

Reforming Victoria's primary health and community service sector: rural implications

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Abstract

In 1999 the Victorian primary care and community support system began a process of substantial reform, involving purchasing reforms and a contested selection process between providers in large catchment areas across the State.

The Liberal Government's electoral defeat in September 1999 led to a review of these reforms. This paper questions the reforms from a rural perspective. They were based on a generic template that did not consider rural-urban differences in health needs or other differences including socio-economic status, and may have reinforced if not aggravated rural-urban differences in the quality of and access to primary health care in Victoria.

Background

Australia's primary health and community support sector has long been regarded as inefficient, uncoordinated, fragmented and lacking cohesion (NCEPH 1992; Draper 1999). Resulting problems include access difficulties, duplication, poor communication between services and a lack of community awareness of some services. These problems may be greater in rural areas with smaller, more dispersed populations (NRHPF 1999).

These views influenced the proposed substantial reforms to the primary care and community support sector in Victoria in 1999 (Auditor-General's Office 1999; DHS 1998a & 1998b, DHS ACMH 1999a). The sector is important for both fiscal and clinical reasons. It accounts for about 25% of health expenditure in Victoria, and it is 'the first point of call for most people who needs assistance to improve or maintain their quality of life and have a physical, mental health, social or environmental health problem' (Ray Smith 1999). The reforms spanned a large array of publicly funded services such as community health centres, dental care, hospital and home-based non-acute care, aged and mental health and a range of allied health services including occupational therapy and physiotherapy.

Under the proposed reforms, services were to be 'bundled' and their delivery to become more integrated and streamlined within 28 large, population-based catchment areas across the State. Purchasing reforms were the linch-pin of the new system. The so-called purchaser-provider split, separating the government role as purchaser of services from the public or private agencies that provide them, had already been established (Muetzelfeldt 1999). The reforms went further in adopting a market-based model whereby potential providers were to compete for government funding in each catchment area.

The reforms were accompanied by an undertaking to be particularly responsive to the health needs of rural Victorians, and to recognise the impact of social and environmental factors on rural health (DHS 1999b). The proposed new system in Victoria went under the acronym of PHACS, the Primary Health and Community Support System.

The Liberal Government's electoral defeat in late 1999 led to a review of these reforms by Professor Raysmith (1999). Many rural voters had rejected the Liberal Government in rural and regional Victoria, and health had been a major electoral issue. The incoming Labor Government objected to the proposed competitive approach to service purchasing and delivery, and the forced amalgamation of several local government areas (LGAs) into large catchment areas. It also criticised the former Government's substantial reduction of community and public health spending in Victoria (by 42%) during its seven-year period of office (Premier's Press Office 1999).

The Raysmith review echoed these criticisms of excessive competition, large catchment sizes and of the former Government for 'reducing expenditures in most fields of human services, often by reducing unit costs'. Regional peculiarities and differences had been ignored, the review concluded, by adopting 'a roll-out of a standardised model across the State' (1999).

If the original reforms were 'rural-blind', however, so too was the otherwise critical Raysmith review. Rarely highlighting rural issues or differences, the review endorsed a Melbourne metropolitan-based study and methodology as a potential '... model for population health planning ... broadly applicable across Victoria' (Raysmith 1999: 25, 44).

This paper evaluates the framework of the PHACS from the perspective of regional and rural Victoria, where 1.28 million people, or 28% of the State's population live (DHS 1999b). It concludes that 'rurality' needs to be meaningfully factored into health planning and funding formulas in order to produce more equitable outcomes for rural Victorians.

The underlying political and economic causes of the reforms

The Victorian health reforms were in the vanguard of reforms mooted by the federal Government for all of rural Australia. A national rural health strategy, 'Healthy Horizons', was launched in March 1999 as a 'partnership document' between the Commonwealth, States and Territories. It highlighted purchasing reforms as one of seven national goals to promote rural health because '... traditional funding arrangement for health and community services are now acting as barriers to the development of innovative models of service delivery, particularly in rural, regional and remote Australia' (NRHPF 1999, Goal 6).

Pressures leading to health reforms were not, however, based on clinical criteria but a combination of economic and political factors. The economic factors are not unique to Australia. One is the long-term growth in health care expenditure and costs which, in a context of increasing fiscal stringency by governments, has made some reform inevitable (Gray 1998; Argy 1998; OECD 1998; Duckett 1999c; Hindle 2000). Another, the ageing of the population, will impose increasing strains on health systems, although its extent has recently been questioned (ABS 1999; Duckett 1999a; Richardson et al 1999).

Several of the political factors are more specific to Australia with its federal system of government and constitutional prescriptions governing relations between the three tiers of government – Local, State and Commonwealth. This fragmented structure has caused problems in health care financing and service delivery. Chief among them is the so-called 'vertical fiscal imbalance', namely an imbalance between the Commonwealth's key role in revenue-raising, and the States' substantially greater responsibilities for providing many services, including health and community services (DHS 1998a; Duckett 1999b). Over the past two decades, the Commonwealth has been the major source of public funding for health care, providing about two-thirds of all government funding (Butler 1999).

Within this lop-sided system and partly springing from it, each State has a fragmented multiplicity of health service providers who are publicly resourced from one or more levels of government and a growing array of private providers, many of whom are also partly publicly financed. This is a major source of many of the problems of state health authorities and policy makers (eg. Brook 1999). Among them, primary health and community support service provision is reported as being provided in a scattergun rather than streamlined fashion. Duplication, wastage and difficulties accessing health services are among the results. These are more likely to adversely affect those with lower income, and rural and regional residents (NRHPF 1997; DHS 1998; DHS 1999b; Draper 1999; Duckett 1999a).

These deficiencies have constrained the supply of health resources while at the same time increasing demand pressures. However, the States' responsibility for health services is constitutionally and fiscally limited in Australia. As a result, they have little leeway to effect whole-of-system changes such as systemic or funding reforms. The main option left them, according to Victorian health bureaucrats, is to improve the technical and financial efficiency of the health system (Brook 1999).

Reforms proposed to the PHACS system in Victoria were based on one additional change - in the nature and style of government. To a certain extent this replicated public policy reforms throughout Australia and other countries (Hindle 2000). The reforms have replaced the traditional welfare model of service delivery with a more market-oriented model. This includes paring down the size and functions of the public sector, introducing the now common purchaser-provider split and reducing governments' role in direct service provision. Governments generally no longer 'row' but 'steer' the social and economic boat, dispensing with the role of direct service provision to become a 'skilful buyer' of goods and services (Osborne & Gaebler 1992). Contracting out is the purchasers' core tool.

The Victorian Government went one step further towards implementing a market model. From 1992 the State became the site of the most radical reforms in Australia to the public service and to social services including health provision (Hancock 1999a & 1999b). Many traditional public service standards and practices were legislatively abolished. Substantial cutbacks to public sector employment, privatisation and enforced contracting out by means of compulsory competitive tendering took place.

Between 1992 and 1999 Victorian public service numbers were reduced by 24.5%, compared with an average reduction of 5.3% for all States and Territories combined (Colebatch 1999). Public bodies and institutions ranging from prisons and electricity supply to some public hospitals were privatised. Local governments were legislatively compelled to tender out at least half of their service budgets. The Victorian Government had also suspended local Councils as it pursued an ambitious program of reducing 210 former Local Government Authorities (LGAs) to 78. These fewer, substantially larger LGAs became in their turn the basis of the PHACS reforms first proposed in 1997. About 1,000 primary and community health service providers throughout the State were obliged to amalgamate into 28 alliances in order to compete for funds in the reformed system (DHS 1999a).

The PHACS reforms

All Victorians were promised improved, more accessible and equitable services as a result of the PHACS reforms. In rural Victoria in particular, stronger links with providers outside the system would allegedly result, including with rural GPs, the State Rural Healthstreams Program and the joint Commonwealth-State Multipurpose Services Program (DHS 1999b). Nine rural outcomes were specified within a framework of three broad goals: to improve public health and health promotion, to ensure service access and quality, and to maintain community safety (DHS 1999a). Improved access was promised both geographically and temporally, the former by providing 'outreach' services from more populous areas, and the latter by instituting a 24-hour 'teleservice' (DHS 1998a).

The principal means by which these goals would be achieved, it was believed, was by reforming purchasing arrangements. Competitive, population-based funding underpinned the proposed model. Amalgamated population-based service providers would form alliances under a single PHACS banner, and competitively tender for funding from the Victorian Department of Human Services (DHS). Although the size of each catchment area was not formally specified, DHS noted that areas in which the volume of services provided was low would need larger catchments for viability (DHS 1998a). In rural areas, groups proposing coverage of only two or three LGAs were allegedly told to amalgamate into larger units again. Funding was no longer to be based on definitive grants and historic costs, but on formula-based targets to meet service outcomes for each catchment's population. Outcomes were to be prescribed in contracts.

The reforms were based on an idealised market structure, in which providers would compete with each other for funding, and presumably for 'customers'. If the reality fell short of this ideal - for example if there were few suppliers or other characteristics of competitive markets such as market pricing - then at the very least they should be 'contestable markets', that is, potentially open to new entrants. This was the preferred ideal of many orthodox economists (Baumol et al 1992; Alford 1992).

Victorian health policy documents reflected these views. DHS Annual Reports became like corporate reports, including 'business directions' to 'utilise contestability and competitive market structures to improve quality, access and cost effectiveness' (DHS 1998b; see also DHS 1998a). Little consideration was given to the health sector's peculiarities and characteristics, which might have made a market model an inappropriate choice on which to base health policy and service provision.

Finally, what did the reforms indicate or promise for rural dwellers who may have feared that reform might mean more cutbacks in the public sector, more damage to rural infrastructure and more, not less community vulnerability in the process? (Senate 1999; Productivity Commission 1999; Baum 1999). Regrettably, no promises were made to retain or build up rural infrastructure support. Rural people faced an array of structural barriers that impact on access to health services, including a lack of transport. According to DHS "... it is acknowledged that (rural) towns require some infrastructure to attract professionals and business, including GPs and pharmacists. However infrastructure cannot be developed unless there is sufficient population' (DHS 1999b, 'Implementing the Strategic Directions').

To compensate for infrastructural and supply shortages in rural Victoria, the Government anticipated that the private sector would step in to fill the breach. The new purchasing system would apparently encourage this by being more flexible. "Public health services will be able to purchase services from local or regional private providers that they could not otherwise provide themselves. Private providers, in particular health professionals, will benefit from the expanded market for their services' (DHS 1999b).

Evaluating the PHACS reforms

Perhaps the most structurally sound feature of the proposals was the population-based funding regime, rather than a more fragmented individual or program base. A system-wide allocation of resources is more likely to generate efficiencies.

Of concern, however, to rural populations, was the sheer geographic size of rural PHACS alliances being proposed. This was justified on the basis of 'economies of scale' (DHS 1999b), that is, that bigger (and fewer) is better. Smaller rural communities disagreed. They resisted rationalisation and reduction of local health services (Strasser et al 1994), and were reportedly opposed to any loss of proximity to their health services. Some feared that the reforms would lead to less community participation and a sense of ownership, and that this would be compounded by the management changes proposed. This proved to be a key concern among rural health providers.

The proposed PHACS management structure was superficially democratic and representative of most or all stakeholders (DHS 1998a). However, one 'lead agency' was to control the funds. In theory, horizontal integration between various health providers was proposed. In practice, it was feared that the system would lead to vertical integration, with a hierarchical regional structure dominated by more powerful providers and institutions, and by hospitals in particular. In its turn this led to a concern that PHACS budgets would be diverted from primary and community health care into secondary and tertiary health care (eg. Moira Shire 1998; Smith 1999).

A second rural concern was the apparent generic 'one size fits all' nature of the PHACS model. The PHACS framework provided a general template for future directions and funding. It did not appear to factor rurality into either the purchasing or service planning framework. Geographic and demographic differences were ignored. So too were the greater socio-economic disadvantages of rural regions (NRHPF 1997; Newman et al 1998; St Vincent de Paul 1999; Jesuit Social Services 1999; DHS 1999c). All were subsumed within what the RaySmith review criticised as 'a roll-out of a standardised model across the State' (1999: 6). The significantly poorer health status of rural Victorians (DHS 1999c) and resulting greater need for health services further reduced the probability that the reforms would benefit rural Victorians.

A third feature of the reforms was more promising, namely the development of common intake and screening procedures and more standardised forms of assessment. 'Clear referral pathways' were proposed, from screening/intake and initial assessment to other services provided by PHACS and other providers. Improving the fragmented, uncoordinated nature of the system depended, however, on two requirements, which may not have been deliverable in the short term.

The first was co-operation or 'collaboration' between service providers within each PHACS alliance, and with external providers and agencies, such as the acute care sector and Divisions of General Practice. Yet there was little in the proposals to encourage collaboration and discourage professional jealousy and 'turf protection' (Duckett 1999c). This is reportedly high in rural communities (CURHEV 1999). The second requirement was more resources. The new system required an upgraded and more managerially skilled workforce to implement the changes. Communication and computer technology was also vital, particularly the development of a comprehensive data base on clients and resources that could be shared by all providers.

In rural Victoria as elsewhere throughout rural Australia, the skill shortage among health professionals is well documented (AMWAC 1996; AIHW 1998). Integrated and continuous 'care management' requires either individual case managers or electronic sharing of information about common clients. The former is costly and was not anticipated, except for 'about 5 to 10 percent' of users who require assistance on an ongoing basis' (DHS 1998a). The alternative is an IT system of computerised reporting and coordination of client-provider interactions, which is linked to all providers and to relevant external agencies. There is some clinical evidence that lack of access to modern IT hinders a more united approach to patient care, for example with diabetes (Simmons & Kenealy 1999). The problems are therefore both clinical and resource-related.

DHS acknowledges that '... technology will be the glue that unites agencies within alliances' (DHS 1999a). However, the IT revolution '... is yet to arrive in the Australian health sector', according to Commonwealth health bureaucrats (Hagan 1999). It is a long way from rural Victoria, where access to and use of advanced information technology is limited (CURHEV 1999). There are additional problems implementing IT in the health sector, particularly electronic health records. Proposed Commonwealth legislation covering the private sector of health is aimed at dealing with privacy concerns (Hagan 1999).

A fourth concern about the PHACS proposed reforms relates to the contractual basis of the model. This was claimed to promote greater competition in the health system in Victoria. There are some potential advantages in health care agencies dispensing with core services in favour of contracting out. This may be particularly so in rural areas where the use of contracted services may allow smaller populations access to services where demand does not warrant full-time local staff. Additionally, resources may be allocated more flexibly if services are 'bundled' and contracted out to the most efficient providers (CURHEV 1999).

There are, however, many less palatable features of contracting out, which may lead to its overall costs exceeding the benefits. The first is that it is a difficult exercise in contractual architecture to forge satisfactory health agreements between purchasers and providers to cover all requirements and contingencies (O'Donahue 1989; Muetzelfeldt 1999). Contract-based relations require explicit specification of tasks and services, and in particular translating outcomes into outputs, and clear monitoring of how much or how well they are being performed (Alford et. al. 1994). Failure to achieve this impoverishes the resulting service delivery and its monitoring and evaluation.

A second difficulty with contracting out public and social services is that certain political and administrative problems arise when government withdraws from direct service provision, winds down the public sector and becomes merely a purchaser of privately provided 'public' services. According to one Australian Professor of Law, it must be '... acknowledged that ... government departments must find it harder and harder to devise policy when they have no-one within their departments with actual ground level experience of how that policy becomes operational, how it's working out' (Aronson cited in Crossland 1999).

A further legal-political difficulty arises from the law of contract, that of 'privity of contract', a doctrine that affects the lives of all citizens affected by contracted-out services. In this case, the two contracting parties were to be the State Government and DHS on the one hand, and PHACS alliances on the other. The third party, health consumers whose lives would be vitally affected by the contract, would not be a contracting party and may have limited legal rights of redress if they are 'ill-affected'. Citizens' legal rights, say, to sue for negligence may be unenforceable. These problems may not be relieved entirely by independent regulation to protect consumer interests, as has been suggested (Duckett & Swerissen 1996). For a parallel case regarding employment services, see the Commonwealth Ombudsman's submission to Senate 1998-9; Moyle cited in Crossland (1999), and Alford & Gullo (2000).

Contracting out has also given rise to problems of secrecy and alleged 'commercial confidentiality' in Victoria in the past few years (Auditor-General Victoria 1999). Consumers and citizens in general suffer as a result. This may have been worse in rural areas under the proposed PHACS reforms, where catchment sizes were to be large, and management distanced from many in the community. This was also at odds with the official expectation that the PHACS model would lead to more 'customer focus', greater transparency and accountability (DHS 1998a).

Service delivery may also suffer as a result of contracting out health services, as more resources are diverted from direct service delivery to management and clerical functions. Health professional staff reportedly spend a disproportionate amount of time preparing, applying for, monitoring and evaluating contracted-out services (Smith 1999; Muetzelfeldt 1999). This adverse impact of contracting out is greatest in rural communities that lack the breadth and depth of managerial talent of larger, urban health agencies. Evidence from other countries, including New Zealand and the U.K., is critical of contracting out on these grounds. This is yet to be informed by a rural perspective. See Peacock (1998) on the UK, and see Moller et al (1998) on New Zealand.

The competitive model underpinning the reform process proposed in Victoria is a final concern. DHS acknowledged that health markets were not well developed in Victoria, particularly in rural regions, and that 'collaboration' should therefore prevail over 'competition' (DHS 1998a). There is some tension between competition and co-operation, with a reputedly high degree of competitiveness between primary health care practitioners, agencies and programs, as well as between the public and private sub-sectors of health (NCEPH 1992; CDHSF 1998; Duckett 1999c). Promoting collaboration or cooperation between health service providers makes excellent sense. The point here is that it may not fit a model predicated on competition and contestability. The market model was also designed and framed for trade in inanimate objects (Quiggin 1997), hence is an unlikely choice of model for health service provision.

There are a number of necessary characteristics of a competitive market, few of which exist in the Victorian primary care and community health sector, particularly in rural Victoria. The first is that there must be a large number of buyers and sellers of a fairly standard product or service. Second, the 'product' has to be priced according to the forces of supply and demand. Third, market participants should compete on roughly equal ground with no market dominance by one or a few dominant players. Fourth, consumers require good or perfect information about suppliers and products, in order to take advantage of competitive markets. Finally, the motivation of market players has to be essentially self-interested rather than altruistic or community-oriented (Arrow 1963; Quiggin 1997; Hancock 1999b).

Regarding the first requirement, there are relatively few suppliers of health services in rural Victoria, while consumers are relatively dispersed and lack an infinite array of choices. The products are not standard, but are services designed to meet a variety of human health needs. Demand is not regular, predictable or based on price as in competitive markets, but on physical and emotional need (Arrow 1963).

The second requirement, for price signals to determine the level of supply and demand, is weak. There are many implicit and explicit price-fixing practices in the health sector, with many non-price factors influencing supply and demand for health services, including government policy, medical need and supplier-induced demand (Arrow 1963; Hancock 1999b).

Market power, the third requirement, is not equally shared, particularly on the supply side. A few larger players dominate, including public hospitals and private GPs. This is particularly evident in rural regions (Strasser et al 1994). Moreover, the low socio-economic status of many health consumers reinforces a power imbalance between them and health service providers (RACP 1999).

The fourth requirement relates to product knowledge. Australia's National Better Health Program concluded in the early 1990s that "... where health services are provided through (competitive) markets, consumer responsiveness depends on adequate information about the kind of service provided and on some kind of organised power in the market, comparable to that of the providers. These conditions are generally not realised in Australia. A coherent consumer voice in various primary markets for health care is not the same thing as health planners acting as surrogate purchasers ... consumer pressure is not always well-informed and does not necessarily encourage excellent primary health care practice' (NCEPH 1992; see also Hancock 1999b).

In short, the health sector is characterised by a fundamental asymmetry of information between providers on the one hand, and consumers on the other. Information is itself an important source of power. Shiell and Carter (1999) note that '... powerlessness is an important 'risk condition' for ill-health' (see also Jesuit Social Services 1999).

In sum, it may be quite inappropriate to propose that something as central as health can be inserted into a market-based model, and for policy and process reforms to be based on this model. The health 'product', if it can be described as such, is not like bananas or tomatoes, cars or caravans, and so on. The model needs to recognise the fundamental driving force of medical and psychological 'needs' rather than consumer 'wants' at its core. As Simmons and Kenealy note in their discussion of diabetes, optimal clinical care 'may be difficult to achieve under situations promoting market-driven approaches to care' (1999).

Conclusions

The troubled state of Commonwealth-State financial relations is a core problem affecting health care funding and service delivery, including in the primary health and community support sector (NCEPH 1992; Duckett 1999a). A Senate inquiry is currently under way to investigate this and other facets of Australia's 'unhealthy' system of health care. Without pre-empting its findings, health professionals and academics' call for constitutional reform is acknowledged as a prerequisite for achieving a number of health policy changes.

In the meantime, the reforms proposed to Victoria's primary health and community service system remain in the wings. They have laudable objectives, and potential strengths. They also contain weaknesses. Some of these have been addressed in the recent Raysmith review (1999). Design and implementation weaknesses are remediable, subject to adequate public funding and genuine community consultation.

Of major concern to smaller rural and regional communities is the issue of catchment size (Raysmith 1999). The idea of capturing economies of scale, that bigger is better, dominated the approach to the PHACS reforms. Large catchments combined with hierarchical management structures may, however, lead to a loss of proximate primary and community health services in rural Victoria, under the guise of rationalisation and economies of scale. Victorian rural reports indicate strong resistance to these trends.

The major weaknesses in the proposed reforms sprang from the underlying model and framework of market competition. Markets or quasi-markets in primary care and community health were to be created, by means of competitive, population-based funding for providers. Contracting out public and community services is itself problematic, particularly when accompanied by substantial downsizing of the public sector. This may lead to government devising and bureaucrats framing policies, but neither knowing how they work or will work in practice. Transparency and accountability may also be lost in the process. They need maintaining or retrieving.

The Raysmith review was also critical of competitive tendering for health services. It recommended a return to the drawing board to devise a new and better funding model. Regrettably, the review remained silent on rural versus urban health needs and other differences. More rural-focused studies are recommended, which compare smaller rural communities with larger metropolitan ones.

The growth in competition, the promotion of market-type behaviour and an emphasis on productive outputs or outcomes are all assumed to lead to efficiency and cost minimisation over time. It was assumed in DHS documentation that this would somehow also promote access, equity and quality, and thereby improved health outcomes. It is not at all clear how or why the proposed PHACS reforms could have achieved these results.

Victoria's reputation throughout most of the 1990s was as the Australian epitome of the 'market state'. Its privatisation and contractual models were promoted to developing countries around the globe, often without measured assessment or evaluation of their impact in Victoria or elsewhere (Hancock 1999a). This paper asserts that the model of health care at the core of the PHACS proposals is fundamentally flawed. If implemented, it may well have reinforced if not aggravated rural-urban differences in the quality of and access to primary health care in Victoria.

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