A Cure for Health Care

A consumer empowerment model of health care provides the most feasible exit strategy out of the current health policy reform impasse, argues **Vern Hughes**

Health is one of the most difficult areas of policy reform in Australia. A highly fragmented service system built around complex disciplinary boundaries, strong professional guilds, residual cottage industry modes of service delivery, dual public and private financing systems, and irrational jurisdictional demarcations, make any would-be reformer's task daunting. Medical providers are amongst the most powerful interest groups in the country. Health consumers, on the other hand, remain vulnerable and poorly informed. For some eight decades, medical providers have defeated attempts to restrict their market power and allow greater competition in the interests of patients. Perhaps more than any other, health is an industry built on a systematic de-alignment of supply and demand.

The public debate about health care in Australia reflects the character of the industry. Detached and disempowered consumers watch a debate conducted almost entirely by provider representatives and politicians. Discussion rarely strays from the question of how much public subsidy is to be allocated to this or that group of suppliers (general practitioners, medical specialists, public hospitals, or private insurers). The debate is never about how the demand for health care is constituted, mediated or regulated. Nor is it about health outcomes—whether Australians are more or less healthy, or indeed whether the service system or the financing system (or even both) can or should be oriented to creating a healthier population.

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No part of our current system has a financial incentive to manage health risks to keep people out of hospital, or develop marketable advantages around good management of health outcomes. Health insurers are not permitted to perform either of these functions. GPs and specialists are not paid to keep people well. Private hospitals do not have an interest in reducing hospitalisation rates. Public hospitals have only one means for managing bed utilisation (rationing) and no means for reducing hospitalisation rates.

The complexity of health financing and provision works against informed public discussion. It is much easier for politicians, the press gallery, and voters alike to focus on an issue like 'bulk-billing' rather than system-wide health care financing arrangements. Information asymmetries between doctor and patient, and between consumer and health administrator, are stark.

The next federal election could well be determined by the extent of public anxiety about health care. Since the health budgets of all governments are constantly overstrained and cannot stretch to accommodate uncapped growth in consumer demand, or unrestrained demand from providers for public subsidies, health reformers face two choices: abandon reform now and seek a quieter life, or empower health consumers to relieve them of their anxiety.

A consumer empowerment strategy is arguably the most feasible path to health reform in Australia. This strategy requires three mechanisms currently absent from the Australian scene: an intermediate structure between patient and doctor (consumer intermediaries), and two new markets—one to create competition amongst consumer intermediaries for the allegiance of consumers, and one to create competition amongst providers in supplying services to intermediaries acting as agents for consumers.

Consumer intermediaries are needed to make available comparative price and service quality data to patients, and enable patients as consumers to purchase (individually or collectively) their preferred services. Agents or brokers like this operate in almost all other industries—finance, real estate, insurance, law, agriculture—but not in the area they are needed most: health.

There need be no prescribed structural form for consumer intermediaries: the function may be performed by a not-for-profit friendly society, a for-profit financial agent, a community health centre, a health fund, a trade union—in short, any entity with a capacity to aggregate member enrolments, manage their financial entitlements and enter into contractual arrangements on their behalf, and manage member relationships to the mutual satisfaction of the intermediary and member. Intermediaries would be permitted to contract with providers and practitioners in developing price and service quality benefits for their members and would be free to develop packages of care, innovations in information management, home-care supports, and ancillary benefits for their pool of consumers. Consumers would be free to select the intermediary of their choice (and to collectively form one if they wish), and to transfer from one to another.

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Consumer intermediaries of this sort were well-developed in Australia in the 19th century. Friendly societies emerged in the Australian colonies as consumer-governed associations which contracted with medical providers for capitation-based payments (payment per head of population) for medical services. For a (usually) quarterly subscription, doctors were contracted by friendly society lodges to provide general practitioner services to a pool of enrollees. Networks of bush and community hospitals were established and financed on a similar subscription basis, with visiting doctors engaged on a mix of capitation-based contracts and fee-for-service (payment according to volume and nature of services provided). Subscription systems of financing

formed the basis of pharmacy service provision through friendly society dispensaries across the country.

These consumer-based innovations are largely unknown to today's health policy analysts and policymakers. From the early- to mid-20th century, medical and pharmacy guilds fought a long battle to free themselves from the contractual and regulatory relationships initiated by consumers and their agents. By the late 1940s the provider guilds had won. The crucial blow for consumer intermediaries was dealt by the Chifley Government's health insurance scheme: its state-run system of insurance removed consumer intermediaries from the landscape. The friendly societies that survived this dual assault from guilds and politicians have today been reduced to insurance houses, with little role in the co-ordination or management of health care.

In health care, the development of functioning consumer intermediaries that win the confidence of consumers is fundamental to public policy change: without them, consumers are likely to view abstract proposals for increased competition or privatisation as threats rather than opportunities.

Reconstructing such intermediaries remains the first and critical task of would-be health reformers. This can be done without radical public policy change. It does, however, require entrepreneurial initiative from below to drive health reform from above. This is a critical point of departure from the way in which health policy reform has been conceived in Australia for the past half century, and it provides the crucial exit strategy out of the current policy impasse.

David Green, whose work on Australian friendly societies in 1984 remains of seminal importance in understanding the present health care stalemate, has called these civil society initiatives 'private action plans'[1]—initiatives that can be undertaken in the present without prior public policy change, but which have the effect of creating conditions and capacities that encourage further public policy innovation. In health care, the development of functioning consumer intermediaries that win the confidence of consumers is fundamental to public policy change: without them, consumers are likely to view abstract proposals for increased competition or privatisation as threats rather than opportunities.

South Kingsville Health Services Co-operative Ltd (SKHS), located in a low-income pocket of Melbourne's western suburbs, is a community initiative with an innovative record in conceptualising health care reform and pioneering its implementation.

Formed in 1980, SKHS is a co-operative of health consumers who elect a governing Board which engages general practitioners, dentists, and a team of allied health practitioners and nursing staff. It operates two clinics in low-income suburbs, and is a self-sustaining not-for-profit business through its fees for services. Since its formation it has received no grant funding for its core operations from any tier of government. Its fees for medical, dental and allied health services differentiate sharply between members and non-members of the co-operative.

From the outset, SKHS sought to integrate health care with social supports for the sick and elderly, and developed extensive teams of volunteer home visitors working in partnership with its primary care practitioners. It is perhaps the only health care entity in Australia that bases its structure and operations on the truism that socially connected people live healthier lives.

For more than 15 years, it has sought (so far unsuccessfully) to convince health bureaucrats to allow it to trial capitation-based payment systems rather than fee-for-service arrangements, so that it may more adequately fulfil its mission of keeping its pool of consumer members healthy and out of surgeries and hospitals.

Politicians, health policymakers, and middle-level bureaucrats are baffled by this grassroots innovation. Because it is a self-funding business, it is not regarded as a community health centre or a public health institution. Because it is owned by its consumers, it is not part of any medical industry lobby. And because it actually contracts with

practitioners, pathology companies, and general practice training providers, it is not regarded by the so-called 'consumer health' networks as a lobbyist for the consumer viewpoint.

SKHS does serve, however, as an illustration of one possible kind of intermediate structure between doctor and patient of the many that might be devised. Because consumer preferences in health care are increasingly diverse, consumer intermediaries would adopt various philosophies of care. Some like SKHS would be based on geographic community, others would be based on communities of interest and would employ community resources, infrastructure and volunteer networks. Not all would necessarily be consumer-governed entities, though it would be appropriate to allow intermediaries of all kinds to exercise a high degree of self-regulation, making their own judgements about which practices enhance good health.

It seems reasonable to assume that a consumer empowerment approach to health care reform would see a proliferation of entities based on consumer governance, since this approach is the only one in health care that is fully compatible with an 'active agency' model to health maintenance and financing. This model, whereby individuals as consumers actively modify their behaviour to manage health risk, is in stark contrast to the 'casualty' model of health care, in which illness is viewed essentially as an act of God. Active agency implies a culture of self-help, not passivity.

For this model of active agency to be fully employed in a consumer intermediary like SKHS, a series of policy and regulatory innovations would be required. The current fragmentation in financing, purchasing and provision thwarts the capacity of intermediaries to manage health maintenance, reduce health risks, and minimise the hospital admissions of its members, and prevents even the most creative intermediary from assuming full responsibility for integrating these tasks across disciplinary and jurisdictional boundaries.

Consumers should be permitted to have their Medicare contribution and their share of Pharmaceutical Benefit Scheme (PBS) expenditure paid directly to the intermediary of their choice. Consumers who register in this way with intermediaries should also be able to receive a cashed-out share of commonwealth and state expenditure on public hospitals payable to their intermediary. These financial entitlements would be adjusted for health risk according to age and health status, so that consumers with a higher health risk profile attract a higher payment. In the case of SKHS, this would mean it would receive a capitation-based proportion of total Medicare and PBS expenditure for each of its enrolled members, adjusted for their health risk profile, payable as an annual up-front payment to the co-operative.

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Consumers who are eligible for Home and Community Care (HACC) and selected mental health and disability services should also be permitted to have these entitlements cashed-out and paid directly to the intermediary of their choice. In turn, the intermediary would be required to meet the full cost of all medical services, public hospital services, and PBS pharmaceuticals for its enrolled consumers. Para-medical services such as dental, allied health, optical services, and pharmaceuticals not covered by PBS would be optional. The intermediary would be permitted to levy its own membership fees, co-payments and/or insurance tables as it sees fit to supplement its receipt of Medicare and PBS income. Since one third of all Australian health expenditure is paid directly by consumers or their insurers, it could be assumed that an intermediary's pool of patients would contribute approximately one third of the total cost of health care for that patient pool.

Since intermediaries would receive risk-rated Medicare payments, higher risk members would attract a higher Medicare payment. This would

offset, at least to some extent, the impact of risk selection within a less regulated health insurance market. Intermediaries that adopt insurance tables which discourage higher risk members would lose the Medicare payment that follows these members.

A more flexible regulatory framework is essential to enable individually-tailored health maintenance strategies. Conventional health insurers lack the capacity to manage the health risks of their members to prevent crises and restrict hospitalisation rates. Intermediaries, on the other hand, would be in the business of employing resources and strategies to manage risk. They would have a financial incentive to keep their members well and out of hospital.[2]

This is an opt-in strategy. In the spirit of competition, intermediaries would be obliged to engage with consumers and communities about health outcome advantages. If consumers were not convinced, they could remain within the old regime.

The introduction of behaviour and outcome-related rebates, bonuses and penalties as incentives for members to manage their own health risks would be critical. It should be permissible, for instance, for intermediary tables to differentiate between smokers and non-smokers. Bonuses and penalties would depend on compliance with strategies involving immunisation, screenings, dietary and exercise patterns, and weight loss. Compliance would be essential for the intermediaries in managing their own financial risk.

Intermediaries would serve as the natural entity in the health system for the introduction of a much-needed longitudinal patient health record. No private or public provider group has, for the past century, had any financial or other incentive to produce a consolidated patient-centred information system that is transferable across practitioner and service types with the aim of integrating various interventions and treatment strategies, preventing illness and enhancing outcome monitoring. Various Australian governments are now exploring the introduction of electronic health records, but they have stalled on the key issue of what incentives might entice disparate and disconnected practitioners and consumers to actually use them.

Consumer intermediaries working within a framework of pre-paid budget-capped health care management would be the only structural entities in the health system with a financial incentive to monitor the outcomes of care of their pools of patients and tailor their practices to objectives such as improved pre-admission and post-discharge reviews, reduced infection rates, fewer post-surgical complications, and lower readmission rates. Their aim would be to develop marketable health value advantages around these outcomes to attract more members, thus creating competition amongst intermediaries for consumer allegiance.

This is an opt-in strategy. In the spirit of competition, intermediaries would be obliged to engage with consumers and communities about health outcome advantages. If consumers were not convinced, they could remain within the old regime. Unlike the current pseudo-competition amongst health insurers or medical practitioners (which avoids any reference to health outcomes), competition between consumer intermediaries would mean they would have to trade in measurable health outcomes and performance.[3]

Three further policy changes would be required for intermediaries to function along these lines:

- First, public hospitals would have to develop a pricing regime for in-patient and out-patient services on a full cost-related basis for episodes of treatment or care. Although some steps towards this regime are underway, an acceleration of this process would be necessary. The market purchasing power of intermediaries would provide an incentive for hospitals to make this change,

but a legislative requirement to this effect may also be required.

- Second, all regulatory restrictions on the capacity of intermediaries to contract with or directly employ medical, dental and pharmacy practitioners should be removed, along with all restrictions on the capacity to own hospitals, medical or dental practices or pharmacies.
- Third, all restrictions on the supply of health practitioners should be removed. Governments still seek to restrict the demand for health services by rationing the supply of practitioners (limiting opportunities for practitioner training and restricting entry of overseas-trained doctors) and thereby colluding with professional bodies against the interests of consumers. The consumers most disadvantaged by these practices are those in rural and disadvantaged areas which face severe general practitioner and specialist shortages.

Some existing health funds, professional associations, credit unions and consumer co-operatives already undertake, in a limited form, some intermediary functions such as aggregated purchasing benefits or preferred provider arrangements in selected health areas. These could be readily expanded in anticipation of public policy changes to enhance the role of health intermediaries.

State or Commonwealth governments could recognise these intermediaries and encourage their development by introducing (without major public policy change) a fee for every enrolled consumer or family (the fee being risk-rated for age and health status to discourage selective enrolment of the young and healthy). The development of competing intermediaries would be the first step towards enhanced competition and a functioning market in health care.

It is significant that the two communities that have explored the 'cashing out' of Medicare in practical terms (SKHS and Cape York aboriginal communities) are closely associated with a self-help philosophy. Passive health is as incongruous as passive welfare. It is highly likely that Australia's first health maintenance organisation will emerge amongst indigenous Australians on Cape York as an antidote to passivity amongst communities ravaged by substance abuse, demoralisation and welfare dependence.

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Health reform in Australia will involve rediscovering a culture of active agency and self-help on the part of consumers, without which the dominance of the health debate and the health system by politicians and provider guilds will continue for a long time to come.

Endnotes

1 David Green, *From Welfare State to Civil Society: Towards Welfare that Works in New Zealand* (Wellington, New Zealand Business Roundtable, 1996); David Green, *Mutual Aid or Welfare State?* (Sydney: Allen & Unwin, 1984).

2 R.J. Blendon, C. Schoen, C. DesRoches et al, 'Common Concerns Amid Diverse Systems: Health Care Experiences in Five countries', *Health Affairs* 22:3 (2003), pp.106-21, in Paul Gross, *Some Economic Arguments for Investing 10% of GDP in Higher Payments for High Quality Integrated Care, Demand-side Incentives and Public-private Partnerships*, unpublished paper presented to the Australian Health Care Summit (Canberra: 2003).

3 Some of these measures have been explored in Paul Gross (see above note); R.B. Scotton, 'Managed Competition: Issues for Australia', *Australian Health Review* 18:1 (1995), pp.82-104; and Productivity Commission, *Managed Competition in Health Care: Workshop Proceedings* (Canberra: AusInfo, 2002).