3

A national health agenda

> *In a single episode of care, individuals may require services from providers in both the public and private sectors, with funding coming from both public and private sources including Medicare, health funds, or their own pockets. Patients rely on the health care system working seamlessly, that is, on collaboration and cooperation between the different sectors, but the financial and administrative arrangements unfortunately do not always support this. It is vital that reforms focus on building a health system based around the needs of the patient, rather than relying solely on the 'goodwill' and professionalism of practitioners.*[1]

3.1 There are a number of areas where the performance of the health system could be improved by reforming funding arrangements. This chapter discusses the shortcomings of current funding arrangements on the incentives for providing quality care to patients during an episode of care and for population 'wellness' to be addressed at an early stage. The committee sets out a number of different funding models proposed by inquiry participants that aim to address some or all of these shortcomings.

3.2 The effects of health funding arrangements on the development of the health workforce, regional, rural and remote health services, and accountability for health service provision and outcomes are separately addressed in chapters 4, 5 and 9 respectively.

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1 Australian Association of Pathology Practices, sub 38, p 9.

3.3 The committee has attempted to assess the potential benefits and costs of implementing several proposed funding models. While there appear to be benefits associated with moving to different funding arrangements, the magnitude of benefits is uncertain and there are risks that would need to be managed. There are, however, also risks in leaving funding arrangements unchanged.

3.4 Irrespective of the funding model adopted by governments, there is a need for a national health agenda to guide future reform. These changes can be implemented independently and incrementally, or as part of a more radical restructuring of funding arrangements.

Problems with existing funding arrangements

3.5 As discussed in chapter 2, current funding arrangements can lead to waste, duplication and cost shifting between jurisdictions. Funding arrangements can reduce the incentives for governments and the population to promote 'wellness' and also reduce opportunities to improve the quality care and continuity of care for patients.

Waste and duplication

3.6 One outcome of the division of funding responsibility between the Commonwealth and state governments is administrative duplication of a range of tasks and the 'wasted' resources that are consumed by the health bureaucracy.

3.7 The committee noted that a recent review in Queensland, described the Queensland health department as having 'a bureaucratic, mechanistic structure characterised by highly centralised formal authority and hierarchical layers of decision making'.[2] The committee also received evidence noting that:

> … only 20 per cent of the [Queensland Health] Department's employees (totalling some 64,000) are doctors and nurses: for every clinician who actually deals with patients, there are four other employees who have to justify their existence within Queensland Health.[3]

2 Foster P, Queensland Health Systems Review, Final Report September 2005 (2005), p 68.

3 Anthony Morris QC, sub 72, p 20.

3.8 However, a much higher proportion of the staff employed directly by public hospital are involved with patient care, as illustrated by figure 3.1.

Figure 3.1 Public hospitals – average full time equivalent staff, states and territories, 2004-05

	Salaried Medical officers	Nurses	Diagnostic and Other Health Professionals	Administrative and Clerical Staff	Personal Care, Domestic and Other Staff	Total
NSW	6698	31858	10002	11700	11679	71937
Vic	5557	24372	11105	9104	6861	56999
Qld	3787	14996	3456	4162	6916	33317
WA	1944	8118	2238	3231	3586	19117
SA	1700	7908	1993	2810	2047	16458
Tas	442	2163	423	601	1060	4689
ACT	373	1493	409	634	350	3259
NT	263	1030	280	394	545	2512
AUSTRALIA	20764	91938	29906	32636	33044	208288

Source *Department of Health and Ageing, The state of our public hospitals, June 2006 report (2006), p 15*

3.9 It is difficult to estimate and verify the cost of wasted bureaucratic effort. Various estimates were provided to the committee giving the costs of inefficiencies, ranging from annual savings of $1.1 billion and up to $4 billion if potential savings in improving population wellness are taken into account.[4]

3.10 Although the committee has not tested the reliability of these estimates, their order of magnitude suggest that there may be significant resources that can be saved within the existing health budget and be directed to more appropriate areas. With over $87 billion in health expenditure in 2004-05, including $2.3 billion in administration costs,[5] there is significant scope for savings by reducing duplication of service provision and/or administration. A 10 per cent reduction in administrative cost, for example, would save $230 million.

Cost shifting

3.11 As noted in chapter 2, cost shifting is at least perceived to be a feature of the health system. Cost shifting between governments, and to

4 Rural Doctors Association of Australia, sub 31, p 9; Australian Association of Pathology Practices, sub 38, p 2; Australian Healthcare Association, sub 62, p 6.

5 Australian Institute of Health and Welfare, *Health expenditure Australia 2004-05* (2006), table A3, p 105.

patients via co-payments, can affect the incentives for providers and patients to access appropriate care options.

3.12 Numerous examples of alleged cost shifting were provided to the committee, including:

- states shifting costs to consumers and the Commonwealth through public hospitals 'encouraging' patients to elect to be private patients,[6]
- cost shifting to the states by diverting after-hours patients from general practice to emergency departments;[7]
- cost shifting to the states when nursing home type patients occupy public hospital beds rather than being accommodated in a residential aged care setting;[8] and
- states shifting costs to the Commonwealth and patients when public hospital patients are sent to have pathology and radiology undertaken either in private practice clinics at the public hospital or sent to general practitioners (GPs) to have the request ordered privately by the GP.[9]

3.13 The shifting of costs from one party to another was seen by the Department of Health and Ageing as a matter of some debate:

> Part of the very nature of 'cost-shifting' is that one person's cost-shifting is another person's good management. So to actually draw a line around a particular piece of money and say, 'This is a cost that has been shifted,' would in fact be subject, in itself, to quite a degree of debate, ambiguity and alleged subjectivity. To try and quantify cost-shifting, you are probably trying to quantify something that is, in itself, fairly vaguely defined.[10]

3.14 In most cases clinicians working in the health system are able to navigate patients through services with different funding arrangements without affecting the quality of care. The Royal Australian College of General Practitioners told the committee that:

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6 Australian Health Insurance Association, sub 16, p 25.

7 Australian College for Emergency Medicine, sub 17, p 1.

8 Australian Association of Gerontology, sub 53, p 3.

9 Australian Nursing Federation, sub 39, p 11; Australian Medical Association (Queensland), sub 104, p 13.

10 Davies P, Department of Health and Ageing, transcript, 30 May 2005, p 16.

> As a general practitioner, I do not particularly think about whether the service that I am referring my patient to is funded by the Commonwealth or by the state. I think about the best service to assist that person whose care I am responsible for.
>
> We are gatekeepers for our patients to the rest of the health sector. We are advocates for our patients. We will become aware of certain parts of the health system where it is easier for patients to get appointments, and they may be the ones we will use. Or we will become aware of services which provide what we may regard as a higher quality care or a safer care, and that is where we will focus. So the issue of cost shifting does not really come into the minds of many general practitioners.[11]

3.15 Where cost shifting is not driven by appropriate clinical practice, it imposes significant system-wide effects that can result in:

- waste and duplication — management time is used to creatively find short-term funding solutions rather than concentrating on improving the efficiency and effectiveness of service delivery and replication of some tasks at different levels of government;[12]
- a reduction in the overall efficiency of the health system — the incentives in funding arrangements may not ensure that care is appropriate throughout the full episode of care, resulting in hospital re-admissions and the prevention of potentially avoidable hospitalisations;[13]
- distorted market signals to private sector providers that result in inappropriate investment in medical technology and 'unfair' competition between the public and private sectors;[14] and
- over-servicing, where three investigations are done when one would be appropriate, or over-investigations are undertaken (by

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11 Kidd M, Royal Australian College of General Practitioners, transcript, 5 July 2005, p 52.

12 Roff M, Australian Private Hospitals Association, transcript, 23 August 2005, p 66; Toemoe G, St Luke's Hospital, transcript, 24 August 2005, p 23; Australian Health Care Association, sub 62, p 4; Macquarie Health Corporation, sub 55, p 4;

13 Local Government Association of NSW and Shires Association of NSW, sub 18, p 9; Australian Association of Gerontology, sub 53, p 3; Dr Ross Cartmill, sub 107, p 3; Enteral Industry Group, sub 119, p 17; Western Australian Government, sub 124, p 23; Australian Health Insurance Association, sub 16, p 9.

14 Australian Diagnostic Imaging Association, sub 21, p 2; Australian Medical Association (Queensland), sub 104, p 13.

private doctors working in private hospitals) – not a 'fair go for all';[15] or Department of Veterans' Affairs (DVA) turnover in private hospitals is 25 per cent of procedures with veterans being only 1.3 per cent of the population.[16]

The 'blame game'

3.16 The 'blame game' between different levels of government over the level of funding and responsibilities can undermine the functioning of political accountability for government actions.[17] Mr Menadue noted that:

> I think all the evidence is clear that we must resolve this problem to ensure integrated care and the avoidance of cost and blame shifting. Both federal and state governments have a vested interest in the present system. They can blame each other. The solution to this requires political action. It is not one for managers.[18]

3.17 It is important that clinicians' decisions about a patient's health care are based on providing high quality health care rather than funding outcomes for individual providers. When non-clinical considerations drive decisions about how and where care is provided, then funding arrangements that create this pressure should be revised.

Promoting wellness

3.18 Hospitals are the most expensive component of the health system, but most interaction with the system occurs outside of institutional settings.[19] Primary care in a community setting also offers more opportunities to promote wellness.

3.19 Primary health care involves treatment in the community by a range of health professionals including, general practitioners, allied health

15 Ralls J, Doctors Reform Society of Western Australia, transcript, 24 August 2006, pp 21 and 24; Armitage M, Australian Health Insurance Association, transcript, 4 September 2006, pp 29–30.

16 Bartlett R, Department of Veterans' Affairs, transcript, 4 September 2006, pp 15 and 29.

17 Australian Health Care Association, sub 62, p 11; Australian Doctors' Fund, sub 78, p 6; Goulston K, Hospital Reform Group, transcript, 29 March 2006, p 2; Singer A, Australasian College for Emergency Medicine, transcript, 28 June 2005, p 42; Mackender D, Hospital Reform Group, transcript, 26 May 2006, p 9.

18 Menadue J, 'Principles and Priorities for Health Care Policy Development' (2005), address to L21 Health and Aged Care Forum, Sydney 22–23 November, exhibit 35, p 5.

19 Duckett S, *The Australian Health Care System* (2004), p 206.

workers, and pharmacists. Primary health care shares the complexity of funding arrangements for other parts of the healthcare system, including multiple government and private funders and providers.

3.20 Current health funding arrangements have an inherent bias towards 'treating' illness rather than preventing illness (or promoting 'wellness').[20] This bias is partly due to incentives in the Commonwealth funded Medicare benefits schedule (MBS) for practitioners to treat conditions rather than averting potential illnesses or hospitalisations. A stark example of this bias was provided by the National Rural Health Alliance, who noted that the amputation of a diabetic foot is reimbursed under the MBS whereas preventative treatment by a podiatrist is not.[21]

3.21 The committee acknowledges, however, that in recent years the Commonwealth has made significant changes to extend services covered by the MBS to strengthen the capacity of primary health care to promote wellness and continuity of care. Services covered include general practitioners providing coordinated care for chronically ill patients and incentives for earlier intervention in selected at risk groups.[22]

3.22 Public health programs cover activities designed to benefit the population and includes activities that emphasise prevention, protection and health promotion as distinct from treatment.[23] Public health expenditure by Australian governments was estimated to be around $1.3 billion in 2003-04, of which $657 million was funded by the Commonwealth and $609 million by the states.[24] Public health

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20 Redcliffe-Bribie-Caboolture Division of General Practice, sub 81; Menadue J, Health Sector Reform Part 2: Primary Care and Wellbeing, exhibit 40; Health Group Strategies, sub 116; Australian Healthcare Reform Alliance, sub 127; Parkes H, Department of Health (South Australia), transcript, 2 May 2006; Meikle R, Australian Diagnostic Imaging Association, transcript, 26 May 2006; Victorian Health Promotion Foundation, sub 8, p 1; Professor Lesley Barclay and Dr Suzanne Belton, Charles Darwin University, sub 76, p 1.

21 National Rural Health Alliance, sub 59, p 7.

22 See for example, Hon Tony Abbott MP, Minister for Health and Ageing, media releases, *GPs benefit from Budget*, 11 May 2005; *New Medicare item for Indigenous health, refugees and palliative care*, 1 May 2006; *Government expands Medicare for chronically ill*, 9 June 2005; *Government expands Medicare for the chronically ill*, 9 June 2005; *Promoting health throughout life*, 9 May 2006.

23 Australian Institute of Health and Welfare, *Australia's health 2006* (2006), p 475.

24 Australian Institute of Health and Welfare, *National public health expenditure report 2001-02 to 2003–04* (2006), p 4.

expenditure as a share of total recurrent health expenditure has remained largely unchanged at around 1.7 per cent since 1999-00.[25]

3.23 There is increasing evidence supporting the need to improve both the community's access to primary health care services and the incentives for medical practitioners to provide better prevention-based health care services. It is also clear that there are significant benefits in investing in preventative and early detection measures for a range of chronic conditions to avoid the future significant costs of hospital treatment (box 3.1).

3.24 The need for additional efforts to be made in primary and public health is also highlighted by the potential costs of not addressing the rising incidence of obesity and diabetes, especially among children. Health Group Strategies noted that:

> Despite six reports since the 1997 report by [the National Health and Medical Research Council], the absence of funded, targeted national policies for obesity prevention in adults and children is another sign of national complacency.…
>
> - overall, during the 20-year period to 2004, the percentage of overweight males and females rose 17.5 per cent and 18 per cent, respectively ….
> - about 60 per cent of the Australian adult population is now overweight or obese, and the International Obesity Task Force estimates that by 2025, 1 in every 3 adults in Australia will be obese.
> - adult obesity is rising at 1 per cent per year, and over 60 per cent of overweight and obese adults in the ABS 2004-05 National Health Survey considered themselves to be at a healthy weight …..
> - healthcare expenditures associated with the downstream effects of obesity - which means large shares of the costs of treating seven major chronic disorders - are rising at about 2 per cent per year. Much of that care is in hospitals only because we refuse to think about policy solutions upstream.[26]

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25 Australian Institute of Health and Welfare, *National public health expenditure report 2001-02 to 2003–04* (2006), p 8.

26 Health Group Strategies, sub 116, pp 23–24.

Box 3.1 Investing in prevention and early detection

Kidney health — Chronic kidney disease is a common, under-recognized, progressive, preventable and treatable condition. Over the last 25 years, while the Australian population has grown less than 40 per cent, the numbers of Australians being treated with dialysis or a kidney transplant has grown by more than 400 per cent. Early diagnosis through screening followed by appropriate treatment can reduce the rate of kidney failure, strokes and other problems by up to 50 per cent. A recent study of the best practice rules by which general practitioners are funded to care for diabetics require foot checks, eye checks and eight other checks— but no check on the function of the kidneys.[27]

Osteoporosis— a skeletal disorder characterised by compromised bone strength predisposing a person to an increased risk of fracture. In 2001, 2 million people had osteoporosis. Direct costs are estimated to be $1.9 billion per annum (concentrated in hospitals and nursing homes) with indirect annual costs of around $5.6 billion (including lost earnings and carers). In 2002, someone was admitted to a hospital with a osteoporotic fracture every 8.1 minutes — this will rise to one every 3.7 minutes by 2021 if no preventative action is taken. While there are a range of medications under the pharmaceutical benefits scheme to treat osteoporosis, the Medicare benefits schedule does not subsidise a bone density test for at risk patients, delaying access to early diagnosis and treatment.[28]

Chronic Obstructive Pulmonary Disease (COPD) — Chronic bronchitis and emphysema are common long-term lung diseases that cause shortness of breath. COPD is Australia's fourth biggest killer, estimated to cost Australian taxpayers $800-900 million each year. Approximately 75 per cent of those with COPD do not know they have it and therefore are not taking the critical steps to manage their condition. COPD is a burden on Medicare through the cost impact of inefficient and delayed diagnosis, which in turn is shifted as a burden to state hospitals that provide for longer bed stays when patients require hospitalisation—which could have been prevented if simple rehabilitation treatments and early diagnosis were more widely available.[29]

Multiple Sclerosis (MS) —MS is a chronic, often disabling disease that randomly attacks the central nervous system. The largest direct cost is the provision of informal care, with the loss of productivity associated with MS of individuals and their carers also a significant issue. Although MS is a long term chronic condition, there is clear benefit to early intervention and health self management programs to ease the disease burden, which stands at the value of $1.3 billion per year.[30]

27 Kidney Health Australia, media release, *Silent killer! Silent governments!*, 7 August 2006.

28 Osteoporosis Australia, *Osteoporosis in Australia: A presentation to the House Standing Committee on Health, September 6 2006*, exhibit 56.

29 Australian Lung Foundation, sub 112; Darbishire W, Australian Lung Foundation, transcript, 21 July 2006, pp 13–25.

30 MS Australia, sub 130.

3.25 As noted in chapter 2, the Treasurer's *Intergenerational Report 2002-03* highlights the need for governments to take strategic action to address the drivers of rising demand for health services. Supporting wellness in the population should be an underlying principle for such strategic action.

3.26 The submission made to the inquiry by the Australian Breastfeeding Association illustrates the kind of action that the committee believes should be assessed. [31] The Association presented evidence that breastfeeding rates in Australia are well below levels recommended by the National Health and Medical Research Council and that increasing the rates would reduce the prevalence of a range of health problems including asthma, diabetes, gastroenteritis and respiratory infections. Prima facie, development and implementation of an action plan to increase the breastfeeding rates would be good long term investment that should be supported by governments.

3.27 In 2007, the committee will examine the health benefits of breastfeeding.

High quality and safe health care

3.28 There are significant economic and social costs associated with poor quality health care. Health funding arrangements need to provide the right incentives for health providers to deliver high quality and safe medical care to the community.[32]

3.29 There is evidence to suggest that the safety and quality of health care in Australia can be improved:

- the reported medical error rates in public and private hospitals in 2003-04 are 5.4 per cent and 3.6 per cent, respectively. The extended treatment of patients affected by these errors increases private health fund pay-outs and public hospital costs by at least these percentages;[33]
- hospital-acquired infections are estimated to generate an annual cost of in the range of $460–$895 million;[34]

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31 Australian Breastfeeding Association, subs 153 and 159.

32 Australian Institute of Medical Scientists, sub 12, p 1; Rural Doctors Association of Australia, sub 31, p 21; Australian Association of Pathology Practices, sub 38, p 8.

33 Health Group Strategies, sub 116, p 25.

34 Health Group Strategies, sub 116, p 25.

- patients, including the elderly are discharged from public hospitals early, leading to unnecessary readmissions;[35] and
- health care for sicker patients — a recent cross national survey of sicker adults in six countries noted that 1 in 4 of the sickest patients interviewed in Australia was not accessing needed care, with access barriers partly caused by co-payments. These sick patients are also trying to warn us that we need to respond to the low rankings on relating to patient safety, effectiveness of care, efficiency of care and timeliness of care.[36]

3.30 While there are already a range of institutional structures and funding mechanisms that focus on improving the quality of health care,[37] there are clearly opportunities for improvements to be made.

Continuity of care

3.31 Continuity of care is increasing in importance as a result of an ageing population and the rising incidence of chronic and complex conditions.[38] Health funding arrangements need to support continuity of care across multiple public and private service providers.

3.32 Changes in the types of care required to support Australia's population are related to success during the twentieth century in reducing mortality rates for children and middle-aged people in particular (figure 3.2).

35 Dr Ross Cartmill, sub 107, p 3.

36 Health Group Strategies, sub 116, pp 10–11.

37 Department of Health and Ageing, sub 43, p 16.

38 Royal Australian College of General Practitioners, sub 66, p 8; ACT Government, sub 64, p 2; MBF Australia Limited, sub 29, p 24; Australian Health Insurance Association, sub 16, p 1; Australian Association of Gerontology, sub 53, p 4.

Figure 3.2 Changes in mortality rates, 1907 to 2000

Source *Podger A, Inaugural Menzies Health Policy Lecture : 3 March 2006, exhibit 27, p 4.*

3.33 The Australian Health Insurance Association noted that current funding arrangements do not provide any responsibility for providers for health outcomes:

> The concept of a continuum of care is undermined by the fact that there are different people paying for different stages of the process. Why does that matter? I think it matters for one reason and one reason only, and that is that with a mixture of different payers no-one has really got a concern about what the outcome is for the patient.[39]

3.34 Inquiry participants raised a number of areas where funding arrangements can affect the continuity of care, including the transition between hospitals and residential or community aged care and mental health services.[40] The Australian Health Care Reform Alliance stated that:

> … whenever our patients move from general practice into hospitals, when they cross a boundary in our health care system if you like, from a community hospital, private to public, inefficiencies travel with them. Often their medical details, their personal health information, does not travel with

39 Schneider R, Australian Health Insurance Association, transcript, 23 August 2006, p 50.

40 ACT Government, sub 64, p 7; The Royal Australian College of General Practitioners, sub 64, p 8; Department of Veterans' Affairs, sub 74, p 10; Caboolture Shire Council (Qld), sub 103, p 11.

> them. Often tests that have been carried out in the community are duplicated when people arrive in hospital. Expensive investigations may be duplicated. People may be discharged back into our care without relevant important information being transferred. Therefore, we may see people who subsequently get sick again because they have not had the proper follow-up which they required after discharge, and they manage to go back into hospital again. So the inefficiencies run across the system.[41]

3.35 The Australian Association of Pathology Practices emphasised the importance of coordination between service providers, noting that:

> Coordination between general practices, other community-based services, secondary care and hospitals is haphazard, and largely reliant on individual relationships among providers and services. Coordination of care must be supported by comprehensive information and communications technology and management systems that provide all health practitioners and care givers with access to accurate and timely information about an individual's treatment.[42]

3.36 The committee was provided with a number of examples of locally-based arrangements aimed at improving communication between hospitals and general practitioners and other allied health professionals, primarily led by Divisions of General Practice.[43] Primarily based on facilitating improved communication, it is clear that better use of information technology is likely to underpin efforts to share patient information across providers.

Funding silos

3.37 The complexity of having multiple health funders and multiple health programs was seen by some inquiry participants as creating funding 'silos', within which funders assess the costs and benefits of programs without considering the potential effects on other programs or service

41 Kidd M, Australian Health Care Reform Alliance, transcript, 21 July 2006, p 45.

42 Australian Association of Pathology Practices, sub 38, p 8.

43 Australian Divisions of General Practice, sub 15, pp 3–4.

providers. This can be the case even when programs delivered by the same level of government are involved.[44]

3.38 Some examples of the impact of funding silos on the delivery of health care raised by participants included:

- expenditure on pharmaceuticals, particularly newer, high technology pharmaceuticals, can be demonstrated in many instances to be accompanied by substantial and real cost-offsets within other areas of the health system;[45]
- pharmaceutical benefits scheme (PBS) funding for medicines to treat or prevent fractures associated with osteoporosis but no MBS items allowing access to screening for bone density in the target population;[46]
- greater investment on preventative dental care can improve individual health outcomes and avoid significant hospital expenditure;[47] and
- supporting health care with appropriate community-based social services, such as home visits for mothers with identified shortfall in their parenting skills, to improve health and education outcomes.[48]

3.39 It is important to acknowledge that there will inevitably be some management of funds within specific areas. The Hospital Reform Group noted that:

> I am always nervous using the word 'silo' to start with. As soon as you break anything up into a manageable unit, it runs the risk of becoming a silo. You can go down the clinical line and say it has been siloed. You can go across sites and say they have siloed. You can go across professions and say they have siloed. Unless you can come up with a matrix which says 'by clinical requirement, the professions, sites and bureaucrats come together with a way of managing clients', the silos will exist no matter what.[49]

44 Australian Private Hospitals Association, sub 27, p 7; Australian Health Care Association, sub 127, p 30; The Australian Psychological Society, sub 136, p 7; Australian Diagnostic Imaging Association, sub 21, p 4; Australian Nursing Federation, sub 39, p 14; Harvey D, Australian Council of Social Service, transcript, 21 September 2005, p 72.

45 Medicines Australia, sub 42, p 3.

46 Osteoporosis Australia, transcript, 6 September 2006.

47 Australian Dental Association, sub 28, p 11.

48 Parkes H, Department of Health (SA), transcript, 7 April 2006, pp 18–19.

49 Stevenson K, Hospital Reform Group, transcript, 26 May 2006, p 7.

3.40 Notwithstanding these realities, it is especially important for health funding decisions at a broad level to be able to acknowledge the costs and benefits of different types of health interventions across the whole health system as well as over an individual's lifetime.

A national health agenda

3.41 Previous sections of this chapter have identified problems relating to waste and duplication, cost shifting, a bias to treatment of illness rather than supporting wellness, and concerns about safety and quality and continuity of care. A comprehensive national approach to addressing these problems is needed. **This requires leadership by the Commonwealth, cooperation by the states and a joint commitment to end the blame game**.

3.42 A multitude of national level 'strategies', 'plans' and 'frameworks' have been adopted by the Commonwealth and state governments. These guide policy makers in setting health priorities, allocating funding and providing feedback on the performance of different parts of the health system (box 3.2). Many states have also developed their own range of policy documents that guide health funding and service delivery.[50]

3.43 These national policy frameworks play an important role in focusing and coordinating Commonwealth and state efforts in particular subject areas. However, almost by definition, they can not address system wide issues such as the balance between resources allocated to prevention or early detection of disease versus treatment of injury and disease, or the structural changes necessary to minimise expensive institution based care.

50 See for example, Department of Premier and Cabinet (Victoria), *Growing Victoria Together: A vision for Victoria to 2010 and beyond* (undated); Department of Health (NSW), *NSW Tobacco Action Plan 2005-2009*, November 2005; Queensland Health, *Action Plan: Building a better health service for Queensland*, October 2005; Department of Health (ACT), *ACT Mental Health Strategy and Action Plan 2003-2008*, September 2006.

Box 3.2 Selected national health strategies, frameworks and programs

'Healthy Horizons: Outlook 2003–2007' — a national health framework for rural, regional and remote Australians. Developed by Commonwealth, state health ministers in 2003, the framework provides a banner under which governments develop strategies and allocate resources to improve the health and well-being of people in rural, regional and remote Australia.[51]

'Report on Government Services' — an annual report commissioned by the Council of Australian Governments to provide information on the efficiency and effectiveness of government services (including health) on a state by state basis.[52]

'National Chronic Disease Strategy' — provides an overarching framework, endorsed by the Australian National Health Ministers' Conference, of national direction for improving chronic disease prevention and care across Australia. Five supporting national service improvement frameworks have been developed for asthma, cancer, diabetes, heart, stroke and vascular disease, osteoarthritis, rheumatoid arthritis and osteoporosis.[53]

'National Health Workforce Strategic Framework' — endorsed by the Australian National Health Ministers' Conference in 2004 is designed to guide national health workforce policy and planning and Australia's investment in its health workforce throughout the decade.[54]

3.44 A number of inquiry participants noted the absence of a high-level national agenda to guide health policy and funding.[55] A national health agenda may lead to major reforms but can also guide incremental reforms if there is general agreement about how the health system needs to change over time. Dr Scotton told the committee:

> I think there is some value in knowing where you would like to be, even if that is some sort of measuring rod when things come up to determine which step is a step forward and which

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51 National Rural Health Alliance, *Health Horizons Outlook 2003–2007*, viewed on 21 September 2006 at www.ruralhealth.org.au/nrhapublic/publicdocs/hh/03_hh0307rep.pdf.

52 Steering Committee for the Review of Government Service Provision, *Report on Government Services 2006* (2006), Productivity Commission.

53 National Health Priority Action Council, *National Chronic Disease Strategy* (2006), Department of Health and Ageing, Canberra.

54 Australian Health Ministers' Conference, *National Health Workforce Strategic Framework* (2004).

55 Webb R, Department of Health (SA), transcript, 2 May 2006, p 32; Australian Healthcare Association, sub 62, pp 9–10; Australian Nursing Federation, sub 39, p 9; Clout T, Hunter New England Health, transcript, 20 July 2006, p 18; Australian Medical Association, sub 30, p 16.

> one is a step back. We do have potentially in the longer term a very serious problem with health costs going to 15 per cent or 18 per cent of GDP. It is a good idea to think well ahead of what you might do to put some sort of brake on that, because there may well come a time when the rising demand for resources for health care may start to impinge on other areas of great value to our society.[56]

3.45 The committee considers that the Commonwealth needs to provide leadership on setting a national health agenda, in consultation with the states. When fully developed, the national agenda should result in:

- policy and funding principles to underpin the long term sustainability of a health system that provides affordable access to best practice care;
- identification of elements of structural and allocative inefficiency in the health system as a whole;
- a clearer articulation about the standards of service that the community can expect to receive including desired population health outcomes, the extent to which rationing is acceptable within the public system and the quality of care that people are entitled to receive;
- strategies to integrate the private sector within the health system to improve continuity of care between the public and private sectors; and
- a framework for reporting on performance of health service providers and governments.

3.46 The national health agenda could establish a basis for major structural reform or could guide incremental reforms.

3.47 As part of addressing the long-term health impact of emerging health concerns the committee considers that the national health agenda also needs to be linked to broader public health strategies. In the case of addressing the rising incidence of childhood obesity and diabetes, which is being examined by a ministerial taskforce,[57] the agenda should integrate with action taken in schools and in the marketing of food.

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56 Scotton R, transcript, 21 July 2006, p 52.

57 Hon Tony Abbott MP, Minister for Health and Ageing, media release, *Tackling obesity head-on*, 19 July 2006.

3.48 Several participants suggested that a set of 'principles' should be used to assess whether proposed reforms are consistent with a reform path.[58] Other participants also noted that reform could be guided by a range of intergovernmental bodies including COAG, health ministers or a newly established national 'commission'.[59]

3.49 The committee believes that health ministers should drive reform but governments need to endorse and support the underlying principles and objectives.

3.50 If the pressures foreshadowed by the Intergenerational report[60] are to be ameliorated, any policy changes that can reduce the long term demand for services or reduce the long term costs of care need to be identified and implemented. As the benefits of some initiatives, such as tackling the prevalence health risk factors, may not be apparent for many years, action should be initiated as soon as possible.

3.51 The community has made it clear that it expects the Commonwealth and states to stop blaming each other for shortcomings in the health system. The committee agrees and recommends accordingly.

58 Australian Health Care Association, sub 62, pp 7–8; Australian Nursing Federation, sub 39, p 6; City of Darebin (Vic), sub 32, p 3.

59 Health Group Strategies, sub 116, p 14; City of Darebin (Vic), sub 32, p 4; Local Government Association of NSW and Shires Association of NSW, sub 18, p 10; Australian Medical Association, sub 30, p 10; Podger A, transcript, 31 May 2006, p 10.

60 The Treasury, *Intergenerational Report 2002-03*, Budget Paper No. 5 (2002).

Recommendation 1

3.52 **The Australian, state and territory governments develop and adopt a national health agenda. The national agenda should identify policy and funding principles and initiatives to:**

- **rationalise the roles and responsibilities of governments, including their funding responsibilities, based on the most cost-effective service delivery arrangements irrespective of governments' historical roles and responsibilities;**
- **improve the long term sustainability of the health system as a whole;**
- **support the best and most appropriate clinical care in the most cost effective setting;**
- **support affordable access to best practice care;**
- **rectify structural and allocative inefficiencies of the whole health system, as it currently operates;**
- **give a clear articulation of the standards of service that the community can expect;**
- **redress inequities in service quality and access; and**
- **provide a reporting framework on the performance of health service providers and governments.**

3.53 The adoption of a national health agenda will require a clear commitment of political will by all levels of government. Difficult as this commitment may be to achieve, the community has made it clear that it expects nothing less.

3.54 A national health agenda should also guide debate about changing health funding arrangements. While there are several alternate funding models that could be used to achieve the national agenda, the committee considers that a high-level commitment to a national agenda is likely to lead to an improved debate about how health funding arrangements should be structured.

Radical reform: possible models

3.55 Inquiry participants nominated a range of different funding models that would, to varying degrees, change the structure of current health funding arrangements. While some funding models could be structured around current service delivery arrangements, most of the proposed models also require changes to governance and service delivery arrangements.

3.56 Many of the suggested models are not new. In 2000, the Senate's Community Affairs Committee considered a number of different reform models as part of its inquiry into public hospital funding.[61]

3.57 One common theme to these proposed models is that they incorporate — to varying extents — a broad pooling of funds from the current 'silos', such as the Australian Health Care Agreements and Commonwealth funded programs such as the PBS and the MBS.

3.58 Some commentators argue that fund pooling is more likely to promote better continuity of care, a stronger emphasis on primary health care and public health and reduce incentives for cost shifting. This is largely due to increased flexibility in the allocation of funds across existing program areas and incentives for fund holders to provide for the long-term health needs of the enrolled community.[62] Mr Podger noted that:

> Perhaps the most significant contribution to inefficiency in our system today however, is not the lack of technical efficiency within particular functional areas such as hospitals or residential aged care or general practice, but allocative inefficiency where the balance of funding between functional areas is not giving best value, and the inability to shift resources between the functional areas at local or regional levels and to link care services to individuals across program boundaries is reducing the effectiveness of the system. [63]

3.59 Some differences between the proposed fund pooling models include the extent that the private sector is incorporated into service delivery

61 Senate Community Affairs Committee, *Healing our hospitals: A report on public hospital funding* (2000).

62 Fitzgerald V, 'Health reform in the federal context', *Productive reform in a federal system* (2006), Productivity Commission, p 120.

63 Podger A, *Inaugural Menzies Health Policy Lecture : 3 March 2006* (2006), exhibit 27, p 7.

arrangements and governance arrangements for distributing funds and monitoring service delivery.

3.60 Mr Podger summarised four main options for reforming Commonwealth/state funding arrangements:

- ONE: the states to have full responsibility for purchasing all health and aged care services;
- TWO: the Commonwealth to take full financial responsibility for the system, as both funder and purchaser;
- THREE: the Commonwealth and the states to pool their funds, with regional purchasers having responsibility across the full range of health and aged care services; and
- FOUR: the Scotton model, or 'managed competition' model, with total Commonwealth and state moneys to be available for channelling through private health insurance funds by way of 'vouchers' equal to each individual's risk-rated premium which the individual may pass to the fund of their choice, the fund then having full responsibility as funder/purchaser of all their health and aged care services.[64]

3.61 These four models, or variants of these models, were raised by inquiry participants as providing a possible solution to overcome some of the deficiencies of current funding arrangements.[65] Mr Podger noted:

> The main differences between different reformers is about what is the best model for a single funder, what is the best role for private funding and private health insurance, and whether we should be pursuing incremental or systemic reform.[66]

3.62 The other main option for health funding is to maintain existing arrangements. A number of ways that current arrangements could be left in place but improved are discussed later in this chapter.

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64 Podger A, *Inaugural Menzies Health Policy Lecture : 3 March 2006* (2006), exhibit 27, p 9.

65 Australian Healthcare Association, sub 62, pp 8–11; Scotton R, transcript, 21 July 2006, pp 50–57; Menadue J, transcript, 21 July 2006, pp 29–30; Municipal Association of Victoria, sub 33, p 3; Redcliffe-Bribie-Caboolture Division of General Practice, sub 81, p 2; Australian Association of Gerontology, sub 53, pp 3–4; Australian Council of Social Service, sub 25, p 1.

66 Podger A, *Inaugural Menzies Health Policy Lecture : 3 March 2006* (2006), exhibit 27, p 12.

1. States — full responsibility

3.63 In Canada, responsibility for health is devolved to the provinces within a federal system.[67] Although giving states full responsibility for the delivery of health services may result in the loss of a 'national' health system, states could be required to meet national principles requiring universal access to services and regular performance measurement.[68]

3.64 The states could also choose whether to have lower level regional purchasers of services, and might agree to cooperate or seek economies of scale through delegated Commonwealth management of certain parts of the system. For example, listing and pricing drugs and medical services, managing the blood supply and regulating private health insurance.[69]

2. Commonwealth — full financial responsibility

3.65 A detailed model for the Commonwealth having full responsibility for funding and purchasing health care has recently been developed by Mr Andrew Podger.[70] One of the features of the model proposed by Mr Podger is the separation of funding and purchasing and a regional approach to service provision (figure 3.3).[71]

67 OECD 2001, *Consulting on health policy in Canada*, viewed on 24 October 2006 at www.oecd.org/dataoecd/53/43/2536423.pdf.

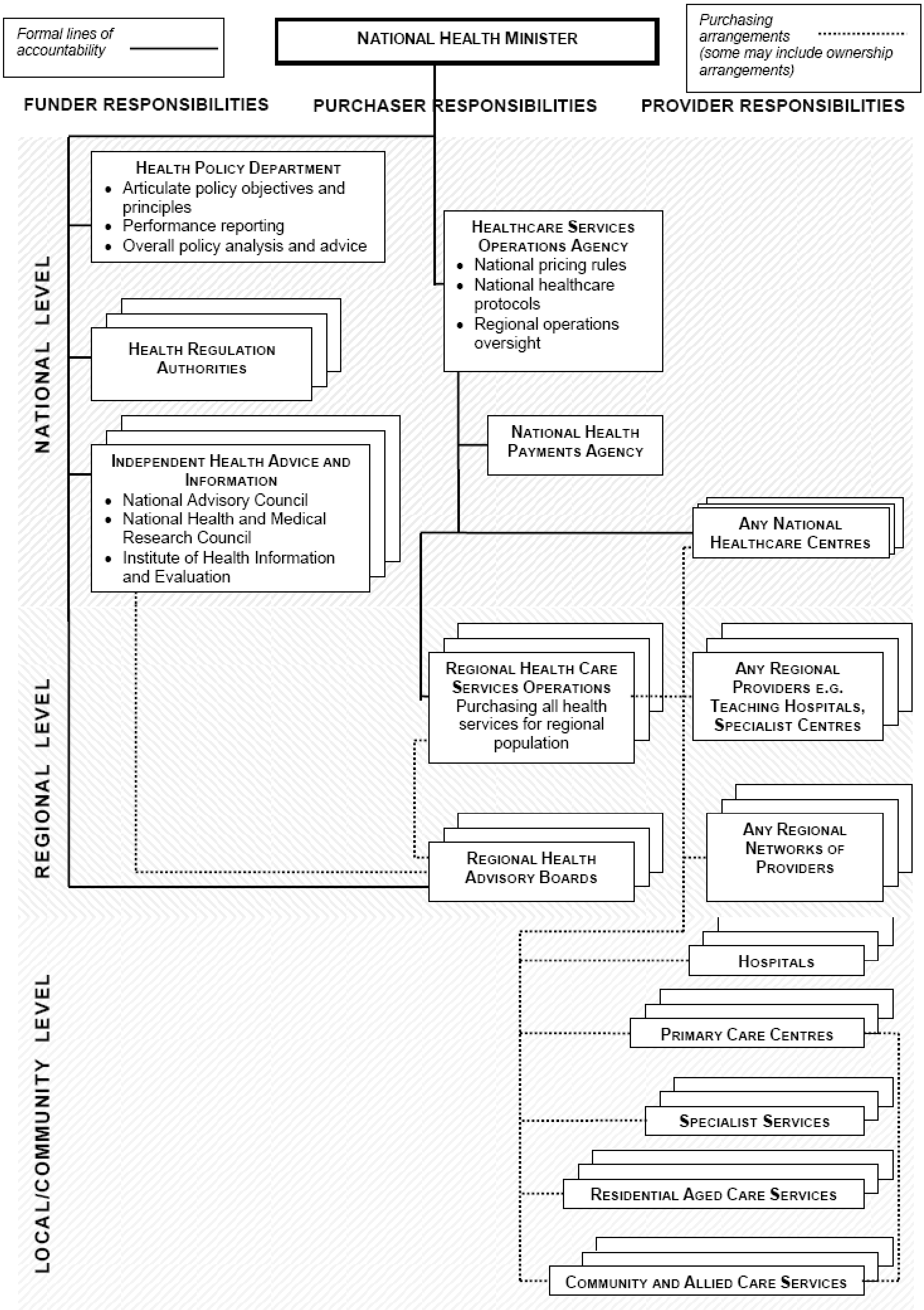
68 Podger A, Directions of health reform in Australia (2005), Productivity Commission,, p 147, exhibit 26.

69 Podger A, Directions of health reform in Australia (2005), Productivity Commission, p 147, exhibit 26.

70 Podger A, transcript, 31 May 2006, p 2.

71 Podger A, *Inaugural Menzies Health Policy Lecture : 3 March 2006* (2006), exhibit 27, p 12.

Figure 3.3 Full financial responsibility to the Commonwealth — proposed financial and governance arrangements



Source *Podger A, Inaugural Menzies Health Policy Lecture: 3 March 2006 (2006), exhibit 27, p 12.*

3.66 Some of the key features of the model proposed by Mr Podger include:

- the Commonwealth to articulate the policy objectives and the general principles, set the conditions within which health care services would be purchased and provided, and establish the framework for reporting on performance. The policy objectives and principles should include the requirements of equity in terms of geographic access, co-payments, safety nets and acceptable queues etc, and the requirements of value-for-money such as cost effectiveness processes for listing and pricing drugs and health services;
- a national (or supra-national by including NZ) approach to most areas of health regulation, at least in standards if not in day-to-day administration. This includes regulation aimed at patient safety and consumer protection, including licensing of products and providers (both individuals and organisations such as hospitals and nursing homes), regulation of the private health insurance industry and the setting of food standards;
- regionally-based purchasing arrangements with around 20-30 regional purchasers having the flexibility to allocate funds according to their most cost effective use to achieve the health objectives for their regional population;
- budget arrangements to involve a 'soft-capped' total budget based on the population's risk profile, with access to some specific national risk pools where the region cannot be expected to manage the risk on its own. These might cover, for example, the impact of the MBS or PBS safety nets, as well as some very high-cost populations or even some high care episodes. The soft cap would also allow budget over-runs if necessary, where the consequences would be some form of performance review rather than penalising the regional population;
- provider arrangements would not be substantially changed, with most doctors and other professional health providers continuing to operate as independent private businesses, and hospitals and aged care providers continuing to operate with a degree of independence as private or charitable organisations, or as public institutions with substantial management autonomy. However, over the longer term expected changes would include a strengthening of primary care arrangements; and

- individual Australians will need to participate in the national patient information record system which, through smart-card technology, would allow considerable patient control over the information – to those having access to it and who can add to it or vary it. Over time, such a system also has the potential to enhance patient control over their own care without jeopardising professional influence about effectiveness and cost-effectiveness.[72]

3. Commonwealth-state — pooled funding

3.67 A Commonwealth-state fund pooling model was recently suggested to the Victorian Government as a way of overcoming some of the disadvantages of current funding arrangements. A similar proposal was also discussed as part of COAG deliberations in the mid 1990s.[73]

3.68 Proponents of this pooled model include governance arrangements that would establish a 'joint health commission', which would be responsible for resource allocation and facilitate integration of services.[74] The commission could assume responsibility for a number of existing health-related programs including public hospitals, veterans' health care, the MBS, PBS and Indigenous health.[75]

3.69 The main feature of this proposal is that implementation could be progressed on a jurisdiction by jurisdiction basis and possibly be tailored to suit the different histories and needs of each jurisdiction.[76]

3.70 Other features of pooled funding models include:

- shared resource allocation through the purchase of various services from providers (Commonwealth, state and local government and non-government providers) as part of a joint strategic plan;
- shared performance management to oversee continuous improvement of the health system, monitor progress and establish reform targets including development of standard measurement, benchmarking and patient-centred best practices; and

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72 Podger A, *Inaugural Menzies Health Policy Lecture : 3 March 2006* (2006), exhibit 27, pp 11-21.

73 Allen Consulting, *Governments working together: A future for all Australians* in Productivity Commission, *Productive Reform in a Federal System* (2006), p 149.

74 Menadue J, *A coalition of the willing*, exhibit 42, p 2.

75 Menadue J, *A coalition of the willing*, exhibit 42, p 2.

76 Menadue J, *A coalition of the willing*, exhibit 42, p 2.

- representation on the governing (not advisory) commission to include equal commonwealth and state representation and include related agencies (such as Department of Education) and people having knowledge of the private sector.[77]

4. Managed competition — Scotton model

3.71 The Scotton model involves the use of financial incentives to modify the actions of funders, service providers and consumers in order to improve the efficiency of the delivery of health care, while at the same time, preserving the government's commitment to universal and equitable access to health services.

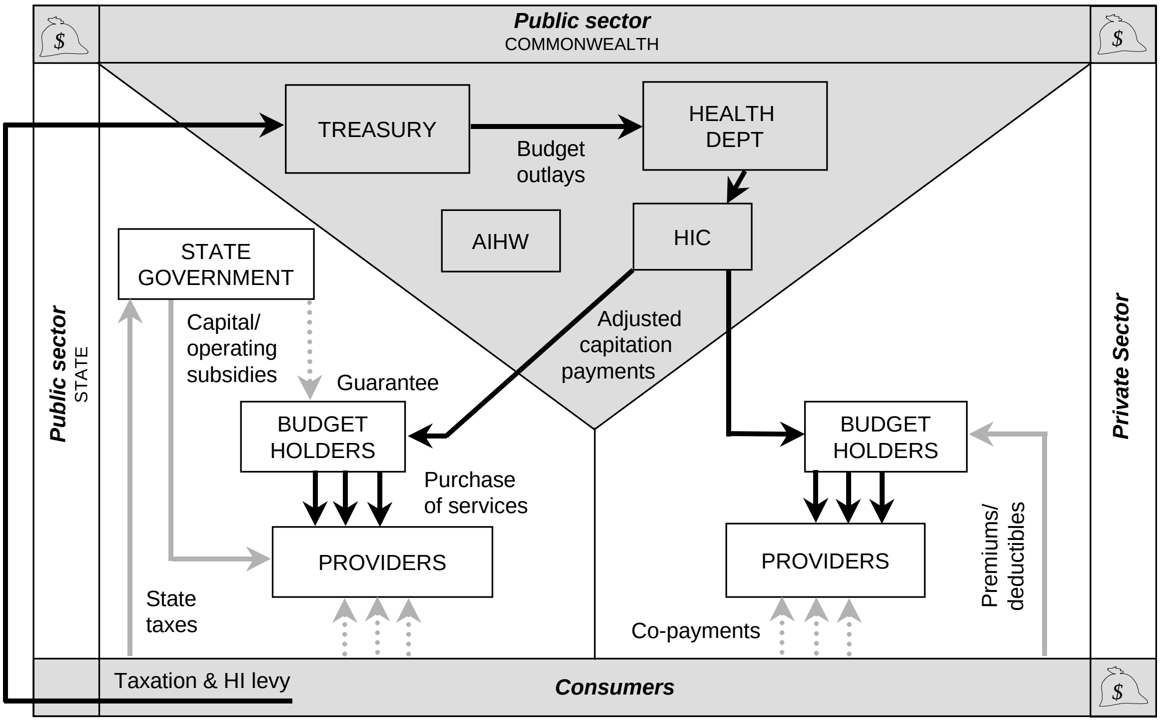
3.72 Developed by Dr Scotton, the model has been the subject of academic discussion for a number of years.[78] The Scotton model is a form of 'managed competition' model that involves setting up a market oriented structure by separating the financing and insurance/third party payer function from the provision of health care services.

3.73 The Scotton model can be outlined in terms of the roles of three participants — Commonwealth government, state governments and private sector — in carrying out the functions of financing, budget holding and service provision. Financial flows under model are outlined in figure 3.4.

77 Menadue J, *A coalition of the willing*, exhibit 42, p 2.

78 See for example, Productivity Commission, *Managed Competition in Health Care* (2002); Scotton R, 'Managed Competition: issues for Australia', *Australian Health Review* (1995), vol 18, no 1, pp 82–104; Productivity Commission and Melbourne Institute of Applied Economic and Social Research, *Health Policy Roundtable* (2002); Productivity Commission, *Productive Reform in a Federal System* (2006).

Figure 3.4 Managed competition model: financial flows



Note *AIHW – Australian Institute of Health and Welfare, HIC – Health Insurance Commission (now Medicare Australia), HI – health insurance.*

Source *Productivity Commission, Managed Competition in Health Care (2002), p 67.*

3.74 Dr Scotton told the committee:

> … [the model] is based on the Commonwealth taking responsibility for the whole lot but devolving that by a formula which incorporates incentives to efficiency, both in the sense of efficient resource use in the health care sector and market efficiency—doing things in the least cost way—and devolving that responsibility. The Commonwealth takes over but it does not get into the service delivery area at all. It devolves the control over service delivery to others—to a lower level where it can be managed.[79]

3.75 The Scotton model is described as the most radical proposal for funding arrangements, with implementation of the full model broadly involving:

- comprehensive amalgamation of existing health programs;

79 Scotton R, transcript, 21 July 2006, p 53.

- clear and separate roles for Commonwealth and State governments; and
- the substantial integration of private sector funding and service provision into a national program using population-based funding for program delivery.[80]

The case against radical reform

3.76 There are a broad range of views on the benefits and risks of adopting more radical proposals for funding reform.

Participants' views on radical reform options

3.77 There is not universal support to move to a different funding model.[81] Mr Deeble told the committee that:

> I would be very cautious about giving one level of government control over all of it because if it was the Commonwealth I think it may be too far away from the delivery interface to respond to what the real pressures are and it will be run too much by Treasury bureaucrats. At the state level it is run more at the state level, and indeed those who are state members are much more active with their minister on behalf of their constituencies than perhaps at the Commonwealth level.
>
> … there is a responsiveness at the state level which is different to the responsiveness at the federal, and I think it is a good thing that there is some competition between the two levels of government in terms of advocacy for health. The Commonwealth will wish to push the states in a certain direction and the states will wish to do something else. I would be uncomfortable with a completely monolithic system.[82]

3.78 No state government directly indicated to the committee that it would support moves to establish single funder arrangements. However, at

80 Productivity Commission, *Managed Competition in Health Care* (2002), p 5.

81 Australian Medical Association, sub 30, p 28; Deeble J, Australian Health Care Association, transcript, 26 May 2006, p 41.

82 Deeble J, Australian Health Care Association, transcript, 26 May 2006, pp 41-42.

various times, the Queensland, South Australian and New South Wales governments have indicated their support for the Commonwealth to take over the operation of the public hospitals (see chapter 7).[83]

3.79 A major benefit shared by the proposed funding models is that, compared to current arrangements, they potentially offer greater flexibility and integration in service provision and patient-centred funding arrangements. These funding models are also likely to provide the funders of health services with greater incentives to promote wellness through public health and primary health care programs, thereby reducing the pressures that are faced by acute service providers.

3.80 Notwithstanding these benefits, the adoption of a different funding model is not likely to solve all of the perceived shortcomings of the Australian health system. Mr Podger noted that:

> One aspect of [the Commonwealth assuming full responsibility] model is that it is trying to superimpose on the system some form of budget holding. I am not talking about an absolute, rigid, cash-limited budget, but this model is premised on a form of budget holding, and the ability for better financial control. There will be, out of that, rationing coming through. But any health system is going to have some rationing, and I think people have got to be realistic about that. It is just trying to get a model of rationing that is most likely still to deliver the best care, and get the best results from the money available.[84]

3.81 It was not clear to the committee that there is one model that overwhelmingly offered greater benefits than the others. While it was possible to identify some of the relative disadvantages of each model, the relative advantages of one model over another are more difficult to identify (table 3.1).

83 Karvelis P. and A. Cresswell, 'States ask Canberra to control hospitals', *The Australian*, 2 June 2006, p 6; Sommerfield J, 'Abbott passes health proposal', *Courier Mail*, 27 August 2005, p 8.

84 Podger A, transcript, 31 May 2006, p 12.

Table 3.1 Summary of inquiry participants' comments on proposed funding models

Model	For	Against
States – full responsibility	• Competitive federalism to encourage innovation and hence greater efficiency and effectiveness.	• Against trend towards greater Commonwealth funding and control. • Complex legislative change and a long controversial debate about principles and the extent of flexibility within national framework. • Substantial doubts about the capacity of smaller jurisdictions to provide the full range of health responsibilities.
Commonwealth – full financial responsibility	• Strengthens political accountability allowing a single minister and department to focus on management and outcomes. • Avoids vertical fiscal imbalance and could allow for local community responsiveness through regional planning and purchasing processes and local provision of services. • Consistent with trend of increasing share of Commonwealth health expenditure.	• Would require significant effort and complementary action to take over state staff and facilities and establish new administrative structures which allow for regional and community level flexibility and input, and enabled more sophisticated planning. • Complex renegotiation of GST agreement. • High political risk for Commonwealth minister.
Commonwealth-state – pooled funding	• Some experience in running successful trials.	• Low optimism for agreement and difficulties in negotiating the pools of funds and sharing of risks. • Unrealistic degree of sustained cooperation to implement. • Unhealthy level of bureaucratic control. • Reliance on output and outcome targets is not sufficient. Serious risk of 'game playing' on the data without agreed commitment on the financial inputs.
Managed competition – Scotton model	• Scope to increase competition amongst funders as well as providers. • Increased choice, of funders and providers, with capacity through private contributions to sign up to the insurance cover the individual would prefer.	• Substantial work would be required to calculate the risk-rated premium for each person to use as their voucher. • Likely to have Commonwealth to take full responsibility as a transition to this model. • Uncertain impact of the extra competition given limited capacity of private insurers to manage the levels and costs of the services doctors provide. • Concern about transition to US-style 'managed care'.

Source *Podger A, Directions for Health Reform in Australia - A Presentation to Productivity Commission Roundtable on Productive Reform in a Federal System, October 2005, exhibit 26; Productivity Commission, Managed Competition in Health Care(2002); Podger A, Inaugural Menzies Health Policy Lecture: 3 March 2006 (2006), exhibit 27; Podger A, transcript, 31 May 2005; Menadue J, transcript, 21 July 2006, pp 26–39; Scotton R, transcript, 21 July 2006, pp 50–57; Australian Health Care Reform Alliance, transcript, 21 July 2006, pp 47–49; Australian Health Care Association, transcript, 26 May 2006, pp 38–55; Catholic Health Australia, sub 35, pp 10–11.*

3.82 Mr Podger, a major proponent of the Commonwealth assuming full responsibility, believed that the political environment favoured this approach, noting that:

> … the only feasible single-funder option for Australia in the medium term is for the Commonwealth to have full financial responsibility for public funded services. This is not to deny the theoretical attractions of some of the other models. Also, compromise on both sides of politics is needed to develop a coherent and sustainable balance between public and private financing. Getting that balance is almost certainly dependant, in the long term, on having a single government funder.[85]

3.83 Mr Menadue believed that a state-by-state approach to fund pooling was more likely to be achievable than the Commonwealth assuming full responsibility, noting that:

> I would favour that model, but I am being a political realist in knowing that it is not likely to happen and that it would be more profitable and successful to go state by state to achieve a result. It may, in the end, produce an outcome such as Andrew Podger has mentioned, but I think that will take some time to achieve.[86]

The case against radical reform: The committee's view

3.84 Overall, the committee considers that the implementation of a model that delegates full responsibility to the states and the Scotton model are less attractive options to pursue.

3.85 It is clear that the full implementation of the 'Commonwealth assuming full financial responsibility' and a 'pooled funding' approach would involve significant up front costs and would require a substantial period to prepare the necessary institutional arrangements. While benefits from either approach can be identified, the magnitude is difficult to determine.

3.86 The committee considers that there is significant benefit in the Commonwealth working with states to develop agreed principles and arrangements to guide health reform over the longer term. Agreed arrangements may cover a range of funding reform options including:

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85 Podger A, transcript, 31 May 2006, p 2.

86 Menadue J, transcript, 21 July 2006, p 34.

- the sharing of downstream savings from investing in primary and public health; and
- making broad adjustments to Commonwealth-state funding after the implementation of more efficient and effective models are care, rather than prior to their implementation as presently occurs.

3.87 A commitment to developing new funding arrangements should also provide impetus for further research on the costs and benefits of different funding approaches.

3.88 Theoretically, the status quo is also an option but it should not be contemplated. While Australia's health system may be generally good, this report highlights many areas where it can be improved. These problems reduce the quality of health care and increase its cost to patients and governments. These adverse effects will significantly increase in the coming decades due to the pressures created by evolving medical technology, community expectations and an ageing population. Action must not be delayed.

Incremental reform

3.89 While the case for more radical restructuring of funding arrangements may need to be further developed, inquiry participants nominated a number of changes that could be made to current arrangements. Some of these changes could be implemented by a single level of government while others require cooperation and coordination between governments.

Strengthening primary health care

3.90 There are a number of areas where funding arrangements for primary health care could be changed to provide incentives that encourage the promotion of 'wellness' and for improved support for the chronically ill and frail aged. The Redcliffe-Bribie-Caboolture Division of General Practice noted that:

> … the Division was struck by the fact that the funding models did not allow for most preventative care. Put starkly, the current funding model maximises income for GPs when their patients are ill, not when their patients are well. It seems that this is like paying our swimmers to swim slowly but still

> expect them to win medals. The country wants to achieve a well population, not an ill one![87]

3.91 Some of the differences between an illness model and wellness model relate to how funding arrangements affect the incentives for service delivery (table 3.2).

Table 3.2 Key differences between 'illness' and 'wellness' models for primary health care services

Illness model	Wellness model
Service provided by general practitioners with support from practice nurses.	Service provided by a multidisciplinary team including GPs, wellness nurses, exercise physiologists, lifestyle coaches, fitness trainers, nutritionists, dieticians, counsellors
Emphasis on curing patients – addresses symptoms	Emphasis on keeping people well – addresses lifestyle issues before they become symptomatic
Mostly individual doctor-patient consultations at a practice	Significant role for nurses and allied health practitioners including group settings and domiciliary care. Consultations by phone and over the Internet
Funding of doctors through a fee for service model	A new funding model based on keeping patients well, and including budget holding for pharmaceuticals and diagnostics
Stand alone practices	A chain of Wellness Centres collaborating with other health, fitness, and welfare organisations in same locality
Occasional reference to lifestyle issues where it affects illness	Ongoing and regular concentration on lifestyle issues such as nutrition, exercise, and substance misuse
Fixed charges to patients	Patient co-payments based on lifestyles
Managed by doctors in their 'spare time'	Managed by managers under a new governance model
Patients phone in to book appointments	Patients can book appointments on the Internet

Source Redcliffe-Bribie-Caboolture Division of General Practice, sub 81, p 4.

3.92 The Commonwealth has introduced a range of measures that support moves towards a wellness model for primary health care delivery. These have included exercise physiology services under the Medicare allied health initiative, a 'well persons health check' available through Medicare for people around 45 years old with one or more health risks and subsidising the employment of practice nurses working in all urban areas of workforce shortage.[88]

87 Redcliffe-Bribie-Caboolture Division of General Practice, sub 81, p 2.

88 Hon Tony Abbott MP, Minister for Health and Ageing, media release, *Exercise physiologists eligible to provide services under Medicare*, 6 September 2005; media release, *Better health for all Australians*, 10 February 2006; media release, *More Government support for nurses working in general practice*, 11 April 2006.

3.93 Inquiry participants suggested a number of measures that would further strengthen the emphasis on building wellness into primary care including:

- greater use of 'blended' payments rather than strict fee-for-service payments that financially reward doctors for achieving or working towards different outcomes, such as increasing the use of information management and information technology, expanding provision of after hours care, student teaching and better prescribing of medicines;[89]
- wider access to the MBS by allied health professionals including physiotherapists, psychologists and nurses;[90]
- revised models of primary practice promoting a multidisciplinary team approach to treatment and prevention by providing for health services by providing access to a range of doctors and allied health professionals working in a coordinated manner.[91] Fund holding of capitation-based payments by divisions of general practice was identified as one way of encouraging more formal team approaches;[92] and
- greater support for the development of information communication technology infrastructure to facilitate greater sharing of patient information and treatment options.[93]

3.94 There appears to be broad support for a move to a wellness model in service delivery. The committee noted that there are concerns about involving allied health professionals outside of general practitioner-led care models and the effectiveness of fund pooling approaches to promoting different models of care.[94]

3.95 While the committee generally supports the move towards a health system that is based around a wellness model, decisions about the

89 Western Australian Government, sub 124, p 24; Rural Doctors Association, sub 31, p 12.

90 Australian Physiotherapy Association, sub 118, p 3; Australian Psychological Society, sub 136, pp 4–5; Professor Stephen Leeder, sub 3, p 1; Western Australian Government, sub 124, p 9; Australian College of Health Service Executives, sub 141, p 11.

91 Australian Division of General Practice, sub 15, p 3; MBF Australia Limited, sub 29, p 5; Health Workforce Queensland, sub 113, p 2; Australian Physiotherapy Association, sub 118.

92 Redcliffe-Bribie-Caboolture Division of General Practice, sub 81, p 2.

93 Rural Doctors Association of Australia, sub 31, p 13; Australian Association of Pathology Practices, sub 38, p 4; Pharmacy Guild of Australia, sub 41, p 5; Health Group Strategies, sub 116, p 25.

94 Australian Medical Association, sub 30, pp 27–28.

appropriateness of different types of health care are best made by medical practitioners and their patients.

Better use of patient information

3.96 Better use of information communication technology and patient level information is not only important in primary care, but has the potential to improve patient care in all settings. Costs and patient inconvenience can be reduced by, for example, avoiding duplication of tests and diagnostic procedures. Improving the range and timeliness of information available to clinicians should result in better diagnosis and treatment.

3.97 All governments have recognised the benefits of electronic storage and transmission of health records and have made significant investments in information technology systems. Hospitals and other organisations, such as divisions of general practice are also heavily involved in the development of information technology systems to allow better communication between providers.[95]

3.98 The Commonwealth is leading the national approach to electronic health records through *HealthConnect* — an overarching national change management strategy to improve safety and quality in health care by establishing and maintaining a range of standardised electronic health information products and services for health care providers and consumers.[96]

3.99 The committee notes that COAG recently agreed to accelerate work on a national electronic health records system to build the capacity for health providers, with their patient's consent, to communicate quickly and securely with other health providers across the hospital, community and primary medical settings. The Commonwealth will contribute $65 million and the states $65 million in the period to 30 June 2009.[97]

3.100 The committee supports the objective of governments to implement effective electronic health records systems in a timely manner. The

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95 Australian Divisions of General Practice, sub 66, pp 2–7; Sprogis A, transcript, 20 July 2006, p 61.

96 Department of Health and Ageing, *HealthConnect*: Introduction, viewed on 22 September 2006 at www.health.gov.au/internet/hconnect/publishing.nsf/Content/intro.

97 Council of Australian Governments, *Council of Australian Governments communique, 14 July 2006* (2006), p 12.

Commonwealth needs to ensure that it continues to lead the development of information technology systems and provide appropriate levels of funding to ensure expanded use of technology in health care as soon as possible.

Commonwealth funding for medical services

3.101 The MBS is regularly updated to reflect government decisions about the services to be funded, to adjust schedule fee and benefit levels in accordance with government policy, and to respond to changes in clinical practice.

3.102 In relation to new medical technologies and procedures, the Minister for Health is advised by the Medical Services Advisory Committee (MSAC) which assesses their safety, effectiveness and cost-effectiveness. In relation to other issues, the Minister is advised by the Medicare Benefits Consultative Committee (MBCC).

3.103 In its recent report on Australia's health workforce, the Productivity Commission noted that the deliberations of MSAC and the MBCC are broadly confined to the inclusion of new technologies into the MBS and the review of items already covered by the schedule.[98] Other changes to the MBS flow from the development of new policies or programs within the government. The Commission saw merit in such changes being subject to a more transparent assessment process and recommended the establishment of a new advisory committee, subsuming the role of MSAC and the MBCC, which would publicly report its assessments.

3.104 The committee notes that the Commonwealth did not accept the Productivity Commission's recommendation to establish a new committee, but indicated that it would improve the efficiency and transparency of existing mechanisms and strengthen the links between MSAC and MBCC.[99]

3.105 The committee supports the thrust of the Productivity Commission's conclusions and noted the Commonwealth's response.

3.106 The Productivity Commission also raised the issue of the appropriateness of MBS fee levels for procedural services relative to consultative services. The committee noted that, in response to the

98 Productivity Commission, *Australia's Health Workforce* (2005), p 171.

99 Council of Australian Governments, *Communique,* 14 July 2006, Attachment A.

Productivity Commission's recommendation, the Commonwealth indicated that it would review the MBS payment methodologies.

Recommendation 2

3.107 **As a matter of priority, the Department of Health and Ageing undertake the actions specified in the July 2006 Council of Australian Governments' response to the Productivity Commission's health workforce inquiry to:**

- **improve the efficiency and transparency of existing mechanisms to assess changes to the Medicare benefits schedule; and**
- **strengthen links between the Medical Services Advisory Committee and the Medicare Benefits Consultative Committee.**

Realigning responsibilities

3.108 One method of overcoming incentives for cost shifting and barriers to the continuity of care is a realignment of government responsibilities for different types of care. The model of care for veterans provided by the Department of Veterans' Affairs was sometimes cited as a successful model of one level of government managing the full health needs of a segment of the population.[100]

3.109 There appear to be several areas where one level of government could take full responsibility for funding as a way of improving health outcomes and accountability including:

- defined population — older age groups may benefit from better coordination and management of their complex care needs.[101] An incremental step towards the Commonwealth assuming greater responsibility for older Australians would be for the Commonwealth to meet the full costs of patients assessed as eligible for residential aged care but waiting in public hospitals for a vacant residential aged care place.[102]

100 Australian Medical Association, sub 30, p 9; Enteral Industry Group, sub 119, p 2; Australian Health Care Association, sub 62, pp 10–11.

101 Australian Health Care Association, sub 62, pp 10–11; Catholic Health Australia, sub 35, pp 2-3.

102 Australian Medical Association, sub 30, p 9

- specific programs/treatments —mixed Commonwealth and state government funding for some programs and treatments has resulted in differences in access. Some areas suggested for a transfer of responsibility include pharmaceuticals, outpatient services, ambulance services and enteral nutrition.[103]
- geographic areas — selecting a designated region for fund pooling.[104] Several geographic pooled funding arrangements have been trialled or are in place including the Coordinated Care Trials and Multi Purpose Services Program.[105]

3.110 Governments have discussed incremental changes to responsibilities in a number of areas as part of negotiations of the Australian Health Care Agreements.[106] These negotiations have largely been unsuccessful (see chapter 7).

3.111 While changing responsibilities appears to offer benefits for some parts of the population, gaining the agreement of governments has proven to be a significant barrier to reform.

Dental care

3.112 The provision of dental care in a timely manner can significantly affect a person's quality of life and future health costs. The Australian Dental Association noted that:

> Like the health system generally, the organisation and delivery of dental care in Australia is characterised by the involvement of Commonwealth, State and territory, and Local Governments. Unlike the health system though, dental care in Australia is largely financed by individual out-of-pocket expenses, with direct payments and subsidies by various levels of government making up the balance of expenditure.[107]

103 Australian Health Care Association, sub 62, pp 10–11; Council of Ambulance Authorities, sub 148, p 9; Enteral Industry Group, sub 119, p 2.

104 Australian Health Care Association, sub 62, pp 10–11.

105 Department of Health and Ageing, sub 142, pp 22–26.

106 Reid M, 'Reform of the Australian Health Care Agreements: progress or political ploy?', *Medical Journal of Australia* (2002), vol 177, no 6, pp 310–312; Duckett S, 'The 2003-2008 Australian Health Care Agreements: an opportunity for reform', *Australian Health Review* (2002), vol 25, no 6, pp 24-26.

107 Australia Dental Association, sub 28, p 1.

> … all governments must recognise dentistry as an essential element of a nation's health service, and as such, oral health care should be available to every section of the community. Governments must also recognise that there are disadvantaged and special needs groups who will be unable to access reasonable levels of oral health care without assistance, and that they have a vital role in providing oral health services for individuals within these groups.[108]

3.113 The Commonwealth and states have recently collaborated, through the National Advisory Committee on Oral Health established by the Australian Health Ministers' Conference (AHMC), to produce a report *Healthy mouths healthy lives: Australia's National Oral Health Plan 2004-2023*. The report, which was endorsed by AHMC on 29 July 2004, identifies a range of issues, particularly relating to funding arrangements and the dental workforce.

3.114 The committee welcomes the creation of this plan and urges the Commonwealth to take a leadership role in its implementation under the national health agenda. In this respect, dental health should be no different to other health care services. The need for Commonwealth leadership was also identified by the Australian Dental Association which said:

> The recognition of a relationship between oral and general health clearly identifies the need for the Commonwealth to undertake a leadership role in the delivery of dental services as an investment in dental care will not only alleviate dental disease but will have the flow-on effect of reducing later general health expenditure.[109]

3.115 The committee is particularly concerned about the waiting times for public dental health services, and considers these to be under-funded. Many Australians who cannot afford private dental services are not receiving the services necessary to maintain oral health.

3.116 The Commonwealth should supplement states funding for appropriate public services so that reasonable access standards can be maintained, particularly for disadvantaged groups. Where appropriate, oral health services should also be covered in other Commonwealth programs such as aboriginal health programs. In this context, the committee noted the views of Professor Deeble and the

108 Australia Dental Association, sub 28, p 3.

109 Australia Dental Association, sub 28, p 13.

Australian Dental Association that funding through the MBS is probably not appropriate.[110]

3.117 Providing greater access to public funding for dental services will also need to be supported by a rise on the number of dentists over the short and medium term through increases in the number of university places (see chapter 4).

3.118 As discussed above, dental health should be an integral part of the national health agenda and, as such, access to public dental services is a joint responsibility of the Commonwealth and state governments. The committee considers that waiting times for access to public dental services are excessive and should be addressed as a matter of priority.

Recommendation 3

3.119 **The Australian Government should supplement state and territory funding for public dental services so that reasonable access standards for appropriate services are maintained, particularly for disadvantaged groups. This should be linked to the achievement of specific service outcomes.**

Breaking down funding silos

3.120 The integrated nature of many health care services should require that governments give consideration to the broader effects of a proposed policy change to an existing program. Inquiry participants nominated a number of health programs where the broader health and social benefits of increased expenditure should be given greater recognition including:

- pharmaceuticals;[111]
- pathology and diagnostic imaging;[112]
- emerging treatment technologies;[113] and
- social services such as housing and education.[114]

110 Australia Dental Association, sub 28, pp 20–21.

111 Medicines Australia, sub 42, p 22.

112 Australian Association of Pathology Practices, sub 38, p 1.

113 Medical Industry Association of Australia, sub 61, p 3; The Australian Proton Project Working Party, sub 115, p 2; St Jude Medical, sub 146, pp 1–2.

3.121 The Australian Diagnostic Imaging Association noted that:

> There is not a government in the world, including this government, that will not accept that preventative medicine and early diagnosis is a far more effective health care delivery system than diagnosing middle and advanced stage disease. What CT, for example, has done is to provide some tools that have changed that paradigm. You can do earlier diagnosis quickly and more safely. More importantly, it is now being used not only as a diagnostic tool but as a triage tool. The only lever that we have used with, for and against us at the moment is a fiscal lever. I actually think that, because of what technology has done, we need some direction and some debate with the department of health to say there is possibly a new paradigm of health care.[115]

3.122 Clinical and cost effectiveness assessments for pharmaceuticals, medical services and vaccines are an important tool for ensuring evidenced-based access to high quality medical services.[116]

3.123 The committee supports evidence-based assessments for new technologies, including pharmaceuticals, vaccines, diagnostic tests and medical and procedures, prior to them being listed for reimbursement on the MBS and PBS.

3.124 Dr Neaverson and other inquiry participants highlighted a number of specific treatments or services that they believed to offer significant benefits to patients, but were not currently included for reimbursement under the MBS or PBS or where further research was required.[117] Selected treatments or services that the committee considers warrant closer attention by expert bodies include:

- Providing incentives to doctors and patients at risk of developing cardiac events to undergo a six-week lifestyle and fitness program, including a requirement for such programs before prescribing lipid

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114 Redcliffe-Bribie-Caboolture Division of General Practice, sub 110, p 1; Caboolture Shire Council (Qld), sub 103, p 8; Royal Australian College of General Practitioners, sub 19, p 3; Blissful Undisturbed Baby's Sleep, sub 134, p 2.

115 Shnier R, Australian Diagnostic Imaging Association, transcript 26 May 2006, pp 59–60.

116 Department of Health and Ageing, sub 142, p 29.

117 Dr M A Neaverson, sub 114; The Australian Proton Project Working Party, sub 115; Flinders Medical Centre, subs 86 and 122; John Barker and Associates, sub 126; Blissful Undisturbed Baby's Sleep, sub 134; Mr Bob Holderness-Roddam, sub 63, p 1.

lowering pharmacological agents. Estimated cost savings of adopting these proposals are over $130 million;[118]

- Re-imbursement by Medicare of cancer treatment using proton therapy. Advocates of the use of proton therapy in the treatment of cancer consider that proton therapy provides better clinical outcomes for most cancers where radiation therapy is the recommended treatment and produces highly favourable results for certain tumours not effectively controlled by conventional radiotherapy. This is especially important in the treatment of cancer in children. The cost of a course of treatment is estimated to be $25,000 per patient;[119] and
- Supporting the provision of home-based family nursing services by a qualified child and family health nurse. Some of the claimed benefits of such an approach include better health outcomes with early detection and intervention, reducing the burden on an overloaded public sector and reduced occurrence and severity of post-natal depression.[120]

3.125 The committee has not considered the relative merits of providing public funding to any of the suggested treatments or services — an assessment that is best left to expert bodies such as the Therapeutic Goods Administration, the National Health and Medical Research Council, Pharmaceutical Benefits Advisory Committee and the Medical Services Advisory Committee.

3.126 The committee considers, however, that assessments of the merits of proposals for research, new services and technology that provide significant health benefits to patients should be done using the broadest possible framework, allowing for costs and benefits to be examined at a whole of community level.

3.127 Guidelines and practices for assessing or providing public funds for new research, services or products should allow maximum flexibility for public funding of beneficial research, services or products. This may provide for funding in advance of service delivery or on a time-limited basis to provide the opportunity for more evidence to be collected and for continued funding to be further evaluated.

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118 Dr M A Neaverson, sub 114.

119 The Australian Proton Project Working Party, sub 115.

120 Blissful Undisturbed Baby's Sleep, sub 134.

Investing in public health

3.128 Many inquiry participants recognise the benefits in investing in public health as a means of preventing future health costs.[121] The Victorian Health Promotion Foundation noted that:

> We appear too consumed with the supply side of the health care equation and not enough concerned with the demand side. The best way to reduce costs and improve health at the same time is not to control the services provided but to reduce the need and demand for care. We need an approach based on health promotion alongside traditional approaches to diagnosis, treatment and prevention.[122]

3.129 The Commonwealth and states have recently strengthened public health as part of the 2006–07 budget, committing $500 million over five years towards the new national programme to promote good health and reduce the burden of chronic disease (*Australian Better Health Initiative*).[123]

3.130 Where additional public health expenditure can be shown to cost effectively improve health status or reduce health risk factors, governments should be willing to invest immediately for the long term benefit of Australians and the health system.

3.131 The committee considers that the Commonwealth should take a leadership role, through the national health agenda, in promoting investment in public health. The Commonwealth should be prepared to jointly fund public health initiatives with states and support other action that complements any additional public health expenditure.

Conclusion

3.132 Many inquiry participants have presented evidence about problems with Australia's health care financing arrangements. Similar issues

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121 Victorian Health Promotion Foundation, sub 8, p 2; Australian Healthcare Reform Alliance, sub 127, p 71; Government of South Australia, sub 117, p 2; Australian Lung Foundation, sub 112, p 3; Marion O'Shea, sub 89, p 2; Government of Victoria, sub 67, pp 1–2; ACT Government, sub 64, p 2; Macquarie Health Corporation, sub 55, p 7; Rural Doctors Association of Australia, sub 31, p 2; Royal Australian College of General Practitioners, sub 19, p 3.

122 Victorian Health Promotion Foundation - VicHealth, sub 8, p 2.

123 Hon Tony Abbott MP, Minister for Health and Ageing, media release, *Promoting health throughout life*, 9 May 2006.

have been raised in many previous reviews and inquiries and by health sector researchers and commentators.

3.133 The committee has not identified, and does not believe that there is, a single 'magic bullet' strategy that will resolve all of the system's problems. Indeed, in many respects the system must strike a balance between competing pressures such as quality versus throughput and access versus affordability.

3.134 While this report recommends a range of actions to address particular issues, the committee considers the key recommendation of this chapter, the development of a national health agenda, to be its most important recommendation. The complexity of the health delivery and financing systems, the rate of development of new health technologies, the ever changing evidence base about best practice and rising community expectations mean that ongoing reform in needed. This needs to be guided through a process that the committee calls the national health agenda. Development and implementation of this national health agenda will require political will from all levels of government.