

Health Reform: Critical Challenges for Health Systems Management - Australian Perspectives

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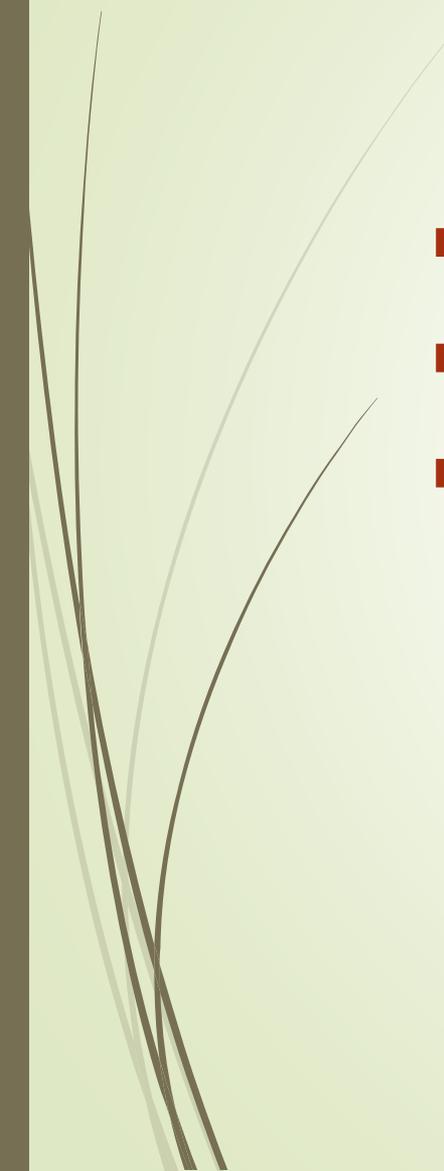
HEALTHCARE DELIVERY AND FINANCING REFORM

Implications for Business, Healthcare Providers and Patient

Hong Kong January 2017

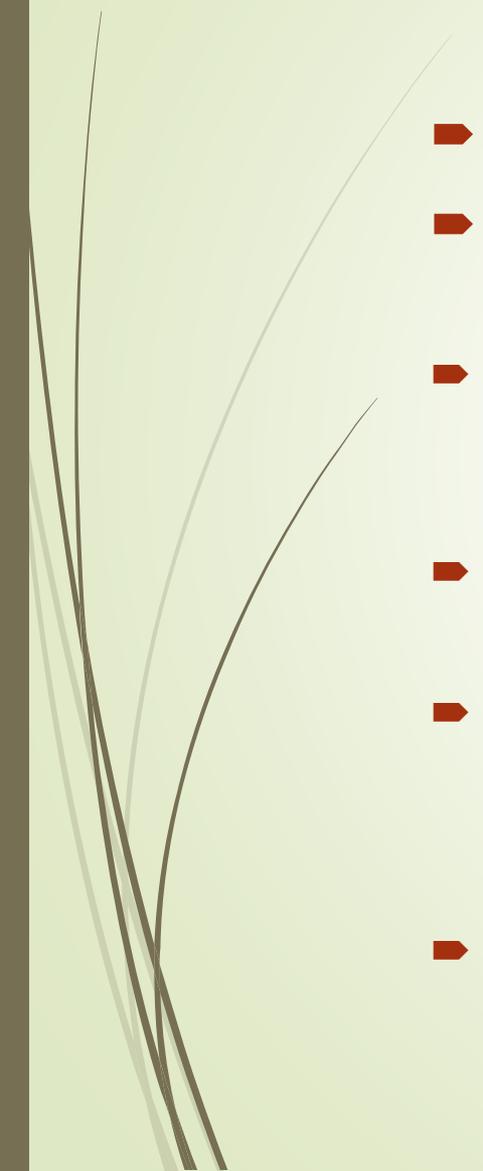


Introduction

- Australian Health System
 - Challenges & Responses
 - Future Directions
- 



Context

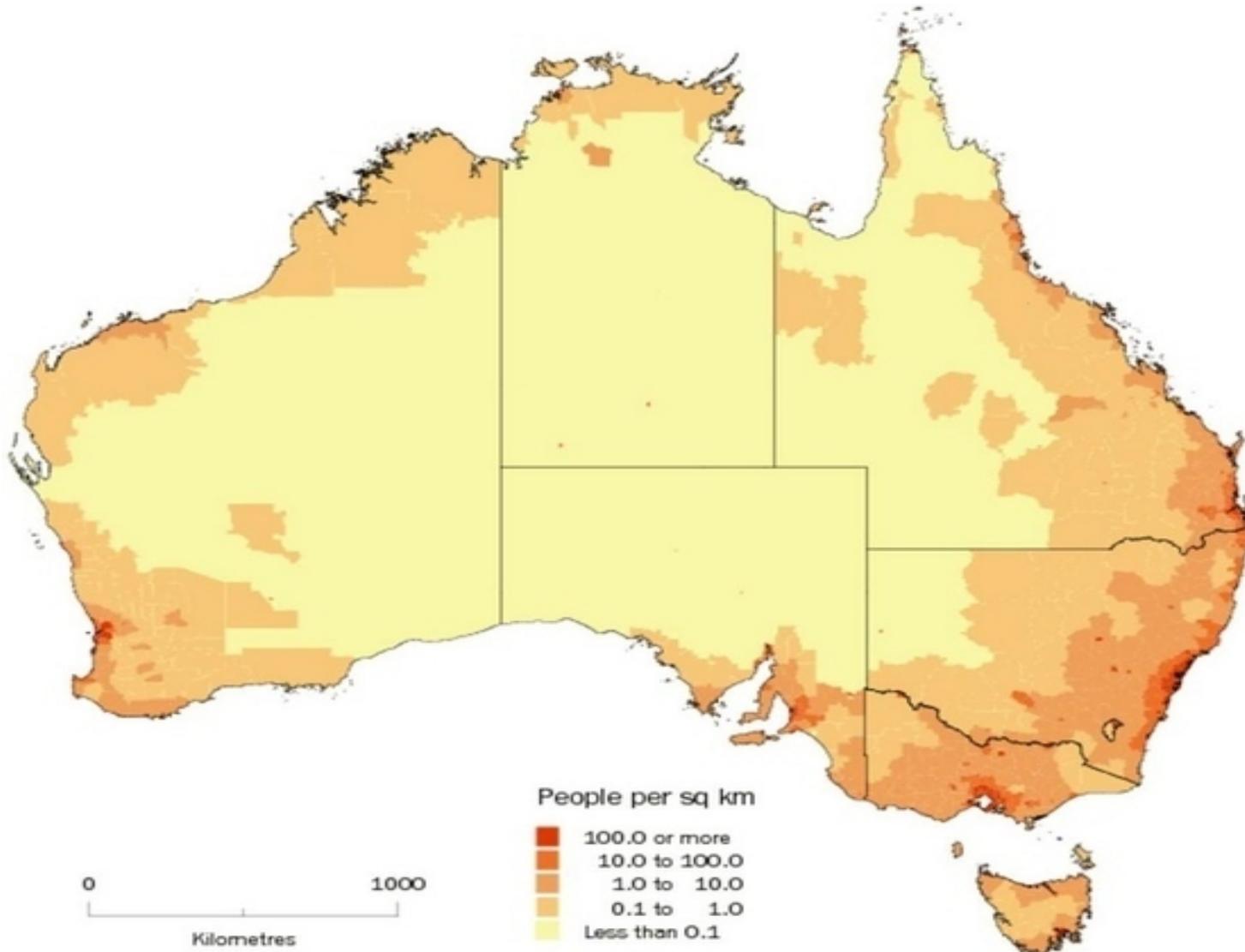


- ▶ Australia has had a lot of reform for health
- ▶ Australia has also had 'Health reform without change and change without health reform'
- ▶ We are a Commonwealth of States a Federation with shared responsibilities for funding and delivering health Service
- ▶ We have Universal Health Coverage that is not 'enshrined' in legislation
- ▶ Public Health Policy is uncertain
 - ▶ National Health Insurance not a National Health System
 - ▶ Tension between UHC and Public Good v Market Forces
- ▶ Generally good outcomes

Australian Health Care System

- Commonwealth Parliament
- Eight States and Territories
- Each with their own elected government
- Divided responsibility for health
- Elected local government
- Highly urbanised coastal population
- 24 million people – 27% overseas born – 3% Indigenous

Australia's population density





Drivers of Expenditure

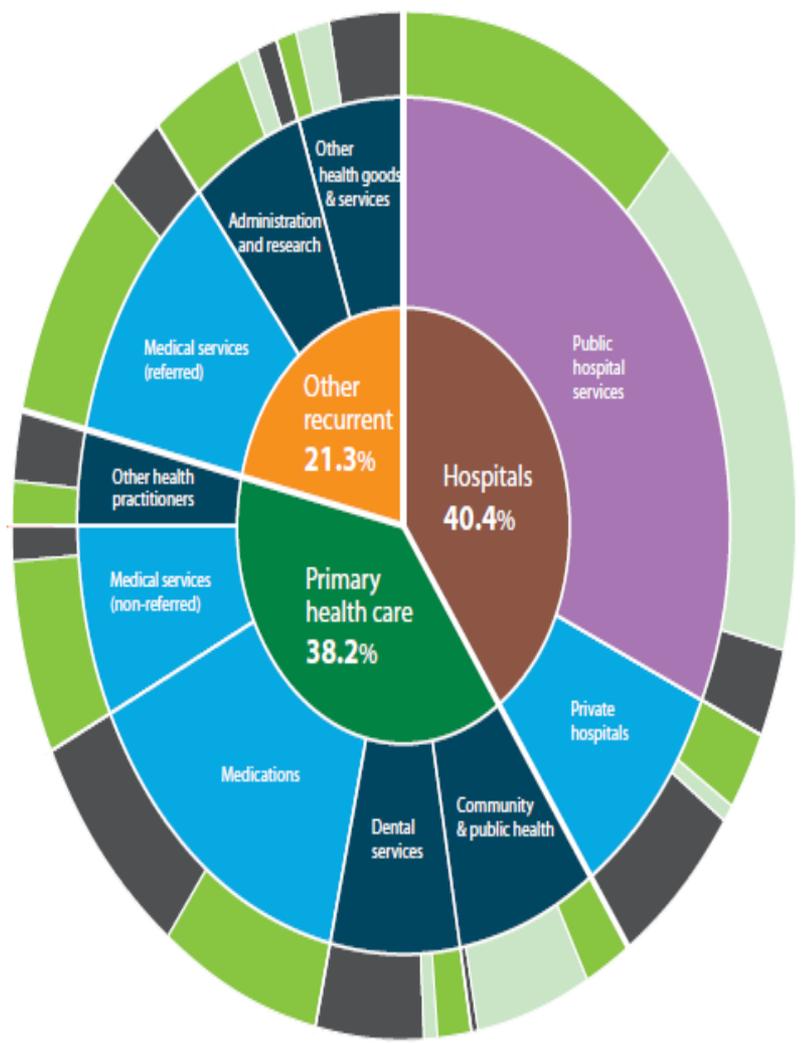
- Ageing population except for Indigenous population
 - Closing the gap
- Aged Standardised death rates declining
- Mortality rates amongst the lowest of OECD countries
- 9.7% of GDP expenditure \$147.4 Billion
- Drivers of expenditure
 - Cardiovascular disease
 - Expenditure on adults aged 85 + almost 20 times as high as expenditure on children aged 5-14
 - Mortality rates of the aged declining through to 85+ group
- Health expenditure has risen faster than either population growth or ageing



Medicare – A National Health System

- A national health insurance system not a national health system and its continued existence is not enshrined in legislation but the Australian public has a high sense of ownership of Medicare
- Medi-Scare a recent political challenge
- Levy at 1.5%, plus a surcharge of 1% to high income earners who do not have private health insurance. 18% of recurrent health funding, private health insurance subsidy
- Pharmaceutical benefits scheme

Figure 2.1



Share of expenditure

- Hospitals
- Primary health care
- Other recurrent

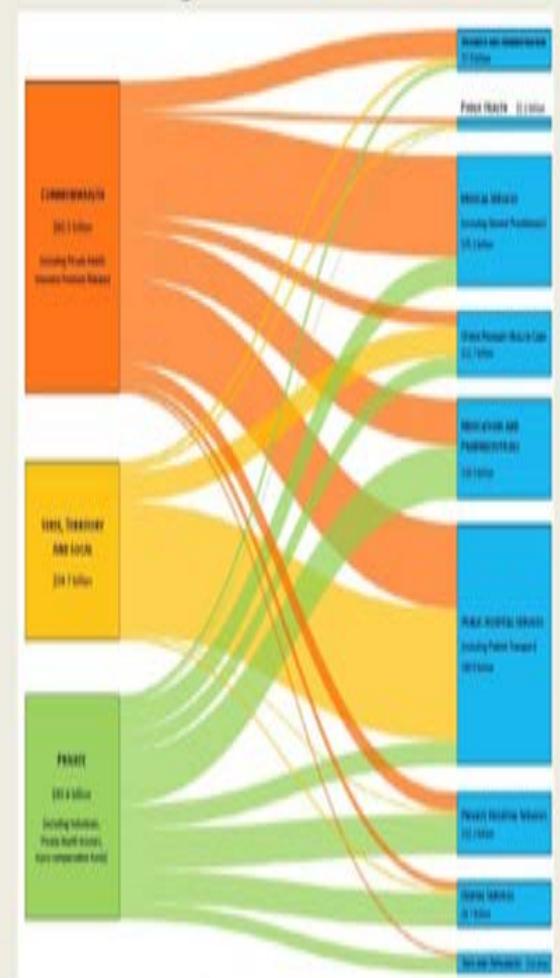
Responsibility for services

- Combined private sector and public sector —all levels of government
- State and territory governments
- Private providers

Funding

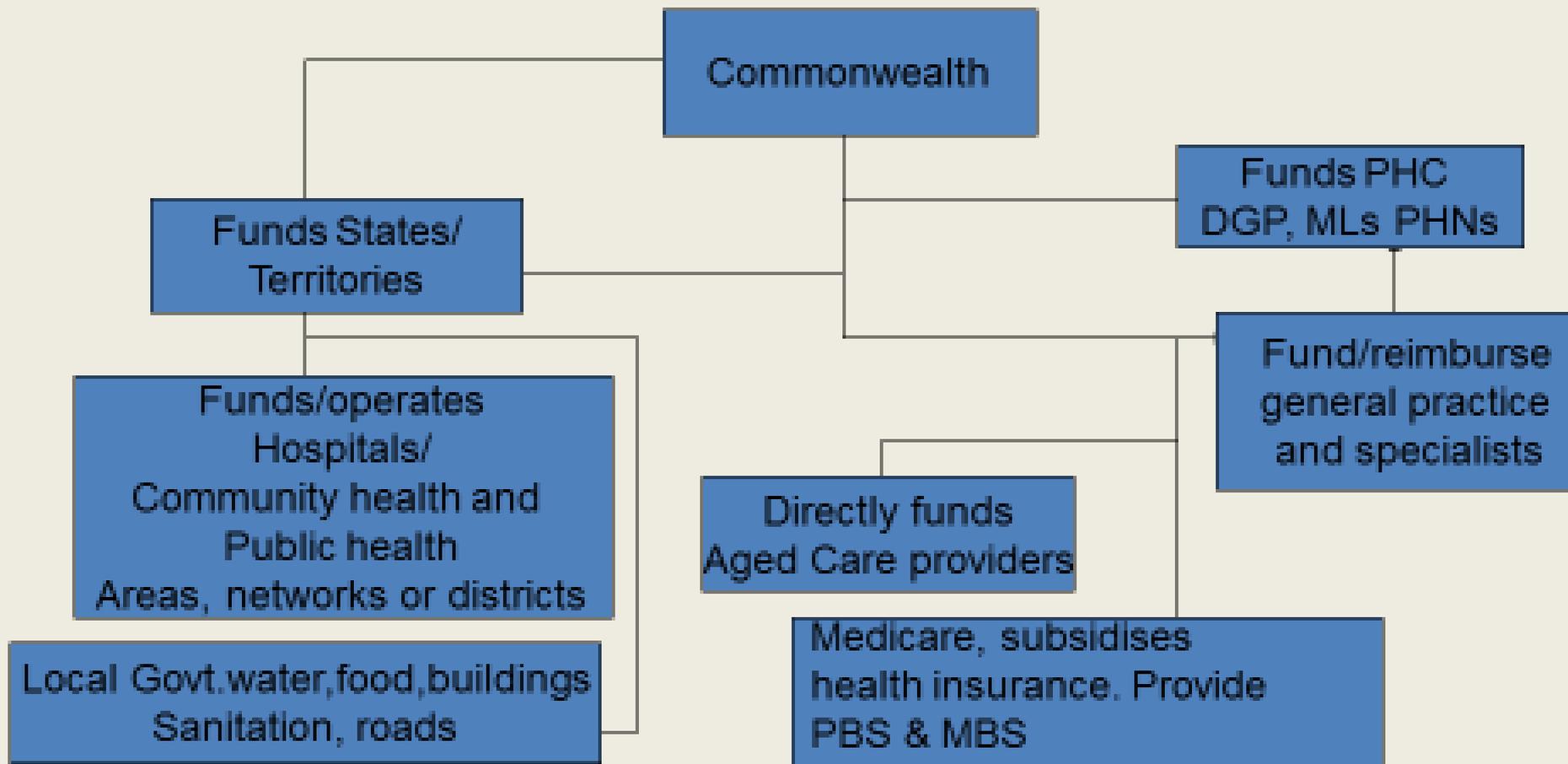
- Australian Government funding share
- State/territory government funding share
- Private funding share

Funding Flows in Australia health care arrangements 2012-13



The Australian Health System-Structure

- Three levels of Government- Commonwealth(National)- State (Provinces)- Local Government

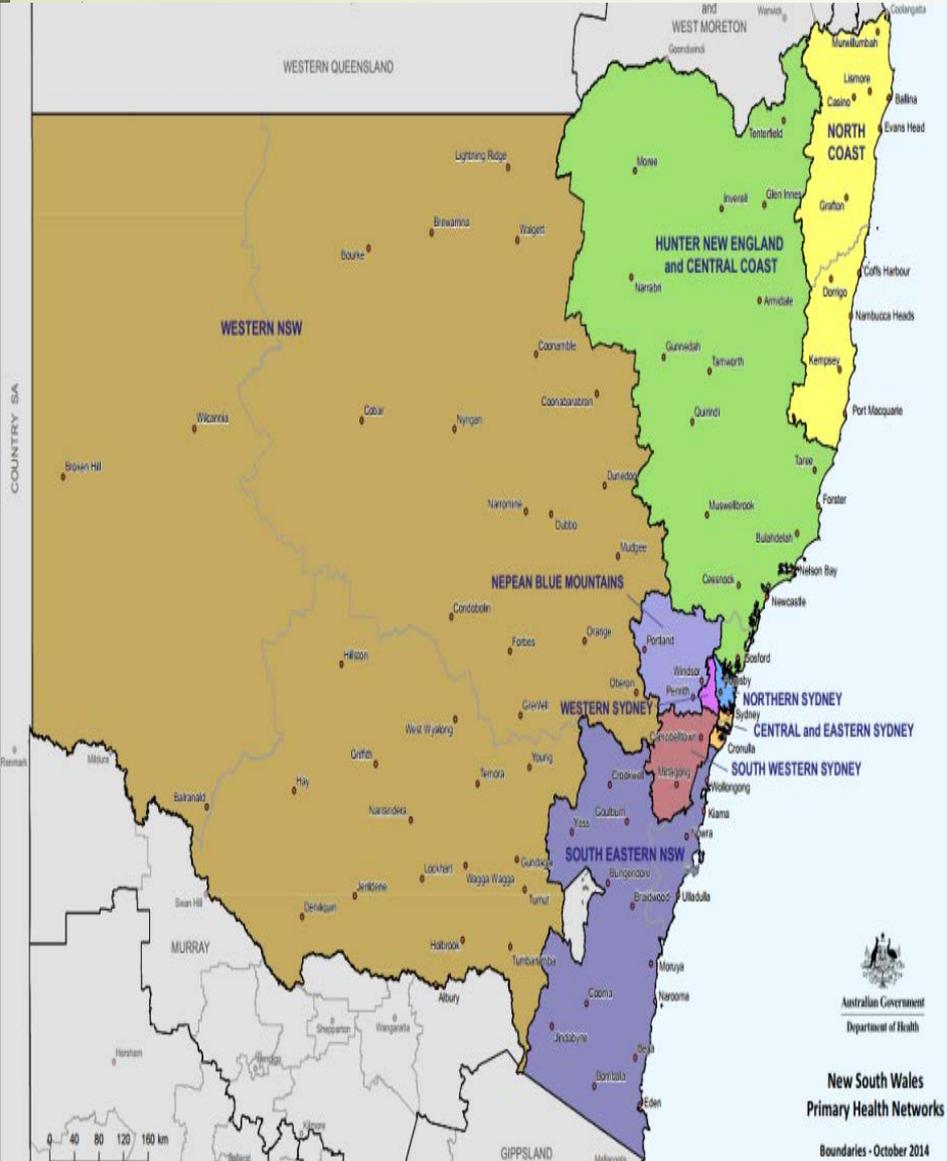




Health Structures and Systems

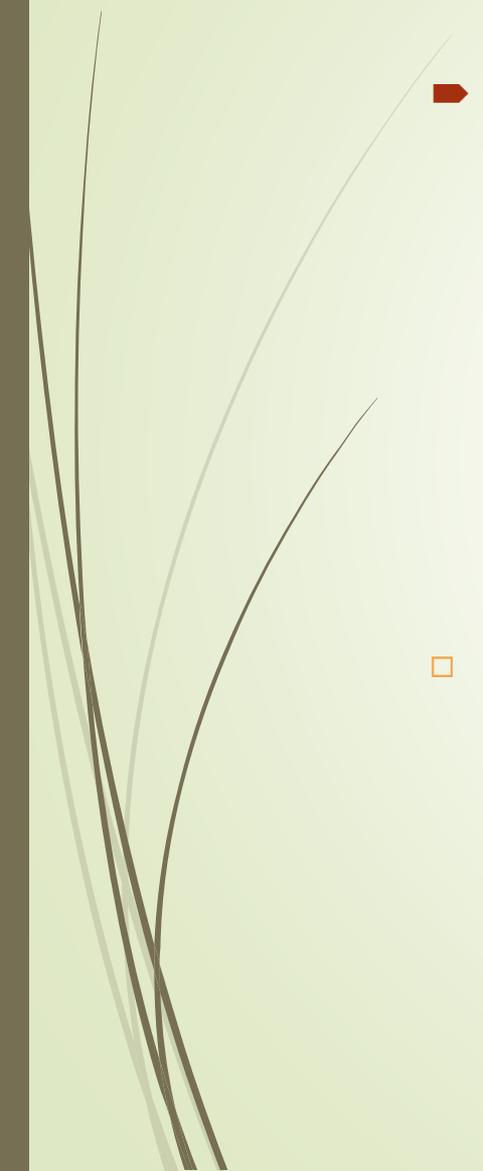
- ▶ Acute care organised into 'Local Health Districts' (LHDs) accountable to a governance Board and the State Minister of Health
 - ▶ Increase use of private sector to provide and manage public hospitals
- ▶ Primary Health Care is fragmented and provided by general practice and both NGO and private providers
- ▶ Primary Health Care Networks (PHNs) recently established as public not for profit companies - Federal Government
- ▶ PHN Role
 - ▶ Commissioning of services
 - ▶ Planning, service design and population health
 - ▶ Practice support, Continuing Professional Development
- ▶ HNECC example – two LHDs, 1.2 million people, 27 LGAs, large Indigenous population, 1322 general practitioners, 31 public hospitals, 138 aged care facilities

Hunter New England Central Coast PHN





Challenges



- ▶ **Managing downward fiscal pressure and increasing capacity and demand for services**
 - ▶ Not letting health spending continue to increase faster than GDP or allowing service providers to exploit their powerful positions.
 - ▶ Define the national principles of Medicare and the health system and the underlying values of a pluralistic society
 - ▶ Accept that we are dealing with a moral hazard where consumers and providers do not need to pay for services and where the market has limited influence
- **Ensuring we deliver the right mix of care for the chronically ill and frail aged, allocating resources optimally**
 - requires a more integrated system with a stronger primary healthcare infrastructure
 - Diabetes and obesity of concern
 - supporting the new primary health networks as they develop partnerships on the ground with local health districts (acute care)



Potential Responses to the Challenges

- Improve the effectiveness of care.
 - Understanding and analysing 'big data'
 - Implementing shared clinical pathways, evidence based medicine, new models of care, 'hospital in the home'
 - Population health – identifying at risk and disadvantaged groups and identifying new approaches to addressing disadvantage (Podger, 2016)
 - Measuring performance and outcomes (Duckett & Leeder 2016)
- Greater investment to address the social determinants of health and Sustainable Development Goals (SDGs)
- Harmonising or a refocus of health insurance systems – consumer choice

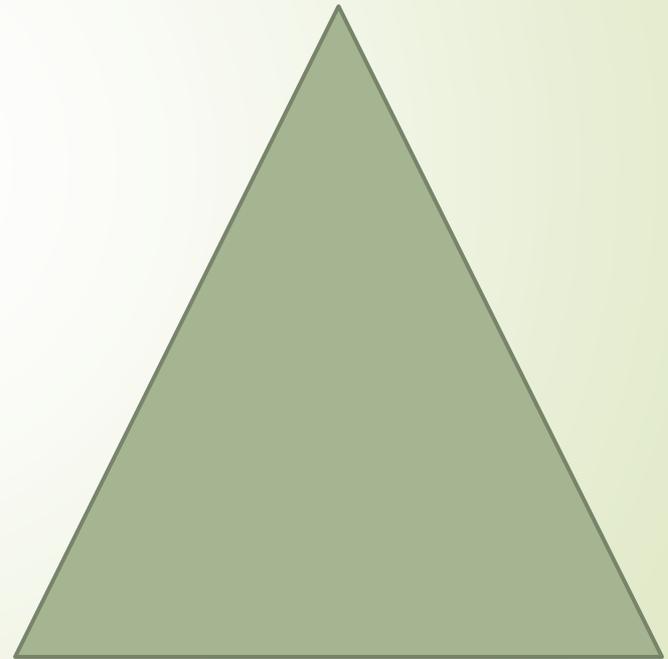


Responding to Challenges

- Local approaches to regional funding without too much prescription
- innovative frameworks of innovation, research, service design, population health and planning (HNECCPHN)-compass
<http://www.hneccphn.com.au/population-health/>
- Using social media to engage and network across organisations with expert groups and communities to innovate how to deliver services in newer more cost effective ways
- PeopleBank – engagement
<http://peoplebank.hneccphn.com.au/>

Triangle that Moves the Mountain and Health Systems Reform Movement

- How can we implement knowledge-based health development successfully is the crucial issue.
- The passive ill-health-oriented system needs to be reformed to a good-health-oriented system.
- Research should lead to development and development lead to more research relevant to development needs.
- pay more attention in finding and developing **health policy leaders** who can mobilize resources for health development
- Creation of Relevant Knowledge – Social Movement – Political Involvement
- Source: Professor Prawase Wasi (2000)





Future Directions from the Language of Health Reform

- Health reform is starting to focus on achieving better health outcomes ahead of reform through restructuring
- There is a need to focus on health outcomes particularly system level measures ahead of the current focus on performance measures
- The health workforce has become globalised and requires a coordinated focus by nation states of the Asia Pacific region
- The emerging language is about collaboration and innovation through distributed networks of practice across organisational boundaries
- Learning needs to be strengthened in the areas of evidenced based management, prevention promotion, wellness and meaningful engagement of communities, consumers and how to become 'patient centric'
- Greater focus on socio-economic determinants, and sustainable development goals (Briggs 2016)



Thank you

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