COMMENTARY

The new market in health care: Prospects for managed care in Australia

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ABSTRACT

Most developed countries are experimenting, or moving at full speed, to implement new forms of health delivery based in part on capitation arrangements and stronger accountability of health service providers. Proposals for introduction of capitation or managed care have been advanced in Australia but have attracted strong opposition from the medical profession. This paper reviews the policy issues surrounding the introduction of managed care, including how Australia's current institutional forms may evolve into managed care provision.

The 1996 election marked an important transition in Australian health policy: for the first time in over 20 years, something approaching bipartisan policies was espoused. The Coalition indicated its support for Medicare, whilst also supporting private health insurance; and the Labor Party provided, through its Family Health Rebate proposal, some assistance for families who choose to take out insurance.

There were obvious differences of emphasis, with the Labor policy emphasising expansion of Medicare and reinforcing a residual role for the private sector, and the Coalition placing a greater emphasis on the virtues of private insurance. However, these differences are marginal in contrast to the fundamental differences that had existed in previous elections. The emerging consensus in health policies means that future health debates can start with a common platform of Medicare providing universal access to hospital and medical services, funded through taxation.

Although popular, Medicare has been subject to some criticism. The Council of Australian Governments (COAG), for example, has stated that the current health care system is '…often unfriendly and complex for the people who use it and inefficient for the governments which fund it' (COAG 1995). The COAG Communique identified a 'need for systemic reform to the way health and community services are organised and funded to ensure both improved health gain and cost effectiveness for all governments'.

The focus on the need to improve the efficiency of the health system might lead uninformed observers to conclude that the Australian health care system is inefficient in some objective sense. Nothing could be further from the truth. In its recent review of the Australian health care system, the OECD concluded that:

> Over recent decades the health status of Australians has improved significantly, helped by the health-care system which guarantees universal coverage and yields a large measure of satisfaction among the population at a reasonable overall cost to the economy' (OECD 1995a, p 71).

This conclusion is not surprising as Australia's per capita health expenditure is 'in line with what would be expected on the basis of the country's per capita income level' (OECD 1995a, p 90). COAG's views on the need to trim health care spending, however, do not reflect the views of the community as a majority of Australians support increased spending on health care (Hayes & VandenHeuvel 1995).

The contrast in the perception of the Australian health care system between the critical views of COAG and the more supportive OECD analysis is not atypical. The global health revolution has a curious and paradoxical base:

> Present health care systems, whatever they may be, are unsatisfactory and must be reformed so as to yield greater 'value for money'...better management is everywhere the central idea, the ideal, the Holy Grail that will make possible better health at lower cost' (Evans 1995).

The 'better management' identified by Evans involves clearer accountability for the medical profession and questioning whether the relative autonomy that had been provided to the medical profession to define health 'needs' should be continued. This questioning has led to attempts to define what are core or priority services (for example, in

Oregon and in New Zealand) or to introduce a separate purchasing function into the health care system (Chernichovsky 1995; Jérôme-Forget, White & Wiener 1995; OECD 1995b). The introduction of a purchasing function is usually accomplished by the creation of an 'internal market' whereby the purchaser (funded on a capitation basis) is organisationally separated from providers. Despite the popularity of this approach to reform, it is important to stress that the evidence of the model's success in achieving key objectives is quite mixed (see Maynard & Bloor 1995).

At the macro-level, the purchasing function involves determining the health needs for the community and negotiating price–volume–quality contracts with providers to meet those needs (Øvretveit 1995). This purchasing function automatically impinges on clinical autonomy, as it is premised on the belief that the purchaser is better able than independent clinicians to determine which needs in a community should be met (from the purchaser's funds) and by whom they should be met (if there is a choice of providers).

Unlike the rest of the OECD, the United States has not adopted a universal and equitable health funding system. The questioning of medical autonomy there, however, is evidenced in the growth of government and employer sponsorship of managed care plans. Managed care plans in the United States have gone somewhat further than typical purchasers in the publicly funded systems by introducing approval processes for treatment plans of individual patients being managed by a single clinician. This move is, however, a difference of degree rather than a difference in type of third-party purchasing.

Developments in the United States have great significance for the rest of the OECD, as policy solutions in that country are often imported, willy-nilly, into other systems, and United States health policy analysts often are adept at proselytising the perceived advantages of the United States experience (Enthoven 1994). Managed care is having a powerful effect on the restructuring of the United States health system. Policy-makers should be cautious about identifying which elements, if any, of 'US styled managed care' are relevant to Australia. Indeed, even some United States commentators are quite sceptical of the relevance of developments in the United States for other countries (White 1995).

Despite the skill with which United States policy prescriptions have been advanced, the medical profession in Australia uses 'US style managed care' as a pejorative term, attempting to foreclose any debate about alternative structural options for paying for health care in Australia. (The

term 'managed care' is still a useful term to describe a policy based on some form of systematic management of care processes and it will be used in that sense in this paper.)

What is managed care?

Essentially, managed care is the arrangement whereby an organisation assumes responsibility for all necessary health care for an individual in exchange for a fixed payment. Managed care organisations need to have more certainty about the care they are to provide and so typically they either employ their own clinical staff or, if patients are able to see independent practitioners, then clinical decisions in patient treatment need to be approved by a third party before they can be implemented.

Initially, managed care involved development of clear protocols for what symptoms and signs should be present before a patient within a managed care program was admitted to hospital. Protocols have now been developed for out-of-hospital treatment, including which drugs should be used to treat certain conditions, when allied staff or specialist counsellors should be involved in care and so on.

It is important to stress that managed care does not rely on 'bureaucrats' making these decisions, but more often emphasises the need for clinicians to verify that their proposed treatment plans are consistent with the treatment protocols which have been endorsed by the managed care organisation.

Clearly, managed care has a number of strengths. The protocols developed by many managed care organisations are evidence-based and ensure that patients receive state-of-the-art, scientifically validated treatment and, conversely, that out-of-date, ineffective treatments are not imposed on the patient.

Adherence to protocols and rigorous screening of the need for hospital care can lead to significant saving; managed care plans in the United States are generally cheaper than fee-for-service plans.

Against these strengths are a number of weaknesses. The most important of these relates to the moral hazard to which doctors are exposed if their income is increased by 'underservicing' a patient; that is, if they have a financial incentive not to provide all necessary care (Rodwin 1993). Underservicing is a short-term strategy if there is any element of patient sovereignty in plan choice, as patients can leave the poorly performing organisation. However, implementation of managed care in the United

States generally involves third-party payers choosing the type of insurance to be provided (via employer-based arrangements) or has a 'charity' ethos (via Medicaid), both of which undermine patient or consumer freedom of choice. Some Australian managed care proposals also involve elements of patient compulsion.

A further weakness occurs if the managed care protocols are not state-of-the-art, that is, designed to achieve the most health gain, but instead are simply designed to minimise short run costs. Rigid protocols, without opportunities to vary them in particular circumstances to take account of individual patient variation, probably lead to poor care in some circumstances and are derided as 'cook-book' medicine. Vague or imprecise protocols, on the other hand, probably fail in their intent of limiting unnecessary outlays on ineffective care.

Why is managed care on the agenda in Australia?

Managed care is seen as being a useful response to two of the core issues in health policy: macro-economic cost control and micro-economic (allocative) efficiency. Managed care is generally advocated to replace open-ended fee-for-service or other payment arrangements as part of restructuring to transfer cost escalation risk from governments to budget holders. It is worth noting, however, that in the United States experience, cost escalation in managed care plans has not been substantially different from fee-for-service plans (Luft 1994).

Managed care can also be seen a way of replacing otherwise inflexible or narrow categorical programs with arrangements which allow a budget holder to choose, from an expanded range, the most efficient mix of services relevant to the consumer need, thus achieving better health outcomes for the same expenditure (Browne et al. 1995). Cost control and a better mix of services (allocative efficiency) are not necessarily mutually exclusive, although, to the extent that new services become available for consumers via the budget holder, it is less likely that costs will be reduced.

Two approaches to managed care have been advanced in Australia: one seeing it as being part of a fundamental restructure of the Australian health care system; the alternative seeing managed care as being of benefit to a limited number of high users of health care.

As indicated above, COAG has identified the need for 'systemic' reform to the health care system and has foreshadowed approaches based on 'pooling'

of funds at State or regional level. These pools could, effectively, abolish the myriad of specific-purpose funding programs and boundaries and provide more flexible service to consumers. However, they would also allow the Commonwealth to offload some of the costs of growth in Medicare outlays onto States and would pave the way for the introduction of comprehensive managed care approaches to health care in this country.

Under the COAG pooling approach, all health funding in a State would be pooled and managed as a single fund with defined growth parameters. Pooling would thus allow one level of government to assume responsibility for all the care of a population. A variant of this approach is for the pooling to be undertaken through separate, competing fundholders (Scotton 1995).

COAG proposed a separate 'stream' for high users, called 'coordinated care', and recognised that there clearly are people who fall through the gaps in services or who are not able to obtain the full range of necessary services, especially those services not covered by Medicare. The alternative approach to managed care involves an exclusive focus on more defined populations.

The Commonwealth's coordinated care proposals (Duckett, Hogan & Southgate 1995) were designed to meet the needs of high users without developing an open-ended system, based on fee-for-service, to cover non-medical services. It features capped, or capitation-based, managed care approaches which were seen by the Commonwealth as providing the best opportunity to meet this currently unmet need. Importantly, the Commonwealth trials explicitly required involvement of consumers in developing protocols and, indeed, in the design of the trials.

The Commonwealth's coordinated care trials are thus testing implementation of managed care type arrangements for high users, as it is for this group that Medicare does not provide comprehensive and relevant services. A focus on a more limited subgroup in the population (such as the chronically ill) can be justified both pragmatically (because there may be cost savings) and on theoretical grounds (Jackson 1996).

A focus on 'high users' begs the question of the definition of 'high users'. In the Labor Government's coordinated care trial proposals, 'high users' were equated with the 'chronically ill' or those with complex needs. In fact, many chronically ill are not frequent users of the health care system, especially if their condition is stabilised. The chronically ill may need services not currently covered by Medicare; for example, a person with diabetes may need access to a podiatrist or a dietitian but not appear to be a high user because these needed services are not available to them.

An alternative definition of 'high users' would be an empirical one: say the top 5 per cent of Australians in terms of Medicare consumption. In fact, in 1993–94 these top 5 per cent consumed 30 per cent of Medicare expenditure, with the top 10 per cent consuming 40 per cent of expenditure, and the top 20 per cent using about 70 per cent of total Medicare outlays. (These figures are based on an analysis of Medicare Benefits Schedule (MBS) data and do not, for example, include information on use of public hospitals; of the top 5 per cent, 88 per cent had no recorded MBS in-hospital use, of the top 20 per cent, 78 per cent had no MBS in-hospital use.)

There are a number of weakness in the 'top user' approach to defining the focus of managed care or coordinated care. Firstly, it is not a stable population. Analysis of the MBS data shows that of the top 20 per cent of MBS users in 1992–93, only 31.5 per cent remained in the top 20 per cent in 1993–94 – although this is still around one million people.

Secondly, a focus on the top users almost inevitably emphasises the cost-saving objective of managed care rather that the service enhancement approach (Henderson et al. 1988), and thus might narrow the range of designs which could be considered in policy development.

Thirdly, a focus on top users could stigmatise those in receipt of managed care, blaming them for their use of what is supposed to be a universal, entitlement-based service. This in turn may lead to narrowing of the scope of services available as part of Medicare. This risk is heightened if access to managed care is not a voluntary choice but is determined by either a central computer program (when expenditure thresholds are exceeded) or by some other person or organisation intervening in the care process.

Politics of managed care

Implementation of managed care in Australia raises important issues. First and foremost, the medical profession has been running a vigorous campaign opposed to the 1995 health insurance reforms because it sees these as presaging the introduction of US style managed care in Australia. As indicated above, there are real weaknesses in managed care which the medical profession is keen to highlight as part of its campaign.

The medical profession in Australia has traditionally been opposed to any moves to increase accountability to third parties, arguing that they intervene in the 'doctor–patient relationship'. This argument may simply be for presentational purposes as increased accountability of doctors to their peers or government rarely, if ever, diminishes accountability to

patients, but rather supplements or reinforces it. The underlying issue for the medical profession remains, however, that third-party intervention may place the medical practitioner in a conflict of interest between the interest of the third-party payer and the patient.

Managed care is not popular amongst United States physicians (White 1995) and the medical profession in Australia is able to trade on 'horror stories' emanating from the United States where professional autonomy has been infringed in undesirable ways. These United States horror stories are further reinforced by stories of the adverse impact of managed care on the demand for medical services, thus affecting the incomes of United States clinicians.

But it is not only medical practitioners who are sceptical of the benefits of managed care. Under current arrangements, patients feel they have extensive freedom of choice for medical care, especially ambulatory care. This range of choice would inevitably be reduced under managed care, although better access to a range of non-medical services may offset these limitations to some extent.

If both doctors and patients are critics, who are the advocates? As White (1995, p 146) has pointed out:

> Managed care...is...more popular with American policy wonks than with the general public. That does not mean that people refuse to participate. People take what they can get...If change is slow enough, they will accommodate themselves. But the charge that choice will be restricted has been a powerful weapon in the American policy debate...Reformers in other countries have to ask themselves why their publics would accept the restrictions necessary to effectively manage care in competing plans.

Implementation issues

Managed care or indeed any form of third-party purchasing will introduce new management challenges for health care managers in Australia (Duckett 1994). Successful managed care organisations will require strategies to develop state-of-the-art treatment protocols, introduce systematic criteria for approving admissions to hospitals (and review of length of stay) and so on. Managed care

will also require involvement of consumers in the design of any proposed managed care arrangements in Australia, to offset any public resistance.

There is almost no tradition in Australia of independent utilisation review and, to the extent such a tradition is developing, it only exists in hospitals funded under casemix funding arrangements where the hospitals themselves are developing techniques to review unnecessary test ordering and so on. Review of quality of care in ambulatory care is even more primitive.

There are also management challenges at the system level. Despite the long experience with managed care in the United States, there are still major concerns about the funders' ability to set fair capitation rates for coverage. This is especially the case since health service utilisation has such a large random component (Newhouse 1994). Weiner (1995) summarised the current state-of-the-art in 'risk adjustment' as being 'inadequate to the task and...major technological breakthroughs in the near future seem unlikely.'

In the absence of fair capitation rates, managed care organisations would be able to 'cream skim', that is, attract healthy patients and be paid as if they were caring for patients with a higher level of illness. As Luft (1994, p 58) has pointed out, it may be far easier for a managed care plan to reduce costs through risk selection (or cream skimming) than though cost-effective provision of services.

Introduction of managed care into Australia will thus require new skill as few organisations have any experience in such areas as determining capitation rates and negotiating with providers. If managed care arrangements are to be introduced, their benefits can be achieved, and unintended effects minimised, only if some mechanism to build relevant skills is introduced as well.

Consideration also needs to be given to the range of potential care managers in Australia. These could include health insurance funds, groups of general practitioners, hospital or area health networks and/or new entrants into the market.

Private health insurers

Currently private health insurance funds are restricted in their scope of operation: until the health insurance reforms of 1995 they were unable to insure contributors against medical costs except for the gap between Medicare's 75 per cent in-hospital rebate and the schedule fee. Following the reforms, fund are now able to cover in-hospital medical costs where the fund

has a contract with the medical practitioner. Funds are not able to cover out-of-hospital medical costs but can and do cover allied health services.

Essentially, the 1995 reforms were permissive: they did not require any change in practice of either hospitals or funds; rather they allowed both to do previously prohibited activities. In particular, the reforms were designed to address what was seen as a factor causing dissatisfaction with health insurance, namely, out-of-pocket costs.

But the reforms could be viewed another way. They could be seen as providing an opportunity for funds, hospitals and doctors to gain experience in negotiations in a relatively protected environment. The funds can also use the reforms to gain experience in negotiating funding of episodes of hospital care through bundling of services as a precursor for managing total episodes of care. In a sense, the reforms could thus be seen as a pilot or experiment for the funds to provide more comprehensive insurance cover, the *sine qua non* of managed care.

Private health insurance in Australia has been an extremely protected industry. For much of its history, funds had to adopt not-for-profit status but, when given the opportunity (in 1985–86), there was little interest from for-profit insurers in participating in the industry. Further, the current reinsurance arrangements are widely believed to provide few incentives for efficiency or for funds to attract new members, again with the effect of discouraging new entrants.

The funds were further sheltered by blaming 'the government' for all their woes: membership declines were blamed on the advent of Medicare or the lack of tax expenditures to reduce the effective price of health insurance. As a result, management of many funds ossified, with a number failing to achieve the statutory minimum reserves and some essentially becoming insolvent.

With this background, it is unrealistic to imagine that the private funds could provide a base for managed care without considerable capacity building. The 1995 private health insurance reforms provide the start of such an opportunity.

General practice fundholding

Central to any consideration of managed care must be the future role of general practice. Most Australians see the general practitioner as the key provider of medical advice, and general practitioners see themselves as having a major role in coordinating the care of their patients. This role has,

however, come under challenge: partly from teaching hospitals and specialists assuming the ongoing care of patients; and partly from consumers themselves seeking alternative, and often multiple, independent sources of advice, for example, from the local pharmacist.

To some extent (admittedly uneven across Australia and across practices), general practitioners provide a rudimentary care coordination function. However, they are handicapped partly because they are at the whim of other providers (of non-medical services) in terms of priority-setting and assessment of the services to be provided. They are also handicapped in that many general practitioners have little training or expertise in mobilising community resources effectively to meet the social needs of patients.

However, the shape of general practice in Australia is now changing, with improved training of general practitioners (associated with vocational registration) and more general practitioners now functioning as part of group practices. General practice could form the base for developing managed care in Australia, either through larger group practices, shared management arrangements (Brand 1996), or through an enhanced role for divisions of general practice. It is this possible direction which underlies the Commonwealth coordinated care trials, most of which have a major involvement of divisions of general practice.

Any capitation arrangement relies on a significant 'risk pool' or population to even out random fluctuations in utilisation and need. Accordingly, solo general practice would not have a sufficient population base to provide for the more comprehensive care approaches.

The Commonwealth's coordinated care trials allow a test of the ability of general practitioners (particularly through divisions of general practice) to move into this broader role. Certainly, general practitioners appear willing to do this and, indeed, many argue that they are already fulfilling this role. As with other options for enhancing the role of general practitioners in managed care developments, significant policy issues need to be addressed (Pritchard & Beilby 1996); and significant capacity building and restructuring will be necessary to allow general practitioners to be the organising frame for the development of managed care.

Hospital networks, area health authorities and community health centres

A number of States have moved to introduce a population focus into their health systems. In some States (for example, New South Wales) the hospital governing body (commonly called an area or district health service) also has responsibility for non-hospital services, whilst in others (for example, Victoria) the hospital authority has responsibility for a number of hospitals serving a particular area but not responsibility for non-hospital services. Community health centres have also assumed a population focus, with a responsibility for the health needs of a defined population.

The population focus of this range of public sector organisations could easily provide the basis for the development of a managed care approach. However, whilst area health boards in New South Wales have had a population responsibility for many years, their success in developing a whole-population focus and managing patients over an entire episode of care is unproven.

In recent years a number of States have encouraged 'hospital-in-the-home' initiatives which provide public hospitals and community services with experience in working together in an holistic way to manage an entire episode of care across the boundaries of a number of service settings, said to be a hallmark of success in managed care.

New entrants

Although the new Liberal Government is committed to 'keeping Medicare in its entirety', and to retention of community rating for health insurance, it is possible that the new government may adopt a pro-competition and deregulatory approach with respect to the health insurance market-place. In turn, this could facilitate new players becoming involved in health financing in Australia. There were reports during the recent federal election campaign, for example, that the United States Health Maintenance Organisation, Kaiser Permanente, was interested in establishing a foothold in health care management in Australia.

New entrants, especially if they were already active in the managed care business, could be expected to bring a new range of skills to Australia. The reality is, however, that the Australian health care system, with its public universal entitlement together with a strong private sector, is unique in the world, and overseas experience may not be easily marketable to consumers and providers.

Nevertheless, overseas entrants could establish here especially if existing Australian institutions do not develop their own home-grown approach to managed care and their own skill base.

Policy implications and conclusion

Managed care or health funding based on capitation is an increasingly common solution to key problems facing health systems throughout the world. Not surprisingly, introduction of managed care has been proposed for Australia.

This development should not necessarily be welcomed. There are some benefits of managed care but there are also attendant risks. To a very large extent, the balance of risks and benefits will depend on the design of a managed care policy. Jackson (1996) has identified a number of features of an ethically sound, practical managed care development for Australia: this involves voluntary enrolment, a focus on a limited number of chronic conditions, and methods to assure standards of care. Each departure from these core elements increases the risk that managed care will not lead to a net improvement in the Australian health care system.

Before the overseas enthusiasm for managed care progresses too far in Australia, it is important that policy-makers clarify several aspects of any proposed Australian managed care initiative. Firstly, clear articulation of the policy goal. As indicated above, managed care advocates emphasise either the cost-saving potential of managed care or its ability to provide a more appropriate mix of services (and only occasionally, both). Managed care policies designed to meet the cost-saving objective would look quite different from those designed to provide a more comprehensive and responsive service mix.

Secondly, it is important to clarify whether managed care is to be a voluntary supplement for defined populations or a compulsory and universal approach. Advocates of the cost-saving goal typically propose a wider net for managed care, at least for Medicare or public patients.

Thirdly, strategies to ensure public accountability of any managed care organisation need to be developed before any form of third-party care management is implemented. There are real risks with the introduction of managed care including the ethical considerations flagged above and issues of adequate financial accountability (to avoid cream skimming). Traditionally, the way of dealing with such uncertainty in terms of design was to require that the managed care organisation be not-for-profit, thus allaying at least

some concerns about incentives of owners of the managed care organisation. Such solutions are no longer in vogue and so other forms of accountability need to be developed. This will require clear specification of what is to be expected from managed care organisations, sanctions for poor performance and some form of public scrutiny (Duckett & Swerissen 1996).

Fourthly, if introduced at all, managed care should only be introduced in a phased way. As indicated above, the complex management required in managed care may require skills not previously evident in Australia, so capacity building is necessary. It is important to test whether all or any of the potential bases for managed care can equip themselves for the complex tasks involved. Testing of different managed care approaches will allow time for the Australian population to assess the strengths and weaknesses of managed care. Testing will also allow consumers to assess directly the benefit (or otherwise) of any move to managed care.

Widespread introduction of managed care should thus be preceded by a period of experimentation and testing to evaluate the different contending approaches. It is important that we do not close off options at this early stage, but rather allow tests of relative strengths and weaknesses.

The Commonwealth's coordinated care trials and the 1995 health insurance reforms are pilots for quite different managed care systems and could provide some of the learning necessary for further policy development. The medical profession, in particular, should reconsider whether its strident opposition to any form of managed care is its best long-term policy and whether a policy of participating in experimentation might be a more productive one. The consumer movement should also ensure that consumers are involved in all stages of the design of any tests of managed care.

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