

13. Raising and spending money for health services

Key messages

- Australia now spends \$94 billion or about 9.0 per cent of gross domestic product on health services. This level of spending is about what would be expected given the size of our economy relative to other countries.
- Investment in the capital infrastructure of our health services accounts for about \$5.3 billion of the \$94 billion, or 5.6 per cent of total health spending. Historically, most capital spending has been directed towards acute hospitals, with relatively low capital investment in other health services, including community-based services and sub-acute services.
- Health and aged care spending is projected to increase to \$246 billion or 12.4 per cent of gross domestic product by 2032–33. Caring for people with chronic diseases will represent one of the major reasons for this growth, with spending on diabetes and dementia among the fastest growing areas.
- The Australian health system benefits from access to a mix of both public and private financing streams. Many other countries are seeking to achieve a balance of public and private financing and the Australian model should be preserved.
- We currently lack good mechanisms to get community feedback on how much we should spend on health services, whether particular services should be funded publicly or privately and other aspects of priority setting in health care.
- An increased share of health costs are now being met directly by Australian households, rather than through taxation or private health insurance. In 2003–04, Australian households spent, on average, about 5.3 per cent of their weekly budget on paying for health services.
- People may incur very high costs for some health services that sit outside our universal access programs (public hospitals, the MBS and PBS). Access to dental care and aids and appliances represents a significant cost burden for some households (with the risk of families not using necessary services). A better system of safety nets is needed to support equitable access to necessary health services.
- We need to ensure that funding approaches achieve our objectives for health services that improve patient outcomes and are efficient, and that additional investment by government converts into real improvements in access and quality.

Our reform directions

13.1 Health and aged care spending is forecast to rise to 12.4 per cent of gross domestic product in 2032–33. We believe that:

- major reforms are needed to improve the outcomes from this spending and national productivity and to contain the upward pressure on health care costs; and
- evidence-based investment in strengthened primary health care services and health promotion and prevention to keep people healthy will help to contain future growth in spending.

13.2 We want to see the overall balance of spending through taxation, private health insurance, and out-of-pocket contribution maintained over the next decade.

13.3 We propose a systematic mechanism to formulating health care priorities that incorporates clinical, economic and community perspectives through vehicles like citizen juries.

13.4 We will explore new safety net arrangements that are more integrated, cover a broader range of health costs and are family-centred to protect families and individuals from unaffordable high out-of-pocket costs of health care.

13.5 We believe that incentives for improved outcomes and efficiency should be strengthened in health care funding arrangements. This will involve a mix of:

- activity-based funding (e.g. fee for service or casemix budgets). This should be the principal mode of funding for hospitals.
- payments for care of people over a course of care or period of time. There should be a greater emphasis on this mode of funding for primary health care.
- payments to reward good performance in outcomes and timeliness of care. There should be a greater emphasis on this mode of funding across all settings.

We further propose that these payments should take account of the cost of capital and cover the full range of health care activities including clinical education.

13.6 We believe that funding arrangements may need to be adjusted to take account of different costs and delivery models in different locations and to encourage service provision in under-serviced locations and populations.

13.7 We believe that additional capital investment will be required on a transitional basis to facilitate our reform directions. In particular, we propose that:

- Priority areas for new capital investment should include: the establishment of Comprehensive Primary Health Care Centres; an expansion of sub-acute services including both inpatient and community-based services; investments to support expansion of clinical education especially in new and underdeveloped settings; and targeted investments in public hospitals to support reshaping of roles and functions, clinical process redesign and a reorientation towards community-based care.
- Capital can be raised through both government and private financing options.
- The ongoing cost of capital should be factored into all service payments, as outlined above.

Don't tell me where your priorities are. Show me where you spend your money and I'll tell you what they are.¹

How and what we spend on health services sheds light on our real priorities

How and what we spend on health services sheds light on our real priorities. During our consultations with the community and health professionals, we frequently heard views about services on which governments should spend more money or how they should change the balance of their spending. Whether individuals and families were paying too much or too little was also the topic of sometimes vigorous debate.

¹ J Frick (undated), at: <http://thinkexist.com/quotes/with/keyword/priorities>

Financing and funding of the health system can be imagined as part of a circular process. The money to run the Australian health system is raised from households, families and individuals, principally through two mechanisms: taxation and voluntary contributions. This money flows via government, private health insurers and by consumer purchases directly through to providers and suppliers of health services (doctors, nurses, allied health staff, hospitals, pharmaceutical companies, pathology companies) who, in turn, provide services back to families and individuals.

Hence, the issues of interest to us can be considered across two major dimensions:

- how we raise money, or the financing of the health system; and
- how we spend money, or the funding models we use to pay for health services.

13.1 Financing choices

The choices open to us in regard to financing include: how much we choose to spend on health services, and where the money is raised from.

13.1.1 How much do we spend on health now?

In Australia, we currently spend \$94 billion on health services – about \$4500 for every man, woman and child. As a nation, health spending accounted for 9 per cent of gross domestic product in 2006–07. If we compare this with a decade ago using today's prices, we spent \$58 billion in 1996–97 with health services accounting for 7.7 per cent of gross domestic product.²

Given the growing burden of chronic disease, technological advances that mean we can treat more people for more conditions, and an ageing population, it is hardly surprising or front-page news that health services represents a bigger share of our total spending.

If we compare our health spending with other countries, Australia's spending is almost exactly what you would expect it to be given the size of our economy and our relative wealth. There is a well-known relationship that, as the wealth of a country increases, it spends more on health services as a share of gross domestic product.³

13.1.2 How much are we going to spend in the future?

Given that our role is to develop a long-term health reform plan, we commissioned some expert work on the projections for future health spending over the next 25 years.⁴

These projections identify how we can expect future health and aged care spending to grow, assuming 'business as usual'. The factors that have been used to develop the projections on future health and aged care spending comprise:

- ageing;
- population growth;
- changes in the pattern or rate of various diseases;
- changes in the volume of health services provided for treated patients (a measure of the 'intensity' with which care is provided);

2 Australian Institute of Health and Welfare (2008), Health expenditure Australia 2006–07 (Australian Institute of Health and Welfare: Canberra).

3 P Gottret and G Scheiber (2006), Health financing revisited: a practitioner's guide (World Bank: Washington).

4 J Goss (2008), Projection of Australian health care expenditure by disease, 2003–2033, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

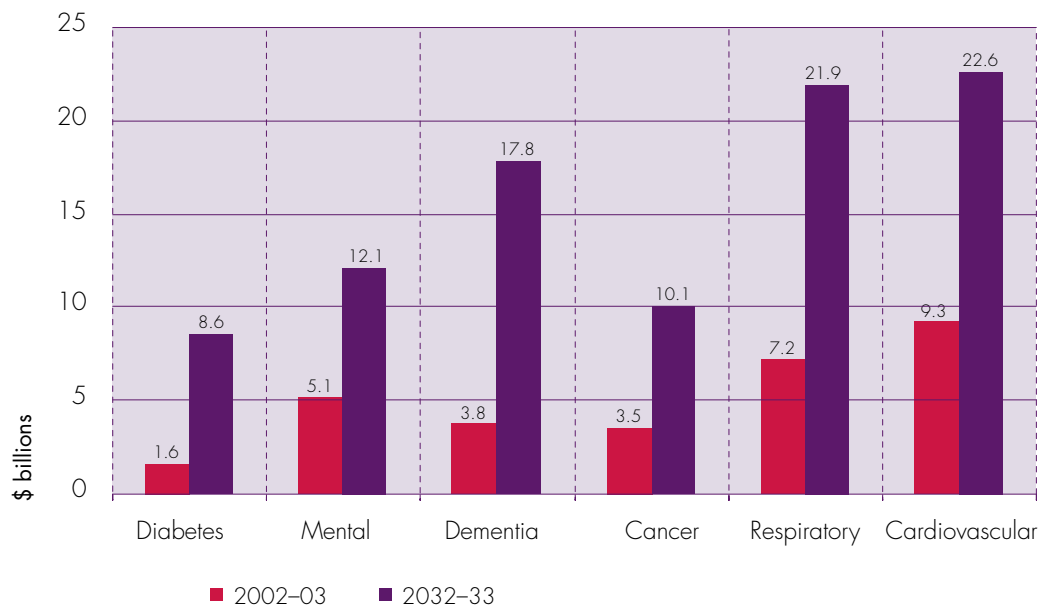
- changes in the share of the population receiving treatment for particular conditions (a measure of the 'coverage' or comprehensiveness of treatment); and
- changes in spending on health relative to general inflation.

Over the next 25 years health and aged care spending will increase to \$246 billion – about one-quarter of a trillion dollars

■ These projections indicate that, over the next 25 years, health and aged care spending will increase to \$246 billion – about one-quarter of a trillion dollars. By 2032–33, health and aged care services will consume 12.4 per cent of gross domestic product.

While health and aged care spending is expected to almost triple from 2002–03 to 2032–33, spending on some conditions will increase even more rapidly (see Figure 13.1). Chronic diseases will dominate the growth of our future health and aged care spending. Spending to treat people with Type 2 diabetes is estimated to increase by 520 per cent, for people with dementia by 364 per cent, and for people with respiratory conditions by 205 per cent.

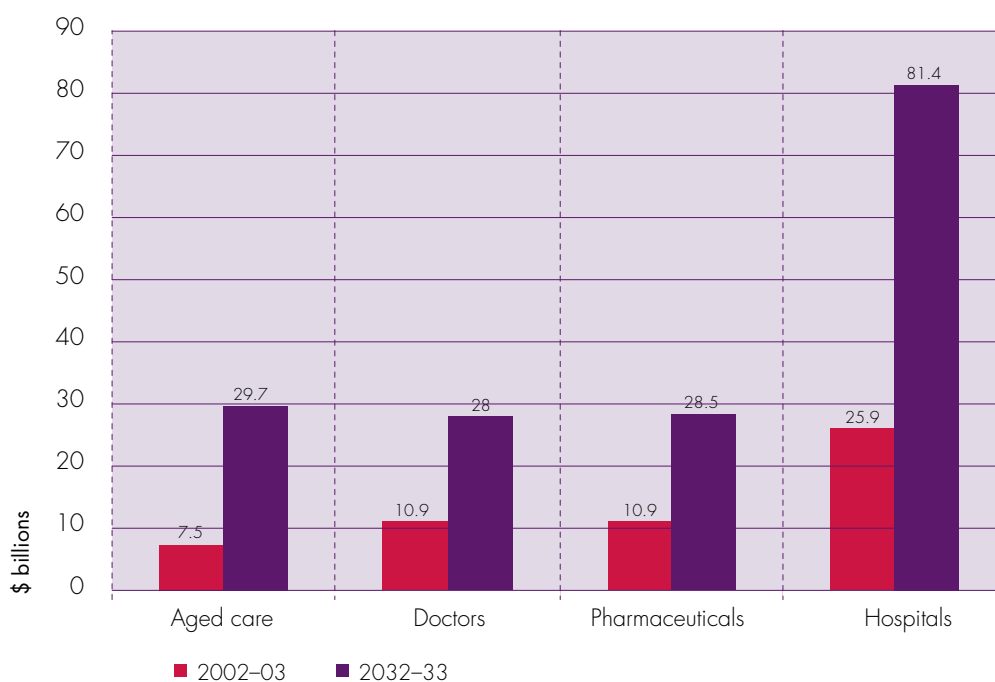
Figure 13.1: Spending on chronic diseases will grow significantly over the next twenty-five years



Source: J Goss (2008), Projection of Australian health care expenditure by disease, 2003–2033, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

If we continue with business as usual, the fastest growing areas of spending will be for acute services, such as hospitals and aged care (see Figure 13.2). Changing how much, and where, we spend will require greater investment in prevention and primary care, coupled with a real commitment to keeping people healthy.

Figure 13.2: The fastest growing areas of spending will be for aged care services and hospital admissions



Source: J Goss (2008), *Projection of Australian health care expenditure by disease, 2003–2033*, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

Reform direction 13.1

Health and aged care spending is forecast to rise to 12.4 per cent of gross domestic product in 2032–33. We believe that:

- Major reforms are needed to improve the outcomes from this spending and national productivity and to contain the upward pressure on health care costs.
- Evidence-based investment in strengthened primary health care services and health promotion and prevention to keep people healthy will help to contain future growth in spending.

13.1.3 How should we raise the money for our health care system?

The question of ‘who should pay’ for health services has no easy answer. Ultimately, all spending is from households, whether it is raised through taxation, purchased through private health insurers or paid for directly by individuals.

In general terms, Australia’s mix of health financing is often thought of as two-thirds flowing via government and one-third flowing from non-government (or private) sources. If we break down the \$94 billion we spent on health services in 2006–07⁵:

- \$39.9 billion (42.4 per cent) came from the Commonwealth Government;
- \$24.7 billion (26.2 per cent) came from state/territory and local governments;
- \$16.0 billion (17.0 per cent) came from individuals directly;

5 Australian Institute of Health and Welfare (2008), *Health expenditure Australia 2006–07* (Australian Institute of Health and Welfare: Canberra).

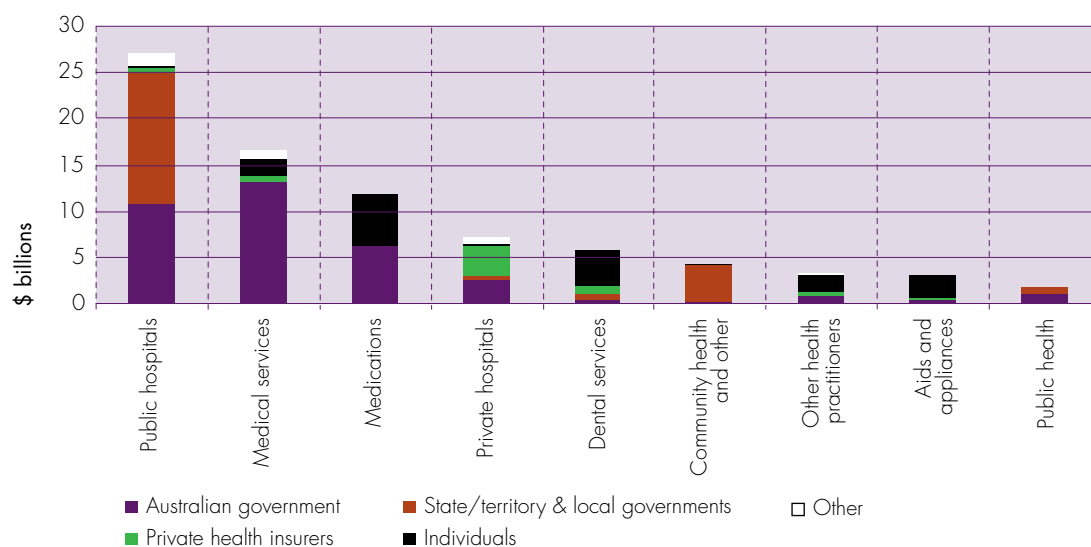
- \$6.9 billion (7.3 per cent) came from private health insurers; and
- \$6.7 billion (7.1 per cent) came from other payers (such as workers' compensation and transport accident insurance schemes).

So, the one-third of non-government or 'private' funding for health services actually comes from many sources. About one in every six dollars spent on health services in Australia is paid for directly by individuals; private health insurers and other payers (accident compensation schemes) each contribute about one in every fourteen dollars. In thinking about the 'public-private' mix of health financing, it is important to recognise that the 'private' contribution is largely paid directly by households, not via private health insurers or other third-party payers.

However, the composition of who pays varies considerably across different types of health services (see Figure 13.3). The Australian Government is the 'majority' funder for medical services (78.3 per cent), for public health (58.4 per cent) and for medications (52.7 per cent). State and territory governments are the majority funder for community health (83 per cent) and public hospitals (53.2 per cent). Private health insurers are the largest funder for private hospitals (46.6 per cent).

Individual households contribute very substantial amounts directly out of their own pockets for aids and appliances (contributing 74.4 per cent of total costs), for dental services (67.3 per cent) and for other health practitioners (such as physiotherapists or dieticians) (52.7 per cent). Hence, governments' priorities about what to fund (and what not to fund) determine what health costs must be met directly by Australian households.

Figure 13.3: Governments, individuals and private health insurers have set different priorities in paying for health care services



Source: Australian Institute of Health and Welfare (2008), Health expenditure Australia 2006–07 (Australian Institute of Health and Welfare: Canberra).

The choices we make about how to raise funding for health services – through taxation or voluntary payments – have consequences

■ The choices we make about how to raise funding for health services – through taxation or voluntary payments – have consequences.

The greater the level of taxation in a country, the less money households can spend on their individual choices between housing, travel, food and health care. Greater levels of taxation are argued to reduce individual incentives to work overtime and invest in new businesses. On the other hand, the incidence of taxation is progressive: wealthier households pay more tax and indeed a greater proportion of their income than poorer households. Taxation serves as a means of making

Australia a more equitable society by redistributing income from wealthier households to poorer households. Funding health services through taxation also serves to redistribute costs from sicker people to healthier people, similar to the way in which community rating works for privately insured people. Taxation redistributes money over a person’s life cycle: from when they are in employment to when they are older and generally have higher health needs.⁶

Voluntary payments (whether through health insurance or as out-of-pocket costs) have different characteristics. On the one hand, they allow households to directly express their preferences for what health services they want to purchase, rather than relying solely on the priorities of governments. On the other hand, voluntary payments are generally less equitable. Even though wealthier people spend more on health services and health insurance, this is generally a lower proportion of their income than for poorer people. Wealthier people are thus able to buy more access to health services but spend a lower proportion of their income for it.

The balance between taxation and voluntary payments (either through health insurance or through out-of-pocket costs) is essentially a political choice. How much does Australia want to raise taxation? How much choice does Australia want to provide households to set their own spending priorities?

There is no ‘right’ mix of government and private funding of health services. We note that most countries use a mix of government and private funding to pay for health services (see Figure 13.4).

■ Most countries use a mix of government and private funding to pay for health services

Figure 13.4: The share of private sector financing varies across countries



Source: Organisation for Economic Cooperation and Development (2008), Health data 2008: Frequently requested data, at: http://www.oecd.org/document/16/0,3343,en_2649_33929_2085200_1_1_11,00.html.

Note: Data are for most recent year (2006), with the exception of Turkey (2005), New Zealand (2003), Denmark (2002) and the Netherlands (2002).

Australia, with more than 30 per cent of health spending through private sources, ranks at the high end of private spending internationally. We also note that the international trend is for a convergence to the mean. That is, countries with historically high public financing (such as the United Kingdom) are increasing their private spending share. And countries with historically high private financing (such as the United States) are increasing their public spending share.

⁶ N Barr (2001), The welfare state as piggy bank: information, risk, uncertainty, and the role of the state (Oxford University Press: Oxford).

The use of co-payments needs to be evidence-based and have regard to the high contributions already made directly by many Australian families ■ In this context, and in light of the already high level of out-of-pocket payments faced by Australian households (see next section), we do not believe that significantly expanding the use of co-payments represents the magic bullet solution to meeting future health service needs. As discussed in Chapter 1, we are open to the evidence-based use of price signals, including the potential use of positive incentives or bonuses to encourage healthy behaviour. The use of co-payments must recognise the inability of many people to distinguish between medically necessary and discretionary services, together with the equity concerns for some population groups. We also believe there is considerable scope for tidying up the existing hotchpotch of safety nets (see next section) that now include different co-payments across different health services. As a general principle, however, the use of co-payments needs to be evidence-based and have regard to the high contributions already made directly by many Australian families to the costs of health care services.

Australia's mix of public and private financing is generally regarded as one of the strengths of our health system. We believe that this balance should be maintained.

Reform direction 13.2

We want to see the overall balance of spending through taxation, private health insurance, and out-of-pocket contribution maintained over the next decade.

In formulating this reform direction, we remain open to options that result in changes to the mix of financing (government, private health insurance, individuals) for particular types of health services. For example, we raise concerns about the costs borne by individuals for some health services (such as dental care and aids and appliances) in the next section. We also want to make clear that maintaining a balanced mix of health financing is not a passive process, but will involve ongoing choices about what services should be funded through what financing stream. This requires balancing key goals such as equity and affordability with the benefits of a mixed public-private system including choice, innovation and investment.

Given that decisions about the level of taxation and private financing of health services must be made at a whole of community level, we support mechanisms to encourage greater community participation in setting health care priorities.

Other than blunt expression through political processes, Australia does not have systematic ways for tapping the views of consumers about levels of health spending, and the purposes for such spending. Many groups and individuals expressed very strong support for greater involvement of the community and health professionals in both contributing to health reform and shaping the priorities for a health system of the future. For example, the Australian Medical Association argued that:

Successful reform is more likely if governments engage communities openly and honestly and if the reform process is a two-way street, with governments listening carefully to the view of patients and providers.⁷

In line with our principle of public voice and community engagement, we believe there needs to be strengthening of mechanisms to facilitate broad, informed public debate about the value of health, how much we spend on health care and what we should spend it on. Informed consumer deliberation (such as citizen juries) could thus occur about what are the service expectations of what should be funded from the public purse.

Reform direction 13.3

We propose a systematic mechanism to formulating health care priorities that incorporates clinical, economic and community perspectives through vehicles like citizen juries.

⁷ Australian Medical Association (2008), Submission 445 to the National Health and Hospitals Reform Commission.

Mechanisms to strengthen community participation are also discussed in Chapter 12.

13.1.4 Is the level of spending on health services by Australian households reasonable?

The high costs faced by some households in paying for health services were mentioned as one of the barriers to access in some of our consultations with community groups and also in the submissions we received.

With Australia having some of the largest out of pocket expenditure payments in the world, a decision to review and initiate a family focused payment system is paramount.⁸

Accordingly, we commissioned the National Centre for Social and Economic Modelling (NATSEM)⁹ to analyse the most recent available data (2003–04) on household spending to identify:

- How much are Australian households spending on health services directly out of their own pockets?
- What types of health services are particularly contributing to high out-of-pocket costs? Are some types of households particularly hard hit by spending on health services?
- Is it getting worse or better? Are people spending more or less on health services relative to other types of household expenses?

NATSEM found that spending on health care was a ‘big ticket’ item among Australian households. Among households who paid for health services, the average weekly spending was \$50.64, equal to 5.2 per cent of total household spending.

■ Spending on health care was a ‘big ticket’ item among Australian households

Paying for private health insurance premiums represented the largest share of spending by households on health costs. Privately insured households spent, on average, \$29.90 each week or 3.3 per cent of total household spending. In comparison, households allocated 3.7 per cent of their total spending to the cost of education (primary, secondary and higher education) and 3.8 per cent of their total spending for fuel and power. Hence, private health insurance represents a significant investment choice for many Australian households.

Dental care represents another major out-of-pocket cost for many Australian households, accounting for 3.1 per cent of total household spending among households with dental costs. However, patterns of spending by different types of households suggest that there are affordability issues for some households in being able to access dental care. So:

- Low income households were much less likely to have spending on dental care (only 1.1 per cent of low income households) than high income households (27.2 per cent).
- When low income households did pay for dental care, it accounted for 8.2 per cent of their total household spending. That is, one in every twelve dollars of all household spending by low income families went to pay for dental care.

The high costs for many households in getting access to dental care are one of the contributing factors that have led us to propose (see Chapter 11) the development of a new funding model to provide universal coverage for dental services.

Some types of health services are used by only a small share of the population, but represent a significant cost burden for these people. One such category is therapeutic appliances which includes items such as wheelchairs, orthopaedic braces, artificial limbs, orthotics and hearing aids. NATSEM found that:

⁸ Cancer Voices Australia (2008), Submission 53 to the National Health and Hospitals Reform Commission.

⁹ National Centre for Social and Economic Modelling (2008), Distribution of expenditure on health goods and services by Australian households, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

- While only 1.4 per cent of households had spending on therapeutic appliances, these households spent \$91.09 a week or 5.1 per cent of their household spending on these items.
- The highest weekly costs for therapeutic appliances were experienced by non-insured households who spent \$243.93 a week.
- The costs were also very high among households with a Concession Card at \$164.51 a week.

Health costs for Australian households increased by 15 per cent between 1998-1999 and 2003-2004

■ NATSEM also examined how household spending on health services had changed over time. It found that health costs for Australian households increased by 15 per cent between 1998-1999 and 2003-04. Health care is consuming a growing share of family budgets – up from 4.5 per cent in 1998-99 to 5.2 per cent in 2003-04 – and hence is displacing other spending priorities of households. And it is apparent from the analysis that some households are facing very high costs, with some types of health services causing major affordability issues for some households.

This uneven distribution of health costs across households reflects the funding priorities of governments, over time and at all levels, about what services should be subsidised from the public purse. Our universal programs – public hospitals, the MBS and PBS – have kept health costs relatively affordable for these services. But the same is clearly not true for some other health services.

Currently, there is a patchwork of funding programs and safety nets.

The safety net scheme for medical benefits is on an individual basis; for pharmaceutical benefits, by contrast, the safety net is on a family basis. Then while safety nets operate [over] calendar years, there is a 20 per cent tax rebate for medical expenses above \$1500 in a financial year, with different definitions of what qualifies as a medical expense. And that's before mentioning concessional arrangements.¹⁰

There are also a range of safety nets and programs designed to protect people who are likely to face high health costs. Some national examples include the National Diabetic Services Scheme and the Continence Aids Assistance Scheme. State governments also offer some assistance towards the costs of patient transport and aids and equipment. The effectiveness of some programs is clearly questionable. The high costs of patient transport have been the subject of a recent Senate inquiry¹¹ and were frequently raised with us during our consultation meetings.

The patchwork of safety nets, including different eligibility rules and requirements for different services, is not compatible with a high-performance, productive health system, where the right services are provided to the right person at the right time.

In our discussion on strengthening and reforming primary care (see Chapter 2), we have referred to the need to develop new funding arrangements and broaden the scope of services that are eligible for public funding. We need to be clear that this does not necessarily mean adding other services to the current Medicare system. (Further work will also be required on the appropriate mix of funding by individuals, private health insurers and government for any new health services.) What it does mean is thinking creatively about the range of services that might receive some public funding. Health costs should not distort sensible service provision, nor impede access to the right care for Australian families.

10 I McAuley (2008), Submission 269 to the National Health and Hospital Reform Commission.

11 Senate Community Affairs Committee (2007), Highway to health: better access for rural, regional and remote patients, at: http://www.aph.gov.au/Senate/committee/clac_ctte/completed_inquiries/2004-07/pats/report/index.htm

We will explore new safety net arrangements that are more integrated, cover a broader range of health costs and are family centred to protect families and individuals from unaffordable high out-of-pocket costs of health care.

13.2 Funding choices

The second part of the 'money cycle' relates to the way in which funding is allocated to pay for health services. We separately consider funding decisions relating to recurrent and capital spending.

13.2.1 Making choices about recurrent spending

There are essentially three main ways in which funding can be distributed:

- payments related to the number of consumers that are cared for over a period (capitation or per-capita payments). One example of this type of payment mechanism is the New South Wales resource allocation formula where Area Health Services are funded predominantly on the basis of their population, with adjustments for factors that might contribute to higher health service needs and costs.
- payments based on the number of services that a health professional or service provides (payments for service that are sometimes called 'activity-based payments'). Examples of activity-based payments include fees paid under the Medicare Benefits Schedule, payments by private health insurers for physiotherapy and dental services and casemix payments used by many states to pay for public hospital services.
- other payments (such as grants, block payments or salaries) that may be determined by policy choices, history, or some other negotiated basis. An example includes a grant to a remote health agency to provide a range of health services. Another example is an 'availability' payment to a public hospital related to keeping an emergency department open, irrespective of how many patients are treated.

The first two of these funding approaches are closely linked, as total expenditure in a population is related to the size of the population multiplied by the services provided per head multiplied by the cost per unit of service.

Different types of approaches to funding health services have different incentive effects. Choices about the allocation of funding need to consider the best type of funding model to achieve the particular objectives being sought.

Under a capitation funding model, a health service has a strong incentive to manage both the volume of services provided to each person and the cost per unit of service. Capitation funding can provide a strong incentive to undertake more prevention and early intervention to keep people healthy. A potential risk with capitation payments is that necessary health services may not be provided. To counter this risk, capitation payments need to be accompanied by clear benchmarks for patient outcomes, access or other measures that ensure necessary care is provided.

As funding under a capitation model is linked to a whole population, there is less focus on prescribing the services or health programs that should be funded. Some groups support more use of capitation funding models (or block grants) to break down multiple funding streams:

Community health centres in Victoria already attempt to provide integrated multidisciplinary care. They can have up to 40 different funding schemes from Federal, State and Local Government.

■ Capitation funding can provide a strong incentive to undertake more prevention and early intervention to keep people healthy

Apart from the bureaucratic nightmare this presents to the organisation in terms of multiple accountability measures and funding applications, it is a further barrier to patient based care. One patient fits the criteria for a certain type of service, and needs a small amount and can easily get it. Another patient desperately needs the same service but doesn't fit the criteria. The care given is not patient-centred, it's program centred.¹²

Capitation payments may also be considered as a type of payment that relates to providing all the necessary care for a person related to a particular condition over a specified time. Depending upon how capitation payments are made, they may also support greater choice if consumers can take 'their' capitation payment and receive health care from the providers of their choice. For example, the Australian College of Midwives provided information to us on the funding model for maternity care in New Zealand where each pregnant woman can elect a Lead Maternity Carer.¹³ Under this approach, the health care provider is able to access government funding that covers the 'course of care' – antenatal and pregnancy care – for each enrolled woman. Capitation payments may also better serve the needs of some patients with chronic and complex conditions, as health professionals and patients may have greater flexibility in accessing the 'right' services for individual patient needs.

A major feature of many activity-based payments is that they drive greater efficiency and productivity

■ Activity-based payments have a different set of incentives, although there is considerable variety in how they can be designed and operate. A major feature of many activity-based payments is that they drive greater efficiency and productivity.

The examples given earlier of activity-based funding payments (to hospitals per patient treated, payments for each medical visit) are somewhat different in kind. A payment for a medical visit under the MBS generally reimburses only the interaction between the doctor and patient. On the other hand, a payment for each hospital patient treated involves the 'bundling' of the range of services involved in that hospital stay. Services such as pathology, radiology, and indeed each day of stay, are all bundled together with the appropriate surgery or medical care and the hospital receives a single composite payment for all these services. In this way a hospital has a financial incentive to manage the use of pathology services, for example, as excess investigations do not attract any additional funding, thus driving efficiencies in care.

Bundling approaches to activity-based funding can also be applied to ambulatory care. In Victoria, funding arrangements for public hospital outpatient services involve the bundling of all investigations for 30 days on either side of the outpatient visit. Again this provides an incentive for the clinician seeing the patient as an outpatient to determine carefully what investigations are necessary.

Similar approaches can be adopted in community care with a payment to a general practitioner or other primary health care professional to manage investigations of a patient around a visit window. For example, an activity-based payment could be made relating to the care of patients over a defined period of three or twelve months. These arrangements could build on the payments for care coordination already incorporated in the Medicare Benefit Schedule. As already discussed in Chapter 2, such an approach would respond to the concern that existing fee-for-service payments are not the best approach to funding primary health care for people with chronic or complex needs.¹⁴

The broader the window of care which is incorporated in an activity-based payment and the greater scope of services that are bundled into that payment, the more the activity-based payment begins to have characteristics of a capitation payment. So, although activity-based payment and capitation are sometimes considered as alternative funding models, it may be better to consider them as points on a continuum rather than simple alternatives.

A risk that needs to be managed with activity-based funding is ensuring that it covers all the major aspects of health services, not only patient care. A frequently raised issue among our submissions was that clinical education was being squeezed within a busy service delivery environment that

12 Doctors' Reform Society (2008), Submission 78 to the National Health and Hospitals Reform Commission.

13 Australian College of Midwives (2008), Submission 27 to the National Health and Hospitals Reform Commission.

14 Australian Association of Occupational Therapists (2008), Submission 23 to the National Health and Hospitals Reform Commission.

was focused on treating more patients. For example, the Australian Medical Students Association argued for 'quarantined investment in infrastructure for education and training', as well as wanting to expand clinical training capacity in rural areas and across a broad range of settings such as community-based and private sector care.¹⁵

While we examine workforce issues in more detail in Chapter 14, we agree with the importance of protecting teaching time and argue that one way to achieve this objective is through explicitly funding clinical education. We believe that activity-based payments should be made for clinical education activity (both undergraduate and postgraduate education), in addition to direct patient care. Clinical education can be funded on the basis of days of undergraduate clinical education provided, or number of postgraduate trainees employed within an organisation. If any essential element of service provision is not appropriately funded, it runs the risk of not being provided.

Activity-based and capitation payments are generally described as being related to the care of patients. Care payments can also be moderated or supplemented by additional payments related to other aspects of the interaction between the patient or consumer and the health care professional. Bonuses or penalties can be introduced relating to the timeliness of care (waiting times for elective surgery, for example) so the additional payments (bonuses) or payment reductions (penalties) can be made for those patients seen (or not seen) within a specified time period.

Additional 'performance related' payments could also be made for other policy goals. These might include payments related to outcomes or processes associated with clinical quality. Providers who undertake a higher level of preventive interventions (ensuring that all patients seen within their practice are appropriately immunised) may attract additional payments; adherence to clinical markers, designated as part of good care, might also be rewarded financially. These 'pay for performance', or outcome-based payments, are used with increasing frequency in health systems internationally¹⁶ and should be implemented in Australia (see Figure 13.5).

■ 'Pay for performance', or outcome-based payments, should be implemented in Australia

Figure 13.5: Queensland is beginning to use 'pay for performance' to achieve better outcomes for public hospital patients

Queensland Health has recently introduced a pay for performance element as part of its funding for public hospitals. Under the Clinical Practice Improvement Payment system, public hospitals are able to receive additional payments if they meet certain clinical indicators.

The Clinical Practice Improvement Program involved 12 months of clinical consultation to ensure that the clinical indicators were evidence-based and acceptable to clinicians. Other key design features included ensuring that bonus payments were able to flow through to the actual clinical units responsible for achieving required performance on the clinical indicators.

The first set of clinical indicators that are being linked to performance payments cover areas including:

- *timely treatment by a community mental health professional for patients with schizophrenia after they are discharged from a hospital;*
- *provision within 48 hours of antiplatelet therapy for patients with an acute stroke;*
- *completion of a discharge medication record for patients leaving hospital with evidence of communication back to the patient's general practitioner or residential aged care facility.*

The performance payments related to meeting these clinical indicators have been set at about 1–3 per cent of the price otherwise paid by Queensland Health for treating relevant hospital patients. As this new payment mechanism only took effect in June 2008, data are not yet available on its impact.

Source: S Duckett, S Daniels, M Kamp and colleagues (2008), 'Pay for performance in Australia: Queensland's new Clinical Practice Improvement Payment', *Journal of Health Services Research and Policy*, 13(3): 174–177

15 Australian Medical Students' Association (2008), Submission 503 to the National Health and Hospitals Reform Commission.

16 P Gross (2008), Submission 448 to the National Health and Hospitals Reform Commission.

We note that reform of payment arrangements focusing on the pay for performance concept was suggested in several submissions. This concept has many meanings and can include both the use of incentives or penalties linked to the standard of performance. For example, the Australian Health Insurance Association (AHIA) has suggested that existing default benefit payments made by private health insurers could be changed:

... to promote real competition and ultimately remove the disincentives for providers offering a lower standard of care and/or less optimal outcomes than their peers.¹⁷

AHIA notes that payment for performance, based on quality and safety metrics, can only be implemented successfully if there is robust information about patient outcomes. Other submissions focused on using payment reform to provide incentives for the right type of care. For example, Paul Gross suggested an array of new payments to encourage 'systemness' including: no patient co-payments for effective preventive services; higher payments from Medicare and private health insurers for high quality medical and hospital care; and new incentives for care outside hospitals and care provided online.¹⁸

Pay for performance raises complex issues about what is the 'base' level of quality and safety that consumers should be able to expect from health care. Do we pay 'extra' for 'higher' quality? Should funders (whether governments, private health insurers or individuals) have the right to withhold payment for poor quality care? And what constitutes unacceptably low quality care for which payment should be withheld (for example, amputation of the wrong limb)? To date, these issues have been little explored in Australia.

Moving now to the issue of capital costs, we believe it is important to incorporate the appropriate cost of capital in all recurrent funding arrangements. This applies to all activity-based payments, including casemix payments for hospitals, new payments for sub-acute services and payments for primary health care services. This relates to how health services are able to cover the replacement or depreciation costs, not major expansions in physical infrastructure which require additional new capital, as further discussed below.

We further note that governments have already identified a move to greater use of activity-based funding as a way of improving the overall efficiency of public hospitals. Our view is that a mix of different funding models will need to be used across the whole health system. Some funding approaches are better suited to certain types of health services or certain settings.

Reform direction 13.5

We believe that incentives for improved outcomes and efficiency should be strengthened in health care funding arrangements. This will involve a mix of:

- activity-based funding (e.g. fee for service or case mix budgets). This should be the principal mode of funding for hospitals.
- payments for care of people over a course of care or period of time. There should be a greater emphasis on this mode of funding for primary health care.
- payments to reward good performance in outcomes and timeliness of care. There should be a greater emphasis on this mode of funding across all settings.

We further propose that these payments should take account of the cost of capital and cover the full range of health care activities including clinical education.

¹⁷ Australian Health Insurance Association (2008), Submission 480 to the National Health and Hospitals Reform Commission.

¹⁸ P Gross (2008), Submission 448 to the National Health and Hospitals Reform Commission.

Irrespective of the funding model used, we also heard frequently about the need to ensure that funding for health services was appropriately adjusted to reflect different cost structures or access problems for under-served populations. Issues relating to ensuring adequate funding for rural and remote populations are considered in more detail in Chapter 9. Here, we emphasise that funding models cannot be a 'one size fits all' approach, but will need to recognise the higher costs of meeting the needs of certain populations.

Reform direction 13.6

We believe that funding arrangements may need to be adjusted to take account of different costs and delivery models in different locations and to encourage service provision in under-serviced locations and populations.

13.2.2 Making choices about capital spending

Almost all the policy and media focus in health is notionally about the recurrent costs of health services. For example, some of the issues that are frequently raised include: How much are public hospital budgets going to grow? Are we spending enough on mental health services? How much are fees (and government benefits) for general practitioner services increasing? What is the growth in private health insurance premiums?

Apart from decisions made by state governments about building or rebuilding an iconic public hospital (such as a children's hospital), we rarely hear about the 'Goldilocks' problem of capital spending: whether we are spending too much, just the right amount, or too little on the capital infrastructure of our health care services. We received a few submissions raising issues about the adequacy of investment in medical technology and equipment. For example, Engineers Australia argued:

A 'typical' public teaching hospital will house clinical equipment with a value in excess of \$50 million. Keeping this equipment current demands that around \$5 million per annum be spent on capital replacement programs. This rarely occurs, resulting in crisis replacement often via truncated procurement processes that do not necessarily deliver value for money ... Poor funding models also often result in piecemeal or ineffectively staged replacement programs.¹⁹

Part of the reason for this lack of focus on capital spending is that it is actually very difficult to accurately measure the current level of investment in health capital (and even harder to estimate whether this is the 'right' level).

The Australian Institute of Health and Welfare reports that in 2006–07 we spent \$5.3 billion on health facilities and equipment – equal to 5.6 per cent of total health spending.²⁰ But when we begin to 'unpack' this spending, it becomes obvious that this reported level of spending on capital conveys only part of the picture.

Of the \$5.3 billion of reported capital investment in health in 2006–07:

- \$2.98 billion (56 per cent) was spent by the non-government (or private) sector.
- \$2.18 billion (42 per cent) was spent by state, territory and local governments.
- \$132 million (2 per cent) was spent by the Commonwealth Government.

■ In 2006-07 we spent \$5.3 billion on health facilities and equipment – equal to 5.6 per cent of total health spending

19 Engineers Australia (2008), Submission 80 to the National Health and Hospitals Reform Commission.

20 Australian Institute of Health and Welfare (2008), Health expenditure Australia 2006–07 (Australian Institute of Health and Welfare: Canberra).

This pattern of capital spending is apparently quite different to the distribution of total spending on health care services that we reported earlier in Section 13.1.3. However, there are several important limitations and qualifications with the available data on capital spending.²¹

First, most of the capital spending in health by the non-government sector represents investment in private hospitals. However, the reported amount of \$2.98 billion on 'health' capital spending by the private sector is actually likely to include significant capital spending on aged care services. This means that it is not possible to directly compare the levels of recurrent and capital spending within the health sector. In addition, the private capital spending is not reported by 'source of funding', again making it difficult to examine relative spending on capital and recurrent by government and non-government sectors.

Second, most of the spending by state governments is on state-run services such as public hospitals and community health services. These data are the most accurate in capturing 'dedicated' or separate funding of capital on health services.

Third, the apparently low level of spending by the Commonwealth Government reflects that:

- In general, it does not directly operate health services but funds health services that are privately delivered (such as general practice, pharmacy and radiology).
- The benefit paid by the Commonwealth Government for each of these health services includes a component for the cost of capital, and so some of the private capital spending is, in fact, sourced from Commonwealth payments for services provided in the private sector. Unlike state government funding of public hospitals, the Commonwealth Government does not separate out capital from recurrent costs, but pays a single price. (The same holds true for payments by private health insurers to private hospitals.)
- The Commonwealth makes a small number of grants (\$24 million in 2006–07) that are of a capital nature, usually to non-government organisations and sometimes to other levels of government (such as state, territory and local governments). In addition it has its own capital expenditure (\$108 million in 2006–07) for its own purposes (largely information technology and property, plant and equipment expenditure to support administration).

Fourth, there are differences between how the public and private sectors obtain capital assets: taxation and other accounting issues place different incentives on the two sectors in terms of the relative attractiveness of direct investment in capital compared to leasing (or rental) arrangements. This in turn affects what capital acquisitions are reported compared to what capital assets are available to be used.

These differences in how we measure and report data on capital investment in the health system make it very challenging to identify relative spending by government and non-government sectors, and whether we have 'got it right' in terms of the overall existing level of investment in health capital.

With regard to long-term reform of the health system, we would argue that there are two important messages in relation to future capital investment.

First, we believe that the cost of capital (which would allow health services to maintain, repair and replace existing equipment and infrastructure) should be included in the 'price' or funding payments made by all payers of health services. This is currently the case with some payments made by the Commonwealth for health services (such as general practice) and payments made by private health insurers for all private health services (such as private hospitals). The same should occur with payments from all funding sources for health services (for example, activity-based payments for public hospitals). These payments should be neutral as to whether the recipient is a public, non-government or private for-profit provider.

21 J Goss, Personal communication with the National Health and Hospitals Reform Commission.

Second, we anticipate that some of the reform directions proposed elsewhere in this report will have capital implications and require the investment of new capital, at least on a transitional or 'hump' funding basis. The reality is that the majority of capital spending in both the public and private sector has historically been directed towards acute hospitals, with lower investment in other community-based services. This dilemma was described in one of our submissions as follows:

Each State and Territory Government has been compelled to use as much of its own funding and available Commonwealth funding for health in sustaining acute health services. Desirable high priority community based services, preventative and health promotion, some mental health and rehabilitation services have competed with acute and emergency services for funds, often with less success. With a focus on obtaining sufficient funds to meet the immediate needs of health care for patients presenting at hospitals, State and Territory governments have had limited opportunity to systematically invest in service delivery.²²

We believe that additional capital investment will be required to build the reform elements of a future health system. We note that the Commonwealth Government has recently established the Health and Hospitals Fund to support strategic investments in health. Moreover, we note that additional capital investment may also be funded through private equity sources. The extra capital required does not all have to be sourced directly through governments.

Reform direction 13.7

We believe that additional capital investment will be required on a transitional basis to facilitate our reform directions. In particular, we propose that:

- Priority areas for new capital investment should include: the establishment of Comprehensive Primary Health Care Centres; an expansion of sub-acute services including both inpatient and community-based services; investments to support expansion of clinical education especially in new and underdeveloped settings; and targeted investments in public hospitals to support reshaping of roles and functions, clinical process redesign and a reorientation towards community-based care.
- Capital can be raised through both government and private financing options.
- The ongoing cost of capital should be factored into all service payments, as outlined above.

22 R Kerr (2008), Submission 312 to the National Health and Hospitals Reform Commission.