A (rural) health system for the 21st century

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Our next speaker on the panel this morning is Professor Jane Hall. Jane is the Director of Strategy and Professor of Health Economics in the UTS Business School. She was the Founding Director of Shere and held that position until 2012. She is a Fellow of the Academy of Social Sciences in Australia. In 2012, Jane was recognised with a UTS Vice Chancellor's Award for Research Excellence in Research Leadership. In 2011, she was awarded the inaugural Professional Award, made by the Health Services Research Association of Australia and New Zealand, for her outstanding contributions to research, developing the field, and mentoring others. She's currently leading the APHCRI-funded Centre for Research Excellence in the Finance and Economics of Primary Care. She's actively involved in the policy analysis and critique, and is a regular commentator on health funding and organisational issues in Australia. Jane's represented Australia in many international health forums. Could you please welcome her to the stage ... Professor Jane Hall.

Thank you, and I was listening to our Chair reflect on the light and dark, the serious and the not so serious parts of this conference, and I can assure you, whenever an economist gets up to speak, nobody thinks it's going to be anything other than serious. What I want to talk about, obviously, is my perspective as an economist, on financing the health care system, and how the financing models we use drive what we do. So I'm going to start with talking a bit about economics and health, pick up then on what I see as the challenges for today's health system, and try not to repeat too much of what Bob said, and therefore where we need to go forward in building the sort of health system we need—we all need—for the 21st century.

So the first lesson of economics is that resources are scarce. And Jessica Irvine, an economics commentator, says there will be no economists in heaven because there's no scarcity. We'll all have what we need. But luckily for those of us who've made a career out of economics, we're still here in a world of resource scarcity. And really, the sort of keynotes that we look at when we look at how to use resources—we have to choose how to use resources because they're scarce—the keynotes that you hear economists coming back to are efficiency and effectiveness, equity and fairness and increasingly, issues about process and how that affects people - not just outcomes, but the process by which outcomes are delivered. So in health care then, the decisions about how we use scarce resources—and they're not just money; they can be physical resources and the human time, which is ultimately our scarcest resource—we're interested in how they affect the health and wellbeing of the population. And the immediate consequence of resource scarcity is opportunity cost. Every time we decide to use resources one way, we're forgoing the good things we could have had by using them in an alternative way. And what economics does and health economics does, is provide the tools and the framework to evaluate those decisions. So that's really all you need to know about economics, to understand, mostly, what we're talking about.

So what are the challenges? Well, as I see it, our health care system is a real victim of its own success, and what this graph shows is just how much the proportion of country's wealth, country's income, has been devoted to health care over the last 40 years. And it's gone from an average of about 5% of gross domestic product, to somewhere up to 10 to 12%, and that's leaving America out of it, because they just change the figures immediately. There's so much in that pile. So why are we a victim of success? Well, one of the big challenges for health care systems has been that until really the mid 19th century, there wasn't much effective treatment around, and medical technology has opened up the range of treatments and the effectiveness of those treatments, so there's a lot more that can be done for a lot more people. And the second challenge of health care systems has been to ensure that the people who are sick, who are needy, can get the care that will help them. And so a challenge still in the United States and in many developing countries, but not so much in the rest of the developed world, is to

provide universal access to health care services. And systems that have achieved that like us—universal access and implementation of modern medical technology—end up with rapidly growing budgets.

Now, how did our health care start? This top picture, see this little thing circled here? This is the first hospital constructed in Australia. And as you can see, that tent was put up when there was very little else there. So one of the first activities of the Australian health care system was to establish a hospital. And our focus has been largely on hospitals ever since. And they morphed from these rather frail, primitive structures, into these very grand, Victorian monoliths. And hospitals, therefore, seem to still be the key point and for many, many communities and indeed for many politicians and certainly for much of the media, the key focus of what our health care system is about.

And that set up a way of us having to design how to pay for health care, with a focus on hospitals. At the same time, back in the 18th and 19th centuries, most out-of-hospital health care was just doctors coming to see patients, and as you can see from this picture, there didn't seem to be much they could do apart from being comforting. And this has moved us, but if we look at health care today, the doctor-patient encounter is quite different. Here's the computer, here's a different set of notes—the interaction is quite different and what the doctor can do for the patient is quite different. And this hint of technology here tells us it doesn't all have to be done on a face-to-face encounter. And yet, our financing system is based on paying for that face-to-face encounter. So you can see why I say, our financing systems were really developed in the 19th century, and we have to question whether they're the financing systems we need for the 21st century.

Now, what's going to happen as we move into the 21st century? Well, we can start with the premise that resource scarcity is going to increase, because we can do more, and it's going to increase for various reasons. The technological developments continue apace, we've seen changing demographics. Partly due to that success of medical technology, people are living much longer. We've seen—I believe that one of the overlooked challenges is going to be the increasing incidence of rare diseases. We've been so focused for the last 20 years on the big killers and the big diseases, I think a lot of our policy has missed the growing incidence of what were once called rare diseases. Diseases that used to kill people early in life, like cystic fibrosis, effective treatments are coming along, and they're becoming chronic diseases, not just diseases of young people. We've got to understand the interplay of health and other support services, as we deal with ageing populations who are not necessarily sick but increasingly frail. We know there's a challenge in terms of increasing our focus on prevention and early intervention, and we know that there are new treatment modalities using modern forms of communication, that are changing the way care can be provided. Remember when many of us were young, going to a hospital meant going through some imposing doors and having your clothes taken away from you and most of your identity. Now, hospitals provide services in all sorts of settings. But, when we look at that resource scarcity, we must remember, though, that Australia's still the lucky country. If you follow what's happening, particularly in Europe, there have been major consequences of the depression and recession that's followed the global financial crisis, and there, health care systems are cutting back now and severely. We are not facing quite that same crisis, so we've got time to think about the response that we need to make to the increasing problems of scarcity.

Now what's that focus on hospitals and doctors seeing, physically seeing patients given us? Well, it's given us the problems of our current funding system. We've got split responsibilities across Commonwealth states and to some extent, local governments; we've got an interaction of public and private sectors, sometimes a complementary interaction, sometimes a competitive one. It's given us complex revenue streams, lots of different programs for lots of different things, and those funding programs tend to be inflexible and largely very fixed. The concerns that then that sort of funding system drives are that we've got inefficient production, are we providing care where it can be funded, or the way it can be most effective, and potentially the over consumption that we often see associated with fee-for-service. But it's also—although we like to think we've solved the access problem by having universal health care, there are still problems of access and unequal outcomes, and I'm sure I don't need to expand on that to this audience.

In rural areas, it seems to me there are some even greater challenges. There's the tyranny of distance, which affects individuals' access to care but also the logistics of providing care. There's the problem of what we economists call economies of scale and economies of scope. Economies of scale means being able to do things at a large enough volume to achieve efficiencies, and economies of scope means being able to have sufficient complementary services that then can work together to deal with the problem. There are problems in attracting and retaining practitioners, problems in providing the appropriate health services for the special populations, both Indigenous populations, but also dealing with the problems that come with rural lifestyles. So if we put all that together, I think what we've got to say is that the balance between access and equity and achieving efficiency in organising services, may well differ in rural communities than it does in urban communities. So we need to look for different solutions.

So what do we need out of our 21st century health system? Well, this is what Commonwealth Treasury says. We need a health system that uses cost-effective interventions; it needs to be able to adopt innovation; it needs to be able to reallocate resources, which means being able to disinvest in things that are no longer efficient and reinvest in things that offer better value for money. We need to have the right professionals in the right locations, and we need to improve safety and quality. So whatever we think about our current financing system, it's not doing those well enough.

Now, if you're going to start on designing a new health care system, where would you start? Well, I think you've got to start with primary care. Over 80 pere cent of the Australian population see a GP, and a GP is still the most visible part of primary care, every year. And that compares with about 13 per cent of us who are admitted to hospital. So if you want to start where the people are, start with what's happening in general practice.

What do we know about paying for general practice? Well, actually we know quite a lot about the three traditional payment mechanisms, which are fee-for-service, salaries and capitation. We know that fee-for-service encourages activity, will get higher volumes of services. It's pretty hard to say what it will do about quality. It tends to lead to a lower referral rate compared to other systems. Don't know what it does about time, but it certainly makes costs hard to control for the funder. Salaries are a much better bet for the funder, because they've got a clear handle on how much those health care services are going to cost. But the volume of service tends to go down, the effects on quality are indeterminate. The referral rate tends to go up, so maybe it's not such a good deal for funders, and the time taken with the individual encounter tends to go up.

And capitation, well again, volume tends to be lower. We can't say much about quality. We can't say much about time, and again, it's a pretty good way for the funders to control their total exposure to costs. So when we look at that sort of evidence, we can see that funding mechanisms have their good points and their bad points. And so that's led us, as well as most other countries to look at different ways of paying their providers, particularly to use elements of those different ways of paying people to try and get better outcomes. And as soon as we move to those blended systems, we can't say very much at all; the same if we moved to more targeted performance, such as the pay-for-performance or quality outcomes framework that tries to reward specific actions or specific outcomes. We really can't say much about what's going to happen.

Let's me show you this graph. So this shows the red line up the top here, is just the rate of increase of MBS payments for unreferred attendances, so it shows you the trend, generally, in GP visits. This lower line is SIP payments for asthma, this one is SIP payments for cervical screening, and this one for diabetes. And what can you say about SIP payments, looking at that? If you can see any general pattern, come see me afterwards; I'll give you a job. But I think what that says is, you can't say anything in general about how those financial incentives work. So financial incentives tell us something, but they're not the whole story. We have to understand financial incentives and the non-financial incentives if we're going to understand what's happening to services. And that's only services; we don't have a handle on health outcomes.

So can we design better incentives? Probably. But we have problems in understanding and measuring productivity in health care, and particularly if we start with primary care. Primary care medical productivity is often talked about in terms of how many patients are seen, how many services are delivered. But that's not necessarily a good measure. If a substitute for many short services, is one longer service, why would you just look at the number of services. We know from evidence that payment systems in urban areas can produce different incentives to when they're applied in rural areas. There are differences between urban and rural settings. We know from Canadian and New Zealand experience, that salaries might be more effective in rural areas, particularly in attracting and retaining practitioners, and we know from some of the preliminary work in my group on Australian data, that it's the younger male doctors, those who say they enjoy their work more and are prepared to put in more effort, who are more likely to move to rural areas. But it's those who grew up in rural areas who are more likely to stay. And women, particularly married women, which tells us something about gender responsibility still, are much less likely to have the mobility to move to rural areas.

So I'm not going to go through the current reforms, because I think Bob's covered that very accurately, but it's interesting that my take on what's happening is about we're trying to change some incentives here. So local decision-making with more flexibility rather than centralised decision-making, activity-based funding for hospitals, which is changing the incentives for how hospitals manage their business, and performance reporting which can be effective in changing provider behaviour as well as consumer behaviour.

So we did a survey, just at the time the reforms were being introduced, of key informants. We recruited these people through the Australian Health and Hospitals Association, so they were key people in hospitals, in health agencies and in community services, and we asked them some questions. We got about 135 responses, which is not bad for surveys of this type. 90 per cent said before the reforms, our health care system needed fundamental change, or complete restructuring. So almost all of those who worked in it agreed it could be much improved. Then we asked them some questions about, once the reforms are implemented, how do you think the system will look then? And you see that many of them seem to welcome the reforms. 36 per cent said more reform would be required; 26 per cent said, yes, some more change. So over 50 per cent are saying more reform is needed. We haven't got there yet. Only 17 per cent were so cynical as to say it wouldn't make much difference, and a few brave souls said yes, it will achieve all we need to achieve for the foreseeable future. One of the things we asked them was about alternative funding mechanisms. Again, overwhelming majority of respondents, around 80 per cent, agreed that we needed to move to more flexible funding to allow for more coordinated care; and yet less than half thought that should be a move to pay-for-performance. So there's still a lot of concern about the impact of pay-for-performance being applied in this country. So when we put all that together, where does that get us? We've got some incentives in the system that are trying to move for more efficiency, but we've got a clear view that much more reform is needed.

What have we got? We've got the states as system managers, but the states' focus is on public hospitals and the non-medical primary and community services. Medical primary health care services still seem to sit mostly under the Commonwealth. So again, we've got this split of funding streams. We've got Medicare Locals with a very clear population focus, and as Bob said, that's the first time we've seen that element strongly injected into the Australian health care system. But as yet, little leverage for changing the behaviour of the other actors and agencies in the system. We've got the local health networks or hospital networks, whatever they're called in the state that you're from, and we've really yet to see what they're going to do. Are they going to be just hospital managers or service managers, or population focused? And so we've got what's coming together with a lot of emphasis on managing the elements of the activity but nothing that is managing the levels of the activity and the appropriateness of the activity, which is why I have the question posed to you there, is there a wise purchaser in the system? And that's the question that other countries are asking themselves and trying to drive organisational reform that changes that.

What about consumers? We still have the possibility that consumers could be empowered to be the purchasers of their own care, and so the role of consumer choice could be far more explored. But one of the problems with trying to empower consumers to manage their own care is that usually it ends up backed up by higher co-payments, and higher co-payments, we know what effect they have. They disadvantage the poor. They have little impact on the better off, but for the poor and sick, they do reduce the level of service use, but not necessarily the services that most people would regard as trivial or unimportant.

So are we there yet? Well, I've been very critical of the existing system for the inflexible funding and organisational arrangements that it had, but in being critical we also have to remember that everything that was done seemed like a good idea at the time. And I think one of the problems is that what seemed like a good idea, was a good idea for one aspect of the system and didn't think about the system as a whole. We know that the old funding solutions are not going to work well in our new environment dealing with our new challenges. We have to find better and smarter ways of providing the health care if we are going to maintain what Treasuries regard as financial sustainability whilst also maintaining equity and universality. There's some evidence to guide us, but it's limited, however it does exist and we have to use it wisely. And there's my acknowledgment of how the research was funded.

Thank you.