A MODEL HEALTH SYSTEM FOR AUSTRALIA

Andrew Podger

3 March 2006

INTRODUCTION

In a paper for the Productivity Commission's Federalism Roundtable late last year I presented a paper on "Directions for Health Reform in Australia". This paper is a little more ambitious, describing a preferred model for the Australian Health System.

Setting a model health system is no easy challenge. There is a serious lesson in the old Irish joke that "if you want to go there, I wouldn't start from here". An Australian model has to fit with our history, our culture and our institutional arrangements, even as it sets something of an ideal we might aspire to. The first and most important lesson of the Four Nations' Conferences I used to attend was that "to learn from, you must first learn about": the context of each nation's health system is critical to its design features, which explains why there is no single international model for an efficient and effective health system.

In taking on this challenge I am also mindful of a regular dialogue I had with my Minister, Dr Michael Wooldridge, while I was secretary of the national health department. The dialogue, which took place almost every year, went like this. I would suggest a major review of the health system or some radical proposal; Dr Wooldridge would note that a clear lesson from both Australian and overseas experience was that "big bang" health reforms were counterproductive, causing more heat than light, and that we must focus on incremental changes; I would agree, but advise that incremental change without a clear sense of direction may well be mere ad hocracy; he would respond that articulating clearly the long-term direction was as politically dangerous as "big bang" reform.

The result was not entirely a stalemate, as the incremental changes over the period of Dr Wooldridge's watch did reveal some important change directions, particularly in strengthening general practice and reinforcing the importance of effectiveness and cost effectiveness in Medicare (enhancing the role of private health insurance was

another important development, but there remains considerable ambiguity about the longer-term role of competition and private financing in health that I shall come to later).

Finally, setting a model for such a huge system as health involves attempting to balance different objectives and different interests, and allowing flexibility to adjust to changing circumstances such as new technology or new health challenges or changing community expectations. Inevitably, there will be considerable room for argument about the balance and how it might need to be adjusted over time. Central to my choice is not only my personal judgement or my take on the likely preference of the Australian public, but also a framework in which there are in-built incentives to find a balance that is likely to optimise health outcomes from the resources available. Whatever the model, it will need to be managed in practice.

DIRECTIONS FOR HEALTH REFORM

Before describing a possible model for Australia's health system, let me summarise some of the points I covered in the Productivity Commission paper about the objectives and nature of health systems, the performance of our current system, some system design principles, and some of the options for change.

Considered as a system, health has four objectives:

- the good health of citizens, though of course this objective relies on much more than the health system;
- equity, ensuring services are available according to need, and are paid for according to capacity to pay;
- low cost, or value for money; and
- the satisfaction of the various participants – consumers in terms of access, quality, effectiveness, courtesy etc; providers in terms of the support the system gives them to apply their professional expertise and in providing reasonable remuneration; and funders in terms of returns on investments.

The nature of health, however, is not just a 'system' that can be centrally designed and structured:

- it is huge – around 9.7 percent of GDP in Australia – and is as much an industry as a system, where consumers and providers exercise a considerable degree of independence;
- for reasons of both social policy and economic efficiency, it is dominated by government as funder and regulator, and also frequently as provider;
- it relies significantly on professionals and beneficent organisations, and their values of concern for patients and the needs and rights particularly of disadvantaged people;
- there are limits therefore to the role of competition in health systems, but this can be exaggerated, with competition and choice amongst providers of care remaining important.

It is important to remind ourselves that Australia ranks highly on a number of indicators of system performance:

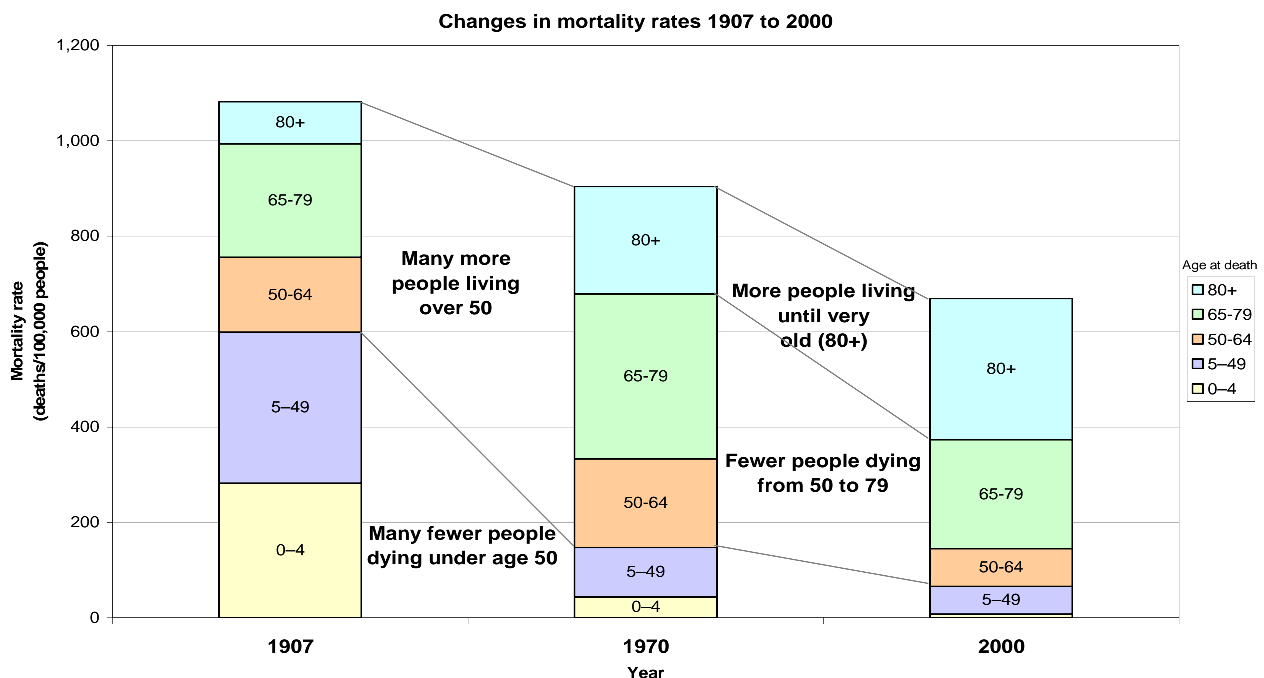
- we rank third amongst comparable OECD countries for life expectancy, sixth for healthy life expectancy and third in overall health system effectiveness;
- relative to Canada, the UK and the US, a higher proportion of Australians see a doctor promptly when they need to, and rate their care as very good or excellent;
- waiting times for emergency departments are shorter than for the US, Canada and the UK;
- waiting times for elective surgery are shorter than for Canada, NZ and the UK.

Our biggest failure is in regard to Indigenous health, where life expectancy is around 17 years lower than for other Australians, this gap being bigger than the gap between Indigenous and non-Indigenous peoples in the US, Canada or NZ.

While the prevalence of some health problems (particularly diabetes and obesity) is on the increase, the mortality rates of most major specific diseases are declining, and our life expectancy is continuing to increase at between 3 and 4 months every year. Indeed, apart from Indigenous health, our biggest challenge is to address the impact of our major successes, the fact that people are living a lot longer today, and are not

dying so rapidly after heart disease and cancer. The following graph illustrates our success, which is reflected also in other developed countries:

- the increase in life expectancy from 1900 to 1970 was dominated by our success in reducing child mortality and mortality amongst those under 50, so that many more people reached age 50;
- but the increase in life expectancy since 1970 has been dominated by our success in ensuring that those who reach age 50 live a lot longer after than point.



One of the impacts of this is that we now have many more frail aged people, and many others who have survived the onset of heart disease or cancer or other diseases including mental illness, but who require some ongoing care to ensure they can live with reasonable independence and quality of life. Indeed, the AIHW has estimated that about 80 percent of the burden of disease in Australia is now related to chronic disease.

There is evidence that our health system could do better in managing chronic disease:

- we have a high rate of potentially avoidable hospitalisations for chronic conditions, particularly amongst those with diabetes of whom only one in five receive best practice care;

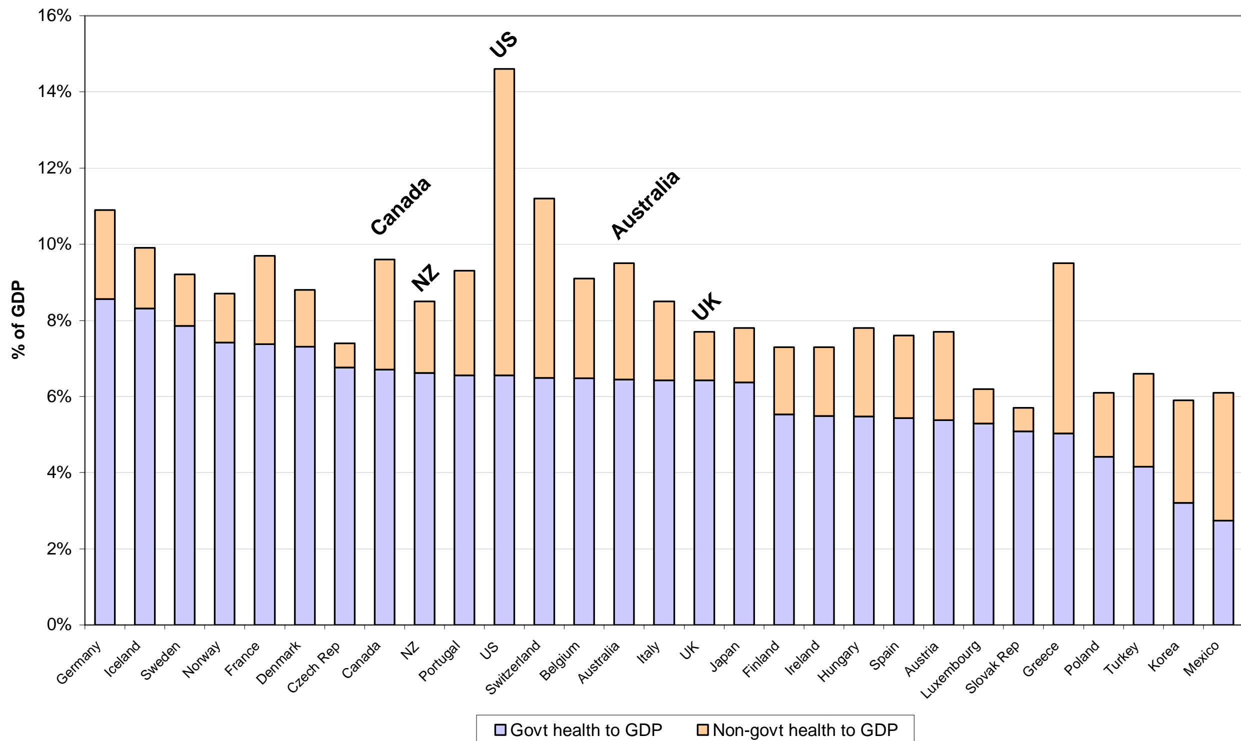
- we don't manage the frail elderly who need some hospital care very well, and too many go to hospital too often. Step down and rehabilitative care has been substantially cut in the last decade or so and, while hospital stays per 1,000 people over 75 have increased around 40% over the last 10 years, the number of bed days has declined by 10%;
- state government claims of around 2,000 elderly people in hospitals who are awaiting residential aged care is about right;
- despite improved incentives for GP's to coordinate care plans for the chronically ill, the take-up of the relevant MBS items has been disappointing and there is very patchy support for those patients needing allied health care and advice;
- increasing obesity and diabetes in Australia suggests also that we may be under-investing in preventive health strategies.

Popular perceptions of the performance of our health system do not generally focus on these issues, but on problems of access to urgently needed care, particularly hospital services, and there is some evidence to support some of the claims of deteriorating performance. I do not want to exaggerate these problems as Australia performs better in these areas than NZ, UK and Canada, we have a relatively high number of hospital beds and hospital separations, and states have increased funding significantly in the last few years. But I suspect we squeezed the system too far and were slow in taking into account increased demand, and we have not done enough to constrain demand by more appropriate care outside the hospital for those at most risk.

The other area of common concern is access to primary care. Again, there is a tendency to exaggerate the problem, but there remain genuine difficulties in some regions, and very serious problems for Indigenous Australians despite the action taken to date to make up for the very low MBS/PBS spending (around 37% of the level for other Australians).

Our generally positive score card comes at a price, however. The total cost of Australia's health is now above the average of comparable OECD countries, though our public spending remains below the average.

Government and Non-Government Health Expenditure as a Proportion of GDP, OECD countries, 2002



Moreover, the Productivity Commission projects growth in public spending on health (excluding aged care) from 6 percent to over 10 percent of GDP over the next 40 years, with public spending on aged care increasing from under 1 percent to around 2.5 percent.

Since presenting my Productivity Commission paper I have read a book by Clive Smee, a friend who recently retired after a distinguished career in the UK Health Department as chief economist. His book has reinforced my view that we need to do more on the economic analysis front in close cooperation with medical experts.

We do have an international reputation for our expertise in applying cost effectiveness requirements for listing and pricing pharmaceuticals, and we are expanding this to medical services, but we could take this a lot further in a more co-ordinated way across the health system, and there is reason for concern about the capacity of private insurers to apply cost-effectiveness controls.

We also have had some significant success in using casemix-based purchasing to drive effectiveness in the hospital sector, but there has been reluctance to use such purchaser/provider arrangements in some states, or similar sophisticated purchasing techniques, and provider competition outside the acute care area. Indeed, even in the acute care area, there are significant problems of uneven playing fields and inappropriate incentives for private insurers and public hospitals in particular.

Perhaps the most significant contribution to inefficiency in our system today however, is not the lack of technical efficiency within particular functional areas such as hospitals or residential aged care or general practice, but allocative inefficiency where the balance of funding between functional areas is not giving best value, and the inability to shift resources between the functional areas at local or regional levels and to link care services to individuals across program boundaries is reducing the effectiveness of the system. The scale of this inefficiency is hard to measure, but a recent study of Kaiser Permanente in California and the NHS suggested that, even between those two systems which both have a single funder, there was a major difference in allocative efficiency. Kaiser achieved considerably better results with similar resources, by investing more in primary and preventive care and in information technology. My strong suspicion is that the problem here is probably greater than in the UK because of our stronger demarcation of program boundaries particularly through having different funders, and the UK's greater experience with integrated purchasing mechanisms such as GP fundholding and primary care trusts.

In summary, despite our strengths, we have the following significant structural problems:

- a lack of patient-oriented care that crosses service boundaries easily with funds following patients, particularly those with chronic diseases, the frail aged and Indigenous people;
- allocative inefficiency with the allocation between different types of care not always achieving the best health outcomes possible, and with obstacles to shifting resources for individuals or communities to allow different mixes reflecting different needs;

- poor use of information technology, where better investments and useage could not only reduce administrative costs but also support more continuity of care, better identification of patients at risk, greater safety and more patient control; and
- poor use of competition, with an uneven playing field in the acute care area, a reluctance to use competition to ensure best access to medical services at reasonable cost, and less choice than should be possible (in aged care in particular).

This overview undoubtedly glosses over other structural issues such as the health workforce. Addressing the structural issues I have focussed upon would ameliorate some of our increasing health workforce problems by promoting flexibility, substitution and competition; in addition, moving towards a single funder which I will discuss shortly, would facilitate better planning and more accountable arrangements for funding education and training.

In considering both our main structural concerns, and the overall objectives and nature of health systems, the following system design principles emerge:

- a national framework which articulates the key objectives and principles and monitors performance, but allows flexibility at a lower level, lower than most of our states;
- a mixed public and private system:
    - with governments concentrating on regulating, funding and purchasing;
    - with service provision being primarily private or charitable;
    - with increased competition amongst providers, and increased sophistication amongst purchasers;
    - a substantial, and possibly broadened, role for private health insurance;
    - a significant role for co-payments and private contributions, particularly if greater choice is to be allowed into the system;
- a single funder and/or single purchaser, with funds following patients rather than being defined by strict functional or jurisdictional boundaries; and

- more emphasis on primary care support, including continuity of care for those who need ongoing services across the system, and increased investment in preventive health.

The main options for systemic change that might reflect these principles, particularly having a single funder and/or purchaser to facilitate more patient-oriented care and greater allocative efficiency, are:

Option (a): the states (and territories) to have full responsibility for purchasing all health and aged care services;

Option (b): the Commonwealth to take full financial responsibility for the system, as both funder and purchaser;

Option (c): the Commonwealth and the states to pool their funds, with regional purchasers having responsibility across the full range of health and aged care services;

Option (d): the Scotton model, or "managed competition" model, with total Commonwealth and state moneys to be available for channelling through private health insurance funds by way of 'vouchers' equal to each individual's risk-rated premium which the individual may pass to the fund of their choice, the fund then having full responsibility as funder/purchaser of all their health and aged care services.

I won't repeat all the arguments here, but in my view the only realistic system change option is Option (b), the Commonwealth having full financial responsibility. Applying the Irish joke, Option (a) would reverse the direction taken progressively over the last sixty years by consecutive national governments that has led to the Commonwealth providing more than two thirds of public spending on health: it is hard to see it being politically acceptable. Equally, Option (d) is a bridge too far at this stage: I strongly suspect it could only be seriously contemplated if we have first moved to Option (b), the Commonwealth having full financial responsibility. Option (c), the pooling option that emerged under COAG back in 1995 and 1996, and is continuing to receive some support from Victoria, requires in my view an unrealistic degree of sustained cooperation and an unhealthy level of bureaucratic control. That said, Option (b) also has risks, not the least being the political risk for the Commonwealth Minister in taking responsibility for individual patients' care in

hospitals. Nonetheless, I firmly believe Option(b) is the only realistic option if we are to move to a single funder.

It is important to note that none of the options would deliver improvements in health outcomes if they did not also involve critical features such as regional budgeting and purchasing arrangements with appropriate flexibility and accountability, improved primary care, integrated information technology, a national framework for pricing acute care services, and so on. Moreover, the management of the change to introduce a new system would take time and would involve costs and risks.

Accordingly, I noted a number of incremental change options that would deliver practical benefits whether or not the Government decided upon systemic reform, and that might complement or even facilitate such reform if it were to be seriously considered. These incremental change options included:

- strengthening general practice further, particularly to improve its links to allied healthcare, so that it is able not only to help with care planning for the chronically ill and frail aged, but also to deliver on those plans, and play a larger role in prevention;
- further investment in primary care for Indigenous communities;
- continued priority on electronic health records and other IT support for continuity of care for the chronically ill and the frail aged;
- some incremental moves towards single funder arrangements focussing on non-acute health and related care services for the aged, where the Commonwealth already has the lion’s share of responsibility;
- increased investment on preventive healthcare, focusing on the major known areas of risk from lifestyle: smoking, obesity, nutrition and physical activity;
- improved competition in the acute care area, in particular, and moves to clarify a sustainable role for private health insurance; and
- improved information and transparency at the regional level, identifying regularly all health-related expenditures, service utilisation and population health, to assist government, Divisions of GP’s and others to consider resource allocation between and within regions.

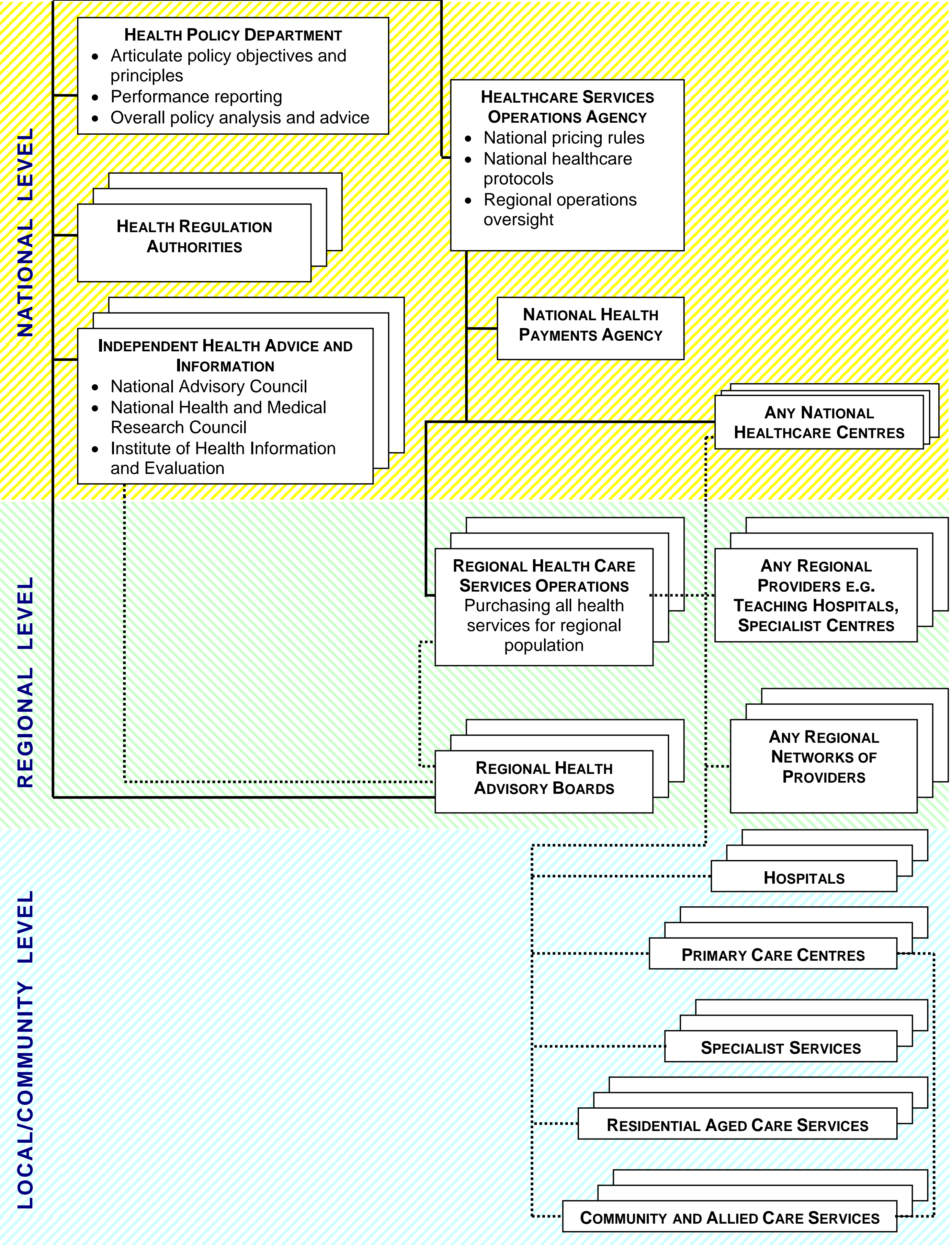
The latest COAG announcements represent a modest advance on this incremental change agenda.

The focus of this paper, however, is not incremental reform but what systemic reform might look like.

WHAT SHOULD A (SINGLE) COMMONWEALTH FUNDED PUBLIC HEALTH SYSTEM LOOK LIKE?

A model Australian health system, with the Commonwealth as the single government funder, would be based on distinguishing between the funder, purchasers and providers. While purchaser/provider splits are not universally supported, they have considerable advantage in terms of clear accountability and the capacity for competition and/or benchmarking amongst providers. Disadvantages such as those experienced by the ACT which has only one major public hospital would be avoided by having a national approach, and the problems of purchasers with no health professional expertise setting constraints on the professional providers can be substantially mitigated by ensuring that the expertise of providers guides the policies of funders and the decisions of purchasers.

The diagram on the following page illustrates the model I propose.


Formal lines of accountability
NATIONAL HEALTH MINISTER
Purchasing arrangements (some may include ownership arrangements)
FUNDER RESPONSIBILITIES
PURCHASER RESPONSIBILITIES
PROVIDER RESPONSIBILITIES
NATIONAL LEVEL
HEALTH POLICY DEPARTMENT
Articulate policy objectives and principles
Performance reporting
Overall policy analysis and advice
HEALTHCARE SERVICES OPERATIONS AGENCY
National pricing rules
National healthcare protocols
Regional operations oversight
HEALTH REGULATION AUTHORITIES
NATIONAL HEALTH PAYMENTS AGENCY
INDEPENDENT HEALTH ADVICE AND INFORMATION
National Advisory Council
National Health and Medical Research Council
Institute of Health Information and Evaluation
ANY NATIONAL HEALTHCARE CENTRES
REGIONAL LEVEL
REGIONAL HEALTH CARE SERVICES OPERATIONS
Purchasing all health services for regional population
ANY REGIONAL PROVIDERS E.G. TEACHING HOSPITALS, SPECIALIST CENTRES
REGIONAL HEALTH ADVISORY BOARDS
ANY REGIONAL NETWORKS OF PROVIDERS
LOCAL/COMMUNITY LEVEL
HOSPITALS
PRIMARY CARE CENTRES
SPECIALIST SERVICES
RESIDENTIAL AGED CARE SERVICES
COMMUNITY AND ALLIED CARE SERVICES

National Arrangements

At the national level, the Australian Government as funder would articulate the policy objectives and the general principles, set the conditions within which health care services would be purchased and provided, and establish the framework for reporting on performance. The policy objectives and principles should include the requirements of equity in terms of geographic access, copayments, safety nets and acceptable queues etc, and the requirements of value-for-money such as cost effectiveness processes for listing and pricing drugs and health services.

Economies of scale would also support a national (or supra-national by including NZ) approach to most areas of health regulation, at least in standards if not in day-to-day administration. This includes regulation aimed at patient safety and consumer protection, including licensing of products and providers (both individuals and organisations such as hospitals and nursing homes), regulation of the private health insurance industry and the setting of food standards. In most cases where this is not currently a national responsibility, there are already mechanisms aimed at harmonising arrangements (such as FSANZ, reciprocal professional registration and consistent hospital accreditation). National regulation has the advantage of reflecting the national (or supra-national) nature of many health and health related industries (e.g. pharmaceuticals, health insurance, hospital networks, residential aged care, diagnostic services, food, and the mobility of both providers and patients).

Economies of scale also suggest a national role in developing good practice protocols, particularly in the areas of chronic disease management and public health and ensuring cost effectiveness as well as health effectiveness.

The national administrative framework needs to be designed to meet a number of key requirements:

- political oversight and accountability;
- policy-advising capacity, well-informed by health and medical expertise;
- professional integrity in setting and administering regulatory standards;
- dedicated effort and appropriate management and technical expertise for operations, particularly for oversight of the nation-wide purchasing function.

In my view, the scale of these responsibilities demands that there be a number of separate agencies performing key roles. At the same time, those agencies need to work together within the policy framework set by the political leadership.

There are many options for the national structure, but I would favour something along the following lines:

- a policy department responsible directly to the Minister for Health, advising expertly on the various health functions (e.g. public health, primary health care, acute health care, aged care), on the health infrastructure (e.g. health and medical research, good practice protocols, workforce, information) and on broad strategic issues (e.g. health financing and economics, safety and quality, general policy coordination);
- a suite of regulatory authorities, with statutory responsibilities, but guided by the policy framework established by the Government;
- an operational or executive agency, responsible for the purchasing of services including the oversight of regional purchasing units (see further below), supported by a national information and payments agency;
- a strong national advisory body, with links to advisory bodies associated with each of the major regulators, and with resources for independent research and independent reporting.

This arrangement could draw very heavily on existing organisations including respectively the department, existing statutory regulators, Medicare Australia, and the NHMRC and AIHW.

The framework recently adopted by the Government following the Uhrig Report for improving the governance of statutory authorities could be used to ensure there is policy coherence across the range of organisations. I would also strongly support all these agencies being in the one portfolio, and to avoid placing some in a separate industry or human services portfolio which may wish to pursue priorities other than health. Some of the regulatory functions could be performed within the department, or within the operational agency; and some of the policy details such as setting

national prices for certain services and products could be handled either in the department or the operational agency. The choices are not clearcut, but I would caution against having too big a policy department, and note that the sensitivities of some regulatory functions might best be handled by separate authorities. Unlike Mr Uhrig, I would prefer to see the departmental secretary or her/his nominee participate in the advisory boards for each of the other portfolio agencies, and for the secretary and the CEO of the operational agency each to be standing members of the other's organisation's executive committee: I do not think this would cause insuperable conflicts of interest.

Regional Arrangements

The key to improving allocational efficiency is the incentive framework created by regional purchasers who have responsibility for the health objectives for their regional population, and the flexibility to allocate funds according to their most cost-effective use. Their flexibility may be constrained, nonetheless, by national policy requirements such as copayment limits and safety nets, and nationally negotiated prices for particular services. Flexibility might also need to be constrained if there is a risk of poor management, or of short-term pressures (e.g. to meet acute care demands) outweighing longer-term more cost effective priorities (e.g. preventive health investments). An option to consider regarding the latter risks is the UK concept of "earned autonomy", where sustained good regional performance is rewarded by increased flexibility.

Regional purchasing arrangements need to meet the following requirements:

- close connections with providers and community organisations to ensure the purchasing is well-informed and responsive to regional requirements;
- clear accountability back to the national operational agency, and compliance with national policies;
- a population large enough so that the regional purchaser can accept responsibility for the vast majority of health risks, and that there are not too many purchasers for the national operational agency to oversight; and

- sufficient clout to negotiate cost effective deals with providers including hospitals, nursing homes and specialists.

There are a number of options for these administrative arrangements, but my own preference would be:

- around 20 – 30 regional purchasers, with the possibility of sub-regional arrangements to assist community responsiveness;
- each regional purchaser to be under the direct control of the national operational authority;
- each to have a strong advisory board involving in particular the relevant GP Division(s) and some other regional providers, and some community organisations, possibly including people from local government (some individual nominees selected by the Minister can also ensure a consumer voice and a sensible balance without unduly politicising the board);
- each to have health expertise as well as management expertise;
- purchasing authority to include responsibility for paying for all services provided to residents in the region, wherever those services are provided (including for example, high level acute services in a national centre outside the region).

The budget arrangements should involve a "soft-capped" total budget based on the population's risk profile, with access to some specific national risk pools where the region cannot be expected to manage the risk on its own. These might cover, for example, the impact of MBS or PBS safety nets, as well as some very high-cost populations or even some high care episodes. The soft cap would also allow budget over-runs if necessary, where the consequences would be some form of performance review rather than penalising the regional population.

The regional budget would identify estimates for component parts, but with specified levels of discretion where the regional purchaser can substantiate claims of savings in one component that might be better employed elsewhere, or can substantiate claims of the positive impact of a proposed investment on both health and costs. The degree of discretion might be widened in the light of proven performance over a period of

several years. Regional purchasers could be expected to develop increasingly sophisticated approaches to managing the risks of sub-populations, particularly the various categories of chronically ill, drawing on the nationally developed protocols of best-practice, cost-effective care. Substantially increased funding of Indigenous communities could be expected, subject to monitoring improved health performance.

Regional purchasers would be required to publish annual reports on performance including health outcomes, service levels and financing, preferably supplemented by broader information reports by the national health statistics organisation for all regions.

These regional purchasing arrangements could draw heavily on current state regional health authorities and state and Commonwealth regional planning arrangements (e.g. for aged care). They could also draw upon, and in time influence, the structure and role of Divisions of GP's.

Provider Arrangements

While, in most respects, provider arrangements would not be substantially changed (with most doctors and other professional health providers continuing to operate as independent private businesses, and hospitals and aged care providers continuing to operate with a degree of independence as private or charitable organisations, or as public institutions with substantial management autonomy), some important changes could be expected over time.

The more integrated and patient-focussed approach will require further strengthening of primary care arrangements, with GP practices becoming increasingly multi-skilled, supported by nursing staff and linked more closely with allied health professionals, as well as specialist medical practitioners. GP practices might effectively exercise increasing responsibility for the health care budget for their patients within the framework developed by regional purchasers. In regional and remote areas, and for Indigenous communities, primary care services may be provided in more flexible and community-responsive ways, to address their particular needs and/or their unique problems in attracting skilled workers.

Regional purchasers might also consider contracting with Divisions of GP's not only to provide support for GP's and for primary care planning in the regions, but also to manage the delivery of some allied or specialist services where the local (private) supply is not adequate. Regional purchasers may also find it cost effective to establish (or re-establish or restructure) associated primary care services such as maternity and child health clinics.

Hospitals providing services to public patients would be funded primarily on a case-mix basis applying nationally developed prices with each region operating a risk pool for handling "outlier" cases. For a period, there would need to be capacity to transition to the benchmark costs, and a process for acceptable variations because of genuine labour market or other unavoidable cost differentials. (I will not go into detail here about funding for teaching and research, other than to say there are major attractions in the New Zealand model of separate identifiable funds, including that it gives clearer direction for workforce planning and financing).

Regional purchasers would be expected to move reasonably quickly to consider options for "contracting out" or for "centres of excellence" for particular procedures and activities to improve efficiency, and hospitals may choose to specialise or to network as well as to improve internal efficiencies to achieve benchmark prices. As important, of course, is to manage demand (quantity of services) in a way that optimises overall effectiveness. This will require hospitals to work much more closely with GP's and other non-hospital providers to reduce the need for hospital care, and to explore with the regional purchasers where hospital outreach services are the most cost-effective way of supporting patients. I suspect this would lead to reversing the decline in rehabilitation services, and in various outpatient services particularly in fields such as dialysis and cancer remediation.

In theory, the ownership of hospitals (or residential aged care facilities) is not a critical issue under a firm purchaser-provider model. But the high capital costs involved in hospitals in particular, and the risks of technology-driven cost increases, suggests the need for a somewhat conservative approach to either privatisation (or transfer to the charitable sector) of public hospitals, or to letting them remain in the hands of state governments. There is a risk of the states not maintaining capital

investment or of not managing assets efficiently or of not integrating them with the Commonwealth's recurrent expenditure efforts. A suitably negotiated transfer to the Commonwealth, drawing on the experience in the other direction of Repatriation Hospitals, could be a first step towards establishing regional networks of hospitals responsive in an integrated way to the requirements of the regional purchasers in terms of delivering the best care for the regional population.

In time, further advantage should be taken of the purchaser/provider structure under which the hospitals would be managed with greater independence from the purchaser, though preferably in a partnership style. The management of public hospitals should involve some direct interaction with the community, and ensure good community access; it should have the full confidence of clinical and professional staff; it needs to have sufficient critical mass to deliver acute care services safely and efficiently; and it needs the flexibility to go with the accountability for delivering efficiently and effectively. Notwithstanding some inconsistency with the Uhrig approach to governance, my own preference would be to establish trusts within the framework of the national operations agency, with executive boards that include health expertise, business acumen and some community standing; alternatively, the hospitals could be separate agencies each managed by a CEO appointed by the national operating organisation and responsible to it, with a strong advisory board. While in time consideration could be given to privatise the hospitals, there are considerable risks involved which might best be managed by retaining a mixture of publicly owned and charitable hospitals, and private hospitals. Private institutions may well contribute to greater efficiency and patient responsiveness in an environment where there are competing providers in the region, but may present a risk of departing from charitable and professional values where they operate in a monopoly position.

Community aged care services would continue to operate along lines similar to those operating now, but with increased opportunity for regional purchasers to negotiate prime contracts with organisations responsible for networks of service providers delivering services in line with individuals' care assessments and customer-responsive authorisation. Over time, there would be opportunities for closer integration of community and residential aged care, and for services that allow more "ageing-in-

place" including more choice for the individuals concerned about the type of accommodation and the services they receive (subject to assessment procedures).

Patient Arrangements

To take best advantage of this more integrated approach, individual Australians will need to participate in the national patient information record system which, through smart-card technology, would allow considerable patient control over the information, who has access to it and who can add to it or vary it. Over time, such a system also has the potential to enhance patient control over their own care without jeopardising professional influence about effectiveness and cost-effectiveness.

I do not believe we need to have patients register with a particular GP, although they should be encouraged to use a particular GP regularly. The IT system can already measure the degree of "patient loyalty" sufficiently to allow doctors to be paid on a (partial) capitation basis for example for having high levels of immunisation or cancer screening amongst their patients, or for planning and managing the care of chronically ill patients. So there is no need to constrain patient choice, and we can continue to use choice of GP as a market discipline to address quality and responsiveness (and the level of copayments) in the primary care system.

As mentioned, there is an important role for copayments, to contain demand, including demand generated by doctors for referred services such as diagnostic services. The equity objective can be addressed by setting limits to copayments including through safety nets. The efficacy of these arrangements could be substantially improved if government payments for services were more directly subject to conditions over the copayments allowed, whether through contract arrangements or through broad agreements with the professions. Regional purchasers in particular could be given some flexibility to negotiate (or set through open competition) additional payments in exchange for specified copayment limits in regions (or localities within regions) where there is evidence of supply problems and hence access problems. An important precedent has already been set for this in MRI arrangements in rural Australia.

The growing demand for more choice, particularly regarding aged care, will require further consideration of control measures including, as Professor Hogan has suggested, more emphasis on user charges in exchange for reduced emphasis on supply-side controls. I suspect there will need to be a mix of demand and supply-side measures, with some population benchmarks to guide those assessing people for eligibility for assistance (as occurs now) but with increased flexibility to meet individuals' preferences for residential arrangements and the quantum of services, subject to people paying for above-standard arrangements and services. With means tests governing access to government subsidies in the area, there is a strong case for removing all existing clawback of additional user-charges. Equity should be addressed by ensuring a good minimum standard of care, not by penalising those who choose to pay more to receive more.

Similar arrangements apply to other parts of the health system, where those advocating more choice need to accept that any consequential escape from supply-side controls (such as queuing for elective surgery) does need to be offset by demand-side controls including private contributions towards private health insurance and copayments.

HOW COULD THIS SYSTEMIC CHANGE BE INTRODUCED?

The takeover by the Commonwealth of full financial responsibility for the health (and aged care) system is certainly feasible, but it would take time, it would involve costs, and there would be considerable risks. Moreover, the benefits will take time, and are conditional on the range of associated changes I have outlined above.

The Constitution (Section 51 (xxiiiA)) provides the Commonwealth with the power to make laws with respect to the provision of sickness and hospital benefits. I understand this would allow the Commonwealth to provide the hospital services itself, and that there is no reason why those services could not be delivered by a hospital owned and managed by the Commonwealth. That said, it would be wise for the Commonwealth to negotiate any transfer from the states rather than attempt a compulsory take-over.

The objective of a more seamless patient-oriented system would suggest the transfer cover not only hospitals, but other elements of state health systems. There would, of course, remain new boundaries with state community services systems but those boundaries would not generally be as disruptive to patient care as the boundaries within health.

The financial implications are very substantial (though less dramatic than the converse option of a state financial takeover). State own-source funding for hospitals and other health services was worth about $13 billion in 2002-03 and this amount has recently been growing faster than GDP. This amount of money could not be found by simply abolishing non-health Commonwealth specific purpose grants to the states. The GST deal would have to be renegotiated. The GST provides around $35 billion (2003-04) to the states. Thus over one-third of the GST would need to be returned to the Commonwealth; and this proportion should grow given the growth of state health spending projected by the Productivity Commission, and the relatively slow rate of growth of other state spending (such as education) that is projected.

A three to five year implementation process would be required to effect the transfer and to bed down the new system. An in-principle agreement with the states would first be required based upon a sufficiently detailed proposition about the financial transfers involved. Subsequently, a dedicated project team under COAG, with associated bilateral task forces, would need to track all government health expenditures to each region, commence joint planning for the initial handover and commence "due diligence" work.

The initial handover might then focus first on allowing the Commonwealth to share management of state primary health care services, and to take over direct responsibility for all non-acute aged care services. It would involve the Commonwealth establishing a skeleton regional structure, with the capacity to progressively transfer state non-hospital staff and programs. Work might also commence on reviewing hospital management structures in liaison with local committees and professional staff, and on clarifying with states any particular terms for hospital transfers. At this stage, the Commonwealth would also need to establish its new national administrative structure, at least in skeleton form.

This would then lead to the transfer stage, involving the transfer of all state health employees to the Commonwealth, along with financial responsibility for hospitals and other remaining health responsibilities. This would no doubt require redeployment and some redundancies, along with the appointment of new advisory boards, trusts and regional organisations.

Following the transfer, the full responsibilities of the regional purchasing organisations would need to be more carefully designed and progressively introduced, national requirements for casemix purchasing and funding for training and research etc clarified, and national, state and regional administrative structures further rationalised.

THE ROLE OF PRIVATE HEALTH INSURANCE

The main focus of this lecture has been on improving the effectiveness and efficiency of the government-funded element of our universal national health system, and setting out a preferred model for purchasing and providing services. That is, in my view, the priority task. A closely related issue but best examined a little separately, concerns the role of private health insurance (PHI) and the optimal model for funding the system. This is not a second-order issue in Australia, particularly given increasing community expectations and demand for choice, but it is not as critical in my view as the first issue I have addressed.

While there are some in Australia who would prefer PHI to play a residual or supplementary role without any government assistance and without community rating regulation, I doubt that it is a politically realistic option for Australia, or that it is the most cost-effective solution in the long run given the extent to which the system would then rely on the quality of government decision-making to contain demand and to allocate resources to services that are genuinely responsive to individual needs and preferences. Even without Australia's long history of substantial PHI covering hospital services that are also available through the public system, both Canada and the UK are facing pressures to widen the role of PHI and the use of both private and public funds to finance services covered by national public health systems.

Equally, however, Australia is extremely unlikely to head down the US route where, at least for those who are not aged or veterans, health care is funded primarily privately, through PHI or similar intermediaries. There is bipartisan commitment in Australia to universal health insurance, and the evident problems in the US of access and equity in particular would not be acceptable here.

Accordingly, to use the terminology of the Productivity Commission's 1998 Report on Private Health Insurance, our system can be expected to remain a mixed one, with both public and private funding contributing to ensure universal health care with a degree of choice. As mentioned earlier, I have assumed this as one of the design principles for any new Australian health system.

Current Weaknesses

That said, our current arrangements could hardly be described as cost effective or even particularly coherent.

Amongst the weaknesses of the Australian arrangements are:

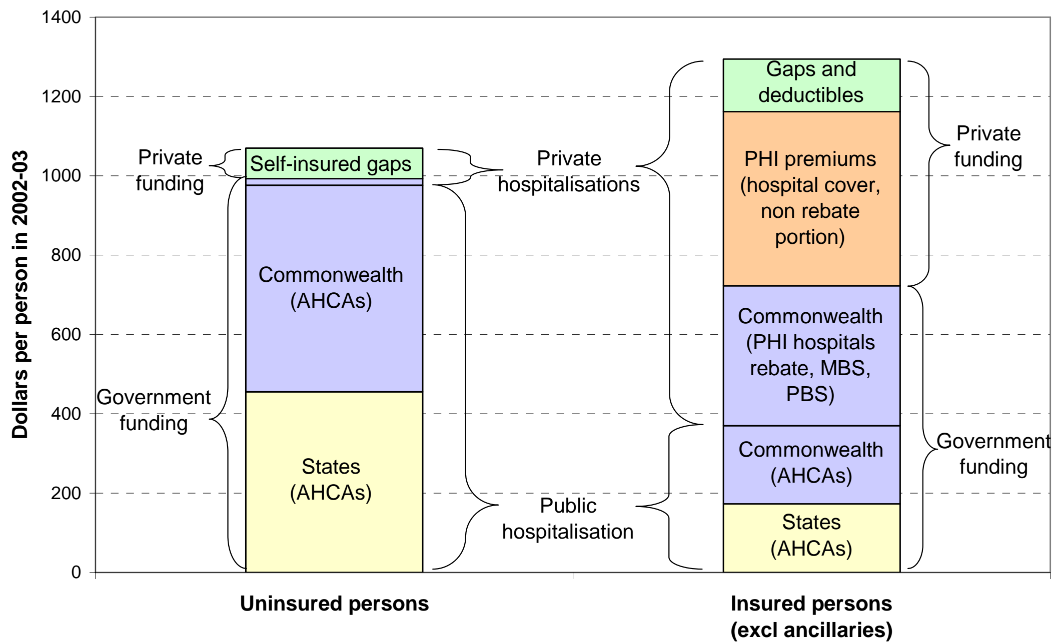
- the uneven playing field amongst hospitals caused by the different funding arrangements from PHI and state governments, with private patient episodes attracting at best only 'default' charges by PHI funds (sometimes less if the patient is directly charged) in public hospitals but full contract charges in private hospitals, and with privately insured patients having financial incentives to go public;
- the limited competition between funds because re-insurance arrangements share out any rewards for more efficiently and effectively managing a fund's membership risk profile;
- the more limited success of PHI funds, compared to government purchasers, to negotiate with doctors on total fees (including out-of-pocket amounts), on billing practice and on treatments on the basis of cost effectiveness;
- the considerable distortions about the choice to seek insurance caused by tax arrangements as well the PHI rebate and other government funding arrangements;

- the capacity for 'cream-skimming' through the variations in the insurance cover, and variations in front-end deductibles and copayment responsibilities;
- the overall complexity of the system for consumers; and
- the uncertain impact on the health system's equity objective.

Some of these weaknesses, including the last one, can be illustrated by analysing the average level of government and private funding for hospital services for people with and without PHI cover. The following table demonstrates, not surprisingly, that those with PHI cover receive substantially more hospital services on average than those without, drawing heavily on their own resources to do so. I strongly suspect this leads to better health outcomes on average for example through better access to diagnostic information and elective services such as cataracts and joint replacements. But it also demonstrates that they still draw heavily on government funding, receiving on average around 73 per cent of the amount of government support for each uninsured person. Importantly, this table does not include government support through the Medicare Safety Net or the rebate on ancillary care, nor does it take account of the Medicare levy surcharge, and of course it represents an average. There is clearly a risk that total government support for some people who are insured is as much or more than they would receive if they were not insured.

As mentioned earlier, the Scotton model of managed competition is an elegant model that would involve the government giving everyone the risk-rated premium required to fund their health care services at the Medicare standard, with the choice to direct that premium to their favoured PHI fund (or leave with a public insurer as a default). It is not, however, a practical option for a considerable time. It is nonetheless noteworthy for several reasons: the role it offers PHI as an alternative purchaser to the government of the full array of health care services; the assumption that those who choose a PHI fund as purchaser have the right to the same level of government support as those who choose to stay with the government purchaser; the ability of those who choose a PHI fund to pay more to get more (by purchasing cover beyond the Medicare standard), without any tax or extra government assistance to do so.

Estimated hospital costs per person per year by funding source, 2002-03



These attributes contribute to the model's simplicity and theoretical elegance, but also reflect some of the risks involved. Given our experience of problems (or at least limited gains from) competition between funds, a model relying even more heavily on the capacity of PHI would need to be carefully developed and tested. The idea that those who opt out, to use a private rather than government purchaser, should receive the full government assistance otherwise available has not been accepted politically in some other areas of social policy in Australia, most evidently in school education. This is a matter for political judgement, but I suspect that those who argue against any assistance are simply revealing their preference for PHI to play a residual rather than complementary role, and that those who argue for support equal to the full government assistance otherwise available are being a little premature about the feasibility of the Scotton model.

A Sustainable Model

I strongly suspect that the desire for choice is likely to grow further, rather than diminish, and that we should therefore be looking to ways to improve competition both amongst health care providers and amongst funds, and to improve the capability of funds to operate as effective purchasers meeting the requirements of their members at best price.

The first step in developing a sustainable role for PHI in the Australian health system in my view then is to address the weaknesses in the competition framework.

In the longer term, an even playing field in the acute care area, without distortions for public or private patients or for public or private hospitals, would best be achieved by having all acute care episodes for privately insured patients to be paid by their PHI fund, and all acute care episodes for uninsured patients paid for by the government's regional purchaser; and with PHI funds able to enter contracts with public and private hospitals without the constraint of default payments. With the government's regional purchasers paying for hospital care for uninsured patients on a casemix basis, both public and private hospitals would be in a position to compete for both uninsured and insured patients' services. The PHI funds would need to ensure their cover included access for free hospital treatment, but subject to the queues and limited choice of doctor and amenity applying to uninsured people. Patient decisions would be based purely on whether they are insured, what cover they have, and the level of service they choose; they would not be influenced by the games the hospitals or funds currently play to press people to "go public" or to "go private".

Without some complementary measures however, such an arrangement would provide windfall financial gains to public hospitals now treating insured patients with associated additional costs for funds. If we had a single government funder, there would be practical options to address this including paying an amount equal to the additional public hospital revenues involved into the PHI reinsurance pool, or varying the PHI rebate.

Competition reform is far more difficult under the current regime of multiple government funding. For example the challenge of overcoming the windfall gains and losses mentioned above would be exacerbated by the fact that states would be the winners and the Commonwealth both a direct loser because of higher PHI costs to subsidise, and an indirect loser as the funds and their members would demand full compensation from the Commonwealth for their higher costs and premiums. These complications make this reform option impossible at present. Indeed, even the more limited option advocated by the Productivity Commission to remove the current

default benefit arrangements is problematic given current Commonwealth-state arrangements: it might encourage firmer contracting between funds and public hospitals, but it would not address the fundamental incentives for many public hospitals to charge below a real price for private patients. Under the current system of both Commonwealth and state government funding of health, the only short-term measure to improve the playing field would be to require the states in the next Australian HealthCare Agreement to fund public hospitals strictly on a casemix basis, reducing public hospital incentives to undercharge private patients and to inappropriately cross subsidise.

A measure which could be implemented more quickly is reform of the reinsurance pool to ensure the more efficient funds are rewarded and the less efficient penalised. This issue has been tossed about now for years, but it is essential if PHI is to play a substantial role in our health system, and if funds are to be encouraged to become more sophisticated purchasers and managers of the health risks of their members.

The other key weakness in the use of competition is the evident difficulty funds have in negotiating contracts with specialist doctors. The common complaint by doctors that the funds are trying to come between them and their patients needs to be firmly rejected: the funds are the third party chosen by their members – the patients of the doctors – to manage the financial risks associated with their health. The members – the patients – expect the funds to keep premiums down and to offer insurance cover where any copayment involved is clearly identified in the insurance policy. This requires the funds to be able to negotiate on behalf of their members both price and location of service. That negotiation may sometimes also go to the cost effectiveness of the treatment. I accept that any such negotiation needs to recognise the professional expertise and independence of the doctors, but there is a strong case for further review by the ACCC in consultation with the professions, funds and hospitals to sort out a way to make the PHI products of better value to members.

A second element in developing a sustainable role for PHI is to clarify the expected range of services that PHI should cover. Theoretically, the benefits of a single funder would suggest PHI cover the full range of health services, as indeed the Scotton model would entail. With a single government funder, and the strengthening of

primary care I have proposed under the preferred model above, however, there would be limited benefits from extending PHI cover into primary care. But there are dysfunctions in the current arrangements. PHI funds should be able to cover out-of-hospital services where these are more cost effective than alternative in-hospital services, or would reduce the need for admitted services, or form part of the overall hospital care episode. This would encourage funds to consider more cost effective approaches to care for their members.

Folding into PHI, the separate government funding (through MBS) of specialist services associated with hospital care represents a further possible step towards single funder arrangements for PHI members. It would provide further incentives for funds and hospitals to find the most cost effective arrangements for providing hospital-related services to members, and could help funds provide members with cover that specifies clearly the total out-of-pocket expenses associated with episodes of care. Those benefits, of course, assume that funds and hospitals are able to negotiate appropriate contracts with specialists. A mechanism would also have to be found for redirecting the MBS savings back to the funds to avoid premium increases. I'll return to this issue of government support for PHI and its members shortly.

While falling short of the elegant Scotton model, this approach to coverage would represent a major move towards single funder/purchaser arrangements for insured people, with associated incentives for improvements in the efficiency and effectiveness of their care. Funds could also choose to offer added encouragement to members to pursue lifestyle and other preventative measures, supplementing the government-funded primary care system, where they considered this to represent value for money in terms of managing the health-cost risks they are responsible for.

Complementing this widening of the coverage of PHI, I believe there is good reason to constrain funds from offering exclusionary products. Such products could in time undermine community rating. While funds do not have to meet the hospital costs of members who present as public patients, these policies also undermine the role of PHI in taking pressure off the public system, the role which justifies the current incentives for PHI membership. To the extent that the longer term sustainable role for PHI is as an alternative option to public hospital and related care, there is a strong case for

requiring that it does cover the full range of services otherwise available through the government-funded system.

The third element of a sustainable role is to settle the appropriate level and form of government support for PHI. To the extent PHI funds services that would otherwise be available through the publicly funded system, there is a case for taxpayer support. Whether that support should be the full amount or something less than would otherwise be available, is a matter for political judgement. Of course, if the full amount is provided, then PHI would not directly take pressure off the public system: it would merely be an alternative mechanism. The potential benefits of PHI would be that it may improve the overall efficiency of the system (through competitive pressures) and it almost certainly would provide an avenue through which those who can afford to can get earlier access to services, with more choice and better amenity, thus perhaps acting as a safety valve relieving some of the pressure to relax supply controls on the public system.

My personal preference at this stage would be to hold overall government support for PHI to around 75 percent of the cost that would otherwise be imposed via the publicly funded system. This is about the current average, before taking into account support for ancillary cover, the Medicare safety net and the Medicare levy surcharge.

There are several options for providing this support. The elegant Scotton approach would involve identifying each individual's risk-rated premium for public funded cover, and providing that (or 75 percent under my suggestion) to the chosen PHI fund. That would obviate the need to regulate for community rating, but it would hardly be an incremental step. Another option would be to direct the funds to the reinsurance pool, for allocation to funds on an aggregate risk-rated basis. And there is the option of setting the PHI rebate at an appropriate level, with suitable constraints and/or caps to ensure it does not lead to excessive government support. I do not support returning to direct subsidies to private hospitals, which would undermine moves to single funder arrangements, and the benefits of separating purchasers from providers.

If the PHI rebate is to continue, there is a strong case to contain it to avoid opportunities for some insured people to get more by way of government subsidies than if they remained in the publicly funded system:

- the rebate should not be available with respect to services not otherwise available through the public system – this means dropping the rebate for ancillary services unless some or all of those services were otherwise funded by the government (most significantly, the rebate might be justified for dental services if ever these were covered by the public system);
- the rebate should be capped by setting a ceiling for the PHI premium that would attract the rebate;
- the additional rebates recently introduced for the elderly should be removed (there is no policy justification for these, which run counter to the whole rationale for lifetime cover which was aimed at attracting and keeping young members and stopping the adverse impact of community rating).

I am also most uneasy about the Medicare levy surcharge arrangement, which is effectively a voluntary means test. If the exemption from the surcharge were regarded as a form of support to PHI, by way of a tax expenditure, it would increase the total government support for many PHI members beyond that which is available via the government funded system. Alternatively, the surcharge may be regarded as a penalty for those on higher incomes who do not take out private health insurance: this presentation of the arrangement may make it seem more acceptable from a policy perspective, but with the rebate and other support being so substantial, and with capacity for people to manipulate their PHI arrangements and rely heavily on public patient care if required, the arrangement is at worst a mechanism for tax minimisation and at best a straight subsidy to the PHI industry.

In summary, if we had a single government funder for the publicly funded system and improved primary care in that system, and if we had PHI covering and paying for all hospital-related services for its members, it would be possible to provide government support to PHI members at around 75 percent of the costs otherwise involved via the rebate and/or via a contribution to the reinsurance pool, allowing PHI after-rebate premiums to be of the same order as at present.

The last element concerns the nature of regulation of PHI. One of the central objectives of the health system is equity, and if PHI is to be the vehicle for more than a residual part of the system, equity is important to PHI. The equity objective could be substantially achieved if the government support were via risk-related premiums, ensuring any personal contribution related primarily to the level of additional care the individual wanted rather than to their personal health risk. In the absence of such a funding arrangement, the equity objective can best be achieved by regulating for community rating. Australia's experience demonstrates the drawbacks of such regulation, but the current lifetime community rating arrangement is probably the best model in terms of limiting those drawbacks.

Drawing these elements together, I suggest a sustainable model for PHI could best be developed within the context of a single government funder for the overall health system, and would involve:

- PHI funds being fully responsible for the hospital related costs of their members, wherever that care is provided, with incentives for improving efficiency and effectiveness through reformed reinsurance arrangements;
- PHI funds able to cover more than in-hospital services, particularly where such services are cost-effective alternatives to hospital services, and not be allowed to offer exclusionary products;
- Government support for PHI be set at a level no higher than the costs that the public system would otherwise bear (with a suggestion of 75 percent), and be provided via the reinsurance pool and/or the PHI rebate, with suitable restrictions on the rebate;
- PHI funds continue to be subject to regulation for life time community rating, unless and until government support is provided via risk-rated premiums.

Such an arrangement would help to build the capability of PHI, and would allow in the very long term the option of seriously considering the Scotton model.

Other Observations about PHI

I commented in my Productivity Commission paper that my suggestions are not the same as the Labor Party's election proposal, 'Medicare Gold'. Yet there are similarities at least in terms of the particular priority I have given to increase Commonwealth financial responsibility for the frail aged, and drawing on the positive experience of the Department of Veterans' Affairs as a single funder of health services for veterans. The main concern I have with Medicare Gold (other than that if the Commonwealth were to accept financial responsibility for hospital care for the aged it might as well go the full distance, as I would strongly prefer), is that it confuses the two issues of multiple government funders and the role of PHI. I was fascinated to read in Mark Latham's Diaries his strong attraction to the Scotton model, and his view that Medicare Gold would be a step towards that model. I cannot see, however, that removing PHI from any role for the frail aged (as implied by Medicare Gold) is likely to help the funds develop the capacity to have full responsibility for the health care of Australians of any age and any health risk. From my perspective, Medicare Gold looks more like a move towards making PHI play a residual role in Australian health system.

There is a perennial public debate in Australia about rising PHI premiums. With improved competition between funds, and between the providers from whom they purchase services, there would be no need for government regulation of PHI prices. But there does need to be some sensible understanding in the community and the media of likely price movements. PHI premiums must rise over time at least as fast as the effective premiums the government funds for those who are not insured. At present, that is faster than the growth of GDP which is well above the CPI. Indeed, it is likely to be higher again if PHI is playing the role of a safety valve, absorbing some of the pressure of public expectations for improved services that would otherwise require even more growth in the public system. Market pressures should moderate this to an extent, but it is also likely that funds will need to use other levers such as tighter controls over providers to alleviate increases in prices.

I am also conscious of critics of PHI who highlight that members paying premiums for additional insurance cover generally find they face copayments which do not apply should they rely solely on the public system. This "anomaly" (Jeff Richardson

uses an exaggerated analogy with the echidna and the platypus) is not so surprising in my view. PHI members do indeed receive additional services for their premiums, and their premiums reflect this. And PHI funds, like all other insurers, need measures to limit 'moral hazard', the tendency of providers and consumers to take advantage of the third party funder. One of those measures is copayments. Governments, of course, rely more heavily on supply-side measures involving queues which is precisely what PHI members are paying to circumvent.

My final observation about PHI relates to sovereign risk. The changes I suggest are significant, but achievable. I would caution against more radical changes. One of the problems for the PHI industry is sovereign risk, which discourages new players from entering into the business and encourages those in the business to be rent-seekers from government rather than focus on improving their performance.

CONCLUSION

I have covered a lot of ground in this lecture. I believe the Australian health system is generally very good, but it faces new challenges which require substantial reform if the system is to remain affordable and effective. There are some sensible, practical incremental improvements that can and should be made, but I would like to see the national government also grasp the nettle to accept full financial responsibility.

To do so will not be easy, but it can be done, and I have outlined what this might entail and what the system might look like. The model I propose would be more patient focussed than the one we have, but would also have in-built incentives to improve efficiency. It would also more effectively address equity, in my view, giving more resources to regions and communities (including Indigenous communities) that most need additional support.

Importantly, I suggest my model could also make improvements to PHI arrangements easier to achieve, and lead to a sustainable role for PHI in Australia.

I do not see the choice for government being between theoretical system changes and practical incremental solutions to immediate problems. If a more incremental approach is pursued, it is important also to have a clear strategic direction to avoid ad

hocracy; if government is willing to consider systemic change, it must include measures that deliver tangible improvements along the way as well as lead to structures with better in-built incentives for improved performance. Clearly my preference is for the latter.

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