

Financing Australian health care

Amid the criticism of our health system **Professor Jane Hall** reviews its performance and offers a solution.

THERE'S BEEN recent and increasing comment of the need for a radical overhaul of the Australian health care system. The commentators call for a greater (or smaller) role for the private sector, more (or less) accountability from providers, a larger (or smaller) purchasing role for funders and more controls on demand (or supply). But nearly everyone agrees that the split responsibilities of Australian and State/Territory governments is a bad thing, leading to cost shifting and poor co-ordination of service delivery; and that one level of government should take over.

What is cost shifting?

At its simplest, it means that a cost that was borne by one program or funding source is transferred to another. Investigations into cost shifting, such as the 2000 Senate Inquiry into Public Hospital Funding, have found it hard to establish just how much of it occurs.

The major source of cost shifting is probably between capped State/Territory public hospital budgets and the open-ended Australian Government funded MBS and PBS.

While the potential for cost shifting in both directions is clear, there is even less evidence on whether it really matters in terms of the costs and outcomes delivered by the system. For in itself, it is neither good nor bad.

Cost-shifting may represent a sensible response to changes in practice. For example, when a new drug allows people who were once treated in hospital to stay active in the community, the change is indeed cost-shifting; but it is almost certainly better for the patients and their families and may be less costly for the health system.

Problems

Of course, cost shifting can be a problem. If it distracts funders, managers and clinical providers from service delivery and into gaming the system, then it carries an opportunity cost and no benefit. It represents waste. But cost shifting is not simply a matter of Australian Government/State and Territory roles and responsibilities. It can occur in any system where there are different streams of funding, and funding agencies are focused on maximising their returns from their budget in isolation from the rest of the

system. So new structures which eliminate one level of government from health care funding may not eliminate cost shifting but just move the boundaries.

Performing well

Before embarking on calls for reform it is useful to review how well the Australian health system performs when compared with similar developed countries. By and large, it does a good job. It provides universal and comprehensive coverage, including pharmaceuticals, while similar countries having developed systems that exclude drugs are grappling with how to make drug therapies affordable. And it does this at a reasonable cost: to the nation, as Australia spends 9.7 per cent of its GDP on health, slightly higher than the OECD average but nowhere near the frightening 15 per cent of GDP spent in the US. And at a reasonable cost for most individuals, a recent survey reported 14 per cent of Australians facing out-of-pocket costs of more than \$US1000, although Australian out-of-pocket spending is higher than the OECD average. The same survey also showed that Australians are reasonably satisfied with the system.

Limitations

The Australian health care system is a complex mix of public and private providers, with multiple and inter-related sources of funds and varying roles and responsibilities across different programs and types of service.

Apart from cost-shifting, this complex arrangement of roles, responsibilities and funding programs can lead to confusion about who pays for what and that makes access to appropriate care difficult for both providers and individuals seeking care.

The consequences of this are poor co-ordination of care (individuals fail to receive appropriate services and some services are duplicated); perverse incentives (arrangements which do not encourage effectiveness and efficiency); and duplication of administrative structures.

New approach

It would seem sensible, then, to pool the different sources of funding and the Federal Government's Co-ordinated Care Trials have done just that. Using existing health resources, the trials have pooled funds and improved care planning, in a bid to enhance



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health outcomes for people with chronic or complex illnesses.

The evaluation of the First Round of Trials showed that gains in terms of better health outcomes and lower costs were not that easy to achieve. This may have resulted from a number of factors and the evidence is equivocal. So we should certainly not conclude that funds pooling could not be beneficial in Australia. However, it does demonstrate that in a complex system, the intended gains may not flow from 'common sense' reform.

At the same time, the Australian health system, in common with other countries no matter what their financing arrangements, faces increasing pressures from the rapid advance of new and often expensive medical technology, increasing consumer expectations, problems with enhancing safety and quality in a complex system, and workforce shortages.

In thinking about health care reform, it is wise to remember the old maxim that for every complex problem there is a simple solution and it is nearly always wrong. **H&h**

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