cases ranking towards the top, but too often unable to deal with the sudden increase in patients, the rising cost of treatment, and the pressures on a skilled workforce spread too thinly and too poorly supported in the dozens of administrative tasks which take them away from their patients.

Given the demographic changes and the rising costs, it is the case that we have entered into a period of crisis for a public hospital system which has always been free and accessible to all.

Although there have been attempts to introduce better performance measures, the budget bottom line is still paramount, and others, such as waiting times for ambulance arrivals in emergency, are open to gaming and manipulation.

The intersection of public hospitals and the other components of the system is where most problems occur. For the relatively healthy, the primary care provided by a medical practitioner meets their needs; in the case of acute major illness, they can be admitted for in-patient treatment, and discharged home when the acute phase is concluded.

However, the gaps in sub-acute care become evident for the elderly, and those with multiple chronic conditions. This vulnerable group may require more than primary medical care to maintain their health, and once in-hospital may require substantial support for rehabilitation and a return to independent living, or other forms of accommodation. These disjunctions in services are reinforced by funding mechanisms that are service-directed, rather than person-directed; and by poor communication across service streams and across providers.

Nonetheless, even in parts of the system that appear to work well, there are problems: problems of unsafe practices and lack of quality; problems of evaluating new technologies before their widespread dissemination; problems of ensuring innovation is implemented and sustained when warranted; problems in determining and assuring value for the health dollar; and monitoring the performance of the system, particularly in terms of outcomes achieved.

Although Australia has largely universal, publicly financed health care, there remain concerns with inequities in the system. The most stark of these surround Aboriginal and Torres Strait Islander (ATSI) peoples; and affect all aspects of health, mortality, chronic disease, access to basic services, and quality of care. But the concern with inequities is not limited to ATSI peoples health. There are various services which are not covered by Medicare, such as dentistry, or are poorly provided in the public sector, such as orthopaedics. Australian geography presents a particular problem. Services and health care professionals are not distributed in the same proportions as the Australian population, leaving gaps in service availability, and concerns for quality and safety. While this is not unique to Australia, the concentration of the population in the major cities and south eastern coastal fringe makes for a different challenge in providing services outside those areas. Many health professionals prefer to live in the population centres; yet mortality, morbidity and risk factors are higher in regional and remote areas. The delivery of specialised services requires not just the availability of trained staff and appropriate facilities, but also an understanding that many aspects of quality are related to the volume of cases treated. Without sufficient caseload, the quality of care can deteriorate. Thus it is not possible for many regions to be self-sufficient in terms of service delivery.

### *Governance Options*

The roundtable then considered the strengths, weaknesses and feasibility of each of the alternative governance structures.

Option A retains both State or Territory and Commonwealth involvement but attempts to clarify responsibilities and funding flows. The Commonwealth would take national leadership by developing a framework, an overarching National Health Strategy, which would in turn lead to eight state and Territory health strategies and eight bilateral agreements. So the negotiating process, and 'blame game' played out between Commonwealth and States is not removed. Community health services would be removed from States to the Commonwealth, and hospital outpatient treatment would be funded by the Commonwealth on an activity basis. The Commonwealth and States would share the funding of inpatient treatment, with a fixed Commonwealth contribution assessed against the 'efficient' cost of treatment.

Option B requires the Commonwealth to take over the functions that currently reside with State health departments, including legislation and regulation. This would

immediately ensure a national framework and a single national approach to replace the jurisdictions of States and Territories. This proposal does not envisage one system of services run from Canberra; rather it requires the Commonwealth to set up regional health authorities to plan and operate public health services. Would regional authorities differ from the current state structure? As agencies established by the Commonwealth, they would remove hospitals and related services from the constraints of State budgets, and the issues of State politics. But, as the Report suggests, they could in fact be States; and in other than NSW and Victoria, it makes little sense to have other than State wide agencies. Even as regional health authorities, the States would have very different roles, responsibilities and risks compared to current arrangements.

Regional authorities would focus on planning and operating health services, thus there would be no purchaser-provider separation. However, their budgets would be determined on a national basis, with a three year agreement negotiated with the Commonwealth. They would operate within a Commonwealth determined framework of user charges, planning of services, capital works planning, and performance monitoring. There would be some sharing of the financial risk between regions and the Commonwealth. The Report has not been specific about the basis for this, other than indicating hospital budgets would be activity-based, with fixed maximum payments, and some form of price-volume agreements under which the marginal price paid decreases as the level of activity increases.

One of the aspects of the universality of current arrangements is their transportability. Australians in any part of Australia are entitled to the same services under the same financial arrangements. Thus, visitors to other States do not need additional insurance to cover unexpected health care; their Medicare card buys the same pharmaceuticals, medical benefits, and free hospital care. Interregional transfers add another layer of complexity to developing appropriate financial arrangements, particularly if the region is at risk for higher service demand.

Under Option B, the existing arrangements for medical services (Medicare), pharmaceuticals (the PBS), and aged care would remain in place. The regional authorities would be responsible for public hospitals, but many other services now funded and operated by the States are transferred to other bodies as outlined above.

Option C is a managed competition model, although the Commission has preferred to term it 'social insurance' perhaps to distance it from the 'US managed care' criticism, and to emphasise the continued reliance on government funding. The idea of managed competition for Australia is not new, and was first advocated by Scotton in the 1980s.<sup>52</sup> The central focus is competing insurance plans, which are required to provide comprehensive coverage for their enrolees. Coverage must be comprehensive so that there is a strong incentive for insurers to actively co-ordinate and manage the care required by their enrolees. This will result in preferred provider arrangements, with negotiations on both price and quality aspects of care. The element of competition for customers is expected to drive their focus on meeting consumer preferences on both price and quality.

The Commission proposed that risk adjustment capitation payments be made to the insurance plans, so that most health care finance is raised through taxation, via an earmarked levy. This would transfer health care financing from general revenue to the Medicare levy. The basic plan would cover all of the existing publicly funded services, including hospital, medical, pharmaceutical, allied health and aged care. Insurers

would be allowed to charge additional premiums to cover any additional services or higher amenity levels as now covered by private insurance. Universality would be maintained by mandating that every Australian enrol in a health plan.

Under Option C, States could remain as owners and operators of public services, or they may choose to privatise the assets. Where they do remain as operators, they would be competing with private and not-for-profit providers for the same revenue under the same pricing rules. Financial risk is radically transferred. The risk for funding operating costs, and for earning a return on capital, is left with the owners and operators of health services. Of course, the inverse of this is that there is no national approach to planning. These providers may be reluctant to invest in small population centres, or where there is little community capacity to buy additional services. This model cannot guarantee service availability, and this could result in lack of services particularly in remote and rural areas.

This option proposes the greatest change to the current structure, and not just the structure but also the skills, expertise and conditions required for this to be implemented. The Commonwealth would have a much greater focus on the responsibility for establishing the regulatory framework, and monitoring performance, of the entire system, than it does now. An absolute pre-requisite is a robust, valid and workable risk adjustment mechanism, and the development of that in turn requires extensive data across existing programs. This is a substantial investment, one which Australia has not yet commenced. In contrast, the Netherlands invested over twenty years' research effort before embarking on the full managed competition model.

The Report acknowledged that managed competition brings with it much higher transaction costs for providers, consumers and insurance plans. Competing insurers will face higher marketing costs and duplicated administrative structures compared to one national insurer. Both insurers and providers are faced with the costs of negotiating arrangements – multiple insurers, who may offer different insurance packages, with multiple providers. Providers also face the costs of checking the insurance cover of consumers at the point of service, and then billing different funds. For consumers, there are also added transaction costs as they are required to consider complex information about insurance packages coverage, quality and cost; a process that needs to be repeated annually. Though not explicitly mentioned in the Report, there are also additional costs for government in maintaining the risk adjustment mechanism and monitoring performance. While performance monitoring should be a stronger component of the current system and risk adjustment can be seen as a component of that, the need for robustness in risk equalisation is much stronger where advantages can be gained by competing private interests.

#### *Is there a preferred national option?*

The Roundtable discussion produced little support for Option B. It was considered that regional health authorities would only be viable in the larger States. That would leave the States as the health authority in most jurisdictions so that Option B represented the least change. Many but not all participants found Option C appealing, as it offered the promise of greater consumer choice and responsiveness. Nonetheless, many participants were doubtful that the necessary changes were feasible which led them to a more pragmatic conclusion that reform could only be implemented in particular service areas.

If the Commission was hoping for strong guidance from the Roundtable, it was not forthcoming. The Options were presented as alternatives. Health care reform requires agreement on the need for change, but while that is necessary it is not sufficient. Agreement that there should be change is not the same as agreeing on the direction of change; and reform requires a constituency to support a particular direction. The third challenge is to determine 'how to get there from here'; and like the old joke, it's often better not to start from here. When one considers how to implement reform, it is clear that the three options are not just alternatives but could be steps along a path of transition. Option A would be the first step and would set some infrastructure in place while developing capacity. Option B would provide further development of the infrastructure, while Option C would represent the final step into a managed competition system.

#### *Commentary on governance options*

Option A is an attempt to fix the current system by moving primary care funding to the Commonwealth, while making the responsibilities and funding for public hospitals more clearly delineated between the two levels of government. The Report is silent on what would happen to private treatment whether in public or private hospitals. Private hospitals have been increasing their admissions and the complexity of cases treated, so they are an important component of the system. The Commonwealth already subsidises private treatment through the 30 per cent rebate applied to private health insurance. The Commission was explicitly directed not to consider removal of the rebate, so criticism on this ground is unwarranted. However, exploring the implications does demonstrate how interconnected parts of the system are.

Currently, patients admitted to public hospitals can elect to be treated privately, in which case the hospital and the treating doctors raise charges, and private insurance can cover all or part of these charges. It is generally felt that the charges raised by public hospitals do not cover the average cost of treatment, but public hospitals have been keen to encourage private treatment, in some cases waiving out-of-pocket costs; so this is an important source of revenue for public hospitals. If private treatment in public hospitals is not included in the cost sharing arrangements, then insurers will be expected to cover a higher proportion of costs (with a flow on to premiums); States with high proportions of privately insured residents may receive a smaller share of Commonwealth funds and feel they are disadvantaged; and as public hospital work becomes less lucrative for medical staff they may increase their activity in private hospitals. If private treatment in public hospitals is included, then private hospitals will feel at a competitive disadvantage. This discussion highlights the need for more detail before the full implications of Option A can be assessed.

The financial risk around public hospitals would be passed, in part, from State and Territory governments to the Commonwealth which would be exposed via some form of hospital benefits table to an open-ended commitment. The Commission proposes that these payments should include an allowance for capital. Hospitals are capital intensive, and the appropriate capital component of an activity based payment depends on the volume of activity over the asset's lifetime. Underestimating the capital component will underfund maintenance and replacement; but overestimation could encourage inefficiency through underuse of facilities. In either case, there are perverse incentives to increase volumes of services. Both governments would share this risk. It

seems that the planning for major new hospital facilities would rest with the States, and so there is no provision for separation of the hospital provision and purchasing role.

Further, the separation between primary, post-acute care, and hospital care, and across different providers with responsibility for the patient's welfare, remains. It is not clear that this will affect management within hospitals or better equip them to deal with innovation, adoption of new technologies, removing outmoded or ineffective treatments, or improve safety.

Option B, according to the Commission, 'would substantially resolve the blame game between governments'. This is a considerable claim. Although States would not directly fund health services, they would still be responsible, through the regions, for operating them. States or regions could be blamed for managerial incompetence, while in return the Commonwealth could be blamed for inadequate funding or poor capital planning. While health services should have little or no claim on State budgets, the shared risk scenario still leaves an opening for State funding. And the round of agreements would be three yearly, rather than the current five yearly Australian Health Care Agreements. The Report suggested that the regions could link to private and not-for-profit providers in their regions, but again did not develop what this would mean in practice. The regions would be operating the public services, in many cases in competition with the private and not-for-profit providers. If these private providers can claim activity-based payments directly from the Commonwealth, there is an incentive for them to cream-skim, leaving the more difficult to manage and less profitable cases for the public providers. Nor is it clear what this would mean for the distribution of the workforce across the public and private sectors. However, it is difficult to see that this would facilitate co-ordinated planning or a population perspective.

Although managed competition, Option C, embraces competitive forces, there is also a strong role for government in setting the regulatory framework – the managed part of managed competition. This has to go beyond the normal prudential regulation. Government must determine the minimum benefits package, and the model will only deliver its desired outcomes if the insurers compete on price and quality, not on selection of better risks. The way that this is achieved is through risk adjusted premiums paid to the insurer, so government is required to determine the risk adjustment mechanism, and monitor performance. The model also relies on consumers exercising their choice, and being able to switch insurers, so appropriate information on costs and services must be readily available to consumers.

The insurance plans also bear much greater risk, as they receive a premium from which they must provide a defined range of services. While they can manage this, by negotiating preferred provider arrangements and focussing on appropriateness of care, they would be limited in the extent to which they could rely on consumer co-payments. It is not clear what this would mean for transferability. The plans are likely to limit their enrollees to their preferred provider networks, but these may well be geographically focussed; meaning that people who move or travel may have more limited coverage. Presumably the Divisions of General Practice or Primary Care are subsumed under these insurance plans. While current insurers are most likely to be transformed into these insurance plans, the Report does suggest that large provider organisations could also become plans; it is not clear whether the Commission considered Divisions of Primary Care could also evolve into insurers.

The insurance plans would also be required to make substantial changes. Historically, Australian health insurance funds have been passive conduits of funds from their members, and government, to providers.<sup>53</sup> Managed competition requires a much more proactive approach with the funds able to attract providers, but under conditions which limit their activity and hence their income. Although there have been various attempts to expand the role of insurance funds, since selective contracting and no-gap contracts were first allowed, through to the most recent provisions under Broader Health Cover<sup>54</sup> which includes outpatient and out-of-hospital services, chronic disease management, and prevention, they have not yet taken a strong proactive approach. Further, the Australian community has been encouraged to see private insurance funds as the means to avoid the restrictions and queues of the public system; this makes it difficult to sell a private insurance approach which will restrict choice. It is surprising that the criticism of 'US style' medicine was slow to emerge.

The role of consumers also has to change. Unless they are prepared to switch insurance plans, the competitive forces which are the basis for achieving efficiency in this model will not take effect. This means that there is a requirement for government to develop and mandate consumer information, though it could be expected that comparative prices should be relatively easily understood. Consumers find it difficult to understand and interpret quality information. In the Netherlands consumers' initial response to choice of insurers resulted in relatively high rates of switching between plans, but the trend is to low rates, less than 5 per cent of consumers changing insurance each year. Similarly low rates have been observed in other countries with insurance choice, Switzerland, Belgium, Germany and Israel, even when there are substantial differences in premiums.<sup>55</sup> Advocates argue, that in spite of the low switching rates, there is sufficient mobility to keep the insurers competing.

Interestingly the model proposed for Denticare moves straight into Option C. Private insurers are given the opportunity to become purchasers of dental services on behalf of their members; consumers are given the opportunity to opt-out of the public system, but their share of public funds is moved with them via a voucher, its value determined through a risk equalisation adjustment.

Finally, there is the question of implementation of whatever option is chosen. Every model proposed requires some funds pooling, certainly in the fully managed competition of Option C, but also in the minimalist change of Option A. Previous experience of funds pooling in this country, the Coordinated Care Trials,<sup>56</sup> demonstrated that this is not easy to implement. This and other examples have shown that a critical condition for implementing new funding mechanisms is the appropriate investment in the underlying research, in this case the risk adjustment formulae. This level of investment must be sustained over time, within a timeframe that allows for the development confidence from policy makers and players in the rigour of the research. This was the approach taken with the development of case-mix funding in this country.<sup>57</sup> Sustained investment in risk adjustment also is a factor in the successful implementation of the Dutch reforms.<sup>58</sup> Several other aspects of implementation have not been addressed by the Commission's proposals, and again these are common to whichever of the options is selected.

Alongside all these options, there are a number of other bodies and programs recommended by the Commission. These are not contingent on which of the three governance options is adopted. This would see the addition of several agencies, Boundaries and responsibilities are not clear, nor is it stated to what extent and how

funding will flow through these agencies, so there is still room for inter-agency duplication and gaps.

The issue of governance of and management within hospitals, particularly public hospitals, has not been addressed, which is interesting given the prominence of this issue in the 2007 election campaign. The role of clinicians as leaders of change, as managers of the system, and as advocates for patients is almost unchallenged; but other than decrying the rise in the number of purely administrative staff, the role of general managers is overlooked. There is no discussion of the extent to which the problems in public hospitals are due to poor management structures rather than lack of funding. In terms of long term funding, the Commission's conclusion is quite definitive. Investment through primary care and prevention to keep people healthy will reduce the upward pressure on health care spending, although overall the evidence on preventive programs is that few are cost saving (as is also the case for treatment).<sup>59</sup>

It is interesting that the problems raised by this Commission are not new. The National Health Strategy, a review established in 1991, contemplated major restructuring of Commonwealth-State arrangements (six options that time) to meet the growing challenges of chronic care and to remove barriers to flexibility and perverse incentives created by separate funding streams.<sup>60</sup> So that prompts the question of why reform has been so difficult to achieve in the Australian system. To some extent, this is the fault of the federal structure of government, as national action requires concerted action across States and the Commonwealth. But then, the Netherlands, too, is a federation and that country presents the most progressive reform currently underway. Health has been highly politicised, and most political analysts rate it as a significant election issue in most federal and state elections. Rather than increasing the intellectual debate about health system performance, the health debate has been stultified, for the most part focusing on the role of private finance and private insurance, or on shifting responsibilities and costs.

#### *Commentary on the role of research and evidence*

The Commission addressed the issue of research explicitly and made a strong recommendation for 'continuous learning in our health system', building on Australia's strong reputation in health and medical research. The notion of evidence-based care has strong traction in medicine and health care: that is, that clinical decisions should be made with a synthesis of the best available scientific evidence. In general, that means a reliance of the results of randomised controlled trials rather than 'experience' and 'hunch'. This reliance on evidence has been incorporated into the approval and funding of new pharmaceuticals and new medical procedures. Two aspects of research were identified: research into the efficacy of new and existing interventions; and research into dissemination so that new findings will be speedily transferred into routine clinical practice. Finally, the Commission called for 'closing the feedback loop' so that all health services are required to report on their activities in research and quality improvement.

There is a welcome recognition of the need for good data and for linked or linkable data. This is necessary but not necessarily sufficient, as there needs also to be capacity in the research community and ready access to data bases and linkage. Within the health arena, many valuable data sets are guarded closely by their custodians, thus limiting the use which can be made of them. However, the tenor of the

Report is around research at the clinical interface and research that is translated into clinical decision making. The recommendation for higher priority for funding for health services research is 'to facilitate the uptake of research findings into practice'. The Commission calls for a cohort of clinical research fellows although there are avenues for clinical research fellows already, with schemes to combine clinical activity with research supported by the National Health and Medical Research Council, the National Institute for Clinical Studies, the Australian Commission on Safety and Quality, and the Australian Primary Health Care Research Institute.

In contrast, there is no recognition of the issues around big picture aspects of health policy/services research. There are non-clinical issues which will affect other aspects of the Report's proposals. Consider the proposals for primary care. Who will own and run the Comprehensive Primary Care Centres? Does it matter whether they are for profit or not-for-profit? What incentives will be generated by multiple providers in some sort of partnership? What size should they be to be efficient? Consider the proposals for expanded Divisions of Primary Care. What is known about what Divisions of Primary Care should be? How big? What form of ownership? Consider the proposals for performance payment for primary care – blended payment systems with a goal of rewarding performance. What is known about selecting performance indicators? With pay-for-performance schemes, too little is about getting the blend and the level right, the UK experience demonstrates the pitfalls of getting the incentives wrong.

There is clearly wide scope for research that would support these policy choices. As Campbell noted, all social policy is experimentation, and the collaboration that bears his name is an ongoing effort to produce evidence to support policy-making for social interventions.<sup>61</sup> Whereas the randomised clinical trial has become dominant in determining the effectiveness of clinical interventions, and hence as the evidence base for clinical decision-making, there is rarely the equivalent of these clinical randomised controlled trials for social policy, and there are different challenges in defining and assembling evidence. For example, controlling all the factors that may influence the outcome is often not possible, and even not appropriate, when the interplay of environmental factors with aspects of the intervention contribute to what works and when. More reliance has to be placed on quasi-experimental approaches, and using a broader range of sources.<sup>62</sup> The Interim Report certainly missed the opportunity to strengthen the support for policy relevant research in Australia. There was no recommendation for research funds or investment in the human capital of research expertise outside of the clinical arena. There was no proposal for research and evaluation beyond the clinical interface. Their definition of health services research was disappointingly narrow in its scope.

### **Post-script: The Final Report**

The Final Report was released in August 2009, followed by the National Preventative Taskforce Report, and the Primary Health Care Strategy (Draft Report). The government is now undertaking a series of consultations around the recommendations. There are 123 recommendations from the Health and Hospitals Reform Commission, most reiterating those already made public. New recommendations seem to cover some specific interests or topics overlooked in the Interim Report, including: ongoing debate about the extent of services which should be provided by public funds (ie the

minimum benefits package); ongoing monitoring of consumer confidence in the system; more support for informal carers; action to address the social determinants of health; subsidies for fresh food in remote Aboriginal and Torres Strait Islander communities; and training support for rural and remote area practitioners.

The main structural elements of the Interim Report have remained and been strengthened. Comprehensive Primary Health Care Services are to be funded through Commonwealth competitive and targeted grants. The idea of enrolment with primary care providers to ensure continuity of care has been strengthened; individuals with complex conditions, young families and Aboriginal and Torres Strait Islander people are to be offered 'health care homes' by enrolling with their preferred primary care service with alternatives to fee for service funding to cover multidisciplinary care and reward good performance. The Divisions of Primary Care have become Primary Health Care Organisations, which will develop from existing Divisions of General Practice to reflect all the clinical disciplines involved in primary care. There is a stronger emphasis on information gathering and planning for a more co-ordinated approach. There is still a separate strategy for a service program aimed at young children, a program of school nurses, and special arrangements for remote and rural communities. Denticare remains. The new purchasing authority for Aboriginal and Torres Strait Islander peoples remains. The new national health promotion agency remains.

National action on health promotion and prevention was further supported by the release of the National Preventative Health Taskforce, although action in this area was established with the 2008 COAG National Partnership Agreement on Preventative Health which committed an investment of \$872m over the next six years. The focus of the Taskforce Report is much more directed towards broad government action, through regulation, taxes, subsidies, and policy instruments other than health service delivery.

On governance reform, the Commission has moved to strong support for 'a uniquely Australian governance model that builds on and expands Medicare' to be known as Medicare Select. It is, in essence, Option C, the managed competition model with some minor changes and re-wording. The term 'social insurance' has been dropped, though an explicit tax for health cover is still favoured. The minimum benefits package has been renamed the universal service obligation. Australians will be automatically enrolled with the government plan, though free to switch to another plan provided by for profit insurers, not for profit enterprises, or other government plans. Special plans may be offered to individuals living in remote areas. Policy and services that will remain the responsibility of the Australian government are identified as biosecurity, ambulance, some public health, and some highly specialised medical care such as organ transplants. There is an explicit intent to ensure a range of alternative plans are available so that consumers are offered meaningful choice. And the Commission has set out a research agenda to be tackled as the basis for moving forward.

Given the range and complexity of the issues that need to be resolved before any implementation of Medicare Select, the Commission has also recommended immediate action to improve Commonwealth-State coordination and co-operation through the 'Healthy Australia Accord'. The features of this are moving a range of funding and policy responsibilities to the Commonwealth. Funding for primary health care, dental care and aged care will move, as will professional registration, performance monitoring and reporting, and private hospital regulation. Commonwealth-State funding agreements for public hospitals will be altered to provide 100 per cent

funding for outpatient services, 40 per cent of public hospital admissions (including sub-acute and mental health facilities) and emergency visits, and 100 per cent clinical education and training costs. The first two will be funded on an activity basis.

Option B, the regional health authorities model, has been dropped. The reasons given are these:

- The risk of the Commonwealth being a single funder given its lack of experience in operating health care systems;
- The inherent difficulties in setting fair budgets;
- The need to adjust for cross-border flows;
- The danger of differential access developing according to where people live, with some organisations able to provide more and better services;
- The problems of implementing the model in rural and remote areas; and
- The need to introduce a new layer of bureaucracy.

It is interesting the same or similar reasons have not been canvassed in relation to Medicare Select. Yet several apply equally. It is not evident that the difficulties inherent in setting regional budgets are greater than the difficulties of developing appropriately fair risk adjustment mechanisms for capitation payments; and under managed competition, there are strong incentives for insurers to engage in favourable risk selection, where as it is almost impossible for regional authorities to select on an individual basis. Under competing insurance plans with alternative cover and different premiums, there will be differential access and this will pose great challenges for ensuring equity. Although regional health authorities represent a new layer of bureaucracy, health plans will also introduce a new function and hence new bureaucrats to take charge of the commissioning and purchasing tasks. Competing plans also impose additional transactions costs on consumers, as they must review the alternative plans on offer, and express their preferences through switching plans if appropriate.

The implementation of change poses a challenge in rural and remote areas, whether it be on financing or in service delivery, as there is a small population base, scattered over a large geographic area. This is a problem under current arrangements, and will remain a problem under Medicare Select, as the Commission acknowledged by suggesting there may have to be special plans for rural areas.

## **Conclusion**

The basic structure of the Australian health care system has remained unchanged over half a century. Ten years ago the Industry Commission described the result:<sup>63</sup>

In undertaking reforms, governments have had a number of objectives, some of which are incompatible...Ad hoc and piecemeal reforms to a complex, interactive system can have some beneficial effects, but also can create further tensions and the need for additional government interventions. The outcome is a system which, despite numerous policy changes, has inherent and unresolved tensions.

In the intervening period, policies have continued to address particular pressures in the system, resulting in a piecemeal approach with small fixes and new spending

programs. In the last ten years, the real growth in average per person health expenditure has been 3.7 per cent, the highest growth in service intensity in ten leading OECD countries.<sup>64</sup> There are few checks and balances in the current system to constrain that growth. Constraints to date have relied on public hospital budget cuts, and out-of-pocket charges.

The Rudd Government promised to sort out the performance of public hospitals, with a Commonwealth takeover if reform was not achieved co-operatively. The Commission promised it would 'go boldly' into reform Territory. A strong and rational reform plan should overcome the piecemeal approach of the past. It should tackle the fundamental underlying pressures that fuel growth in services and expenditure. It should provide a blueprint for a health system that can adapt to the twenty first century. What has the Commission delivered? The Commonwealth is certainly 'off the hook' for its mooted takeover of public hospitals. The Commission has firmly recommended against this course of action. Medicare Select, if implemented, would certainly change the landscape of health care finance and delivery in this country. However, there are a range of challenges to be overcome, both technical and political. The biggest technical challenge is the development of a fair and robust risk adjustment mechanism. The political challenges are several, and involve the States, existing providers, the medical profession and overall the acceptance of the Australian public that all their health services would be financed through insurers. So Medicare Select will not come soon, if it even comes at all.

In the meantime, the health system has been left with the Healthy Australia Accord. The Commonwealth will assume additional responsibilities for primary and aged care. That may help with better co-ordination of services within those sectors but it does seem that the cost is an additional layer of bureaucracy at the Primary Health Care Organisation level. Public hospitals remain with the States, and with periodic funding agreements negotiated with the Commonwealth. The split and potential for shifting of costs and responsibilities has not been eliminated, rather the boundaries have been moved. Perhaps the Commission was trapped by its initial approach, being the acceptance of much of the existing system, as articulated in its Interim Report. For example, reform direction (13.2) that stated 'we want to see the overall balance of spending through taxation, private health insurance, and out-of-pocket contribution maintained over the next decade'. This contrasts with the approach of defining the desirable features of a well performing health care system, and then asking what should be done differently.<sup>65</sup> It is inherently bound to produce further piecemeal additions.



**Jane Hall** is Professor of health economics in the Faculty of Business, University of Technology, Sydney and Director of the Centre for Health Economics Research and Evaluation. Her research interests have covered many aspects of health economics, including economic evaluation studies in health services and public health. Among her current research are studies of unpaid health care, and of the nursing workforce. She was President of the International Health Economics Association 2006-07. She is well known for her analysis of developments in the Australian health care system and she is involved in health policy and planning issues both in Australia and internationally.

- 
- 1 See ABC News (2007) *Rudd Announces Hospital Takeover Plan* <http://www.abc.net.au/news/stories/2007/08/23/2012915.htm> (Accessed October 1 2009).
  - 2 See National Health and Hospitals Reform Commission home page <http://www.nhrc.org.au/> (Accessed 13 January 2009).
  - 3 National Health and Hospitals Reform Commission (2009a). *A Healthier Future for all Australians: Interim Report December 2008*. Canberra: Commonwealth of Australia.
  - 4 National Health and Hospitals Reform Commission (2009b). *A Healthier Future for all Australians: Final Report*. Canberra: Commonwealth of Australia.
  - 5 Australian Institute of Health and Welfare (2008a). *Health Expenditure Australia 2006-07*. Canberra: Australian Institute of Health and Welfare.
  - 6 Australian Institute of Health and Welfare (2008b). *Australia's Health 2008: The Eleventh Biennial Health Report of the Australian Institute of Health and Welfare*. Canberra: Australian Institute of Health and Welfare.
  - 7 Goss, J (2008). *Projection of Australian Health Care Expenditure by Disease, 2003 to 2033*. Canberra: Australian Institute of Health and Welfare.
  - 8 Australian Institute of Health and Welfare (2008b) *op cit*.
  - 9 Department of Treasury (2007). *Intergenerational Report 2007*. Canberra: Commonwealth of Australia.
  - 10 Australian Institute of Health and Welfare (2008a) *op cit*.
  - 11 Crichton, A (1990). *Slowly Taking Control? Australian Governments and Health Care Provision, 1788-1988*. Sydney: Allen & Unwin.
  - 12 *Ibid*.
  - 13 Hall J (1999). 'Incremental change in the Australian health care system'. *Health Affairs*, 18: 95-110.  
Hall, J and Savage, E (2005). 'The role of the private sector in the Australian healthcare system' in Maynard, A (ed) *The Public-Private Mix for Health*, Abingdon: Radcliffe.
  - 14 Australian Institute of Health and Welfare (2008b) *op cit*.
  - 15 Podger, A (1999). 'Reforming the Australian health care system: A Government perspective'. *Health Affairs*, 18: 111-113.
  - 16 Sax, S (1984). *A Strife of Interests: Politics and Policies in Australian Health Services*. Sydney: George Allen & Unwin.  
Sax, S (1990). *Health Care Choices and the Public Purse*. Sydney: Allen & Unwin.  
Scotton, RB (2001). 'The making of Medibank', in Mooney, G and Plant, A (eds) *Daring to Dream: The future of Australian health care. Essays in honour of John Deeble*, Bently: Black Swan Press.

- <sup>17</sup> Gauld, R (2008). 'The unintended consequences of New Zealand's primary health care reforms'. *Journal of Health Politics, Policy and Law*, 33: 93-115.
- Mays, N and Devlin, N (2005). 'The public-private mix in health services in New Zealand', in Maynard, A (ed) *op cit*.
- <sup>18</sup> Feldstein, M (2006). 'Balancing the goals of healthcare provision and financing'. *Health Affairs*, 25: 1603-1611.
- Pauly, MV (2000). 'Insurance reimbursement', in Culyer, AJ and Newhouse, J (eds) *Handbook of Health Economics: Volume 1*. Amsterdam: Elsevier : 537
- <sup>19</sup> Cutler, D and Zechauser, R (2000). 'The anatomy of health insurance', in Culyer and Newhouse *ibid*: 563.
- <sup>20</sup> Pfaff, M and Kern, A (2005). 'Public-private mix for health care in Germany', in Maynard, A (ed) *op cit*.
- <sup>21</sup> Klein, R (2005). 'The public-private mix in the UK', in Maynard, A (ed) *ibid*.
- <sup>22</sup> Fuchs, V (1998). *Who Shall Live? Health, Economics, and Social Choice*. New York: World Scientific Publishing Company.
- <sup>23</sup> Keen, J, Light, D and Mays, N (2001). *Public-private Relations in Health Care*. London: King's Fund.
- <sup>24</sup> See OECD (2008), *OECD Health Data*. OECD, Paris.
- <sup>25</sup> Enthoven, AC (1978b). 'Consumer-choice health plan (second of two parts). A national-health-insurance proposal based on regulated competition in the private sector'. *New England Journal of Medicine*, 298: 709-720.
- Enthoven, AC (1978a). 'Consumer-choice health plan (first of two parts). Inflation and inequity in health care today: Alternatives for cost control and an analysis of proposals for national health insurance'. *New England Journal of Medicine*, 298: 650-658.
- <sup>26</sup> Sax, S (1972). *Medical Care in the Melting Pot: An Australian review*. Sydney: Angus and Robertson.
- <sup>27</sup> Hall, J (2004). *Can we Design a Market for Competitive Health Insurance? CHERE discussion paper 53*. Sydney: Centre for Health Economics Research & Evaluation (CHERE).
- <sup>28</sup> van de Ven, W and Schut, FT (2007). *Risk Equalization in an Individual Health Insurance Market: The only escape from the tradeoff between affordability, efficiency and selection. The Netherlands as a case study*.  
[http://www.fresh-thinking.org/docs/workshop\\_070503/PaperVandeVenSchut02apr07.pdf](http://www.fresh-thinking.org/docs/workshop_070503/PaperVandeVenSchut02apr07.pdf)  
(Accessed 10 August 2007).
- <sup>29</sup> van de Ven, WPMM and Ellis, RP (2000). Risk adjustment in competitive health plan markets, in Culyer and Newhouse (eds) *op cit*.
- <sup>30</sup> See Hall, J (2004) *op cit and*  
van de Ven, WPMM and Ellis, RP (2000) *op cit* for further discussion.
- <sup>31</sup> Glied, S (2000). 'Managed care', in Culyer and Newhouse (eds) *op cit*.
- <sup>32</sup> Enthoven, A and Kronick, R (1989b). 'A consumer-choice health plan for the 1990s. Universal health insurance in a system designed to promote quality and economy (2)'. *New England Journal of Medicine* 320: 94-101;
- Enthoven, A and Kronick, R (1989a). 'A consumer-choice health plan for the 1990s. Universal health insurance in a system designed to promote quality and economy (1)'. *New England Journal of Medicine* 320: 29-37.
- <sup>33</sup> European Observatory on Health Care Systems (1999). *Health Care Systems in Transition: United Kingdom*. Copenhagen: European Observatory on Health Care Systems;
- Hurst, JW (1991). 'Reforming health care in seven European nations'. *Health Affairs* 10: 7-21.
- <sup>34</sup> Maynard, A (2005). 'UK health care reform: Continuity and change', in Maynard (ed) *op cit*.
- <sup>35</sup> Le Grand, J (1999). 'Competition, cooperation, or control? Tales from the British national health service'. *Health Affairs* 18: 27-39.

- <sup>36</sup> OECD (2008) *op cit*.
- <sup>37</sup> Schut, FT and van Doorslaer, EK (1999). 'Towards a reinforced agency role of health insurers in Belgium and The Netherlands'. *Health Policy* 48: 47-67.
- <sup>38</sup> van de Ven, WP and Schut, FT (2009). 'Managed competition in The Netherlands: Still work-in-progress'. *Health Economics* 18: 253-255.
- <sup>39</sup> Scott, A and Hall, J (1995). 'Evaluating the effects of GP remuneration: Problems and prospects'. *Health Policy* 31: 183-195.
- <sup>40</sup> Rosenthal, MB and Dudley, RA (2007). 'Pay-for-performance: Will the latest payment trend improve care?' *JAMA* 297: 740-744.
- <sup>41</sup> Committee on Quality of Health Care in America (2001). *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington: Institute of Medicine.
- Committee on Redesigning Health Insurance Performance Measures, Payment and Performance Improvement Programs Institute of Medicine (2007). *Rewarding Provider Performance: Aligning Incentives in Medicare*. Washington DC: National Academies Press.
- <sup>42</sup> Berwick, DM (2003). 'Same price, better care: Commentary on "Getting more for their dollar: A comparison of the NHS with California's kaiser permanente"'. *BMJ* 324: 142-143.
- <sup>43</sup> Productivity Commission (2005). *Review of National Competition Policy Reforms*. Canberra: Productivity Commission.
- <sup>44</sup> Bloor, K, Maynard, A and Freemantle, N (2004). 'Variation in activity rates of consultant surgeons and the influence of reward structures in the English NHS'. *Journal of Health Services Research and Policy* 9: 76-84.
- <sup>45</sup> Epstein, AM (2007). 'Pay for performance at the tipping point'. *New England Journal of Medicine* 356: 515-517.
- <sup>46</sup> Galvin, R (2006). 'Pay-for-performance: Too much of a good thing? A conversation with Martin Roland'. *Health Affairs* 25: w412-w419.
- Maynard, A (2007). 'Is doctors' self-interest undermining the NHS?' *BMJ* 334: 224.
- <sup>47</sup> Campbell, S, Reeves, D, Kontopantelis, E, Middleton, E, Sibbald, B and Roland M (2007). 'Quality of primary care in England with the introduction of pay for performance'. *New England Journal of Medicine* 357: 181-109.
- <sup>48</sup> Downing, A, Rudge, G, Cheng, Y, Tu, Y, Keen, J and Gilthorpe, M (2007). 'Do the UK government's new quality and outcomes framework (QOF) scores adequately measure primary care performance? A cross-sectional survey of routine healthcare data'. *BMC Health Services Research* 7:166.
- <sup>49</sup> Dudley, RA, (2004). *Strategies to Support Quality-based Purchasing: A Review of the Evidence*. Rockville: Agency for Healthcare Research & Quality.
- <sup>50</sup> Australian Institute of Health and Welfare (2008b) *op cit*.
- <sup>51</sup> Garling, P (2008). *Final Report of the Special Commission of Inquiry. Acute Care Services in NSW Public Hospitals*, in NSW Special Commission of Inquiry, p3 1 22 1.23. Sydney: NSW Special Commission of Inquiry.
- <sup>52</sup> Scotton, R (1999). 'Managed competition', in Mooney, G and Scotton, R (eds) *Economics and Australian Health Policy*, Sydney: Allen & Unwin.
- Scotton, RB (1990). 'Integrating Medicare with private health insurance: The best of both worlds?' In Selby Smith, C (ed) *Economics and Health 1989: Proceedings of the Eleventh Australian Conference of Health Economists*. Clayton: Monash University.
- <sup>53</sup> Willcox, S (2005). 'Buying best value health care: Evolution of purchasing among Australian private insurers'. *Australia and New Zealand Health Policy* 2:6.
- <sup>54</sup> Broader Health Cover is the name given to the new insurance regulations which permit funds to offer cover for out of hospital care which will substitute for or prevent hospital admissions.
- <sup>55</sup> Leu, RE, Rutten, FFH, Brouwer, W, Matter, P and Rüttschi, C (2009). *The Swiss and Dutch Health Insurance Systems: Universal Coverage and Regulated Competitive Insurance Markets*. New York: The Commonwealth Fund.

- <sup>56</sup> The Coordinated Care Trials were pilot schemes which allowed the pooling of funds from the MBS, PBS and some publicly funded community services under the management of a case co-ordinator for a defined population group.
- <sup>57</sup> Hall, J and Viney, R (2008). 'National health reform needs strategic investment in health services research'. *Medical Journal of Australia*, 188: 33-35.
- <sup>58</sup> van de Ven, WP and Schut, FT (2009) *op cit*.
- <sup>59</sup> Russell, LB (2007). *Prevention's Potential for Slowing the Growth of Medical Spending*. Washington, DC: National Coalition on Health Care.
- <sup>60</sup> National Health Strategy (Australia) (1991a). *Hospital Services in Australia: Access and Financing*. Canberra: Department of Health, Housing and Community Services.
- National Health Strategy (Australia) (1991). *The Australian Health Jigsaw: Integration of Health Care Delivery*. Canberra: Department of Health, Housing and Community Services.
- <sup>61</sup> Campbell, DT (1969). 'Reforms as experiments'. *American Psychologist* 24: 409-429.
- <sup>62</sup> See Banks, G. *Evidence-based policy-making: What is it? How do we get it?* <http://www.pc.gov.au/speeches/cs20090204> (Accessed 10 March 2009).
- <sup>63</sup> Industry Commission (1997). *Private Health Insurance*. Canberra: AGPS.
- <sup>64</sup> Australian Institute of Health and Welfare (2007). *Health Expenditure Australia 2005-06*. Canberra: AIHW.
- <sup>65</sup> The Commonwealth Fund Commission on a High Performance Health System (2009). *The Path to a High Performance US Health System: A 2020 Vision and the Policies to Pave the Way*. New York: The Commonwealth Fund.

