

# The AHA's ideas on health policies for Australia

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In late 1997 the Australian Healthcare Association (AHA) began a process of reviewing and updating its ideas on health care in Australia. One important activity comprised a strategic planning workshop in February 1998, which was attended by members of the National Council. Experts from government and other health associations also participated, and their support was greatly appreciated.

Preliminary ideas arising from the deliberations are summarised in a discussion paper which has been widely distributed for comment (AHA 1998). The following is a condensed version, although the scope is hardly affected.

## **1 Overall funding levels: deciding how much to spend on health**

Australia has consistently spent around 9% of its GDP on health over the last two decades. This is about average for OECD countries. For example, the United States spends over 14% whereas the United Kingdom spends around 7%.

The level may be appropriate, but there has hardly been an informed public debate. Nor has there been any sophisticated analysis of the effects of other levels of expenditure. More will need to be done in these respects, if the reasonable expectations of a progressively more informed community are to be met.

There should be a move towards the use of more formal ways of determining the appropriate level of funding of health care over time. In particular, a methodology should be established which takes account of estimates of health

gain per unit of expenditure (such as QALYs per dollar) applied at the margins, so that incremental increases or reductions can be appraised in terms of their likely impact on health.

There is an increasingly common political view that the public health care system is a financial burden on the economy, and is provided out of sympathy to those in the community who are incapable of providing for themselves. This view is unsupported by the evidence, which clearly indicates that health care is a contributor to a healthy workforce and hence to the nation's economic well-being. Governments of all kinds are therefore encouraged not only to accept but also publicly to state the latter view. Poor decisions about health are more likely if the realities are misunderstood.

## **2 Rationing: accepting we cannot afford everything**

It will never be the case that all health care needs and expectations of the community are able to be met. It is inevitable that some will not be fully satisfied, either by accident or design. The latter approach is preferable in all respects. It will be hard to establish an ongoing process of formal and explicit rationing. However, there is no option, and the AHA is eager to work with other bodies to help resolve the many technical, social, and political constraints.

Federal, State and Territory governments should adopt the routine practice of stating their aims with respect to rationing at all relevant opportunities. In particular, when changes are being made in such matters as the level of health care funding or methods of service provision, there should be a clear statement of the intent with respect to rationing (to increase or reduce services, to change the nature of rationing or the target groups, and so on).

Care providers of all types should also move progressively towards more formal statements about their own rationing policies. Again, the intention should be to facilitate the critical appraisal of their policies by consumers and the community at large. Care providers should also conduct and report on periodic evaluations of the effects of their rationing decisions.

Work should begin as soon as possible to design and implement a process whereby overall performance (in terms of the gap between needs and expectations and actual service provision) may be routinely measured. This may present some technical difficulties, but there is no justification for failing to move forward. Informed estimates are more useful than wild assertions.

All governments and health care agencies should commit themselves to inform the community about the nature and extent of rationing, the factors which affect

rationing, and about the rights of the community to be involved in the determination of policies for rationing. In particular, all parties should formally accept that the community has a right to know, so that it might express a view as to whether the gap is appropriate on an ongoing basis. Inter alia, there should be a formal process of informing the community about the impossibility of meeting continual increases in expectations if health expenditures are not to be increased.

Governments have the responsibility to make rationing decisions (as was the case when funding was recently cut for dental services). They also have the responsibility to explain the consequences to the community (and indeed to seek its views before rationing decisions are finalised).

It continues to be of concern that governments and health care agencies are using information about elective waitlists as a measure of health system performance. The evidence shows that waitlist data are imprecise and invalid measures of the level and nature of rationing. In particular, it should be recognised that most recipients of care are never on waitlists, and the correlation between overall performance and waitlist attributes is low. More sophisticated and comprehensive measures should be used.

### **3 National planning for health**

Federal, State and Territory governments need to ensure there is a cohesive national policy for health, which is updated at annual intervals, and publicly available for comment. The intention should be to establish a much more structured and consultative approach to high-level management of the Australian health care system than that which has existed in the past.

Many governments and political parties do not have comprehensive and up-to-date sets of policies on health and health care. Indeed, a few governments have taken the view that the best election strategy is to avoid public debate. This is unfortunate, given the need for the community to form views about a matter which is consistently at the top of its list of concerns. It would therefore be useful if a report were produced routinely which compares policies across governments and parties, and comments on perceived strengths and weaknesses. The AHA is willing to collaborate with others in the conduct of periodic survey of governments and political parties with respect to their policies on a structured set of issues.

The Association believes governments should establish and maintain a 10-year rolling horizon national strategic plan for health which includes targets, strategies,

resourcing, and assignment of responsibilities. Other strategic plans covering specific components of the health system should be linked as a matter of course to the broader content of the national strategic plan.

Federal, State and Territory governments should explore ways of refining the process of negotiation of the five-year Health Care Agreements. Of particular importance, the contents of each round of Agreements should be based on the long-term health plan described above. Other refinements which need to be considered include a more formal separation of the cost-sharing from the health planning functions during the negotiation process, and greater involvement of the health care delivery sector and the community. There should be a longer period of design: ideas should be developed over a period of at least two years in advance of the date of activation, with public consultations at frequent intervals.

There should be improved methods of collaboration between governments, funders and purchasers of health care, and care providers with respect to strategic planning. This is not only because there are benefits in involving more people in the search for better ways. An important additional consideration is that there is greater commitment to the implementation of health policies and strategies from those who have been actively involved in their formulation.

Three practical suggestions are proposed by the Association. First, the Federal, State and Territory governments should establish a national health forum for the purpose of discussing health policies and strategies. The forum might include representation of governments, funders, providers and consumers and meet every six months. Second, the Federal Government should consider establishing an expert policy advice group, which is directed to provide brief but carefully structured papers on health policy and strategy. The papers could be used as inputs to meetings of the national health forum. Third, the AHA intends to take action to construct alliances with the main health care provider associations with a view to formation of a cohesive approach to topics of common interest. A standard way of specification of alliance responsibilities will be developed.

## **4 Raising money: methods of health care financing**

Australia has been attempting to determine a stable and effective strategy for revenue generation for 50 years. This issue has often dominated the health care debate, while other countries have been able to move on to other (inherently more important) matters. It is time that Australia clarified its strategic preferences in terms of such matters as funding from general or health-specific taxation, which level of government should be responsible for revenue generation, the

extent to which (and in what manner) private insurance should be encouraged, and so on.

Current arrangements are summarised in Figure 1. A model has been developed, which the AHA believes might be much more effective. It is illustrated in two versions in Figures 2 and 3, and its main features are explained below.

The Association favours retention of current arrangements, whereby there are two main levels of insurance, for the foreseeable future. Thus there should be a national compulsory insurance scheme (called *basic insurance* below) for services of sufficient value relative to cost (called *core services* below). There should also be the option of paying more to obtain higher levels of service (termed *optional additional insurance*). The mix is justified in part because of apparent majority support in the community. However, community attitudes should be monitored in this regard.

Current arrangements should be retained, whereby basic insurance is funded from general revenue and contributions are proportional to income. Other models which allow some degree of discretion for basic insurance, such as vouchers or variable co-payments, should be rejected on grounds of risks to equity (and their questionable cost-effectiveness in many circumstances).

There is no obvious reason to retain the separate Medicare levy. If the purpose were to give the community a message regarding health care costs, the present level of the levy means that the message is misleading.

Free access to health care in accordance with need has long been a key feature of the health policy of most Australian political parties, in terms of basic insurance. This should continue to be the case: funding must be sufficient to ensure all citizens have reasonable access without charge to core services. Processes need to be established to ensure the community is involved in ongoing refinement of views about the constitution of core services, and the trade-off between their scope and cost to the community. As noted earlier, rationing is unavoidable and should be more formal and explicit in future. Determination of the structure of core services is a critical aspect of rationing policy.

The Association accepts the majority community view that people should be able to pay more in order to obtain additional health care services. However, it is concerned about the suitability of current private insurance arrangements. There are many problems, including incompleteness of scope of covered services, lack of clarity of additional benefits to the privately insured, and perverse incentives regarding selection of the care provider. The degree of instability is of particular concern, and adversely affects the performance of all parts of the health care system.

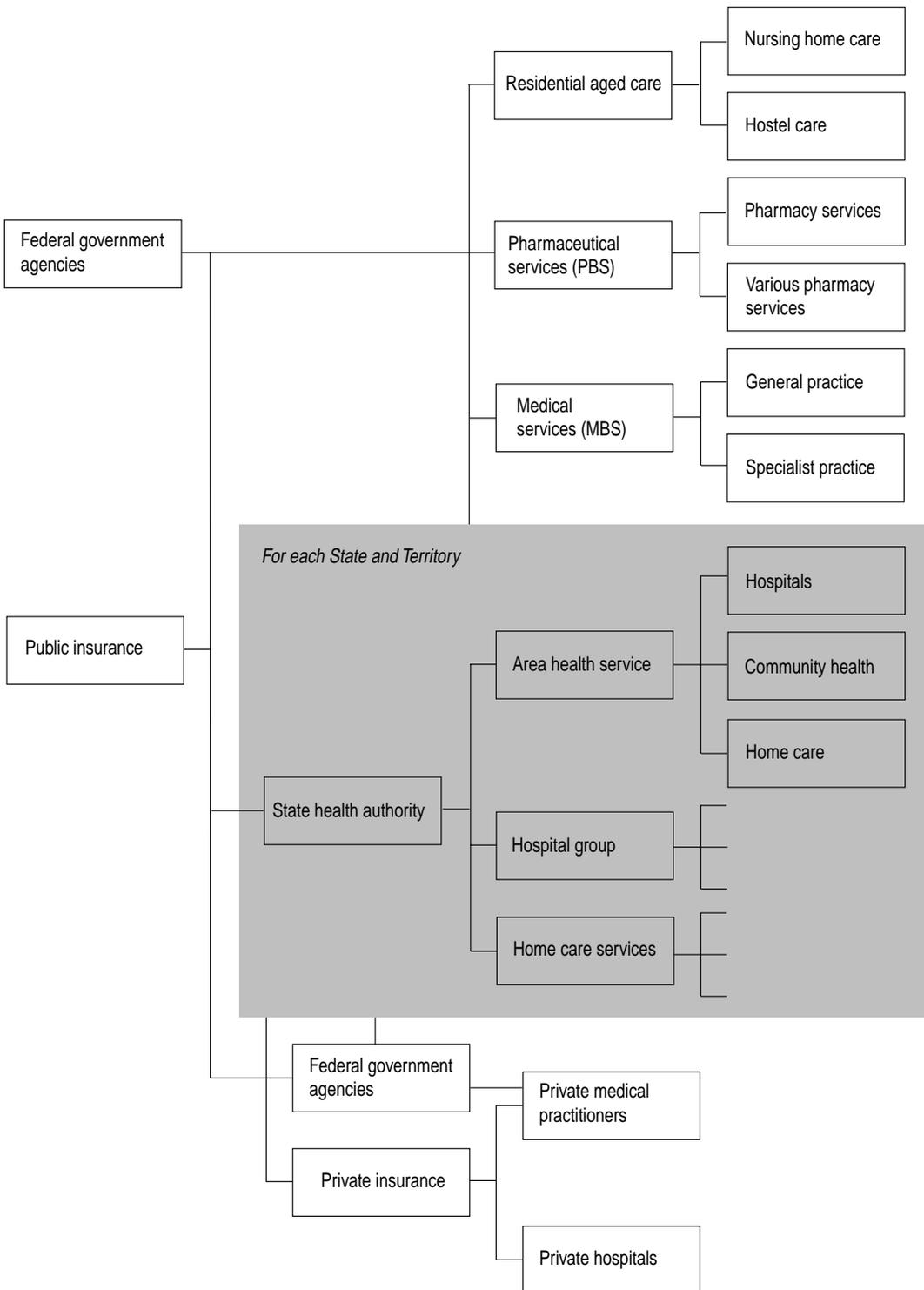


Figure 1: A simplified representation of the current financing model

It is unlikely that the problems can be resolved by ad hoc adjustments at the margins, such as increases in taxation incentives for membership or revised methods of private hospital billing. The Association therefore recommends that significantly different options be considered with a view to establishment of a system with long-term viability by the year 2000 at the latest.

As a minimum, consideration might be given to three types of models. First, the possibility should be explored of retaining as much of the current arrangements as possible, and making only the minimum changes necessary to achieve the aim of stability. Second, there is a set of options involving the establishment of a single national and publicly funded insurance scheme with optional levels of benefits, as an extension of Medicare. Third, Enthoven's managed competition model and its various extensions should be appraised.

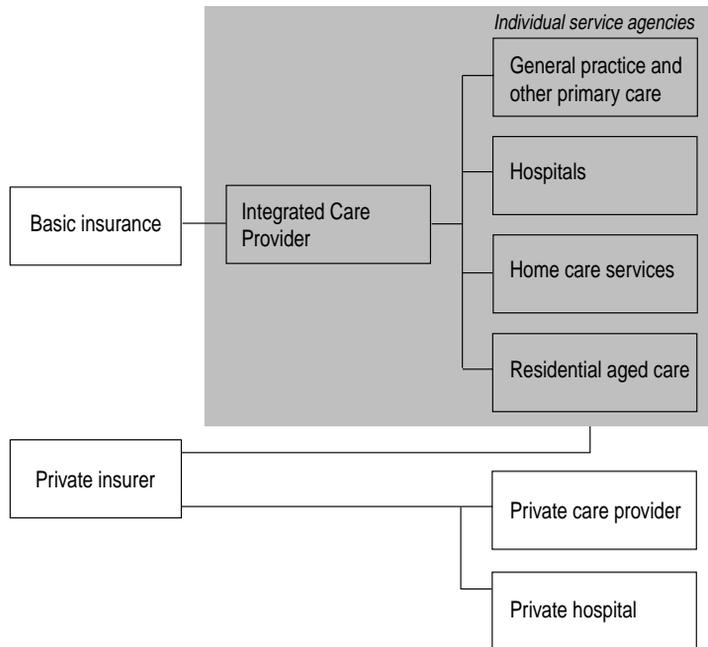
## **5 Passing money from funders to providers: resource allocation**

Current arrangements are far from ideal. There are many well-designed components, but Australia does not yet have a complete solution on the ground. Part of the problem is a lack of coherence: elements differ in structure and design quality from State to State. There is sufficient knowledge in Australia to produce major improvements. A transition path should therefore be agreed among all governments, whereby a better approach is developed and implemented over a period of 10 years.

There should be a single agency in Australia, termed the *basic insurance agency* here, which has the responsibility for providing funds to all care providers with respect to the core services available under basic insurance. It should be established by agreement among all governments. Many arrangements would be suitable, including the use of State or Territory health authorities as agents.

The basic insurance agency should contract directly only with what are termed *Integrated Care Providers* (ICPs) in this paper. The ICP is one which is responsible for and capable of meeting all kinds of needs for care in its service population (which will usually comprise residents in a geographical area). The Association envisages that there might be around 50 covering the whole of Australia. No other significant funding routes should exist. For example, general practice and home care should not be funded separately. The ICP must be the channel for the resourcing of all types of care covered by the basic insurance scheme.

The basic insurance agency should make payments to the ICPs on the basis of population numbers adjusted for differential needs. A national standard method of needs estimation should be established. The Association believes this is justified for reasons of effectiveness and equity.



**Figure 2: A minimum-change version of the proposed new financing model**

Each Integrated Care Provider should contract with a wide range of agencies which are directly involved in provision of a subset of core services (termed *Individual Service Agencies* here). They would include hospitals, hospital groups, nursing homes, home care teams, general practitioners, and so on. Combinations are possible (and indeed desirable). The structure of contracts between the ICP and Individual Service Agencies should be restricted in only elementary ways, to ensure there is freedom for the ICP to reflect local factors and preferences (and to avoid constraining innovation). The key restrictions should relate to use of national standard service type classifications, and methods of volume estimation and outcomes measurement. The responsibility for setting of prices and target volumes is best devolved to the Integrated Care Providers.

For the most part, the ICP should make payments to Individual Service Agencies on the basis of contracted prices for agreed volumes by product type. This approach, usually termed output-based (or casemix) funding, should also involve the use of a national standard method. Key elements of the AHA's preferred model are described in section 6.

Coordinated care can be both a method of resource allocation and an approach to care delivery. The Integrated Care Provider model described above is obviously suited to coordinated care, but this is not a requirement by definition. The

Association therefore wishes to emphasise its view that coordinated care is an essential component of the health system, regardless of the general model of resource allocation.

It needs to be promoted in various ways. Although it can take many forms, key features are the central role of primary care providers in care coordination and purchasing, comprehensiveness of available services, multidisciplinary assessment and coordination teams, and the use of protocols. It is important that there is careful evaluation of the Coordinated Care Trials and other related experiences in Australia. Consideration should be given to experiences outside Australia (although it should be recognised that no model developed overseas is likely to be suitable without major adjustments). Account should be taken of the core ideas of GP fundholding (and especially of the new Primary Care Groups) in the United Kingdom, and health maintenance organisations in the United States.

It was argued above that there should be optional additional insurance. There is some uncertainty about the way it might operate, and we have suggested three main kinds of models should be considered. A few general conclusions may be drawn, however, about the way in which services might be funded.

For the most part, the same approaches should apply as for basic insurance. Thus, where practical, the agency (or agencies) responsible for the optional additional insurance scheme should contract directly only with Integrated Care Providers. Needs-based funding should be applied where it is possible to define a discrete population, and output-based funding should be used in contracts with Individual Service Agencies. Ideas of coordinated care should be applied in full. There are some distinctive aspects, depending on the model of management of the additional optional insurance. In general, the aim should be to ensure it responds to market forces in terms of the range of services covered. The current approach, which restricts private insurance to a subset (mainly acute hospital) of services, is inherently undesirable for several reasons.

The most interesting possibilities apply where optional additional insurance is provided within the framework of a publicly funded insurance scheme with optional levels of benefits. In this case, it would be possible to use the same model applied to distribution of basic insurance funding to Integrated Care Providers, but with populations computed according to the number of residents actually opting for the additional cover. There appear to be major advantages in this approach, although care will need to be taken to ensure there is adequate accountability as a substitute for competition.

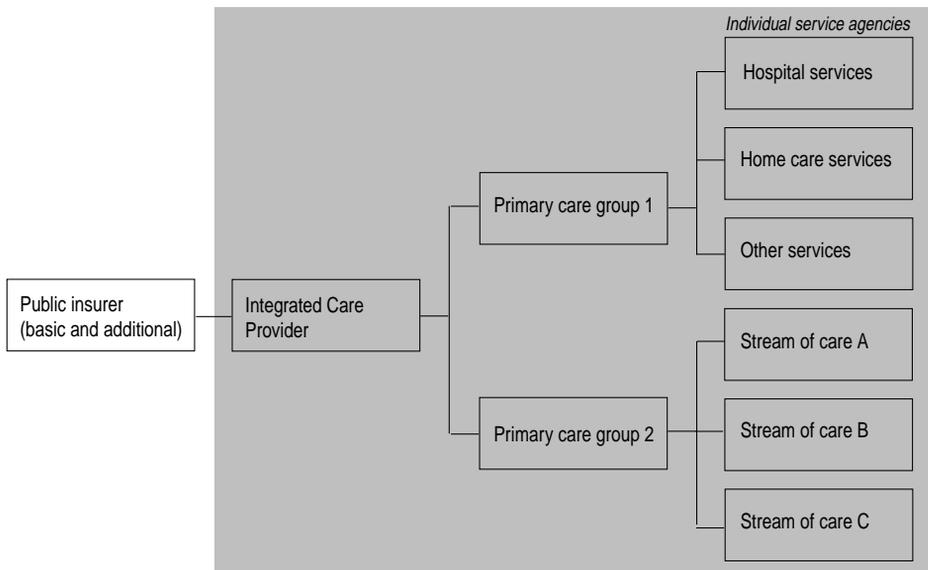


Figure 3: A more advanced version of the proposed new financing model

## 6 Funding providers for their products: output-based funding

By output-based funding, we mean payment of a care provider according to the number of products of different types. The volumes may be estimated, targeted, or actual. As outlined above, the purchaser (the Integrated Care Provider) should make payments to care providers (the Individual Service Agencies) on the basis of contracted prices for agreed volumes by product type. Other methods, such as block contracts and cost reimbursement, should be used as interim measures only if this is unavoidable.

Experiences with output-based funding models should be pooled, and a national standard model developed, for application by all Integrated Care Providers. There is no justification for the use of different methods of specification of products by health authorities and purchasing agencies. The best method should be chosen and applied by all parties.

An ongoing process of product classification development and maintenance should be established under the National Health Information Agreement. A broader and more purposeful definition of product classification is required, which breaks away from the simplistic models of DRG development. Inter alia, efforts must be made to ensure that the next generation of product classifications includes health promotion, disease prevention, assessment, and other processes not recognised by the existing single-setting classifications.

The focus in future should be the development of product classifications which are directly relevant to the management of care across settings and over time. Account should therefore be taken of existing cross-setting classifications (such as the UK's Health Benefit Groups) and experiences in the coordinated care trials, when establishing suitable cross-setting classifications for Australia.

The basis for class definition should include consideration of variations in utility and outcome, and not only cost, as the new generation of product classifications is developed and progressively refined. It is therefore essential that account be taken of existing classifications of this type, including the Oregon casemix system and the United Kingdom's Health Benefit Groups, when developing Australian classifications.

Setting-specific classifications need to be designed to map to cross-setting classifications. In other words, they must be able to be used as building blocks in creating multi-setting product definitions, as well as by themselves for the purpose of setting management and in other ways.

As noted elsewhere, most care is counted and funded at present according to setting. When the setting changes (for example, a patient is admitted to home care after discharge from hospital, or is discharged from a nursing home and admitted to hospital), one episode of care ends and another begins. This approach may simplify data collection and funding arrangements, but it is not conducive to continuity of care. The Association believes there must be a move towards counting and funding according to *episode management units* (also known as streams of care). While an episode of care involves a single setting, the episode management unit concerns care in respect of a health problem by a single care team across as many settings as are appropriate. In other words, if the patient requires care in more than one setting over prolonged periods of time, it is better to define the episode accordingly, and to fund a single care team to manage the patient for as long as it is clinically desirable.

Further efforts need to be made to resolve weaknesses in the setting-specific product classifications. There appear to be obvious opportunities for improvement of DRGs with respect to such aspects as the treatment of same-day and overnight stays, transfers, intensive care, and prostheses. Similar opportunities exist for refinement of other setting-specific classifications including the combined RCI-PCAI for residential aged care and the HACC classification.

Progress should continue with respect to the establishment of common data elements in product classifications, and particularly those which are setting-specific but which relate to people who require care in more than one setting.

One high-priority example is measurement of dependency regarding activities of daily living (ADL). This is sometimes the dominant concern for care providers, and it is potentially important in all care settings (and particularly in residential aged care, home care, palliation, rehabilitation, and non-acute admitted patient care).

## **7 Payments which take account of value for money**

The recent moves towards funding of health care on the basis of average costs of defined products have been justified, and represent a significant advance over previous methods of input-based funding (that is, reimbursement of expected or actual expenditures). However, there is now sufficient knowledge to allow a progressive move towards funding which also takes account of utility (and hence value for money measured as utility per dollar).

The Association believes that various kinds of funding incentives should be provided in the short term, including rewards for measurement of outcomes, and use of high-quality clinical pathways. In due course, all types of products should be defined to take account of evidence of effectiveness, and prices and volumes set accordingly.

## **8 Capital infrastructure funding by governments**

There is reason to believe that the level of investment by public owners in major capital items (and particularly buildings, sites, plant, and major medical and scientific equipment) has been inadequate in many cases, resulting in a decline in cost-effectiveness of capital items. There is also reason to believe that the kinds of investments have been suboptimal in some cases.

The Association suggests that all governments should participate in a detailed review of the processes whereby capital investments are appraised and capital items are managed through their useful life. The aim should be to establish and then maintain a common methodology, and associated analytical results. Inter alia, there should be more commonality of investment appraisal methods (such as discounting of costs and benefits), a greater degree of consultation with interested parties, and the application of more rigour with respect to a routine process of evaluation of capital investment decisions. It is particularly important to ensure that there are standard and valid measures of health benefits expected from investments.

Fair competition between public and private sector care providers is a desirable goal if it is carefully managed. However, it is an unattainable goal unless changes are made in the ways in which capital investments are managed in the public sector. The main difference is that public sector care providers are not allowed the same degree of freedom in capital investment decisions as private sector owners. Indeed, it has often been the case that providers have not only lacked the authority to make investment decisions, but also given no particular responsibility for ensuring investments were sound. Another important manifestation of unfair constraints is that the overall level of capital investment has tended to be lower for public than for private care facilities, without adequate justification in terms of productive efficiency.

Public sector owners of health care facilities should move towards the integration of responsibilities for capital and non-capital funding processes. The aim should be to ensure that an appropriate balance is struck between recurrent and capital expenditure in both the short and the long term.

Public sector owners of health care facilities should devolve much of the responsibility for capital investment decisions to those directly concerned with service provision. There may be political advantages in retaining control at higher levels, but that is insufficient reason to maintain current arrangements in view of the seriousness of the problem. It will be necessary to constrain investments to take account of such matters as the risk of inefficient duplication. The State and Territory health authorities will need to maintain and strengthen their facilities planning and related functions as responsibilities are progressively devolved to service providers.

## **9 The research and education products of the health care system**

It is important that the value of health care *research*, as undertaken in association with health care provision, be clearly recognised. The recent increases in pressure on research funding are unjustified by any scientific evidence, and caution is advisable pending the development of an adequate basis for judgement. There should be a progressive move towards the pooling of research funds, including those currently hidden and expended as part of a global budget to a health care provider. It is important that all available resources are allocated through a process of selection by expert review of competing proposals.

Similarly, it is important to recognise the value of *health professional education*, as undertaken in association with health care provision and research. Again, it is probably unwise to continue to put pressure on funding, in the absence of an adequate scientific basis for such a policy. As for research, there should be a move

towards the more precise separation of education costs (and budgets) from those of patient care. The aim should be to allocate available resources through a process of competition supported by expert appraisal. Care will need to be taken to ensure contracts are of multi-year duration in some cases, in order to allow sufficient stability to encourage capital investments.

## **10 Primary care and general practice**

No effort should be spared to enhance the role of primary care in all its forms. It is fundamental to the health of all Australians, and needs to be given a more central role than has been the case in the past. Some progress is already being made. In particular, current discussions on general practice between the Commonwealth and the medical professions appear to be heading in a sensible direction. The AHA's suggestions are not intended to substitute for ideas under consideration, but rather to present one possible framework within which evolutionary changes might take place.

There should be a progressive move away from the payment of general practitioners on a fee-for-service basis (and towards capitation) for services provided under basic insurance. The aim should be to obtain the benefits of changed financial incentives without prejudice to desirable attributes of current arrangements. In particular, the aim should be to increase the degree of freedom of GPs, and to provide increased financial rewards for well-run practices. The role of the GP as an independent practitioner should not be prejudiced. Inter alia, the GPs must continue to be free to accept only those patients who will pay on a fee-for-service basis, and to charge whatever the patient is willing to pay.

In due course, the funding of general practice for services under basic insurance might better be through contracts with Integrated Care Providers, in the same way as the majority of other services. It follows that a more comprehensive classification of GP services is required than MBS, together with enhanced national standards for needs assessment and outcome evaluation.

A trial should be initiated as soon as possible, whereby a pure capitation or a mixed capitation and fee-for-service model is applied to a contract between selected group practices or divisions of general practice and an ICP. It would be essential to ensure general practitioners were involved in designing and managing the trial. As an expedient (pending the establishment of full-function Integrated Care Providers) it could be set in the context of a formal trial of transfer of GP funding responsibilities to one or more similar agencies (such as the area health service agency in New South Wales). This would represent a significant extension of the coordinated care trials currently under way.

It is widely agreed that general practice has an essential role to play with respect to primary care, coordinated care, illness prevention and health promotion, and other important goals. The Association is therefore concerned about the increasing constraints on funding of general practice. There seems to be little sense in adopting the strategy of restricting total expenditures while retaining current methods of payment.

The main issue is not the total cost of general practice. Indeed, there are reasons for believing it is underfunded. Rather, the main weakness is in what GPs are encouraged to do: to see patients, and only for reasons specified in the Commonwealth Medicare Benefits Schedule, rather than to create health gains.

An investigation should be undertaken of the effects of increased funding of primary care, in terms of estimated changes in utility per unit of expenditure. It should be set in the context of capitation, in the interests of ensuring there are more appropriate incentives for the management of service utilisation.

Recent progress towards the linking of general practice and other forms of primary care is encouraging, but the rate of change needs to be increased. One way of facilitating the process is by creation of a purchasing role for appropriately constituted multidisciplinary teams. Particular attention should be given to the possibility of adapting the United Kingdom's primary care group model. The aim should be to transfer some of the purchasing responsibilities of the Integrated Care Providers to primary care groups based on an expanded group general practice (and including other primary care providers).

## **11 Home and community care**

By home and community care, we mean those services delivered to clients in their private homes. Its core is the set of services currently delivered under the HACC program (home nursing, mobile meals, and so on) but other services fall under this heading and need to be jointly managed in future.

The funding of home and community care should be through contracts with Integrated Care Providers, in the same way as the majority of other services. A national classification of episodes of home and community care should be established as soon as possible. The design should be such that it can be subjected to continual improvement, and it should be based from the outset on incorporation of ideas of utility and health gain and not only cost. In due course, care protocols should form the basis of classification for payment purposes.

Agreed national standards should be established for needs assessment across all care providers, rather than separately for each component service. Particular

attention should be given to ensuring that care provision is in accordance with auditable protocols, and that outcome evaluation is established as a routine process.

## **12 Residential aged care**

By residential aged care, we mean services provided to elderly people who are living in institutional settings such as nursing homes and hostels.

The funding of residential aged care services should be through contracts with Integrated Care Providers, in the same way as the majority of other services. The national classification of these services (the combined RCI-PCAI instrument) represents a major step forward. There should be renewed efforts to ensure the classification (and its use in payment) is subjected to continual improvement. Experiences with the HACC classification should be taken into account, with the intention of replicating the incorporation of measures of utility. As for HACC services, there should be a progressive move towards the use of agreed care protocols as the basis of classification for payment purposes.

Increased emphasis should be given to the establishment of enhanced national standards for needs assessment, care provision against auditable protocols, and outcome evaluation. Every effort should be made to apply common methods of measurement across settings, including the same methods of measurement of dependency for activities of daily living across HACC and residential aged care services.

Rules regarding rights to ownership of nursing homes need to be determined by the interests of the community as a whole, and not on the basis of a dogmatic commitment to one type of ownership or another. Every effort should be made to ensure that there is equity in respect of access to, the costs to consumers, and the quality of residential aged care across Australia. Standard instruments should be developed for the purpose of evaluation.

## **13 Private medical specialist services**

There are many reasons for concern about current arrangements. The most important is the weakness of some kinds of links to the rest of the health care system. A general challenge is that of retaining the rights of specialists to choose to operate as independent contractors, while overcoming the many structural and cultural constraints to more effective relationships.

The Commonwealth Medicare Benefits Schedule should be retained and enhanced, to serve as the basis for the purchase of medical services by a variety of agencies. Enhancements should be made with respect to the method of indexation, responses to changes in clinical practice, and greater use of evidence of effectiveness in the determination of appropriate pricing relativities.

The Federal Government should work with the medical profession to plan a move away from direct payment of medical specialist services, and towards the model described above (where all payments under the public insurance scheme are made through contracts with Integrated Care Providers). However, there should be no constraints on the prices charged directly to private patients. Many types of contracts should be permitted, including direct fee-for-service as at present (but managed by the ICP rather than the Commonwealth Government), coordinated care, and fee-for-service and sessional contracts with individual care providers such as hospitals. Where purchasing by Integrated Care Providers is devolved to primary care groups, they might also be purchasers of specialist medical services in the same manner.

## **14 Public health issues**

Australia has long had a highly effective public health care sector. However, there are continuing resource pressures, and the desired trend towards health promotion and illness prevention has failed to meet expectations in recent years. All parties need to re-commit themselves to this goal.

All parties are encouraged to commit themselves to the handling of drug abuse and misuse as public health rather than criminal matters. In particular, they must consistently and aggressively refute suggestions that people with health problems of these types are in any way undeserving of care. Allocation of resources must be on the same basis (expected utility relative to cost) as for all other types of health care needs.

There should be increased concern and appropriate action to promote protection of the environment including land, water and atmosphere on the grounds that it is correlated with improved health status. Inter alia, further effort is required to reduce the adverse effects on the environment of health care activities themselves, including poor management of emissions and solid waste.

Community support for and the relative success of control over advertising which is detrimental to health (such as that relating to tobacco) should encourage more widespread and aggressive actions in respect of other products. Particular emphasis needs to be given to advertising directed at children. For example, it

is widely accepted that health care problems (and resultant costs) are affected by poor nutritional habits learned in childhood, and consideration should therefore be given to the introduction of additional constraints. Particular attention needs to be paid to commercially motivated advertising directed at children.

## **15 Redesigning State and Commonwealth responsibilities**

It has long been recognised that the assignment of roles in health care among multiple levels of government may be less than optimal. Some gains have been made, but most attempts have been less than successfully implemented for many reasons, including a lack of trust. Further progress in this regard is badly needed.

The Association believes many of the current divisions of funding and purchasing responsibilities are dysfunctional. If responsibilities are to be split, they should *not* be divided according to setting (such as the Commonwealth handling outpatient services and the State having responsibility for admitted patient services). It is preferable in most cases to split only according to care needs or population groups.

An example of unsatisfactory current arrangements is where services for people requiring diabetes care are purchased by the Commonwealth when in a general practice setting, but by the State health authority when in a hospital setting. The AHA approach would require care to be purchased for a needs group like diabetes patients by a single level of government. The same argument applies to type of care provider. It is undesirable for (say) the Commonwealth to pay doctors and the State health authority to pay nurses.

We have suggested earlier in this document that there should be a single national funder of services under the basic insurance scheme. For similar reasons, attention should be given to the possibility of moving the responsibility for (say) health information or outcome auditing to a single level of government (and in most cases to a national agency). At least, there should be early moves towards ensuring that there are collaborative arrangements between governments which have been designed to minimise mistrust.

It was noted above that there is room for improvement of the process of negotiation of the five-year Health Care Agreements. Here, we wish to point out that minor changes in the assignment of funding responsibilities could significantly reduce the level of dispute between the Commonwealth and other governments during the negotiation cycle. Retention of the current division of responsibilities will inevitably lead to disruption of the health planning process, and serve to perpetuate mistrust.

## **16 Public and private health care services**

There is an accelerating trend towards various forms of privatisation of health care delivery, ranging from outsourcing to complete ownership and operation of facilities. The Association is concerned about the extent to which the trends are adequately informed with respect to long-term effects on the health care system. There would be similar concerns if the trends were in other directions without adequate analytical justification.

Health care is too important and complicated to be subjected to unconstrained commercial pressures. For example, significant deregulation with respect to the locations and methods of operation of health care providers is not an option worth considering. However, regulation must be driven predominantly by the long-term health interests of the community. Controls should be reviewed with this in mind.

The Association recognises the long-time commitment of most Australian governments and political parties to a strong public health care provider sector. This is well-founded, and should not be prejudiced by short-term political gains through privatisation. There are overwhelming arguments against exclusive public ownership. However, a strong and competitive publicly owned care provider sector is an essential guarantee that privately owned for-profit facilities will not carry commercial interest to excess, or that non-government not-for-profit facilities will lose a sense of balance relative to their other reasons for existence.

The Federal, State and Territory governments are encouraged to commit themselves to the development and application of a common methodology for appraisal and evaluation of privatisation. They should also ensure there are ways of sharing experiences (and in particular of avoiding duplication of errors). One important aim is that of reducing the degree of effort devoted to what should be a minor aspect of health care management. The methodology should cover all forms, ranging from commercialisation of relationships between components of a publicly owned and operated health service with outsourcing of non-health functions, through private management contracting of services in publicly owned facilities, to private ownership of the entire operation including capital facilities.

All parties need to take the view that both competition and collaboration are valuable attributes, and both need to be promoted in appropriate places. The greatest risk is that they are seen to be mutually exclusive.

It is widely believed that publicly owned and not-for-profit health care providers deliver value not usually present in for-profit provider agencies. On the other hand, there are common claims about the relative inefficiency of publicly

operated health care services, and that the injection of private sector attitudes and practices can help to break down the undesirable features of public health sector culture.

Concerned agencies need to explore the justification for these kinds of assertions. In particular, they should encourage the development of a definition and a method of measurement of social capital. Potentially important elements (such as the degree to which there is a willingness to share knowledge which for-profit operators would judge to be 'commercially sensitive') need to be assessed with great care.

Governments should be encouraged to accept and publicly state the view that social capital is relevant, and that it must be taken into account when making decisions about health care financing. Inter alia, it is clearly relevant to privatisation decisions.

The type of ownership of a particular health care facility (public, private for-profit, private not-for-profit) should be of no particular significance. The main concern should be its performance in terms of value for money. All parties are therefore encouraged to look for opportunities to reduce the extent to which ownership of health care facilities affects funding, service provision, information reporting, and so on. There are many current distinctions which have little or no relevance to current and future needs of the health system, such as differences in reporting requirements and billing methods.

## **17 Community and consumer participation**

By this, we mean the involvement of the community as a whole, and current and previous recipients of health care, in planning and evaluation of health care. The distinction between 'the community' and 'consumers' appears to be of little importance, given that virtually all members of the community are potential or actual users of the health care system.

National standards should be established with respect to the degree and nature of involvement of consumers. Inter alia, the standards should be used in the establishment of targets for increased community and consumer involvement in the planning and evaluation of health care. The Federal, State and Territory governments should agree to a routine sample audit of community and consumer participation. After a trial period, the results should be routinely reported in the public domain.

Purchasers of health care could encourage the increased involvement of community and consumer groups by specifying minimum levels for services

covered by contracts with health care providers. This would constitute a useful incentive for providers, and would also give a tangible indication of the purchasers' concerns for their beneficiaries.

Participation is not only important from the point of view of consumer rights. If well managed, it will make a significant contribution to the cost-effectiveness of the health system. There is reason to consider increased investment in participation. This should include the resourcing of processes directed at ensuring the community is well informed about its rights to participate, and about ways in which participation may be sought.

## **18 National data standards**

The National Health Information Agreement (and associated mechanisms including the National Health Information Management Group and the National Health Data Dictionary) should be subjected to review as soon as possible. The main aims should be to ensure it leads to better national standards covering a greater scope, and that there is a higher degree of compliance. At present, these processes are dominated by the Commonwealth, State and Territory health authorities. Membership needs to be broadened to include representation of key clinical groups and care provider associations.

The Private Hospitals Data Bureau and other distinctive data sets and reporting requirements should be amalgamated with a national reporting system which applies to all care delivery activities without regard to the ownership of the care provider agency or the source of funding.

## **19 Product costing**

By this, we mean the process of determination of the costs of health care products (such as episodes of care by type, or research) as opposed to the standard accounting process of measurement of the costs of inputs (like nursing salaries or medical supplies).

National standards for cost measurement need to be developed and incorporated into the national information management system, including the data dictionary and data model. The de facto standards applied in the 1996–97 National Hospital Cost Data Collection could be used as the starting point, and refined and extended as appropriate.

The focus in product costing thus far has been full average cost. All concerned parties should work to broaden the scope. In particular, systems should be

established for the routine measurement and reporting of fixed and volume-dependent costs, and the expected (planned or standard) costs of products defined by clinical pathways.

A national system should be established for the routine reporting of costs. It should be based on the collation of by-product data from a sample of health care providers. As a minimum, the target should be to establish national reporting of annual statistics on health care provider input prices, expenditures, and product costs by the year 2000.

Health authorities should take steps to ensure that care providers are well informed about the options for routine product costing, and how appropriate trade-offs can be made between the effort of costing and the precision and usefulness of the results. An important element is that of judging whether the costing of every episode of care is justified on a routine basis.

## **20 Utility of health care**

By utility, we mean the benefit derived by a consumer of health services (and by family and friends) as a consequence of the health care intervention. The benefit includes both the change in quality of life and the duration of the change.

High priority should be given to the establishment of a standard set of measures which indicate the utility of health care to consumers. The aim should be to create a battery of measures, ranging from those which are most easily captured routinely (such as crude indicators like complication rates) to those which are the most valid possible (such as QALYs) but are impractical as routine measures.

There should be progressive moves towards the routine measurement of utility. Early attention should be directed towards the generation and use of utility data in the assessment of critical areas of health care (including intensive care at one extreme and mobile meals at the other).

## **21 Best practice information**

By best practice, we mean methods of delivery of health services which have been judged by expert opinion to constitute optimal value for money. The scope of national collaboration on information sharing should be broadened to include standard terms and definitions for concepts and instruments related to clinical practice methods. In particular, terms and definitions should be established for best practice, clinical guidelines, and clinical pathways.

A national repository of best practice information needs to be established, which is accessible by computer. It might be formed by incorporation of several existing sets of information such as the Cochran Centre and the ACHS clinical guidelines.

## **22 National health and health care databases**

The focus here is on the creation of computerised databases which contain national data on health and health care, and which are accessible nationally by appropriate parties. Systems need to be established to permit routine health care information to be accessed in a national database by computer. Attention must be paid to the protection of secrecy and confidentiality, but there are satisfactory solutions.

The immediate target should be the establishment of morbidity system data in a nationally consistent way no more than three months after the end of a reporting period. Other nationally important data collections should be added over time, in accordance with an agreed national development plan.

All parties should collaborate to design and conduct a survey of community attitudes towards the possibility of establishing a national health database containing uniquely identified person records and accessible by computer at all health care locations. The survey should be preceded by an extended period of education on the risks and benefits, with particular emphasis on opt-out and personal veto on contents along the lines applied in Sweden and elsewhere. Subject to community support, all parties should collaborate in the design and implementation of a national health database containing uniquely identified person records and accessible by computer at all health care locations.

## **23 Equity of access and service provision**

By this, we mean the degree to which health care is available to all Australians with reasonable degrees of equity, and to which services are actually provided in an equitable way.

The Federal, State and Territory governments should establish routine measures of equity of access and service provision. Particular emphasis should be given to ensuring the measures are sensitive to attributes of those groups known to be most at risk.

The main structural change should be that of routine measurement of equity, because problems may change over time. However, some populations are

particularly at risk, and need to be given special attention when designing the processes of measurement.

*Remote communities* have long had special difficulties. Account needs to be taken of current areas of deficit, including support for mental illness.

*The elderly population* will continue to be at high risk. Health care in this population needs to be the subject of an informed public debate. Particular attention should be given to the balance to be found between high-touch and high-technology interventions, equity of access and service provision, equity of charges to consumers, and the quality of care. Inter alia, the cost-effectiveness of different packages of care (and particularly of residential aged care and home care) should be carefully analysed, taking account of costs and benefits to all parties, including consumers. The degree of subsidisation of residential aged care should be determined after careful consideration of the costs of other forms of care for the community as a whole.

*People with mental illness* continue to be disadvantaged. The recent efforts to reduce the stigma associated with mental illness, which have had some success, need to be pursued with increased vigour and skill. There should be ongoing vigilance to ensure there are no perverse incentives for care in inappropriate settings, and that the availability of services by setting is based on careful measurement of the needs rather than a result of historical accident or simplistic views. The same principles should be applied to the funding of psychiatric services as apply to all other types of care. In particular, the error must be avoided of assuming that the validity of needs-based and output-based funding models is prejudiced simply because there are more difficulties of measurement.

*Indigenous Australians* have continually comprised the majority of the most disadvantaged. The disappointing degree of progress thus far should be used as a reason for renewed efforts rather than despair.

The Association believes that a task force needs to be formed in the immediate future, and given the resources and time to ensure actions are taken which improve the situation. The commitment must be to use as many resources as necessary to achieve the goal, rather than to do what is possible with a predetermined set of resources. There is no justification for continuing previous approaches characterised by partial solutions, rushed planning, and simple ideas about a change of direction.

It is important to accept that there are no simple answers, and that progress will be made only through the design of a highly complicated approach involving sophisticated ideas and models. Steps should be taken to improve the capabilities

of involved parties to manage complexity where it is needed, rather than trying to avoid it.

All parties have the responsibility to indicate clearly that the differences in health status between indigenous and other Australians are a community responsibility, and that it is unacceptable to suggest, imply, or state that indigenous Australians are to blame.

## **24 Methods of care**

In general, clinical aspects of the Australian health care system are of extremely high quality in the circumstances. However, there are a few matters which need to be addressed in part at the health system level, rather than only within specific clinical professions.

As noted above, there should be a nationally accessible source of information on evidence, accessible by computer. Incentives should be given for the application of evidence to practice changes, and audits should focus on the extent to which practice varies from recognised best evidence.

Care providers need to be encouraged to recognise that there are no minimum levels of precision and detail, but rather that a clinical pathway simply reflects the level of precision and detail to which the care team can agree. They should therefore be expected to have pathways of varying degrees of precision covering all of their admissions. Plans should exist, whereby care providers will progressively increase the degree of discrimination between case types (and hence increase the number of pathways) and the level of detail and precision within particular pathways.

One highly desirable feature of clinical pathways is that they should also be presented in a form which is suitable for patients, their friends and families, and other members of the community. This should be viewed as a high priority, if only because it is a highly effective way of promoting the general goal of consumer participation.

A template (or data model) needs to be established for clinical pathways, and used as the basis for establishment of a national database of pathways accessible by computer. Particular attention must be paid to description of the extent to which pathways are multidisciplinary, multi-setting, and available in a consumer-oriented format.

National standards need to be agreed with respect to measurement, management, and audit of quality of care. As a minimum, there should be early agreement on

both generic and condition-specific outcome instruments (including HoNOS), health status instruments (including the SF-36), and patient satisfaction instruments (including Picker-Commonwealth). A routine national reporting system should be established. Key statistics should be continually compiled for access in the public domain, and used as the basis for setting performance standards in contracts between care providers and purchasers.

A standard set of instruments should be established for sample chart review. As a minimum, standard instruments need to be agreed for hospital admission, hospital days of stay, and admission to and discharge from home care and residential aged care. Care providers should be required to undertake periodic sample audits, with sampling in proportion to risk, and to provide the results in the public domain. There should not be excessive reliance on the use of retrospective data, whether as statistical by-products or chart reviews. The core of utilisation management should be proaction by use of the clinical pathway.

Much has been done to increase the degree of control over the ordering of diagnostic procedures including pathology and imaging. However, pattern analysis of medical claims by the Health Insurance Commission is not sufficient by itself, no matter how sophisticated it might be. All parties should accept the view that utilisation can be managed in particularly effective ways through the development and use of clinical guidelines as manifested in pathways. Efforts should therefore be focused on facilitation of their use, and on auditing of utilisation rates in the context of specific pathways.

Care provider agencies of all types should be encouraged to devolve the responsibilities for resource management to the care teams responsible for clinical management. Care will be needed to ensure that there are appropriate rewards and penalties for financial management performance. There should be renewed efforts to provide clinician managers with the knowledge and experience to play a more significant role in resource management than has been the case in the past.

Health care provision is an information-intensive activity, and Australia has fallen behind most similar countries with respect to computer support (and especially support for clinicians in the management of patient care). This is a mistake, in view of the potential for improved cost-effectiveness. Governments are encouraged to take steps to redress the balance. However, great care will be required, because design of systems which clinicians' current and future needs is an extremely difficult task which requires the involvement and commitment of the care providers themselves.

## 25 Audit and accreditation

The Federal, State and Territory governments should collaborate in the establishment of a single national accreditation process for all types of health care facilities. The proliferation of different standards for the same types of facilities, and of different ways of measuring the same features in multiple settings, is of considerable concern.

The focus of accreditation should be moved away from inputs, processes, and simple indicators of the quality of products (such as infection rates) and towards the audit of clinical pathways (and associated variance analyses and outcome statistics). A related concern is that clinical indicator work has tended to focus on particular professions in isolation. A multidisciplinary approach is to be preferred, and this is facilitated by giving emphasis to accreditation of clinical pathways.

Care must be taken to avoid the excesses of some forms of managed care in the United States, which were implemented in a crisis (and in the absence of resolution of basic problems which Australia has never had). In particular, features to be avoided include the use of for-profit third parties, routine pre-intervention approval, and direct oversight of the care of individual patients. Far more cost-effective processes exist, and particularly proactive introduction of guidelines and care paths.

## 26 Health care workforce

For the most part, Australia has an appropriate health care workforce and methods of managing it for the future. The Association wishes only to emphasise two matters, as follows.

First, plans for the health care workforce need to be associated with (or form a component of) the national long-term health plan described in section 3 of this document. Inter alia, care needs to be taken to ensure that workforce education is adjusted to take account of changes in roles and skill requirements.

Second, a long-term strategy should be developed for modification of the expectations of tasks and relationships between professions, with the intention of strengthening the collegial relationships between professions. In particular, it is recommended that increased attention be paid to the creation of multidisciplinary training opportunities.

## Reference

Australian Healthcare Association 1998, *Redesigning the future: An AHA discussion paper on health policies for Australia*, AHA, Canberra.