hfma briefing

Contributing to the debate on NHS finance
June 2009

Study tour: Australia

The HFMA and ACCA jointly organised a study tour to investigate aspects of the Australian healthcare system. Here the participants share their views and the lessons learned.

Foreword

Health systems around the world face the same problems. Populations are getting older. Expectations of health and healthcare are rising, as is demand for services. And we face common challenges in dealing with chronic and long term illnesses and providing access to the latest and often expensive technologies, drugs and therapies. Improving value for money and efficiency in healthcare – particularly given the global economic position – is now an international imperative.

There is much that can be learnt by sharing good practice from within our own health systems or across the UK family of health services. But there are lessons to be learnt from further afield as well.

The HFMA has a track record in looking to learn from international experience. Its long standing UK/US exchange programme has brought NHS and US finance practitioners together each year to discuss common challenges and possible solutions. But in recent years it has attempted to build on this by making contacts in other countries. It has overseen practitioner exchanges and study tours in a number of countries including Australia, Russia and Holland.

At the beginning of 2009, the association collaborated with accountancy body ACCA to arrange a study tour to Australia. The tour was a follow up to an earlier visit at the end of 2004. On that earlier occasion, with England busy implementing payment by the results, Australia's 10 years of experience (specifically in Victoria) of casemix funding was seen as a rich source for learning.

This return visit was an opportunity to update the position and take a broader view of current challenges. Of particular interest was the current reform agenda in Australia, approaches to policy development and experience with franchising.

Study tours are not about comparing health systems and their funding arrangements at a macro-level. Instead we are looking for insights and ideas at the individual service or organisation level, providing development opportunities for the practitioners involved and potentially a chance to spread learning across a wider finance community.

Mark Knight, HFMA chief executive

Acknowledgements

The January 2009 study tour of Australia was arranged by the HFMA and ACCA and included Mark Knight, HFMA chief executive; Mark Millar, chief executive of Hinchingbrooke Health Care NHS Trust and chairman of ACCA's health service network panel; Phil Taylor, HFMA international officer and independent management consultant; Paul Assinder, director of finance of Dudley Group of Hospitals NHS FT and vice-chairman of HFMA; and Dean Westcott, director of finance and deputy chief executive at NHS West Essex and ACCA vice-president.

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Australian healthcare: an overview

Mark Millar provides some essential background to the Australian healthcare system

Australia's healthcare system faces the same challenges as health services in the UK and around the globe. This point was underlined in a report last year by the National Health and Hospitals Reform Commission. The commission was set up to inform a reform programme to meet a range of long-term challenges. These included access to services, the growing burden of chronic disease, population ageing, costs and inefficiencies generated by blame and cost shifting and the escalating costs of new health technologies.

The commission's initial report, published in April 2008, *Beyond the blame game: accountability and performance benchmarks for the next Australian healthcare agreements*, in fact identified 12 challenges facing its health services – virtually all of which would translate to a UK context (see box below). The commission's second and interim main report was published on 16 February 2009, just a few weeks after the HFMA/ACCA study tour. This is covered in more detail elsewhere in this briefing (see page 10).

The current Australian system is complex, essentially because of:

- separation of Commonwealth and state (and territory) funding
- free market in primary care
- significant elective private sector market
- taxation incentives for private health insurance.

Healthcare expenditure runs at some 9% of gross domestic product with the federal or Commonwealth government providing just over two fifths of the total. A further quarter of the funding comes from state and local government with the significant remainder (roughly a third) covered by private health insurance, co-payments or other private funding (see box below)

Where the money comes from

Australian (Federal or Commonwealth) government	42%
State and local governments	26%
Private health insurance	8%
Out-of-pocket (co-payment)	17%
Other private funding	7%

In broad terms, the federal government pays for primary care and makes grants to the states as a contribution to the costs of hospital care through healthcare agreements. One of the contentious issues is the falling percentage of hospital costs funded by these agreements, though the federal government refutes this 'after allowing for specific grants'. The states fund the balance of hospital-based costs. What we would call community care is funded by a series of arrangements and grants across federal and state governments.

It is evident that these arrangements allow each part of the system to operate in isolation and give rise for significant opportunity to shift costs and blame. One thing is clear – Australia does not have a comprehensive national health system. This is the background in which the reform commission has been operating.

The system includes elements of co-payment and insurance funded care. The Australian culture values choice in primary care and has accepted the co-payment model. Primary care is a free market where any suitably qualified doctor can apply for a provider number and set up business without geographical restriction. There are incentives in place to encourage doctors to set up in more rural areas (3% of the 21 million Australians live in 90% of the land mass), but that is really the extent of primary care coverage planning.

Access to services in 'country' areas can be a real

Australia's 12 challenges

- Closing the gap in indigenous health services (health inequalities)
- Investing in prevention
- Ensuring a healthy start in life
- Redesigning care for those with chronic and complex conditions
- Recognising the health needs of the whole person
- Ensuring timely hospital access
- Caring for and respecting the needs of people at the end of life
- Promoting improved safety and quality of healthcare
- Improving distribution and equitable access to services
- Ensuring access on the basis of need, not the ability to pay
- Improving and connecting information to support high quality care
- Ensuring enough, well trained health professionals and promoting research.

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problem, especially when the definitions extend to the suburbs of major cities. We travelled only 30 minutes outside of Adelaide city centre to be in a 'country' area, where each community has it's own hospital built by public subscription and medically managed by local GPs.

If you visit a primary care doctor, you may well pay upfront whatever the doctor sets as the market rate and then seek reimbursement through the Medical Benefits Scheme (MBS) funded by the federal government. Reimbursement is likely to be 85% to 100% of the fee charged. Increasingly, doctors who charge only the standard reimbursement fee are being encouraged to 'bulk bill' MBS directly, taking some of the administrative overheads out of the system.

A similar system is in place through the Pharmaceutical Benefit Scheme for drugs where there is a standard co-payment of $30 (approx $2 to £1) or $5 for concessions. Various discounts are on offer to heavy users as in the UK.

Public hospitals – paid under different systems in different states (but including a payment by results-style casemix funding system in Victoria) – are free to patients but they are not without access issues in some areas. As one manager put it, services are free 'if you can get in'.

Roll back the NHS a few years with few hard performance targets and you begin to get a feel of the Australian system

Roll back the NHS a few years with few hard performance targets and you begin to get a feel of the Australian system. There are very few hard targets for hospital performance in terms of waiting times, either in accident and emergency or elective care. Waiting for elective care in the public system can extend into years and on one visit we were told that 50% of patients in A&E had been there over eight hours. The introduction of a more rigorous performance management regime is a key component of *Beyond the blame game*. Who do the Australian people blame for the health system? Asking this question drew silence from every federal or state office we visited, although it appeared that the public did not blame individual institutions.

The private market in Australia has traditionally had a greater penetration than in the UK. Around 60% of elective work is undertaken in the private sector. This may be a result of long waits, but the sense I had is that it is actually the other way around. There is an expectation of payment of at least part of the cost and an acceptance that elective care is a consumer good that has to be paid for, with the public system more reserved for urgent and emergency services. Certainly, there has been little shift in the balance between public and private over the years.

Around 44% of Australians have private health insurance, so why is it that only 8% of health costs are funded through this route? The reconciliation of 60% private elective care against these figures might be at least partially explained by the following.

Individuals are driven into private insurance through sticks and carrots in the taxation system. Premiums attract a tax rebate of between 30% and 45% and the absence of health cover progressively drives up the costs of national insurance. For middle income Australians, the cost of health insurance is less that the tax savings and avoided costs of not having it. The premiums are less than the tax rebate and penalty avoided.

It appears that the tax advantages can be gained with fairly minimal coverage. When it comes to making a claim, therefore, there is still a substantial out of pocket or co-payment cost. Remember that these costs account for 17% of the health spend. As health costs have continued to rise, these payments have grown as the financial coverage of the insurance policies has remained static. So, when the same group is asked about the use of their insurance, the view is very much that they may not look to use their policy because of the levels of excess and co-payment that would be required. The private elective procedures have a heavy bias to those that are high volume, simple and relatively low cost.

There are a number of areas that insurance cannot cover, for example any primary care costs over and above the Medical Benefits Scheme reimbursement.

For all of these problems, the health outcomes for Australians compare well internationally. Both life expectancy and five-year cancer survival rates are better than the UK. Many of the features around performance standards and different funding streams are not unfamiliar to the NHS of a few years ago. It will be fascinating to follow the debate ignited by the reform commission interim report on the way forward.

Mark Millar is chief executive of Hinchingbrooke Health Care NHS Trust and chairman of ACCA's health service network panel

Spending power

Before comparing approaches to healthcare delivery in the UK and Australia, it is important to understand the relative levels of healthcare spending in the two countries. Phil Taylor provides some high level analysis

The recent HFMA/ACCA study tour to Australia provided the opportunity to compare and contrast healthcare funding and spending across the two countries. It also provided an opportunity to review where both countries stand in the Organisation for Economic Co-operation and Development (OECD) health spending league.

The issue of comparative levels of healthcare spending hit the headlines in the UK in 2000, when then prime minister Tony Blair pledged that spending would rise to meet the European average of 8% over a five year period. This was later clarified as: 'in broad terms we have under investment and under capacity and in broad terms we have to match other European countries'.

Table 1 shows health spending levels as a percentage of gross domestic product (GDP) for a selection of OECD countries and how they have changed over 10 years. The per capita figures are for illustration only as they are based on exchange rates at a point in time.

TABLE 1

	1996 % Health/GDP	2001 % Health/GDP	2006 % Health/GDP	2006 £ Per Head
United States	13.2	13.9	15.3	4734
France	9.8	9.7	11.1	2431
Germany	10.4	10.4	10.6	2377
Canada	8.8	9.3	10.0	2593
New Zealand	7.1	7.8	9.3	1726
Italy	7.4	8.2	9.0	1843
Australia	**7.6**	**8.4**	**8.7**	**2191**
Spain	7.5	7.2	8.4	1733
United Kingdom	**7.0**	**7.5**	**8.4**	**1946**
Ireland	6.5	6.9	7.5	2173
OECD (29 countries)				
- Weighted Average	9.6	10.2	11.2	2416
- Median	7.8	8.3	9.0	2173

This indicates that spending in the UK exceeded the 8% target by 2006. Indeed between 2001 and 2006, UK healthcare spend increased from 7.5% of GDP to 8.4%, an increase of 0.9 percentage points. However, over the same period the weighted average of OECD countries moved from 10.2% to 11.2%, an increase of one percentage point. So a different perspective would suggest the UK was falling further behind the average.

Looking specifically at the UK and Australia, for the five years to 2001 we fell further behind Australia from 0.6% less in 1996 to 0.9% in 2001. The period of 'unprecedented growth' in NHS spending has seen us close the GDP spend gap to only 0.3% less by 2006. However, both Australia and the UK are fairly well down the league in terms of actual health spending as a percentage of GDP at 16th and 19th respectively out of 29 countries.

The picture shown by these statistics seems like a good reflection of the actual positions of the two countries, particularly in secondary care. There feels to be slightly more funding in the Australian system and staff don't seem quite as rushed or stretched. This is despite apparently higher overall staffing levels in the UK (although slightly fewer doctors):

- Australia has an average of 24.7 doctors per 10,000 population compared to 23.1 in the UK
- Australia has an average of 97 nurses and midwives per 10,000 population compared to 128 in the UK

In terms of hospital beds, the two countries are very similar with 40 beds per 10,000 in Australia compared to 39 in the UK.

And what about outcomes? The Australians are rightly proud of their performance in terms of life expectancy. Australia currently has the highest life expectancy at birth of all the countries listed in the table, at an average of 82 years (84 years for females and 79 for males). At the same time they are ashamed of the fact that aboriginal Australians life expectancy is 17 years less than the overall average. There are also problems with rural, remote and poorer people, who have worse health outcomes and less spent on their healthcare.

With the exception of the US, the UK has the lowest life expectancy of all the countries listed in the table at an average of 79 years (81 for females and 77 for males).

Both Australia and the UK are fairly well down the league in terms of actual health spending as a percentage of GDP

UK government funding at 87% is an outlier compared to most western governments that fund around 75%.

This is all interesting, perhaps, but can you compare two countries with such different climates and lifestyles? Well, if we assume these factors are roughly constant over time, the statistics are even more worrying, because this life expectancy gap appears to be increasing. Over the period 1970 to 2003, Australian life expectancy increased by an average of 0.27 years per annum compared to 0.20 in the UK.

So if there is a need for increasing healthcare spending in the UK, how are we going to fund it (particularly with the credit crunch,) and can we learn from Australia?

Table 2 compares total spend to the level of government spend on healthcare. For most of these countries, the positions are similar in both rankings because their governments fund between 70% and 80% of healthcare costs. The US is the obvious big difference, but two other outliers are the UK and Australia. The Australian government share is low at 67.7% and the UK is high at 87.3%. So the argument would be that the Australian state can afford higher levels of spend on healthcare because it only funds two thirds of it.

TABLE 2

2006 figures	Total Health Spend GDP %	OECD Rank	Government Spend GDP %	OECD Rank	Share of Total
United States	15.3	1	7.0	10 =	45.8
France	11.1	3	8.9	1	79.7
Germany	10.6	4	8.1	2	76.9
Canada	10.0	8	7.0	10 =	70.4
New Zealand	9.3	11	7.3	6 =	77.8
Italy	9.0	15	6.9	12	77.2
Australia	**8.7**	**16**	**5.9**	**18 =**	**67.7**
Spain	8.4	18	6.0	16	71.2
United Kingdom	**8.4**	**19**	**7.3**	**6 =**	**87.3**
Ireland	7.5	22	5.9	18 =	78.3
OECD Weighted Average	11.2		6.7		59.2
OECD Median	9.0		6.8		76.1

The sources of healthcare funding in Australia are:

	% 2006/07
Australian government	42.4
State/territory/local government	26.2
TOTAL GOVERNMENT	68.6
Health insurance funds	7.3
Individuals	17.0
Other non government	7.1
	100.0

One striking feature is that almost one fifth of healthcare is funded directly by individuals out of their own pockets. And this does not appear to be a problem for most Australians. They may not like it, but on the whole it is accepted.

The main items covered by these out-of-pocket expenses include:

- Medications (ie pharmaceuticals) 33.9%
- Dental services 23.6%
- Aids and appliances (including glasses and wheelchairs) 12.5%
- Other health practitioners (physio, chiropodists, podiatrists) 10.6%

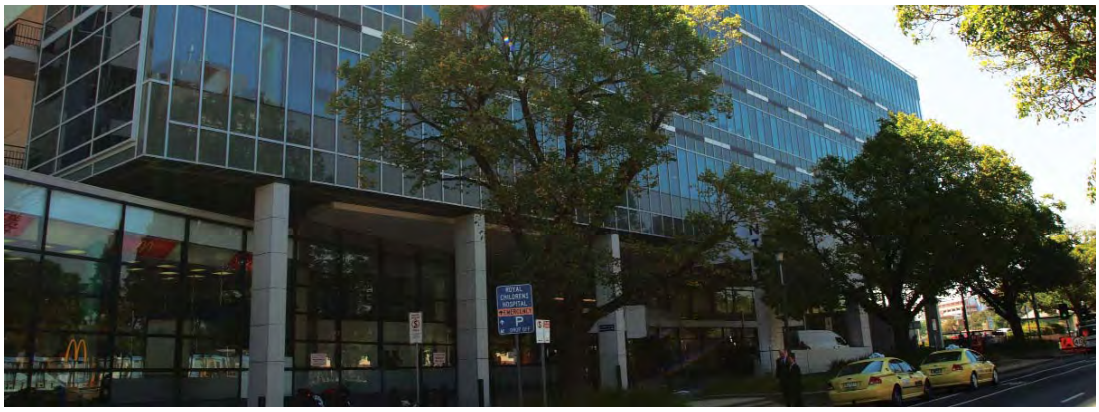
There is much more talk about the second highest non-government funding element: health insurance funding. In Australia there is an incentive scheme that provides a non-means-tested 30% rebate on private health insurance contributions. These rebates are treated as healthcare funding by the government rather than a reduction in tax revenues.

The remaining 7.1% of non-government funding comes mainly from compulsory motor vehicle third party and workers compensation insurers, which also seems much higher than the UK.

The question for us then in the UK is whether additional investment in healthcare could be generated from non-government sources. The OECD average of around 60% of healthcare funding provided by governments is heavily influenced by the position of the US. But even excluding this, UK government funding at 87% is an outlier compared to most western governments that fund around 75%.

The two big areas of additional funding in Australia are co-payments and private health insurance.

The major element of co-payment by value in Australia is medications. Under the Pharmaceutical Benefit Scheme (PBS), prescription charges are relatively higher than in the UK. They are up to about £15 ($33) for most PBS medicines or £2.50 ($5) for concessions. In the UK prescriptions are now £7.20 or free for a concession, and only £104 for a 12 month prepayment certificate. The Australians have an



annual safety net at around £600 ($1,265) or £150 ($318) for concessions.

While there is general acceptance of out-of-pocket contributions, the level of co-payment is contentious in Australia with arguments that the poorest and most deprived miss out medication because of cost. One study showed that in 2008, 36% of chronically ill Australians said that they had failed to fill a prescription or skipped medication doses, did not visit a doctor when they had a medical problem or did not get recommended tests, treatment or follow up because of cost. On the other hand, supporters claim it reduces unnecessary medication and waste, and that the demand for medication is virtually price inelastic.

The issue for us is simply that Australians pay much more for their prescriptions, and so should we consider moving in the opposite direction to Scotland to increase charges in England?

The second big difference is the use of incentives to encourage private health insurance. Some 44% of Australians are now covered by private health insurance. This is despite a universal taxation-funded Medicare system covering many healthcare costs. Private healthcare insurance provides additional cover for some services not covered by Medicare. If individuals do not rely solely on Medicare there are many possible levels and types of private cover to add to it.

Under Medicare, you can be treated as a public patient in a public hospital at no charge. You cannot choose your own doctor and you may not have a choice about when you are admitted or the length of time you wait (above 12 months for a hip replacement in some states) but you will get treated. As a private patient, you choose your own doctor, decide which hospital you attend, have a reduced wait and a choice of admission dates and Medicare will cover you for 75% of the standard fee for medical costs. You will be charged the remaining 25% plus some or all of the costs of: accommodation, theatre fees, ICU costs, drugs dressings and consumables, prostheses, diagnostics, and any additional doctors fees. Overall then, despite the Medicare contribution, private healthcare can be very expensive. Private healthcare insurance can be tailored to cover all or some of these costs, and there are two major financial incentives to take it up

A government rebate of 30% of the cost
Avoidance of a 1% tax surcharge for all taxpayers earning above about £35,000 who do not have private health insurance

The result is that over 50% of elective surgery is performed in the private sector, mostly paid for by health insurance benefits. (Only 6.7% of these benefits go to public hospital services).

Both co-payment and insurance options would be possible in the UK. Both would provide additional funding. But neither are likely to prove popular.

Whether they are desirable or politically feasible is another question. What the public wants is improvements in healthcare that they don't have to pay for. And that is what we all work hard to achieve each day. However there must be a limit to the rate at which efficiency and productivity can improve. Given that the NHS has achieved central efficiency targets year after year, do we have the capacity to increase the level of improvement to meet the additional requirement that we are likely to face in 2010/11?

If not, could increasing co-payments and rates of private health cover make a significant contribution?

Phil Taylor, an independent management consultant, is currently HFMA international officer

44% of Australians are now covered by private health insurance, despite a universal taxation-funded Medicare system covering many healthcare costs

Franchise experience

With England investigating the possibility of running a hospital under franchise, Mark Millar looks at a similar arrangement in Western Australia

Hinchingbrooke Health Care NHS Trust, where I am chief executive, may well be the first district general hospital in the NHS to be offered as an operating franchise to both the public and private sector, (the East of England Strategic Health Authority preferred option currently under discussion). So I jumped at the chance to visit a broadly comparable facility managed under this arrangement in Australia.

JOONDALUP STATISTICS

	2006/07	2007/08
Admissions	38,817	39,768
Day only patients	19,822	20,857
Births	1,879	2,113
Public	1,305	1,439
Private	574	674
Operations	15,008	16,046
Total public operations	9,348	10,176
Total private operations	5,660	5,870
Total emergency attendances	52,769	59,485

Joondalup is about 20 miles north of Perth, within the North Metropolitan Area Health Service – one of four in Western Australia – which provides public hospital, community and mental health services to more than half a million people in Perth's northern suburbs. The organisation directly manages a number of hospitals within the area, but has an arm's-length relationship with Ramsay Health Care for the operation of Joondalup Health Campus. Ramsay, which is a global healthcare provider with 22 hospitals in the UK, was not the original partner, but acquired the contract.

The campus has 379 beds of which 309 are public and 70 dedicated private. Public and private wards are adjacent and indistinguishable, save for the carpet in the private area. The hospital was a private sector build and operate initiative, opening in January 1998 with a franchise with the Western Australia health minister for the provision of public services for 20 years and private for 40 years. Ownership has transferred over the years as the private health sector has consolidated and changed through merger and acquisition. There is a view that some operators performed better than others.

Public and private wards are adjacent and indistinguishable, save for the carpet in the private area

Although a separate entrance signifies Joondalup Private Hospital, it is in fact little more than the outpatient consulting rooms. Public and private wards mirror each other across a central lobby. The financial terms of public provision are agreed each year and the private income is open to the vagaries of the market and not guaranteed.

Following the success of the hospital and the need for redevelopment, this has now been extended for a further 10 and 20 years respectively.

Joondalup is in an area of growing population and the workload of the hospital has grown since opening with those increases continuing in recent years (see box). A $230m (approx £110m) redevelopment contract was signed in January 2009. The hospital currently officially has 17 accident and emergency (A&E) bays, eight observation beds and 10 critical care beds, though is actually running with 30 A&E bays. This demonstrates the population growth in the area and underlines the need for the recently agreed redevelopment. Incidentally, doctors working in the emergency department are unusual in that they are salaried, while other medical staff enjoy the benefits of fee for service.

There is no four-hour A&E wait target in Australia and we saw at least six patients who would have breached the 'no go' 12 hour target. Hospitals in the state share information about emergency department pressure in real time and are far more likely to go onto divert than in the UK. The hospital offers a wide range of general services including mental health beds with a secure unit contained within it.

Funding arrangements

Hospitals in Western Australia are effectively funded on a grant or block basis but Joondalup funding is based on casemix and consists of the following public funding streams:

Diagnosis related groups (DRGs)

- Surgical
- Medical

Bedday payments

- Mental health
- Rehabilitation
- Nursing home type
- Palliative care

Occasion of service

- Emergency department attendances
- After hours GP attendances
- Clinics – allied health, day therapy, antenatal
- Oncology
- ECT
- MRIs

Other funding as agreed

- Junior medical officers, clinical academics.

In addition, the hospital generates income through private patients.

Unit prices are set using benchmarking data from Western Australia's public hospitals. This incentivises the private operator to stay ahead of improvements at hospitals across the state if it is to generate profits. The state appears to take no account of costs and prices in other Australian states such as Victoria, which uses a tariff-based system to fund its hospitals.

Joondalup appears to be well integrated into the rest of the health system and, funding mechanism aside, seems to be treated in an even handed way in performance and planning decisions. It operates under a more disciplined financial regime than other hospitals we visited. Elsewhere it appeared that where a unit overspent, as long as there was a credible (usually workload-related) reason, the overspend was massaged away by the state treasury, and also added to the following year's grant.

The hospital is also paid to train health professionals. It has the ability to attract medical staff to work in the facility, bearing in mind that GPs and consultants are both paid on a fee for service basis. Many of the doctors worked in a number of locations and were reasonably flexible about their arrangements. Across the state the exception appeared to be emergency department doctors, who form a strong group in Australia and are salaried.

Western Australia has been reviewing its hospital service provision following a report by a specially created health reform committee, which reported in 2004 – the Reid report. It is as a result of this that Joondalup has secured the expansion signed in January. This will give the hospital

- A new emergency department
- New operating theatres
- New public wards
- New critical care.

The plan for the redevelopment is for a reverse private finance initiative. The state will fund the public use infrastructure and effectively charge back to the operator an availability charge.

A private sector run district general hospital within what is otherwise a public sector system appears to work well in Joondalup. However, when comparing it with a potential solution for Hinchingbrooke, my current trust, we need to bear in mind that this is a hospital that has always been in the private sector and therefore created as 'additional' to existing services – akin to the UK treatment centres – rather than through a transfer of an existing entity.

When talking to staff therefore, they have chosen to operate in that setting and were not subject to compulsory transfer. However, there was as much focus on delivering emergency and indeed mental healthcare as private elective surgery and a sense that the hospital was looking to play a full part in the wider health system.

It is impossible to escape the sense that the method of determining the annual funding for the public services at Joondalup is less than transparent. The state appears not to use all the comparative information it might and the management was not forthcoming on the profitability of the hospital. However, assuming it reasonably reflects costs in other local hospitals, it could be argued that whatever upside the operator is making, value for money for the public purse has been satisfied. This argument might be easier to sustain if there were more explicit quality and performance measures sitting alongside the financial arrangements.

It is certainly a very different arrangement to that in place for independent sector treatment centres in the UK. Here the element of subsidy is much clearer through the minimum income guarantee and the premium over tariff, both in the public domain. This, of course, was the inducement to enter the market on a much shorter contract of five years than the 20 year minimum seen in Joondalup.

If Hinchingbrooke is offered as an operating franchise, the emerging rules suggest that neither a minimum guaranteed income or tariff premium would be applied. Bidders could be expected to make their case at tariff. One might anticipate however a range of bids, which may, at one end of the scale, deliver an annual dividend back to the NHS or, at the other, require a premium over tariff.

We would all expect to be able to succeed in a growing market. The rapid population growth in Joondalup has probably ensured a financially successful franchise and become an irresistible force for the expansion recently agreed. But how much private or public sector appetite might there be to enter a financially level playing field for an established operation in a mature market? As someone likely be caught up in much of this territory – watch this space.

There was as much focus on delivering emergency and indeed mental healthcare as private elective surgery and a sense that the hospital was looking to play a full part in the wider health system

Kevin Rudd's government made an election pledge to take over the financial running of hospitals if things did not improve by the end of this year

Australian healthcare reforms

Australia is contemplating a major overhaul in the way it funds and delivers healthcare. Dean Westcott reports

In common with most developed healthcare systems, the Australian system faces the challenges of an ageing population, increased demand for services, increasing prevalence of chronic diseases and rising costs. There are additional challenges within the Australian healthcare system resulting from the way services are currently delivered and where responsibility lies.

The challenges and tensions resulted in prime minister Kevin Rudd's government making an election pledge to take over the financial running of hospitals if things did not improve by the end of this year. A National Health and Hospitals Reform Commission has been established to provide advice on performance benchmarks and practical reforms to the Australian healthcare system that could be implemented in the short and longer term to address these challenges.

So what is it about the structure of the Australian healthcare system that has given rise to accusations of cost shifting and a culture now often referred to as the 'blame game'?

The Australian healthcare system is characterised by a federal system of government, where power and responsibility is spilt between the Commonwealth and state governments. In broad terms, the Commonwealth government has the main revenue raising powers through general taxation. The Commonwealth government is responsible for directly funding certain elements of the system – GPs, the Pharmaceutical Benefits Scheme and aged care – and provides funding to the states and territories to run the public hospital system. The hospital funding is delivered via time-limited written agreements known as the Australian healthcare agreements, which cover national priorities.

The states and territories are then responsible for a range of services including running the public hospital system, whose funding is supplemented from limited local tax revenues, predominantly arising from goods and services taxation.

It is this mix of funding and responsibility for delivery that has led to a culture of cost shifting and blame for many years and which, arguably, has prevented the development of integrated care for patients.

The terms of reference for the reform commission contained two major work streams:
1. To provide advice on the framework for the next Australian healthcare agreements (AHCAs), including robust performance benchmarks in areas such as elective surgery, aged and transition care and quality of healthcare

Reform response

Perhaps unsurprisingly given the wide ranging stakeholders, reaction to the draft reform proposals has been mixed.

This is particularly pronounced for key specific proposals – for instance the proposal to provide universal dental care for all through an increase in tax. But there is also a degree of consensus. This consensus is at its greatest behind the view that reform is needed and long overdue. It is the specific shape of the reforms that is a major issue for debate.

There is widespread acknowledgement that the report has been bold in its proposals. Two of the three options for governing the future health system, removing the current two tier responsibility between Commonwealth and state governments, are seen as particularly radical.

A number of state governments oppose the Commonwealth assuming overall responsibility for health, suggesting this approach would increase bureaucracy and create a system that was less responsive to patients' needs. This is clearly a potential risk. But arguably the current system, which is typified by a blame culture and fragmentation, can hardly be in the best interests of patients or improving longer term health outcomes.

A number of commentators cite lack of funding as the key issue for the current failings. However by international standards, with expenditure at 9% of gross domestic product, Australia compares favourably with other OECD countries. Others point to wide scale inefficiencies within the system, which the reforms must address.

And they highlight not only the level of administration and system performance management, but also the wider structural issues. It is acknowledged for example that Australia has one of the highest hospitalisation rates in the world and that there should be a greater focus on alternatives,

2. To report on a long-term health reform plan to provide sustainable improvements in the performance of the health system.

The commission published the first of its reports – *Beyond the blame game – accountability and performance benchmarks for the next Australian healthcare agreements* – in April 2008. The second report, an interim report on system reform, was published in February 2009 and contained some potentially far reaching proposals for the future structure and delivery of healthcare in Australia.

The directions for reform contained within the report are built around four main themes:

- Taking responsibility – individual and collective action to build good health and wellbeing by people, families, communities, health professionals, employers and governments
- Connecting care – comprehensive care for people over their lifetime
- Facing inequities – recognise and tackle the causes and impacts of health inequalities
- Driving quality performance – better use of people, resources and evolving knowledge.

The interim report contains many proposals for reform in specific areas of the healthcare system ranging from mental health to dental care and also includes a proposal for the establishment of a special health authority to deal with the health needs of aborigines and Torres Strait islanders.

The main focus of the report however is on the future governance of the healthcare system. Put another way – who should run the system? The report does not make any firm recommendations – these will be made in the final report due in June. But it does put forward three options for debate and consideration.

As an overarching point, the report recognises that primary care is the foundation of the healthcare system and that the current split in funding and responsibility weakens the effectiveness of primary healthcare, distorting priorities and causing problems with service delivery. It recommends that,

something that the system as currently organised is not well placed to facilitate.

The interim report urges more resources to be spent on prevention and proposes a national agency to take this agenda forward. Many agree that increased investment in prevention will enable future generations to enjoy better health and lead to a better use of resources. Others argue that much more could be done now within existing resources to improve both outcomes and prevention. In particular there is support for the report's proposal to change the way in which GPs are paid to assist.

The commission suggested an increased emphasis on paying GPs and primary health workers for episodes of care, coupled with payments for good performance. While there are small scale examples of payments for performance targets, for instance covering immunisations, the current system is essentially a fee for service system. This is akin to buying a doctor's time with no links to effective outcomes or improved treatments. A move away from this would be seen as a radical departure and is likely to meet strong opposition from some sections of the medical profession.

With a clear need for reform and widespread backing for this, the focus will shift to the government and the level of political will to introduce real change. Some of the proposals are undeniably radical. And the government has raised expectations by making a commitment to take over the financial control of hospitals if the states do not commit to reform.

While broadly welcoming the report, the government has also been careful to distance itself from some of the more radical elements although it has welcomed further debate in advance of the final report. One thing is certain – whichever route is chosen there will be pressure from some quarters to resist reform. However, there is a feeling that the opportunity to introduce real change and build a healthcare system fit for the challenges of the future should not be wasted.

whichever model of governance is eventually chosen, the Commonwealth should take responsibility for policy and funding of all primary healthcare.

The three key options for reform are;

Option A – Continued shared responsibility between governments but with clearer accountability and more direct commonwealth involvement.

Under this option the Commonwealth would be responsible for all funding and policy relating to primary care and would pay states and territories a percentage of the episode 'efficient' cost of providing inpatient and emergency care and the full cost of outpatient episodes based on budget negotiations with each state. It suggests that these arrangements would be established through a national health strategy covering all health policies and programmes.

Compared with current arrangements, this option has the advantage that both levels of government continue to be involved. The states would remain accountable to their own populations and could therefore deal with issues of diversity. It would also strengthen the provision of integrated care by making outpatient and primary care the responsibility of the Commonwealth.

In addition, by paying for every episode of hospital care, the Commonwealth will have the incentive to shape the programmes it is responsible for. It could also start to address issues related to the increasing demand for emergency care and admitted care as well as addressing issues of cost efficiency (with episode payments based on the efficient cost of delivery). It is acknowledged that this proposal would involve minimal disruption and transition risk to current arrangements. However by retaining the involvement of two levels of government, it would not entirely address the underlying reasons for the current tensions and leaves challenges with regards to the coordination of policies and programmes.

Given the current widespread dissatisfaction with the way services are organised, the commission's draft report represents a watershed

Option B – Commonwealth to be solely responsible for all aspects of healthcare delivered through regional health authorities.

This option radically changes the current governance and responsibility arrangements and would see total responsibility for public funding, policy and regulation of healthcare transfer to the Commonwealth. The Commonwealth would then establish and fund regional health authorities to take over responsibility for health services currently run by the states.

This option has the significant benefit of a single national approach to healthcare policy and delivery, although regional health authorities would be required to engage locally and identify local priorities for service development and health improvement. In theory at least this model should also deal with the issues around blame and cost shifting and has enormous potential to better integrate healthcare. The potential disadvantages are the risk associated with the major change that would be required and the potential weakening of local accountability.

Option C – Commonwealth to be solely responsible for all aspects of health and healthcare, establishing compulsory social insurance to fund local delivery.

A variation on option B, this option would see the establishment of a tax funded community insurance scheme under which people would choose from multiple, competing health plans. These plans would be required to cover a mandatory set of services including hospital, medical, pharmaceutical, allied health and aged care services. A key advantage of this option is the incentive for health plans to be responsive to the needs of members and to purchase integrated care in line with those needs, with members able to switch plans if these needs are not being met.

There are significant pressures facing the current Australian healthcare system. Like other systems, it faces major challenges in the coming years. And given the current widespread dissatisfaction with the way services are organised, the commission's draft report represents a watershed moment for the government to make real change happen.

Dean Westcott is director of finance and deputy chief executive at NHS West Essex and ACCA vice-president

Does Britain need a productivity commission?

Paul Assinder examines an Australian organisation set up to inform and improve the development of government policy and asks whether the UK could benefit from a similar body

As you read this, somewhere in the bowels of Walworth Road, Smith Square and wherever the Liberals live these days, teams of policy advisers, focus groups and party faithful will be toiling away on their parties' manifestos for government. The framework of European democratic party government is well rehearsed over centuries past. Political parties develop policy, governments enact it and the opposition parties oppose it as a matter of course. But there might just be a better way of generating national policy alternatives that gives independent credibility and rigour to the proposed direction of travel.

One approach to policy determination and the establishment of cross party consensus on matters of national importance is the Australian model of an independent policy research body – Australia's Productivity Commission.

The Productivity Commission (PC) is independent of government, along the lines of the UK Audit Commission or National Audit Office. Unlike these bodies, its scope and powers extend well beyond the efficient and effective implementation of government policy. Its role in life is essentially to conduct research into economic, social and environmental issues affecting the welfare of Australians, to help governments make better policy.

It employs over 200 permanent research staff and is accountable to a small group of eminent commissioners, appointed by the governor general. All reports produced are submitted to Parliament via the Treasurer's Department of the Canberra Government. The PC works through direct investigation and research, holds formal hearings and public meetings and has the legal right to summon the attendance of Australian nationals. It accepts referrals from government on current matters of public concern and is not above 'stirring the waters' in its own right when it feels that government is slow in referring, through the issuing of highly regarded discussion documents.

Productivity Commission – current work

- Executive remuneration
- Contribution of the not-for-profit sector to the economy
- Impact of the regulatory burden on the petroleum industry
- Gambling

The PC was created by an act of the Australian Parliament in 1998 and its name was intended to emphasise the need for future government policy to deliver a more productive and efficient economy – the key to better living standards in a time of growing demographic pressures. The PC's core function in the Australian system is to conduct independent research or inquiry into key national policy or regulatory issues – but crucially to do this before the government of the day decides on policy.

In addition the commission has a major role in retrospectively evaluating policy actions and undertakes (on behalf of the Council of Australian Governments) the much revered Review of Government Service Provision. This effectively marks national and state governments performance in meeting productivity and social objectives. Since 2002 it has been given a national role to report on disadvantage towards indigenous Australian people.

Principled approach

The work of the PC is governed by three main principles:

- Independence – it answers to no single political or interest group.
- Transparency – the PC's advice to government and the information and analysis upon which it is based is fully open to public scrutiny.
- Community-wide perspective – it is statutorily required to take the interests of all Australians into account.

Upon receiving a policy referral (see box for current work programme), a series of public meetings is held to explore the issues and determine the scope of the study before the commission advertises for expressions of interest. Visits to interested parties are conducted, meetings held with key opinion formers, discussion papers written and public meetings called. Within six to nine months, a draft report is issued on which comments are invited. Hearings are usually held on the draft and commissioners consider these and approve a

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Its value lies essentially in its independence and its operating integrity. It seems to make the inherently messy business of government more business-like

final report to be considered by ministers. The treasurer (chancellor of the exchequer) is required to table this report in Parliament.

In its distinguished 10 year history, the commission has made some significant contributions to the development of Australian government policy, including the resourcing of university education, an evaluation of measures taken to preserve and protect the Great Barrier Reef and, in the field of health, a celebrated exposé on the investment programmes of the pharmaceutical industry and an analysis of the real costs to Australians of the system for financing GP care.

Reviewing policy

Probably the PC's most widely acknowledged role is its 'no holds barred' annual assessment of the performance of Australian government, which leads to a report known as 'blue book'. This provides independent objective information about the performance of government services to improve future policy. The review measures service efficiency (for example using international comparison); effectiveness (achieving stated measurable objectives); and equity. It is a genuine attempt at honest performance appraisal that is keenly reviewed by the Australian media and taxpayers alike and as such is the scourge of many a government minister.

The 2009 key performance indicator sets for primary and community care (chapter 11) and hospital services (chapter 10) are highly interesting in the UK context. The output and efficiency measures used largely mirror Department of Health and Care Quality Commission standards, supplemented with a valiant attempt to measure user satisfaction, CQUIN style quality indicators and an assessment of equity of access for hard to reach and deprived communities.

From my research and reading, and in the opinion of some senior commentators in Australia with whom I've discussed its role, the PC is a firm and valued aid to policy determination. Its value lies essentially in its independence and its operating integrity. It seems to make the inherently messy business of government more business-like and that could only be a good thing for us in the UK.

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About this guide

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Home truths

Mark Millar offers an insight into the funding of residential and community care down under.

Silver Chain Nursing Association in Perth, Western Australia, has come a long way since it was founded in 1905. Infant mortality was running at 25% and Silver Chain was set up as a district nursing service with a single nurse. Today it employs more than 2,400 people with an annual operating budget of $127m, just short of £60m.

The not-for-profit organisation provides a range of services including: home help; personal care; general community nursing; and intensive home nursing. It also owns and operates six nursing homes.

Similar in size to many English PCT provider arms, there are key differences in the services offered. For instance, it delivers a number of services provided in the UK by local authorities or the private sector. However it does not offer therapy services, which in the main are privately provided in Australia.

A major difference is the funding source. Silver Chain identified 26 different funding sources across four major government departments.

- The Department of Health of Western Australia – $79m across 11 community based care headings.
- The Department of Veteran's Affairs – $5m in four streams for community and residential services
- The Commonwealth Department of Health and Ageing – $28m in six streams for residential and community care
- The Disabilities Services Commission – $3m
- The $12m balance comes from non-government sources including residents' fees and fundraising.

For each funding stream there is an accountability requirement to justify the expenditure. This inevitably provides a logistical nightmare. It is perhaps not surprising that the chief executive 's primary focus is delivering services and then meeting the funding body reporting requirements.

In visiting Silver Chain, we were intrigued by the nursing home sector. This seems quite a regulated sector in that the states determine the number of places that should be available and also set a rate of reimbursement. Providers can charge more and residents will pay a top-up. The economics of the business now seem to mean that many providers cannot build homes that are affordable under the state reimbursement and a top-up that the market can bear. As a result, instead of there being a competitive auction of the limited quota of beds, many quotas are left unfilled.

A typical daily rate in a Silver Chain home is $112. The government will reimburse $105, leaving the resident to fund $7. Income levels per bed as measured through EBITDA (earnings before interest, taxation, depreciation and amortisation) range from $2,500 per annum (not for profit sector) to $6,000 (private sector). With building costs of $180,000 per bed, the economics are difficult to achieve.

One way around this is to ask residents to fund the capital cost through a bond to the capital value of the residential place, say $180,000. The home owner will have use of the capital which will be returned to the resident or their estate on departure. This will be the identical sum – without any interest. I wonder whether this is a business model that could be brought to the UK?

The tour party included (l to r) Dean Westcott, Mark Knight, Paul Assinder, Mark Millar and Phil Taylor

Instead of there being a competitive auction of the limited quota of beds, many quotas are left unfilled

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