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Australia's health system is fundamentally sound today, but needs to change

Grattan Institute submission to Senate Select Committee on Health

By Stephen Duckett and Peter Breadon

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This report was written by Stephen Duckett, Grattan Institute Health Program Director and Peter Breadon, Health Fellow.

Stephen Duckett is a member of the Board of Northern Melbourne Medicare Local.

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1. Australia's performance

International comparisons

The performance of health systems can be measured in a number of ways. Two of the most common are the overall level of spending and a specific outcome, such as life expectancy. Australia performs well on both measures.

Comparisons of health systems often focus only on costs. Costs are important, but any reasonable comparison also takes into account what we get for the spending. Measuring costs is relatively easy. Cost per head spent on health care (standardised across countries into a common monetary unit) or costs as a share of gross domestic product are easy to compare.

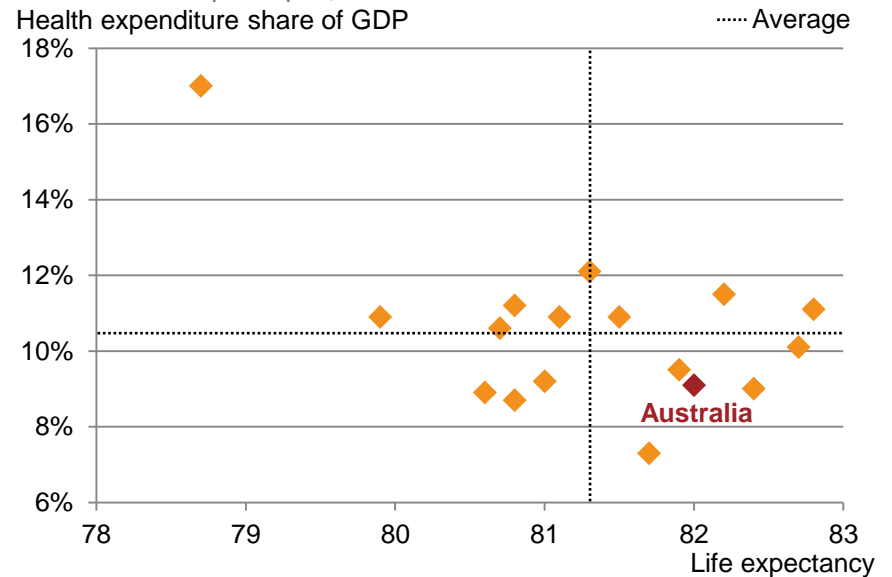
Measuring benefits is trickier. The most common comparisons of outcomes are mortality-based measures, partly because measurement is definitive. There are choices here too. Life expectancy and a measure of early deaths (deaths before age 70) known as potential years of life lost are the two most common.

Yet using these measures to compare health systems has a number of weaknesses. They assume that the health system's most important role is to delay death, ignoring quality of life. They also assume that the health system is the most important contributor to life expectancy, ignoring broader socio-economic and environmental factors such as clean water, employment and good nutrition. Despite these weaknesses, the measures are commonly used and readily available for comparable countries.

Figure 1 shows where Australia sits on these measures compared to similar OECD countries (countries within 25 per cent of Australian GDP per capita). Countries that are better than the OECD average on life expectancy are on the right hand side. Countries that spend a smaller share of gross domestic product on health care are on the lower part of the graph.

Figure 1: Australia performs well on both input (cost) and outcome (life expectancy) compared to comparable countries

Health expenditure and life expectancy in OECD countries within 25% of Australia's GDP per capita, 2011



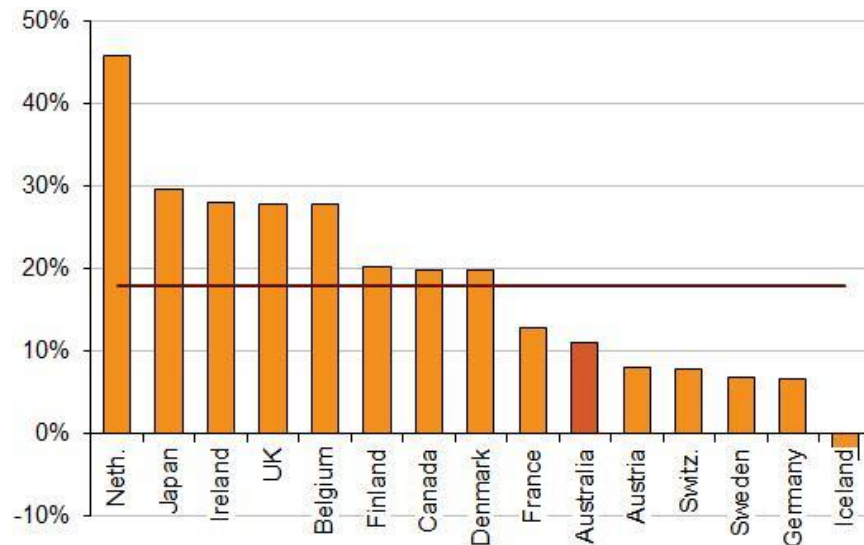
Source: Grattan Institute based on OECD data

Australia is in the good quadrant: better than average life expectancy, with lower than average spending. The stand out poor-performing country is the United States, with high costs and poor outcomes.

Australia's spending trend is also better than comparable countries. Figure 2 shows the percentage change in the health share of GDP. Australia's health spending grew more slowly than that in most other countries.

Figure 2: Health spending in Australia grew more slowly than comparable countries

Change in GDP share spent on health care, 2001-2011



Note: Countries +/-25% of Australian GDP in 2001 and 2011
 Source: Grattan Institute based on OECD data

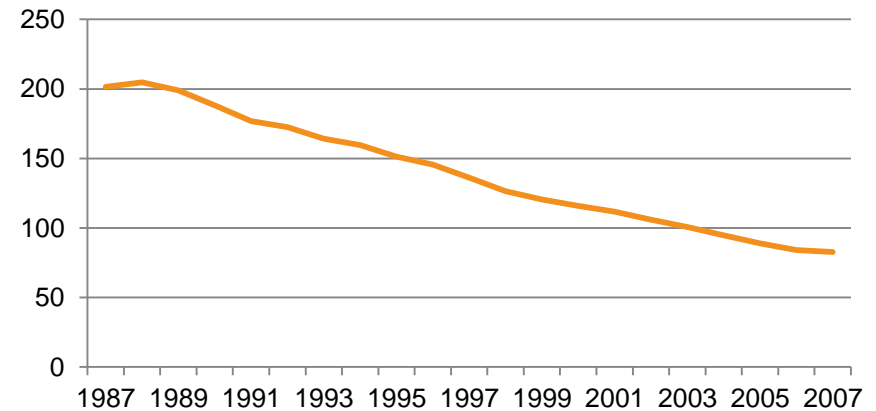
Improvements in outcomes

Another measure of the performance of the health system is amenable mortality. This is a measure of the death rate from conditions where health care can make a difference.¹ Again there is good news (Figure 3). The amenable death rate has fallen steadily, declining by over half since 1987.

Figure 3: The death rate for conditions where health care makes a difference is declining

Amenable death rate, Australia, 1987-2011

Amenable deaths per 100,000



Source: Glover (2006) and additional information provided by Dr Glover

¹ Kamarudeen (2010)

No cause for complacency

Our relatively good performance largely reflects policies introduced up to the late 20th century. These reforms tackled the health problems of that time and created environments that encouraged healthy development for those born up to the middle of last century. But what worked in the past might not work as well in the future.

Changing food production and consumption patterns, and changing patterns of energy expenditure, create the conditions for a global obesity epidemic,² which may make the next generation the first to have shorter lives than its parents.³

Because of changes like this, past performance might not be a good guide to the coming decades. For example, the Australian Institute of Health and Welfare estimates that health expenditure will grow to around 12 per cent of gross domestic product over the next 20 years.⁴

These changes will be slow and steady – we can plan for them. Also, spending of this magnitude is not necessarily unsustainable. A number of countries already have health spending above that level. As countries get wealthier, they tend to spend more on health care, suggesting they value getting more and better health care more highly than purchasing other goods or services.

While different health needs and growing expenditure are not a reason to panic, they will require big changes to our health system. The rest of this submission briefly outlines some of the most important things that need to be addressed:

- some groups do far worse than average, with low access to care, high financial burdens and poor outcomes
- policy and delivery is not coordinated across levels of government
- the system must be re-oriented to focus on chronic conditions and prevention and
- waste must be cut to improve efficiency and fund improvement.

² Swinburn, *et al.* (2011)

³ Olshansky, *et al.* (2005)

⁴Goss (2008)

2. Low access and uneven outcomes

Australia's relatively good average performance in international terms masks very poor performance for some groups.

Indigenous health

The stand out failure is the health of Indigenous people. Figure 4 shows the ratio of death rates in three measures for Indigenous populations in NSW, Queensland, WA, SA and the NT. The all-cause mortality rate for Indigenous Australians, after standardising for the age distribution of the population, is 15 times that for non-Indigenous people.

Indigenous Australians are 3.5 times more likely to die from preventable causes or treatable (amenable) causes than non-Indigenous Australians.

Access to care

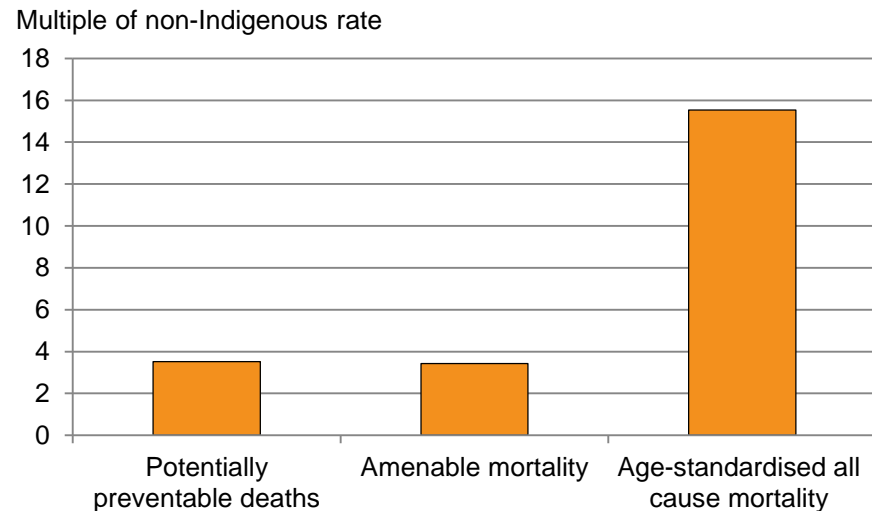
Despite the success of Medicare in reducing financial barriers to care, lower income households still defer care, and cannot afford to fill prescriptions because of high out-of-pocket costs. Grattan Institute's submission to the recent Senate Inquiry into out-of-pocket costs, attached to this submission, canvasses those issues.⁵

Another area of concern is access to care for people in rural and remote Australia. The benefits of the significant growth in medical graduates over the last decade have not trickled down to most

remote regions. Some parts of Australia have access to only half the number of medical practitioners per head of population as the wealthier suburbs of Sydney or Melbourne. Grattan Institute outlines strategies to address this issue in the attached report.⁶

Figure 4: Indigenous populations have far worse outcomes than non-Indigenous populations

Indigenous as multiples of non-Indigenous mortality rates, 2007-2011



Source: Steering Committee for the Review of Government Service Provision (SCRGSP) (2014)

⁵ Duckett and Breadon (2014)

⁶ Duckett, *et al.* (2013)

3. The federalism omelette

Federalism makes Australia's health system more complex, and probably adds to its cost. The divided responsibilities between Commonwealth and state governments slow reform and create missed opportunities for system reform.

Since a 1949 constitutional amendment, the Commonwealth has had power over medical and dental services and hospital benefits.⁷ Despite this, funding of health care is shared between the Commonwealth and state and territory governments.

There is almost no area of health care in Australia where policy and funding is the sole preserve of one level of government. Moreover, services provided by the Commonwealth and states are not independent. What one level of government does changes the services that the other must provide.

If the states cut hospital funding there will be more demand for community-based care, which is largely funded by the Commonwealth. If missing out on hospital care makes people sicker, it will increase the need for Commonwealth disability and unemployment benefits. If the Commonwealth provides less GP and dental care, more people will end up in hospitals, which are mostly funded by the states. This two-way feedback is known as reciprocal interdependence.⁸ Managing it well requires sophisticated coordination and cooperation.

The complexity of Commonwealth-state relations in health is exacerbated by the Commonwealth's tendency to create multiple funding streams sprinkled like "programmatically confetti" into the health system.⁹ Both major parties are guilty of this.

There are two broad options to reform federal-state relations in health: to assign responsibility for health care to one level of government or to improve joint working.

Unscramble the omelette: one level of government?

Advocates for one level of government controlling healthcare often think it should be the Commonwealth. This is partly because of the Commonwealth's greater revenue base, and partly because of a desire to avoid inequities among states if health care were assigned to them. The alternative disentangling path – of state responsibility – is the Canadian approach, where the provinces have both income tax powers as well as the ability to impose (and vary) sales taxes.

It is not clear whether it is feasible for a single level of government to be responsible for health care. It would be a huge change. If funding was also reallocated – to fully clarify accountability – it would take major tax reform. This is possible, but seems unlikely in the short term. In the meantime, we must find better ways for governments to work together.

⁷McMillan (1992)

⁸Thompson (1967)

⁹ Moran (2010)

Working together: funding

The Commonwealth Government's unilateral and unforeseen reduction in state funding in the 2014 Budget has made federal-state co-operation in health more difficult. The cuts contradicted a signed agreement on long-term funding between the states and the previous Commonwealth Government and has done a lot of damage to trust between governments.

The 2014 Budget also reduced the alignment of interests between the Commonwealth and states. Under current funding arrangements, the Commonwealth pays 45 per cent of the cost of increases in public hospital activity (at an "efficient price"). This was important because it gave the Commonwealth a financial interest in developing and implementing policy to reduce hospital admissions or to moderate hospital cost growth. That cost sharing will now be abolished from 2017.

There will always be sovereign risk. But just as it should be minimised in relations between government and commercial entities, it should also be limited in relations between governments.

Intergovernmental agreements that govern funding flows should be made more binding. This could be achieved by incorporating them in legislation, making them justiciable in event of disputes, or framing them as commercial contracts.

To reduce cost-shifting and better align incentives, the Commonwealth should reverse its decisions on hospital funding. It may be appropriate to negotiate a different cost sharing rate or other changes. The Commonwealth should continue to share

growth in hospital expenditure and link funding to demand and need (using activity-based funding) instead of returning to a formula based on population share.

Working together: system management

The Government's announcement that Medicare Locals will be replaced by a smaller number of Primary Health Networks creates an opportunity to overcome the conflicting interests of the Commonwealth and states at a local level. Networks could play a crucial role in coordinating care, improving quality and developing evidence about how the health system can work better.

To make sure this happens, Networks should aim to improve care for patients holistically rather than being restricted to pursuing the objectives of a single level of government. Both the Commonwealth and states should be involved in working with Networks, in terms of setting objectives and providing funding.

Yet integrating numerous perspectives – those of the Commonwealth, States, health care providers and patients – should not result in restrictive micro-management. Networks should have clear, agreed objectives that focus on costs to the whole system and outcomes for patients. They should then receive pooled funding to achieve these outcomes, and clear accountability for doing so.

4. Shifting system focus

Our health system has evolved over decades, but it isn't keeping up with our shifting health needs. To keep making people healthier we have to start earlier by stopping diseases from appearing and managing them better when they do.

Strengthen prevention

Australia has a strong track record in many types of prevention. Over decades, we have led the world in prevention efforts, ranging from road trauma (seat belts) to AIDS to cigarette smoking. These reforms used a mix of community engagement, social marketing campaigns, taxes and regulation to change community behaviour. We need to confront obesity with the same determination and the same mix of tools.¹⁰

Improve systems to support people with chronic illness

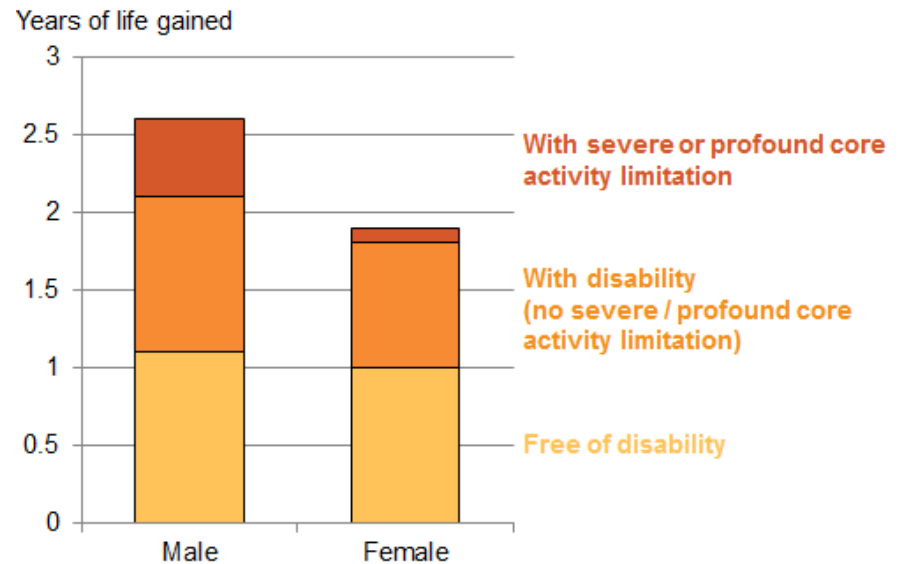
The health system needs to be better at managing the growing burden of chronic disease.¹¹ As one example, older people are living longer but more than half of the years gained are lived with disability (Figure 5).

Reorienting the health system to address the challenges of chronic disease is hard. It seems obvious that a system that pays doctors for seeing patients again and again is probably not suitable to encourage continuity of care and coach people to look after themselves better.

¹⁰ Gortmaker, *et al.* (2011)

¹¹ Australian Institute of Health and Welfare (2014)

Figure 5: Over half the extra years of life are lived with disability
Gains in expected years at 65 from 1998-2009 by disability



Source: Australian Institute of Health and Welfare (2012)

Unfortunately, getting beyond that simplistic statement is complex. The evidence on the best way to pay doctors is quite weak. Moving forward on better payment systems will require experimentation to identify what works in the Australian context.¹²

¹² Scott, *et al.* (2011) Gosden, *et al.* (2000)

Structural changes to improve seamlessness of care across a range of health professions are also required. This should be a key role of the proposed Primary Healthcare Networks.

A person with chronic illness lives with their condition 24 hours a day, seven days a week. Improving management of chronic conditions needs to start with supporting self-management and supporting carers as part of a longer-term goal to build health literacy. Again, this could be an important role for the proposed Primary Healthcare Networks.¹³

¹³Koh, *et al.* (2013).

5. Room to save

Even though Australia's health spending is below that in many comparable countries, there are still opportunities to reduce current spending or slow spending growth. Cutting waste is the best way to fund improvements to the system and better services for people who miss out. The alternatives are fewer services, worse services, higher taxes or higher debt.

A number of Grattan Institute reports have identified big opportunities to do this. They include:

- Savings of \$1 billion a year from reducing inefficiency in public hospitals;¹⁴
- Savings of around \$500 million a year through workforce reform in public hospitals;¹⁵
- Savings of at least \$400 to \$500 million a year from adopting benchmark pricing for generic pharmaceuticals. Further savings could be made from better use of patented pharmaceuticals.^{16,17}

¹⁴ Duckett, *et al.* (2014)

¹⁵ Duckett, *et al.* (2014)

¹⁶ Duckett, *et al.* (2013)

¹⁷ Duckett, *et al.* (2013)

6. Conclusion

In some ways, Australia's health expenditure and outcomes compare well to those in many similar countries. But those results are the fruit of reforms in previous decades. We are going through huge changes in the nature of disease and we have not yet solved the severe and persistent health problems faced by some communities. If we want to sustain and improve our health in the future, we can't rest on our laurels.

This submission briefly outlines some of the major challenges and opportunities that our health system faces. There is a lot of room to make the system fairer, more efficient and to manage it better.

These are big issues that have to be addressed over the long-term. In many cases, this will mean difficult and complex reforms and standing up to vested interests. In some areas – such as coordinated care, new payment models, and Indigenous health – we need to increase our investment in experimentation and evaluation to find out what works.

However, we are fortunate to inherit a good health system and to have time to prepare for the long-term changes that are underway.

Many of the issues touched on in this submission are explored in more detail in other Grattan Institute reports, which are available at: <http://grattan.edu.au/home/health/>.

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