Australian Health Care Reform Alliance
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Achieving Equity & Efficiency in paying for health Care

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Definitions of Equity

i) **Horizontal equity** **equal access for ALL for equal need**

ii) **Vertical equity** **greater access for greater need**

iii) **Equalisation of health** **– reduce/minimise avoidable differences in health outcomes 'Close the gap'**

What type of funding & delivery models will contribute to equity?

i/ii) Access to health care for ALL a/c need

1. **Zero/minimal 'out-of pocket payments'**
   → **fund via taxation a/c capacity to pay**

2. **Resources to patients/citizens a/c need**
   → **risk/needs adjusted capitation funding**
   → **NOT a/c provider location**
   → **NOT a/c Capacity to pay (can't pay to jump Qs)**

3. **Accessible - can (will) get to services**
   → **geographic distribution, outreach, supported transport**

What type of funding & delivery models will contribute to equity?

i/ii) Access to health care for ALL a/c need

4. **Quality guaranteed - regardless of where care obtained**
   → **training, accreditation, quality audit, accountable**

5. **Comprehensive**
   → **cover ALL services core to health & wellbeing**
   (dental, allied health, health promotion, mental health, child health, ambulance not just medical)

6. **Appropriate – will want to use services**
   → **culturally, language, respectful, welcoming**

What type of funding & delivery models will contribute to equity?

iii) Reduce health disparities

Identify groups with poorer outcomes (well known)

Promote access to high quality, culturally relevant health care & promotion for these groups

through

- **Targeted programs – developed by/with communities + LT commitment**
- **Funding level preferably > needs adjustment**

Arguments against tax funded universal health insurance with zero/low co-payments

Cost on Government 'not sustainable'?

But

- Aust spending on health 16th in OECD @8.8% GDP (2006)
- Govt share 6th lowest in the OECD at 68% (2006)
- By 2033 health will cost est 10.8% of GDP (< USA, France, Switzerland) Vos et al *Projections of health care expenditure by disease for Australia to 2033*, Canberra AIHW,2008
- For society the Q is total resources allocated to health **not** cost to govt. → adopt the most efficient & equitable model.
- Policies to support PHI → ↑ in PHI have increased (not↓) in cost to govt.

Arguments against tax funded universal health insurance with zero/minimum co-payments?

Moral hazard? → Excessive consumption

But

- High patient payments
  → indiscriminate reduction in use of health care
  → poorer health outcomes esp. for low Y
- Better ways to target health care at those with clinical need:
  - inform/empower consumers
  - clinical guidelines/clinical audit
  - performance-based funding
  - vouchers
  - gate keepers
  - capitation funding

Arguments against tax funded universal health insurance with zero/low co-pay

Won't support private providers?

- Universal/tax funded insurance obviously consistent with private clinicians (eg MBS, PBS) and private hospitals (eg Vet Affairs). Funding separate from provision

Won't support consumer choice?

- Can still allow choice of provider and choice of insurer under 'managed competition'
- Evidence that choice especially especialy of insurer not necessarily desirable

Efficiency

What do we mean by efficient health system?

Maximise wellbeing for resources allocated

i. **Least cost w/o compromise to quality**
ii. **Appropriate mix of services**
iii. **Incorporate incentives that promote dynamic efficiency**

Funding & delivery model for an efficient & equitable health system

i. Least cost w/o compromise to quality

1. Accountable/measurable
2. Quality driven/quality audit
3. Adopt standard industry approaches to cost control (eg democratise work place/healthy work place, lean thinking, computerised info systems)
4. Adopt suitable payment models – still debate but all need accountability processes
   - Throughput/FFS (compromise quality, least flexible)
   - Salaried (promote flexibility, compromise thruput?)
   - Capitated + enrolled popn (promote flexibility, LT a/c)

Funding & delivery for efficiency

ii Allocative efficiency

- Promote more c-e services (>benefit /$)
- Defund not c-e (<benefit/$)
- Requires
- Evidence on costs & benefits(health + xxx)
- One funding threshold for all services/health technologies
- Flexible Supply - resources can move between programs, settings, services, health professionals
- Flexible models of care

  1:1, 1:>1, >1:1 IT/phone,

  health professional based on competency

Funding & delivery for efficiency

iii Dynamic efficiency

= 'correct' incentives/signals not distorted by market or policy failure

Empower consumers to 'drive' the health system

- Knowledge/skills/confidence re own health, health behaviours, health care

Ensure responsive supply system

- Level playing field - not discriminatory funding eg pharmaceuticals, medical services
- Flexible delivery models
- Choice of provider, dependent only on competence

Funding & delivery for efficiency

Address other attributes of market failure eg

- Externalities – adjust pricing eg ↑ tax where –ve spillovers (alcohol, tobacco) so individuals & producers face true cost; subsidize where +ve spillovers eg vaccination, fruit & vege
- Public goods – directly fund (clean water, food safety, etc)
- Merit goods – intervene in adoption of harmful behaviours esp. wrt children (eg drug & alcohol use by parents, esp during pregnancy early child hood).

Comment on current Australian health funding & deliver: Sources of inefficiency

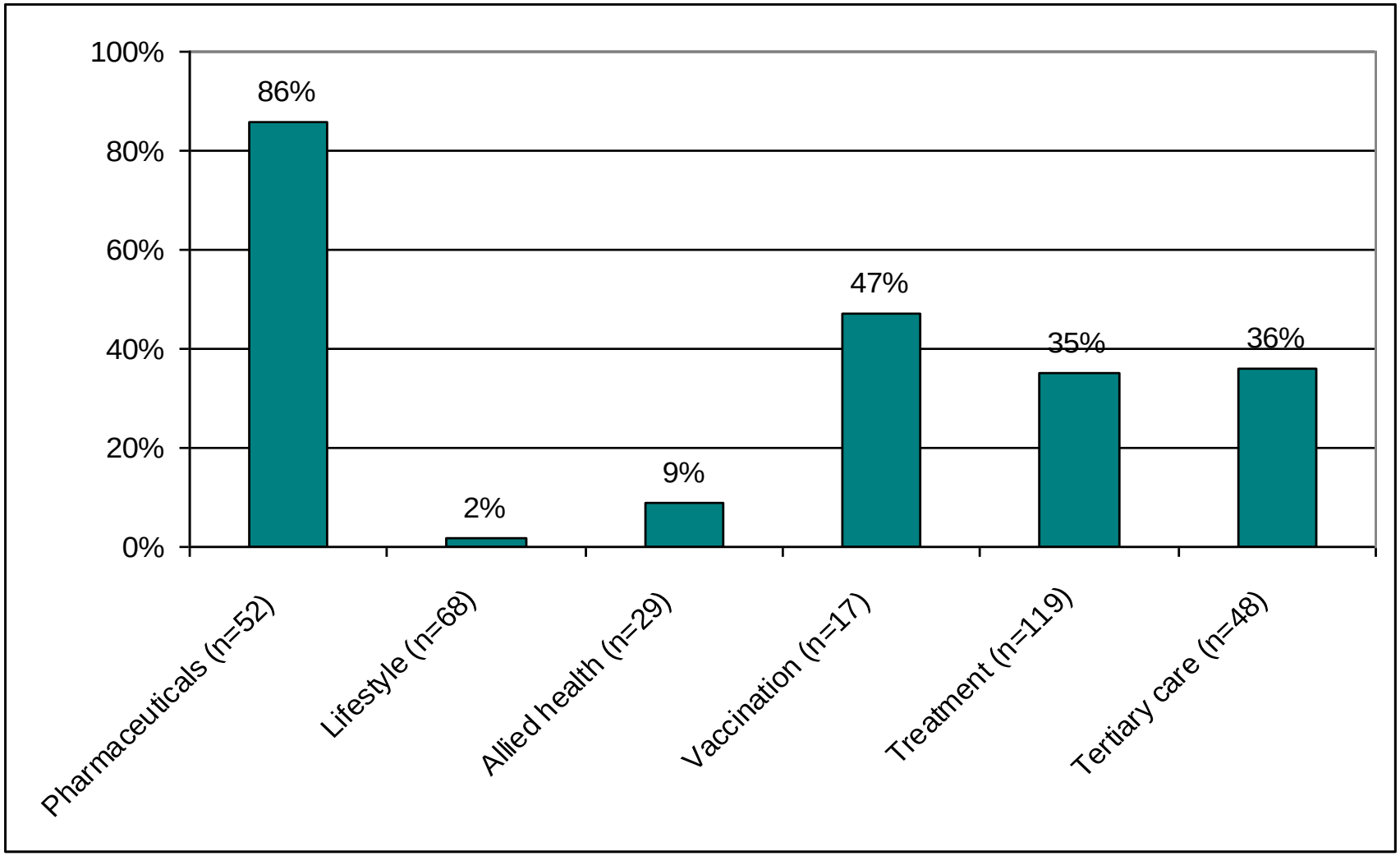
1. Disempowers consumers/citizens - Provider driven
2. Supply
   - Unresponsive: nature of FFS, program-based funding
   - NOT LT, holistic, or whole of life
3. Lack of accountability/quality audit/clinical governance
   - No patient identifier/electronic health record
   - Funding not tied to quality
   - Spilt/unclear responsibility b/w levels of govt. & agencies
   - Fiscal imbalance b/w revenue raising & responsibility
     → budget problem for state/territory & local govt

Comment on current Australian health funding & delivery: Sources of inefficiency

4. Distorted signals – not level playing field
   - favours medical & pharmaceutical
   - NOT life style, allied health **(Segal et al *Health Economics* 2009, in press)**

5. Subsidy to PHI → higher health care costs
   - Admin/profit ~14% cf 3% public
   - Not quality driven, not assess C-E
   - no cost control
   - insuring >scheduled fee → higher clinician fees
   - Compete resources away from public

Likelihood of govt. funding to meet ALL clinical need



Comment on current Australian health funding & delivery arrangements: Inequity

Gross inequities in health outcomes are well documented
(AIHW Australia's Health 2008)

By SES

- Rates of disease ~50% higher in lowest quintile cf top

Male cf Female, Remote cf Major City

- Life Expectancy

	City	Regional	Remote
Male	79	77.6	77
Female	84	83	82

Indigenous

- Life expectancy Males 59 Females 65
- % die younger than 65 years

71% Indigenous 21% all Australians

Comment on current Australian health funding & delivery arrangements: Inequity

1. Allocation of primary care resources predominantly thru FFS → related to provider location NOT need (MBS disparity >500% in favour of wealthy suburbs), especially affects rural & remote
2. Support for PHI → priority access to health care for those with **PHI** (generally higher Y, unrelated to need, supported by taxes):
   - ‘elective’ surgery >40% shorter waiting time for persons with PHI (NSW, Vic)
   - dental (Aust. govt. >$300m/an PHI rebate for dental + >$100m for physio etc.)
3. Unequal/inadequate access to various program funded services; eg mental health, early childhood, allied health

NHHRC report: General Comments

Many recommendations designed to promote equity & efficiency: eg

- Promote health literacy
- Dental Medicare
- Comprehensive primary care centres/patient enrolment for people with chronic illness/electronic health record
- Support for multi-purpose in rural and remote
- Support for early start ETC.

Issues not yet/not fully addressed

- PHI
- FFS payments
- Approach to accountability/quality?

Comment on NHHRC options A/C

A: *Commonwealth responsibility for primary care incl. outpatient + defined % of in-patient*

- Leave many sources of inequity and inefficiency
- Commonwealth doesn't have good track record in managing primary care eg EPC expensive/not accountable

C: managed competition: competitive single fund-holding (see Segal et al *J. Health Services Research & Policy*,2004)

- Risk selection (aim to attract better risks)
- Less incentive for LT planning, whole of life care
- Benefit of choice of insurer not clear.
  - Consumers can find choice confusing, what happens if make poor choice, issues of regret

Comment on NHHRC option B

B Regional fund-holding

May promote equity & efficiency

- But depends on how implemented.
- Risk in retaining MBS & PBS which may undermine capacity to be responsive and achieve equity goals.

Ideal Regional Fund-holding model

(Segal et al JHSRP, 2004)

- Single fundholder (Could be jointly funded by Commonwealth & State)
- Funded a/c Needs adjusted population-based
- Enrolled population – based on place of residence
- Community control
- Mixed payment models – incl. salaried (less FFS)
- Strengthen Universal coverage – remove PHI subsidy/incentives, leave PHI to market
- Quality driven - clinical governance/quality audit/ accountability systems

Single Fund Holder

Funders

Australian & State Govt. Private insurers?

Role: Determine RAF, Budget, Core services, Quality assurance process

Resource Allocation Formula (RAF)

Fund Holder

Regional Health Authority

Disease management group

Private insurer

Role: Planning Purchasing

Providers

Employees of fundholder Private providers

↓

Services

Consumers/patients/citizens

Enrolled based on Residential location, Health problem, Age, Choice

Theoretical Benefits of model

1. **On-going responsibility for health of defined population ~for life**
   - Not cost shift
   - Address LT/whole of life health needs
   - Support public health & LT population-based preventative strategies
   - Take community not individual perspective
   - Support cross-agency and cross portfolio activites
2. **RAF based on expected health care needs**
   - Support equity

Theoretical Benefits of Model

3. **Support a single regional planning**
   - Workforce and services planning
   - Quality assurance processes
   - Comprehensive IT system to share patient level data, for decision support, benchmarking, accountability
   - Single entry/screening tool to access intensive/specialist services
4. **Support resource shifts** between care models, modalities, health delivery settings

Key challenges of model

- Requires high level management skills for planning, clinical governance, quality assurance
- High management costs?
- Culture change

Can work?

– Katherine West Health Service – Primary Care

– being rolled out in the NT

Katherine West Health Service

1997→ (www.kwhb.com.au)

Evolved

- thru CCT then PHCAP + other initiatives

Key Components of Model

- Single fundholder for primary care
- Local Management Board - Katherine West Health Board Aboriginal Corporation
- All persons in region covered
- 'RAF' through PHCAP → ↑ funds

Katherine West Health Board: Key service elements

Strong focus on community programs

- not just individual care
- high preventive focus

A nutrition program to improve nutrition status of the community; via food supply, education, work with store managers, health centres, crèches/schools, vulnerable groups (eg women of child bearing)

Maternal Health Coordinator – focus on community engagement, via women's centres, crèches etc.

KWHB: Key service elements

- **Environmental Health Program** - eg covering insect control, water, waste management, health, education, housing etc.
- **Child health Program –** preventive health checks (monitor growth, ear, skin check, immunisation, parent information/education) for all children 0-5; Liaise with clinical teams, maternal health coordinator etc.
- **Chronic disease program** supported by multi-disciplinary team care – not just medical
- **Quality Focus**

KWHB: Quality Focus
Especially for chronic disease management

Comprehensive clinical governance system

- All community ‘enrolled’
- Electronic health record (share patient data)
- Decision support, including patient recall
- Dedicated quality manager – promote aaccountability via peer review etc.
- Quality use of medicines program
- Critical incident reporting
- Participate in Australian Primary Care Collaboratives (APCC) 2005→

KWHB: Outcomes?

Implementation feasible; But takes

- Time
- Large investment in capacity of Community controlled health Board members
- High level & dedicated Clinical leadership
- Extra funds (through CCT & PHCAP)

Formal evaluation yet to be completed

- Considerable shift in pattern of services towards community-based preventive care

Partial Results

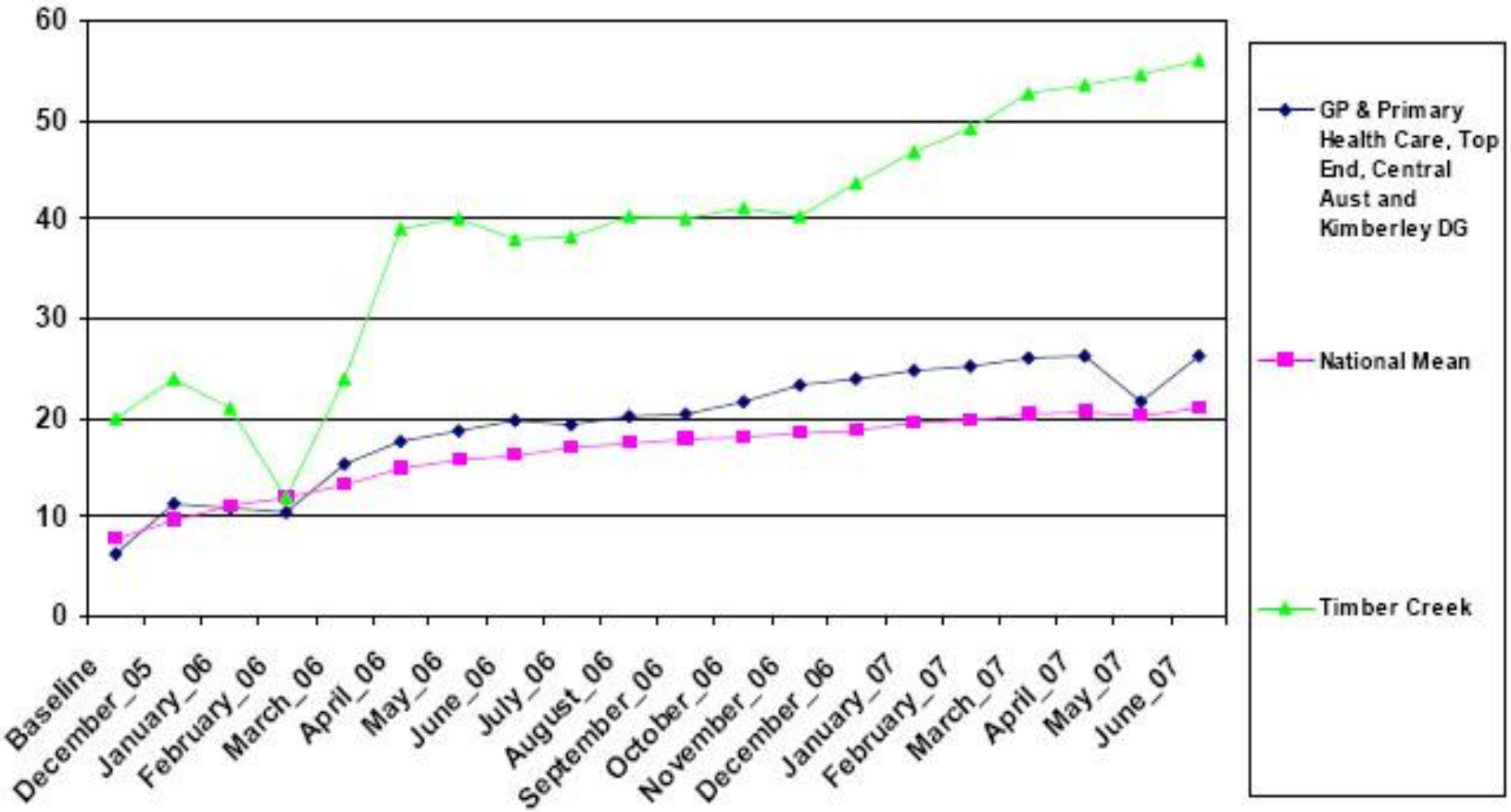
- for Timber Creek site of APCC

Source – Presentation Dr Andrew Bell to Chronic Disease forum on Remote communities (Broken Hill, May 2008) + direct communication

National Primary Care Collaboratives

Timber Creek

Percentage of Patients with Diabetes with Cholesterol <4mmol/l
Practice vs. Divisional and National Mean Trends - Wave 2

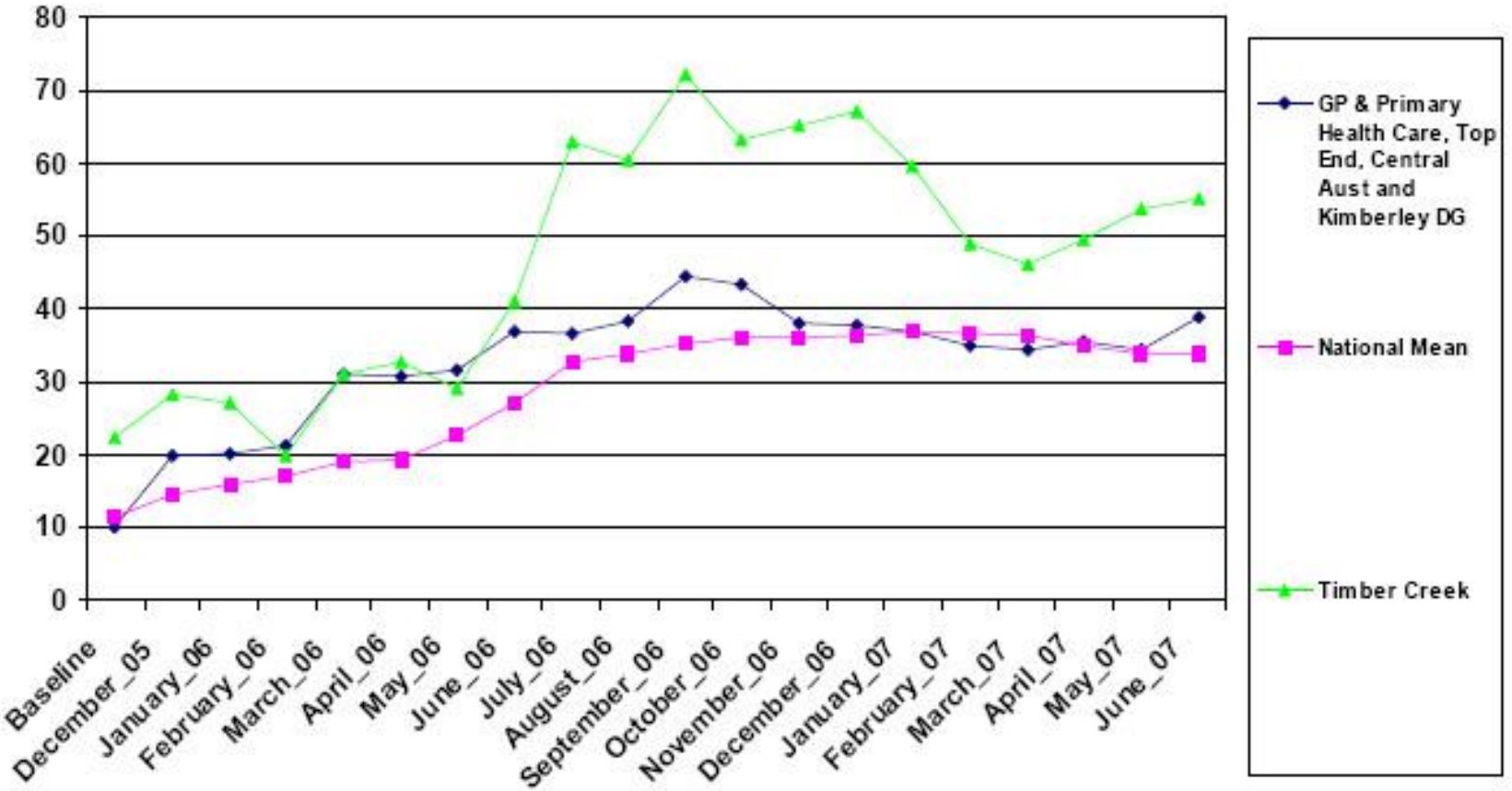


National Primary Care Collaboratives

Timber Creek

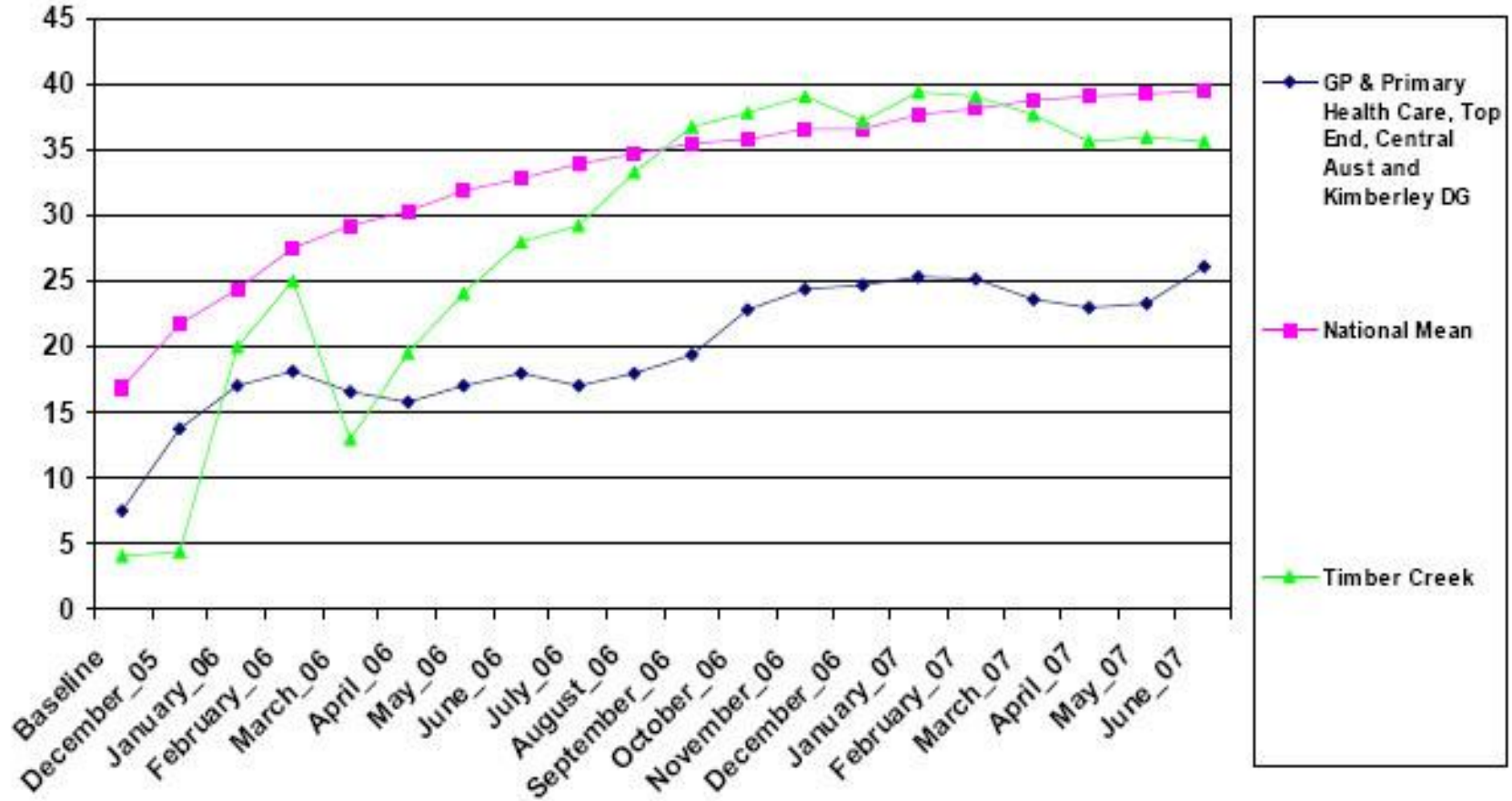
Percentage of Patients with Diabetes with BP <=130/80 mm Hg

Practice vs. Divisional and National Mean Trends - Wave 2



National Primary Care Collaboratives

Timber Creek
Percentage of Patients with Diabetes with HbA1c <=7%
Practice vs. Divisional and National Mean Trends - Wave 2



Thank You

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