



Consumers
Health Forum
of Australia

Health Voices

JOURNAL OF THE CONSUMERS HEALTH FORUM OF AUSTRALIA



Better bang
for your buck

representing
consumers
on national
health issues

Health Voices

Health Voices is published twice each year. Each issue has a theme that promotes debate on issues of interest to health consumers, government and industry.

Readers are encouraged to write letters to CHF in response to journal articles or other issues in Australian health care.

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The Consumers Health Forum of Australia

The Consumers Health Forum of Australia (CHF) is the national peak body representing the interests of Australian health care consumers.

CHF works to achieve safe, quality, timely health care for all Australians, supported by accessible health information and systems.

CHF does this by:

1. advocating for appropriate and equitable health care
2. undertaking consumer-based research and developing a strong consumer knowledge base
3. identifying key issues in safety and quality of health services for consumers
4. raising the health literacy of consumers, health professionals and stakeholders
5. providing a strong national voice for health consumers and supporting consumer participation in health policy and program decision making

CHF values:

- our members' knowledge, experience and involvement
- development of an integrated health care system that values the consumer experience
- early intervention, prevention and early diagnosis
- collaborative integrated health care
- working in partnership

CHF member organisations reach Australian health consumers across a wide range of health interests and health system experiences. CHF policy is developed through consultation with members, ensuring that CHF maintains a broad, representative, health consumer perspective.

CHF is committed to being an active advocate in the ongoing development of Australian health policy and practice.

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Editorial



The striking feature that emerges from this **Better Bang for your Buck** issue of *Health Voices* is how many of the remedies to the malaise of Australia's health system are essentially achievable. And there is a swelling mood for change.

We at CHF, prompted by speculation of greater user pays in health, approached the writers published here to give their ideas on how we can make our health system work better and more cost effectively before imposing fresh expense on the health consumer.

That such a diverse and distinguished group of committed health system experts should have given their views for this special edition, tells us there is great brain power available for project "Medicare renewal".

An end to the 1980s Medicare model is what Health Minister, Peter Dutton, is clearly signalling here. The debate ignited by a proposal for a \$6 GP co-payment has fuelled the liveliest exchanges on the issue of payment for health services that we have seen for many years, including during the previous government's health reform process.

CHF has campaigned against rising out of pocket health bills over the past year. It has become clear to us that we have to challenge the tide of rising costs fuelled by the status quo system if we are to ensure that health care remains in reach of all Australians.

There is uniformity in the view of our contributors in that none believes the current system is perfect. Each has offered a thoughtful and, at times, thought-provoking, perspective on changes to the funding of our health care system. CHF supports the debate on health funding sustainability and will continue to contribute actively to these discussions. Consumers, as the reason which the system exists, should be the beneficiaries of health system change, not poorer because of it.

The articles that follow give strong evidence there is much that can be done to counter the immense challenges facing our health system, and improve outcomes, without hitting consumers or blowing the nation's budget.

Health Minister **Peter Dutton**, makes it clear that indeed he is discussing dramatic changes. Public hospital waiting lists are "shackled by archaic practices" but the greatest challenge, and opportunity, ahead lies in primary care, he says. We need to look at better ways to manage chronic care and "perhaps better models for paying the health professionals who provide that care".



Shadow Health Minister, **Catherine King**, says the best way to get good value for money from health spending is to preserve the integrity of our system with Medicare at its heart.

Greens health spokesman, **Richard Di Natale**, says there is potential for savings but we should not discourage access to primary care. "We shouldn't be afraid to invest in health care. What could be a higher priority?"

As Australia's sage of public health, **Stephen Leeder**, writes: "Strange things happen." Health costs can stop rising at terrifying rates. There is, says Emeritus Professor Leeder, no reason for government to back away from universal health care.

"It is more a matter of getting the system right...Others have done it: so can we." He pinpoints six features of success: rewards for effective and excellent care, robust governance, ehealth, clinical leadership, realistic planning, and patient engagement.

That last point is what drives CHF's own campaign to ensure consumer experience is central to health care through its Real People, Real Data project. "We know the answer is often as much about self-care as medical treatment," write CHF's **Deborah Smith** and **Sarah Spiller**.

Stephen Duckett calls for new funding and delivery arrangements to increase the "visibility" of general practice and encourage continuity of care. And Australia needs to look at "provider waste" in the system. "It is simply unethical to shift costs to poorer people and/or to reduce service access while there are still opportunities to make the system more efficient," says Professor Duckett.

Former chair of the National Hospitals and Health Reform Commission, **Christine Bennett**, writes that we cannot wait for a single funder to enable a new structure to drive integrated or connected care. "What we can focus on right now within current funding and delivery responsibilities is taking effective local action and implementing system-wide catalysts to support integrated care. State health departments, the Commonwealth, private health insurers, local councils and local communities all have roles to play."

Dollars are not the major problem, says **John Dwyer**. He argues for an end to state-federal duplication, the redirection of the health insurance rebate to public hospitals, stopping unnecessarily expensive medical procedures, and better primary care to counter unnecessary hospital admissions. "What is in short supply is political wisdom and courage to resist the voices of vested interests and take us on this journey."

Terry Barnes, the policy consultant who catalysed debate with his \$6 co-payment plan, says the argument that savings can be found elsewhere misses the point, "... the culture of health care access, in which increasingly expensive services are taken for granted by many providers and consumers, and moral hazard reigns, must change".

Jennifer Doggett argues there are five steps we can take before reaching into the pockets of vulnerable people: focus spending on best value activities like preventive services rather than on the estimated 150 low value acute services; counter federal state dysfunction by starting with a national Health Consumers Charter outlining uniform care standards; foster better care for chronic conditions through capitation funding; promote team-based primary care and extend Medicare rebates for nurse practitioners; direct health insurance rebate to support patient choice of public or private systems providing best value care.

There is already available a recognised but often over-looked solution to costly, unnecessary acute hospital stays. It's the Hospital In The Home, says **Alison Verhoeven**. With increasing pressure on health system financing, the transition of HITH to a sophisticated component of the health system is essential.

In a letter to Mr Dutton and Treasurer Joe Hockey, **John Ferguson** gives a rare insight into the disturbing deployment of Medicare funding in public hospitals. Medicare fails to target areas of need, he says. "It is poorly audited and widely manipulated for purposes of State, institutional and personal gain by some." Public health care funding needs to be re-examined to reduce waste and encourage medical training aimed at geographical and speciality areas of need.

Karen Howard offers a business perspective: real value is about viewing a product or service from the customer's viewpoint and delivering on those expectations.

Nicholas Graves proposes three steps: generate information on cost-effectiveness of services; incentivise clinicians and managers to choose cost-effective services and stop poor value for money services; implement changes on a large scale, rather than pilot projects, to demonstrate value for money.

On the subject of better choices, **Adam Elshaug** refers to an American initiative that lists medical tests and procedures that may be inappropriate which could lead to dramatic practice changes, such as not scheduling elective caesarean sections prior to 39 weeks or not doing imaging for low back pain unless red flagged. "Doctors, patients, and the community are uniquely positioned to recognise inefficiency in the system but are seldom empowered with the information or avenues they need to reduce harmful spending, until now."

And tinkering is not enough to save Medicare, says **Jeremy Sammut**. He suggests splitting Medicare into two funding streams. One stream would fund personal "Health Savings Accounts" into which the government would make annual deposits. Individuals could withdraw money from the accounts for lower-cost health services such as GP visits. The second stream would fund health insurance vouchers allowing people to purchase health plans from competing health funds to cover higher cost treatments, providing the incentive for better, more cost-effective approaches to health care.

But what about the efficiency and equity of Australia's current unique mix of public and private sector care? ask

Terence Cheng and **Anthony Scott**. It is clear Australian voters value the choice of private or public care, while for some hospital queue-jumping seems inequitable and could be inefficient. More examination is needed into "whether the balance can be changed to improve efficiency and equity in the health system".

Chris Van Weel examines the result of system changes in his native Netherlands and says the experience has forced more scrutiny of costs and wasteful, spurious interventions in hospitals, and, more positively, further development of community-based primary health care and general practice.

David Baker explores the potential for further changes to prescription programs to increase the used of less expensive generic medicines.

The final word comes from **Paul Gross**, a long-standing consultant to governments in Australia and around the world on health system policy. He pinpoints four inefficiencies in Medicare and private health insurance need big reform. These including holes in Medicare caused by government "quick fixes", dangerous gaps and overlaps in government commitments to mental health services and the National Disability Insurance Scheme; messy health insurance rebates and regulation constraining better care and incentives to change unhealthy and costly lifestyles; and high hospital readmission rates and adverse events. To ignore these is to fan "mural dyslexia --- the unwillingness of politicians to see the writing on the wall when we have an ageing society with unfunded care needs".

Adam Stankevicius is Chief Executive Officer of the Consumers Health Forum of Australia.

Change is imperative to end archaic practices



Peter Dutton

The health of our health system has been a focus of national debate for several years now, but unfortunately to a large extent that is all it has been talk – there has been little genuine reform.

Labor's answer in government to 'fix' the system's health was to throw ever increasing amounts of money at it – billions of dollars, but seven years after Kevin Rudd's promise we can see that little has changed except for the fact that we no longer have more and more money as a possible antidote to the system's ills.

Growth in spending on health is unsustainable.

Over the last decade we have seen the cost of the MBS increase by 124 per cent, the cost of the PBS has risen 90 per cent and spending on public hospitals rose by 83 per cent.

As a nation in the 2011-12 year we spent \$140 billion on health – an increase of 122 per cent on a decade ago.

The most recent Treasury update predicted that Commonwealth health expenditure would continue to rise by around five per cent a year, although the growth rate could be even higher because of our ageing population and the rising tide of chronic diseases.

We can't continue on a trajectory like that.

We have to live within our means, yet at the same time we have to continue to provide the high quality health care delivered by our health professionals and we have to provide the treatments, new technology and ever more specialised and personalised medicines will bring in the future.

So change is imperative. We must make our health care system sustainable.

In our public hospitals dramatic improvements in productivity and efficiencies that are part and parcel of the private sector are essential.

The public sector can no longer be shackled by archaic practices that deliver the waiting lists that leave tens of thousands of Australians in pain and

unable to access a service for extended periods of time.

The health care system as a whole must be open to the innovation and the bold new ideas that come from the private sector.

In the pharmaceutical sector, the price disclosure reforms initiated by the Howard Government in 2007 are bearing fruit. The rapid cost increases of past years slowed significantly in recent times.

So perhaps the biggest challenge – and the greatest opportunity – ahead, lies in primary care.

We need to do more in primary care, but more efficiently and in so doing ease the burden on the nation's tertiary facilities.

As I have indicated, while all components of federal health spending have risen greatly in the past 10 years, the fastest growing element has been Medicare payments.

Last financial year (2012-13) the Commonwealth spent \$18.6 billion on Medicare payments, an increase of 5.3 per cent from the previous year although the population only grew by an estimated 2.6 per cent.

Medicare is a central feature of Australia's health system.

When it was conceived decades ago you could buy a house in our cities for between forty and eighty thousand dollars, the Holden Kingswood was probably the best-selling car. It was a different world.

Much has changed. I doubt many Australians would find the features of a 1970s or 80s Kingswood would meet their expectations of a vehicle today.

Yet that is what we are doing with Medicare – we're still using the 80s model.

Australians know all is not well when they can't book a timely visit to the GP, when they're given a bill for out-of-pocket expenses for so-called elective surgery, they hear it through the stories of hidden waiting lists and inequities which shouldn't be tolerated.

So we need to modernise and strengthen Medicare and in so doing help to heal our health system.

More than half of Medicare spending goes to 8.6 million Australians who hold concession cards. In 2012-13 just 10 per cent of patients accounted for 46 per cent of Medicare costs.

So we need to look at better ways to manage these patients who need more frequent care and perhaps better models for paying the health professionals who provide that care and to that end I have initiated discussions with various stakeholder groups on this issue.

Let me also say that it seems sensible to me that private health insurers may want to involve themselves in the primary care of their members, particularly those with chronic disease and considerable needs for medical care or treatment.

If that involvement can avoid the necessity for tertiary care later then it is in the patient's best interests and ultimately that of the Australian taxpayer as well. It does not mean that the patient opts out of Medicare.

If an insurer can provide additional support to a doctor why would we resist that? It has the potential to save a lot in human and financial terms.

So the challenge is before us.

Numerous suggestions for change have been put forward already and I'm sure other contributors to this issue of *Health Voices* will have further suggestions.

In conclusion - if we do not build a sustainable system now in a planned and cohesive way then sudden adjustments may be forced upon us – as they were forced upon other countries by the Global Financial Crisis – an outcome I'm sure none of us want.

I think there is recognition and acceptance that we must make changes.

To do nothing is not an option.

Peter Dutton is the Minister for Health and Minister for Sport. Formerly a police officer and company director, he entered Parliament in 2001. He held ministerial posts in the Howard Government, including Assistant Treasurer. He was Shadow Health Minister from 2008 until last September's change of Government.



Preserve Medicare to ensure value for our health dollars

Catherine King

In February this year we celebrated the 30th anniversary of the commencement of Medicare.

For millions of Australians there has never been anything but Medicare. Every Australian under 30 has grown up under a system of universal care, and it's important to take that in context for what it has meant for health outcomes in Australia.

When Bob Hawke as Prime Minister introduced Medicare he warned that without it, more than 2 million Australians 'faced potential financial ruin in the event of major illness'. Australia's life expectancy today is almost 80 years which is a significant rise from what it was in 1974.

And for a country that spends a lot less as a percentage of GDP on health care than many other developed countries, it is very encouraging. Of course advances in medical treatment, new medicines and other factors have all contributed to this, but all Australians have had access to these treatments and medicines because of Medicare.

What is important about Medicare is that it has not only afforded universal access but has kept costs down across the system and for all Australians. Having an equitable health system with the purchasing capacity of the Commonwealth at its heart has been one of the most important factors in getting value out of Australia's health system.

This is why the statements by the government regarding its plans to change the structure of Medicare are of deep concern. A particularly noteworthy example to date has been the move by some private health insurers into the delivery of primary care. The Minister for Health has indicated he will entertain legislative change to encourage this sort of activity if necessary.

This is something Labor opposes as a matter of principle. There is no doubt

about the appeal of such a change to a group of consumers, but that is the whole point – it is a very select group. For the millions of Australians who choose not to or cannot afford private health insurance such a scheme would almost certainly be to their detriment.

Guaranteeing a level of access to health services for those who can afford it whilst neglecting to improve services for Australia's most marginalised is the exact opposite of what Medicare is intended to do. The government's consistent refusal to rule out the introduction of Medicare co-payments has been driven by similar principles. This would spell the end to bulk billing and have a devastating effect on millions of Australians.

Comments that health costs in Australia are 'spiralling out of control' and are 'unsustainable' do not help the debate. Governments have an obligation to get the best value for money out of taxpayers' dollars and Australians do get very good value out of Medicare.

Shifting costs to consumers and privatising Australia's health system will reduce health spending for Tony Abbott's budget but the individual budgets of every Australian will take a big hit in turn. A good example of this is the current level of bulk billing. Bulk billing rates in Australia are at more than 82 per cent - the highest rate in Medicare's entire 30 year history.

Having access to bulk billing makes a difference for millions of Australians. GPs are important when it comes to preventative health, and providing as few barriers as possible to accessing GPs leads to early detection of disease, prevents hospitalisations and can make a fundamental difference to a person's mental health.

Ending bulk billing would further marginalise millions of vulnerable Australians and put Australia on the path to a two-tiered health system at great speed, as well as significantly adding to the costs of the health system overall.

One of the areas that will result in long-term savings to the health budget that is not discussed enough, particularly by this Government, is the possibilities that exist in prevention. In government Labor established the Australian National Preventive Health Agency to prioritise preventive health and better coordinate the Commonwealth's efforts to reduce rates of obesity, address the consumption of alcohol at risky levels – particularly through partnering with national sporting organisations, further reduce smoking rates, and to continue work on disease prevention and health promotion.

Medicare Locals have been an effective mechanism to deliver this work and are already having tangible benefits across Australia. Medicare Locals provide an opportunity to increase the focus of health care to primary care. This of course provides opportunities to reduce hospitalisations and keep people healthier, but importantly as well to keep the focus on prevention.

The ability to collect data at a local level then prioritise health services to target specific community need has been a capacity Australia's health system has been lacking for too long. Likewise has been the ability to partner with all providers of health care whether they be GP super clinics, local hospitals, community health centres, Headspace centres, aged care services, speech pathology and more. Medicare Locals are bringing together all the available services and coordinating their delivery. This will lead to better health outcomes for Australian families and over time reduce the cost on the health system.

Too many people end up with chronic conditions that could have been prevented and often in hospital for the same reason. This is a reality the new Health Minister needs to accept. Rather than trying to frame a debate around 'unsustainable' costs, the Government needs to focus on the sensible measures already underway that will result in true

savings to the health system over the long-term.

Privatising Australia's health system will not result in savings to the system overall. It might mean the Commonwealth government spends less on health but it will not mean Australians do. Medicare has not only delivered Australians a very high quality of care over its 30 year history, it has also provided very good value for the health care system overall.

The best way of ensuring Australia continues to get good value for money on what we spend on health is to preserve the integrity of our system with Medicare at its heart.

Catherine King, the Shadow Health Minister, was elected as Federal MP for Ballarat in 2001. She has been a Parliamentary Secretary in the portfolios of Health and Ageing and Infrastructure and Transport in the Gillard Government following the 2010 election and later

elevated to Minister for Regional Services, Local Communities and Territories and Minister for Road Safety. She was subsequently promoted to Cabinet in July 2013, as Minister for Regional Australia, Local Government and Territories in the Rudd Government. She holds a Degree in Social Work and a Masters in Public Policy from the Australian National University and is currently completing a law degree from Deakin University.

Let's improve, not discourage, access to primary care



Richard Di Natale

The Abbott Government claims that Australia's health care system is unsustainable and spiralling out of control but the facts say otherwise.

Spending on health as a proportion of GDP has increased only slightly over the last decade. Projections suggest we are on track to spend an additional one percent of GDP over the next decade. This small increase has little to do with unnecessary GP visits, as the Health Minister would have us believe, but is primarily the result of access to improving medical technology leading to better investigations and treatments. Far from being a crisis, the fact that we have new options that can help us live longer, healthier and more productive lives is something to celebrate. Would anyone actually prefer that Australians miss out on new and better therapies for serious diseases?

The most important thing that Australia can do to make sure we get the most from the health care dollar is to protect Medicare. Medicare is one of the great Australian public policy success stories. It may not be perfect but for 30 years it has delivered health care fairly and efficiently. It keeps costs down because as a single universal insurer Medicare has the power to set prices which keep a

lid on the cost of a visit to a doctor. The result is that everyone gets access to high quality health care, no matter what the size of their wallet or whether they are unlucky enough to be born with a chronic disease.

Tony Abbott claims to be Medicare's best friend but his government appears determined to dismantle it. The Health Minister believes there should be a bigger role for private health insurance in primary care but allowing insurers to cover general practice services will take the lid off the price of a doctor's visit and everyone will end up paying more. While health insurers providing GP cover has superficial appeal, this change will mark the end of Medicare as we know it. Private health insurance would become a necessity to see a GP yet insurance premiums will skyrocket. It would take us further towards a two-tiered American-style health system so I have introduced a bill into the Senate to prevent it.

Mandatory co-payments or means-testing bulk billing won't work either. Putting a price barrier between a patient and their doctor would disproportionately impact on low-income Australians who also tend to be less knowledgeable about health and have poorer health. Some of these people will present to expensive

emergency departments impacting on people who need urgent care. Others will stay away from the doctor completely until their simple treatable illness becomes a more serious and potentially life threatening condition requiring intensive and costly hospital treatment. The South Australian Health Department modelled the impact of a GP co-payment and it demonstrated that any potential savings in primary care would be greatly outweighed by an increase in hospital costs. Most importantly, the cost of a consultation shouldn't be a factor when someone is considering whether their chest pain is just indigestion or something more serious.

The proposal for a co-payment undermines the direction of public policy in health care over recent decades. We must improve access to primary care rather than discourage it. We want people visiting their doctor for screening and early intervention; we want people getting medical advice when they have a concern. Catching problems early and treating them is not only good for the patient, it is a good investment.

To do this we need to ensure our primary care system works better. It needs to be better coordinated, which is where a Medicare Locals have

great potential. We need to develop complementary models alongside fee for service to fund long term treatment for people with chronic diseases. We need to ensure that evidence based health care, regardless of who provides it, is funded through the MBS.

Tough decisions also need to be made. We need to reassess many of our existing practices and decide whether they are based on good evidence and provide value for money. There are many that don't. We should look at the many good international models that demonstrate what a rigorous health technology evaluation process looks like and reform our current system.

There are also potential savings to be made in the area of medicines. The introduction of price disclosure, which brings down the cost of medicines over time, was an important reform. Incentives to encourage the use of generic medicines and investing more in the National Prescribing Service to

ensure more rational prescribing would also help. Groups such as the Grattan Institute, have proposed changes to the way we purchase medicines that could save billions and these are worthy of consideration.

And while treating illnesses early saves money, preventing them is even cheaper. Prioritising effective preventive policies like plain packaging of tobacco, junk food labelling and alcohol pricing and advertising would result in tremendous health gains. This is why the Greens have great concerns about the likely axing of the National Preventative Health Agency.

Saving money in health also requires us to look outside the health budget. Addressing the social and environmental determinants of health is just as important. Ensuring access to clean air, housing, and education will reduce the burden of disease and prevent unnecessary spending in the health budget.

Finally, it's important to remember that spending money on health is a good thing. Of course we should spend our health dollar as efficiently as possible and make savings where we can. But we are a rich country and as we become ever more prosperous we shouldn't be afraid to invest in health care. What could be a higher priority?

Dr Richard Di Natale is a Greens Senator for Victoria. His portfolios include health, sport, multiculturalism, gambling and youth. Before entering parliament Richard was a general practitioner and public health specialist. He worked in Aboriginal health in the Northern Territory, on HIV prevention in India and in the drug and alcohol sector. Richard, his wife Lucy and two young sons live on a small, working farm in the foothills of Victoria's Otway Range.



Six steps to help preserve universal health care

Stephen Leeder

Strange things happen: in the past three years health care costs have stopped rising at terrifying rates in the US¹. No one reason stands out; instead, economists suggest that industry, which has borne the heaviest burdens in costs because much private health insurance is paid for by employers, has applied pressure on insurers because of the general belt-tightening induced by the GFC. There has been much discussion in medical circles about 'effectiveness research' that provides intelligence on which investments in health care have the highest yields in health gains. Obamacare debates have sensitised the community and possibly heightened public awareness that ever more expensive care does not mean ever better health care.

In Australia health care costs are by no means wholly met from taxation – our own and others' studies have shown that 30 per cent of health costs in Australia come from people's pockets, or health insurance, and that this percentage rises among those with chronic illness or disability. Medicare leaves proportionately large gaps (\$35 a script) to be paid for by the sufferer for listed drugs and private care, even when covered by private insurance.

Because health care costs continue to increase at a rate faster than that of our economic growth and because it is apparent that the configuration of our health service (hospitals required to do many things for which they are ill-equipped in caring for people with multiple, serious and continuing health problems, with general practice expected to fill holes, stop gaps and pick up pieces), it is critically important

to develop effective new ways of organising what we do. This is tricky.

The assumption that these new models of care will cost less is just that – in fact, in some cases properly coordinated care will cost more than what we pay at present because it unearths unmet need. So the discussion about coordinated care boils down to a concern about the best, not necessarily the cheapest, way of treating patients.

Almost all economically advanced nations provide tax-funded health care for their citizens and hence are concerned with the rising costs. Many are taking active interest in linking in community care for the rising numbers of people with chronic problems so that they do not occupy expensive hospital services that are often not the best for them anyway. McKinsey and Company, a consultancy, has accumulated extensive

experience with programs of integrated care in parts of Australia, the UK, the US and Europe². In summarising their experience in helping successful integrated care developments they point to six common features that apply just about everywhere:

1. Reimbursement and incentives must be taken seriously. Successful trials in the US and the UK depended on a move from fixed reimbursement for service (often without measurement of what the service achieved) to greater accountability, rewarding effective and excellent care and an ability to plough savings (if any) back into the service and offer incentives for the providers (US).

2. Governance. This is an unfamiliar word, but powerful. It refers to the way players in coordinated care are brought together – a board might be used to reflect the multiple interests of the providers. The report on the Australian trials said that while the importance ‘of governance and management may seem obvious from first principles, the clear and strong message from the evaluation ... is that robust arrangements cannot be taken for granted. They must be actively put in place at the outset, monitored and nurtured to underpin success.’

3. Information. This concerns the cost and effects of what we do. Without it we are navigating without a map. Australia is 20 years behind best practice in relation to information management and technology. As a document that described Australia’s coordinated care trials report said, ‘the inability to achieve the goals of electronic communication, networking and data flows was a major impediment to the trials. All trials underestimated the resources and skills required.’

4. Clinical leadership. Coordinated care requires clinical champions. I heard of no successful effort in which it was missing.

5. Patient engagement. The coordination of care for people with multiple health problems can be greatly assisted by clinical protocols and care plans. These need to be located in a context that fully recognises the massive individual variation in our patients. If we follow the first principle of Don Berwick,



an outstanding US quality guru, we will make the patient the centre of everything we do – EVERYTHING.

6. Plan to scale from the beginning – avoid boutique pilot studies that employ a coalition of the willing. Many trials (and we could add many clinical trials of drugs) have been done with selected patients and enthusiastic practitioners. Do not be beguiled: there is much work to be done recruiting wider participation from the outset of both practitioners and patients.

As consumers and community members we should note the fifth point carefully. Pressing our health planners and policy makers to take it seriously is a matter for consumer advocacy. Heroes in the consumer movement will tell you this has always been the case.

Consumer vigilance is needed to ensure that efficiency gains are not won by reducing quality of care. It is my belief based on my experience observing and working in the health system that huge economies can be achieved by the use of IT, superior quality management and attention to closing loops that permit provider greed to run riot. There is no reason for government to back away from universal health care. It is more a matter of getting the system right and managing it well. It can be done: others have done it: so can we.

Stephen Leeder is a Professor Emeritus of public health and community medicine at the University of Sydney. He is Chair of the Western Sydney Local

Health District Board, and Director, Research Network, Western Sydney Local Health District. Stephen was appointed Editor-in-Chief, Medical Journal of Australia, in 2013. He has a long history of involvement in public health research, educational development and policy. His research interests as a clinical epidemiologist have been mainly asthma and cardiovascular disease. His interest in public health was stimulated by spending 1968 in the highlands of Papua New Guinea. In 2003-04, Professor Leeder worked at Columbia University, New York, in the Earth Institute and Mailman School of Public Health, developing a substantial report, based on research data and scientific interpretation, of the economic consequences of cardiovascular disease (CVD) in developing economies. In recent years, Professor Leeder has directed the development of the Menzies Centre for Health Policy, a collaborative centre between The Australian National University and the University of Sydney.

1. http://www.nytimes.com/2013/12/19/us/growth-in-us-health-care-spending-slows-but-out-of-pocket-costs-rise.html?_r=0
2. <https://www.google.com.au/#q=what+does+it+take+to+make+integrated+care+work+mckinsey+quarterly+january+2010>



Real people, real data and real solutions

Deborah Smith and Sarah Spiller

"The first two weeks after Mum had her stroke she was in a specialist stroke unit. That was fantastic. She was then sent to another hospital for six weeks' rehabilitation... but that ended up being 15 or 20 minutes ... a day. The rest of the day she was in bed. They said she was too tired... We wanted to look after her at home but ... the reaction was, 'oh no, that'll be really hard, you won't be able to do it'. Just before she left hospital they assessed her to go into aged care permanently, without our knowledge. There was absolutely no encouragement about getting her home. We just didn't know who to turn to ... when we realised that she was in aged care permanently. We eventually got her reassessed and got her home. She is not a person who cries much but ...she said she cried all the time..." - Victorian consumer

In this story, our health dollar bought:

- Short-term care in a specialist stroke unit... that was fantastic
- Weeks in a rehab hospital... for 15-20 minutes rehabilitation per day
- Discharge to residential aged care... when the family sought to care for their mother at home
- Health professional override on care planning that led to stress and tears

Finding out what works, what doesn't and where and how we can get a better bang for our buck starts with listening to what consumers can tell us - about the health system, health costs and health outcomes.

"Despite having top hospital cover for the last 52 years, when I was diagnosed with aggressive breast Cancer, I have found that often less than half of the costs are covered! We are out of pocket by \$6,700 the first time, and ... we had to pay everything BEFORE the operations. As the first one was urgent I had no option but to borrow to pay the fees... To make it worse, while I was in intensive care, Centrelink cancelled my pension because I had not reported our income!

...I could not get my medicines because my card was cancelled." - Consumer post to the OurHealth website.

Consumer experience – as told by consumers – is essential evidence for health care.

Stories flesh out the data. Most health service data are quantitative: numbers and statistics. But stories and statistics together provide a more complete picture. For example, statistics tell us that the growing number of people with chronic conditions places new cost burdens on our health system. **We know the answer is often as much about self-care as medical treatment.** The stories of consumers and carers can suggest how to do this.

"I would change some things about being sent home from hospital. Just sort of, not being left out in the cold. The hospital staff really care, and they can't intuitively know what discharge information every medical problem needs. But I had to learn so much for myself. People with neurological damage cannot be expected to 'just know'. Fact sheets would have been a great source of comfort to me and my family. They would have helped us know what to expect. An information pack when you leave hospital ... saying where to go and what to do once you're home... would help." - Consumer from QLD

Stories drive better health outcomes. Listening to, and acting on, consumer stories are ways to engage and support consumers. Consumer engagement and partnership are requirements of the National Safety and Quality Health Standards (and state and territory legislative and policy frameworks). They are proven means of delivering improved clinical quality and outcomes, more cost effective service delivery, and better consumer experiences of care.

Giving the 'human side' of policy debates and service challenges can "build understanding, create a platform for discussion and motivate people" to

act for an improved health system.

Health consumers see it all. They can provide crucial information about things like quality, safety, coordination and continuity of care; and about the longer-term outcomes. Aspects of care impacting profoundly on health outcomes can be overlooked by health care services.

"Dad... had kidney failure. His kidney specialist had told him to be on a low sodium diet. ... we could not convince the hospital my father needed low salt food. They said they couldn't do anything until they'd contacted his specialist to find out. But even then we could not get a low salt diet from the kitchen. So he pretty much only ate whatever on his plate was low salt. He was basically starving... They brought him through surgery but they still couldn't provide a low sodium diet for him." - Consumer from NSW.

People's stories also provide information about the personal, community and social factors that shape health outcomes. Stories can highlight the role of policies, services and experiences that are outside the health system but powerfully affect health outcomes.

When you get over the medical side of things, just know that that's terrible and everything, but that's about five per cent of what you've got to worry about. The 95 per cent is the financial, the social, the relationships, this whole other big circle. No specialist can tell you all of that stuff, but it would have changed the whole course of how I'd lived the next part of my life if someone had just sat me down and said... let's just make a bit of a path for you here.

Stories "contain almost everything that is required for a deep appreciative understanding of the strengths and weaknesses" of a service, system or situation.

This data fills the critical gap in health performance reporting identified by

AIHW Chair, Hon Andrew Refshauge :
For reasons beyond any individual government's or organisation's control, it seems that we can often report on services or report on health status, but drawing links between the two is a challenge.

Real people can give us real data that demonstrates what health benefits we actually realise from our health spend, and how we might get better bang for our buck.

CHF is developing the Real People, Real Data consultation tool to bring

consumer experience more effectively to health decision-making. It describes the patient experience through respectful qualitative interviewing. It uses indicators of patient centred care, such as informed consent, patient choice and affordable access, to guide analysis. It respects consumer ownership of their story and provides decision-makers with a one-page summary of key evidence. This robust consultation tool will help move consumer stories from 'anecdote', to evidence that shapes decisions about health policy, services and expenditure.

Deborah Smith is CHF's Consumer Relationships Manager and Sarah Spiller is the Project and Policy Officer. Together they have developed the Real People, Real Data project with the guidance of an expert reference group and CHF members.

The Real People, Real Data project is funded by the Australian Government, Department of Health, with the toolset due for general release in June 2014. The review of literature and Australian and international practice that underpins this work is available on the CHF website at: <https://www.chf.org.au/pdfs/rep/rep-1142-Literature-Review-Using-Consumer-Narrative-to-Inform-Better-Health-Outcomes.pdf>

Needed reform in health care



Stephen Duckett

Recent media commentary would have us believe that the health system is in dire straits. There have been claims it is unsustainable and that drastic change, such as compulsory co-payments, is necessary to slow cost growth. This scare-mongering, or 'sustainability panic', sets the scene for dramatic, regressive and unwarranted changes to our health system.

Never let facts stand in the way of a good argument. Australia spends less per person on health care than the average of other developed countries and it has better than average life expectancy.

The relatively good position of Australia's health system doesn't mean we should be complacent. System improvement is needed to ensure we adapt to the demographic and technological changes that the health system needs to address.

In 2009 the National Health and Hospitals Reform Commission presented its report, providing a blueprint for needed change. Many of its recommendations are still relevant.

They include:

- Investments are required in the early years, to make sure kids have a healthy start;
- The interface between the primary care system and hospitals needs to be transformed, to ensure a seamless transition for patients as they cross that boundary;
- There needs to be a revitalisation of primary care, helping this sector adapt to the increased prevalence and importance of chronic conditions;
- The skills of health professionals are not being used properly, and workforce reform needs to be given a higher priority; and
- There is waste in the health system. If it can be reduced or eliminated, the savings can fund services to meet new needs.

The Federal Government's response to the Reform Commission's Report was somewhat disappointing. Then Prime Minister Kevin Rudd embarked on an extensive consultation process, duplicating that of the Reform Commission, and invented his own recommendations for public hospital

funding. Cutting a long story short, these recommendations didn't go anywhere and Prime Minister Gillard introduced new proposals more in line with the Commission's recommendations. These were implemented.

In parallel, Medicare Locals – new organisations to address the underdevelopment of primary care – replaced 'Divisions of General Practice'. Medicare Locals often had fraught beginnings, hindering implementation of the new structures. The new government is reviewing their role.

Yet both the hospital and 'Medicare Local' reforms were important. Both are in their implementation phase and both better position the health system for the challenges it faces.

There are two places to look to get better bang for the buck in health care. First, we need to make sure the right investments are made and the right priorities set. The Reform Commission's agenda, particularly the need to improve primary care, still provides a good framework in this regard.

Unfortunately, the Medicare Local changes in primary care don't go far

enough. Current delivery and funding arrangements in the health system are still shaped by what went before. Payments for general practice are still primarily on the basis of fee-for-service, a funding model developed when the main health conditions were acute or episodic visits provided by individual medical professionals generally in solo professional practice. Neither is true today. The main health problems are chronic conditions - often more than one condition - and many services are delivered by corporatised chains, some of them listed on the stock exchange.

New funding and delivery arrangements are needed to increase the visibility of general practice so that people think about it as a viable option to get after-hours care, and to encourage continuity of care and attachment to a single practice. Use of all the skills of other professionals (nurses, pharmacists and so on) needs to be encouraged. Countries with strong primary care systems generally have lower costs, as investment in primary care leads to healthier populations and reduced admission rates to hospitals.

Secondly, we need to look at provider waste in the system. It is simply unethical to shift costs to poorer people and/or to reduce service access while

there are still opportunities to make the system more efficient.

It is partly for this reason that Grattan Institute has a 'waste' theme in its work plan. Waste in this context is interpreted broadly but examples include:

- Paying too much for inputs into care (salaries, goods);
- Administrative 'red tape' burden;
- Providing ineffective care or care of marginal value; and
- The effect of poor quality care (for example, readmissions)

Grattan has issued two reports to date examining excess prices for pharmaceuticals. Both showed that when you examine what other jurisdictions (other countries and state public hospitals) pay for pharmaceuticals, Australia's Pharmaceutical Benefits Scheme is paying far more than it should. The excess cost to the taxpayer of about \$1 billion a year. There are excess costs to consumers too. Savings per prescription of \$20 (for people without a concession card) on some very common drugs such as atorvastatin can be achieved.

Another Grattan report has examined public hospital inefficiency. After taking into account the type of treatment (hip replacement, heart attack) and other

relevant factors, we find that hospitals in every state vary considerably in the cost of care. We argue that better funding arrangements for public hospitals could also save \$1 billion a year.

Australia spends just over 9 per cent of its Gross Domestic Product (national wealth) on health care every year. This is predicted to rise to about 12 per cent over the next 20 years. It is a large increase but it is affordable - we'll just need to spend less on something else. An increased share of Gross Domestic Product spent on health may just indicate that, as the country grows wealthier, we give priority to spending the increased wealth on health. It would be even better, though, if we could bend this cost curve by eliminating waste and making sure we're investing in the right things, especially primary care.

Professor Stephen Duckett is Director of the Health Program at the Grattan Institute and Professor of Health Policy at La Trobe University. He has a reputation for creativity, evidence-based innovation and reform in areas ranging from the introduction of activity-based funding for hospitals, to new systems of accountability for the safety of hospital care. An economist, he is a Fellow of the Academy of the Social Sciences in Australia.



Putting people at the centre of their health care: practical approaches to more integrated care

Christine Bennett

In Australia there are challenges in achieving comprehensive, connected care for people at the right place and time, due to the health system's fractured governance (who is responsible) and financing (who pays). While many remain convinced that Commonwealth and state responsibilities must be reshaped toward a single national public funder, at one level of government or through pooled funding, we cannot wait for a

new structure to drive integrated or connected care.

What we can focus on right now within current funding and delivery responsibilities is taking effective local action and implementing system-wide enablers to support integrated care. State health departments, the Commonwealth, private health insurers, local councils and local communities all have roles to play. Some interesting initiatives are underway around Australia and it is important that we evaluate and share experiences and successes.

Much has been said and written about the importance of "person-centred" health care. The first design principle of the National Health and Hospitals Reform Commission's blueprint for health reform, released in July 2009, was the goal of delivering "people and family centred care".

The NHHRC report emphasised that the essential point was for a person to get the right care, at the right place, at the right time. Importantly the person should be central to his or her health care decisions and be supported in

navigating the system and making informed choices.

To understand the challenges of connecting or integrating health care around the individual, it is important to recognise that while two thirds of health care spending is by Commonwealth and state governments, two thirds of the delivery is within the private sectors - private hospitals, general practices, community pharmacies, other private health practitioners and non-government provider organisations. Furthermore the balance of services and who provides them varies across Australia. A local approach that involves the public, private and non-profit sectors is therefore critical.

A powerful opportunity for local action arises in enhancing working connections between Medicare Locals, State health departments and their associated local health networks and aged care providers. These local structures will be most effective if they collaborate in developing solutions to community health needs and service gaps.

There are many examples of successes that the whole system would benefit from sharing. The Mental Health Intervention Coordinator Program, in the Darling Downs Local Health Network in Queensland, pioneered a tri-agency approach to the prevention and safe resolution of mental health crisis situations, using training and coordinators to better connect Queensland Health, the Queensland Police Service, and the Queensland Ambulance Service.

In the Gold Coast Health Service District, the Aged Care Early Intervention and Management program has helped deliver acute services to aged care facility residents, reducing the presentation of these residents to Emergency Departments by 83 per cent. The program integrated primary care and hospital services through an educational initiative called "Bridging the Gap".

In NSW, the Hunter New England Local Health District and the Hunter Medicare Local have collaborated on the delivery of the Connecting Care Program. The program thus far has proved highly cost-effective in reducing emergency attendances, hospital admissions, and the time patients stay in hospital.

The NSW Government recently committed \$120 million over four years to foster locally-led models of integrated care, through joint governance arrangements, shared financial incentives to encourage collaboration, and new IT systems. The program will also implement system-wide enablers, with a focus on Health-e-Net to map and connect patient information across local health districts; risk stratification to identify high need patients; patient reported outcomes measures and real time patient feedback.

There are a number of important system-wide investments that States and/or the Commonwealth could make to support the local efforts. These include:

- better health information systems including the person-controlled electronic health record which could be further enhanced with state and private sector health data;
- clinical decision support and data systems that inform service providers to the level of each individual clinician about their practice and outcomes against best practice benchmarks and peers;
- shared informed decision making tools for people to make more informed health care decisions;
- adding patient reported outcome measures to other patient centred tools such as patient satisfaction and patient experience surveys and ensuring this information is fed back to local services and clinicians to enable improvements.

Health insurers are also recognising the value of reducing unnecessary hospitalisations by investing in coordinated care and health coaching that supports the person in navigating health care services and supporting them in making more informed decisions.

Medibank Private has been working with several state governments on establishing and evaluating a pilot to better coordinate care for high-need patients, by managing the cycle of care from primary through to high-intensity, acute care to ensure the right care is delivered in the right setting.

In another example, Bupa is focusing on empowering people in their health care

decisions through further development of health information hubs; shared informed decision-making tools to assist people in deciding whether a procedure is right for them; and apps such as FoodSwitch to support healthy eating choices.

A state or preferably national clearinghouse mechanism for meaningful and timely sharing and comparing of results – both successes and failures – of local initiatives could ensure that national policy and guidance is informed by the experiences of local innovation.

Whatever the governance and financing, whether delivered by public or private health, a state or preferably national clearinghouse mechanism for meaningful and timely sharing and comparing of successes and failures of local initiatives will ensure that national policy is informed by the experiences of local innovation.

Steps to help develop integrated care include: better defining appropriate care explicitly seeking the person's informed decisions; filling service gaps such as rehabilitation, palliative care, specialist teams in the community, home based care and aged care services; better connecting care and providers through the personally controlled electronic health record, apps and telehealth; and smart purchasing of care such as bundled packages of care across providers with an outcome focus.

Professor Christine Bennett AO is Dean of the School of Medicine, The University of Notre Dame Sydney, a former Chair of the National Health and Hospitals Reform Commission and former public hospital chief executive.



A better health system for fewer dollars by embracing needed reforms

John Dwyer

Introduction

Medicare is so expensive and uncontrollable that it is financially unsustainable, say our Treasurer and Health Minister. Indeed they suggest that if we don't rein in Medicare expenditure Australia will be bankrupt! We are told government spending must be curtailed everywhere, including Medicare where we currently spend about \$18 billion each year.

The Abbott Government is trying to sell us a simple solution embodied in the repeated mantra "Why should not those who can afford it pay more for their health care?" In truth, out-of-pocket expenses paid by us for health care are growing more rapidly than any other sector of the system. Last year Australians spent more than \$29 billion in this way. Those who cannot co-contribute are significantly disadvantaged. Our health system is increasingly inequitable.

On the cost of Medicare one vital reality needs to be emphasised. Hospital expenditure dwarfs primary care expenditure so looking at the cost of Medicare divorced from a system-wide analysis of health care costs is nonsensical.

The compartmentalisation represented by Minister Dutton's focus on the cost of Medicare is the price we pay for the wretched jurisdictional separation of funding arrangements for Hospital and Primary Care services. The success or otherwise of Medicare's primary care system seriously influences how much is spent on hospital care. Into the future that will only be manageable if a remodelled primary care system can reduce demand for hospital admissions. We need to spend more on a reformed Medicare, not less.

What do we want?

We need a national system characterised by its resourcing of evidence-based strategies that prevent avoidable illness and provides cost effective quality care on the basis of need not financial wellbeing. We cannot do so without major structural, financial and sociological changes.

What is wrong with our current system?

While rising health costs need addressing, asking Australians to pay more for the health care status quo should be unacceptable. Billions of dollars could be saved by structural reforms and redirecting priorities. These would provide needed dollars, better health outcomes and allow us to restore the equity of access to quality care that is rapidly slipping. It is not shortage of dollars that is our problem, it's the shortage of political courage and wisdom to embrace health system reforms that we need even without budgetary problems.

Few countries handle serious illnesses and health emergencies better than Australia. However many other desirable attributes of a health system are increasingly inadequate including cost effectiveness, equity of access to needed services and an emphasis on avoiding illness. Internationally our system is regarded as hospital/doctor/sickness centred. Our health "silos" fracture rather than focus patient care.

Poor use of health dollars.

One of our Federal system's greatest disasters is the nine departments of Health (?Sickness) established for 23 million citizens. Duplication alone costs us \$4 billion a year and the division of responsibilities stifles efforts to integrate care to ensure hospital, community and primary care are a continuum. Blame and cost shifting has become an art form.

The annual \$5 billion dollar subsidy of private health insurance represents poor policy. That money would provide much more health if it were available to public hospitals. We now know that the expectation that more private health insurance would relieve the demand for public hospital services was wrong.

Unnecessary or unnecessarily expensive procedures cost us about \$20 billion a year¹. We need more peer-accepted standards to address that problem. Australians are hoodwinked into spending upwards of \$2 billion dollars a year on supplements they don't need. But the largest of all the cost inefficiencies, inextricably linked to poorer health outcomes, demands an urgent restructuring of Medicare as we know it.

Each year more than 600,000 public hospital admissions (cost at least \$5000) could be avoided with an effective community intervention (cost \$300) in the three weeks before eventual admission. To reverse that situation we need "New Medicare"

What would New Medicare look like?

We need Medicare to become a funder of a *Primary Care system* to meet contemporary needs.

Around the world the trend is to establish Primary Care systems that encourage citizens to enrol in a wellness maintenance program. The psychology associated with voluntary enrolment is important. The philosophy involves acceptance of the concept that we need to take more responsibility for our own health but with personalised and ongoing assistance from appropriate health professionals. The infrastructure involves having such a program available from one's Primary Care practice and is not necessarily delivered by doctors.

Integrated Primary Care

This new system embraces “team medicine”, wherein enrolled patients would have access to allied health, nursing and medical practitioners paid by Medicare. Eighty-five per cent of New Zealanders are voluntarily enrolled in a primary health care organisation. The most appropriate professional(s) provides the care needed at a given time. Such “Integrated Primary Care” (IPC) programs focus on education and continuity of personalised care to maintain wellness, the earlier diagnosis of problems that could become chronic, team management of chronic and complex diseases and care in the community for many currently sent to hospital.

The Health Reform journey

The concept of a health reform journey is all important for it cuts through the “it’s all too complicated” barrier.

International experience suggests our journey would take about ten years.

The destination would be a thriving and effective IPC, a single health funder, a sophisticated life- and money-saving electronic health record, evidence-based care delivery that has eliminated the \$20 billion spent on unnecessary procedures, better educated Australians no longer wasting \$2 billion a year on unnecessary supplements and rural health policies to minimise the current inequities in the bush.

Conclusion

It is not dollars that are the major problem. We spend only 9.2 per cent of GDP on health. What is in short supply is political wisdom and courage to resist the voices of vested interests and take us on this journey. Will the “greatest friend Medicare ever had” lead us to the fairer, better, affordable system we need and deserve?

Professor John Dwyer AO, PhD, FRACP, FRCPI, Doc Uni (Hon) ACU, was appointed Emeritus Professor of Medicine, University of New South Wales in 2005 after a distinguished career which included 15 years in the United States, and at the Department of Immunology, Yale University. He has championed clinician governance and structural reform in health care delivery and the development of “Integrated Primary Care” in Australia. He co-chairs the Medical Staff Executive Council of NSW. He founded the Australian Health Care Reform Alliance. He remains active as a teacher, particularly in the area of HIV/AIDS, and has worked with Charles Sturt University on plans to increase Australian-trained doctor numbers in rural and remote communities.

1. <http://www.smh.com.au/federal-politics/political-news/pm-tony-abbott-under-fire-over-looming-health-bill-surge-20140101-30666.html>

Extending user-pays in Medicare



Terry Barnes

Whatever you think of the proposal to allow a \$6 co-payment for bulk billed GP services, the debate over Medicare and health care sustainability isn’t going away. The recent Fairfax Nielsen poll, showing surprisingly strong public support for user-pays measures to help keep Medicare fiscally manageable, indicates a community appetite to at least consider challenging and tough options hitherto banished to dark political corners.

Co-payments in Medicare and Pharmaceutical Benefits Scheme have existed for decades. While most experts and stakeholders, including the Consumers Health Forum, disagree, extending pay-as-you-go in Medicare is now firmly on the political agenda. Signals in recent weeks from Health Minister Peter Dutton indicate that as far as the Abbott Government goes, it’s a matter of when, not if.

With this in mind, I want to make some comments about the Australian Centre for Health Research proposal, and a few suggestions about where else in the health care framework user-pays could be extended.

Comments on the co-payment proposal

Provided it has a reasonable ceiling to protect the less well-off, chronically ill and families with young children, there is no reason why a modest \$6 co-payment on bulk billed services should stop people going to the GP when they need to. Proposals routinely advocated by health policy experts for “fat taxes” on junk food and soft drinks (let alone tobacco excise) would be far more regressive than the 12 visit co-payment ceiling (\$72 per year) in my paper.

The \$750 million saving I estimated over four years relates only to Medicare rebates for GP services. I did not

calculate flow-on savings such as specialist referrals, PBS prescriptions, care planning and referrals to allied health professionals. The reason was that flow-ons are difficult to generalise. My rough estimate, however, is that savings from flow-ons that would have originated with the foregone GP services would double or more the GP rebate saving. That’s money better spent elsewhere in the health system.

Extending user-pays to public hospitals

GP-type services in public hospitals should attract the same price signals they would in a GP’s surgery. If a GP is readily accessible outside an emergency department, public hospitals should send a price signal to patients that low-level services should be sought elsewhere. It would also discourage people going to EDs to avoid a bulk billing co-payment.

EDs are for genuine emergencies, but are clogged by those who have been reckless in their choices and behaviour. Public hospitals therefore should also be able to use discretionary charging to penalise those who never would have presented had they been prudent and responsible. Price signals can be “sticks” encouraging good health behaviours: to the extent these can be applied fairly and consistently in ED settings, they should be considered.

Similarly, provided it is done compassionately and sensitively, public hospitals could charge moderate excesses for public inpatient admissions. If a person can afford to make a small contribution to their public patient care, they should. If this was adopted, if you're eligible for bulk billing you could be exempted from a public hospital excess. Revenue from excesses then could go back into hospitals' recurrent or capital budgets, and help stretch these that much further.

Modifying community rating for private health insurance

When it comes to heavily-subsidised private health insurance, those assuming avoidable risks get a free ride from other health fund members. That's because premiums are “community-rated”: set without regard to a person's age or health risk.

But why shouldn't people pay premium loadings if they choose to run avoidable health risks or not comply with their condition management regimes, and expect the same benefits as those making an effort to look after themselves? Community rating was never intended to subsidise adverse selection, and should be modified to remove perverse incentives for bad health behaviours: let's look at it.

Public acceptance of the need for price signals

If Medicare is about everyone paying according to their means, surely those with means should pay. The recent Nielsen poll results indicate that this principle resonates in the wider Australian community. There clearly is a willingness at least to consider tough questions about how we pay for costly health care services, who should contribute and on what terms.

What has been particularly striking is the willingness of many people who could be presumed as being most affected by primary care co-payments – the less well-off, concession card holders and people with chronic conditions – to make an affordable contribution. Clearly, those who receive GP and other primary care services most frequently value them the most.

Provided there are effective protections for the disadvantaged, governments extending price signals will not be out of step with public opinion, nor would be the Commission of Audit if it so recommends.

Where to from here?

Contrary to assertions by some critics, the co-payment proposal was never claimed as a “magic bullet” to fix the ills of Australian health financing. But if people can afford to pay more than now for the private good element of their health care – the benefit to their personal well-being and prosperity – then they should.

It has been suggested, notably by Stephen Duckett and Paul Gross, that bigger savings can be found elsewhere (particularly in reining in adverse events, and pharmaceutical and public hospital episodic costs), and therefore that Medicare co-contribution

changes should be dismissed. This, however, misses the point that the culture of health care access, in which increasingly-expensive services are taken for granted by many providers and consumers, and moral hazard reigns, must change. Moderate but targeted price signals may seem insignificant against a \$140 billion national health spend, but they help drive such attitudinal change.

On balance, a comprehensive bulk billing means test is a better, broader-based and less blunt option than a narrow-cast co-payment on bulk billed GP services, provided that co-pays in future have maximum limits to ensure practices do not gouge patients. I accept that some of the other suggestions made here are politically too hard. But any pay-as-you-go options are fairer and less regressive than simply raising the Medicare levy still higher, as ACOSS and others have argued.

Critics of user-pays talk about equity and minimising the burden on disadvantaged individuals, especially the poor and chronically ill. That is appropriate, but ministers and policy-makers have to think of minimising the burden on taxpayers too. While heresy to some, it is important to consider spreading the cost burden among those best able to bear it.

Terry Barnes authored the recent Australian Centre for Health Research discussion paper on co-payments for bulk billed GP services. He is a policy consultant specialising in health care, worked for 25 years in government including as senior policy adviser to federal health ministers Michael Wooldridge and Tony Abbott, and is also a regular writer and commentator on politics and social issues.

First steps to better value health care



Jennifer Doggett

The debate about how much we should be spending on health care may never be resolved. However, one issue everyone can agree on is the importance of getting maximum value out of every dollar that we invest in our health system.

Before we look to new and potentially controversial options for raising additional health funding (such as co-payments for bulk billed GP services) we need to focus on improving the returns we get from our current funding.

Australians already pay for a high proportion of their health care through direct payments. Increasing the cost burden of care on consumers would increase this burden and risk creating barriers to access for some of the most vulnerable in the community.

The following five examples demonstrate that we can provide Australians with better value for their health dollars without requiring either consumers or governments to reach into their pockets.

Better priority setting

No matter how much we spend, there will always be some forms of health care that we can't afford. But by focussing our spending on those services that deliver the best value we can ensure that our limited resources are delivering us maximum results.

Evidence shows that preventive health delivers the best 'bang for the buck' in terms of long term benefits. However, currently less than 2 per cent of Australia's total health budget goes to preventive health services.

Within acute care, many services routinely provided have little value. One recent study identified 150 such services are of questionable benefit.¹

Diverting funding from low value acute care services to high value preventive care would increase the returns on our investment in the health system.

Of course, it is always important to ensure that consumers (and not politicians, bureaucrats or doctors) are central to the decision-making process about what types of health care are considered low and high value.

Early gains could be made by reducing Medicare rebates for services which provide little clinical benefit, using the saved resources to increase preventive health efforts.

Structural issues

The duplication, cost-shifting and gaps that exist between services run by federal and state/territory governments wastes money and time, and reduces quality of care.

The solution is to establish a single funder and single point of accountability for all health care. However that has proven politically too difficult to achieve for successive governments.

The wait for a political 'perfect storm', where the Commonwealth and the state/territories all agree on structural reform, may be long. But in the meantime progress towards a more coordinated health system could be achieved through creating a national Health Consumers' Charter which builds on the existing Charter of Health care Rights to outline the standards of care people are entitled to within our health system. It should also include effective avenues for complaint and redress when these standards are not met.

This would articulate the goals of our health system at all levels and provide some accountability for governments. It would also give consumers an avenue for seeking the coordinated, efficient and comprehensive care that they deserve.

Better remuneration systems

Our fee-for-service payment system for doctors and other health care providers does not support them to deliver early-intervention, comprehensive and preventive care.

A payment system which promotes a more efficient use of providers' time (for example a capitation model, with patient enrolment) would reduce the waste in the current fee-for-service system.

Capitated funding may not suit all consumers or GPs and there are likely to be political barriers to its implementation nationally.

However, there is no reason why capitated funding cannot be used on a more limited basis in cases where both consumers and providers agree that it will promote high quality care. For example, consumers with chronic and complex conditions could be given the opportunity to select a GP (or other relevant health care provider) to manage their care for a 12 month period, with a fixed level of remuneration.

This would provide greater flexibility in primary health care as well as evidence to examine the potential for expanding capitation models.

Workforce issues

The workforce is our most precious health resource. However, our health system is currently not structured to support efficient use of health professionals.

Promoting better workforce practices (such as a team-based primary care) would help eliminate wasteful practices and develop workplaces that support more efficient care.

Longer term strategies to achieve include training more nurse practitioners and other 'intermediate health professionals', alongside medical and nursing students. In the short term, Medicare rebates could be extended to nurse practitioners already working in a primary health care facility, giving consumers a choice of provider and delivering potential savings to Medicare.

Private health insurance

The Australian health system is characterised by significant involvement of both private and public sectors.

We need policies and funding systems which support the efficient use of both sectors, rather than encouraging unnecessary duplication.

The private health insurance rebate is an extremely expensive and uncapped subsidy which has been shown to be ineffective in encouraging uptake of insurance. It also does not meet the needs of many consumers, for example people with chronic illnesses who require regular allied health services.

This money could be better spent in supporting consumer choice through funding which goes to either public or private systems providing best value.

For example, consumers could be offered a choice of a rebate subsidy or direct funding of private health care services to the same value (currently around \$460 per person per year). This would enable people to use this funding in a way which delivers them maximum benefits, whether that is on allied health, over the counter medicines, aids and appliances or other forms of health care.

Conclusion

Regardless of funding level, there will always be a spending limit. We need to ensure maximum benefits from these limited resources.

By focussing on 'spending better', rather than on 'spending more' we can achieve better health outcomes without the need for additional funding. Even in an area as controversial and

politically contested as health care funding, this should be something we can all agree on.

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1. Adam G Elshaug, Amber M Watt, Linda Mundy and Cameron D Willis, Over 150 potentially low-value health care practices: an Australian study, Med J Aust 2012; 197 (10): 556-560



Beyond hospital walls— making the health dollar go further

Alison Verhoeven

With health care costs continuing to rise, and hospitals struggling with increasing demand, there have been calls to overhaul the funding and governance structures in the Australian health system. With hospitals accounting for around 40 per cent of health expenditure in Australia, there is rightly a focus on how efficiently services are delivered, and the various models available for optimal service funding and delivery.

Much of the health care debate in recent months has centred on who owns or delivers the service (public, private, not-for-profit, or a combination of these) and who pays for it (Medicare, private health insurance, or consumers directly as out-of-pocket expenses). The simplistic solution for budget-challenged governments would be to shift the problem to consumers and the private sector. But the elephant in the room is the underlying and untested

assumption that this solution will be cost-effective, affordable, and efficient.

When seeking cost-saving measures in health, it is essential that an evidence-based long-term view is taken – not least because we depend on good decision-making in order to ensure good health outcomes for Australia. Our political leaders must be encouraged to look beyond the temptation to implement short-term budget management responses and lead more substantial debate about investments and disinvestments which will improve the efficiency and effectiveness of the health system and better health outcomes for Australians in the longer term.

One positive step, which would build on reforms already underway, is to consider alternative models of care that have steadily been gaining support and credibility over recent years.

In November 2013, the National Health Performance Authority (NHPA) released

two reports: one identifying the variation between hospitals in the length of stay for patients with same condition, the other highlighting the large number of potentially avoidable admissions to hospitals in 2011-12.

Unnecessarily long stays in hospital and avoidable admissions are obvious areas of waste in the health system and an opportunity for significant improvement in efficiency. The availability of appropriate primary care services and community-based care options is a key factor that influences the need for hospital admission and discharge delays.

Hospital in the Home (HITH) programs are one such option for acute and post-acute care outside traditional hospital settings, and can assist in making better use of an already stretched health budget. HITH programs can reduce unnecessary admissions to hospital, releasing resources to care for those for whom hospital admission is the only option. Decreasing avoidable admissions

can reduce 'bed-block', which in turn helps hospitals achieve emergency department and elective surgery performance targets.

Historically, the financial incentives for avoiding hospital admissions or reducing length of stay were minimal as other patients would always fill the beds and no realisable savings would be made. The incentives that did exist related to freeing up hospital beds for elective surgery patients. This group was a priority as there was often additional funding available for efforts to tackle the highly public and political issue of elective surgery waiting times.

Additionally, the responsibility for funding HITH services was often complicated and debated between the Commonwealth-funded primary care sector and the state-funded hospital sector. The result of this was a lack of collaboration, service duplication and accusations of cost-shifting between Commonwealth and states.

While a Deloitte Access Economics review in 2011 confirmed the cost/benefits associated with HITH, Professor Debora Picone, CEO of the Australian Commission on Safety and Quality in Health Care, alluded to outdated attitudes and beliefs of senior clinicians and managers, particularly in relation to cost, as a major barrier to greater use of HITH programs when she spoke at the annual HITH Society Conference in late 2013.

With the introduction of an activity-based funding model, where hospitals are paid for the actual number and type of services they provide, there is greater impetus to implement HITH models.

While the incentive to drive elective surgery throughput remains, the activity-driven funding model provides the capacity to access funding for both the HITH program and the additional hospital activity that the HITH programs allow.

HITH programs rely on effective collaboration between the acute hospital sector and primary and community care services. Medicare Locals have played an emerging but important role in facilitating cooperation between existing services and supporting the development of new services where gaps existed. Insufficient and uncoordinated primary care services inevitably lead to



Photo: Australian Health care and Hospitals Association

increased demand on acute hospitals through outpatient clinics, emergency departments and hospital admissions. Ideally funding arrangements should be patient-centred, facilitating the right care in the most appropriate environment and reducing unnecessary hospital admissions and presentations. Bundled payment options for patients with chronic or complex conditions should be implemented as soon as possible.

While hospitals currently fund a range of HITH programs, other primary care and community-based providers need a defined funding source to encourage further expansion of services. With increasing pressure on the health system's financial sustainability, the transition of HITH from small locally led "innovations" to a sophisticated component of the overall health system structure is essential.

For many patients, HITH programs provide a safe and effective alternative to a hospital stay. Increased use of HITH programs will free up hospital resources to treat those for whom hospital admission is the only option. This approach has been recognised by the Queensland Government, which has allocated \$28 million for new HITH programs in Townsville and the Sunshine Coast and expanded programs in Brisbane.

The national health reform process has delivered a funding model that better supports the HITH approach. We now need to encourage greater support for HITH from health service administrators and to ensure that the integration of care across sectors is not just a priority but also a reality for health professionals, policymakers and consumers in the years to come.

Alison Verhoeven is Chief Executive of the Australian Health care and Hospitals Association which represents Australia's largest group of health care providers in public hospitals, community and primary health sectors and advocates for universal high quality health care to benefit the whole community.



Memo ministers: why not direct Medicare funds to where they are needed?

John Ferguson

Dear Health Minister Peter Dutton and Treasurer Joe Hockey,

Re: Medicare and its reform

I write in a personal capacity and these views are not necessarily those of my employer, a NSW local health district.

Several years ago I received an analysis of the annual workforce survey conducted by my specialist college, the Royal Australasian College of Physicians (RACP). In the practice of specialist internal medicine, it is widely acknowledged that there are great shortages of specialists in General Medicine, Rehabilitation Medicine and Geriatrics. These are specialties under particular demand in the aging Australian population. At one level, one might say why not ensure that more people to take up these worthy roles? Unfortunately the workforce survey contained bad news- there were very few trainees proceeding into these disciplines- only 2 of 64 trainees. In contrast, 33 of the 64 had chosen to train in the procedural specialties of cardiology, gastroenterology, respiratory medicine and neurology all of which have more than adequate numbers of specialists.

Why? One probable reason is that Medicare particularly rewards those specialties where interventional procedures can be done to the patient. The average Medicare billing amounts compared across specialties provide stark evidence of this. One can closely correlate a specialty's average Medicare income with the number of trainees entering that discipline. A perverse incentive is at work. The RACP does not attempt to redress the situation, however it is apparent that the specialties in the majority in the college do not have an interest in changing the status quo. I believe the situation is similar in the Surgical Colleges, although the added deterrent of high medical

indemnity requirements for certain specialities (e.g. obstetrics) influences trainee entry as well.

Rural Australia is crying out for more health care services and doctors, especially general practitioners but also surgeons and physicians. Amongst the key determinants of whether medical practitioners will move to work in rural areas is Medicare. Basically, Medicare income provides doctors in 'private' practice with income wherever they work. To avoid the significant inconvenience and long hours of rural practice, most doctors opt for the easier option of city practice. As an aside, the use of the word 'private' for practice that is mostly funded with public money is a misnomer. Under current mechanisms, it is almost impossible to target Medicare funding to regions on the basis of need. The Medicare funds go to where the doctors are. This leads to gross imbalance between the per capita Medicare income going to rural regions compared with cities. This occurs in the face of the demonstrated poorer health and treatment outcomes of many people in rural areas, some of which relates to poorer availability of services.

A related problem is that the state-funded public hospitals use Medicare to generate income for patient care. This is the absurd syndrome of 'cost-shifting'. The most adept at doing so are the larger city hospitals. This process then channels even more Medicare funds away from rural areas of need. Most large hospitals now have extensive business infrastructures designed to ensure that whenever it is legal, patient interactions are 'billed' to Medicare. Generally this can be done for outpatients referred for review by a hospital specialist (including laboratory investigations by pathologists) or with medical consultant services for inpatients who elect to go 'private' in the public hospital. As a hospital specialist, I am expected to play my part in cost-shifting. The carrot to me is that my salary gets topped up as a result

with a small proportion of the bills to Medicare in my name (the hospital takes between 40 and 90 per cent of the income as a facility charge). It's a win-win-lose for the hospital specialist, the state health department and the Federal Government respectively- the cost of my salary is subsidised by Medicare and the hospital generates large amounts with the facility charge for general use. However this dysfunctional State-Federal divide in funding produces wasteful bureaucracy and removes transparency from regional health fund allocation formulae.

'Doctor got \$380,000 for bogus operations' went one headline. As reported in the past by ABC's Four Corners, Medicare fraud is difficult to detect and very infrequently results in prosecution. Medicare's Professional Services Review can only detect quite blatant abuses. Unless one is able to analyse every patient-doctor interaction, one cannot know that a particular procedure or consultation was warranted in an actual case. The Medicare system of payment for services rendered is inherently difficult to audit. I am not reassured by assurances that levels of fraud are low. Quite frankly, Medicare has no way of knowing. There are also shades of grey and practices that are designed to maximise income without being illegal. Some of these practices lead to excessive consultation visits, investigations or procedures for patients with relatively minor conditions. The patient often feels that he/she has been managed well and the doctor may defend his/her practice if challenged by saying that he/she was avoiding medico-legal challenge or that there is support for this way of practice in the medical literature.

We deserve better value for the vast sums of public money that Medicare consumes. The Medicare system fails to target spending to areas of need. It is poorly audited and widely manipulated for purposes of state, institutional and

personal gain by some. The whole basis of public health care funding needs to be re-examined to develop ways of reducing waste and encouraging doctors to be trained for geographical and specialty areas of need. A large part of the current doctor 'shortage' is being generated by a maldistribution of available medical staff and trainees that has been the result of perverse incentives created by Medicare. The Medicare system as it currently exists is unable to put a cap on expenditure. It rewards activity and doctors in hospitals and the community are masters at producing and justifying such activity!

More efficient mechanisms for financing health care exist and these should be considered urgently before we pour more good money into the failing Medicare system. For instance, a possible solution for the geographical maldistribution of medical specialists might be to ration the availability of specialist provider numbers for popular urban regions and make location-specific numbers available elsewhere. There are also very good examples from overseas and a wealth of experts in health service design and funding in Australia to consult with.

Good luck with this endeavour!

John Ferguson FRACP, FRCPA.

John Ferguson is a microbiologist and infectious diseases physician. His interests include health care-associated infection and antibiotic resistance and stewardship. He is Chair of the Health care-associated Infection Advisory Committee at the Australian Commission on Safety and Quality in Health care. He provides support for undergraduate and postgraduate teaching for the University of Papua New Guinea and the National Academy of Medical Sciences in Nepal.

Good health is good business



Karen Howard

Health care is in many ways a business; in fact it is very big business. In our region, the Hunter, our Local Health District is our biggest employer. The organisation that I chair, Hunter Medicare Local, represents hundreds of clinicians who are also small business operators.

I am a small business owner myself, having become a board member and then the first non- GP Chair of the former Hunter Urban Division of General Practice. My appointment to this role was, in part, recognition of the need to bring a stronger business focus to the issues of local health care provision.

As a business person I bring a particular perspective to the conversation about achieving a "better bang for our buck" from our health care system. People with a business perspective know the difference between price and value. Perhaps more importantly, I have learnt that a focus on costs without a proper consideration about value is a recipe for business failure. Real value is about viewing a product or service from the customer's viewpoint and delivering on those expectations.

There are some very practical implications to this business view of health care.

Michael Porter, a Business Professor at Harvard Business School and recognised as a world leader in corporate strategy, has used his substantial intellect to examine health care systems¹. His conclusion is that significant changes must be made to health care systems if they are to solve the challenges of an ageing population and the increasing costs of new medical technology.

Professor Porter argues that the central focus for change must be on increasing value for patients — or, the health outcomes achieved per dollar spent. At a practical level Professor Porter suggests that to achieve better bang for the buck, outcomes must be measured over the full cycle of care for a medical condition, not separately for each intervention. Outcomes of care are inherently multidimensional, including not only survival, but also the degree of health or recovery achieved, the time needed for recovery, the discomfort of care, and the sustainability of recovery.

Professor Porter also points out the need for health care systems to

overhaul the delivery of prevention, wellness, screening, and routine health maintenance services. Not only does he say that there is under-investment in preventive health relative to the value it creates, but furthermore, that primary care providers are asked to deliver disparate services with limited staff to excessively broad patient populations. As a result, delivery of such care is fragmented and often ineffective and inefficient.

The implication of Professor Porter's work is that health care systems should be structured so that they are aligned around improving value for patients, reimbursement should move to single bundled payments covering the entire cycle of care for a medical condition, including all providers and services. Bundled payments should shift the focus to restoring and maintaining health, providing a mix of services that optimises outcomes, and reorganising care into integrated practice structures. For chronic conditions, bundled payments should cover extended periods of care and include responsibility for evaluating and addressing complications.



Karen Howard FAICD, chairs Hunter Medicare Local. An advocate for equitable access to health care, she is an experienced business entrepreneur and has been a director and board chair in a variety of organisations across the NGO and government sectors in the Hunter Region for over 25 years. Her current directorships include Hunter Development Corporation and the NSW Business Chamber. She was previously on the Boards of Nova Credit Union, Westpac Rescue Helicopter Service, NSW Small Business Development Corporation and the Hunter Business Chamber.

1. <http://www.nejm.org/doi/full/10.1056/NEJMp0904131>

Most importantly, this strong business focus suggests consumers must become much more involved in their health and their health care. Unless we are able to work with patients and convince them of the need to comply with recommended care and take responsibility for their health, even the best doctor or team will fail. Simply forcing consumers to pay more for their care is not the answer. New integrated care delivery structures, together with bundled reimbursement for full care cycles, should enable vast improvements in patient engagement, as will the availability of good outcome data.

It is interesting that the ultimate consequence of adopting a business approach in health care is to place greater emphasis on the patient experience of care, the patient outcome, greater emphasis on less expensive primary care, better integration of services, and taking a longer term perspective on health investment, health return and patient benefits.

The fact is we have a very good health care system, one that Minister Dutton has said 'compared to other developed countries, we have a system that delivers'. Minister Dutton has also taken a positive position in emphasising the need to improve the prevention and management of preventable chronic diseases (in particular obesity and diabetes). He emphasised that 'one-third of Australia's burden of disease is due to 'lifestyle' health risks such as poor diet, obesity, physical inactivity, smoking and alcohol misuse.' and signals that this will be a high priority for his Ministry. Further encouraging news from the speech was the Minister's acknowledgement that

these issues need be addressed at the primary care level and he indicated that changes to funding arrangements may be on the agenda.

At the Hunter Medicare Local we have welcomed any review of the health system and are very confident that any examination of the system will confirm what has been consistently demonstrated in international studies for more than a decade; the sustainability of any health care system is improved by strengthening primary health care.

It is in this area that Hunter Medicare Local is actively focusing its work, strengthening our local primary health system, reducing the demand for more expensive hospital care, developing a more connected experience of health care, and ensuring more efficient access to quality health services closer to where people live.

Just like business works to obtain the most productive bang for its buck, so should effective primary health care organisations seek to achieve better health outcomes for our community by developing more appropriate measures and accountabilities. It is this stronger business approach that leads to a more patient-centred form of health care.

It is to be hoped that the government will base its review and decisions about health care on evidence. If it does, those of us working in primary care can expect greater investment so we can achieve better value for our community. It seems to me that should be the real goal of all investment in health.

Life and death issues: how the dismal science can help



Nicholas Graves

If Australians are to continue to enjoy high quality health care services things will have to change. In the last 10 years growth in health spending has averaged 6 per cent a year and this compares badly with a growth in GDP of 2.5 per cent a year. It's not hard to see that spending habits need to be change. As governments and private insurers tighten their belts they must choose services that generate good health returns per dollar spent. Services that deliver zero or low health benefits per dollar spent might be reduced. Hard as it seems, we are facing the economic reality of scarce resources.

This will not be nice or easy. Thomas Carlyle, a Scottish writer and historian, described economics as the dismal science because it is about choosing what to do with resources given that we can't meet every need requested of them. The choosing is particularly dismal in health care because after we have decided who gets the services we can afford, there will be groups who miss out on services and they will have less health and die sooner. This is a difficult issue for politicians as voters are likely to be highly motivated when it comes to the health of their families.

The best response to this challenge is good information and planning, and I would propose three things. First is to generate information on the cost-effectiveness of services we currently deliver. Second is to incentivise clinicians and managers to choose cost-effective services, and disinvest from bad value for money services. Third is to implement changes on a large scale, rather than have only pilot projects among health services demonstrating value for money. We need to build a culture of cost-effectiveness inside Australian health services. Bashing doctors, nurses and allied health care professionals over the head with cost-

effectiveness data is a poor strategy. We must value those who deliver care, identify changes that are needed and empower and incentivise health workers to adapt to the reality of scarce resources.

Generating cost-effectiveness information can be done with the existing data collected by health services. When required this can be augmented with information from randomised controlled trials and clinical registers. All relevant information can be assembled into a modelling study that makes predictions of the cost per unit of health gained. Typically the quality adjusted life year is the measure of health benefits. These studies can show us when services are costly and harm patients, and examples might be futile care at the end of life (always disinvest from these); when services are cost saving and benefit health, examples might be falls reduction or infection control (always invest); when services increase costs and increase health benefits, examples might be new drug therapies for cancer (the cost per unit of health benefit needs to be known); and, when disinvesting from services saves a large amount of costs for a small reduction in health benefits, examples might be reducing access to breast cancer screening for low risk groups (the cost saved per unit of health benefit foregone needs to be known).

Incentivising clinicians and managers is likely to require more carrot and hardly any stick. Carrots might be: the provision of data about appropriate treatment plans for certain groups, clear policies and support from health departments, the NHMRC and Royal Colleges; and, public health information campaigns to change public preferences. Two campaigns spring to mind. First might be information about end of life care and some alternatives to dying in a hospital bed, that is a costly and possibly an unpleasant experience.

Second might be a general education campaign about scarcity of resources and the fact that governments will have to explicitly choose the services to provide. Stick might be withdrawing re-imbursements for therapies and treatments that are bad value for money, or monitoring clinicians for unwarranted clinical variations for diagnoses and treatments with rapid feedback to individuals.

Implementing cost-effective services on a large scale requires the information and incentives to be aligned. A large hurdle is inertia in health services, which manifests as an inability to change and improve. Reducing this will require preparation for change, having a capacity for change in terms of people and organisations, identifying the model for implementation that fits the service and organisation, mobilising resources and leveraging from appropriate groups and then working on the sustainability of making the change. An example of this is the recent national hand hygiene initiative that addressed all of these challenges and broke inertia in the system (<http://www.hha.org.au/>). The aims of Hand Hygiene Australia were supported politically, clinically and with resources.

Further activities might be pursued to get a better bang for buck. We might offer education to health care professionals about important topics such as health economics, end of life care, and health law and implementation science. These could be introduced into undergraduate programmes or offered in Masters Degrees. Short courses on hospital campuses might be valuable too, with support from the hospital executive to allow staff to participate. Funding simple clinician initiated research will generate evidence to make large improvements to health services. Clinicians can often see the issue but cannot quantify it or show the

value of the solution with data, and so a partnership with an academic is useful. The Australian Centre for Health Services Innovation (www.aushsi.org.au) has funded 32 such small projects and the first four have identified large cost savings, and these are accompanied by improved health outcomes. Better education and evidence from the grass roots of health services will be a good complement to addressing cost-effectiveness, incentives and scaling up. The McKeon review identified a very sensible plan for improving bang for

buck, one that emerges from evidence and implementation. We hope current governments engage with this plan and prioritise the economics of health services.

Nicholas Graves is Professor of Health Economics with a joint appointment in the Institute of Biomedical and Health Innovation, School of Public Health, Queensland University of Technology and the Centre for Health care Related Infection Control and Surveillance, Queensland Health.

His applied research brings economics to the study of health care. He supervises PhD students, teaches economics to post-graduate students and has made research contributions of international significance, published in Nature, BMJ, AIDS, Health Economics, Lancet Infectious Diseases, The Journal of Infectious Diseases and Emerging Infectious Diseases.



Empowered voices – patients, doctors, politicians - choosing wisely in health care

Adam Elshaug

Scarcely a day passes without news flashing of Australia's 'unsustainable health care system'. Sustainability is a matter of pertinence, no question, but too often the 30 second news grabs focus overly on costs at the expense of an equally important element; quality of care. It's not all about bucks, but achieving the best bang for the bucks invested. And, historically Australia has held an enviable record in this regard around the world. Our health care expenditure as a proportion of Gross Domestic Product (GDP) sits within the average for OECD nations, yet historically we have sat towards the top on performance and outcome measures. Staying near the top is not assured. We are told that only half of care delivered is in line with guidelines, one-third is thought to be waste, and much is not evidence-based¹. With one eye on the short-medium term horizon, the challenge for Australia is to work collectively at holding near (or arguably rescuing) the tenets that once carried us to the status of a world-leading health care system (universality; equity; quality) while re-shaping those components that have lagged Australia's changing health care needs (chronic and multi-morbidity; increasingly specialised and high-tech

care; multiple siloed funders including federal, state, private health insurance, which complicates efforts at care coordination). What would just a few practical win-win ideas for reorienting the health care system look like?

Reducing or eliminating waste

and inefficiency in health care is heralding new avenues for patient and practitioner-led reforms that can achieve an important triple-aim: Improving the patient experience of care (including quality and satisfaction); improving the health of populations; and reducing the per capita cost of health care. For decades we have been formally weighing costs and benefits when purchasing new pharmaceuticals and medical technologies and services, via our Pharmaceutical Benefits Advisory Committee (PBAC) and Medical Services Advisory Committee (MSAC) processes, for example. In recent years, however, recognition has grown that those same principles should be extended for more critical reviews of existing services, those that might have been funded by Medicare for years but where new evidence might question their safety and effectiveness. In Ontario, Canada, an 'Appropriateness Initiative' is targeting health care interventions thought to be inappropriately overused, thereby

placing patients at risk and wasting dollars that could be better used elsewhere in the system². The Ontario initiative has succeeded in reducing the inappropriate overuse of a host of medical services (e.g. Vitamin D blood tests; imaging for low back pain, artificial disk replacements) with annual savings of hundreds of millions of dollars, available for reallocation to other areas of health care.

Empowered Voices: Australia's Department of Health staff have been working on a similar initiative focusing on the Medicare Benefits Schedule (MBS)^{3,4}. A vital ingredient which has led to the Ontario success is the unwavering support from the Ontario Health Minister, in supporting evidence-based recommendations that there be reductions in inappropriate services. The win-win mantra of improving safety, quality and appropriateness of care came with the bonus of freeing resources for better care elsewhere in the system. Some conventional perspectives have held that 'taking something away' in health care risks political backlash. Yet contemporary research is pointing in the opposite direction. As part of an international survey⁵, Australian patients were asked, "in the last 2 years has a doctor recommended a test or treatment

you thought had little or no benefit?” Seventeen percent responded ‘yes’, highlighting that the notion of waste is within the public’s consciousness. Furthermore, work that I have been involved in has clearly pointed out that Australian patients, community members and health care providers, understand the finite nature of health funding, and the notion that difficult decisions must be made when treatment costs expand within a context of limited resources⁶.

Choosing Wisely: A ground-breaking initiative from the United States is ‘Choosing Wisely’. Specialty medical societies representing more than 500,000 U.S. physicians developed lists of Five Things Physicians and Patients Should Question in recognition of the importance of doctor and patient conversations to improve care and eliminate unnecessary tests and procedures⁷. Each list provides information on when tests and procedures may be inappropriate. Some of these measures could lead to dramatic practice changes (e.g. not scheduling elective caesarean sections prior to 39 weeks or not doing imaging for low back pain unless red flags are present). In addition, Choosing Wisely has re-invigorated the concept

of medical professionalism and responsibility for resource stewardship. Is it time for Australia’s own Choosing Wisely campaign?

Doctors, patients, and the community are uniquely positioned to recognise inefficiency in the system but are seldom empowered with the information or avenues they need to reduce harmful spending, until now. The borderline between waste and marginal benefits can be uncertain, so research must continue to identify who will, and will not benefit, from various health care interventions. Political leaders should also harness a conviction to leave a legacy of positive reform. Moving the debate beyond hyperbole and redoubling a focus on safety, quality and efficiency is a good foreground position to take against a legitimate background concern for sustainability.

Associate Professor Adam Elshaug holds a NHMRC Sidney Sax Fellowship and HCF Research Foundation Principal Research Fellowship at the Menzies Centre for Health Policy, University of Sydney. Adam works closely with policy, clinical and patient groups to design and implement reforms aimed at reducing waste and optimizing value in health care. He returned to Australia

in September 2013 after spending 3 years in the USA, at Harvard Medical School and as a Commonwealth Fund Harkness Fellow at the Agency for Health care Research and Quality (AHRQ) in Washington DC and New York City. A/Prof Elshaug sits on the Choosing Wisely International Planning Committee and advises the Australian Department of Health - Medical Benefits Division; Cancer Australia; and NPS MedicineWise.

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Tinkering is not enough to save Medicare



Jeremy Sammut

It helps to think about the major challenges facing the Australian health system as a number of intersecting problems.

The first problem is that Australian governments will struggle to fund the cost of Medicare as the population rapidly ages in coming decades.

The second is that Medicare (with its primary focus on open-ended funding of fee-for-service medical care) does not provide comprehensive care (on-going and full courses of treatment) for the chronically ill. This is an increasingly serious defect given the nation’s

mounting chronic disease burden.

The third is that Australia’s ‘free’ public hospitals are high-cost and low-productivity services. The Queensland Commission of Audit recently found that while expenditure on public hospitals in Queensland had ‘increased 43 per cent between 2007–08 and 2011–12, activity increased by less than half (only 17 per cent)’. Inefficiencies on this scale exacerbate the shortages and queues that plague public hospital systems in all jurisdictions.

The problems with Medicare, in short, are that governments will not have enough money to spend on health; too much is spent on the wrong things (too

much on universal, on-demand access to medical care and not enough on targeted, needs-based chronic services); and we don’t get enough bang (i.e. hospital care) for the billions of bucks that are spent on public hospitals.

These problems reflect how out-dated Medicare has become. Pay-as-you-go, taxpayer-funded public health systems are a twentieth century social policy more suited to an age of relatively cheap and basic health care, and are less suited to dealing with the high-tech, high-cost, and demographic and epidemiological realities of health care in the twenty-first century.

Since 2000, combined Federal, state

and territory expenditure on health has increased by 85 per cent in real terms, and has grown at over 5 per cent on average each year at more than two-thirds the rate of GDP. The Intergenerational Reports have repeatedly warned that the increasing cost of Medicare represents the tip of the iceberg of unsustainable, ageing-related health costs that are projected to swamp government budgets in the years ahead.

Pouring more taxpayer's dollars into Medicare is not an option. Not only is this unaffordable given the fiscal realities we face in the post-mining boom economic environment, but 'more funding' spent in the same ways will not address the fundamental distortions in the health system.

If we do not reform the way health services are financed and purchased, chronic care 'gaps' will persist for increasing numbers of Australians, and waiting times for hospital care will worsen as government's are unable to source sufficient funding to meet demand for public hospital care amidst myriad competing priorities.

Greater cost-sharing and personal responsibility for health care, revised public insurance coverage arrangements involving expanded use of the private health funds, and the introduction of market forces and competition into the public hospital sector are all urgently required.

Reforming Medicare does not mean dispensing with the principle of equitable access to publicly-funded health services for all Australians regardless of income. The key to health reform is to re-configure the way existing public subsidies for health are used to fund current and future health care needs in a more sustainable way and to ensure the right services are available for the right patients.

The health system needs to undergo the a similar transition to that which occurred in the 1990s when the compulsory superannuation system was introduced and individuals were required to self-fund their own retirement incomes to reduce the call on the public pension. We need to shift to a 'save-as-you go' health financing system to shift some of the cost of health off government budgets and onto private sources.

This could be achieved by splitting existing Medicare funding into two new funding streams.

One stream would fund a national

system of personal, 'super-style', Health Savings Accounts (HSAs) into which annual deposits would be made by the Federal government. Individuals would make withdrawals from their HSAs to fund lower-cost health services such as GP visits and basic medical tests.

A second stream would fund a national system of health insurance vouchers, along the lines of the 'Medicare Select' proposal outlined in the final report of the National Health and Hospitals Reform Commission. These vouchers would allow individuals and families to purchase health plans from competing private insurance funds which would cover the treatment of higher cost chronic and catastrophic illnesses.

Older age groups, who have had no opportunity to acquire health savings, would be exempted from participating in the 'New Medicare'. Retirees or near retirees would remain covered by the old Medicare scheme, which would be transformed into an age-limited program, which could be abolished when the health savings/insurance voucher system matures.

The advantages of the New Medicare would include directly addressing the major cost and access problems we face.

Reliance on government funding for health will be significantly reduced over time as health services will increasingly be paid for either out of the funds accumulated in personal HSAs or by private health funds, and not out of taxes.

Because financial risk for members will be carried by private insurers, health funds will have an incentive to properly manage the care of chronic disease sufferers and ensure all clinically necessary care is received to maintain the health of the chronically ill and avoid high cost hospital admissions.

Health funds will also be required to purchase hospital services on member's behalf from either public or private hospitals. Public hospitals will need to address barriers to productivity in order to compete with more efficient private operators. Stimulating genuine public hospital reform will permit the community to receive more hospital services for our increasingly scarce health dollars.

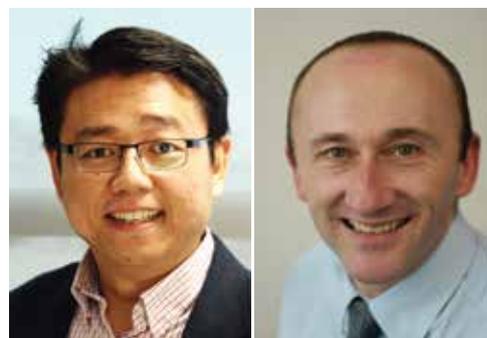
The New Medicare scheme would expand private financing for health, close service gaps by better targeting of services for chronic illness, and improve efficiency in the most costly single area of health spending – the

\$40 billion-plus (and rapidly growing) public hospital sector.

Given what's at stake – the sustainability of the health system and its ability to provide sick Australian's with access to vital health services – now is not the time for tinkering around the edges of the health system. It's time to save Medicare – but not as we currently know it.

Dr Jeremy Sammut is a Research Fellow at the Centre for Independent Studies. He has authored numerous research reports on health policy including: The False Promise of GP Super Clinics (2008), Why Public Hospitals are Overcrowded (2009), and How! Not How Much: Medicare Spending and Health Resource Allocation in Australia (2011). His work has featured in The Australian, The Sydney Morning Herald, The Canberra Times, and The Drum. His latest book, Saving Medicare But NOT As We Know It (2013) is available at cis.org.au.

Getting the right balance in Australia's public and private health care system



Terence Cheng and Anthony Scott

Australia maintains a unique mix of public and private involvement in financing and providing health care services. This mixed approach has allowed the system to strike the often hard balance between its objectives of promoting equitable access to care, cost efficiency and sustainability, and the responsiveness of the health system to individual needs.

In this article we highlight some areas of our health system which can be improved to achieve the “best bang for the buck”. We focus on two aspects of public and private mix: the choice of doctors to work in both public and private sectors; and private health insurance rebates.

Public and private practice by doctors

The decisions by medical practitioners to allocate time between public and private sectors can have important effects on health care costs and population health. In public hospitals, more patients are of lower socio-economic status, in poorer health, and have more complex medical conditions, compared to the private health care sector¹. Do patients in public hospitals have a greater capacity to benefit from health care interventions compared to patients in private hospitals? Will investing more dollars in the public sector lead to greater health gains than investing those same dollars in the private sector? If a doctor spends an extra session in the public sector, will this result in more health gains than if they spent their extra session in the private sector?

Unfortunately, there is very little evidence to answer these questions. In addition to efficiency (ie, examining the changes in costs and benefits of public versus private care), equity issues are also important, such that resources

should be focussed on the least well off regardless of their capacity to benefit. Both the efficiency and equity arguments would suggest that the development of evidence-based policies to influence the allocation of doctors' time between sectors is worth consideration.

There has been little government policy and planning on the distribution of doctors between the public and private sectors despite its potential implications on health outcomes and health system cost. A recent review of the Rights of Private Practice scheme in Queensland public hospitals has found that the scheme is expensive, and has cost the public health system at least \$804million over the last decade since it came into operation². Designing doctors' contracts that include both their public and private practice is important in providing the correct rewards for doctors to improve population health.

There is on the whole little data on the prevalence and nature of doctors' cross sector work. Our research using data from the MABEL longitudinal survey of doctors has shown that close to half of all medical specialists combine public and private sector work, and that there is considerable variation in work settings and remuneration arrangements, both across and within settings³. There is some evidence that doctors are responsive to changes in public and private remuneration by reallocating working hours to the sector with relatively higher earnings⁴. This suggests that policy makers can influence the allocation of time doctors spend in public and private sectors by increasing salaries in the public sector.

Private health insurance rebates

Another way to alter the public-private mix is through changing government subsidies across the two sectors. Research from the Melbourne Institute⁵

and used by the Grattan Institute⁶ has shown that removing the rebate for private health insurance can generate substantial public sector savings, and that these savings more than offset the expected increase in the utilisation of public hospital services. Additionally there is international evidence that the cost of subsidising private health insurance exceeds the fiscal benefits to the public sector⁷. One reason why this is so may be because individuals are not very responsive to price changes when it comes to buying health insurance. Hence a subsidy needs to be sufficiently generous and expensive if it were to be effective in encouraging individuals to take up private cover.

The recent introduction of means testing is a positive step towards promoting fiscal sustainability of government expenditure on these rebates, which was projected to increase significantly if nothing is done to control its growth⁸. The next step should be a thorough evaluation of the impact of means-testing of government spending on rebates, and assess how this policy has influenced individuals' decisions on whether to buy private health insurance, and on the type of coverage.

Conclusion

The receipt of health care in Australia depends on ability to pay. The government subsidises both private and public health care, such that the half of the population with private health insurance can be seen quite quickly in the private sector if they are prepared to pay. It is clear that Australian voters value having this choice, but is the population less healthy as a result? For some, queue jumping seems inequitable and could be inefficient. More debate and evidence is needed that examines whether the balance can be changed to improve efficiency and equity in the health care system.

Dr Terence Cheng is a Research Fellow at the Melbourne Institute of Applied Economic and Social Research. His current research is in the areas of health care financing and physician labour markets in mixed public and private systems. Terence is a member of the Centre of Research Excellence in Medical Workforce Dynamics, the MABEL Australian Longitudinal Survey of Doctors Study. He is also an affiliate of the Health, Econometrics and Data Group at the University of York.

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Health care in The Netherlands – experiences from a natural experiment introducing a leading role for private insurance



Chris Van Weel

In 2006 a reform of the Dutch health care system was implemented, under which single payer private health care insurance was introduced. The main objective of the reform was to introduce market mechanisms to reduce health care costs through insurers' buying the best care for the lowest price for their insurees/patients. The reform was a major move from the health care system that had effectively been introduced in 1941, in which not-for-profit Sick Funds had been the main funders of health care.

The reform was a 'natural experiment' that triggered great excitement and anxiety at the same time^{1,2}. The initial concept of the reform aimed at the unimpeded introduction of market mechanisms and challenged all existing roles, regulations and positions. This included the primary health care structure with general practice as the exclusive point of entry in the system, patients listing with a personal general practitioner (GP) and capitation fees, as the prevailing form of payment for primary health care.

This paper presents a number of experiences with this reform from its conception through its introduction to its current performance, with special focus on how the creation of values and financial incentives are interacting.

Primary health care lead – now as before

A first major revision was inserted before the introduction. While the leading role of primary health care was maintained in the system, every citizen has to take health insurance, and each insurance policy has to cover primary health care as the obligatory entry point for health care. Patients register with a practice and receive all their health care through this practice. Capitation payment has been retained, but its quantum is reduced to about two-third

of practice income. The remaining part is based on a pay for performance basis.

Important in this is that each practice can still define its 'practice population' and allocate specific health risks and needs to this population. A new development in the system is that practices can now negotiate with the insurer for financial support for the provision of additional care, relevant to the needs of that population. Particularly when investment in more primary health care opens perspectives of reducing costs elsewhere in the system, insurers are receptive for this. There are even prudent moves to look beyond health care³, at other sectors of society with health care insurers as co-sponsors. Comprehensive community approaches towards lifestyle and obesity would be a good example.

Rising health care costs – now as before

The reform has been disappointing in two respects. The first was the promotion of prevention. Research had established that there was sub-optimal use of prevention in the Dutch population⁴ and it had been expected that insurers in aiming to provide the best care for the lowest price would focus on prevention. This has not materialised: insurers are reluctant to invest in long term health benefits – with inevitably initial higher costs and premiums – when patients may later switch to their competitors who will then cash-in the prevention benefits. Scientists and professionals lead the drive towards better use of preventive interventions⁵.

The most disappointing experience has been the continued rise in health care costs. In 2011 health care costs represented 12 per cent of the country's GDP and 15 per cent when home care and non-medical geriatric care are included⁶. On average patients pay € 150 (\$Aus230) a month for their health insurance. Market mechanisms

apparently were unable to stem this tide and health policy is directed at a 'regulation' of the health care market. Concepts like necessary interventions, waste and spurious care are heading the political agenda again. An interesting experience, though, is that the focus is on hospitals and (sub)specialist care. This is in marked difference to the experiences in the 1990s when health policy had been very successful in strengthening primary health care and achieved a major shift of more health problems treated completely in primary health care – from 90 per cent in 1989⁷ to more than 96 per cent in 2001⁸. The subsequent investment had not been backed-up by a targeted reduction of secondary care. Currently, rationing of specialty care in the form of concentration of specialist interventions in designated hospitals, reductions of hospitals and limits to specialist interventions are high on the agenda. The positive of this in itself disruptive process is that the 2006 reform has helped to look at the health care system in its totality and identify the strength of person- and population-centred primary health care. The challenge is to allocate a hospital and specialist's function in balance with the primary health care function.

The perversity of incentives – now as before

Given the problems of making financial ends meet, there has been an upward pressure on insurance premiums. Increasing premiums has been considered unattractive, as this might hamper competition and movement of patients between insurance companies. An alternative way to cover the rising costs is an 'out of pocket' contribution from all insurees. This contribution is a flat rate for everyone, on top of the insurance premium. The insurance schemes are required to cover the basics: relevant, effective health care. Reduction of the

insurance package offers companies cost saving opportunities, but the margins are small in removing cover for extras like complementary medicine, aesthetic interventions including cosmetic surgery, physiotherapy and dentistry. In the search for ways to cover rising health care costs, co-payment of interventions a patient/insuree has undergone, has been considered. But this has thus far not been introduced as their impact is uncertain. Co-payment of primary health care may reduce costs in that sector but lead to a shift to more costly interventions in other sectors and result in higher overall costs in the long term. Co-payment of hospital and specialist interventions may lead to delays in important treatment and further costs downstream.

In conclusion, the 2006 health care reform failed in its first objective: to reduce the level and increase in health care expenditure. But it changed the performance of the system, by mobilising the flow of financial resources across sections of the system. This resulted in the possibility of additional funding of extraordinary care plans.

The experiences forced insurers and policy makers to look at the system as a whole, identifying cost levels and wasteful spurious interventions in the hospital sector as important determinants of rising costs. Most positive is the further development of community based primary health care and general practice.

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Changing the script: curbing the cost of medicine by automating prescriptions by active ingredient



David Baker

Leaving the doctor's with a script is a common experience. In 2010 the Australian Bureau of Statistics reported that 81 per cent of GP visits by people aged 15 years and over resulted in patients leaving with a prescription. *The Medical Journal of Australia* also reported in 2010 that nearly 70 per cent of prescriptions are repeat prescriptions. However, the extra cost of a prescription on top of perhaps having just paid to see the doctor can be unwelcome – especially when we are sick.

This article offers straightforward procedural change to prescribing medicine that could be used to curb out-of-pocket expenses.

The Medical Journal of Australia reported in 2007 that a third of Australians perceive the cost of prescription medications to be a 'moderate to extreme' burden and the ABS found that in 2008 almost 1 in 10 people delayed purchasing or did not purchase the medication they had been prescribed because of the cost.

The cost of medication can be further extended through the addition of a brand premium. In 2009-10 16.7 million prescriptions were dispensed with a brand premium. In 2013 the average brand premium payable for PBS listed medications was \$3.72.

Savings are available, however, through the distribution of generic medications. A generic medication is a product that contains the same active ingredient(s) as a brand name medication but generally costs less.

A 2010 article in consumer magazine *Choice* about the price of medication reported that prices vary considerably between pharmacies. For example, the cost for the common antibiotic amoxicillin ranged between \$6.50

for a generic brand and \$12.00 for the branded Amoxil option. The average price reported by the PBS was \$10.77. In the financial year 2009-10 there were 2.4 million units of this medication dispensed which adds up to \$25.8 million. If every prescription for amoxicillin had been filled with a generic option costing \$6.50 Australians would have saved \$10.2 million.

The generic medicines lobby has claimed that the public's reported trust in doctors together with the prescribing habits they employ may help partially explain why generic medications accounted for only a third of dispensed medicines in 2008-09. In the decade to 2007-08 the rate of prescribing generic medications was steady, averaging 14 per cent of prescriptions (University of Sydney and Australian Institute of Health and Welfare).

In a 2008 *Choice* survey of 180 Australian GPs it was found that drug companies have an inappropriate level of influence over the prescriptions made by some GPs. This influence was found to outweigh the reported reliance on material produced by the National Prescribing Service (NPS) with only half the doctors surveyed reporting an awareness of this government body. The potential for doctors to help Australians save on their health bills by prescribing and promoting generic medications is undermined by the influence of pharmaceutical companies.

A 2011 NPS awareness campaign aiming to promote awareness of active ingredients advised how to identify medicines by their generic name, rather than by the medication's brand name. The campaign also pointed out that in some cases you can choose which brand of medicine you buy, but it stopped short of encouraging people to switch to a cheaper generic option.

Despite such awareness campaigns, the influence of medical professionals can conflict with this message. As a result consumers can be 'reluctant' to choose generic products unless they receive 'specific advice' from their doctors or other prescribers (see Consumer Health, 2007 document). The NPS reported in 2007 that one in two patients would not use generic medication without first checking with their GP.

The Government introduced incentives in 2008 to encourage pharmacists to promote generic medications. The value of incentives (\$1.56) is half the average brand premium (\$3.72) a differential this is likely to hamper the success of this approach to curbing the cost burden of medication.

There is another option. In 2008 the *National Health (Pharmaceutical Benefits) Regulations* were changed to prohibit a default setting in computerised prescription software that checked the "no brand substitution" box on prescriptions. This box is available for doctors to check if they believe that changing the colour or shape of a medication may cause confusion for the patient. The previous default setting to this option irrespective of a patient's needs effectively closed out many options to purchase cheaper generic alternatives.

A 2010 study published in *The Medical Journal of Australia* found this amendment reduced from 27 per cent down to 1 per cent the number of prescriptions for antibiotics in which the "no brand substitution" box was checked. This successful example highlights the potential that exists for government action to positively affect the amount Australians pay for medication.

A further change to the setting of prescription programs could further



increase the proportion of prescriptions filled with generic options.

There are existing computer programs for prescriptions that have an 'equivalency' function which lists all medication options that contain a specific active ingredient. By requiring a default setting that uses the active ingredient – except where the “no brand substitution” box is marked – it has the potential to achieve similar success to regulated changes to the default setting passed in 2008.

Automatically prescribing medications by their active ingredient would reduce reliance on consumer awareness of generics and incentive payments to pharmacists, with cost savings for individuals and the government.

Additional costs are faced each time a service is charged over the scheduled fee or a brand premium is paid for medication when cheaper generic options are available. The market-orientated policy option of paying incentives to service providers rather

than regulating aspects of the referral or prescription process (which have been successful in the past) identified in this paper inevitably adds to the cost pressure on the health budget.

While governments may be historically tied to a model of private health provision, a choice between regulatory or market approaches to future operational and funding legislation and reform remains. This paper identifies operational and procedural changes that could be acted on immediately with positive outcomes for the health budget of households and the government.

David Baker, is Research Director at the Australia Institute. He has a Bachelor of Arts (Sociology) from Latrobe University and is currently studying for a Masters in Criminology. Formerly an automotive designer, he has also written extensively on the social welfare safety net and who is missing out, suggesting policy to ensure more equitable outcomes. He is working on the Australia Institute's equity research stream

Australian health and welfare funding: a review is timely



Paul Gross

Our health care system will generate national health expenditure of about \$158 billion in 2014, roughly 10 per cent of GDP.

This will be funded from our taxes, our private health insurance premiums, our uninsurable co-payments and our investments in companies that own hospitals and aged care facilities.

National health expenditure is rising at two percentage points faster than real GDP. That growth rate is unsustainable with other demands on the public purse. The current health care system is inefficient and we need to retool it to create less expensive care of the chronically ill and disabled, we need new funding sources to pay for that retooling, and we also need to increase GDP by reducing the tax share of GDP.

If the 6.4 per cent extra needed for health care, disability and aged care were funded by taxes, we would see a 6.4 per cent fall in real GDP per capita by 2059/60, and 1.2 per cent by 2023.

It is time to talk about the long-term drag of health and welfare entitlements on economic competitiveness, and curtail middle-class welfare by fairer means-testing of benefits and access to health care.

Hopefully the Commission on Audit did not waste its time on the \$6 GP co-payment as a short-term budget-balancing fix (\$750 million over 4 years) or as a price signal to reinforce personal responsibility. There are far larger sources of waste that have been ignored by successive governments.

We need to remove four inefficiencies in Medicare and private health insurance:

- the impact on access caused by quick fixes to the MBS and PBS by the last five governments that left other holes;
- the dangerous combinations of overlaps and gaps that will blunt the

intended gains from new government commitments to mental health services and the NDIS;

- the untidy mess in health insurance rebates and regulation constraining benefits for more appropriate care and incentives to change unhealthy and costly behaviours; and
- the untouched losses in national productivity due to high hospital readmission rates and adverse events affecting about 10 per cent of overnight stays.

Medicare quick fixes have created new financial barriers to care

The Consumers Health Forum released a report by consultant Jennifer Doggett, showing 18 per cent of national expenditures on health care are from uninsurable co-payments for GPs, specialists, diagnostic tests, drugs, dentists, nursing homes, home care and other products and services.

The CHF report came after the Commission on Audit received a submission suggesting that an extra co-payment of \$6 per GP visit should be introduced as a price signal to patients and to reduce Medicare outlays by \$750 million over four years. CHF also noted that around 14,000 persons had sought to access their private superannuation to pay for medical bills, and 8,000 had been given such access.

An OECD report last November reported that in Australia in 2011, 22 per cent of poorer patients, as against 12 per cent of richer patients, did not visit a doctor or fill a script when they had a medical problem.

A major cause of the current co-payment mess is that successive governments – in one-off fixes – have created an MBS safety net and a PBS safety net but there is no safety net for allied health care, dental care or aged care.

Even worse, from 1 January 2014 Medicare will provide 3.5 million children whose families receive Tax

Benefit A with up to \$1,000 of dental care every two years, but the dentist average fee is 20 per cent higher than the Medicare payment, there will be more co-payments from the start.

And in January, Medibank Private announced a trial that would give members more access to GPs at no cost. The immediate reaction is this will create two-tier GP access, exacerbating the current access problems of the uninsured.

New promises for mental health and disability are not creating more efficient and integrated services for vulnerable Australians

A Medibank Private/Nous report in 2013 concluded that Australia spends about \$14 billion on the direct costs of mental health care. The Better Access program was launched with a 4-year budget of \$538 million, but with the pent-up demand the costs blew out to \$2 billion over four years. One estimate has costs rising to \$50 billion by 2025 if mental health services are based on today's payment models. We have unmet demand.

Australia has launched a national disability insurance scheme (NDIS) covering 410,000 persons as the first priority, with the Government Actuary estimating the first year cost at \$22 billion. The previous federal government committed \$8 billion, but with uncertainty about whether this includes the current \$3 billion. Assuming the States provide their current \$5 billion, there is a \$9 billion shortfall at start-up – and some experts think the real cost will be \$29 billion.

At a February 2014 Senate hearing, mental health experts said that they cannot yet tell whether the disabled mentally ill will get access to NDIS subsidies. The mentally disabled are threatened with a reduced disability support pension when they work 30 days and they have to await a review to retrieve a full pension if they lose their job.



Rather than separate funding of mental health, disability and care of the chronically ill, with the shortfalls in funding and the impact of higher taxes on national economic growth, it is time to ask: does Australia need new types of insurance with incentives that return the disabled to work as soon as possible, prevent or delay chronic conditions that cause disability in retirement, and encourage informal care and self-care where feasible?

Private health insurance is over-regulated and hospital-driven, and we are wasting an opportunity to create new funding for care of the aged, chronically-ill and disabled outside hospitals

The current government subsidies draw complaints from private owners of aged care facilities. We need new government incentives - not necessarily higher subsidies for institutional care - that cover more non-hospital care for aged and chronically-ill, and which also create incentives for healthier lifestyles and self-care management up to and in retirement.

Two pillars of aged care are the private aged care sector and the informal carer providing 80 per cent of the home care. The former, watching the levels of patient acuity rise in nursing homes with staff untrained to offer acute care, can see new roles for aged care providers in preventing a hospital admission with subsidies that retrain staff for the higher acute load.

The latter, family and friends who are the informal carers, need better financial protection – and politicians need to think about the future of informal

carers as we age. For them, it is time to think about long-term care insurance that pays for informal home health care and for formal home care provided by professional carers. A next step would allow households to quarantine 1 or 2 per cent of superannuation savings to pay for new types of coverage for home health care, with incentives that reward households for self-care, informal care and healthy behaviour.

To get to that point, we need a Productivity Commission review of today's private health insurance rebates and regulations that impede product development. That review should assess how the 30 per cent rebate and a completely dysfunctional retrospective risk equalisation pool can be transformed by a new regulatory framework administered by PHIAC and by a prospective risk equalisation scheme for insurers that takes into account age, gender, multi-morbidity, and disability, encouraging insurers to pay for interventions that prevent or delay morbidity and disability. Recent German reforms are instructive.

Efficiency gains by getting serious about waste in hospitals

The two largest causes of preventable hospital inefficiencies are unplanned readmissions to hospitals, and adverse events (surgical and medication mistakes and in-hospital infections and falls).

About 20 per cent of all admissions to acute hospitals are potentially preventable by better primary care, better care management in nursing homes, IT-driven coordination of patient care and incentives that pay more for

measured quality of care.

Such measures would save \$6 billion per year. We can buy a lot of home care, community care and transitions care for \$6 billion per year.

To ignore these four reforms is to fan the damaging epidemic of mural dyslexia, the unwillingness of politicians to see the writing on the wall when we have an ageing society with unfunded care needs.

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Production Editor: Fiona Walls

Publisher: Consumers Health Forum
of Australia Ltd

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© Consumers Health Forum of
Australia Ltd 2012

ISSN 1835-5862 (Print)

ISSN 1835-8810 (Online)

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