POPULATION HEALTH AND THE FINANCING AND STRUCTURE OF HEALTH SYSTEMS: THE AUSTRALIAN CASE

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THE FINANCING AND STRUCTURE OF HEALTH SYSTEMS

- just two of many factors that influence population health

SOCIAL VIEW OF HEALTH

- gender, economic security, physical security, race, access to services, access to appropriate services and so on -- all impact on health outcomes

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WILKINSON AND PICKETT (2009) The Spirit Level, why more equal societies always do better/ Why greater equality makes societies stronger

- study of 23 of the world's richest countries and the States of the United States
- Japan, the Nordic countries and New Hampshire do best
- United States as a whole, United Kingdom and Portugal do worst
- countries with the highest levels of income inequality, the biggest gaps between rich and poor, have the worst health outcomes
- poorer physical health, more mental illness, more drug and alcohol related problems, more obesity, higher rates of teenage pregnancy, poorer educational performance and literacy, higher rates of homicide and violence, higher rates of imprisonment, lower rates of child well-being and so on

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WILKINSON AND PICKETT'S EXPLANATION:

- status differences matter
- inequality increases stress, the rich fear the poor, poor experience low status, low levels of respect and feelings of low self-esteem
- Result: an increase in diseases and behavioural problems, especially for people in low socio-economic groups

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THE TYPE OF HEALTH SYSTEM in place exacerbates or improves the inequalities that exist within all countries (some more extreme than others)

- provides/does not provide an appropriate range of services
- ensures/does not ensure geographical access to services
- ensures/does not ensure that financial barriers to service use are non-existent or negligible

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HOW WELL DOES THE AUSTRALIAN SYSTEM DO?

PRIVATE PRACTICE, PUBLICLY-SUBSIDISED (Sir Theodore Fox, The Lancet, 1963).

Most medical practitioners and many allied health workers operate from private practices -- with no requirement to

- locate in any particular area
- provide any particular range of services
- abide by any particular fee structure (yet in 2011, Australian government funded 78.1% of the cost of medical services, AIHW Health Expenditure in Australia, 2010-11, 2012

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AN APPROPRIATE RANGE OF SERVICES?

Old idea: health systems should provide hospital and medical services

Newer Idea: health systems should provide a much wider range of services, especially a comprehensive range of primary health care services (WHO, 2008, The World Health Report, 2008: Primary Health Care -- Now More Than Ever)

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BARRIERS TO A MORE COMPREHENSIVE RANGE OF SERVICES

- focus on a medical model of care among health practitioners
- continuing preference for solo or small group practice
- continuing use of medical, surgical and diagnostic practices that offer little or no benefit. 150 such practices identified in 2013 (Elshaug, Watt, Mundy and Willis, Medical Journal of Australia, 197, November, 2012)
- the fee-for-service system of medical remuneration encourages fast throughput
- continuing medicalisation of childbirth
- the high cost of existing hospital and medical services -- militates against increased investment in primary health care (total health bill 2010-11, $130.3 billion. All public health plus community health expenditure, $8.3 billion -- or 6.3%. AIHW 2012)
- lack of political will in the face of commitment existing provider interests to the present system

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National Health and Hospitals Reform Commission (2009)

- no nationally coordinated mechanism to deliver preventive care
- less than 2% of the health budget is spent on chronic disease "a problem which consumes a major proportion of health expenditure"
- 2010, Australian cervical cancer screening rate, 58.2%, most European countries, 70+ percent, United States 85% (The Commonwealth Fund 2012, Multinational Comparisons of Health System Data)

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AUSTRALIAN HEALTH INDICATORS -- A (The Commonwealth Fund, International Profiles of Health Care Systems, 2012) 15 OECD countries

- relatively low rates of daily smoking (15.1%) compared with France and Italy (23%) and UK and Germany (21%)

BUT

- comparatively high rates of obesity (BMI greater than 30)

- US 35%, New Zealand 27%, UK 26%, Canada and Australia 24% (English speaking???)

- whereas Japan 3%, Switzerland 8%, Norway and Italy 10%, Netherlands 11%, Sweden and France 12%, Denmark 13%, Germany 14%

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People with a disability in Australia

- have 70% of the income of those without disability (lowest among 27 OECD countries)
- 45% of people with a disability live in poverty or near poverty
- relatedly, are half as likely to be employed as those without a disability (OECD average 60%) VicHealth, Disability and Health Inequalities in Australia, August 2012

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SERIOUS GEOGRAPHICAL IMBALANCE IN SPREAD OF MEDICAL AND HEALTH SERVICES (despite a range of Commonwealth economic incentive schemes)

- Underserviced: regional, rural, remote, poorer areas of large cities
- Possibly over Serviced: the better off areas of large cities

RURAL DWELLERS

- shorter lives
- higher levels of illness and disease risk factors
- less access to goods and services, including fresh food
- fewer educational, employment and income opportunities (AIHW, Australia's Health, 2013).

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FINANCIAL BARRIERS TO SERVICE USE IN AUSTRALIA

- Doctors determine total fees charged. Australian government sets the benefit levels -- gap
- gap filled by consumers -- user charges/out of pocket expenses
- established beyond doubt that user charges reduce the use of both essential and non-essential services, with higher impact among the least well off

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AUSTRALIAN USER CHARGES HIGH BY INTERNATIONAL STANDARDS -- AND INCREASING

- average 2010 out-of-pocket expenditure $94 higher than the OECD average
- average out-of-pocket expenditure, 2000, $548. Average out-of-pocket expenditure, 2010, $1075. Real growth -- 6.2% per year between 2000 and 2010 (AIHW 2012)

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COST RELATED ACCESS PROBLEMS (11 country survey, the Commonwealth Fund)

- 12% of Australians did not fill prescriptions or skipped doses (second to US at 25%)
- 13% had medical problem but didn't visit doctor (third to Germany 16% and US 22%
- 14% skipped test, treatment or follow-up (second to US 22%)
- 21% faced more than $1000 in out of pocket expenses (third to Switzerland 25% and US 35%)
- In total, 22% of Australians went without care because of cost in 2010

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WHAT CAN BE DONE?

A MORE COMPREHENSIVE RANGE OF SERVICES AND IMPROVED GEOGRAPHICAL ACCESS

- establish a network of primary health care centres in regional, rural and remote areas, staffed by salaried or contract based personnel
- Invest more heavily in Medicare locals to induce the production of more comprehensive services in diverse locations
- invest more heavily in rural location incentive schemes

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WHO (2008)

- universal coverage
- service delivery reforms to build a primary health care oriented system
- reforms integrating public health initiatives into primary health care settings
- leadership promoting dialogue among stakeholders

Not achieved anywhere but small incremental changes in policy in some countries. (Gauld et al, 2012, The World Health Report 2008….)

Significant transformation of primary health care achieved in Canada to varying degrees in different provinces. Change has required determined government and professional leadership (Hutchison et al, 2011) Primary Health Care in Canada: Systems in Motion).

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REDUCED FINANCIAL BARRIERS TO ACCESS

Dilemma -- increase in government benefits -- leads to providers increasing fees -- leads to no reduction in gap (and steady upwards creep over time)

Canada -- outlawed user charges in the early 1980s -- but heavy political costs
New Zealand -- all general practitioners on contract -- historical change

Again -- Significant change in Australia would require a strong government with a clear set of objectives to take a determine leadership role.