

# POLICY OPTIONS

## Primary Health Care in Australia: towards a more sustainable and equitable health care system

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Kees van Gool and Jane Hall, on behalf of the REFinE team

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### Policy context

Health care is the fastest growing component of Commonwealth Government outlays. Not surprisingly, policy advisers have made health care system sustainability a central policy target. However, health care reforms aimed at making the system more financially sustainable often do so at the expense of fairness. The mandatory co-payments for general practice (GP) consultations proposed in 2014 were a good example of this. On the one hand, the proposal would make Medicare expenditure more sustainable, but on the other hand it could reduce access to general practitioners, particularly among low income people and the elderly. The ensuing debate was hotly contested, ideologically driven and largely absent of relevant evidence.

Within this discussion, greater emphasis is being given to the role of primary care. In Australia, the establishment of the Primary Health Care Taskforce and its ensuing recommendations are a good example of this. In part, the Task Force's recommendations were driven by the promise of better prevention and management of chronic diseases to prevent further declines in health status and escalating health care costs.

Our understanding of the potential impact of health care policy is limited. The interrelationships between primary care and other sectors of the system, including hospital, specialist and emergency care are not well understood. Any policy measure targeted at a particular health care sector can have unintended and counterproductive consequences in other sectors. Such consequences may affect not only the overall efficiency of the system, but also equity of access and outcomes.

### Key findings

## THE ROLE OF PRIMARY CARE IN MITIGATING GROWTH IN HEALTH CARE EXPENDITURE

### Aligning responsibilities and incentives for better care: the case of diabetes

As the population ages and chronic diseases become more prevalent, health care costs will increase. The cost of treating diabetes is twice as much as for someone without diabetes. For those patients with serious diabetes-related complications, health care cost can increase to \$100,000 per patient per year. This shows that better prevention and management have the potential to deliver better health outcomes and savings. Typically, as patients become more complex and health status declines, greater responsibilities fall on public hospitals and state government budgets. Yet state governments have limited powers to influence the primary care sector. The alignment of responsibilities and financial incentives is one of the underlying challenges of Australia's health care funding arrangements.

### Drivers of health care use vary across the country

There is considerable variation in the use of GP care across local areas. In areas with lower GP access, indicators of need such as age and socioeconomic status are important determinants of GP use. Conversely, factors other than need are important drivers of GP use in areas where access is high. The availability of emergency departments has a positive influence on GP use, indicating that there are important supply side interactions between primary care and acute care.

### Living arrangements can have significant implications on the health care system

Individuals who live alone are at greater risk of hospitalisation and also longer stays. Our results indicate that beyond good primary care management, social factors can also influence hospital use and subsequent costs. Services aimed at older singles that support them at home have the potential to be effective at reducing downstream health care costs. This means developing policy that goes beyond current services to different types of out of hospital services and funding.

## ACCESS AND EQUITY

### Fees and co-payments for specialists create barriers to access

The fees charged by doctors have a direct bearing on the co-payments faced by patients. Both GPs and specialists vary their fees substantially depending on patient characteristics, with most doctors charging high-income patients higher fees. The higher willingness to pay among higher income groups is a potential driver for specialists to locate in affluent areas. This, in turn, creates further barriers to access for lower income patients in addition to the co-payments they face.

### Higher co-payments can lead to financial hardship

Despite our universal insurance system, many elderly Australians are at risk of financial difficulties, particularly those with multiple chronic conditions. Fourteen percent of survey participants spent more than 10% of their income on health-related expenses. This indicates that there are insufficient safeguards in the Australian health care system to protect patients from financial hardship. In part these results are driven by the myriad of public and private insurance programs that have complex rules on eligibility, are not well coordinated and lack transparency.

### Affordability is a key determinant in the choice of clinical pathway

Health care use increases dramatically following the onset of disease but the type of care used varies considerably according to income group. Low income patients tend to increase their use of GP services whereas high income patients increase specialist use. Low and high income patients are navigating different care pathways and affordability is a major driver of the chosen pathway. Patients also face substantial increases in out-of-pocket (OOP) costs after the onset of disease which could represent a greater financial burden on the poor in terms of affordability.

The overarching theme from the body of work is that the Australian health care system has created numerous distortions that prevent optimum health care delivery and use. Some examples include:

- > Specialists have an incentive to set up practice in wealthier areas even though these areas may not be where health care need is greatest.
- > Patients navigate a care pathway of least costs to them, rather than the most effective or efficient care.
- > Governments look to reduce costs in health care sectors for which they have financial responsibility but possibly increasing overall costs.

These distortions create disincentives to allocate scarce resources where they could deliver most health gain. The distortions are widespread and affect administrators, providers, patients and governments. Whilst the research highlights the presence of these distortions, there is no clear measure on the overall costs these distortions impose on the system. This produces a cautionary warning against system wide reform that is not evidence-based. Any reform option needs to

recognise that the Australian health system performs well against virtually all international benchmarks. As a result, reform should be well targeted and aligned to the problem that it is trying to solve.

## Policy options

The discussion below outlines a number of policy options that are aimed at removing the distortions that have been highlighted by the body of research undertaken by the REFinE team.

### Greater transparency in fees and out of pocket costs

There is a lack of information within the system about doctors' fees and OOP costs faced by patients, particularly when they are referred from the primary care system. Even GPs have little information about what other doctors charge their patients, making it difficult to make informed financial choices. This lack of transparency creates substantive barriers to price competition which in turn creates distortions around choosing the most optimum care pathway.

New policies around price disclosure could help overcome this problem. Greater transparency can be achieved through dedicated websites that provide information to patients and GPs about average fees for particular Medicare items and gives personalised information about the likely OOP costs for a service or episode of care.

At the same time, caution is required as any new level of competition could have an impact on price discrimination practices that, in turn, could affect some population groups. This points to the need for further research into how greater price disclosure may affect provider and patient behaviour.

### Re-align co-payments

Australia's system of co-payment is uncoordinated and ad hoc – based around particular insurance programs. They are there to discourage use rather than create incentives for patients to choose optimum treatment pathways. There is a need to re-examine the system of co-payments in a completely new light. Patients and providers should be encouraged to use the most effective and efficient care. This implies that co-payments should not be structured around particular health care sectors but instead around evidence-based episodes or bundles of care. Higher co-payments can then be used as a dis-incentive and discourage use of less than optimal care.

Furthermore, current co-payments are badly targeted. There are many wealthy sections of the community who face low co-payments and many poor sections who face high co-payments. Currently, concession card status and usage are the only policy instruments by which co-payments are determined. In many cases, these instruments are very blunt and create substantial risks of financial hardship, create barriers to access and make care unaffordable for certain sections of the community.

The re-alignment of co-payments could include a wider but more targeted use of bulk billing incentives.

### Design governance structures that align financial responsibility with care responsibility

Australian funding responsibilities are predominantly sector based. The Australian government is financially responsible for pharmaceuticals and medical services whereas state governments are responsible for public hospitals. The system offers little rewards and few tools for any single institution to look after the long-term needs of patients – particularly those with chronic diseases. There is a need to structure the system so that social, primary and acute care services are integrated and delivering the most effective and efficient care at the right time and place.

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