Health Reform in an Ageing Australia: Silos or Structural Reform?

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Delivery of Hospital Services

The topic for this session, 'The Delivery of Health Services', primarily turns our minds to hospital services and, more particularly, what to do about the 'crisis' in public hospitals.

Hospital admissions are currently growing by 4% a year, faster than population growth, and this reflects the ageing of population. Long waiting times, not only for elective surgery but also for emergency treatment and admissions, are standard features of the public hospital system Australia-wide.

The Current Reform Debate

There is growing realisation that the challenges facing the Australian health system are too great for ad hoc measures and political fixes, and that structural reform is essential to redesign the system to deal with challenges associated with population ageing. However the current health reform debate has either been dominated by calls for the Commonwealth to throw more money at the state-run public hospital system, or all the talk has been about spending more on prevention so that governments can avoid the entire problem of delivering hospital services to the sick.

To its credit, the Howard Government issued the two Intergenerational Reports (IGRs) in 2002 and 2007 which warned that over the next forty years, in the absence of policy changes or cuts to government services, the ageing of the population and the rising cost of Medicare will impose unmanageable tax and spending burdens on younger generations.[1] Yet in the second IGR, the lone policy

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[1] *Intergenerational Report 2002–03,* Canberra: Commonwealth of Australia, 2002; *Intergenerational Report 2007*, Canberra: Commonwealth of Australia, 2007.

Australasian Parliamentary Review, Spring 2009, Vol. 24(2), 33–49.

proposal, to make ‘health spending as efficient and effective as possible’, is a tame reference to the ‘promotion of healthier lifestyles [that] can prevent many health problems and reduce overall health costs over time.’[2]

The idea that a greater focus on prevention will ensure the sustainability of the health system is a prime example of the political caution that stymies health reform. It is also a siren song. This sounds like structural reform — refocusing the health system on ‘wellness not illness’, as the slogan goes. But we need to be aware that the clamour for more spending on prevention emanates from the public and community health providers, which have a vested interest in getting governments to pour more funding into their particular ‘silos’ in the health system.

GP Super Clinics

The Rudd government, led by Health Minister Nicola Roxon, has enthusiastically taken up the idea that more prevention will cure what ails the health and hospitals system.

The government’s health reform agenda is predicated on five key ideas. The first is that the major problem with the health system is that it is too ‘hospital-centric’. The second is that the health system therefore needs to be reorientated around ‘community-based’ primary care. The third is that adopting a ‘new approach’ to primary care will boost the primary and secondary prevention of chronic disease. The fourth is that ‘investing’ in prevention will contain anticipated growth in health costs in the ‘the long run’ by reducing prevalence of lifestyle disease. The fifth is that enhancing the role of preventive primary care will — in the favourite phrase of the federal health — ‘keep people well and out of hospital’.[3]

These ideas were the major themes of the 2020 Summit, and they dominate the first report the National Health and Hospital Reform Commission released in April. Unsurprisingly the commission fully supported the Rudd government’s first move in this direction — a national network of GP Super Clinics.

The 2008 federal budget allocated an initial $275 million dollars towards the start-up of the first thirty-one Super Clinics. GP Super Clinics are designed to provide local communities with enhanced access to both general practice and allied health services, with a particular focus on preventive primary care to stem the lifestyle disease ‘epidemic’, and on coordinated chronic disease care to keep elderly people out of hospital. The government claims that a national network of GP Super Clinics is a major step towards restructuring the health system, taking the pressure off

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[2] Commonwealth of Australia, *Intergenerational Report 2007 — Overview*, Canberra: Commonwealth of Australia, 2007, www.treasury.gov.au/igr/overview/pdf/IGR2_Overview_Web.pdf, 12.

[3] Nicola Roxon, ‘ALP Offers the Healthier Option,’ *The Australian*, 28 August 2007.

public hospitals, and preparing to meet the inevitable challenges created by population ageing.

While the federal government, commendably, is committed to 'ending the blame game' and taking political responsibility for improving the performance of public hospitals, I grow increasingly sceptical about its Super Clinics policy, as well as its performance-based funding plan to fix the hospital crisis.

The first concern is that the emphasis on prevention — targeting obesity and lifestyle-related chronic disease — is not an example of 'evidence-based policy'. The assertions and assumptions behind preventive strategies are rarely, if ever, subject to analysis and scrutiny.

Primary Prevention

It is routinely claimed — usually in association with the perennial complaint that only 2% of government health spending is devoted to prevention — that 'investing in promoting increased levels of physical activity and healthy eating in Australians would reduce the burden of chronic disease now and in the future.'[4] A greater emphasis 'on personal lifestyle and wellbeing (preventative care)' and 'on public health programs that keep people out of hospital,' we are assured, 'should result in medium to long term reductions in overall expenditure'.[5]

Yet if you go looking for the evidence to support these claims you find there is slim evidence. After forty years of public health promotion policies targeting the risk factors associated with poor diet and lack of exercise, the healthy lifestyle message is well and truly 'out there'. Some people have put this into practice, more in the middle classes, and some, more in lower income groups, have not. The results have been mixed because, in the end, lifestyle modification comes down to individual choices. Governments can encourage but cannot (yet, at least) force people to change what are often entrenched and pleasurable unhealthy behaviours.[6]

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[4] ACDPA (Australian Chronic Disease Prevention Alliance), *Chronic Illness: Australia's Health Challenge—The Economic Case for Physical Activity and Nutrition in the Prevention of Chronic Disease*, January 2004, www.goforyourlife.vic.gov.au/hav/articles.nsf/pracpages/The_Economic_Case_for_Physical_Activity_and_Nutrition?open, 6.

[5] ACHR (Australian Centre for Health Research), *Report into the Operation and Future of the Australian Healthcare Agreements and the Funding of Public Hospitals*, Melbourne: ACHR, 2008, 6, 24, 74.

[6] For an extended discussion of the 'limits of prevention' see Jeremy Sammut, *The False Promise of GP Super Clinics Part 1: Preventive Care,* Papers in Health and Ageing (3). CIS Policy Monograph 84, Sydney, CIS, 2008.

Reports on the effectiveness and cost effective of public health promotion policies were published in Australia and the UK in 2004. Both reached the same conclusions and used almost identical language. As the British report put it, 'levels of physical activity have remained relatively stable over the last decade, [and] obesity levels have been rising.'[7]

This report also confirmed what others reviews of the evidence have found.[8] There is a 'very poor information base' which does not provide 'conclusive evidence for action'. There is 'little evidence about the cost-effectiveness of public health and preventive policies or their practical implementation'. And there is 'little evidence about what works among disadvantaged groups to tackle some of the key determinants of health inequalities'.[9]

Preventive Primary Care

The stated rationale for the federal government's Super Clinics policy is that international studies show that health systems orientated towards cheaper so-called preventive primary care achieve better health outcomes at a lower cost than health systems which are orientated towards higher-cost hospital care.[10]

Once again, the evidence does not stack up. Read these international studies and you will find they contain no evidence that 'stronger' primary care actually had a preventive effect and reduced lifestyle diseases such as obesity and heart disease. These studies also admit that improved health outcomes depend on an 'appropriate balance' between primary and secondary care, and that 'international comparisons and studies within the United States point to this conclusion.' For example, a 2002 cross country analysis of thirteen OECD countries reveals that countries with relatively weaker primary care system — including Australia — that spent more on

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[7] Derek Wanless, *Securing Good Health for the Whole Population*, London: HM Treasury, 2004, 77; See also Applied Economics, *Returns on Investment in Public Health: An Epidemiological and Economic Analysis prepared for the Department of Health and Ageing*, Canberra: Department of Health and Ageing, 2003, 3

[8] ACDPA, *Chronic Illness*, 9, 14; Monash University Centre for Health Economics, *Risk Factor Study: How to Reduce the Burden of Harm from Poor Nutrition, Tobacco Smoking, Physical Inactivity and Alcohol Misuse: Cost Utility Analysis of 29 Interventions*, Research Paper 2005(1), 7–8.

[9] Wanless, *Securing Good Health for the Whole Population*, 5, 7.

[10] Kevin Rudd and Nicola Roxon*, New Directions for Australia's Health: Delivering GP Super Clinics to Local Communities*, August 2007, www.alp.org.au/download/now/new_directions_for_australias_health_gp_super_clinics_final.pdf, 17. Labor's policy was directly inspired by Jennifer Doggett, *A New Approach to Primary Care for Australia*, Centre for Policy Development Occasional Paper 1, Sydney: Centre for Policy Development, 2007.

hospital care achieved better health outcomes than those with health systems more strongly oriented to primary care.[11]

Studies of high-intensity multidisciplinary lifestyle interventions — which GP Super Clinics are designed to provide[12] — also show low impact on the key behaviour, the long-term retention of lifestyle modification.[13]

For this reason, more spending on prevention has been rightly called a 'policy looking for an evidence base' rather than evidence-based policy.[14]

Hospital Overcrowding

Besides whether this actually works, the real question is whether more spending prevention is the right policy priority for an ageing Australia.

Public hospitals are already bearing the burden of an ageing population. Admissions by 'very old' patients, aged seventy-five and over, are increasing, and this is leading to endemic emergency overcrowding (or access block), which forces over one-third of patients — especially frail, elderly patients — to wait longer than eight hours on trolleys in corridors while waiting for a ward bed to become available.[15]

Overcrowding occurs when emergency departments contain more patients who require admission than there are unoccupied, staffed, ward beds available elsewhere in the hospital to accommodate them. The inability to transfer patients to a ward bed forces emergency staff to care for patients in corridors. Caring for access block

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[11] B. Starfield and L. Shi, 'Policy Relevant Determinants of Health: An International Perspective,' *Health Policy* 60 (2002), 201. See Appendix 1, Sammut, *False Promise of GP Super Clinics Part 1.*

[12] The inspiration comes from Dr John Stafford: John Stafford, *Wellness Centres Revisited: A New Model of Primary Healthcare for North Lakes and Surrounding Suburbs*, Submission to the Standing Committee on Health and Ageing of the Commonwealth House of Representatives, February 2005, www.aph.gov.au/house/committee/haa/healthfunding/subs/sub081.pdf, 10.

[13] USPSTF (United States Preventive Services Task Force), *Screening for Obesity in Adults: Recommendations and Rationale*, AHRQ Pub. No. 04-0528A, December (Rockvile, MD: USPSTF, 2003).

[14] Annie S. Anderson, 'Obesity Prevention and Management — Evidence and Policy,' *Journal of Human Nutrition and Dietetics* 18:1 (February 2005), 1–2.

[15] Natasha Wallace, 'Casualty crisis: many wait eight hours', *Sydney Morning Herald*, 2 August 2007.

patients now constitutes 40% of the emergency workload in major public hospitals.[16]

Emergency departments providing this amount of inpatient care are unable to efficiently provide the acute care they are designed to deliver. The inevitable result is prolonged delays and long waiting times before new patients can be assessed and treated.

Studies have linked overcrowding to worse patient outcomes including longer length of stay and higher mortality.[17] Recent work by Professor Drew Richardson of the ANU found that overcrowding is associated with 1500 avoidable deaths/year — higher than national road toll.[18] The reason emergency departments experience endemic overcrowding is average bed occupancy rates greater than 90 — 95% caused by rising demand and the pressure on hospital managers to run major urban public hospitals at maximum capacity to reduce politically-sensitive elective waiting lists.

International studies show that access block is discernable once hospital occupancy rates exceed the safe level of 85%. Once occupancy is regularly >90%, hospitals can expect regular bed shortages and emergency overcrowding. Once occupancy is >95%, emergency departments almost always operate in crisis mode, with no spare bed capacity to cope with surges in demand for admission without unacceptable delays.[19]

Lack of free beds is the single most important reason why public hospitals are in crisis.[20] This was the 'sole reason', for example, why Jana Horska miscarried in the public toilets at Royal North Shore Hospital, since at the time: 'the hospital was full

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[16] 'Australia's Emergency Departments continue to decline in function, new "snapshot" reveals', Australian College of Emergency Medicine Media Release, 1 August 2008: http://www.acem.org.au/media/media_releases/access_block_release_july_2007.pdf

[17] Drew B. Richardson, 'The access-block effect: relationship between delay to reaching an inpatient bed and inpatient length of stay', *Medical Journal of Australia*, 2002, 177, 492–95; Peter C. Sprivulis, 'The association between hospital overcrowding and mortality among patients admitted via Western Australian emergency departments', *Medical Journal of Australia*, 2006, 184, 208–212; Drew B. Richardson, 'Increase in patient mortality at 10 days associated with emergency department overcrowding', *Medical Journal of Australia*, 2006, 184, 213–6.

[18] Jamie Walker, 'Minister John Hill's Fury at patient death claims', *The Australian,* 26 September 2008.

[19] A. Bagust, et al, 'Dynamics of bed use in accommodating emergency admissions: stochastic simulation model,' *British Medical Journal*, 1999, 319, 155–58.

[20] Australasian College of Emergency Medicine, *Access Block and Overcrowding in Emergency Departments*, ACEM, Melbourne, April 2004, 11: http://www.acem.org.au/media/Access_Block1.pdf

to capacity and no bed was available ... there were 46 patients in the ED, with all beds occupied, and 16 admitted patients waiting to go to the ward.' [21]

Why GP-Style Patients Don't Cause Overcrowding

An entirely erroneous idea is that the reason public hospital emergency departments are overcrowded is because they are being swamped by 'GP-style patients'.

Anytime the crisis in hospitals is in the news, State health ministers, almost like clockwork, front the media and say that the problems are all caused by the number of people who cannot see a bulk-billing or after hours GP.[22] In other words, it is all the fault of the Commonwealth.

This claim is nonsence: a patient who could see a GP does not take up a bed or lie on a trolley. It is obvious that the number of patients who need admission to bed is the cause of overcrowding.[23]

Coordinated Primary Care

Another assumption which is guiding policy-making is that because rising numbers of very old patients suffering complex chronic conditions are presenting at overcrowded emergency departments, they are the equivalent of chronic disease patients, and would have their conditions better managed and receive more appropriate community-based primary care in a GP Super Clinic.[24]

As the population continues to age, there are going to be increasing numbers of frail very old Australians. Emergency specialists have suggested to me that it is very rare to find a very old acutely ill patient whose admission could have been prevented by better care in the community.

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[21] Robert Forero and Ken Hillman, Access Block and Overcrowding: A Literature Review, Report prepared for Australasian College of Emergency Medicine, September 2008, 9

[22] For example, see the retelling of this myth by the federal minister at the ACEM Access Block Summit in Melbourne this year: The Hon. Nicola Roxon MP, Minister for Health and Ageing, Speech to the Australasian College for Emergency Medicine, Access Block Solutions Summit – Hilton Hotel Melbourne, 12 September 2008: http://www.health.gov.au/internet/ministers/publishing.nsf/650f3eec0dfb990fca25692100069854/918D216F71CBB56ACA2574C2001FDD01/$File/nrsp120908.pdf

[23] For a yet to be refuted account of why 'GP-style patients' don't cause overcrowding see Australasian College of Emergency Medicine, *The Relationship Between Emergency Department Overcrowding and Alternative After Hours GP Services,* ACEM, Melbourne, August 2004.

[24] Tony J O'Connell, 'Health services under siege: the case for clinical process redesign', *Medical Journal of Australia*, 2008, 188, 6 Suppl., S9-S13.

This is supported by the results of the second round of the Australian Coordinated Care Trials, which targeted the key demographic, very old and chronically ill patients. Coordinating the care of these patients does not appear to have produced a significant reduction in hospital use compared to the control group which continued usual GP care. In fact, patients receiving coordinated care appear to have used more hospital services at the beginning, end, and throughout the trial on average than control group.[25]

There has been a huge expansion of community-based care since the 1970s, and a large number of Commonwealth and State programs are already providing care for the elderly in the community. A 2007 report on the drivers of emergency demand in public hospitals, prepared for NSW Health, found that these programs are working well, and keeping increasing numbers of elderly people well enough to remain in the community longer, and enter 'high-care' nursing homes at older ages than in the past. But as a result, these older and sicker patients are more likely to need referral to hospital, are almost always true emergency cases, and almost always require admission to a ward bed.[26]

This is consistent with the findings of another study released this year which found that the use of emergency departments by elderly patients is mostly appropriate and unavoidable, because the majority of attendances are for 'high-intensity' reasons. Diverting the elderly to more 'appropriate' primary care, in other words, is not feasible and won't relieve overcrowding.[27]

Less Focus on Hospitals, and More on Prevention?

Can it be said that the problems in public hospitals stem from too much focus on acute care hospitals, and not enough on prevention? Or is it the other way around? The counter-thesis is the problems in public hospitals stem from the success of better (easy) primary and secondary prevention. This is the big paradox about the current push for greater attention to prevention.

People are now living longer as rates of heart attack and stroke fall due to better medication and lifestyle changes. People who once would have died in fifties and sixties are now living to very old ages. Better prevention has led to a phenomenon

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[25] Department of Health and Ageing, *The National Evaluation of the Second Round of Coordinated Care Trials*, Commonwealth Department of Health and Ageing (Canberra: Commonwealth of Australia, 2007), part 3, 595, 621–2, 627, 630–1.

[26] Booze Allen Hamilton, *Key Drivers of Demand in the Emergency Department*: *a hypothesis driven approach to analyse supply and demand,* New South Wales Department of Health, Sydney December 2007, 72, 115

[27] F.D. Wolinsky, et al, 'Emergency department utilisation patterns among older adults', *The Journals of Gerontology Series A: Biological Sciences and Medical Sciences*, 2008, 63, 204–209.

called delayed hospital demand. Use of hospitals by people aged 65 to74 fell in the 1990s,[28] and, as a consequence, use of hospitals by the 75+ age group is increasing in the 2000s.[29]

People whose deaths have been deferred (this is the other way to look at this) will inevitably fall acutely ill due to onset of conditions linked to age, and genetic and hereditary factors. Hospitals, we can predict, will face an unprecedented tsunami of demand for hospital care from very old patients who require multi-day admission and traditional bed-based acute medical and nursing care.

The Continuing Crisis

For decades, Australian governments have been cutting public hospital bed numbers, based partly on the planning assumption that beds and bed numbers are ‘less important’ due to rising day surgeries and dramatic falls in lengths of stay.[30] The result — as overcrowding shows — is that public hospitals are already unable to cope with rising ageing-driven demand.

While partly a response to changing clinical practice and the resultant efficiency gains, beds were also cut to ration ‘free’ public hospital care and limit costs by creating waiting lists for elective surgery. There has been a dramatic fall in the number of hospital beds in Australia — from 6.2 per 1000 head of population in 1983 to 4 per 1000 today.

Total beds numbered 94,000 in 1983, with 74,000 beds in public hospitals. Private beds have increased to 26,758 in 2006–07. Public acute beds troughed in 2001 at just below 50,000, and bed numbers have since increased by just 0.6 per 1000 to 53,563 in 2006–07 — one-third less than twenty-five years ago. At present, there are approximately 2.6 public acute hospital beds per 1000, a huge falling taking population growth into account, down from 4.8 per 1000 in 1983.

Falling length of stay and rising day procedures have not offset bed cuts and rising demand. Due to the impact of ageing, multi-day separations have continued to increase, and demand for public hospitals admission is driven by an increasingly heavy acute medical case mix.[31]

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[28] Len C. Gray, et al, ‘Trends in use of hospital beds by older people in Australia: 1993–2002’, *Medical Journal of Australia*, 2004 181,478–81.

[29] In the last five years, separations by patients aged 75–84 and 85 and over have increased by 25 per cent. Australian Institute of Health and Welfare, *Australian Hospital Statistics 2006–07*, AIHW, Canberra, 2008, 171

[30] Australian Institute of Health and Welfare, *Australia’s Health 2008*, AIHW, Canberra 2008, 346

[31] The rise in admissions is ‘mainly accounted for by an increase in acute medical care admissions’, which have increased by 23 per cent since 1998, and by 7 per cent alone

Contrary to what is sometimes claimed, Australia doesn't have an internationally (OECD) comparable 3.9 acute hospital beds. 1.3 beds — 33% of the national total — are in private hospitals and most of these beds are not available for use by emergency patients.

Due to bed reductions, rationing — or the queue for 'free' hospital treatment — now starts in ED corridors filled mainly with very old people waiting on trolleys for a bed. This is the reality of the public hospitals system which no bed-phobic, cost-conscious Australian government is prepared to admit to. So, instead, they tend to grab onto any other 'solution', such as more prevention or coordinated care, so long as it doesn't involve more beds and bed-based nursing and medical care.

Avoidance and Denial

Health ministers (along with associated bureaucrats and academics with a vested interest in or ideological commitment to the status quo) are understandably reluctant to admit the truth: that governments cannot provide 'free' hospital care on demand as promised, that public hospitals do not have enough beds to provide a basic and safe standard of emergency care for people who cannot be treated elsewhere in the health system, and that overcrowding is the result of deliberate strategy to cut beds to limit costs, meaning it is cheaper for governments to have patients queue (and suffer) in corridors than to open and staff extra beds.

Owning up is hard to do, because admitting lack of beds is the problem draws attention to the systemic problems in the public hospital system, which demand more fundamental reforms than tinkering with funding levels in different silos in the system. Despite the argy-bargy over the Commonwealth's declining share of hospital funding over the life of the last Australian Healthcare Agreement, and the perennial claim that lack of funding is the problem, during the last decade real spending on public hospitals has increased by 64% to $26 billion annually.[32]

Systemic Problems

The systemic problem, which is highlighted by overcrowding and the fact hospitals do not have enough beds for the sick to lie down on is that public hospitals, in practice, have a monopoly over the provision of taxpayer-funded hospital care. Because there is no choice or competition, and because money doesn't follow patients, this permits the misallocation of resources away from frontline patient care.

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since 2004-05. Department of Health and Ageing, *State of our Public Hospitals,* June 2007 Report, Australian Government, Canberra 2007, p 24, 28.

[32] Australian Institute of Health and Welfare, *Health Expenditure Australia 2006–07*, AIHW, Canberra, 2008, 45–7.

As clinical staff will tell you, a lot the money gets wasted on bureaucratic positions, especially in the Area Health Services. The Area Health Services have a top-heavy corporate and complex administrative structures, take nurses out of the wards into offices or into positions in community health, and are notorious for being overstaffed by 'countless people who have spent their working lives attending endless meetings, staring at computer screens, and doing precious little else.'[33] While estimates of the size of the health bureaucracy vary, Anthony Morris QC, the former 'Dr Death' Royal Commissioner, estimates that just 20% of Queensland Health's 64,000 strong workforce are doctors and nurses who actually deal with patient care.[34]

These problems, and the fact the community receives less hospital care than its tax dollars warrant, are implicitly admitted in the current Australian Healthcare Agreement negotiations, where all the talk is about the need to implement activity based case mix and incentive based funding models to try to iron out the inefficiencies in the public system.

The Australian Medical Association calculates that the Australian public hospital system is short 3,750 beds, or 6.6% of the national public acute total. According to these estimates, just to allow hospitals to operate safely at 85% occupancy would require a $3 billion or 8% increase in public hospital funding.[35]

Whether such a funding increase is possible in the current economic climate is uncertain. Regardless, to the best of my knowledge, no government acknowledges the capacity constraints created by lack of beds, and not one is talking about tying funding increases to reversing bed cuts or holding hospital occupancy to 85%.

Realising Reform

An alternative approach to structural reform is to try to maximise the amount of healthcare we get for health dollars, and maximise the use of the more efficient private hospital sector to relieve the pressure on the public system.

Capping private patients in public hospitals

Current practices already minimise the role of private hospitals in the Australian health system.

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[33] Dr John Graham, 'Turning Back the Tide of Errors', *The Australian*, 4 October 2007.

[34] Submission by Anthony Morris QC, cited in House of Representatives Inquiry into Health Funding p 36.

[35] Australian Medical Association, *A Public Hospital Report Card 2007*: *An Analysis of Australia's public hospital system,* AMA, Canberra, 2007.

In 2006–07, 10% of public hospitals admissions were by privately-insured patients. Funding ‘double dipping’ while public patients suffer on trolleys is unconscionable. Capping private patient admissions at 10%, with gradual reductions to no more than 5% over the life of the next AHCA, would end the unfair competition and undercutting of the private sector that public hospitals stand accused of.[36]

Another option is to require public hospitals to charge the full cost of treating privately insured patients to ensure public and private hospitals compete on a more level playing field.

Contracting out

Following the recovery of private insurance coverage since the late 1990s, private hospitals now account for over 40% of hospital separations, carry out 60% of surgery, and are able to provide virtually all procedures (658 of the 662) undertaken in Australian hospitals — at a cost of around $7 billion a year.[37] Public hospitals have a far higher acute medical case mix than private hospitals, which accounts for public hospitals providing 70% of bed days. Around 20% of public separations are surgical.[38]

There is therefore scope for governments to relieve the pressure on public hospitals and more fully harness the private hospital sector to treat public elective patients, by contract, by tender, or even a voucher system. The additional incentive, and on top of that potential to reduce elective waiting lists, is cost-effectiveness.

The Department of Veterans’ Affairs (DVA) purchases hospital services on behalf of the veterans’ community from both public and private hospitals by contract and tender. While the private sector is paid at close to market rates, the public sector is remunerated on a cost-recovery basis. An analysis performed by the DVA, comparing the cost differential for equivalent services and treatment, was referred to in evidence before the House of Representative Committee of Inquiry into Health Funding in 2006. This showed that the department paid ‘significantly lower prices in the private sector than in the public sector.’[39]

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[36] Australian Private Hospitals Association, *Summary and Recommendations of Submission from Australian Private Hospitals Association to the National Health and Hospitals Reform Commission,* p 10–12: http://www.apha.org.au/publications.html

[37] *Australian Hospital Statistics*, table 8.1; *Health expenditure in Australia*, xiv.

[38] Commonwealth Department of Health and Ageing, *State of Our Public Hospitals, June 2008 Report*, Australian Government, Canberra, 2008, 17.

[39] Official Committee Hansard, House of Representatives Standing Committee on Health and Ageing, 4 September 2006, HA 11

Performance measures

The use of performance reporting and benchmarks tied to funding incentives is a key element of what has become known as the Rudd Hospital Plan. Since the aim is to imitate the last decade of reform in the UK, the prospects of success are low. In the UK, report after report has found that funding increases in concert with incentive based initiatives have not been as successful as hoped.[40]

While funding boosts do have some impact on service levels, because bureaucratic public health systems are notoriously inefficient at controlling costs and allocating resources, as per Gammon's Law, by the time the funding is funnelled through the bureaucracy, not enough of the extra money gets through to the frontline as hospital services.

The boost in services doesn't turn out to be proportionate to the size of the increase in the funding, as has been demonstrated by the low productivity returns on the massive funding boost the British NHS has received over the last decade.[41]

The same proviso applies to expanding the role of the private sector in the hope that greater choice and competition have limited potential to improve the performance of public hospitals. Pseudo-competition is no substitute for the real thing. So long as public hospitals remain government-owned-and-operated, they have far weaker incentives to improve productivity because, unlike private providers, they can never go bankrupt.[42]

The unspoken question is why, in this day and age, governments should continue to run hospitals for ideological reasons, rather than seek to ensure all Australians can access necessary hospital care regardless of their means. This is a debate we are yet to have. But it is a debate we move closer to having, the more public hospitals demonstrate how impossible it is for governments to provide 'free' care — even basic emergency care — to all and sundry.[43]

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[40] James Grubb, *Reform at the mercy of government: healthcare lessons from the UK,* Frasier Forum, 09/08 15–16.

[41] Commission on Reform of Public Services, *A Better Way*, Reform, London, 2003, p 26; Reform, *Why the NHS Needs Real Reform*, Reform, London, 2003. As per Gammon's law: 'in any bureaucratic system as government funding increases, productivity declines.'

[42] G. De Pouvourville, 'Hospital funding and Competition', European Journal of Health Economics, 2004, 5, p 3–5

[43] Geoff Davies, 'Patient's risk death in sick hospitals,' *The Australian*, 16 January 2008.

Aged care and 'refundable deposits'

Canadian estimates suggest that at least 20% of the care delivered in hospitals could be provided in an alternative setting, such as a nursing home.[44]

The residential 'high care' sector in Australia is plagued by funding, financial, regulatory, and workforce problems, and is presently in no position to expand capacity to meet the needs of the ageing population, let alone start to get equipped to provide sub-acute and respite care for elderly patients to take the pressure off hospitals.

Immediate federal government action to allow refundable deposits ('accommodation bonds') to be collected for 'high care' nursing homes, as recommended by the 2004 Hogan Report, is the most practical step the federal government could take to prepare the health and aged care system for the inevitable consequences of ageing.[45]

Integration

The Californian HMO (Health Maintenance Organisation) Kaiser Permanente attracted international attention following a 2002 study which showed that Kaiser delivered more treatments at a lower cost compared to the British NHS. The reason Kaiser is more cost effective is that it operates integrated community-based (non-hospital) health centres that can substitute higher cost hospital based inpatient care with lower-cost outpatient care.[46]

In a paper released in June this year, I argued that rather than creating Super Clinics focusing on allied health, the Kaiser model should be investigated and emulated if practical, as a more effective way to ease the pressure on hospitals.[47] Others have quietly agreed.[48] But as the first report of the National Health and Hospital Reform Commission showed, the federal government appears more interested in

[44] Position Statement on Emergency Department Overcrowding *From the Canadian Association of Emergency Physicians February 2007 http://www.caep.ca/template.asp?id=37C951DE051A45979A9BDD0C5715C9FE*

[45] See Warren Hogan, *The organisation of residential aged care for an ageing population*, Papers in Health and Ageing (3). CIS Policy Monograph 79, CIS, Sydney, 2007).

[46] R. G. A. Feachem and others, 'Getting More for their Dollar: A Comparison of the NHS with California's Kaiser Permanente,' *British Medical Journal*, 2002, 324, 135.

[47] Jeremy Sammut, *The False Promise of GP Super Clinics Part 2: Coordinated Care,* Papers in Health and Ageing (4). CIS Policy Monograph 85, Sydney, CIS, 2008).

[48] See Professor Jim Butler's comment that outpatients should be referred to Super Clinics to alleviate demand on hospitals, Siobhain Ryan, 'Emergency Patients for super clinics', *The Australian*, 13 August 2008.

Commonwealth takeover of allied health and bringing this under the umbrella of Medicare.[49]

Choice and Competition

The biggest lesson Kaiser teaches is about the benefits of choice and competition. Kaiser has to compete with other HMOs for the custom of healthcare purchasers (mainly governments and employers) that bargain hard on price. More than an insurance fund, Kaiser is responsible for coordinating and managing the healthcare of its members. It also has to satisfy individual members, who are demanding customers and are free to move between HMOs if dissatisfied. Competition and choice create the financial incentive to keep costs low while being responsive to patient demand and ensuring fast access to both primary and hospital care.

This is the antithesis of our high-cost, low-quality provider dominated 'free' public health system. Private alternatives to Medicare, which encourage greater choice and competition for consumers, are the long-term solution for the challenges that will face the health system in coming decades.[50]

Opting Out for Gen X and Y

Current projections are that federal health spending as a percentage of GDP will at least double over the next forty years to at least 10% of GDP, but the figure is likely to be higher due to the way the interaction between new technology and an ageing population escalates health costs.[51] PAYG taxpayer-funded, 'free and universal' health systems were never designed to cope with the unparalleled ageing of the population that will occur in coming decades.[52]

In recent years, the former federal treasurer, the former Reserve Bank governor, and the Treasury secretary have all warned of that the rising cost of Medicare has to potential to create intergenerational conflict over higher taxes or cuts to government services. But despite the high-level acknowledgement of a serious policy failure, there has been no major policy response.

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[49] *Beyond the Blame Game: Accountability and performance benchmarks for the next Australian Healthcare Agreements*, A Report from the National Health and Hospital Reform Commission, April 2008.

[50] On the benefits of consumer empowerment and the general issue of creating healthcare intermediaries, see Vern Hughes, 'A Cure for Healthcare', *Policy*, Autumn, 2004, 22–27.

[51] Productivity Commission, *Economic Implications of an Ageing Australia*, Productivity Commission, Research Report, (Canberra: Commonwealth of Australia, 2005), 172,

[52] Brian F. Oldenburg and Todd A. Harper, 'Investing in the future: prevention a priority at last', *Medical Journal of Australia*, 2008, 189, 267–68.

Beginning the transition from a taxpayer-funded system to a pre-funded or self-funded health system, similar to the one that has occurred in retirement incomes policy via our internationally acclaimed superannuation system,[53] is the sustainable solution for the intergenerational challenges Australia faces.[54] Countries with health savings systems, which encourage people to save throughout their lives to meet the inevitably high healthcare costs of old age, have established a new, significant, and sustainable source of future healthcare funding, and set themselves up to better cope with the impact of ageing.[55]

Under a voluntary Medicare opt-out system, adults who voluntarily opt to 'cash out' their entitlement to Medicare-funded medical treatment would receive a tax credit to fund a tax advantaged Health Savings Account (HSA) (see Box 1). They would use their health savings to pay for their day to day medical expenses, and would be required to take out (mandatory) private health insurance to cover expensive hospital care and treatments.[56] Creating a consumer driven alternative to the public system would allow those who save to self-fund their own healthcare to enjoy the benefits of choice and competition, and have greater control over what healthcare they consume in the future, rather than continue to rely on the faltering public system. The demonstrated benefits of opting out would encourage others to do likewise, and the idea of health reform would come to be seen as an opportunity rather than a threat.

Box 1:
Health Groups Strategies Proposal for Health Savings Accounts (HSAs).

- 'a mandatory high deductible, minimum coverage health insurance plan that allows new incentives (including no-claim bonuses) to reduce risk factors and trivial claims;
- at the insuree's informed choice, an optional catastrophic plan that covers high-cost care at a lower premium than today's insurance;
- the insuree's choice to meet co-payments imposed at the point of service from the HSA.
- the individual or household with a personal HSA would receive each year a risk-

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[53] Paul Johnson, 'Ageing in the twenty-first century: implications for public policy', in Productivity Commission and Melbourne Institute of Applied Economic and Social Research, *Policy Implications of the Ageing of Australia's Population*, Conference Proceedings, AusInfo, Canberra 1999, 11–33, 23.

[54] Allen Consulting Group, *Australia's National Saving Revisited: Where do we stand now?*, Report to Investment and Financial Services Australia, August 2008.

[55] Allen Consulting Group, *Medical Savings Accounts: A Discussion Paper*, Parliamentary (Melbourne: Allen Consulting Group, 2004), 10, 17.

[56] Peter Saunders, *A Welfare State for Those Who Want One, Opt-outs for Those Who Don't,* CIS Issue Analysis 79, Sydney, CIS, 2007).

rated income — based subsidy from the government, applicable only to health insurance coverage;

- using much the same calculation proposed by advocates of the Health Reform Commission the subsidy would be the cashed-out value of all government subsidies for Medicare, PBS and private health insurance, indexed for inflation;
- low income groups would have the same subsidy, but there would be a need to consider safety nets;
- any HSA balance at the end of the year would be rolled over and would be tax-exempt. Any HSA balance at death would pass to the estate of the deceased;
- as in some US HSA's, healthy behaviour would entitle the insure to a higher interest rate on the HSA balance if they maintained weight loss or stopped smoking for 2 years in a row, or they would receive lower private health insurance premiums in year 3;
- individuals could opt for care at public or private hospitals, and all hospitals would be paid by today's casemix method but weighted higher for hospitals submitting data on their safety, efficiency and clinical quality;
- the market for transparent quality and safety, supported by health insurers and state governments advertising agreed performance data, would allow consumers to see what they are buying; and
- the HSA would pay 100 per cent for all preventive care, offer discounted weight reduction products and pay bonus interest rates on the HSA balances, all embedded in US and South African HSA models. This is an economic incentive that will appeal to the young, as the take-up rates of the new New Zealand accounts suggest.'

Source: House of Representatives Standing Committee on Health and Ageing, *The Blame Game: Report on the inquiry into health funding*, Commonwealth of Australia, November 2006, 191.

Is a Transition Politically Feasible?

The advantage of a voluntary Medicare opt-out system is that while it is a 'big bang' reform, it's clearly a transitional arrangement, just like the existing mix of superannuation and government pension. It recognises that younger generations have an obligation to pay through Medicare for the healthcare of the elderly who have not been expected to save to fund their own care. The option of sticking with the public system would insulate the elderly and those near retirement age against changes to their current Medicare entitlements.

Ultimately, younger generations are going to have to pay for their healthcare and the healthcare of a much larger elderly population. The question is whether it is best to do so entirely through the tax system and continue to run the bulk of health spending through the inefficient public health systems, or shift, as much as possible, the funding and provision of healthcare into the more efficient private sector *for those who chose to take on the financial responsibility for their own healthcare*.

Unlike previous generations, Gen X and Y 'have internalised the values of individualism'[57] and have abandoned notions such as the 'right' to an old age pension,[58] and are therefore more likely to support self-funding their own healthcare, particularly when the alternatives are higher tax, poorer public health services.

The Business Council of Australia recently noted the lack of 'broad community understanding of the extent or nature of the challenges facing Australia's health system', and the need for 'to build strong support for change among the community'.[59] Younger generations, used to self-reliance and with little attachment to the social policy precepts of previous eras, are the natural constituency for what would amount to real structural reform of the health system. ▲

[57] According to social researcher Mark McCrindle, 'you're not going to have intergenerational war; your not going to have a group of people who've internalised the value of individualism and diversity mobilising on a generational basis to push against another generation.' Nigel Bowen, 'The generation snap', *Sydney Morning Herald*, 14 June 2008.

[58] A 2005 House of Representatives inquiry into superannuation funding found that unlike earlier generations, Gen X and Y 'believes in the concept of self-funded retirement'. Cited in Allen Consulting Group, *Australia's National Savings Revisited*, 59.

[59] Business Council of Australia, *Health is Everybody's Business: The BCA's role in Australia's Health Discussion,* Business Council of Australia: Melbourne, 2008, 8.