

**Response to  
A Healthier Future For All Australians Interim Report**

**Menzies Centre for Health Policy  
Australian National University and University of Sydney**



The Menzies Centre for Health Policy has reviewed the Interim Report of the National Health and Hospitals Reform Commission. This response is intended to contribute to NHHRC's deliberations and refinement of the report into its final reform.

The report covers a great deal of ground and to do each element justice would require a response that approached the length of the original. There will be official and unofficial responses from many sources and we are confident that all significant aspects will generate responses and advice. As a result the Centre's response focuses on aspects of the report that we regard as foundational.

## A. CULTURAL, HISTORICAL, AND OTHER CONTEXTUAL FACTORS

There is no shortage of calls for sweeping health reform in Australia and other countries. The typical fate of these proposals is fairly broad intellectual agreement among academics and disinterested policy analysts; mixed responses among practitioners; reluctance by government to push controversial reform items; and bewilderment on the part of the public. This leads, typically, to cherry-picking certain recommendations and ignoring others, and a series of negotiations at multiple levels that in the end tinker incrementally with the status quo.

We state this as an empirical reality rather than as a criticism. There is a large and respected body of political theory that rejects sweeping change as dangerously disruptive and likely to fail to meet stated objectives. Grand social engineering acquired a deservedly spotty reputation given the excesses of the last century. Social scientists have developed the theory of path dependency, which essentially holds that future possibilities are constrained by historical and institutional traditions. These insights argue in favour of gradual, incremental change, and aligning ambition with the practicalities of making it happen.

However, history is not linear, and there are defining moments and windows of opportunity to change things dramatically for the better. Kuhn's famous paradigm shifts do occur. The Iron Curtain did not erode gradually; it tumbled, somewhat unpredictably, in a few months. The elements and forces for large-scale change may assemble gradually and even invisibly, but eventually they gather strength and manifest with unusual speed and scope. This tends to occur when the status quo is revealed as non-viable, whether it is a heliocentric view of the world or the compatibility of totalitarianism with human aspirations. Put another way, the evidence that favours change overwhelms the defence of the status quo.

The first question, then, is whether the health care system's status quo is fundamentally unsustainable, and if so, on what grounds. The interim report's perspective is that the system needs a major overhaul. We concur – there is sufficient evidence of its failure to deliver quality, value for money, accessibility, and equity to warrant a transformation. Again, this is not unique to Australia: there is remarkable consensus internationally that this is the case.

The need for reform is a necessary but not sufficient condition for its achievement. Australia is a federal country where health care responsibilities are unusually fragmented and interest groups are (not so unusually) powerful. In such arrangements one cannot discuss health reform in isolation from Constitutional law, Commonwealth-State relations, taxation power, political sensitivities, administrative structures, practice cultures, and a whole host of related variables. Practically speaking, it is to be hoped that major substantive change is possible without major structural change. But practically speaking, that may not be possible.



These understandings underlie our response.

## B. CRITERIA FOR ASSESSING THE INTERIM REPORT PROPOSALS

Our analysis is based on the following criteria:

1. What major goals are advanced in the report, and are they internally consistent? What problems are proposed options designed to solve?
2. Are the main structures and recommendations likely to achieve the intended results?
3. Where are the gaps in the proposals? Which need to be elaborated more fully?
4. Which proposals carry the greatest risk of producing unintended consequences and how might these be mitigated?
5. How have other countries experienced and dealt with similar reform challenges and how might the lessons learned be applied to Australia?
6. What historical and contextual features appear to have influenced the proposals, and to what extent do they affect the likelihood of attaining the report's ambitious goals?

## C. THE 3 MAIN STRUCTURAL OPTIONS

***Option A: Continued shared responsibility between governments, with clearer accountability and more direct Commonwealth involvement***

Under this option, the Commonwealth would:

1. be responsible for all funding, policy and regulation for primary health care;
2. pay to states and territories a hospital benefit per episode of the efficient costs of inpatient and emergency department treatment (set at, say, 40 per cent). Outlays would be limited by the level of expenditure each state or territory would support paying for the balance of the cost of hospital treatment; and
3. pay, using a casemix classification, 100 per cent of the efficient costs of delivery of hospital outpatient treatments, according to a budget negotiated with each state and territory.

- 
1. International recognition of the importance of integrated approaches to care (both vertically and horizontally), has led to an interest in developing structures that promote or at the very least permit a more seamless, systemic approach to care, both upstream (health promotion, prevention, primary health care) and downstream (acute and sub-acute care, long term residential care, specialized services). There should be incentives at all levels, from individual through organizational, to minimize the need for expensive care and to deliver care efficiently and fairly.



2. The historical legacy that divides responsibility for related sectors and activities between two levels of government is a challenge. It is quite clear that the assignment of responsibility for some parts of the care continuum to the States and others to the Commonwealth creates tensions, inconsistencies, and misalignments. The interim report gamely tries to make a virtue out of the perceived need to retain historical and Constitutional arrangements; it is conceivable that it has made the right call in accepting that which cannot be changed. However, it is important to establish mechanisms and transparent criteria by which the two levels of government can negotiate significant changes in these arrangements based on mutual interests and guided by a focus on serving people better.
3. While beyond the mandate of the Commission, the issue of fiscal capacity and imbalance will have to be addressed if sound and durable solutions are to be achieved. Responsibility and taxation power must be aligned. It is vital to remove perennial sources of intergovernmental tension and the temptation to offload and game the system. More importantly, intergovernmental rivalries and sources of friction should be invisible at the local delivery level, where coordination and integration are essential.
4. The model proposes full Commonwealth responsibility for primary health care (PHC) and outpatient care. Combined responsibility for these services makes sense: if the expansion of PHC is successful there should be less need for specialty care, and the authority to invest where it makes most sense along the continuum should be consolidated. Whether this responsibility should lie at the State or Commonwealth level is a key question. Historically, the State has been more closely involved in the provision as well as the funding of services. One of the declared Commission goals of the reforms is to retain the more intimate State relationship with its citizenry. PHC is an obvious point of connection since virtually everyone uses PHC annually while relatively few use hospitals, and then for typically short periods of time. The report touts the advantages of Commonwealth responsibility to include consistency of approach and improved health human resources (HHR) planning. However, there is no proven ideal model for PHC and some natural experimentation is inherently desirable. HHR planning can be done cooperatively through intergovernmental councils, but perhaps more to the point, States may have legitimately different views on needs, priorities, and how to address them, which suggests some degree of autonomy over the education and distribution of personnel.
5. The cost-sharing model for hospital inpatient care has the virtue of creating a common interest in controlling costs and overall system planning. Judging from experiences elsewhere, the Commonwealth may perceive itself to be at risk because its share is entirely dependent on the actions of the States. For the Commonwealth, the incentive is to minimize hospitalization to keep its costs down; its main levers of influence are effective PHC and outpatient care, which in this model it would fund exclusively. For the States, there is at least a partial incentive to maximize hospitalizations because a) access and wait times are usually hot political buttons; b) giving providers more capacity to perform more procedures is often politically attractive; and c) 60 cents of additional spending automatically trigger 40 cents from Canberra.

This option requires a very information-rich environment to calculate efficient costs and understand the relationship between inputs and outcomes. Logically, authority should be commensurate with responsibility; having one government pay a fraction of costs of programs over which it has little or



no influence is an obligation unlikely to be warmly embraced. If hospital services are to be cost-shared, it would therefore seem prudent – from the Commonwealth perspective – to secure a substantive role in determining the nature and size of the hospital envelope, and in setting overall direction for the sector.

Finally, if the goal is to definitively improve coordination and align incentives and responsibilities with intended results, this option addresses only part of the problem. Its practicality is also its defect: it is minimally disruptive structurally but also unlikely to remove the barriers that impede seamless delivery of care and shared accountability.

***Option B: Commonwealth to be solely responsible for all aspects of health care, delivering through regional health authorities***

**This option would transfer all responsibility for public funding, policy and regulation for health care to the Commonwealth. The Commonwealth would establish and fund regional health authorities to take responsibility for former state health services, such as public hospitals and community health services. Existing national Commonwealth payments would be retained (such as the MBS, Pharmaceutical Benefits Scheme (PBS) and aged care subsidies).**

1. This option has the virtue of neatness and simplicity. It would create a system analogous to the English NHS in many respects. It eliminates many tensions, dual accountabilities, cost-shifting, and administrative complexity. It also frees State governments from a major preoccupation with health, allowing them to turn their attention to other portfolios. It creates the potential for a number of efficiencies, including planning, e-health, standards and accreditation, purchasing, etc.
2. The creation of regions would mirror, on a national level, the model most Canadian provinces have adopted, with 2 major objectives:
  - a. Combine health care budgets to create incentives and mechanisms to allocate dollars optimally among the sectors, and especially to decant spending from high-cost to lower-cost venues; and
  - b. Move to a population-based funding model that rewards the production and maintenance of health instead of health care activity.
3. Regionalization was to be both a devolution of power from the state to the region, and a consolidation of power from local institutions and small communities to the region. In Canada, the latter has been achieved; the former has not. Governments in recent years have tended to reappropriate authority from the regions on the grounds that they never did manage to devolve accountability along with authority.<sup>1</sup>

<sup>1</sup> The anatomy of these developments is the subject of much debate and is worthy of a separate analysis in itself. Suffice it to say that governments do not allow regions to make any major capital or program decision unilaterally.



4. No one has documented the extent to which regionalization has influenced the reallocation of resources; such data would be hard to come by in Canada, and in any event there has been a secular trend towards reallocation, principally from hospitals to drugs. Upstream (health promotion, prevention, classical public health) expenditures have grown somewhat but still remain a small proportion of total spending. Notably, pharmaceutical and physician expenditures never were folded into regional budgets; this is widely regarded as a major limitation on what regions can accomplish and a de facto enshrinement of undesirable silo effects.
5. The report outlines, fairly, the substantive difficulties inherent in this option. Some of these could be overcome – e.g., the loss of local influence through new structures and councils, community engagement strategies, transparency in reporting and accountability, etc. A further difficulty, however, would be the temptation for States to “run against Canberra” given that they would no longer play much of a substantive role. It is also debatable whether it serves the public interest to have Canberra shoulder the entire responsibility for health because the “crowding out” phenomenon can occur at this level just as it might at the State level.

On logical grounds, this is the least complex option that has the greatest potential to align incentives and funding with desired outcomes, and to eliminate serious intergovernmental financial (but not all political) tensions. Rarely do logical blueprints trump Constitutional, historical, and contextual factors in determining policy and structure. Such an option may not require Constitutional amendment if there were unanimous consensus in favour of implementation, but to achieve this either in theory or in practice given the stakes involved is virtually unimaginable. Conceivably the Commonwealth and one or more States could negotiate the transition as proof of concept, but again, it is difficult to envision a circumstance where the perceived self-interest of both levels of government would be met in an agreement both were willing to sign.

Given that health care is ultimately local, one might imagine the transfer of responsibility in the other direction, with the States acquiring full authority for health services. This is more or less the circumstance in Canada<sup>2</sup>. In Australia this would require a major new fiscal arrangement, with cash and/or taxation capacity transferred from the Commonwealth to the State governments. It would also reverse the historical pendulum, which has swung towards the Commonwealth in health matters. In Canada, the perceived advantages of this arrangement is that provincial governments are more sensitive to local nuances, political accountability is clear, and natural experimentation occurs. The disadvantages are duplication of bureaucracies, inconsistencies in public funding of services beyond those mandated by the Canada Health Act, and variable levels of cooperation and joint planning depending on the state of federalism.

Wholesale formal restructuring is fraught with difficulties, both political and practical. Moreover, if the goal is to become a genuinely high-performing health system, restructuring is just as likely to be a distraction and even an impediment as it is to be the solution. Those systems that appear to

---

That 3 provinces have effectively de-regionalized suggests that with 40% and more of provincial government budgets at stake, there is enormous reluctance to devolve real authority regardless of the difficulty of micro-managing complex health systems from the capital, and long-standing inability to drive substantive reforms.

<sup>2</sup> The provinces are Constitutionally responsible for health care except for services to the armed forces, Royal Canadian Mounted Police, aboriginal peoples covered by treaties, and some public health safety measures.



have achieved the highest levels of quality and efficiency relied less on structure than on cultural change at all levels, supported by tools and techniques such as advanced access scheduling, queuing theory, etc.<sup>3</sup>

***Option C: Commonwealth to be solely responsible for all aspects of health and health care, establishing compulsory social insurance to fund local delivery***

This option would transfer all responsibility for public funding, policy and regulation for health care to the Commonwealth, with the Commonwealth establishing a tax-funded community insurance scheme under which people would choose from multiple, competing health plans. The key features of this option are:

- All Australians would be required to enrol with a health plan of their choice. Health plans would have no right to refuse an individual.
- The Commonwealth would raise funding via an identified health levy to meet the full costs of the scheme. This funding would be allocated to a health plan of the citizen's choice based on the 'risk adjusted' membership profile of each plan.
- The plans would be required to cover a mandatory set of services, including hospital, medical, pharmaceutical, allied health and aged care.
- Health plans would be free to strike their own arrangements with providers, including entering into preferred provider arrangements.
- Co-payments for mandatory coverage could be limited by regulation.

- 
1. This is a variation on a European social insurance scheme, with some significant differences. It is directly tax-funded rather than a payroll tax, but since both are mandatory, they behave like taxes. Though not clear from the way it is written, it appears as if the government establishes the size of the budget and taxes accordingly. In most European countries with a mandatory social insurance model, the budgets and premium rates are set either by the plans themselves, or in consultation with the government. So in essence this is a dedicated health tax that would be apportioned to the equivalent of arm's length or Crown corporations to operate comprehensive health systems, presumably as purchasers of services.
  2. There is some interesting recent analysis of how single-payer, tax-funded systems differ from mandatory multi-payer social insurance systems. Wagstaff<sup>4</sup> found that

...A]dopting health insurance in preference to tax financing increases per capita health spending by 3–4 percent, reduces the formal sector

---

<sup>3</sup> Baker R et al. High performing healthcare systems: Delivering Quality by Design. Toronto: Longwoods, 2008. <http://www.longwoods.com/home.php?cat=571>

<sup>4</sup> Wagstaff A. Social health insurance vs. tax-financed health systems: Evidence from the OECD. The World Bank, Development Research Group, Human Development and Public Services Team, January 2009.



share of employment by 8–10 percent, and reduces total employment by as much as 6 percent. For the most part, social health insurance adoption has no significant impact on amenable mortality, but for one cause—breast cancer among women—social health insurance systems perform significantly worse, with 5-6 percent more potential years of life lost.

3. The report acknowledges that establishing causation is difficult. While intuitively one might infer that tax-financed and mandatory social insurance schemes are more or less interchangeable, they work quite differently and over time the incentives and behaviours that the different models entail can lead to surprisingly large differences in impact.
4. Funnelling tax revenues to competing social health insurance (SHI) organizations is presumably designed both to reduce the influence of immediate political and partisan interests in decision-making, and to introduce meaningful competition. However, it raises a whole raft of policy and procedural issues, including:
  - a. For consumers to choose meaningfully among them there would have to be very good performance measurement and reporting, and Australia is not yet advanced in this regard.
  - b. If the SHIs aim to expand market share they will have to behave in some respects like marketers, which may steer all the competitors toward certain programs and services and away from others. Market failure is endemic to health care, and the government would have to constrain the freedom of the SHIs to select areas of emphasis if needs are to be met fairly and comprehensively.
  - c. Since the model envisions overt tax funding it may be optimistic to assume that the government would be less vulnerable to the vagaries and pressures of health care politics.
  - d. Deciding on the size of the overall budget requires transparent and defensible criteria, value-for-money assessments, etc. Who would do this and on what basis would have to be worked out. It could be simply tied to a base funding allocation with defined escalator clauses, which would at least lend some stability to the sector and acknowledge the impossibility of objectively defining the “right” amount of health spending.
  - e. It may be inefficient to have competition outside large urban areas, in which case there would have to be rules surrounding economies of scale and contractual monopolies.
  - f. There would need to be clarification of what SHIs were allowed to do with “retained earnings” or unspent funds.
  - g. There would presumably have to be a general set of rules governing major capital expenditures to avoid over-capacity and ensure reasonable distribution.

In summary, it is not clear what problems this option is designed to solve. Decoupling it from payroll taxes is a twist that should be attractive to both business and labour because it reduces the highly visible overhead of doing business and removes a barrier to labour mobility. Otherwise it introduces elements of competition whose benefits are unclear – indeed it is not clear whether and how effective competitive behaviours would emerge. It also creates the risk of focusing on the



needs of higher SES groups – those most likely to exercise choice – and set back the cause of disparities reduction. To mitigate this risk would require a funding approach that created an incentive to enrol high-needs groups. Even here, though, intersectoral initiatives may be more difficult to establish if there are three arm's-length health care agencies forging alliances or coordinating services with State and/or Commonwealth government departments.

Furthermore, a number of OECD countries have moved from SHIs to tax-based financing while only the former Soviet bloc countries have moved in the other direction. There may be a lesson in this.

## D. MAJOR SUBSTANTIVE ISSUES

### 1. The Public-Private Split

The report identifies the mix of public and private insurance and public and private payment as an intrinsic virtue. Australia (like Canada) funds a relatively low proportion of total health spending through taxes and public subsidies. Systems that typically turn up at the top of health status and value for money league tables – an admittedly controversial methodological area – are closer to 80-20 public/private than Australia's 70/30. Expanded and simplified public coverage tends to improve equity, reduce transaction costs, and facilitate price and cost control.

### 2. Health, Health Care and Inequality

The countries with the best outcomes also tend to have more extensive social support systems beyond health care, built along the lines of the classic northern European social democracies. The extent of socio-economic inequality – often measured by the Gini Index – powerfully influences relative, and arguably absolute levels of health status. Two major implications follow. First, as is well known, the health care system by itself cannot achieve major reductions in health inequalities, so it would be unwise to expect too much of health reform on this front. Second, this reality should not lead to the conclusion that the structure and financing of the health care system plays no role in reducing or expanding disparities. The less public the system, the more likely there will be differences in access to care that exacerbate inequalities<sup>5</sup>. Additionally, how the system is organized, irrespective of coverage, can alter the effectiveness of health quite significantly. For example, it is widely recognized that a truly comprehensive PHC model focused on meeting the needs of the frail elderly, people with multiple chronic diseases, and lower SES groups could contribute significantly to reducing health disparities.

### 3. Value for Money, Quality, and Pay for Performance

The report mentions various funding mechanisms, including some that are activity-based, some based on episodes, and some based on performance. There are several possible observations to be made here:

---

<sup>5</sup> Even within public systems there are SES-related differences in access when care is free to the user of services. More than strictly money is at work.



- a. A recent paper by Alan Maynard<sup>6</sup> reviews pay-for-performance (P4P) experiences and concludes that they have generally delivered less than they have promised, while noting that it is difficult to design systems immune to gaming.
- b. All advanced countries practice “flat of the curve” health care; beyond about \$1000 US per capita there is little or no relationship between spending and major health indicators such as life expectancy and infant mortality<sup>7</sup>. It is very difficult to conceive of any incentives or fine-tuning that would purchase visibly improved health status.
- c. If the desire is to shift to a quality orientation, the reality is that better quality is almost invariably cheaper – as much as 30% cheaper according to Berwick and others. So whatever rewards one might wish to confer on high performing organizations, money would seem to be the least of what they need. The phenomenon of huge variations in costs with no commensurate benefits has been well-studied; famously, there are close to three-fold variations in expenditures on Medicare (elderly) beneficiaries among US cities, and if anything, care is better in the lower-spending areas<sup>8</sup>.
- d. There is no ideal way to fund health care – just about every mechanism has virtues and defects (with the apparent exception of for-profit, which seems to produce the highest costs and the lowest quality)<sup>9</sup>.
- e. Assuming that health care actors are undiluted economic beings reflexively responsive to financial incentives is too simplistic. Most people in health care are motivated by generous sentiments. Payment and funding systems do influence their behaviour – FFS has had an especially powerful influence on how a great deal of medicine is practiced. The question is whether it is desirable to create a system and policies that encourage practitioners and organizations to be even more focused on the financial aspects rather than less. We would argue for a combination of mechanisms that encourage financial prudence and good stewardship, but that once in place, they cease to be constant preoccupations for those charged with meeting patients’ needs. To that end, there is much to be said for simplicity that relieves administrators and practitioners from endlessly seeking advantage in the entrails of the “rules of the game”.
- f. That said, one neglected area of financial efficiency is price. Health care systems are often price-takers: they often do not bargain very effectively to align pricing with

---

<sup>6</sup> Maynard A (2008). Payment for performance (P4P): International experience and a cautionary proposal for Estonia. WHO Europe, Health Financing Policy Paper prepared for the Estonian Health Insurance Fund.

<sup>7</sup> Leon DA, Walt G, Gilson L. Recent advances: International perspectives on health inequalities and policy. *BMJ* 2002;322(7286):591-4.

<sup>8</sup> Fisher ES et al. Payments for care at private for-profit and private not-for-profit hospitals: a systematic review and meta-analysis. *Ann Intern Med.* 2003 Feb 18;138(4):273-87.

<sup>9</sup> Devereaux PJ et al. Payments for care at private for-profit and private not-for-profit hospitals: a systematic review and meta-analysis. *CMAJ.* 2004 Jun 8;170(12):1817-24. Review.



observed benefit. Shifting the focus from cost-plus pricing to a value-for-money approach would be a monumental sea change. For example, if one paid for additional medical imaging units at a price commensurate with marginal benefits, the price would plunge. The same is true for me-too new drugs, and very high cost, low-benefit drugs in general. Smarter purchasing has much to offer in some areas, but the history of attempting to improve practice by offering financial carrots has not yielded much. So again, while better and more transparent purchasing is a worthy goal, one should not expect miracles from it.

- g. Notably, the QI literature almost never refers to financial incentives because at the heart of transformation is a profound awareness that the status quo is unsatisfactory, a respect for analysis and high quality data, and a focus on meeting people's needs well. Where this cultural transformation has occurred, pay-for-performance, prudent purchasing, and sensible pricing almost invariably follow. They are the happy by-products rather than the root causes of improvement.

#### 4. Primary Health Care Models

The call for comprehensive polyclinics to deliver a wide range of services that meet patients' needs conveniently mirrors recommendations from around the world. There are a number of elements to the sought-after transformation, including team-based practice, maximizing the skills of all health care occupations, enhanced e-health, and funding systems that encourage excellence, prevention, and attention to the needs of the disadvantaged. The barriers to implementation are at least as much cultural as structural. If there is truly a will to accelerate the uptake of a new approach across the board, several initiatives are essential.

- a. The funding and remuneration schemes must be aligned with the desired structures. Primary care medical practice is a business based for the most part on a fee-for-service payment model. While we do not know the best way to pay for primary health care services and remunerate practitioners, it is quite clear that fee-for-service is the worst. It is very difficult to implement innovative PHC and retain FFS; some would argue that it is impossible.
- b. Getting occupations to work with each other effectively requires more than housing them together and funding them under the same envelope. It requires training, exposure, understanding, and trust. It also requires joint recognition of general and specific health goals and processes that enhance quality and outcomes. International experience suggests that it will take leadership, investment, educational innovation, and great ingenuity to effect large-scale change in this domain.
- c. Performance measurement and accountability will have to be redefined to make the proposed model work. Policy and incentives will have to align with the desired outcomes. If the system is to move from an activity-based to an outcomes-based orientation, there will have to be different and valid measures of value. Total system utilization and costs is more important than the cost of PHC per se. If greater investment at the front end of the system reduces the need for more expensive and complex care down the road, there is a net benefit in terms of both health and



efficiency. Information systems have to be compatible with these concepts and able to measure meaningful differences over time.

## **Acknowledgement**

Professor Steven Lewis, Visiting Menzies Fellow and Adjunct Professor (Health Policy), University of Calgary provided expert commentary for the Menzies Centre for Health Policy's submission on the Interim Report.

