

THE STRUCTURE OF AUSTRALIAN HEALTH CARE PROVISION

AIM: To describe Medicare, including its benefits and central relationship to the wider structure of the Australian health care system. To explain some controversial initiatives to improve health service management such as managed care, purchaser/provider splits, case management, pooled regional funds, and diagnostically related group funding.

AN OVERVIEW OF HEALTH EXPENDITURE

An earlier lecture discussed health promotion in Australia. However, one can see from the figures below that health promotion and related community based expenditures are small in comparison with what is spent on hospitals, doctors and pharmaceuticals - the three areas of expenditure which, along with veterans affairs, are administered by the Health Insurance Commission through the Medicare system. In 2004-5 the Australian government spent more than \$40.5 billion on health care for a national population of around 20 million people and this cost has been rising sharply. The Australian Institute of Health and Welfare (AIHW) indicates that in 2000 expenditure on health care accounted for 8.3% of Australian gross domestic product (GDP). Duckett's work suggests this had increased to 9.3% by 2004. Governments provide most of the expenditure on health care. The Commonwealth provides around 45% of the expenditure and the state and local governments nearly 25%. The non-government sector provides the rest. The distribution of expenditure, according to the AIHW, is outlined below. Duckett's later work provides a similar picture.

- Public acute care hospitals 31%
- Medical services 19%
- Pharmaceuticals 12%
- Private hospitals 8%
- Nursing homes 8%
- Community public health 5%
- Dental services 6%
- Research 1%

Health care may be funded primarily from private expenditure, as in the U.S., or may be overwhelmingly publicly funded, as in the United Kingdom. Australia has a mixed system of provision. The percentage of total health expenditure from public sources in Australia has remained constant at around 70% since 1984, when the Medicare system was introduced. Medicare is the foundation of the Australian health care system. It guarantees free hospital and medical services, as well as a range of subsidised pharmaceuticals to all Australian residents. However, the current mix of health funding sources and responsibilities has developed historically with the political relationship between the states and the Commonwealth, rather than more logically. This has made Australian health care administration unnecessarily complex, expensive, and lacking in transparency.

Early in the 20th century, Australian government health care expenditure was directed overwhelmingly to State hospitals. Since then an increasingly tangled array of Commonwealth and state regulations and policies have developed, as the Commonwealth has gradually extended its influence over the states through providing them with additional taxpayer funding for specific purposes. The Commonwealth currently continues this process primarily through five year Medicare Agreements made with the states. Block grants, which include health related funding, are also provided on a regular basis. Since the early 1990s the Council of Australian

Governments (COAG) has committed itself to a national and competitive approach to the design of health policy and standards. This requires clear, reliable information to be publicly available to purchasers and consumers. Ideally, health services should be administered transparently on a regional basis, so that the comparative outcome of administration and treatments can be effectively compared. This is an essential aspect of the development of evidence-based care.

COST, ACCESS, EQUITY AND QUALITY OF HEALTH SERVICES

According to Duckett the amount that Australia spends on all its health care services has been comparatively stable in the latter part of the 20th century and there has been little inflation of health care prices. The health share of gross domestic product (GDP) was between 8% and 8.5% throughout the 1990s. Australian government spending on health care increased from under 50% in 1960, to about 70% in 1975 with the introduction of Medibank, the precursor to Medicare. The publicly funded proportion of health care fell in the 1970s when Medibank was dismantled, but increased again to around 70% in 1984 after the introduction of Medicare, and has remained stable since.

Contrary to what some may believe, a larger role for the private sector in health care provision has been shown to increase health care costs, not reduce them. This is because government monopoly of health care funds may be able to put downward pressure on the price that health providers charge for this essential service, whether they operate in the public or private sector. It is generally recognised that the U.S. health care system costs nearly twice as much, yet performs worse in terms of meeting broader community requirements, than other health care systems where government plays a much larger role, such as Canada, Britain or Australia. Tiffen and Gittins (2004) show that of seventeen developed countries, the US spends the most money on health care but the population have a shorter life span than in any other developed nation.

Health care is a vital human need when individuals are at their weakest. Ordinary people, especially sick ones, have little bargaining power against the collective might of health care providers. These include health fund managers, hospitals, doctors, drug companies and researchers who generally understand how to operate the system well and who seek to earn as much as possible. If government can design the total health care provision so that it can exercise a monopoly influence over the prices charged by health care providers, as well as gaining the benefits of competitive service delivery, then people appear to have better access to care. This is the general European, Australian and Canadian pattern, which is not favour in the U.S.

Duckett has compared Australia and the U.S. health care systems in terms of their cost, access, equity and quality. The two systems are designed very differently. In the U.S., employers take out health care for their employees, or individuals purchase it from competing health care funds on their own behalf if their employer does not carry it. The government provides a safety net system of health care, which applies only to a small minority of impoverished people, although the health care of the aged may also be subsidised. The effect of this private sector delivery plus residual government safety net approach has been that health care prices and related premium costs have risen to a point where over thirty million people can no longer afford health insurance coverage. However, they are not poor enough to qualify for government funded health care.

In Australia, Medicare provides free, taxpayer funded, health care services to the total population. People who would like extra services can purchase them through taking out private health insurance designed on top of this basic, universal provision. If people do not think the private sector provides a sufficiently valuable service, they have the Medicare alternative to go back to. Duckett has shown that this design puts a continuing downward pressure on private sector health

care prices, and also ensures the whole population gets better access to services. He also showed that poorer people, who research shows are less likely to be healthy, are the ones who use health services most in Australia. On the other hand, the quality of health care services in the U.S. appears higher than their quality in Australia. At first glance this might seem surprising, since the Australian Medicare system provides the potential to systematically gather data about treatments in both the public and private sector, and for the entire population, in order to compare and thus improve them. However, Australians do not yet have the kind of access to comparative information about the quality of health provider performance that most American consumers of health care take for granted as their right.

As a proportion of GDP, the U.S. spends almost twice as much on the provision of health care as Australia does. In the U.S., however, health services are also most likely to be used by wealthier members of the society, because they can afford them. Their face lifts may therefore be subsidised by the insurance of poorer people with more urgent medical needs who cannot afford to act on them fully. Although the U.S. spend much more on research than most nations, funds are also likely to be targeted primarily to the development of products and services that will bring in most money. When publicly funded universities and research institutes are driven by purely sectional interests, they are likely to be drawn into serving the interests of the wealthy, rather than those of the ordinary taxpayer or the poor.

HEALTH INSURANCE - RISK RATING AND COMMUNITY RATING

It is important to understand the various meanings behind the loosely used term 'health insurance' because the development of an effective, transparent, and low-cost national health system depends upon structuring the fund well. The terms 'health fund' and 'health insurer' are often used synonymously. However, although Australians talk about health insurance, Medicare is funded from a much larger pool of general taxation revenues. In the traditional insurance industry, premium levels are worked out mathematically. Their level relates to the assumed likelihood of people making claims and what each claim will cost the insurer in the future. An insurance scheme may be operated as a pay-as-you-go system or a fully funded one. In the former case, the outgoings of any particular year are met by the premium of that year. In an extreme version of such a system, nothing is brought in from previous years, and nothing is put aside for the future. A fully funded scheme involves the calculation and provision for future liabilities arising from each claim incurred in a particular year, rather than the deferment of these liabilities. This is generally considered safer and more equitable than a partially funded scheme.

In the 'ideal' private sector insurance scheme, the people who experience the highest risk of needing insurance related support are usually also the ones who must pay the highest premiums. Estimating the future level of claims accurately, in order to set current premium rates appropriately, is the business of actuaries. It is generally thought that an absence of premium cross subsidy is fair, and in the general interest, because risk rating should also provide high risk purchasers of insurance with incentives to reduce their levels of risk. In the real world, however, this does not always occur. (For example, a government inquiry into why so many ships had sunk off the Australian coast in the early 1990s produced the 'Ships of Shame' report. It showed that international insurers were continuing to insure ships, which were little more than rotting hulks, because of their primary focus on taking insurance business away from their competitors. The failure of the giant British insurer Lloyds was partly related to this kind of problem.)

In Australia, State workers' compensation acts require all employers to take out workers' compensation insurance to cover workers who may be injured at work. The individual employer's premium level is set according to the industry risk rating to which the employer belongs.

Construction, for example, has some of the highest premium rates, while retail has some of the lowest. Large employers also pay premiums on the basis of their past individual injury and rehabilitation performance, as well as their industry risk rating. Risk rating gives them incentives to lower their premium through introducing better management systems to prevent injury and to rehabilitate the injured. Some employers in high risk industries such as mining and construction may take out extra insurance, usually called 'top-up', which provides injured workers with a higher rate of benefits than those required by law. This only occurs where trade unions are strong enough to negotiate them successfully.

The health care costs, which are incurred under workers' compensation schemes, are much higher than the health care costs under Medicare and also tend to rise much faster. This is partly because health care providers are able to charge more for this comparatively small volume of services, which are provided to injured workers, through their employers' insurers. It is also because any court disputes about the extent of a worker's disability will mean that the opposing lawyers for the employer's insurer and for the injured worker will both call upon their particular tribes of health related expert witnesses.

It would substantially reduce health care costs to industry if there was more effective integration between the management of Medicare and workers compensation insurance. However, the 'ideal' insurance practice of risk rating premiums has been considered discriminatory and inappropriate in regard to the establishment of general health care systems. Chronically ill people are comparatively likely to be poor or old, and to use health services often. In some cases they may be able to change their behaviour in a way that will make them healthier, so that they use health services less frequently. However, the potential for this is extremely limited, and policing dangerous personal health behaviour, such as smoking, diet or lack of exercise, to make sure it conforms to specific premium rates, would be costly and probably impossible.

For good reason, therefore, it is considered morally wrong for governments to set higher premiums for those people who appear likely to use health services most frequently. A community rated health insurance scheme usually establishes its requirements on the basis of the estimated cost of the treatment needs of the whole population covered by the system, irrespective of their apparent likelihood of using its services. Under a full community rated scheme the sick pay the same amount as the well, and young people pay the same as old people, even though they are much less likely to need hospital care.

In Australia Medicare is a community rated insurance system. The government also requires private health insurance to be community rated, not risk rated. This makes it difficult for private health insurers to establish premiums accurately. For example, if a large proportion of elderly people take out private insurance, and then become comparatively high users of the private health care system, this may send an insurer broke. To guard against this the Commonwealth has established an administratively complicated back-up system for private health insurers, where the latter pay part of their premium pool to government, as a kind of 're-insurance', in case they need government financial support themselves, further down the track.

BRIEF HISTORY OF AUSTRALIAN HEALTH CARE DEVELOPMENT

When the Australian Commonwealth was established in 1901 health care was available through state based, private health insurance funds. These insurers offered individuals coverage for treatment in hospitals for which state governments also provided funding. The Commonwealth department of health was established in 1921, but for many years its primary responsibility was for quarantine and the care of war veterans. An amendment of the Constitution in 1946 gave the

Commonwealth powers to make laws with respect to the provision of a range of pensions and also some pharmaceutical, sickness and hospital benefits, and medical and dental services. Private medical insurance also became available to individuals during that period. The National Health Act of 1953 provided for a highly subsidised national health insurance scheme through private health insurance taken out by individuals. In 1968 the Nimmo Committee estimated that at least a million Australians suffered hardship because of the costs of insurance. It argued that gaps between fees and rebates were variable and considerable, and that insurance premiums discriminated against the chronically ill and those with pre-existing illness.

As a result of these continuing criticisms the Whitlam Labor government established the Health Insurance Commission in 1973 to administer the Medibank system. Medibank was designed as a public, non-contributory, national health insurance scheme, which provided universal access to medical and hospital services regardless of income. The Commonwealth also made specific payments to the States to fund related hospital care. It also funded extensive new hospital construction through the Health and Hospital Services Commission, and established community health centres. The Community Health Program established in 1973 provided for services to be responsible for the health of a specific geographical area. The service was established around a multidisciplinary health centre but had no legislative backing and was not well integrated with existing health or welfare services. Medibank was dismantled when the government lost office in 1975 and a Liberal coalition government came to power. By 1981, universal, non-contributory insurance had been abandoned in favour of a safety net for the disadvantaged and contributory private insurance with tax rebate incentives for the rest of the population.

When the Hawke Labor government gained office it introduced Medicare in 1984. It was much like its predecessor, Medibank. However, Medicare's introduction involved an explicit government agreement with the trade union movement, whereby national wage increases were publicly discounted to allow for the introduction of the system, and a Medicare levy to be collected through taxation was introduced. This was to publicly demonstrate that no country could pay both high wages and high levels of welfare unless its international trading position is healthy. Deregulation of the Australian wages system represented part of the trade-off for Medicare introduction. Although Medicare is financed partly through a general levy of 1.5% of taxable income, this levy contributes only around 10% of health expenditure overall, and less than 20% of Commonwealth expenditure on health. Its level is tokenistic in that it in no way reflects the real cost of health care to the community.

Private health insurance is provided by two kinds of organizations. Open, state registered organizations, like Medibank Private, have around 90% of total private insurance membership. Employee based, restricted membership organizations also provide their members with health insurance. Such private insurance contributes about 11% to the community's total health expenditure. Other forms of Commonwealth or state taxation provide for the rest, with the exception of a comparatively small amount of personal or premium related expenditure from other sources. Today, however, the Medicare system has bipartisan political support. Internationally it is well regarded as doing a good job.

BASIC MEDICARE STRUCTURES

From the consumer perspective, the Medicare system provides a guaranteed safety net of hospital, medical and pharmaceutical benefits to all Australian residents. Extra entitlements may be accessed by the purchase of private health insurance cover. During the 1990s the Liberal coalition government subsidised take-up of private health insurance heavily so that more health funding and facilities would become available to serve the whole community and waiting lists would be

reduced. The Commonwealth medical benefit schedule (MBS) is a price list of treatments, which is like the backbone of Medicare, because its use as a universal reference point puts a downward pressure on prices for the majority of health care services in Australia, whether they are delivered in public or private settings.

Prior to 1953 there was no Commonwealth involvement in the process of fee determination for doctors. This changed when the MBS was first published and set benefits payable to health funds by the Commonwealth for specified medical services. The current MBS price setting structure is based on a list of 'most common fees' charged for 1880 medical items first drawn up by the Commonwealth and the Australian Medical Association in 1970. In the light of recent discussions about the importance of evidence-based health care, future modifications to the list should increasingly be related to the demonstrated health benefits of various medical treatments, and to the competitively determined cost of their treatment inputs.

Under Medicare all Australians are entitled to free medical procedures in public hospitals, even if they are privately insured. For the privately insured patient, Medicare provides 85% of the MBS rate to any public or private hospital. Medicare patients may also get free medical treatment from any doctor who bulk bills Medicare. The doctor will get a rebate of 85% of the MBS fee for a particular service from the Health Insurance Commission. Alternatively, a person may pay the fee, which the doctor requires up front, and apply for a rebate of 85% of the MBS fee from Medicare himself or herself. They will apply to their health fund if privately insured. Fifty-eight percent of medical services were bulk billed in 1990 and this percentage has been gradually increasing since, to around 74% in 2004. A doctor is free to choose whether to bulk bill patients. The decision may be influenced by the socio-economic status of the clients, and by the number of competing service providers available in an area. In 2004 the government provided increased support for general practitioners every time they bulk bill children under sixteen or people with a Commonwealth concession card. From a community perspective, the situation of a registered general practitioner might be compared with that of a teacher. While teachers are allocated to particular schools, general practitioners have choice over where to set up their practices, although further education and specialisation incentives are now being linked to country service. A result of the current system is an oversupply of general practitioners (and probably related over-servicing) in urban areas, and major shortages in rural areas.

The Pharmaceutical Benefits Scheme (PBS) subsidises the cost of approximately 650 drugs, available in approximately 1500 forms and strengths, and marketed as approximately 2000 different brands. The government reduces the cost of pharmaceuticals by negotiating an agreed wholesale price with the supplier of a particular product through the Pharmaceutical Benefits Remuneration Tribunal, and subsidising the cost of the product to patients above a specified prescription charge or co-payment. People who hold pensioner health benefit cards pay a set contribution to the pharmacist for each listed item. The pharmacist then claims the remainder of the price of the item from the Health Insurance Commission. According to Baume, about 70% of Australians have used a therapeutic drug in any two week period, increasing with age. Half of these drugs are on prescription – of which 75% qualify for benefits under the PBS. The policy task is to try to provide people with effective health care affordably, as distinct from providing incentives for legitimated drug use as the first answer to any medical or social problem. This is a particularly important issue in regard to any mental health related diagnosis and treatment.

PRIVATE HEALTH INSURANCE

According to a recent Industry Commission study, people who take out private health insurance appear to be wealthier, older, and in better health than those who rely solely on Medicare. They nominate 'security' and 'peace of mind' as the most important reasons for having private health insurance and see avoidance of waiting lists for elective surgery, and access to the doctor of their choice as the most important reasons for having it. (It should be noted, however, that the Australian health care system is far from transparent and people have little reliable data available to them about whether their chosen doctor is a comparatively expert practitioner or not.) Other perceived benefits of private health insurance are access to the quality environment of a private hospital, and subsidised payments for ancillary services such as physiotherapy, acupuncture or dentistry. Until recently people had been progressively dropping private health insurance because it was perceived as poor value for money.

Private insurance coverage recently dropped to a third of the population, compared to 50% before the introduction of Medicare in 1984. Apparently successful efforts have recently been made to reverse this slide, although whether they will have a long-term effect seems unlikely because of rising private insurance premiums. The Medicare levy collected through taxation was increased by 1% for high-income earners who had not taken out additional private health insurance. (An earlier budget had added an extra .2% to the Medicare levy to fund a guns buy back scheme to recompense gun owners in the face of new gun control legislation.) A substantial tax rebate was also introduced for all people who take out private health insurance, regardless of their socio-economic status. However, the resultant higher utilisation of private health facilities has also had the recent unintended consequence of increasing private health insurance premiums. The Labor opposition now argues that government support for private insurance has primarily benefited the comparatively wealthy, and will not achieve the desired objective. They claim that more funds should be made available for public hospitals rather than trying to encourage the establishment and use of private ones. This seems to be the route Britain has gone down. It has a much smaller private health insurance sector than Australia.

From a government perspective, the point of encouraging private health insurance is primarily to increase the overall pool of health funds and facilities available for general use. In the past, treating the private patient in a public institution has often proved an attractive option for doctors, hospitals and health funds alike. For example, some doctors with privately insured patients work in public hospitals on a sessional basis. These specialists were charged a facilities fee by the hospital when they treated their private patients in public institutions. Such economic incentives promoted over reliance on the public purse and under utilisation of private sector facilities. In recent years there has been an increase in government purchase of treatment for public patients in hospitals built and/or run by the private sector. This is consistent with the national competition policy that public and private sector health service providers should compete on equal terms on 'a level playing field' of national standards. The argument is that people with urgent needs should not have to wait for treatment, but should be found a bed immediately in a public or private facility, with treatment provided according to the patient's Medicare or private insurance status.

The Medicare system depresses the cost of health care provision by linking all government reimbursements to health care providers to the CMBS, and prohibiting private health funds from insuring for the full difference between the total amounts the health service provider charges, and the amount Medicare will reimburse. Insurers can only cover the difference between the Medicare rebate and the MBS price for the service. Individual patients have to pay any extra costs themselves. This contributes to people seeing private health insurance as poor value for money. A vicious cycle is established as people relinquish private insurance coverage because of

the combination of high premiums and unexpected and uninsurable 'gap' payments, which may have to be made to a doctor or hospital after treatment.

A related common complaint is the stream of bills, which an ex-patient may have to face, sometimes for treatments and services which the patient has forgotten about or was not aware of having. Each specialist likes to bill their patients separately, and most doctors are unwilling to relinquish this control so that their service is reduced to an item on a single, comprehensive, patient account. The extra cost of this situation means that many people with private health insurance who are aware of their full options, may in some cases still choose to enter hospital under the Medicare system.

To phrase it another way – there are two funding ‘gaps’ in private health insurance. The first gap is between the MBS fee and the Medicare rebate. Health funds are able to insure this gap. A second gap is between the MBS fee and what the private hospital or doctor actually charges. The patient must pay this difference. Since 1996 the government has supported private health insurers partly to give them incentives to negotiate agreements with hospitals and doctors that they will either charge no more than the MBS price for their services, or will state up-front to the patient what the difference between the MBS price and their actual fee for service will be. Doctors have resisted entering such ‘no-gap’ or ‘known gap’ arrangements with health insurers and hospitals. The results of this may be that people continue to drop out of private health insurance as a result of gap costs and/or the continually rising price of premiums. The current relationship between the Medicare system and private health insurers is administratively complicated and expensive. Other insurance options obviously need to be investigated which do not damage Medicare.

MANAGED CARE

‘Managed care’ may mean many things, depending upon the design of the health care system in a particular country. In Australia, negotiations are continuing between the Commonwealth, health funds, doctors, and hospitals over what ‘managed care’ should look like, and about the related provision of a single bill to cover all the health services provided during a patient's hospital stay. In this country, the concept of managed care is perhaps most clearly related to the necessary development of strong distinctions between the organizations which are responsible for purchasing health care on the one hand, and the organizations or individuals who are responsible for providing it on the other. The requirements of the Competition Policy Reform Act of 1995 are that the rules of market conduct should uniformly apply to all market participants whether they are public or private sector service providers. Government is increasingly being seen as the appropriate national regulator, which provides funding to a range of public and private sector managers or service providers, on equal terms and conditions, in order to compare outcomes.

Funding for public hospitals has historically been a joint Commonwealth/state responsibility, and state health departments have been regulators, purchasers and providers of many services. ‘Purchaser/provider splits’, are the development of a clear and essential distinction between those organizations which purchase services and those which provide them. Such splits are considered necessary for effective and transparent management, in order to continuously improve health service outcomes. Since the 1980s in NSW area health service management structures have been set up to integrate all public health care for a defined geographic area under a single management and purchasing structure. While the principle purchasers of health services are area health service managers, private health insurers also purchase the services of hospitals, doctors and others. Although hospitals are providers, they may also be purchasers of doctors’ services. Because the Medicare system collects data related to private sector health care as well as publicly provided care, a reasonable amount of comparative treatment data for both sectors is available to the Health

Insurance Commission. Recent studies have shown interesting differences between the treatment provided in these two systems, with apparent strengths and weaknesses in each area. However, there is currently an absence of data which allows public identification of particular providers.

Many people do not like the increasingly common term 'case management'. This seems fair enough, because the term implies that each individual patient or welfare recipient should be looked on as a health practitioner's 'case'. The term care coordinator is better, except that the term manager more clearly identifies responsibility for performance. It is important to understand what these terms mean, because the implementation of case management is expected to lead to better care. Currently, an individual might need to go to a range of separate health care providers, to access their care for themselves. This system does not work well. For example, research has shown that a small minority of the community appears to go regularly to many different doctors, apparently taking out a very large number of prescriptions. Another group of people, such as those with disabilities, may not have the knowledge or confidence to access all the systems necessary to gain the continuing health care they need. Under case management, a care manager is provided with a budget for a specific client with a chronic condition. They develop a care plan in consultation with the client, and then purchase the relevant services on the client's behalf. Ideally this system should be more equitable and safer than the current one which is client driven. It should also allow the care manager much wider latitude to purchase those services most relevant for the client's welfare, whether they come from the private or public sector.

REGIONAL MANAGEMENT OF COMMUNITY CARE

The Commonwealth funding which is provided to the States every five years under their Medicare agreements is for use in specific, geographically defined areas. Area health service managers are provided with this funding, which is adjusted to reflect state based service operation costs and the demographic and special needs identified in the regional population base, such as the proportion of elderly, Aboriginal or rural residents. It has been argued that the supposed efficiencies to be derived from the diagnostically related group funding (casemix) system, which is discussed later, are often the result of neglecting the needs of the individual, or shifting the cost of health service provision from the hospital to the community sector. If, in accordance with government policy, patients are to be increasingly supported in community settings rather than in hospitals, their discharge planning needs to be good, and community based service provision needs to be effectively co-ordinated and managed. Sufficient people also need to be employed in the community to meet the demand created. Duckett and many others argue that more effective coordination of many community-based services is now a pressing community need.

In 1995 the Council of Australian Governments decided to fund area health services' purchase of three separate streams of care. General care funds are for some primary health care, allied health and community care, and community support services. Acute care funding covers needs requiring an episode of treatment, mainly in a hospital setting. Co-ordinated care funding is for complex and ongoing needs requiring a mix of services over an extended period and the assistance of a care co-ordinator or case manager. In 1999 the Government introduced a new range of Medicare services. These allow specified primary care providers (especially general practitioners) to focus on preventative care for older Australians and better coordinated care for people with chronic illness and multidisciplinary care needs. These new Medicare items – **health assessments, multidisciplinary care plans, and case conferences** – have as their stated aim a multidisciplinary approach to health care provision through a more flexible, efficient and responsible match between care recipients' needs and the services provided. General practitioners do not organise a multidisciplinary care plan for people receiving care in a residential aged care facility, as the organization is already required to prepare such care plans for its residents.

In 2000 the newly established NSW Health Council recommended that the seventeen area health services in the state should develop health plans based on population profiles. A discussion of aged and other community based care occurs in later lectures. In general, the evidence is that comparatively few people will require residential care before they die, and that, in accordance with their normally expressed wishes, the emphasis should be on assisting them to be maintained independently in their own homes wherever possible. Kendig and Duckett have suggested that the need for residential aged care is a highly uncertain and expensive risk which is suited to policy treatment through some form of insurance. They argue that government should accordingly treat and fund the housing component and the level of care component in all services for the aged according to separately streamed criteria. They also argue that a regionally pooled and managed approach should be taken to handling funds for care for the aged. A regionally pooled approach to funding childcare and welfare services would generally seem appropriate.

DIAGNOSTICALLY RELATED GROUP FUNDING (CASEMIX)

Prospective payment systems generally entail a fixed-fee method of reimbursing hospitals for treatment which is based on patient diagnosis. They were introduced in US hospitals in 1983. They have recently been adopted in Australia in an attempt to establish more efficient systems where the particular output and related cost-effectiveness of health services can be estimated better. With the introduction of the 'Casemix' system the Commonwealth and the states committed themselves to work in partnership to establish a nationally consistent Australian National Diagnosis Related Groups (AN DRG) funding, management and information system which should serve as the foundation for a national health information network, developing health goals and targets, and developing national health care quality measures. Service contracts between insurers, hospitals and doctors are to be negotiated on the basis of payment for the provision of a specified casemix. This system seeks to delineate the roles of service purchasers and service providers more clearly in order to compare outcomes better.

Complex Commonwealth/state responsibility for funding public hospitals has also increased the difficulty of comparing public and private health services to identify their outcome and cost. Hospital billing has historically been based on the number of days a patient spent in hospital, with additional payments made according to their intensive care requirements. Payments were also adjusted according to the level of sophistication of a hospital's facilities. An additional payment was made for the type of treatment provided, as indicated in the Commonwealth MBS. Other tests and procedures carried out by a range of specialists have been billed separately, consistent with the expectations of professional autonomy. Such a system provided economic incentives to increase the length of stay in hospitals, to provide many tests, and to increase the technological sophistication of hospital services, without providing any indication of whether this was the best use of resources in terms of providing cost effective access and quality outcomes to patients. Government, health funds, and individual patients could not control costs or make adequately informed judgements about the relative merits of various treatments and facilities.

The new casemix system is designed to allow comparative examination of each health service episode provided. Hospital activities are divided into five major kinds and funded separately. These activities are classified as acute inpatient; non-acute inpatient; research; teaching and other. The acute inpatient category is the major focus of attention in the casemix system, and it is based on a principle and, if necessary, secondary patient diagnosis. Data is captured about the surgical procedure provided as a result of the diagnosis, and information about the age, gender, and situation on discharge of the patient is also obtained. With the exception of payments to the doctors for their labour, all costs of patient care are included in a price which has been set for a

specified diagnosis and the related treatment which would normally be undertaken. A major point of the system is for purchasers of health services to eventually be able to compare providers, taking into account their outcomes and their service prices for treatment of a range of diagnoses. Hospitals are to be paid for their throughput of particular diagnosed conditions, according to prices which are based on the average cost of treatment of each specified diagnosis. This is likely to promote specialisation of hospital service delivery in areas where their comparative expertise and treatment advantage is greatest. This should also promote more effective use of very expensive technology.

If a hospital treats a patient at less cost than the casemix payment it receives for their diagnosis, the hospital will make money, but if the treatment costs more, it will lose money. A very valid criticism of the casemix approach to service provision has been that it could lead to hospitals discharging patients 'quicker and sicker', especially if the patient is hard to diagnose or has extra health related problems, because of their age, family responsibilities, or lack of family support. On the other hand, casemix has been promoted as a means of reducing hospital waiting lists through more effective throughput, as well as containing cost. The casemix system potentially generates a capacity for health related information gathering, analysis and choice by government and consumers which did not previously exist. It also provides a basis for further health related research through the identification of 'at risk' patients, whose treatment pattern and cost are not typical and who require additional support from community services on discharge. However, achievement of these goals depends upon effective collection and dissemination of service outcome data. A range of related quality management issues will be discussed in other lectures.

CONCLUSION

Medicare, Australia's universal, taxpayer funded system of hospital, medical and pharmaceutical provision appears to be performing comparatively well in regard to cost, access, and equity, but less well in regard to quality of care. Through private health insurance, Australians may take out additional benefits to those available to all through Medicare. Government encourages this in order to promote the range of hospital and medical facilities available to the community and to reduce waiting times for treatment. The relationship between the Medical Benefit Schedule and government reimbursements to all health care providers is an important aspect of the total system, which facilitates cost containment and national data gathering. However, the relationship between the Medicare system and private health insurers is both administratively complex and expensive and requires further consideration. The requirement for geographically defined area health service management and clear purchaser/provider splits is gradually replacing earlier systems of Commonwealth and State funding which were neither efficient nor transparent. Better community based case management structures also need to be developed for people with chronic conditions. Regionally pooled and managed funding for aged care and a range of other community service provision would be consistent with this approach. Consideration of effective community-based management becomes increasingly important as the introduction diagnostically related group funding threatens to remove people from hospital 'quicker and sicker'.

FURTHER READING

Baume P. How Do Decisions on the Listing of Pharmaceuticals Influence Health and Health Service in Australia? Australian Health Policy Institute, Sydney University, Commissioned Paper Series, 2001/03.

Duckett, S.J. The Australian Health Care System, Oxford University Press, Melbourne, 2004.

Clinton M. and Scheiwe D. Management in the Australian Health Care Industry, Longman, 2nd edition, HarperEducational (Aust.) Pty, Ltd., 1998.

Eager K., Grant P., and Lin V. Health Planning: Australian Perspectives, Allen and Unwin, Sydney, 2001.

Gardner H. (ed) Health Policy in Australia, Oxford University Press, Melbourne, 1997.

Grbich C. Health in Australia: Sociological Concepts and Issues, Longman, Melbourne, 1999.

Industry Commission, Private Health Insurance, Melbourne, 1997.

Lupton G. and Najman J. Sociology of Health and Illness, 2nd ed., MacMillan Education Aust. Pty. Ltd., South Melbourne, 1995.

Palmer R. and Short S. Health Care and Public Policy: An Australian Analysis, MacMillan Education Australia, Melbourne, 2nd ed., 1998.

Tiffen R. and Gittins R. How Australian Compares, Cambridge University Press, Cambridge.