

THE GOVERNMENT'S HEALTH REFORMS: FILLING THE GAPS TO MAXIMISE POTENTIAL GAINS

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Performance of Australian health system

1. Health outcomes

- Amongst the best in terms of life expectancy, years of healthy living etc
- Exception of Indigenous health

2. Equity

- Universal health insurance coverage
- Copayments may be limiting access by some
- Serious problems for Indigenous Australians
- Problems also in rural and outer metropolitan areas (though no more than other nations)

3. Cost

- Total around OECD average
- Some strengths re cost effectiveness (eg PBS)
- Weaknesses re resource allocation, growth in services per capita, high rates of hospitalisation, substitutability of high for lower cost services

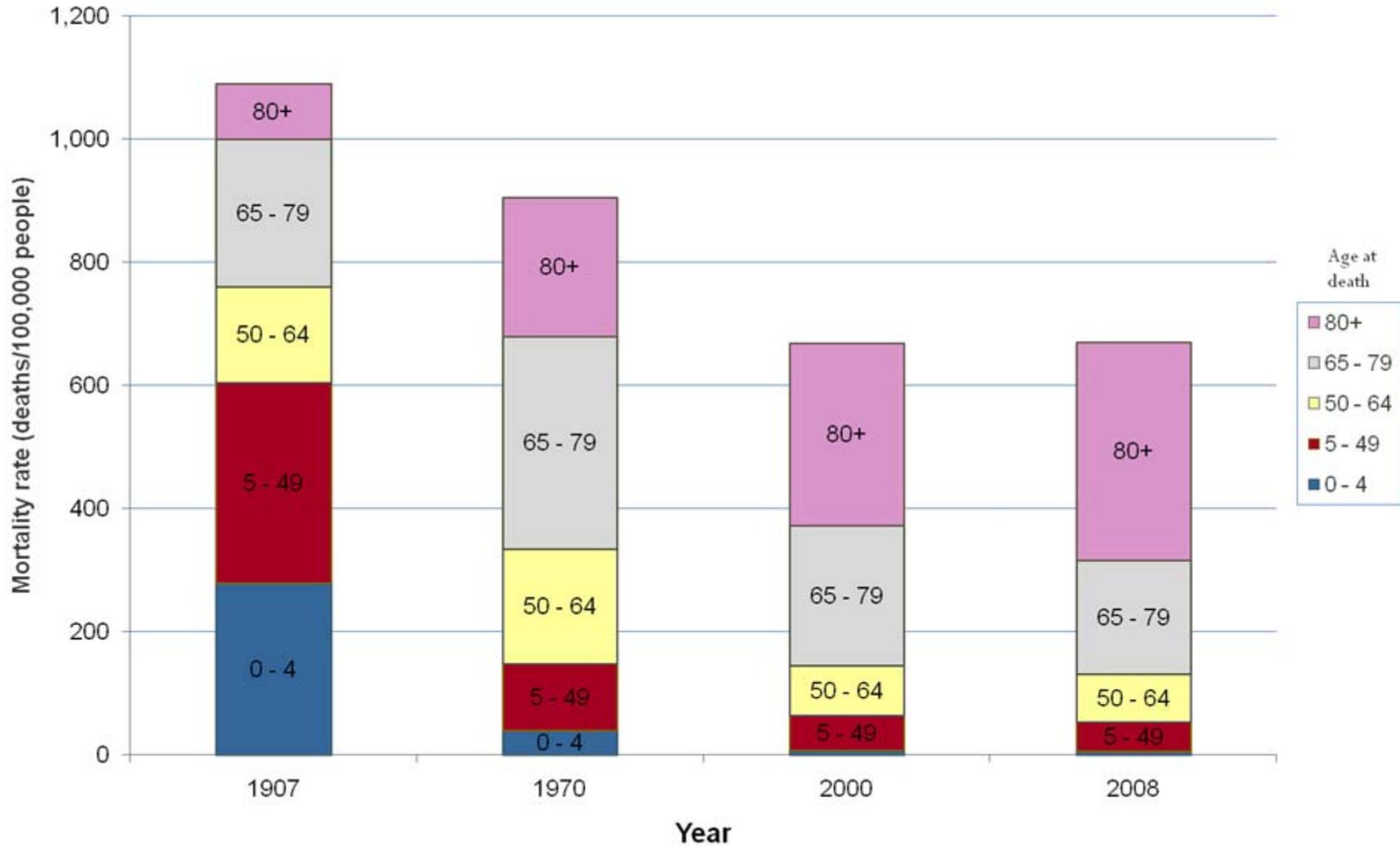
4. Satisfaction of participants

- Waiting times around par
- Quality and safety around par
- GPs relatively unhappy still (?)

New challenges

- Flipside to our successes in increased life expectancy
- More frail aged, more 'chronic illness'
- Increased 'lifestyle' health problems
- Combined financial pressures from ageing and new technology
- Demand for patient control, choice given more wealth and information
- Workforce pressures from ageing, lack of flexibility, geographic distribution

Changes in Mortality Rates 1907 to 2008



Australia's systemic problems

- *Stovepipes* – based on types of services and service providers, not on patients
- *Exacerbated by different funders* – with cost-shifting, blaming, excess bureaucracy
- *Not conducive to best patient care* – particularly for complex and chronic conditions
- *Allocative inefficiency* – between streams of services, regions and communities
- *Lack of flexibility* – including in workforce
- *Incoherent public / private arrangements* – PHI, copayments: insufficient competition and inadequate incentives for efficiency

Structural Reform Priorities

1. *More patient-oriented system*

- Rather than input and provider oriented system
- Particularly through strengthened primary care

2. *Improved efficiency*

- Reduced cost of outputs, improved cost effectiveness
- Greater flexibility to shift resources to ensure most appropriate mix of care services for different groups

3. *Improved use of information technology*

4. *More coherent copayments*

- Encouraging personal responsibility while not imposing barriers to care

5. *Better use of competition*

- Particularly amongst providers, and increased choice

6. *More flexibility in the health labour force*

7. *Financial arrangements which encourage improved outcomes*

The Government's Reforms

1. 'Reforming fundamentals' including funding and governance

- Commonwealth as dominant funder with increased direct involvement
- Activity based funding of Local Hospital Networks
- Full financial responsibility for GP and primary care including outpatient services
- Transparent reporting against national standards
- Revised GST arrangements with Commonwealth accepting more of the risk re future costs

The Government's Reforms

2. 'Changing the way services are delivered'

- New funding arrangements to give C'wlth incentives to pursue integrated care, keep people out of hospitals
- Expanded access to care outside hospitals including primary care (eg super clinics), aged care and sub-acute care
- 'Medicare Locals' to promote integrated care, better access, report on regional performance of system
- C'wlth full responsibility for aged care (including HACCC) and, over time, for sub-acute care
- New chronic illness care (starting with diabetes)
- Investment in e-health

The Government's Reforms

3. 'Providing better care and better access to services for patients right now'

- Additional funding for hospitals
- Additional funding for GP 'super clinics' etc
- Additional funding for workforce training places
- Also for aged care places, mental health, e-health, prevention
- In addition to earlier investments from 2008 National Health Care Agreement, increased beds, workforce (particularly in regional and rural areas), 'super clinics', Indigenous health, prevention, research and training
- More foreshadowed for mental health, dental health

(Despite importance of this new money, my focus today is on the structural reforms; arguably, a better balance of the extra money would have achieved more to reinforce the structural reforms.)

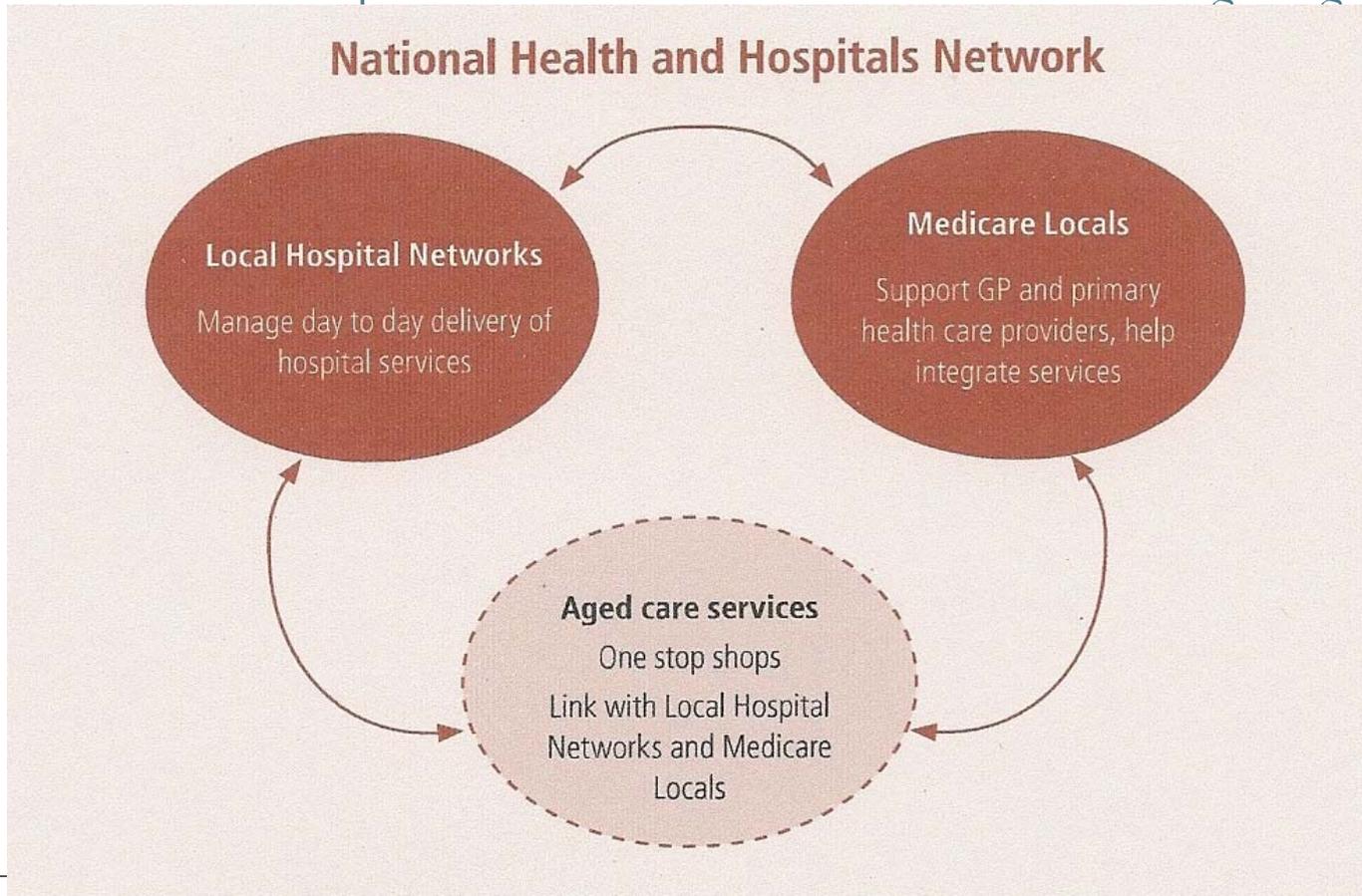
First Round Assessment against Structural Reform Priorities

- Patient orientation – some potential gain
- Efficiency – considerable potential gain in technical efficiency, and some possible in allocational efficiency
- Information technology – some potential gain
- More coherent co-payments – no advance
- Better use of competition – some improvement re hospitals, no advance re choice
- Labour force flexibility – some gain
- Financial incentives – some potential gain

A. Regional arrangements

Gaps, weaknesses and risks

- How will primary care, aged care and acute care work together on the ground?
- Will there be any new capacity to shift resources between types of care, or between regions?
- Risks of continued hospital domination and new boundaries limiting integrated care



A. Regional arrangements

Implementation priorities

- Set the right regional (and sub-regional) boundaries
- Build the capacity of the Regional Primary Health Organisations
 - clarify their role in system-wide planning and reporting, not providing
 - give them purchasing capacity to address gaps, particularly in poorly resourced regions
 - give them clout and bureaucratic support despite their ‘independence’
 - complement their role with further MBS reforms supporting integrated care
- Review the size and governance of the LHNs
 - more local than regional
- Aged care
 - clarify who owns triage and care management (what and where is one-stop-shop?)
 - integrate HACC into articulated care assessment and service access schedule from lowest to highest care
 - involve Primary Health Organisations in developing clear regional plans and targets that providers can respond to

B. Hospitals:

Gaps, weaknesses and risks

- What is the 'efficient price'? Who in practice manages case-mix? Who bears what risks?
- Size of LHNs: local or regional?
- Responsibilities of LHNs and relations with both states and Medicare Locals
- Planning and funding infrastructure
- Risks of states resisting devolution, hospitals lacking genuine local community and professional involvement (or excessive self-interest), hospitals dominating health system

B. Hospitals

Implementation priorities

- Holding firm on the governance reforms, ensuring genuine devolution of authority, professional boards etc, subject to transparent performance reporting
- Ensure State service agreements are akin to ‘commissioning’, and respond to Primary Health Care Organisation plans
- Setting the ‘efficient price’:
 - Major policy issues to be resolved including marginal or average pricing, re-insurance arrangements, treatment of capital
 - Related issues concerning the design of the regulator
 - Important not too parsimonious – give time to press major productivity gains
 - Must provide most hospitals with considerable certainty, real incentives for innovation and limit capacity for State political interference
- Note that longer-term reforms such as introduction of extended DRGs only possible with single government funder

C. Commonwealth and State Structures

Gaps, weaknesses and risks

- How will Commonwealth agencies restructure? How will all the agencies work together in the portfolio? Where will Medicare Australia fit? Where is capacity to go beyond diabetes to develop effective strategies to manage chronic illness? Will there be regional offices or planning units? Who employs community health workers?
- How will the States restructure? How much will transfer to the Commonwealth and how much disappear? Will States' centralist culture change? What do they see as their long-term role now?
- Risks
 - Excessive bureaucracy
 - Insufficient regional support
 - Lack of coordination nationally
 - Excessive political involvement at state or national levels
 - Excessive influence of clinicians and other providers
 - Disruption to existing patient care

C. Commonwealth and State Structures

Implementation priorities

- **Establishing high level implementation teams**
 - National team linked to joint teams in each state and territory
 - Cultural change essential re shared learning during (and after) initial implementation
 - A clear, shared communications strategy linked to a broad and public implementation schedule, allowing consultation on details at different levels to be managed without raising expectations too high
- **Commonwealth**
 - I understand structures review already underway
 - More than just managing the bigger national agenda (requiring early moves to support Regional Primary Health Care Organisations and to transfer certain State staff to C'wlth)
 - Need for re-vitalised 'insurance' role, analysing health and financial risks across the system and developing national strategies to address them (could be achieved by splitting Medicare Australia, handing Medicare offices etc to Centrelink and bringing back into Health portfolio the central purchasing and insurance roles)
 - Split of policy from administration almost certainly required, but not until initial reform measures introduced; regulating agencies linked primarily to the administration agency, but all feeding into the policy department
- **States**
 - Restructuring central departments for new, devolved environment for hospitals
 - Develop plans to transfer relevant staff to Commonwealth (primary care, aged care)
 - Plan for inevitable downsizing of departments

D. Wider health system and its interests

Gaps, weaknesses and risks

- How can consumers, providers, professional organisations, NGOs etc contribute to implementation?
- How might doctors be encouraged to cooperate?
- How will private hospitals react? Will/should they look in future to expand public patient rather than private patient care?
- What is the future role of PHI, particularly given guarantees over public patient access to elective surgery?
- Risks
 - Lack of incentives for various players to cooperate, provide integrated services, pursue efficiencies
 - Limited choice and competition, excessive government control

D. Wider health system and its interests

Implementation priorities

- Importance of communications strategy
 - Engaging local communities, providers and their organisations, as well as national organisations and the public at large
 - Importance of language, stories, relevance to patient journeys, tangible and realistic
- Doctor incentives
 - Involvement in LHNs and Primary Health Care Organisations
 - More emphasis on MBS reforms rather than top-down ‘super clinics’
- Role of private hospitals
 - Clarify that LHNs not states will have authority to purchase public patient services from local private hospitals
 - Future role re private patients depends upon future role of PHI
- Clarify intentions re PHI
 - Drop the means-test/increased surcharge nonsense?
 - Consider instead Henry approach (if not NHHRC’s Medicare Select), with subsidies based on firm provision of Medicare-covered services?
 - Or let them wither as implied by Gillard’s 2004 ‘Medicare Gold’?
 - Debate hinges on philosophical view re choice and equity
 - Incremental moves only possible until Commonwealth has full financial responsibility for Medicare

Conclusions

- Reforms are substantial, with considerable potential gains
- Inevitably there is devil in the detail
- Good implementation can address many of the gaps, weaknesses, risks
 - Most notably the lack of detail on how an integrated system will work on the ground, and in Canberra
- This requires some hard decisions and firm action to complement the big dollops of money
- But there also remain very substantial issues to be addressed in the future, including:
 - Serious control of total costs, particularly to manage demand
 - Rationalising copayments
 - Reviewing aged care financing
 - Clarifying the role of PHI
- Until there is a single government funder/purchaser, the gains will be less than optimal