

Reforming The Australian Health Care System: A Government Perspective

Australia's unique public/private mix is complex, which might explain its low profile in international health system comparisons.

by **Andrew Podger**

OVERALL, AUSTRALIANS have reason to be satisfied with their health and health care costs. On average, Australians are a healthy lot and getting healthier: As in other industrialized countries, death rates continue to decline and life expectancies to increase; the rate of life-threatening diseases is low; and the health care system provides universal access according to medical need. Also, the cost is not exorbitant: Australia devotes around 8.5 percent of gross domestic product (GDP) to health (although, granted, we have a relatively young population compared with those of some industrialized countries). In the words of the Australian prime minister during the 1998 election campaign, "If you were going to get ill and you don't have a high income it is better that that occur in Australia than in any other country of the world."

However, like other countries, we cannot afford to be complacent. The aging of the population, new technology, and rising expectations (especially as well-educated and assertive groups move into high-use age groups) will increase pressures on costs (and therefore on the resources devoted to health). Also, good health is not enjoyed by all; Aboriginal and Torres Strait Islander peoples' health is poor by any standard. Finally, it remains an ever-present challenge for Australian governments to ensure that the (mainly public) health care dollar is spent wisely—that is, that it buys as much health as possible.

Role Of Government In Health

Governments around the world tend to play a large role in health—to ensure that disadvantaged persons have access to basic health care, to ensure that the cost of that care is not excessive, and to address market failure in this major sector of the economy. Public and private health insurers also must grapple with the problem of moral hazard, as health providers and consumers have a common interest in maximizing health care services paid for by insurers. This mix of social objectives, market failure, and moral hazard, combined with continuing major technological advances, presents all countries with enormous challenges. Enthusiasm about the potential for governmental involvement in health to help people enjoy longer, healthier, and more productive lives must be tempered by acknowledging that ill-advised interventions may lead to scarce resources' being misallocated or wasted. It is hard for government-dominated systems to come up with adequate responses that enjoy widespread support—particularly, how to ration supply in the face of potentially unlimited demand.

Australia's Health Care System

As elaborated in Jane Hall's paper, Australia's health care system is characterized by (1) its federal structure of government, with all three tiers—commonwealth, state, and local—involved in the system; (2) the dominant role of

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private practitioners in providing care, mostly on a fee-for-service basis, but with governments increasingly influencing the structure of health services through their financing arrangements; (3) universal access to high-quality medical care via commonwealth and state funding for Medicare; and (4) substantial private funding (particularly through private health insurance) supported and regulated by the commonwealth, so that the system offers a degree of choice (particularly for hospital care).

■ **Public/private mix.** The role of private health insurance in Australia is considerably greater than that in the United Kingdom and Canada, but less than in the United States. In essence, Australians not only may supplement their (universal) Medicare benefits through private health insurance, but also may opt out of Medicare-funded public hospital care. Since the introduction of Medicare in 1984, however, the role of private health insurance has declined; despite wide and bipartisan support of Medicare, there is ongoing debate about the appropriate balance between public and private insurance arrangements.

A key issue has been the appropriate level of governmental support for private health insurance. The government's strong view is that private health insurance should not be allowed to wither, partly because of the cost implications for Medicare and partly because of concern about limiting individual choice through overreliance on public choice via a single, government-funded Medicare system. Private health insurance also faces structural problems leading to adverse selection, escalating costs and premiums, and limited ability to manage risks (and moral hazard). Much effort is focused on regulatory reform of the industry to improve competition and to encourage better risk management. Along with additional government funding, the goal is to stabilize private insurance participation at around one-third of the population.

In parallel with these developments, state and territorial governments are experimenting with contracting out public hospital care to

private hospitals and with privatizing public hospitals. This clearer separation of purchasing and providing care has been assisted by a national effort to introduce case-mix funding of hospitals. States that are most advanced in applying case-mix have achieved substantial efficiency gains, well beyond the gains in other jurisdictions. With the use of competition and output-based benchmarking, further efficiencies are forecast.

■ **Shifting the focus to outcomes and consumers.** Australia's federal system tends to exacerbate the common problem of "stove-pipe" funding programs that subsidize health inputs and are dedicated to providers rather than to patients. There has been concerted action over recent years to focus more on outcomes and quality, and on patients rather than on providers.

The recently negotiated Australian Health Care Agreements, which channel national government funding to the states to ensure free and universal access to public hospital care, include provisions to facilitate substitution of state hospital funds and (commonwealth) medical and pharmaceutical funds where better health outcomes or efficiency gains can be shown. This cooperative approach contrasts sharply with traditional (and often justified) accusations of cost shifting between the different jurisdictions.

These agreements are intended to draw on the lessons from a series of coordinated-care trials around the country. These trials involve the pooling of all sources of public health funds for an identified population group. The hypothesis is that health outcomes and quality can be improved within existing total funds through coordinated care for those with identified chronic or complex health problems (such as frail aged persons or diabetics). One challenge here is to improve allocative efficiency while not undermining efforts to improve technical efficiency through measures such as case-mix hospital funding.

The wider application of coordinated care, and improvements in allocative efficiency, hinges on improvements in information. Aus-

tralia's national medical and pharmaceutical benefits systems provide the potential for building the infrastructure for integrated information. This is very much on the agenda, but there is a long way to go.

■ **Cost control, quality, and evidence-based medicine.** Australia's cost control has focused on price schedules for medical and pharmaceutical services and indexed cost caps for hospital services, with primary care physicians acting as gatekeepers to specialty and hospital care. Increasingly, these supply-side controls have been complemented by measures linked to quality and effectiveness: (1) Pure "fee-for-service" is being modified, for example, by rewarding best-practice behavior by service providers and by supporting networks (or divisions) of general practitioners. Price/volume caps also have been introduced in areas such as pathology and radiology. Budget holding has not been introduced (beyond the coordinated care trials). (2) The size of the health workforce—particularly the number of general practitioners who generate, through referrals and prescriptions, much of the cost of the system—is being managed using professional requirements for appropriate training. (3) Of particular interest, cost-effectiveness criteria are being systematically applied in listing and pricing pharmaceuticals and controlling their use. The government has recently introduced a similar requirement for medical services. Australia's relative success in controlling pharmaceutical costs is largely attributable to this process.

Demand-side measures also have been used, particularly for pharmaceuticals. However, there is not strong public support for broadening charges for medical and hospital services.

■ **Population health and health priorities.** Australia has a particularly good track record in many population health areas, including human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS) prevention and antismoking initiatives. A key element in this success has been the innovative, and sometimes politically cou-

rageous, use of partnerships with nongovernmental community groups. Incentive-based funding for state governments, doctors, and relevant population groups also has been used successfully to achieve immunization and cancer-screening targets. Detailed strategies have been pursued for each of the identified National Health Priority Areas (cardiovascular, cancer, mental health, injury, diabetes, and asthma).

Over the past two years substantial effort also has been put into improving the population health infrastructure, including surveillance and regulation, through a National Public Health Partnership between the national and state governments, with extensive involvement beyond the health bureaucracies.

Our weakest area in terms of achievement is Aboriginal and Torres Strait Islander health. Concerted effort is being made, including through partnerships between the national and state health departments, the Aboriginal and Torres Strait Islander Commission (an authority controlled by a community-elected board, with major responsibilities for housing and infrastructure), and the Community-Controlled Aboriginal Health sector. The emphasis is on both cooperation and community control, particularly in view of the dependence of public health activity upon community endorsement. There is evidence that this is a sensible approach, but results so far are modest.

Australia's unique federal and public/private mix is complex, which might explain its low profile in international assessments of health care systems. The incremental approach to reform in recent years has not attracted the attention it may have deserved. Our overall performance is relatively good. Moreover, a number of the innovations and the debate over the public/private mix provide material that ought to attract substantial interest abroad.

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