Prospects for Managed Health Care in Australia
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About the author

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<table>
<thead>
<tr>
<th>Abbreviation</th>
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<tr>
<td>COAG</td>
<td>Council of Australian Governments</td>
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<td>DRG</td>
<td>Diagnosis Related Groups</td>
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<td>GP</td>
<td>General Practitioner</td>
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<td>HIC</td>
<td>Health Insurance Commission</td>
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<td>HMO</td>
<td>Health Maintenance Organisation</td>
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<td>IPA</td>
<td>Independent Practice Organisation</td>
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<td>LOS</td>
<td>Length of Stay (in hospital)</td>
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<td>MBS</td>
<td>Medical Benefits Scheme</td>
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<td>MCO</td>
<td>Managed Care Organisation</td>
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<td>NHS</td>
<td>National Health Service (UK)</td>
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<td>NPS</td>
<td>National Provider Service</td>
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<td>PBS</td>
<td>Pharmaceutical Benefits Scheme</td>
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Major Issues

Emerging in the US in the 1980s, the concepts of managed health care are increasingly seen around the world as useful approaches to improving the efficiency and effectiveness of health care. It is extremely difficult to define managed care, except very broadly as an attempt to influence the cost, mode of delivery or quality of health care.

Managed health care is controversial. In the US, it has been blamed for restricting patient choice, limiting professional medical autonomy in order to reduce costs and reducing the quality of health care. Some of these claims are true, but conversely managed care has also led to many useful innovations and improvements. Some of these innovations include organising care around disease groups ('disease management'), better use of clinical and cost information for managing care, and standardising care to reduce the variability in cost, quality and access to services. US-style managed care in fact comes in many varieties. Moreover, the managed care industry is rapidly changing in response to intense competition, greater government regulation and consumer concerns at over-zealous gate-keeping by some companies. Managed care is not a monolithic approach, but in fact consists of a range of relatively distinct tools that can be applied in various ways, without the heavy-handed emphasis on cost control used in the US.

US-style managed care also reflects the for-profit motives of many managed care organisations and that private employers are the main source of funds. For example by the late 1980s General Motors was spending around US$1200 per car on health benefits to its employees, at a total cost of $4.8 billion. The US Government is, however, now contracting with managed care organisations for the provision of its major public health programs so it too can take advantage of reduced costs. The cost-control focus of US managed care has made an impact—the annual rate of growth in health plan costs to employers declined from 10.9 per cent in 1992 to 4.8 per cent in 1994, and plan costs actually fell in 1996.

The challenge for US managed care has been to achieve cost control without compromising quality. To date, the jury is still out, though one major review found that quality in managed care organisations was not clearly worse than in other forms of care—nor was it noticeably better.

Managed care has aroused much opposition in Australia, but while clearly many doctors in the US would prefer not to have managed care staff conducting reviews of their practices or of their clinical decisions such reviews now seem an accepted part of contemporary medical practice.
Despite recent moves in the direction of evidence based medicine much health policy is driven by advocacy, anecdote and funding availability rather than evidence. The Australian health system currently suffers several painful symptoms—cost-shifting and poor coordination between various levels of government, cost pressures (though overall costs are relatively stable as a share of GDP) and large variations in access to a full range of quality services. This variation in access, typified by sharply varying rates of procedures between regions and population groups, is possibly the main justification for introducing managed care to Australia.

There are already several quasi-managed care initiatives in Australia. These include the Coordinated Care Trials, pilots in private health insurance arrangements, national attempts by the Commonwealth to influence prescribing and treatment patterns, and a host of State/Territory smaller-scale projects aimed at standardising and integrating care in hospitals and other contexts.

The major remaining steps for managed care to fully emerge in Australia are integrating the current myriad funding and information arrangements. Some governments are examining concepts of 'integrated care' which combine the pooled funding approaches pioneered in the Coordinated Care Trials with managed care tools of utilisation review, standardised care protocols and advanced information management. Similarly, without much better information on who is using what services it is impossible to know why hospital admissions are high, or why GP or pharmaceutical use is rising or falling.

The purpose of this paper is not confuse these activities with full-blown managed care. Rather, it is to make the point that attempts to 'manage care' are scattered along a continuum from informal peer discussion within an existing institution, such as a hospital, and professional education on, for example, evidence based medical procedures through to formalised protocols and radical funding changes. The aim is to show that the debate on managed care be focused on where in the continuum of managed care Australia might aim and under which circumstances.

Within a few years it is likely that Australia will see identifiable managed care services up and running, if only as pilots. Governments will be seeking to get better value for money for the health budgets by eliminating as much as possible any variations in access and practice.

Despite being vociferous in its attacks on managed care, organisations such as the Australian Medical Association (AMA) are not likely to be able to stem the trend toward this approach. As the US system changes, and as softer versions of the key managed care concepts become embedded in the Australian system, the reliance on campaigns against 'US-style' managed care will become less effective. More substantive obstacles will be the lack of an integrated health information infrastructure, an only slightly interested private health insurance industry and the lack of some of the financial tools needed to equitably allocate health dollars. Most significant of all will be both major parties' reluctance to be seen as endangering Medicare by allowing or stimulating the spread of managed care.
Introduction

The challenges facing governments to ensure that quality, efficient and equitable health care is available to their populations are long-standing and global. Whether in the 'advanced' OECD economies, the emerging former Socialist economies or in the developing economies of Asia and Africa health policy reform is increasingly seen through the prism of 'managed care'.

Australia is no different. Compared with many nations, Australia's health system is efficient, equitable and effective. Nevertheless, there will never be sufficient resources to fund every need (as the recent debate over the subsidy of Viagra on the Pharmaceutical Benefits Scheme or access to Magnetic Resonance Imaging shows). Thus, despite Australia's relatively well run system there are constant pressures to ensure that dollars are wisely spent and directed to the greatest area of community benefit. Most governments have already introduced purchaser-provider arrangements to clarify the often complex relationships in health care. One new set of tools increasingly looked to as a way of improving the efficiency and effectiveness of the health system is managed care.

The aim of this paper is to explain the origins of managed care in the US health system, separate some of the myths from the realities of what managed care is (and might be) and suggest how careful use of some managed care approaches may benefit the Australian health system.

Origins and growth of managed care

Emergence of managed care in the US

Managed care has been defined as any action that attempts to control the price, location or use of health care. The aim of managed care is to '...eliminate the anarchy of the medical workplace'. In understanding managed care, we need to consider its origins in the US health care system of the 1980s.

Unlike Australia, Canada and the United Kingdom, the United States does not have a universal publicly financed health scheme. While it does have two publicly funded schemes for the elderly and some of the poor, the working population are either covered by private health insurance or are uninsured.
The managed care industry was born in the United States during the 1980s. For many years, US health expenditure had been high (50 per cent higher than the OECD median even in 1960) and growing. The main funders (the private employers who contributed to their employees' health funds) faced health costs that threatened their international competitiveness. By the late 1990s, for example, General Motors was spending around US$1200 per car on health benefits to its employees, at a total cost of $4.8 billion—more than the entire South African health budget. The existing health insurance funds that were carrying the risk for care—known as indemnity funds—were doing little to control these costs, or manage care, and had high administrative overheads. Payments to doctors were mainly fee-for-service and any increases in charges were simply passed on to employers. Since doctors and hospitals charged the health funds at similar rates, there was little price competition. Consumers generally had choice in which doctors or services they used, and any excessive costs were passed on to the indemnity fund, which in turn would pass these on to the employer.

New organisations emerged that saw the potential to make large savings for employers by being more assertive in managing care and costs. These new organisations, known as managed care organisations or MCOs, took a variety of forms but were, unlike the traditional indemnity funds, mainly for-profit organisations. Spurred by the need to generate profits and provide returns to shareholders MCOs made several innovations in order to reduce costs to employers and gain market share. They were, overall, extremely successful and have come to dominate the health care industry. Soon the major Federal Government health programs, Medicare and Medicaid, as well as related State programs, were putting their clients into managed care arrangements.

The new organisations emerged in different forms, with the predominant form becoming the 'Health Maintenance Organisation' or HMO. HMOs had already existed for over 50 years in the US, but changes to the tax and health systems in the 1980s led to enormous expansion. HMOs:

- accept the risk of funding the health care needs of its members from the fees paid to it
- offer prepaid, comprehensive health coverage for both hospital and physician services (that is, the consumer or their employer pay the health plan up front, and the plan must then live within the budget of what it takes in). Payment is usually capitated, that is, a standard amount per consumer. This payment, being paid in advance, creates an incentive for the plan to be economical in how much care it provides, as it must fund any excess use
- enter into contracts with health-care providers (e.g. physicians, hospitals, and other health professionals). This contract is usually again on a capitated payment rather than the traditional fee-for-service, and
- require members to use participating providers for all health services. If they use a provider from outside their plan, the consumer must usually pay a higher co-payment for that service.

These organisations thus use similar approaches to Australian health insurance funds. The major local differences are that there is less exclusive contracting with providers, members in health funds may still see any provider they wish (though increasingly there are incentives to go to
contracted providers) and, most importantly, local funds are much less interested in seeking to influence provider behaviour.

HMOs come in a variety of forms. These include staff (where doctors are directly employed by the HMO), group practice (where the HMO contracts with a separate group of providers), network (using multiple groups and single-practitioners) and independent practice association or IPA (where a formal doctor organisation acts as an intermediary between the HMO and individual doctors).5

**Key actions of managed care**

[in the US] … managed care has come to denote a confusing variety of structures and strategies to improve the performance of the health care system; these range from reimbursement incentives to alternative delivery systems to detailed protocols guiding physician behaviour.6

Managed care organisations use a complex mix of tools and techniques to achieve their aim of controlling costs and quality. It has been the application of these tools that makes managed care what it is, and accounts for some (but not all) of the controversy surrounding it. Figure 1 lists some of the major tools and processes used in managed care. These processes can be drawn together into the following elements common to most managed care organisations:

1. contracts with selected physicians and hospitals for a comprehensive set of health care services to be provided to a defined population;
2. utilisation and quality controls negotiated with providers;
3. the extensive use of guidelines and protocols to regulate the provision of care by providers;
4. the use of information technology to monitor services, quality and outcomes;
5. financial incentives for patients to use the plan's providers and services (there may be greater co-payments for use of a provider who is not on the plan's list);
6. the assumption of some financial risk by physicians, 'thus fundamentally altering their role from serving as agent for the patient's welfare to balancing the patient's needs against the need for cost control'.7
Figure 1: Managed Care Tools

Capitation
Allocating resources to purchasers or providers on a per-capita basis—which is then usually capped with a global total. Capitation can be on a regional or other basis (such as a particular disease group). The aim is to encourage those funded to be more economical in the use of services and to find the most effective combination of services to achieve the most health benefit within the amount available.

Risk adjustment/Risk-adjusted capitation
Simple capitation of a flat amount per person will often be inequitable, as different people and populations have different needs and costs. The aim of risk-adjustment is to recognise these differences in need by varying the amount capitated depending on the person or group's age, sex, disease status or past use of health services. This helps reduce the incentive for providers to unduly limit services to those in need. Capitation is said to encourage under-provision of services, as any 'excess' provision is not paid for. On the other hand it encourages investment in preventive care, since providers have an incentive to avoid, for example, hospitalisations that might have been prevented by better (and cheaper) community care or support.

Utilisation review/Pre-authorisation
a) Staff in the MCO review and control a patient's use of medical services and the appropriateness and quality of that care. Involves data collection, review, and/or authorisation, especially for services such as specialist referrals, emergency room use and hospitalisation.

b) A cost-control method used by some insurers and employers to identify and reduce inappropriate and unnecessary care.

Claims review
The method by which a consumer's health-care service claims are reviewed by a third party (usually an agent employed by a managed care plan) prior to reimbursement to validate the medical necessity of the service and that costs are not excessive. This usually involves the Managed Care Organisation (MCO) reviewing claims made by a medical provider for services already delivered, and thus puts the provider at some risk. It is primarily a cost-control measure.

Concurrent/Pre-admission review
The Managed Care Organisation will require the review of a proposed procedure or hospital admission done by a health care professional (usually a nurse) before or while the service is being performed—usually done by telephone, fax or at the site.

Risk-sharing
Risk can be shared between the MCO and providers, for example if hospitalisation rates exceed agreed thresholds then doctors will bear some of these excess costs.

Formulary
A list of selected Pharmaceuticals and their appropriate dosages felt to be the most useful and cost-effective for patient care. In HMOs doctors are often required to prescribe from the formulary. Similar to the role played by the Pharmaceutical Benefits Scheme in Australia.

Medically necessary
Those covered services required to preserve and maintain the health status of a member or eligible person in accordance with the area standards of medical practice. The definition of 'medically necessary' is controversial, and a frequent source of debate between providers and the MCO.

Outcomes management
The use of studies to measure and evaluate health status and quality of life and document changes in these as a result of therapeutic interventions. Outcomes management differs from clinical trials in that data are collected as part of routine medical care, and it attempts to determine what is appropriate resource consumption. Requires excellent patient information linking service use and outcomes to diagnosis and demographic information.

Closed panel
Access to providers is limited to those participating (either directly, or under contract) to a particular plan. Referrals to specialists may also be limited to a designated list, unless the patient chooses to pay for the visit. Different types of managed care impose these limits to varying degrees.

Disease management
The disease management model is based on the premise that the health of individuals with chronic diseases (or other acute conditions likely to lead to regular hospital admission) can be successfully managed and the cost of the required health care resources can be reduced if all individuals with a particular chronic disease are viewed as a separate population. This approach has been largely driven by the pharmaceutical companies, which are striving to ensure that the pharmaceuticals they develop to assist physicians manage and improve a patient's condition are clearly associated with the disease management process adopted by a physician. As a result, information on this form of reimbursement is disproportionately available for disease categories that require substantial amounts of pharmaceuticals.

Figure 2 shows how these tools are used in the various forms of managed care. Whatever the differences between different types of managed care, the major difference is with the traditional indemnity plan. These plans generally allowed the consumer freedom of choice in providers, had no utilisation review of physician decisions and paid physicians by fee-for-service rather than capitation. Managed care does, however, generally offer more preventive care and lower co-payments.

Figure 2: The Managed Care Continuum

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<tr>
<th>Tool</th>
<th>&quot;Pure&quot; Indemnity</th>
<th>Modified Indemnity</th>
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<td></td>
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<td>Preferred Provider Organisation (PPO)</td>
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<td>Utilisation Review</td>
<td>No utilisation review</td>
<td>Pre-admission certification</td>
<td>Management information system</td>
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<tr>
<td>Provider Panel</td>
<td>No provider selection</td>
<td>Selected providers</td>
<td></td>
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<tr>
<td>Consumer choice of provider</td>
<td>Total freedom of choice</td>
<td>Incentives to limit choice</td>
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| Benefit structure     | Varied coverage
Deductibles, coinsurance, routine preventive care uncovered | Waives deductibles
Reduces coinsurance | Comprehensively coverage
Including preventive care
Limited co-payments | |
| Provider payment      | Fee-for-service payment |                   |                   |                     |                   |                   | Salary |
| Rating method         | Experience rated |                   |                   |                     |                   | Community rated | Group practice |
| Practice setting      | Independent practice |                   |                   |                     |                   |                   |                |


US Managed Care—an assessment

With differences between managed care approaches, and changes within the managed care industry, it is difficult to form overall conclusions about the impact of managed care. However, at the risk of simplification, some assessments can be made.
Cost and quality

In terms of costs, managed care has clearly achieved control (at least for the time being) in both costs to employers and the economy.8 The annual rate of growth in health plan costs to employers declined from 10.9 per cent in 1992 to 4.8 per cent in 1994, and plan costs actually fell in 1996. There is some evidence that consumers' out of pocket costs have started to rise, as plans impose more co-payments on members.9 The success in cutting costs is not surprising, given the focus of managed care. The major question is whether this has been at the cost of quality.

One recent review of the impact of managed care on quality found mixed results.10 Although most quality-of-care results were favourable to HMOs or showed similar quality of care (compared to traditional fee-for service plans), some comparisons were unfavourable. As an unbiased observer would expect, there was a range of results, depending on the orientation of the individual organisation. The authors concluded, however, that the mixed results disproved the thesis that HMOs were only interested in cost cutting. If this was their sole focus, a more consistently negative pattern would have been expected.

One issue of controversy for managed care is the impact on length of stay in hospital, with complaints of 'drive-through mastectomies' and pressure on doctors to discharge as soon as possible. Apart from evidence that shortened length of stays can actually improve outcomes if complemented by supportive care after discharge, early discharge has also been an issue in many countries without managed care—including Australia. Shortened stays in hospital after childbirth has been blamed on managed care in the US where length of stay (LOS) averages 1.5 days. Interestingly Australia, Turkey and New Zealand are the only other countries with an average LOS of 3 days or less after a normal delivery.11 Since 1960 reductions in average length-of-stay in the US have been comparable to or slower than in most other OECD countries. The point of these comparisons is to show that not all alleged defects attributed to managed care are unique to that form of care.

A major area of concern with US managed care is the treatment of expensive patients such as those with chronic illnesses. There is no doubt that some plans have biased their selection of patients toward less-expensive patients.12 There is less evidence that MCOs have 'stinted' on the care given to such patients. Over time the industry has responded to the needs of the chronically ill, and implemented innovative case-management approaches, or segmented their patient populations (so-called 'carve outs') to better focus on their needs. These efforts (and also those in Australia in the Coordinated Care Trials) have been driven by the disproportionate share of the health dollar consumed by people with complex, chronic needs. There have also been moves to improve the incentive to recruit expensive patients, by paying plans more for such patients, so they can be confident they will have the resources to meet their needs.
Impact on clinical autonomy

Ideally, medicine should be ruled by rationality and efficiency in the choice and implementation of evaluations and treatments. This means that the variability between providers not only should be but can be eliminated, and the only factors that should make a difference in deciding who to treat and what treatment to undertake is the nature of the patient's disease or injury.13

… sensible debate over Managed Care has been impeded by the successful attempt of the medical profession to discredit it. The attempt is unsurprising as the beneficial effects of Managed Care—lower costs, coordinated and better care—translate into lower medical incomes and interference with medical autonomy.14

In its drive to standardise and optimise patient care, managed care does challenge traditional concepts of clinical autonomy. Utilisation review (where provider service patterns in prescribing drugs or ordering procedures are reviewed by a third party) is a common strategy and one some doctors find objectionable. One study found that around 40 per cent of all patients (in managed care plans and conventional plans) were reviewed for length of stay, site of care or appropriateness of treatment.15 The rates for doctors in managed care plans would have been even higher. This perceived second-guessing, compounded by high levels of administration and limits on referrals accounts for much of the hostility to managed care by providers. Other studies suggest that the level of actual denials of service is quite small, with one study suggesting only 3 per cent of doctor recommendations about medical care, 1 per cent of hospital admissions and no more than 1.2 per cent of surgical procedures are denied or reversed by HMOs.16 In other words, the utilisation review process is resented as time-consuming and an intrusion, but the actual outcomes (in terms of care delivered) are only occasionally affected. Compounding physician dislike of utilisation reviews' impact on their autonomy is the fact that reviewers were often not doctors, but were nurses or had no medical qualifications at all.

Utilisation review can be done in far less intrusive ways. In the British National Health Service, for example, concepts of peer review within a group GP practice are increasingly accepted. In the 'pure' HMO model peer review is often the main mechanism for utilisation review (see Figure 2).

MCOs also make use of protocols and guidelines, often requiring doctors to abide by such guidelines as a condition of contract or employment.

Impact on patient autonomy

Managed care clearly imposes and partly relies on restrictions on consumer choice. Particular plans recruit or contract with doctors and hospitals to take their patients under conditions of price, quality review and so on. Patients can go 'off-plan' but may have to pay for this privilege. As discussed above, consumers are seeking plans that give greater
choice and MCOs are responding by offering this either within the plan or with additional co-payments. Should managed care emerge in Australia, persuading consumers to limit their choice could be a great barrier. On the other hand, Australian consumers are largely 'guided' through the system as it stands, taking their GP's advice on suitable specialists or hospitals.

Service innovations and disease management

One of the greatest impacts of managed care has been to stimulate change in the way health care is delivered. Some organisations have established call centres to offer advice to members and case management programs where high-risk patients get extra assistance and guidance in using services and managing their condition. Others have tested also self-care programs where patients are given intensive education and resources to manage better their own care or have established intricate health information systems in order to improve effectiveness and lower costs. Some of the best models have taken a particular disease as their focus. The 'disease management' approach is based on the premise that the health of individuals with chronic diseases can be successfully managed and the cost of the required health care resources can be reduced if all individuals with a particular disease or condition are viewed as a separate population. For example:

- In one study of cardiovascular disease, the use of direct feedback to practitioners of outcome data on their patients, application of continuous quality improvements and site visits to participating providers led to a 24 per cent reduction in mortality associated with coronary artery bypass graft surgery.\(^{17}\)

- In another study of the use of disease management for diabetes in a US scheme found first year outcomes of:
  - 12.3 per cent reduction in costs
  - 74 per cent rise in eye examinations and an even greater rise in foot examinations
  - an 18 per cent fall in hospital admissions
  - a 22 per cent fall in bed days.

- A program using a call centre to target high-risk pregnancies is reported as achieving an 18 per cent fall in neonatal intensive care unit days, cost savings of $500 000 and reduced the incidence of very-low birthweight babies by 12.5 per cent.\(^{18}\) One of the most cost-effective approaches is to empower patients to self-manage their illness or condition.
Prospects for Managed Health Care in Australia

Self-management is the key to Olsten Health Services' asthma program, which has served more than 1,200 adults and children in the last four years. Based on the National Institutes of Health Guidelines for the Diagnosis and Management of Asthma, Olsten's Adult and Pediatric Self-Management Program is conducted in the patient's home. Specially trained nurses spend time in the patient's home to determine what may trigger asthma attacks—wall-to-wall carpeting, smoke, allergens and pets—and then tailor a program to the needs of each patient.

Nurses spend about three, two-hour sessions with each participant and review their medications, teach them how to use the peak flow meter for monitoring lung capacity, instruct them on what to do in an emergency, illustrate relaxation exercises, create problem-solving scenarios, give tips on how to predict an oncoming episode and help patients learn how to communicate better with their providers.

A recent study indicated that adults who participated in the Self-Management Asthma Program each saved payers an average of $10,000 annually. Hospitalization for children within three months prior to enrollment was 36% and dropped to 9% within three months of the program's conclusion. In addition, 5% of children, compared with 14% before enrollment, considered themselves severe asthmatics.


Such interventions are possible under a traditional system. However they are more likely to occur if funding is integrated, and one funder bears responsibility for, as an example, all health outcomes in a region, rather than just hospital or primary health care costs. When funding is not integrated no one funder has an incentive to make improvements that might benefit another funder.

Developing a population health perspective

Paradoxically (given the private nature of US health care) one of the strengths of managed care has been its ability to respond to the determinants of health outside the health system. MCOs are not bound to spend only on direct health services such as the disease management approaches above. Some MCOs, especially those working in mental health and substance abuse sectors, have developed innovative programs to tackle stress, family support and other factors affecting health. Other examples include MCOs tackling community injury hazards in order to reduce expensive neck injuries—a self-interested motivation, but one which also works in the community's interest.19

Future of US Managed Care

Despite rapid gains in market share in recent years the future of managed care is not guaranteed. According to one commentator '…within 10 years little will remain of orthodox managed care'. Some major HMOs face insolvency. Returns to shareholders are falling, as are satisfaction rates by enrollees. The major cause of this decline is consumer dislike of the restrictions of capitation-based managed care, in particular because of the limited choice in providers available. The public image of HMOs and managed care is
poor. Extreme examples of over-zealous gate-keeping, early discharge and denial of benefits have led State governments to correct what was probably under-regulation by enacting a range of 'patient rights' or Managed Care Bills. Over 1 000 bills affecting managed care were introduced into US State legislatures in 1996 and over 100 signed into law. These have mandated minimum length-of-stay and enshrined provider rights to criticise or disagree with plans. There are also indications that costs could again be rising as HMOs struggle to contain pharmaceutical and technology costs. In response some corporate purchasers are banding together to buy care directly from provider networks, bypassing MCOs.\textsuperscript{21}

HMOs are responding to these challenges in two ways. First by limiting the use of capitation as a way to fund providers and moving to a mixed system of capitation and discounted fee-for-service. This allows doctors and patients more flexibility, for example by rewarding doctors for extra service (while capitation tends to reward under-servicing and preventive care). The second strategy is to allow greater access to non-HMO providers, giving patients more choice.

The next wave of change is unlikely to be a return to the pre-managed care era. On the contrary, competition in the market place will encourage further dissemination of managed care concepts across different styles of health plans, as plans try to find the balance between cost and quality control, and consumer acceptance, as one recent commentator put it:

Indemnity carriers, Blue Cross plans, and [fee-for-service] Medicare relied heavily on deductibles [excess payments], coinsurance, exclusions of preventive services, annual limits on hospital days, and maximum lifetime payment. HMOs offered comprehensive benefits without deductibles, coinsurance, and maximums but with modest co-payments at the time of service. Recent years have witnessed partial convergence, as indemnity plans cover more preventive services and HMOs experiment with higher co-payments for emergency room and hospital use. The dominant trend, however, has been toward the proliferation of benefit designs to accommodate the differences among consumers in preferences and ability to pay.\textsuperscript{22}

Distinct managed care organisations may fade away, but managed care techniques and concepts are almost certain to continue. Managed care concepts have already spread to many countries, with one example near to Australia being New Zealand.

\textbf{New Zealand-style managed care—Integrated Care}

Managed care models mirror their environments. The American models were created in an environment dominated by the drive of employers to contain the costs of health care... The New Zealand approach is different. We access our health care and disability support services through a system operated largely by monopoly purchasers securing the
supply of services, and monopoly providers providing these services. We have a
different system with different issues, different incentives.\textsuperscript{23}

New Zealand recently introduced a series of reforms based on the concept of 'integrated
care'. A new national Health Funding Authority (HFA) is responsible for purchasing
services from the full range of providers from GPs to hospitals, midwives and
pharmaceutical companies. The HFA's goal is to purchase services in a way that achieves
the maximum gain for the people of New Zealand within the available budget.\textsuperscript{24}

New Zealand's \textit{Integrated Care Initiative} consists of 18 projects testing out a range of
approaches to provide seamless care to consumers. The initiative is seen to be more likely
to succeed than previous attempts by providers as the HFA can use financial incentives
and purchasing agreements to achieve flexibility and coordination among providers. The
definition of integrated care can include projects ranging from the promotion of clinical
guidelines to the total transfer of a capitated budget for all services in a region. The
initiative is testing a range of hypotheses that include:

\begin{itemize}
  \item 'Integrating service delivery is dependent on integrating funding streams', and
  \item 'Budget responsibility for a wide range of primary care services improves health outcomes
        and is cost effective.'\textsuperscript{25}
\end{itemize}

The New Zealand approach to Integrated Care is very similar to that used in the Australian
Coordinated Care Trials, with the major difference being that integrated care allows the
possibility of purchasing for the full population, rather than the chronically ill sub-groups
in coordinated care. The initiative uses the concept of 'delegated purchasing' to give an
agent with the most information about health needs and services the ability to make
decisions. The concept of integrated care has emerged as one way to meet these goals.
Integrated care is described as having three tenets of:

\begin{itemize}
  \item continuity of care
  \item appropriateness of care and interventions, and
  \item value for money.\textsuperscript{26}
\end{itemize}

\textbf{Is managed care needed in Australia?}

\textbf{The state of health care in Australia}

The Australian system is generally acknowledged to be high quality and relatively
efficient. Compared to the US system it is vastly cheaper with as good if not better health
outcomes. Nevertheless, managed health care techniques are under active consideration in Australia as a possible solution to some long-standing problems. Should managed care be more widely used in Australia, it will reflect the local environment (such as the far greater role of government and emphasis on equity) and be a very different creature to that in the US.

Despite the diversity of views on what exactly ails the Australian health system, the major concerns usually include:

- cost-shifting
- fragmentation
- unplanned care
- variable quality
- rising costs.

**Cost shifting**

Cost shifting occurs whenever two or more funders are potentially liable to fund a service. Each will try to pass the cost to another funder. Typical cost-shifting tactics include closing public outpatient departments and referring patients to Medicare funded GPs, or limiting the amount and size of prescriptions to patients on discharge and asking patients to get a new script from their GP. This passes the cost to the Commonwealth-funded Medical Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS).

Cost shifting has several negative impacts:

- patients lose access to free services from public hospitals and may have to pay co-payments for GP or specialist services and pharmaceuticals
- patients face travel costs to see providers in different geographic locations or in different clinical contexts
- training opportunities for clinical staff diminish
- patients may be in hospital inappropriately, for example if rationed nursing home beds are not available
- longer waiting times for emergency treatment for urgent and non-urgent care due to lack of after-hours or bulk billing GP services
- the flow of information about a particular patient is disrupted as clinical records become fragmented, making adverse events more likely.\(^{27}\)
Fragmentation

Fragmentation of the system, between public and private, hospital and GP, health and community services has several consequences. While cost shifting diverts energy in an active quest for savings at other funders' expense, fragmentation of management and funding discourages innovation where other funders might reap the benefits. Hospitals have no incentive to engage in patient education that might save GP visits, and GPs have little incentive to work cooperatively with other providers if demand for their services (and income) is affected. That innovation does occur at all is a tribute to the values and commitment of individual providers.

Fragmentation adds to costs by making the system harder to navigate for consumers and providers. It makes sensible substitution between higher and lower modes of care difficult, if not impossible. It makes it far harder to assemble packages of care to respond to complex medical or other needs. Various solutions have been proposed, most notably under the Council of Australian Governments (COAG) proposals of the late 1990s when it was suggested that a new, national system be constructed rolling the multiplicity of separate programs into a single health and community care program. Indirectly, fragmentation affects quality of care as possible poor quality care (especially from the consumer's perspective) can often be attributed to breakdown in continuity. Such breakdowns are especially significant between hospitals and primary health care, between primary health and community health sectors and across Commonwealth and State program boundaries.

Unplanned care and variations in access

Who determines who will get access to what treatment when? At present the answers to these questions are … inefficient, confused and undemocratic. Hopefully in the next decade [effort] will create greater efficiency and openness in resource allocation systems in health care.

Most in the community would expect that, with a publicly funded national system such as Medicare, services will be available and used generally according to need. Thus the rate of appendectomies or heart surgery should (after adjustment for the age and sex of the population) show little variation across Australia. In fact, recent studies found a wide variation in the distribution of 15 well defined hospital procedures across Victoria. For some procedures the variance across regions was 45 times what would be expected, given the age and sex distribution (i.e. the 'need') in these areas. Contrary to an expectation that resources available should reflect need, the authors found that 'for some procedures resources are almost randomly allocated across the state'.

Studies of surgical procedures routinely find significant disparities between geographic areas. In one study of breast surgery, the share of women undergoing breast conserving surgery varied from 34 per cent in Western Australia to 49 per cent in South Australia and the Northern Territory. The authors were unable to explain the variation, though it is most
likely due to the attitudes of individual surgeons. The same study noted that the rate of breast-conserving surgery in rural areas was sharply lower than in urban areas, suggesting that while some variation is random, other variation is more structural.\footnote{31}

The recent report of the NSW Health Council found that women living in one Area Health Service are twice as likely to undergo a hysterectomy than women of similar age in another area. Similarly, the report found there were twice as many tonsillectomies performed on patients in one part of NSW versus similar types of patients in other parts of NSW.\footnote{32}

**Uncertain quality**

The Commonwealth's recent establishment of a new *Australian Council for Safety and Quality in Health Care* demonstrated its intention to tackle undesirable rates of medical misadventure and variations in quality. Evidence on the quality of the health care system is difficult to come by. Some studies have been conducted which suggest problems, especially in prescribing, but more detailed information will depend on the impact of the Council. There were also concerns about the quality of prescribing which led to the establishment of the National Prescribing Service.

The 1995 Quality in Australian Health Study suggested a higher-than expected number of hospital admissions were associated with adverse events, however there is little objective evidence on the overall quality of the health care system.\footnote{33}

**Rising costs**

The threat of rising health care costs is usually portrayed as in the future rather than the present. Australia's record on health care costs is generally good—at around 8.5 per cent of GDP Australia is around the middle of the OECD ladder. In 1996, the United Kingdom and New Zealand spent proportionately less on health than Australia, at 6.9 per cent of GDP and 7.2 per cent of GDP respectively, while Canada (9.2 per cent of GDP), France (9.6 per cent of GDP) and the United States (14.2 per cent of GDP) spent more.\footnote{34} The ageing of the population is said to pose a future threat to health costs, however there is controversy over this, with some commentators noting that European countries manage to cope with 'older' populations than ours, and that future 80-year-olds will be much healthier than current people of that age. There is more consensus that the rising cost of acute care and pharmaceutical technologies pose more of a challenge, and that tighter controls will be needed to limit their impact. Recent controversies over access to expensive pharmaceuticals (Viagra) or diagnostic procedures (Magnetic Resonance Imaging (MRI)) show that competition for funding is intense.
Prospects for Managed Health Care in Australia

Managed care trends in Australia

Traditional fee-for-service arrangements provide few mechanisms for funders of health care services to specify health care priorities or to cap the benefits payable annually for such services. Priority has now been given to developing such mechanisms, but this process is still in its early stages.35

We saw above that the term 'managed care' covers a wide variety of policy directions that share a common focus of influencing the cost, quality or method of care. As such, managed care is far broader than US-style attempts to control doctor incomes.

The concepts of managed care are already in Australia. There is already discussion over what models might work and which might not. There is also a range of initiatives currently being tested or implemented that, while not 'full-blown' managed care, do echo its directions. Some of these initiatives are discussed below. The purpose is not to confuse these activities with full-blown managed care, but to make the point that attempts to 'manage care' are scattered along a continuum from informal peer discussion within an existing institution such as a hospital, professional education of, for example, evidence based medical procedures through to formalised protocols and radical funding changes. The aim is to show that the debate on managed care should not be either/or, but deciding where in the continuum of managed care Australia might aim and under which circumstances.

Coordinated Care

The series of Coordinated Care Trials now running in Australia embody many elements of managed care approaches.36 Trials consist of:

- a Trial sponsor (such as an area health service or Division of General Practice) which is contracted to State and Commonwealth governments to manage the funds allocated to the Trial for services and set-up costs
- a funding 'pool' which combines funds drawn from a range of Commonwealth and State health care programs such as the Medicare Benefits Scheme (MBS), Pharmaceutical Benefits Scheme (PBS) and hospital funding; which can be used to buy any services for individual patients thought appropriate, and which supports
- a care coordination process which can be undertaken by a person (say a local GP or designated coordinator), a service (such as an Aged Care Advisory Team) or even through a computer system, and which deals with
- a defined client group (usually people with high care needs with a particular diagnosis or condition, or those with a range of chronic illnesses).

The Trials thus include aspects of managed care such as:
Prospects for Managed Health Care in Australia

- an independent, third-party purchaser who receives capitated payments from separate funders which are adjusted for risk or experience (i.e. are not community rated)

- contracts or agreements with providers to deliver services to the Trial clients

- the use of guidelines, protocols or incentives to encourage particular patterns of care

- the use of incentives (including the promise of better care) for patients to stay within the Trial, and

- at least limited use of utilisation review of provider behaviour and performance.

The Trials were established in response to the same problems of cost-shifting, perverse incentives and the particular problems people with multiple or chronic conditions faced in gaining appropriate care. The Trials were controversial when established, and accused of being 'US style managed care'. Nevertheless, they managed to recruit large numbers of GPs. This was partly as a result of two policy tenets introduced by the current Government. The first was that the Trials had to be 'GP centred'. A set of guidelines cementing the role was developed and enforced. The other was that the concept of clinical autonomy was specifically addressed, with trials directed that they had to 'maintain the medical practitioner's freedom, within the scope of accepted clinical practice, to identify appropriate treatments'. Interestingly, this policy has since been inserted into recent changes to private health insurance legislation dealing with purchaser-provider agreements (section 73BDA of the National Health Act 1953).

The interim evaluation of the Trials has now been completed. That evaluation found that:

- care coordination has not led to any significant change between intervention and control group clients

- cost per client day for trial clients had not been reduced

- hospitalisation rates had not been reduced

- coordination costs as a share of the total pool ranged from 11–22 per cent, and

- some Trials had recruited the wrong clients, tending to be those who did not need intensive coordinated care.

These findings were based on preliminary data and the final evaluation, due later in 2000, is hoped to be able to give more authoritative findings. At this stage it seems premature to claim that the Trials are a success or not in terms of improving health outcomes for their clients. The Trials have, however, definitely expanded the boundaries of health system reform by showing that pooling across program and governmental boundaries can be done.
Influencing GP prescribing behaviour

The Pharmaceutical Benefits Scheme (PBS) subsidises approximately $3.0 billion of medication each year. In Australia it is estimated that over 80,000 people are admitted to hospital each year for problems related to medicinal drugs—half of these admissions may be preventable.38

Much as managed care organisations limit the drugs available and attempt to influence prescribing behaviour, the Commonwealth has put in place a range of measures with the same aim. The PBS itself places limits on what drugs are subsidised. The Commonwealth has also established:

- The Quality Incentives for Prescribing scheme, which offers to share benefits of reduced (but still appropriate) prescribing with GPs. The scheme was announced in the 1999—2000 Budget and is still being negotiated with GPs.

- The National Prescribing Service. The NPS is an independent public company, operating within the framework of the National Medicinal Drug Policy. The goal of the NPS is to improve the health outcomes of the community through quality (judicious, appropriate, safe and cost-effective) use of medicines. During 1998–99, it ran a series of communication and information programs, GP visits, clinical audits and other strategies to encourage better prescribing by medical practitioners.

National provider agreements—Pathology and MBS

Over recent budgets, the Commonwealth has developed agreements with radiologists, pathologists and GPs to limit growth in outlays. To varying degrees, these agreements have enabled the Commonwealth to negotiate 'capped' budgets that make each profession responsible for ensuring the budget is not exceeded.39 Some of the achievements in the first pathology agreement were:

- agreed fiscal outcomes (i.e. growth was limited to the target range)
- access to quality services was preserved
- an enhanced evidence base for pathology, and
- a proven capacity to target interventions in identified problems.40

However, the financial impact of capped budgets may not solely affect medical practitioners. Experience suggests that reducing funding from one source can simply deflect pressure to other sources, such as consumer co-payments. It will be interesting to see the impact of the pathology agreement on patient payments and the incidence of bulk-
billing by radiologists, as practitioners attempt to maintain their incomes from sources other than Medicare rebates.

**Demand management**

The West Australian Government recently established a telephone-based demand management system called HealthDirect. The service uses a call centre to provide 24-hour health information and advice and triage of services to the population of Perth, covering around 1.6 million people.41

**Private Health Insurance Pilot programs**

The Commonwealth is facilitating innovation in the provision of private health insurance services. The projects include early discharge programs that allow patients to go home sooner, with additional in-home support paid for by their health fund. This saves the fund money (as in-home care can be cheaper than a hospital bed) and enables the patient to return to familiar surrounds. The projects are to be evaluated to assess if they are safe, are accepted by clinicians, beneficial to patients, are cost-effective, and are a true substitution of care rather than an additional service.42

**Evidence based care, outcomes management and coordination**

Many of the tools used in managed care are already being applied as 'quality improvement' projects within hospital systems. A recent round of funding in Victoria supported projects to:

- improve training on appropriate use of expensive drugs in acute coronary syndromes
- improve consistency of good clinical practice and reduce variations across a hospital in obstetrics and gynaecology
- develop 'managed care plans' for the top 10 high volume Diagnosis Related Groups (DRGs) and those DRGs identified as complex43
- 'improve continuity of care from pre-admission to discharge thereby reducing length of stay … and increase consumer and provider satisfaction', and
- improve health outcomes and reduce variations in practice across emergency departments.44
How might managed care work in Australia?

It is highly desirable that managed care regimes should be undertaken in accordance with protocols and guidelines incorporating expert medical opinion, based on the best evidence, and be under the control of medically qualified people, with the aim of maximising clinical effectiveness, rather than minimising costs.45

Objectives for health, and health reform.

One of the major analysts of Australian health policy, Professor Richard Scotton, suggested in a recent review that the goals for health policy are:

• Efficiency: the optimal allocation of resources
• Health: favouring services and delivery modes which have higher returns in terms of health improvement per unit of resources used
• Equity: no person's access to medically effective health services should be limited by capacity to pay or result in financial hardship.46

Other commentators have suggested a framework of: good health, low cost, satisfaction on the part of both consumers and providers, and equity (medical and financial).47 While these categories can be reshuffled endlessly, there is broad consensus that they are important. There is less consensus about the strategies needed to achieve these goals.

Integrated Care Australian-style

There are signs that 'integrated care' is emerging in Australia as a concept that tries to adapt the tools of managed care to the Australian context.

The clearest exposition of integrated care was contained in a discussion paper released jointly by the ACT Department of Health and the ACT Division of General Practice in 1999. Interestingly, the ACT Division later distanced itself from the proposals in the paper.

Proponents of integrated care are vague on its exact shape, but it would most likely:

• exist as a discrete Integrated Care Organisation (ICO) which includes provider representation in the governing structures
• be based on a single-funder—taking funds from Commonwealth and State health and related programs to avoid problems of cost-shifting and provide the basis for more flexible
funding to services and consumers. The budget for the ICO would be based on risk-adjusted capitation

- have a regional focus and an identified population—once having defined a population, the ICO would focus on an agreed set of health outcomes for that population
- have a population-health focus—the emphasis would be to have a better mix of treatment, prevention and health promotion
- emphasise the needs of patients, not providers, while maintaining choice of GP and Medicare-like services (interestingly, the current Health Care Agreements require reform proposals to preserve consumer entitlement to Medicare Benefits Schedule services 'or their equivalent')
- be able to use tools and incentives for quality outcomes that reflect best clinical practice-utilisation review and continuing education, presumably negotiated with providers
- establish systems that encourage cost-effective care, and
- support a choice in the amount of risk borne by the ICO, governments and providers.  

Establishing such a model will require substantial shifts and changes in the health care system.

The Australian Democrats have recently released a proposal that centres care around the patient, pooling all health care funding under the administration of new Regional Health Authorities.

**Issues and Players**

Medicare now has bipartisan commitment. Paradoxically, such commitment may prevent the full investigation of possible reforms, as both parties strive to avoid doing anything that may be construed as damaging Medicare. Nevertheless, the logic of reform makes it increasingly likely that concepts of managed or integrated care will continue to emerge in Australia.

Moves toward managed care will continue to face criticism from a range of perspectives—some self-interested, some more principled. Managed care does carry with it some risks:

- it may be more expensive than is justified by the health benefit or other efficiency improvements due to the greater cost of information and care management systems
- it may put consumer privacy at greater risk (though this could be protected with enhanced safeguards), and
it will be difficult to strike a balance between standardising better care and unduly restricting medical judgement and autonomy.

The potential benefits in addressing some of the acknowledged problems in the health system could be to:

- reduce the focus on cost-shifting by pooling funds. Purchasers could then make decisions based on their health impact, not on short term budget savings
- reduce fragmentation, by allowing the formation of, for example, regional health services to develop, implement and fund programs that coordinate hospital, GP and allied health services
- improve equity and consistency of access to services, through greater standardisation of treatment pathways
- facilitate quality improvements through better information on the impact and outcomes of different services.

Preconditions for change

Government and private funders are continually pushing back the boundaries of reform. Managed care-style approaches are already being tested within the current system(s). These innovations, however are limited in scope to either particular providers (e.g. within hospitals) or special environments (such as Coordinated Care). The momentum is building for broader change, centred on the integrated care approach of a regional fundholder contracting with purchasers to manage services for an entire population. While, to some extent, financing changes can be separated from managed care, one tends to lead to the other. The main benefit of delegating purchasing is to delegate financial risk by putting at least a 'soft' cap on funding—this provides the purchaser with the incentive to more actively manage care.

Is managed care on the march in Australia? Despite opposition from some, the logic of these techniques will continue to make them attractive to governments and some more progressive providers. However these steps will tend to be small, fragmented and incremental until some more substantial building blocks are in place. Each of these building blocks is, in the author's opinion, worthwhile in itself and while they would not automatically lead to more formal managed care systems, at least some are necessary preconditions.
Better information systems

Reaping many of the benefits of managed care and outcomes management will require much better information on patient usage of services. Linking financial, service and diagnostic information will allow much more informed judgements to be made about what works and what doesn't.

Outside hospital contexts there is little systematic data collected on the clinical drivers of service use. Without this data it is impossible to know why hospital admissions are high, or why GP or pharmaceutical use is rising or falling. As a result health policy is driven by advocacy and anecdote rather than evidence. Recent initiatives by the Commonwealth such as the Medicare Services Advisory Committee are attempting to introduce a greater evidence basis into what services are subsidised.

Progress on diagnostic coding (where the reason for each service is collected and recorded) is frustrated by a multiplicity of possible systems. Each of these would allow providers and policy makers to understand how much a case of influenza or diabetes costs, and combined with a patient identifier, how a patient moves through the health system. Coding could occur at two levels of intensity. The broader, more detailed and more costly approach would be to code each episode (for example each visit to a GP). The provider would put a diagnostic code on the patient's Medicare bill along with their provider number, and this would be recorded on the patient's file. Alternatively, patients could self-nominate to have a general indicator put as a flag on their data. Such a system would also require improvement in the use of the Medicare number as a unique patient identifier.

Thus people with diabetes, or asthma, could be identified in MBS and PBS data. This would allow far better understanding of usage patterns, and allowing some steps toward automatic feedback and monitoring (if the HIC also had the patient's address, they or their nominated provider could be notified when an annual check-up was needed).

In a managed care context, diagnostic coding allows better utilisation review (how are different doctors treating children with asthma) and the development of better risk-adjusters for capitation (how much do children with asthma, in general, cost).

Such coding and collection of individual diagnoses creates a host of privacy and confidentiality issues. However, if in the long term the community could be reassured of the security of the data there would be clear benefits in developing better approaches to care. Some indicative data is becoming available through the Bettering the Evaluation and Care of Health (BEACH) program. A report on the first year of the program (1998–99) has recently been released.
Risk-adjustment

If funding is pooled and devolved to regional bodies, the distribution of the funds will need to be seen as 'fair'. Fairness is generally seen as compensating per-capita allocations for likely differences in the population. An area with an older population, or a high proportion living with AIDS, should be funded to recognise and reflect the likely level of needs the purchaser will need to meet. This compensation is called 'risk adjustment'. The smaller the enrolled pool, the greater the need for risk adjustment, as the purchaser has less scope to 'average' costs. Under the current Australian system, for example, funds distributed to States/Territories reflect the age distribution of their populations. In the Coordinated Care Trials, funds from Commonwealth and State budgets given to the trials reflected a mix of demographic, clinical and financial data (such as diagnosis and prior use of health services).

Good risk adjustment makes it less likely (but does not guarantee) that purchasers will then:

• allocate funds fairly, reflecting need, as the purchaser knows that they have been funded to meet those needs (and that high need groups will get the services they need)

• recruit fairly (i.e. not exclude potentially expensive clients) since they know that they will be funded to meet their needs. This is a problem faced even in existing public programs, perhaps most notably those expensive cases of dual diagnosis, where the patient/client is shunted between the health and disability/community services system with each program trying to avoid funding responsibility

• strive for excellence—to establish the best cancer service in the state is self-defeating if the purchaser is not funded for the services it provides.

There are ways to indirectly influence client composition—for example private health insurers rarely advertise to the aged and infirm—instead targeting younger consumers less likely to need services.

Unfortunately, risk adjustment is still a very inexact science. The Coordinated Care Trials have found it difficult to predict future utilisation and costs. One approach would be to offer purchasers a combination of a risk-adjusted capitation amount and a payment based on actual use of services.49

A good risk adjuster would make a purchaser's capitation payment match expected expenditures. Expected expenditures are the focus as the aim is to foster good behaviour at recruitment time rather than predict perfectly actual expenditures.
Provider support

Providers, especially GPs, will need to be persuaded to participate in any managed/integrated care organisations. No government is likely to compel GPs to participate, however, GPs may participate for several reasons. First, the policy consensus is that while some intervention into patterns of clinical care may be needed, it must be done by doctors, not bureaucrats or accountants. Such clinical oversight could also be achieved collegiately, perhaps via divisions of general practice. The benchmark may well be the current provision (s. 73BDA (2)(d)) for Medical purchaser-provider agreements in the National Health Act which:

'require the organisation to maintain the medical practitioners professional freedom, within the scope of accepted clinical practice, to identify appropriate treatments…'.

Second, enough GPs may be interested in getting off the fee-for-service treadmill (at least partially) to focus on community and preventive care. Thirdly, remuneration will have to be sufficient. Governments may be more interested in supporting GP incomes if it is not via an open-ended MBS, and if providers reap some of the benefits of, for example, better prescribing practices. Fourth, the justification for integrated care will have to be better health, not lower costs. Better health in this context can mean more equitable, consistent access to and utilisation of care. Finally, GP support may come from realising that while change could be resisted for some time, perhaps 5–10 years, eventually it may be imposed from the outside in a far less flexible form.

The prospects for provider support are reasonable, but not exciting. The AMA has already commenced its campaign ('say NO to managed care') asserting that the Commonwealth is about to introduce 'US Style Managed Care' which will restrict patient choice, 'have power over doctors' and that funds will 'control costs by reducing quality'. Many GPs eventually supported many of the Coordinated Care Trials, and a second round of these trials is now commencing. GPs are seeing that not all 'planned' care is bad.

Consumer-friendly models

No party or government will want to be seen to be undermining Medicare. The Coordinated Care Trials had significant difficulties recruiting clients to participate. This was despite the Trials offering 'more' to clients who were already high users of the system and who, presumably, were careful health care consumers. Any model of integrated care will need to put as few limits as possible on consumer access—and to be accepted will need to be almost invisible to consumers. Consumer concern will act as a valuable counterweight to managed-care enthusiasts. Some proponents of managed care suggest introducing multiple organisations that can then compete for consumers.
A more active private health insurance industry

Until recently, the Australian private health insurance industry has operated much like older indemnity funds in the US—passively taking in premiums and paying out to providers. There are now signs that the industry may be more interested in change. There is reportedly more serious interest in the next round of Coordinated Care Trials. Some funds have been trialing innovative early discharge trials, under Commonwealth supervision. If managed/integrated care is to develop, the industry will have to take up the reforms with more enthusiasm.

Conclusions

Managed care concepts are already actively discussed and tested in Australia. The extent to which managed care emerges as a distinct model or program will depend on a complex interaction of Commonwealth policies, health industry interest in change and consumer attitudes. While demonising or dismissing the benefits of managed care would needlessly undermine some useful reforms, proponents of managed care also have some hurdles to clear in order to show that the benefits will outweigh the costs.

The future of managed care in Australia will depend on how well policy-makers can resolve the tensions between:

• patient autonomy and the need to control access to services
• clinical autonomy and the need to standardise care
• encouraging innovation and a cost-controlled environment, and
• improved data and information and patient confidentiality.

The prospects for sensible reform appear reasonable, but changes are likely to be gradual and piecemeal.

Endnotes

1. Or more precisely, funder-purchaser-provider relationships where government takes on an overall priority setting role as ultimate funder of health. It then funds purchasers (often departments or other agencies and intermediaries) who are charged with defining and buying services to meet these priorities from providers. In the Australian system providers can be public or private, while purchasers are mainly public. Purchasing could in the future be
performed by private agencies (such as health funds or non-government agencies). In the Coordinated Care Trials, for example, the Trial auspice takes on the purchasing role itself.


7. ibid., p. 2.

8. [Economist, 1999 #40]


16. J. C. Lewis, Mapping International Health Challenges for Managed Care, op. cit.


19. Thanks to Jeff Richardson for this example.


22. J. C. Robinson, 'The future of the managed care organisation', *Health Affairs*, vol. 18, no. 2, 1999; pp. 7-.


25. ibid.


30. J. Richardson, *Funding and Future Options for the Reform of Medicare*, op. cit.


41. I. Lazarus, A. Wilson, A. Cullen, 'Australia pioneers new directions in care management', *Managed Healthcare*, vol. 9, no. 12, 1999, pp. 26–28. Triage is the sorting of and allocation of treatment to patients according to a system of priorities.

43. Diagnosis Related Groups (DRGs) are a way of classifying surgical and medical interventions, based mainly on the principal diagnosis.


46. R. Scotton, Managed Competition: the Policy Context, op. cit.


50. Australian Medical Association, ‘Say No to Managed Care’, AMA undated.

51. R. Scotton, Managed Competition: the Policy Context, op. cit.