Challenges for Health Systems: Australian Perspectives

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Abstract

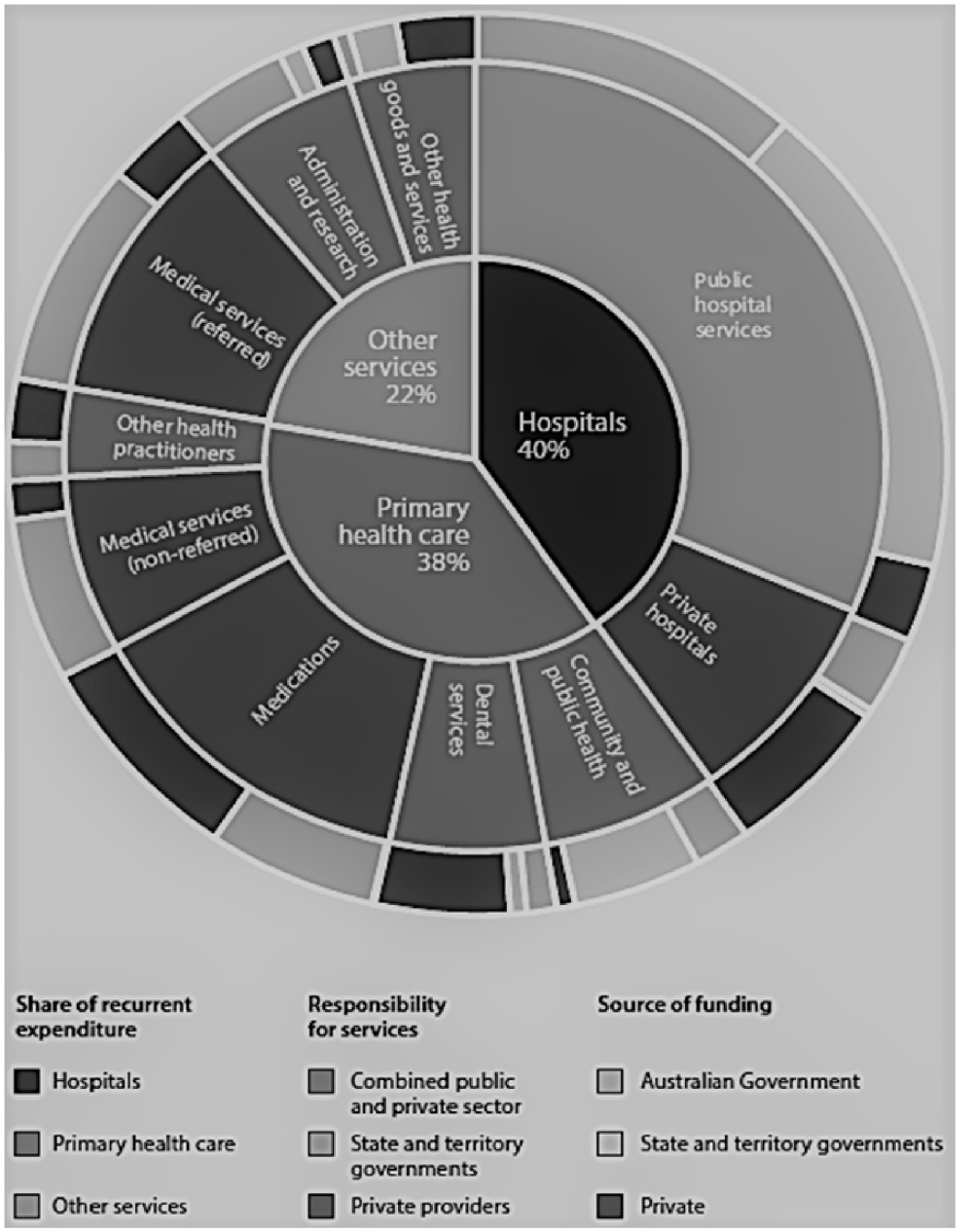
This article describes the Australian Health care system which is one of the best performing health systems across the range of OECD countries. The system has experienced continuous health reform focused on structure and restructure. Demand and utilization of services are high while health expenditure has risen faster than either population growth or ageing. Challenges for the Australian health system are identified as managing downward fiscal pressure and increasing capacity and demand for services; ensuring delivery of the right mix of care for the chronically ill, frail aged by allocating resources optimally; a continued concern for improved quality and safety of care. The article is developed from contemporary literature about the Australian health system, the future directions are identified from invited expert papers in the current issue of APJHM 3(11). The article describes possible responses to the challenges described; suggests emerging themes and approaches to reform. The emphasis of reform will move from structure to an emphasis on health outcomes using knowledge, research and social movement, the improvement of collaborative and networked practice. The article concludes by suggesting probable future directions from an analysis of the language of health reform.

Key words: health reform, health systems challenges, Acute care, aged and disability, Primary health, universal health care.

Context

Australia is a nation best described as a Commonwealth of States, a Federation consisting of eight states and territories, each with their own elected government, together with a Commonwealth Parliament where the majority political party or coalitions form the National government. There is also local government at the more localized community level. There is divided responsibility between the Commonwealth and the States on responsibility for both funding and delivery of services and these divisions are negotiated from time to time through Councils of Australian Government (COAG). This institution consists of the first ministers of the States and the Commonwealth with a collective responsibility, such as the Australian Health Ministers Advisory Council (AHMAC). This provides a forum for negotiated agreement on service levels, funding, outputs, and priorities. Most but not all revenues are collected by the Commonwealth and in part redistributed to States for predetermined service provision (Podger, 2016). This context suggests that health reform in Australia is complex and difficult to achieve and that substantially most reforms have been partially implemented before the next attempt at reform is initiated at State or Commonwealth level or at both levels. The complexity of health service responsibilities for financing and service delivery are best expressed in Figure 1 below.

Figure 1: Australian Health Services - funding and delivery responsibility, 2013-14



Source: Published AIHW material, Australia's Health 2016. Http://www.aihw.gov.au/australias-health/2016/

Australia is a large continent and in size could easily accommodate more than the area of approximately 20 other countries. However, it is also a very dry continent with large areas of the interior very sparsely habitated. Australians are essentially urban dwellers, located on the coastal strips, with more than 71% living in major cities (AIHW 2016a). The population is currently at more than 24 million with 28% overseas born and some 3% Indigenous Aboriginal and Torres Strait Islanders (AIHW 2014). Population growth is through natural increase (40%) and migration (60%). Australia ranks as the 56th most populous country in the world. Life expectancy has increased towards the mid 80 years old (AIHW 2016a).

Health Status

As described by Podger (2016) Australia's success in increased lifestyle, decreased mortality amongst children and the middle aged has now led to reductions in mortality at older ages increasingly up to 90 years with increased rates above that age (Podger, 2016, P.30) and this means that we will experience the burden of chronic disease within an ageing and perhaps frailer population. The implications are a shift from episodic care to a need for more continuous and integrated care. The increased epidemic of obesity also extends to younger age groups and Australia is not alone in being described as having more than 23% of the population as having 'insufficient physical activity to be healthy' (Martins 2016, p.47) and with obesity levels greater than a quarter of the population. Closing the gap on the poorer outcomes of the Indigenous population remains a challenge for Australia with that gap being at 11years less than the Australian population as at 2010-2012 (AIHW, 2015; Martins, 2016).

There has been a 'long and continuing fall in death rates and... coronary heart disease remains the leading underlying cause of death', followed by stroke, dementias and lung cancer. Cardiovascular diseases, cancer, injury, diabetes and respiratory diseases 'are the leading cause of death for Indigenous Australians' (AIHW, 2016a, p.20). Chronic diseases represent the health burden for Australians whilst mortality rates are amongst the lowest of OECD countries (AIHWa, 2016, p. 2,5).

The Australian Health System

The above heading suggests a national health system but the descriptor falls short of what might constitute a truly national system. As a federation, there is a division of power between the Commonwealth and the States in the Constitution that adds to the difficulty of understanding how it is financed and how services are delivered. This complexity is in part an outcome of the division of powers between the Commonwealth and states and interpretation of the powers and meaning over time and as tested since Federation in 1901. For a fuller discussion of the complexity of our federated system please see the discussion by Podger (2016) and the Commonwealth Fund analysis of International Health systems profiles (2016, pp. 11-19). Martins (2016) also provides a comparative analysis of the Australian health system to that of four other countries. Responsibility for the funding and delivery of major services of primary care, acute

care, aged and disability services and health insurance context are described in Figure 2 below.

Figure 2: Main roles of government in Australia's health system

Sources: Biggs 2013; COAG 2012; Department of Health 2015b; Duckett & Willcox 2015; PM&C 2014. As presented in Australia's Health 2016. http://www.aihw.gov.au/australias-health/2016/

Further details about the main areas of healthcare delivery are now analysed below.

Primary Care

Essentially, The Commonwealth has direct responsibility for the funding of primary health care. This is achieved by direct reimbursement (fee for service) to general practitioners and/or patients for individual medical services through the Medical Benefits Schedule (MBS). There is potential for general practice to 'bulk bill' the Commonwealth rather than charge the patients who seek the reimbursement. The MBS fee is not mandated and individual doctors can and do charge above that fee and that component is not recoverable by the patient. Australia has a process of approval for pharmaceuticals before they can be added to the Pharmaceutical Benefits Scheme (PBS) which provides relatively low cost pharmaceuticals on prescription with an emphasis on

the generic rather than 'brand' product and safety nets for the chronically ill. (AIHW, 2016, Podger, 2016)

The delivery of primary care in Australia is mostly through general practice operating as individual or group providers in for profit and not for profit practices. General practice has had a history of being poorly supported and partly sitting outside mainstream health systems as practitioners conduct their practice in small business fashion. This approach has subsequently seen an aggregation of practitioners in larger group practices in both not for profit and for profit contexts. To address the earlier feelings of isolation and the perceived exclusion of general practice from mainstream health care it was recognized as a distinct medical discipline in 1989 and a future orientated policy to support general practice - 'The Future of General Practice: a strategy for the nineties and beyond' (1992) was established, followed by the establishment of Divisions of General Practice together with practice grant funding in 1992/93 (Harris & Zwar, 2014).

110 geographically defined divisions of general practice were established across Australia, each governed by a Board consisting mostly of general practitioners to provide continuing professional development of PHC health professionals, practice support, business services, information and workforce support, advocacy and clinical services. These Divisions provide an effective role in support of general practice for a considerable time until an incoming Federal government rolled them up into larger and fewer entities named 'Medicare Locals' some 61 in number. They had similar functions to the former divisions but had extended roles of improving patient journeys through integrated and coordinated care, identifying local health needs, developing positive responses, facilitating implementation of PHC initiatives and programs.

These entities were governed by general practitioners, other primary care professionals and citizen appointed board members. The life of Medicare Locals was short lived given suspicion based on the name that government was moving into direct provision of PHC services, in competition with general practitioners and that the close affinity experienced with GPs in the former Divisions had been lost. The Medicare locals were closed and the market was opened for potential providers to become Primary Health Networks (PHNs).

In all 30 PHNs were established by contestable bids. They had similar roles to MLs but were not to be service providers. Instead their primary roles were to purchase, contract and commission services, reduce fragmentation of care, leverage improved healthcare as facilitators and purchasers. GP engagement was paramount in addition to that of other health professionals together with effective community engagement. Interestingly, all this was to be achieved with little written or established public policy to guide or provide consistency to the implementation processes. The PHNs have been established and are at the end of the second operational year. The author has direct involvement at the governance level of one PHNs and would encourage readers to visit http://www.hneccphn.com.au/ to gain a better appreciation of how a PHN works.

Acute Care

This sector is essentially a public health system, predominately the responsibility of State and Territory governments, mostly directly delivered by those State governments through entities currently described as Local Health Districts (LHDs) across Australia. The Acute care sector had been the subject of almost continuous organizational restructures over recent decades, mostly away from localized community engagement and control to increasingly larger centrally (State) controlled Area Health Services. Major failures of these large systems in two States saw Special Inquiries and a Judicial Inquiry (Davies, 2005, Forster,2005, NSW Health, 2008) into the failures and a National Health Reform Commission (NHHRC, 2009) outcomes saw a more localized geographic organization of hospital and community health services called Local Health Districts/networks (LHD/LHN). The essence of this approach is that hospitals are organized into a system of care to meet the differing needs of patients and communities. Increasingly this process is being informed by the adoption of evidence based clinical pathways to ensure a patient transition through that system.

From the perspective of this author there are important lessons to learn from the Australian pre-occupation in the early 2000s with an over- emphasis on restructuring of organization as an approach to health reform, presumably where an improved more effective delivery system is the anticipated outcome. First, the move to large centralized health systems without community engagement at the governance and service delivery level is likely to produce systems failures, poor health outcomes and a dis-affected health workforce as described in the abovementioned Inquiries. Secondly and subsequently the emphasis on the word 'local' to redress those adverse outcomes brings into play the concepts of localism and subsidiarity (Briggs, 2014, Podger, 2016). These suggest that services should be engaged and delivered as close to those who use them as possible and both are important principles that have helped reduce the extent of constant structural change and brought a greater period of stability to the governance and management of health organizations in Australia, post 2010. Finally, the development of hospitals into large systemized health systems continues to demonstrate variable utilization and outcomes evident across the system and between States and territories (Productivity Commission, 2017).

While hospital services are predominantly delivered by the States, their funding is shared between States and the Commonwealth agreements negotiated through the AHMAC and COAG processes. It is ironic that Australia was a leader in the Australian National Diagnostic Groups (ANDRG) costing system but apart from Victoria, most States avoided its implementation as a funding system. Since the National Health Reforms, agreement has been reached to adopt a national 'fair price' concept that will be the basis of future hospital funding. While perhaps fairer, most hospitals currently operate with waiting lists for elective surgery and with emergency departments often dealing with overload through being used for care normally delivered through general practice. There is also known variation around public hospital utilisation suggesting that

we could do better. The health reform language is about, 'preventability' of hospital acquired diagnoses, 'avoidable' admissions and variable utilization. Duckett (2016) describes the use of the term 'preventable' as fraught and as a 'slippery' concept and goes to several reasons as to why this is so. Despite these difficulties, the COAG has agreed to utilize the fair price concept to place greater emphasis on both clinicians and manager's accountability in the safety and quality space in agreements from 2017.

Australia also enjoys a high quality private hospital sector that provides 34% of available Australian beds (AIHW) and that also operates internationally. For those who hold private hospital insurance this provides options of choice about where elective surgery is undertaken and what specialist might provide that care and, the added advantage of avoiding waiting lists operating in the public sector. There is also an increased propensity for State governments to enter into contracts for private sector involvement in the design, development and management of public hospitals.

Public hospital expenditure at 2014-5 was at $AUD 57 billion and private hospitals at $AUD 12 billion. While public hospitals are State run, their funding is shared. In 2013, this was 37% by the Australian Government, 54% by State and Territory governments with 9% funding from non-government sources. 66% of private hospital funding came from non- government sources (AIHW, 2016b).

Aged Care and Disability

Aged care and Disability services both community and residential, services are a Commonwealth government funding responsibility and are delivered through a myriad of both for profit and not for profit non-government organizations. The main services are *residential care* for permanent care and for temporary respite care. In addition, *community based care* is delivered through the Commonwealth Home Support Program for assistance with daily living to enable people to live independently at home, through a jointly funded Commonwealth - State funded Home and Community (HACC) program. More complex, coordinated and personalized care at home is delivered through four packages of increasing levels of need and the consumer directs the purchase and preferences for provider options. Of the Australian population over 65 7.8% (270,559) were in residential aged care facilities over the 2013 - 14 year. 2.4% of those aged 65 and over received Home Care (AIHW, 2017).

In response to an earlier Productivity Report on Ageing, the Commonwealth government in 2012 announced 'The living longer living better' $3.7 billion program over five years as the start of a 10-year reform to 'create a flexible, seamless system providing consumers with more choice, control and easier access to services. The reforms are also meant 'to meet the social and economic challenges of the nation's ageing population' (DoH&A, 2017). The evidence suggests increased longevity of older people with recourse to acute care occurring later in life for an acuter but shorter utilisation period of that care. The interface between aged care, residential care and the acute sector remains problematical with approaches to improve access for those in

residential care to avoid acute care by better access to primary care being implemented.

Universal Health Care (UHC) and Health Insurance

Even though the above description of who funds and delivers health care in Australia suggests that we do not have a national health systems but a complicated arrangement between levels of government and the private sector, we can claim to have a national health insurance system. Medicare is the name mostly used to describe that system. However, the bulk of funding for the health system comes from general tax revenues and this is supplemented by a Medicare tax level nominally set at 1.5% of income. This is a nominal rate because low income earners are exempt and the percentage increases to 1.5% at higher levels. Equally if you are a high-income earner without private health insurance you are subject to an additional 1% surcharge. If you privately insure at a young age your levy is discounted long term to encourage the maintenance of your private insurance. The Commonwealth government also provides a subsidy to private health insurance. In recent times a .5% levy was added to support the funding of national approach to disability service funding. Private health insurance provides those insured with choice of specialist care and private or public hospitalization of choice, together with optional cover for allied health services, optical and dental type services as well as some support to healthy lifestyle choices. Access to general practice and pharmaceutical services are covered by MBS and PBS schemes described earlier. You cannot insure for gap payments paid by patients directly to general practitioners above the 'scheduled' MBS fee.

This context describes that Australia is committed to UHC. However, that position has been contested by both sides of politics over the evolution of the health and insurance systems but is not enshrined in constitutional or legislative arrangements. At the most recent federal election, the opposition party was able to suggest that plans to privatise the 'back office' accounting and IT arrangements for Medicare was tantamount to its privatization. This became the 'Mediscare' campaign that in the end saw both sides of politics solemnly declare that Medicare would not be privatized. It is evident that the Australian public has a very strong attachment to Medicare and the concept of UHC. Podger (2016) has suggested some principles that might be enshrined to ensure the place of UHC and Medicare and are repeated here in the hope that public policy and the political process might adopt them:

1. Universal coverage: that all Australians should have access to health services according to their health needs;

2. Equitable financing: that the health system should be funded according to people's capacity to pay;

3. Efficiency and effectiveness: that government support for the system should be based on cost effectiveness in terms of health outcomes; and

4. Consumer and provider satisfaction: that the system should be oriented to

patients and consumers, providing safe, high quality and convenient healthcare, while also respecting the professionalism of those providing the services (Podger, 2016, p.34).

Challenges and Opportunities

Fiscal Considerations

Australia and I suspect most countries are in a period of low economic growth following the well-publicized global financial crisis (GFC) and are focused on reducing the national debt no doubt created by the profligate spending on such things as health by previous governments (that are now 'the opposition'). Australia spends about (9.7% of GDP on health against an OECD average of 9.3 %. So, at the moment health policy is as much directed by fiscal policy that focusses on cutting expenditure rather than necessarily improving health outcomes. This downward pressure is directed to ensuing that health expenditure will not increase faster than GDP in the face of increased needs for chronic care in an ageing and perhaps frailer population and providers wishing to respond to that demand and the utilisation expectation of the acute hospital sector. The increased focus on disability services and a growing concern of communities about access to health services being variable as demonstrated by socio determinants of health, add to the pressure and demand for more services (Podger, 2016; AIHW 2016).

Despite the political posturing and the reasonable concern about growth in the sector it needs to be remembered that other nation states, such as Thailand, implemented UHC and dramatically improved a national health system at a time and during a period of low fiscal growth and from a much lower base than Australia (Tejativaddhana et al., 2016). So, this suggests that we need to be sanguine about political posturing around financing and the economics of health service delivery.

The way forward to improve the Australian health care system is not necessarily to pursue more structural reform as the evidence suggests that that approach may not achieve positive outcomes. In fact, recent research suggests that we all should move away from a culture that values healthcare to one that values a culture of health (Weil, 2016). Evidence further suggests that utilisation and cost of healthcare remains variable and there is room for improvement across the system (Hillis et al., 2016). Bikshandi (2017) draws attention to the perverse outcomes of some clinical outcomes with the use of antibiotics meant to address infections leading to antibiotic resistant bacteria, with prosthetics presenting an array of new problems, as a few examples. Elshaug (2017) focusses on combatting overuse and under use of healthcare. He cites the use of high cost services of little or no use while cost effective proven approaches are ignored. While suggesting that we are all heading in the wrong direction he remains positive given the problems are well stated and recognized and can no longer be ignored.

Universal Healthcare

Australians emphatically have endorsed their preference for them to have access to

universal healthcare but as this is not yet enshrined and will continue to be an area of tensions with opposing ideological views and it would seem prudent for a supportive government to at some stage codify the principles espoused by Podger (2016).

Chronic Care, Frail aged and Obese Populations

While concerns about aging populations are not new the experience so far suggests that the aged population is living longer with shortened periods of need for acute care extending out to the 80+ population. A coming threat already of significant proportion is the obesity epidemic and the rise of diabetes in younger populations who may not demonstrate the same robust resilience of the existing aged population. In the Australian context, this will require a greater integration of service provision and increased coordination and collaboration across the various health subsectors. It will require significant support to the new and emerging PHNs still in their formative years, to ensure that we have the right mix of accessible care in community settings (Podger, 2016, AIHW 2016).

Local Approaches and Innovation

While some commentators in Australia express some frustration at operating in a federated system of competing responsibilities for health it appears that the challenges facing unitary, national health systems such as those of New Zealand and Thailand report that their systems facing very similar challenges to the Australian experience (Tejativaddhana et al., 2016, Gauld, 2016).

The recent establishment of PHN's in Australian was notable in that the geographic definition of PHNs by the Commonwealth government see them replicate the same geographic boundaries as the LHD's that deliver state based acute care services. This alignment might suggest that we are being given license to engage across those boundaries to collaborate and improve the coordination of care. The creation of the PHN to commission PHC services also suggests the potential to develop local approaches to regional funding without too much prescription. It also suggests that innovative frameworks of service delivery might become possible locally as evidenced by efforts to undertake extensive population health and planning approaches by the emergent PHNs exampled at http://www.hneccphn.com.au/population-health/ and an increased use of social media engagement in newer and more cost effective ways as exampled by 'PeopleBank' at http://peoplebank.hneccphn.com.au/ (Briggs & Isouard, 2016).

Conclusion

This analysis of health reform and the research of others has led this author to conclude that health reform is increasingly becoming focused on achieving better outcomes by seeking systems improvement and the earlier focus on reform through restructuring is much diminished. The focus on performance measurement needs to have a broader focus on health outcomes particularly system level measures.

The health workforce has become global, is a critical issue and requires a coordinated focus by nation states of the Asia Pacific region. There is much to be accomplished in the education development and personal learning of health professionals in the emerging language of 'collaboration, innovation and collaboration' through networks and from the diversity of differences of health systems across the nation states of the Asia Pacific region.

In that learning, there needs to be a greater emphasis on evidence-based management, health prevention, promotion, wellness and meaningful 'engagement of communities, consumers and being patient centric'. This learning needs to be strengthened by a greater emphasis on the evidence base of population health, the socio-economics determinants of health and the achievement of forthcoming sustainable development goals.

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References

AIHW, Australia's Health. (2014). The 14th biennial health report of the Australian Institute of Health and Welfare no. 14. Cat. AUS 178. Canberra. Available from http://www.aihw.gov.au/publication-detail/?id=60129547205

AIHW. (2015). Australian Institute of Health and Welfare The health and welfare of Australia's Aboriginal people and Torres Strait Islander peoples 2015. Canberra.

AIHW. (2016a). Australian Institute of Health and Welfare. Australia's Health 2016. Available from http://www.aihw.gov.au/australias-health/2016/

AIHW. (2016b) Australian Institute of Health and Welfare). Hospital resources 2014-15: Australian hospital statistics. Health services series no. 71. Cat. no. HSE 176. Canberra. Available from http://www.aihw.gov.au/publication-detail/?id=60129556122

AIHW. (2017). Aged Care. Available from http://www.aihw.gov.au/aged-care/

Bikshandi, B. (2017). The revenge effect in medicine. MJA Insight. 6th February. Available from http://www.doctorportal.com.au/mjainsight/2017/4/the-revenge-effect-in-medicine/

Briggs D.S. (2014). Localism: A way Forward? *Asia Pacific Journal Health Management*, 9:1, p.4-6.

Commonwealth Fund. (2016). E. Mosialos, M. Wenzel, R. Osborn and D. Sarnack, (Eds), 2015 International Health Profiles. PP. 11-19. New York. Available from http://www.commonwealthfund.org/~/media/files/publications/fund-report/2016/jan/1857_mossialos_intl_profiles_2015_v7.pdf

Davies G. (2005). Public Hospital Commission of Inquiry Report. Queensland Health; Brisbane.

DoHA. (2017). Living longer, Living Better. Australian Government, Department of Health and Ageing. Available from http://webarchive.nla.gov.au/gov/20130410102018/http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-aged-care-review-measures-living.htm

Duckett, S. (2016). What problem is being solved: 'preventability' and the case of fair pricing for safety and quality. *Asia Pacific Journal of Health Management*. 11(3): pp.18-21.

Elshaug, A. (2017). Combatting Overuse and Underuse in Healthcare. Q&A. The Commonwealth Fund. Available from http://www.commonwealthfund.org/publications/q-and-a/2017/feb/combating-overuse-and-underuse-in-health-care. February, 23, 2017.

Forster P. (2005). Queensland Health System Review. Independent Review Brisbane.

Gauld, R. (2016). Healthcare System Restructuring in New Zealand: problems and proposed solutions. *Asia Pacific Journal Health Management*. 11(3) pp. 75-80.

Harris, M. F. Zwar, N. A. (2014). Reflections on the history of general practice in Australia. Med J Aust;201 (1 Suppl): S37-S40. Doi:10.5694/mja14.00141. Available from https://www.mja.com.au/journal/2014/201/1/reflections-history-general-practice-australia

Martins, Jo. (2016). Health Systems in Australia and Four Other Countries: choices and challenges. *Asia Pacific Journal of Health Management*, Vol.11, (3), 45-57.

National Health and Hospital Reform Commission. (2009). A Healthier Future for All Australians. Canberra: Commonwealth of Australia; 2009. ISBN: 1-74186-940-4

NSW Health. (2008). Special Commission of Inquiry into Acute Care Services in New South Wales Hospitals: Sydney; NSW Health.

Podger, A. (2016). Federalism and Australia's National Health System. *Asia Pacific Journal Health Management*, 11, (3), 26-37.

Productivity Commission. (2017). Report on Government Services, Public Hospitals. Australian Government Productivity Commission. Available from http://www.pc.gov.au/research/ongoing/report-on-government-services/2016/health/public-hospitals/rogs-2016-volumee-chapter11.pdf

Tejativaddhana, P., Briggs D.S. & Tonglor, R. (2016). From Global to Local: strengthening district health systems management as entry point to achieve health-related sustainable development goals. *Asia Pacific Journal Health Management*. 11:3, p. 81- 86.

Weil, A.R. (2016). Building a culture of Health. Health Affairs (35):11, pp. 1953-1958. doi: 10.1377/hlthaff.2016.0913