

The False Promise of GP Super Clinics

Part 2: Coordinated Care



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Jeremy Sammut

Papers in Health and Ageing (4)

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Executive summary

This is the second of a pair of Policy Monographs that examine the evidence base and assumptions of four key health policy areas. Each of these areas is widely considered to be pertinent to whether the Medicare system will be sustainable into the twenty-first century, given the demands of the ageing of Australia's population, the rising chronic disease burden, and the anticipated acceleration of health costs in coming decades. This second part deals with the following two major issues:

1. the implications of the government's plan to use GP Super Clinics to boost the secondary prevention of chronic disease and 'take the pressure off hospitals' by 'coordinating' the primary care the chronically ill receive—with particular regard to the real impact coordinated primary care is likely to have on both health costs and on demand for hospital services
2. the merits of an alternative plan where Super Clinics would substitute inpatient hospital care with community-based outpatient services and ensure integrated tertiary care is delivered in the most cost-effective setting

This monograph subjects to evidence-based scrutiny the much-publicised claims the proponents of GP Super Clinics have made about the benefits of more federal government spending on coordinated care. Super Clinics delivering coordinated chronic disease care are being promoted as an effective method of addressing the major challenges facing the Australian health system in relation to ageing and chronic disease. But this monograph finds that the evidence strongly suggests Super Clinics will *not* lower health costs or take the pressure off hospitals as has been promised. The evidence showing that these promises and related claims are unrealistic has been ignored, obfuscated, misread, and misrepresented in the surrounding policy discussion. This is due to a number of factors, including the vested interests of those who stand to gain from this policy's implementation. The real agenda of the advocates of GP Super Clinics is to facilitate the expansion of Medicare to cover the allied health sector, thereby allowing the ageing baby boomers of Australia to transfer the cost of loosening their stiff backs and soothing their sore feet onto the taxpayers of Gen X and Y.

In the 2008–09 federal budget, the Rudd government allocated \$275 million to the establishment of a national network of (an initial) thirty-one GP Super Clinics. Part of the government's GP Super Clinics plan is to boost the secondary prevention of chronic disease by giving the chronically ill access to 'coordinated' primary care. Coordinated care (which is sometimes called 'managed care' or 'disease management') involves a GP or a practice nurse monitoring the condition and managing the care of the chronically ill to ensure patients receive all available care from a wide variety of allied health providers. Coordinated care also involves educating patients about their disease so they can better self-manage their condition and maintain their health. The claim is that coordinated care will keep the chronically ill 'well and out of hospital' and yield savings on health costs.

Yet the evidence strongly suggests that because lack of coordination acts as a 'rationing' device, coordinated care programs in the United Kingdom, New Zealand, and Australia have had the predictable effect of uncovering unmet need and new cases requiring hospital-based treatment. This suggests that if the Rudd government proceeds with its Super Clinics policy, it will improve the quality and quantity of Australian primary care, and coordinated care will enhance primary care's traditional roles in detection and referral to secondary and tertiary care. It would therefore be strange to argue against Super Clinics, since it is highly likely that Super Clinics will enable more chronically ill Australians to secure all the beneficial care they need—a good thing for patients. But the surrounding policy discussion has not acknowledged that the evidence strongly suggests that rather than lowering health costs and taking the pressure off hospitals as promised, Super Clinics will increase demand for hospital care and increase both primary care and hospital costs.

The 'managed care' regimes that health maintenance organisations (HMOs) pioneered in the United States are often cited in support of the promised benefits of coordinated primary healthcare, especially the model of care developed by the California HMO Kaiser Permanente. But the lessons of the Kaiser model are selectively cited. A 2002 study found that the principal reason Kaiser Permanente delivers more treatments at a lower cost, compared to the British National

Health Service, is that it has substituted higher-cost hospital-based inpatient care with lower-cost outpatient care delivered in community-based (non-hospital) health centres. If properly interpreted, this international evidence suggests that health systems oriented towards community-based treatment are more cost-effective and use hospital-based services more efficiently. The newly created National Health and Hospital Commission should advise the Rudd government accordingly—based on the Kaiser model—about the design features needed to equip Super Clinics to deliver integrated medical services in the most cost-effective setting. The commission should also advise the government on the necessary adjustments this would entail to the Australian Health Care Agreement and the level of the federal hospital funding provided to the states to compensate the commonwealth for assuming the additional costs of outpatient services.¹

¹ This is a case of of opting for the best worst reform. If real patient choice and provider competition existed in the health system, governments would not need to engineer this cost-effective outcome. Providers, competing for customers on price and quality, would do it themselves to provide patients with the most timely and appropriate care. The CIS therefore advocates a voluntary national system of Medicare opt-outs to free up the demand and supply sides of the health system. See Peter Saunders, *A Welfare State for Those Who Want One, Opt-outs for Those Who Don't*, CIS Issue Analysis 79 (Sydney: CIS, 2007).

Introduction

In the 2008–09 federal budget, the Rudd government allocated \$275 million to the establishment of a national network of (an initial) thirty-one GP Super Clinics. Super Clinics will be multidisciplinary primary care centres bringing previously dispersed general practitioners, practice nurses, and other allied health workers together under one roof. Pursuing this policy will involve a significant expansion of Medicare beyond traditional fee-for-service GP primary care. Super Clinics will expand Medicare-funded access to a range of ‘wellness’-promoting services—from dietitians to physiotherapists and psychologists—which, despite recent initiatives, Medicare has so far provided only limited access to.¹

The government maintains that the aim of its Super Clinics policy is to develop new models of ‘preventive health services.’ To boost the secondary prevention of chronic disease, Super Clinics are currently designed to provide patients with established chronic disease (especially elderly patients) with enhanced access to ‘coordinated’ primary care.

Coordinated primary care (which is sometimes referred to as ‘managed care’ or ‘disease management’) involves a GP or a practice nurse monitoring the condition and managing the care of chronically ill patients to ensure they receive all available care from a wide variety of allied health providers. Coordinated care also involves better educating patients about their disease so they can better self-manage their condition and maintain their health, with particular regard to the secondary prevention of lifestyle-related comorbidities (an additional one or more chronic conditions—diabetes, for instance, can lead to heart disease and stroke), which can cause complications and more frequent, longer, and costlier hospital stays.

According to the proponents of GP Super Clinics, coordinating the care of chronically ill patients with complex needs—who are expected to overwhelm the public hospital system as the population ages into the middle of the twenty-first century—will produce better health outcomes at a lower cost. The attractive idea is that coordinated care will prevent chronic conditions from deteriorating, and so will prevent patients from requiring higher-cost secondary care and emergency department and inpatient services. If the primary care received by the chronically ill is coordinated, they will supposedly not need referral to secondary specialist and hospital-based tertiary care, and their condition will be less likely to deteriorate to the point where they require urgent, unplanned, and ‘avoidable’ admission into hospitals. Champions of investing in coordinated care therefore suggest that while it is more expensive than traditional primary care, the cost will be offset by the savings achieved by substituting cheaper primary care for more expensive treatments, and by reducing the utilisation of higher-cost hospital-centred services.

The Rudd government therefore maintains that its investment in coordinated primary care represents a cost saving and hospital demand management measure, since Super Clinics will, in the words of Health Minister Nicola Roxon, ‘keep people in good health and take pressure off public hospitals.’²

More spending on coordinated primary care will neither lower health costs nor reduce utilisation of hospital services.

The false promise of coordinated care

The claims, the evidence, and the alternative

The problem with this claim is that a considerable body of evidence strongly suggests that more spending on coordinated primary care will neither lower health costs nor reduce utilisation of hospital services, as is often predicted. Instead, what the results of various coordinated care programs in Australia and overseas appear to have demonstrated is that lack of coordination acts as a rationing device. The evidence strongly suggests that improving the access chronically ill patients have to coordinated primary care tends to uncover unmet needs and new cases requiring hospital-based treatment.

This suggests that we must think about Super Clinics in terms of their real impact on primary care. If the government can find the doctors to staff them, Super Clinics will put more primary care resources on the ground, especially if they are located, as announced, in low-income areas suffering GP shortages. Because the current primary care system is of relatively low quality, Super Clinics offering coordinated care will almost certainly increase the quantity and quality of primary care offered. The likely result is that Super Clinics will enable more chronically ill Australians to

secure all available beneficial care. Better ensuring primary care can fulfil its traditional role of timely detection and appropriate referral to necessary treatment would undoubtedly be a good thing for patients. Given all this, it would be strange to argue the government should not proceed with the Super Clinics policy.

Yet the impact and implications Super Clinics will have has not at all been acknowledged in the broader policy discussion. Rather than alleviating the pressure on public hospitals by ‘keeping patients well and out of hospital,’ the evidence examined in this paper suggests that GP Super Clinics are highly likely to add to the pressure on public hospitals and to lead to higher, rather than lower, costs for primary and hospital care.

To be blunt, the policy discussion concerning the role and effect of Super Clinics has been unrealistic. If the government does proceed with this policy, a dose of realism is urgently required, and the effect on health costs and demand for hospital services needs to be properly assessed. While Super Clinics have been promoted as an effective method of addressing the major challenges facing the health system, the evidence strongly suggests that Super Clinics will *not* take the pressure off hospitals as has been falsely promised. Due to the mix of factors, discussed below, including vested interest, the evidence that this promise is unrealistic has so far been ignored, obfuscated, misread and misrepresented.

The lesson of Kaiser Permanente

The ‘managed care’ regimes pioneered in the United States by Health Maintenance Organisations (HMOs), are often cited in support of the promised benefits of coordinated primary care. The model of care developed by the California HMO Kaiser Permanente is an especially popular example, but the lessons it presents are selectively cited.³

Kaiser Permanente does provide high-quality coordinated care and management programs for chronic disease. However, a 2004 study found that while improving the standard of patient care, these programs had not decreased health costs as expected, and had not produced the predicted reductions in hospital admissions to offset the substantially higher cost of providing higher quality primary care.⁴

But the Kaiser model does have a great advantage over other health systems—such as Australia’s—that are still largely fragmented by a traditional divide between primary and tertiary care. Due to advances in medical technology, an increasing number of tertiary treatments that were once exclusively available as high-cost inpatient services in hospitals are now deliverable as lower-cost outpatient, day-surgery, or ‘community-based’ procedures.

Kaiser Permanente, for instance, provides integrated medical care and rigorously manages hospital admissions and discharge procedures. It operates multidisciplinary health centres that employ accredited doctors able to perform quite complex procedures in the primary care setting, which frees up specialists and hospital beds for more serious cases. This explained why a 2002 study found that compared to the British National Health Service (NHS), Kaiser patients spend a third less time in hospital, and accounted for why Kaiser uses only a quarter of the beds and can deliver far more medical interventions with shorter waiting time for the same cost.

That study demonstrated there is indeed international evidence that health costs could be kept lower than they otherwise would be, if Super Clinics were designed to substitute expensive inpatient services with less-expensive outpatient care. Rather than focus on expanding Medicare coverage to include ‘wellness’ services, the international evidence suggests that Super Clinics would create a more integrated and efficient health system, and better manage demand for hospital services, if designed to allow what are currently hospital-based services to be delivered in the most cost-effective, non-hospital setting.

Why the evidence base is ignored: the real agenda(s)

Why, until now, has the evidence that GP Super Clinics delivering coordinated chronic disease care will not lower health costs or reduce utilisation of hospital services been ignored? The realist’s answer is that the push to convince governments to spend more money right now on coordinated care, to save money ‘in the long run,’ suits the vested interests of those who have the most to gain from the implementation of these policies.

As healthcare's procedural focus and technological sophistication has increased in recent decades, the remuneration and status of general practitioners has declined relative to other members of the medical profession. One appreciates the legitimate concerns of clinicians who believe their unhealthy or chronically ill patients would benefit from access to allied health services not traditionally covered by Medicare. But there is more to the current debate over more spending on primary care and 'less' on hospitals. Primary care providers and general practice lobby groups such as the Australian General Practice Network, which represents GPs and other health professionals involved in general practice, are trying to win command of a larger share of the health budget relative to other specialists. Some doctors, by way of illustrating the stakes, have reportedly doubled their fees thanks to the lucrative GP Management Plan rebates alone. These were introduced by the Howard Government in 2005, and have allowed chronic disease patients to access Medicare-funded care from up to five allied health providers.

Providers in the allied health sector—to say nothing of nurses keen to enhance their professional prospects and carve out a more independent role for practice nurses in the health system—also have a vested interest in the outcome. The recent report by the Medicare watchdog, the Professional Services Review, also drew attention to the exploitation of existing coordinated-care arrangements. It cited anecdotal reports that some patients (predominantly affluent converts to the 'wellness' cult who want the cost of their 'active' lifestyles subsidised by taxpayers) are pressuring their GPs to secure Management Plans for themselves, and some allied health providers (such as physiotherapists) are telling patients to return to their GPs to 'get a plan.'⁵ Outside of the other concerns this paper canvasses, the nexus between patient and provider interest strongly suggests that expanding Medicare-funded entitlement to allied health services will lead to greater and greater political pressure for the full extension of Medicare rebates to the allied health sector.

Expanding Medicare-funded entitlement to allied health services will lead to ... political pressure for the full extension of Medicare rebates to the allied health sector.

This is also directly relevant to why the evidence is ignored by many of those engaged in the formulation and promotion of health policy. Many of the proponents of coordinated care, in the health bureaucracies and the academy, are true believers who think all healthcare should be provided 'free' by governments and paid for out of taxation. From this perspective, support for more spending on 'cost saving' coordinated care looks suspiciously like a stalking horse, exploited to prosecute the timeworn agenda of creating a truly 'universal and free' health service.

The real agenda here is not difficult to discover, given the political realities of an ageing Australia. The richest pickings for the allied health sector lie in providing services to elderly Australians, who will want to access a wider range of health services (especially if they are 'free') to improve the quality of their lifestyle (and, for example, help seventy-year-olds ski and eighty-year-olds bushwalk). Allied health providers also know that once chronically ill members of the community are receiving these services, funded by Medicare, it is virtually guaranteed that ageing baby boomers will start to demand greater Medicare-funded access, and that the size and electoral influence of this constituency means governments will ultimately agree to their demands as politicians rush to curry favour with elderly voters. In an ageing Australia, the creaky joints, rather than the squeaky wheels, will get the grease.

Already, the Rudd government has given the game away by incautiously admitting that the Super Clinics policy is intended to provide 'a range of other health services such as physiotherapy, dietary, podiatry ... *for seniors*.'⁶ Instead of Super Clinics ensuring that better care is taken of the poor, and the old and chronically sick, ultimately the government's policy is paving the way for Medicare to pay for the physiotherapy and podiatry of affluent baby boomers, who will transfer the cost of loosening their stiff backs and soothing their sore feet on to the taxpayers of Gen X and Y.

Why 'GP Super Clinics' won't lower health costs or reduce the pressure on hospitals

Potential benefits ... maybe

Better-managed primary care lowers hospitalisations and costs ... doesn't it? The *potential* benefits of better coordinating the primary care of high-risk chronic disease patients seem clear, at least in terms of improving outcomes for individual patients. There is, for instance, some evidence that

coordinated care programs have led to lower use of hospital services where programs have targeted hospital attendees at risk of readmission.⁷ There is also evidence, based mainly on trial programs, that diabetes sufferers respond to education programs that teach the skills that enable patients to better self-manage their chronic illness. Ideally, chronically ill patients will stick to recommended treatment protocols to stabilise their condition, maintain their general health, control risk factors, and help them stay out of the hospital system, due to high risk of severe complications, such as amputations and kidney failure in the case of diabetes.

Yet even the champions of coordinated chronic disease care and ‘disease management’ programs have started to change tack. They are increasingly inclined to claim (correctly, I think) that coordinated care programs will improve the quality of care the chronically ill receive, rather than to claim it will prevent patients from utilising GP and hospital services and lower health costs.⁸ This reflects the fact that a considerable body of evidence strongly suggests that the case for greater spending on elaborate and expensive care programs needs careful consideration. For it is by no means clear that this is a pathway to reducing hospital admissions and health costs by ‘keeping people well,’ as the proponents of GP Super Clinics promise. What sounds right in theory has not worked out in practice.

These kinds of programs can have some success when highly motivated patients volunteer to participate, but ... the effects tend to disappear when ... trial programs are transplanted into in the ‘real world.’

UK and Australian programs

In Britain, the introduction of coordinated care and disease management programs to the NHS has not been as successful as hoped. The ‘Expert Patients Programme’ had limited uptake and limited success. A national evaluation published in 2007 found ‘some reductions in costs of hospital use,’ but warned that the results should be treated with caution because they ‘are pertinent to people who volunteer to go on such a course and not those with long-term conditions generally.’⁹

This suggests that these kinds of programs can have some success when highly motivated patients volunteer to participate, but that the effects tend to disappear when unmotivated patients are recruited and trial programs are transplanted into in the ‘real world.’ In other words,

there is a lack of hard evidence to support predictions that hospital use and health costs will decrease.¹⁰ When trial programs have been introduced to wider general practice populations, they have indeed failed to produce significant reductions in use of medical services.¹¹ In Australia, the commonwealth government’s \$36.2 million Sharing Health Care Initiative, which targeted the key patient base—the elderly and chronically ill—produced only ‘small’ reductions in the number of hospital visits among enrolled patients.¹²

The explanation for this may well be that outside of well-motivated volunteers, chronically ill patients can find it difficult to self-manage their conditions and comply with recommended treatment guidelines.¹³ This is particularly so when compliance involves modifying long-term diet and exercise habits to prevent comorbidities.¹⁴ It may also be that coordinated care programs promote patient well-being by encouraging people to see their doctors more regularly and to secure all available beneficial care.¹⁵

Alternatively, this may simply reflect the underlying prevalence and progress of chronic disease. Outside of coordinated care’s effectiveness in individual cases, hospitalisations might still rise due to the rising numbers of people in the community suffering diabetes, for example.¹⁶ Rather than highlighting ‘gaps’ in the primary care system, in these circumstances greater use of hospital services reflects greater need.¹⁷

This is relevant to another reservation concerning the impact of coordinated care on the key demographic: elderly chronically ill patients. It is rising numbers of chronically ill patients aged seventy-five and over who are putting the greatest pressure on public hospitals, by presenting at emergency departments and requiring admission to scarce hospital beds in increasing numbers.¹⁸ Unfortunately, there is less scope to maintain the health of this patient group, and hence the limits of coordinated primary care need to be acknowledged.¹⁹ Regardless of how well-coordinated the care is, chronic conditions tend to deteriorate with age. Many elderly patients inevitably require intensive tertiary care for major diseases, and hospital admission for complex chronic conditions.

Perverse but predictable effects

Australian and other international evidence also warns against exaggerating the extent to which coordinated care will ‘take the pressure off public hospitals.’²⁰ To the contrary, the evidence points to the propensity of coordinated care to increase patient access to secondary care and tertiary treatments.

In 2003, the UK government commissioned a pilot coordinated care program. Practice nurses conducted comprehensive geriatric assessments of elderly patients not in regular contact with general practice services, designed individual care plans, and undertook follow-up monitoring. The evaluation of the pilot program found that ‘case management had no significant impact on rates of emergency admission, bed days, or mortality in high risk cohorts.’ The evaluation suggested that while better coordination might avoid hospitalisations in individual cases, overall, instead of reducing admissions in the wider population, improved access to coordinated primary care uncovered new cases requiring hospitalisation.²¹

In 2004, the New Zealand Ministry of Health introduced a new scheme to coordinate the care of chronic disease patients. The ‘Care Plus’ program allocated extra funding to New Zealand’s eighty-one publicly funded Primary Health Organisations. This entitled the chronically ill to receive reduced-cost nurse or doctor visits, care planning, and self-management support.

The independent evaluation found that the program had improved the care of Care Plus patients, but had led to higher, not lower, utilisation of medical services. In this case, when coordinated care was translated from the trial to the real world, it led to consultation rates increasing by four visits per annum on average. This led to hospital admissions rising by 40%, which was attributed to better monitoring of chronically ill patients’ conditions.²²

The Australian Coordinated Care Trials

The experience in the UK and New Zealand is consistent with the results of the Australian Coordinated Care Trials of the late-1990s.

The Coordinated Care Trials were an ambitious experiment, specifically designed to deliver coordinated primary care and keep chronic disease patients well and out of hospital. Funding from existing state and commonwealth health programs was ‘pooled’ and reallocated to nine community-based ‘fundholding’ organisations in six states and territories. The theory—still popular among those who support funding primary care providers on a ‘population health’ rather than fee-for-service basis, to support a multidisciplinary approach to chronic disease care²³—was that because the fundholding primary care organisations were responsible for meeting all the healthcare needs of enrolled patients, they, like HMOs in the US, would have a financial incentive to adopt prevention-based strategies. By targeting and intensively managing the care of high-risk chronically ill patients, fundholders would recoup the higher cost of coordinated care from the savings achieved on ‘avoidable’ hospital admissions.

The Department of Health and Ageing published the national evaluation report on the trials in 2002. The evaluation found that in general the trials had not improved health outcomes among participants and that most programs operated at a loss.²⁴ The South Australian ‘Health Plus’ trial was partly successful and achieved some improvement in patient outcomes. Yet even in this trial—one of only three to register a significant reduction in hospital admissions—the savings on hospital costs were not sufficient to cover the higher costs of coordination.²⁵ Commenting on the results in the *Medical Journal of Australia*, Adrian Esterman and David Ben-Tovim explained that the trials showed

the essential premise that better coordination reduces hospitalisations is misguided. It may be that lack of coordination in a complex care system operates as a functioning rationing system, so that better care coordination reveals unmet needs rather than resolving them.²⁶

In other words, instead of savings on hospital costs and reducing demand for hospital services through the secondary prevention of chronic illness, coordinated care appears to enhance primary care’s traditional roles of detection and referral. Coordinated care, it seems, enables

Instead of reducing admissions in the wider population, improved access to coordinated primary care uncovered new cases requiring hospitalisation.

more chronically ill patients to receive all available beneficial care and secure referral to necessary hospital-based treatment.

What about Kaiser Permanente?

The ‘managed care’ regimes developed by Kaiser Permanente are often cited in support of the need to ‘invest’ in lower-cost coordinated primary care. Yet the evidence has been misrepresented, and the lessons of the Kaiser model of care have been selectively cited.

Kaiser Permanente attracted international attention following the publication of the 2002 study that compared its performance against the British NHS. This study found that Kaiser achieved better performance outcomes at a lower cost: far superior access to specialist and tertiary treatment compared to the much longer waiting times for specialist and hospital treatment in the NHS. The key finding was that ‘age adjusted rates of use of hospital services in Kaiser were one third of those in the NHS.’²⁷

Due to the competitive nature of the US health market,²⁸ HMOs aim to provide almost immediate access to medical care, and they accomplish this by ‘managing the care’ of patients to ensure all medical services are provided in the most appropriate, efficient, and cost-effective setting. To this end, Kaiser operates community-based health centres that employ physician assistants and nurses to provide patient care, as well as accredited doctors who are able to perform quite complex procedures to free up other specialists for more serious cases. Kaiser, like other HMOs in the US, also identifies high-risk chronic disease patients and offers coordinated chronic disease programs led by practice nurses.²⁹

The 2002 study found that compared with NHS patients, ‘Kaiser patients are far more likely to receive appropriate treatment and intervention for diabetes and heart disease.’³⁰ On this basis, the proponents of GP Super Clinics have attributed Kaiser’s lower ‘frequency’ of hospital admission to the resources devoted to secondary prevention regimes, the suggestion being that the ‘strengthening of the nurse practitioner/practice nurse role’ kept the chronically ill out of hospital.³¹

However, this overlooks a 2004 study by Firemen and others, which found that Kaiser Permanente’s programs, while improving the quality of patient care, did not decrease costs as expected. Higher spending on better-coordinated primary care had not produced the predicted cost savings on reduced hospital admissions—which ‘did not happen, despite increased use of effective medications and improved risk-factor control’—to offset the substantially larger cost of providing higher quality primary care.³²

A primary-care-oriented health system can be more cost-effective ... because of the emphasis it places on substituting primary care for higher cost hospital-based care.

A truer reading of the evidence suggests, therefore, that it is misleading to single out the Kaiser model as proof that ‘investing’ in ‘stronger’ coordinated primary care has a guaranteed secondary preventive effect that lowers costs, keeps chronically ill patients well, and reduces ‘unnecessary’ hospital admission.³³ The 2002 study found that what overwhelmingly accounted for ‘the nearly four times the number of acute bed days per 1000 population per year in the NHS than in Kaiser’ was efficient use of expensive hospital beds. The reason for Kaiser delivering more care more cheaply was, as the study explained, the striking difference ‘in the management of admissions and length of stays,’ which meant that ‘Kaiser members spend one third of the time

in hospital compared with NHS patients.’³⁴ In other words, hospital beds were used less because they are needed less, since Kaiser can treat more patients for more conditions in its community-based health centres.

This—plus having two to three times the number of specialists the NHS does—was why ‘Kaiser can provide more and better paid specialists and perform more medical interventions with much shorter waiting times than the NHS for roughly the same per capita cost.’ The study also indicated that this was why Kaiser could afford the additional costs of superior-quality nurse-led chronic disease care.³⁵

This is to say that when properly interpreted, the international evidence does show that a primary-care-oriented health system can be more cost-effective. But the Kaiser model delivers more cost-effective healthcare mainly because of the emphasis it places on substituting primary

care for higher cost hospital-based care. Kaiser, compared to less integrated health systems, is able to avoid ‘unnecessary’ hospital admissions by ensuring that necessary care can be delivered in the most appropriate (and lower-cost) community-based (non-hospital) setting.

The misunderstood impact and implications of coordinated care

In the last decade, federal and state governments have made improving the care of chronic disease a priority.³⁶ The Rudd government intends to build on these efforts by taking a comprehensive national approach to the secondary prevention of chronic disease. But what the evidence strongly suggests is that more spending on coordinated chronic disease care will not lower health costs and alleviate the pressure on hospitals as promised. ‘Better’ primary care does not necessarily mean ‘cheaper’ care, and, as the evidence shows, despite the potential for lower costs, the predicted savings and reductions in use of hospital care have not been realised.

What the evidence indicates is that lack of coordination operates as a rationing device, and that therefore GP Super Clinics offering coordinated care for the chronically ill will uncover unmet need and bring forward demand for hospital services.³⁷ If the Rudd government proceeds with the Super Clinics policy, and, as planned, locates Super Clinics in low socioeconomic status areas with existing GP shortages, the likely outcome is that more chronically ill Australians will secure referrals to all beneficial secondary care and tertiary treatments.

But what this strongly suggests is that the impact and implications of coordinated care have to be understood in terms of increasing demand for hospital-based services.

Super Clinics ... will accentuate, not alleviate, the challenges facing Medicare.

Therefore, unless Super Clinics are designed to substitute lower-cost outpatient services for inpatient hospital care, more government spending on coordinated care will have two unintended but predictable consequences. One is that Super Clinics will be likely to increase the pressure on struggling public hospitals. Second, rather than create a lower-cost health system oriented to primary care, Super Clinics will be highly likely to increase the costs of primary and hospital care. In the long-term, this will accentuate, not alleviate, the challenges facing Medicare.

The model's the thing

The Rudd government has recently established the National Health and Hospital Commission to oversee national health reform. The commission's brief is to report on the framework for the next Australian Health Care Agreement (the instrument through which the commonwealth gives hospital funding to the states), and then draw up a national reform blueprint to equip the health system to meet the challenges of the twenty-first century.

The commission should recognise that the vital issue, where Super Clinics are concerned, is the model of care. Vested stakeholders will surely attempt to draw the commission's attention to the findings of the recently released national evaluation of the second round of coordinated care trials by way of recommending that Super Clinics focus on providing a ‘holistic’ approach to filling the ‘gaps’ in non-hospital care. The commission should treat the evidence base purportedly generated by the trials with due caution. This includes the publicised claim that one of the two ‘mainstream’ trials, the Brisbane-based Team Care Health II trial, reduced hospitalisation and lowered costs.

A counter-reading of evidence-base contained in *The National Evaluation of the Second Round of Coordinated Care Trials* appears to support the idea that lack of coordination operates as a rationing device (see the appendix to this monograph). The commission should also note the findings of the study by Firemen and others:

We doubt the validity of reports of big, quick savings from [disease management/coordinated care programs]; however, if [disease management/coordinated care] has accomplished some quick savings, *it is more plausible that it was done by utilization management than by making a chronic disease population healthier.*³⁸

The evidence examined here suggests the following:

- Coordinated care does not lower hospital usage and costs.
- Coordinated care increases or brings forward demand for hospital care.
- Subject to the design of the model of care, health systems oriented towards community-based treatment can be more cost-effective and use hospital-based services more efficiently.
- Shifting as many hospital services as possible into community-based facilities is an effective method of better managing the cost of and demand for hospital services.

The evidence therefore suggests that if Super Clinics are to relieve rather than exacerbate, the pressure on hospitals, the National Health and Hospital Commission should focus on how Super Clinics can best provide substitutes for higher-costing hospital-based services. This is the best way for them to equip the health system to deal with the expected increase in demand for hospital care as a result of the ageing of the population.³⁹

This would resolve a major inefficiency in the health system, often commented upon, that stems from the federal division of health responsibilities. This is the difficulty practitioners and patients commonly encounter trying to negotiate the transition from commonwealth-funded

primary care to state-run public hospital care, which by all reports causes delays and extra costs. If Super Clinics can substitute inpatient hospital services by providing the same care as outpatient services instead, effective commonwealth leadership would ensure smoother patient journeys through the health system by integrating primary care and hospital services.⁴⁰

The commission should advise the government with the Kaiser model in mind. It should also look to other international examples of tertiary care successfully being offered outside of the traditional hospital setting,⁴¹ for the design features required to equip Super Clinics to deliver integrated medical services in the most cost-effective way. The

commission should also advise the government on the adjustments to the terms of the Australian Health Care Agreement and to the level of the hospital funding provided to the states, necessary to compensate the commonwealth for assuming the additional cost of outpatient care.

Super Clinics can ... provide substitutes for higher-costing hospital-based services ... to equip the health system to deal with the expected increase in demand.

Coda

Before the 2008–09 federal budget, the National Health and Hospitals Commission (NHHC) issued its first report on the future of the commonwealth–state health agreements. Though charged with reconsidering the federal division of health responsibilities, the NHHC’s interim report followed the lead of the Rudd government’s Super Clinics policy. The chief recommendations were that the commonwealth should take over complete control of primary care services (by assuming responsibility for community and mental health from the states), and should broaden its public health role to take in allied health through Medicare. Otherwise, the report endorsed the status quo: states, the NHHC advised, should retain complete control of hospitals. The NHHC squibbed the tough issue, and failed to advise the government to do the heavy lifting required and sort out the structural inefficiencies in the provision of public hospital services (which would antagonise state Labor colleagues and political allies in the cosseted public-sector health unions). Instead, the NHHC gave the government what it wanted: a warrant to expand Medicare and lumber Gen X and Y taxpayers with the allied healthcare costs of ageing baby boomers.

Appendix: The second-round coordinated care trial—An alternative reading

Overall, this analysis indicates that a substitution in service utilisation occurred. That is, intervention participants received more Medicare Benefits Schedule (MBS) services and less inpatient services during the trial compared with pre-commencement than control participants.

However, it needs to be noted that there is a difference in pre-commencement inpatient hospital service utilisation between the control and intervention groups. Controlling for pre-commencement utilisation by assuming that pre-commencement services were the same for both control and intervention participants did not result in a substitution effect.

—Department of Health and Ageing, *The National Evaluation of the Second Round of Coordinated Care Trials*⁴²

According to the Australian General Practice Network, by substituting enhanced access to coordinated primary care for hospital-based care of the chronically ill, the Brisbane-based Team Care Health II coordinated care trial reduced hospital admissions by 25% and costs by 8% among intervention patients, compared to a randomised control group of patients whose care was not coordinated.⁴³ If the common-sense meaning of reduced admissions and reduced costs applies, this presentation is exaggerated at best, and misleading at worst.

The national evaluation report on the second round of Coordinated Care Trials found that during the trial, ‘inpatient services and costs increased to a *lesser extent* for intervention participants compared with control participants’ (emphasis added) compared with rates of utilisation of inpatient services for the six-month pre-commencement period. A statistical analysis performed to ascertain the trend in service utilisation did find a difference of 25% in the rate of growth of average inpatient usage (a ‘lower level of increase’). During the trial compared to the pre-commencement period, use of inpatient services by intervention patients *grew* by 8% compared to 33% growth for patients in the control group. Use of primary care GP and Diagnostic Imaging (DI) services for intervention patients both increased by 5% during the trial compared to pre-commencement, while use of GP services fell by 3% and DI rose only by 1% for the control, and there was no significant increase in the cost of these services for the control group.⁴⁴ On this basis, the evaluators suggested that the slower growth in use of inpatient services by intervention patients was due to service substitution having taken place, which was of benefit to patients. The implication is that the rate of growth of use of hospital-based care was less because more coordinated primary care kept intervention patients healthy.

The intervention achieved no real reduction in inpatient service use.

This is a highly questionable conclusion. The intervention achieved no real reduction in inpatient service use. Despite the additional access to and cost of coordinated primary care, inpatient service utilisation rates and costs were higher for the intervention group during the trial compared to the pre-trial period. Inpatient service costs for the intervention patients not only grew, they also ‘received significantly more inpatient services than control patients throughout the majority of the trial period, but especially in early trial.’⁴⁵ The intervention—the significantly higher levels of primary care received (significantly increased use of the ‘Enhanced Primary Care’ Medicare item, in particular)—appears to be linked to increased utilisation of inpatient services, especially early in the trial. Overall, inpatient service usage in the intervention group remained significantly higher during the trial compared with the control group, and was relatively steady throughout compared to the widely fluctuating inpatient utilisation in the control (see figure 1 below).⁴⁶ Does this amount to ‘clear indications of reduced inpatient utilization relative to the control group’ as suggested in the report?⁴⁷

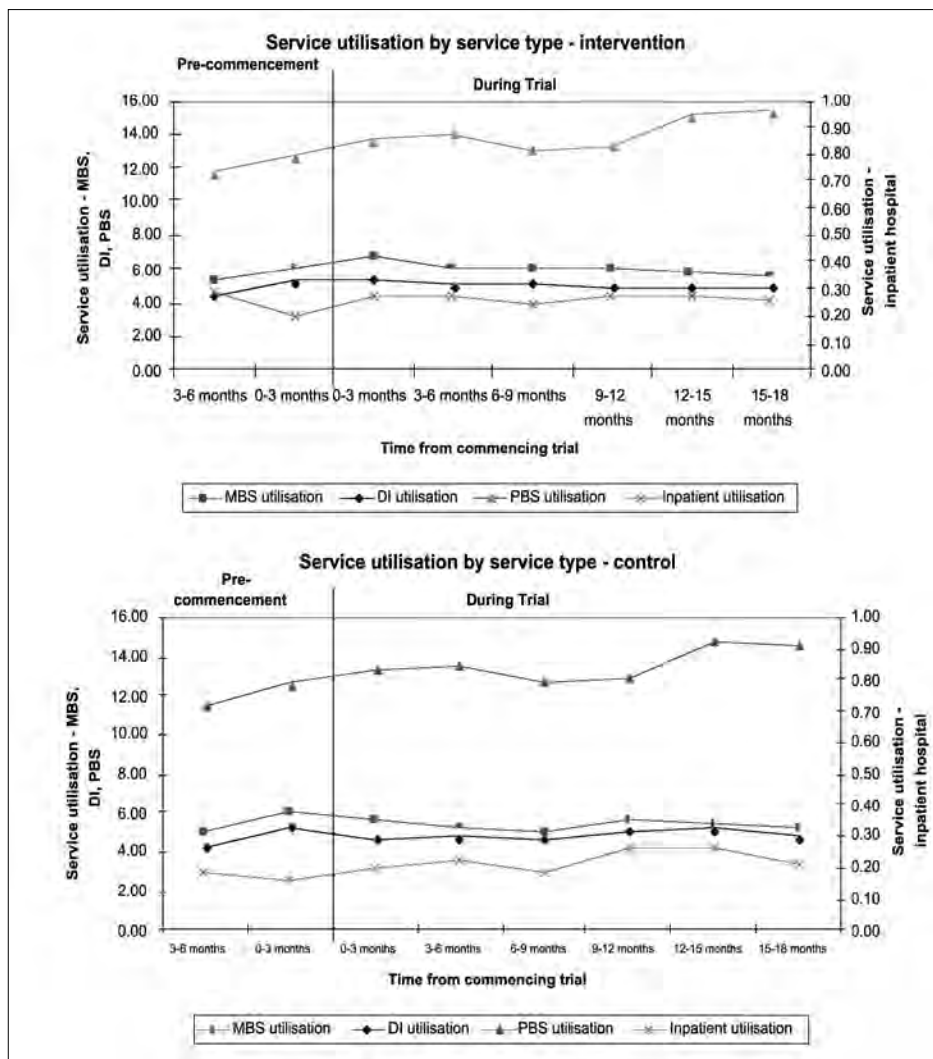
The report itself severely qualifies its own ‘findings.’ When the unexpected difference in pre-commencement utilisation rates was controlled for, and, presumably, utilisation rates during the trial were directly compared for the control and intervention group, *the ‘substitution effect’ disappeared.* In other words, when one overlooks the trend and assesses total usage rates, the results do not show real substitution or that more use of coordinated primary care reduced the use of

inpatient services for the intervention group compared to the control. The figures on costs and utilisation rates support this analysis.

Inpatient costs for the intervention group grew by 8%, and were 18.5% higher on average than for the control group during the trial. While total costs compared to the pre-commencement period did grow 8% slower (there was a ‘lower level of increase,’ in the language of the report) for the intervention compared to the control group (26%, or \$1,618), total costs in the intervention group still grew by 18% and were 5.5% higher (\$1,711) than for the control.⁴⁸ Annual per capita costs for the whole eighteen-month trial period were higher for the intervention group (\$7,816) than the control (\$6,620), but annual per capita costs were slightly lower (\$7,641) for the intervention group in the six to eighteen month period following the commencement of the trial period.

The higher cost of the intervention was the result of higher costs for primary care *and inpatient service use*, the link between which the report fails to candidly address.⁴⁹ That the trial model of care proved more expensive than normal care was attributed in one part of the report to the high cost of coordinating the care of frail elderly patients.⁵⁰ In other places, without mentioning inpatient costs and utilisation, the report suggests that the increase in services and costs for the intervention group was due to the greater average change in the cost of GP service use and the Pharmaceutical Benefits Scheme compared to the control group—particularly in the first three months, as health assessment and care planning began—and also due to higher use of DI services compared to the control group in that period. The report acknowledges that the additional cost of care coordination was not absorbed by cost savings achieved on the ‘lesser increase’ and ‘substitution’ of inpatient service use and costs for the intervention group.⁵¹

Figure 1: The ‘substitution’ effect?



Source: Department of Health and Ageing⁵²

While inpatient costs spiked in the initial period for the intervention group, for the control group they rose gradually, spiked after twelve months, then fell gradually. (Both spikes occurred around the same cost of just under \$1,000.) Both the intervention and the control spent roughly the same amount on inpatient services, but at different times. Overall costs were slightly higher for the intervention group's use of inpatient services (\$853) compared to the control group (\$831), but by the end of the trial, intervention group inpatient costs had fallen to around \$750, compared to \$800 for the control.

The report argues that that higher costs for the intervention group were largely driven by the initial spike in primary care and inpatient costs in the first three to nine months, given that the difference in per capita costs narrowed in the period between months six and eighteen of the trial (\$7641 compared to \$7088). But because the cost of inpatient services for the intervention group was trending down at the end of the intervention period, the report suggests that 'the downward trend' is evidence that the substitution effect was taking place. The expectation, purportedly fulfilled, was that the increase in primary care service expenditure in the initial period led to lower inpatient service costs in the later period, and that the pattern of falling inpatient costs as the trial proceeded showed the patients were deriving long-term health benefits from increased access to more effective primary care. On this basis, the report suggests that if the trial period had been extended and the trend continued, the additional cost of care coordination may have potentially been 'absorbed' and become 'cost-neutral,' offset by 'possible' cost savings on inpatient care.

While inpatient costs (but not utilisation rates) clearly fell in the intervention over time, the explanation and analysis the report offers overlooks the significance of the marked effect the intervention had on inpatient service costs during the first nine months of the trial. The report does acknowledge 'an initial increase following entry to the trial [for GP, DI, and inpatient services costs] followed by a flattening and perhaps a reduction at later periods.' But we should remember that inpatient service utilisation remained higher than for the control and steady throughout the trial. The crucial thing is understanding the cause of and the relationship between the corresponding spike in primary care, DI, and inpatient costs in the initial period and the subsequent flattening and reduction, with respect to whether this was the result of service substitution and coordinated care improving health outcomes and reducing demand for hospital care.

Better primary care and monitoring of conditions increases demand for tertiary care and raises total (primary and tertiary care) costs.

Were these effects caused by primary care improving the health status of targeted population? The evidence is mixed. The intervention was found to have had no effect on the intervention group's length of hospital stays compared to the control. Nor, most importantly, was it found to have an effect on rates of primary-care-sensitive hospitalisations, which remained constant in the intervention. The proportion of primary-care-sensitive hospitalisation utilisation, however, did increase less in the intervention, and this category formed a higher proportion of total hospitalisations in the control, particularly in later stages of the trial.⁵³ Higher use of effective medications due to better primary care could be part of the reason for this, given that the accumulated cost of pharmaceuticals was 5% higher for the intervention group compared to the control.⁵⁴ The subsequent fall in the cost of inpatient services could also be because the provision of tertiary care earlier than would otherwise have been the case improved patients' conditions and decreased over time the number of emergency admissions and primary-care-sensitive hospitalisations. Avoidable admissions were considerably higher in the control group compared to the intervention, particularly in the later stages of the trial.⁵⁵

If faster access to tertiary treatment improved the health of intervention patients, this is not evidence that 'preventive'⁵⁶ coordinated primary care improved health outcomes and achieved real reductions in the need and demand for hospital-based care. This suggests that the real trend in the intervention is that coordinated care increases demand for tertiary care by bringing forward and uncovering unmet needs, and ensuring patients get all beneficial care. This analysis is supported by the initial spike in demand and the consistently higher and steady rate of inpatient service utilisation for the intervention group.

If this analysis is correct, it supports the idea that lack of coordination operates as a rationing device. The significance of this is that coordinated care's biggest effect may lie in influencing tertiary care utilisation. It may not be that better coordination improves health, reduces need for hospital care, and generates cost savings that offset the cost of coordination. Rather, as other evidence seems to confirm, it may be that better primary care and monitoring of conditions increases demand for tertiary care and raises total (primary and tertiary care) costs. This does not mean coordination is not worth pursuing, since it will result in better and timelier care, and improved health for the sick. However, if coordinated care increases hospital demand and costs, that will reinforce the importance of ensuring hospital services are provided in the most cost-effective setting. Otherwise, care coordination is likely to further overburden hospitals and increase health costs more than is needed.

Endnotes

- 1 Recognising this, the former federal government introduced the Enhanced Primary Care package in 1999, which established a Medicare Benefits Schedule (MBS) item covering chronic illness and enabled GPs to undertake health assessment, multidisciplinary care planning, and monitoring. Since 2005, patients with complex needs have been able to access Medicare-funded 'GP Management Plans' and 'Team Care' from up to five allied health providers and three dental services per year.
- 2 Nicola Roxon, 'ALP Offers the Healthier Option,' *The Australian* (28 August 2007).
- 3 Jennifer Doggett, *A New Approach to Primary Care for Australia*, Centre for Policy Development Occasional Paper 1 (Sydney: Centre for Policy Development, 2007), 6, 15–16.
- 4 B. Firemen and others, 'Can Disease Management Reduce Health Care Costs by Improving Quality?' *Health Affairs* 23: 6 (November/December 2004), 63–75.
- 5 Mark Metherell, 'Hasty GP Referrals Come Under Attack,' *Sydney Morning Herald* (3 April 2008).
- 6 Australian Government, *Budget Paper No. 2 2008–09* (Canberra: Commonwealth of Australia, 2008), 212 (emphasis added).
- 7 See the impressive results of the Hospital Admissions Risk Program (HARP) in Victoria, which cut emergency visits, admissions, and unscheduled bed days by coordinating the care of patients at risk of re-presenting at public hospital emergency departments. Victorian Government Department of Human Services, *Improving Care: Hospital Admissions Risk Program—Public Report* (Melbourne: Metropolitan Health and Aged Care Services Division, 2006). Note this report did not use a randomised control to generate its results, or examine the overall effect of care coordination on scheduled hospitalisation and access to secondary treatment of patients whose care was coordinated. Note that similar results—lower hospitalisation—have not been achieved in either the first or the second round of the Australian Coordinated Care Trials when care coordination has been introduced into broader populations. Note, as well, that other research based on the HARP has found that case management increased rather than reduced emergency department presentations and admissions when it targeted the most frequent users. G. A. Phillips and others, 'The Effect of Multidisciplinary Case Management on Selected Outcomes for Frequent Attenders at an Emergency Department,' *Medical Journal of Australia* 184:12 (2006), 602–660.
- 8 See the recent editorial in the *Medical Journal of Australia* by Joanne Jordan and Richard Osborne. This called for the full integration of disease management programs into coordinated primary care, in combination with more intensive (and costly) reinforcement methods to ensure patient compliance with recommended treatments. Joanne E. Jordan and Richard H. Osborne, 'Chronic Disease Self-management Education Programs: Challenges Ahead,' *Medical Journal of Australia* 186:2 (15 January 2007), 84–87. Richard Osborne, interview by Norman Swann, *Health Report*, ABC Radio National (29 January 2007), www.abc.net.au/rn/healthreport/stories/2007/1833599.htm.
- 9 See for example, National Primary Care Research and Development Centre, 'National Evaluation of Expert Patients Programme: Key Findings (Research into Expert Patients—Outcomes in a Randomised Trial,' Executive Summary 44 (March 2007), www.npcrdc.ac.uk/Publications/National_Evaluation_of_EPP_-_Shanleys.pdf.
- 10 A. Kennedy, C. Gately, and A. Rogers, *National Evaluation of the Expert Patients Programme* (Manchester: National Primary Care Research and Development Centre, 2004), www.npcrdc.ac.uk/PublicationDetail.cfm?ID=105. The response from government has been to encourage the take-up of the Expert Patients Programme by giving additional funding to primary care practices that do so. Joanne Jordan and Richard Osborne, 'Chronic Disease Self-management Education Programs,' 84.
- 11 The difference between promising trial results for chronic disease self-management programs and the results once these programs are delivered in the general population (to people who have not volunteered) have been highlighted in a recent British study of the 'Challenging Arthritis' self-management program, which found no significant reduction in doctor visits among enrolled patients. M. Buszewicz and others, 'Self Management of Arthritis in Primary Care: Randomised Controlled Trial,' *British Medical Journal* 333 (2006), 879. Another factor could be that providing these programs to patients that already largely comply with treatment protocols raises primary care costs while delivering no benefit in reduction of tertiary costs. Devon M. Herrick, *Consumer Driven Health Care: The Changing Role of the Patient*, National Center for Policy Analysis (NCPA) Policy Report 276 (Dallas: NCPA, 2005), www.ncpa.org/pub/st/st276/st276.pdf.
- 12 The commonwealth government expanded the Sharing Health Care Initiative from eight to twelve self-management demonstration projects, despite the findings of the national evaluation regarding the small reduction in hospital visits. Commonwealth Department of Health and Ageing, *National Evaluation of Sharing Health Care Demonstration Projects, Final Report—Executive Summary* (Canberra: June 2005), 3, 27–28, www.healthconnect.gov.au/internet/main/publishing.nsf/Content/

- 58F87503A43034DFCA25735C00098161/\$File/Executive%20Summary.pdf. Added to the failure of the Coordinated Care Trials, the previous commonwealth commitment in 2006–07 of \$250 million in extra spending on chronic disease management—justified as a way to save on hospital costs—proceeded against the grain of the evidence.
- 13 Acknowledging that education is often not enough, and that the problem is how to motivate patients to improve compliance, more intensive follow-up (use of telephone coaching and the internet) is now being recommended to encourage ongoing participation, in the hope this will be more successful at securing compliance than education alone. Joanne Jordan and Richard Osborne, 'Chronic Disease Self-management Education Programs,' 85.
 - 14 For instance, meta-analyses measuring the effectiveness of disease management programs have found no evidence of an effect on weight loss among diabetic patients in intervention compared to control groups. J. Chodosh, 'Meta-analysis: Chronic Disease Self-Management Programs for Older Adults,' *Annals of Internal Medicine* 143:6 (September 2005), 427–438. The authors also point out, that 'one important outcome we did not include is cost-effectiveness that could be achieved by reducing health care utilization; it was reported too infrequently and too variably to justify statistical pooling' (436). See also finding that disease management had no effect on obesity, exercise, or even smoking, in of B. Firemen and others, 'Can Disease Management Reduce Health Care Costs By Improving Quality?' *Health Affairs*. 'Improvement in lipid and BP control appears to have been accomplished more by medications than by weight management and exercise. From 1996 to 2002 obesity increased from 32 percent to 39 percent of patients with any of the four chronic diseases, while frequency of self-reported exercise did not change. Similar changes in obesity and exercise were observed among adults without these conditions. Among the chronically ill, smoking rates remained at about 11 percent.'
 - 15 There is similar evidence that educational programs and telephone counselling increase hospital admissions. A. Bagust and others, 'Dynamics of Bed Use in Accommodating Emergency Admissions: A Stochastic Simulation Model,' *British Medical Journal* 319 (1999), 157.
 - 16 Productivity Commission, *Report on Government Services 2008* (Canberra: Productivity Commission, 2008), 11.54.
 - 17 As pointed out in AIHW (Australian Institute of Health and Welfare), *Australian Hospital Statistics 2005–06*, (Canberra: AIHW, 2007), 51.
 - 18 On the causes of 'access block,' see ACEM (Australasian College for Emergency Medicine), 'Access Block and Overcrowding in Emergency Departments' (April 2004), www.acem.org.au/media/Access_Block1.pdf.
 - 19 G. Braitberg, 'Emergency Department Overcrowding: Dying to Get In?,' *Medical Journal of Australia* 187 (11/12 December 2007), 624–625.
 - 20 As the review of chronic disease management by N. Zwar and others noted, 'Improvements in patient care have not always been associated with reduced health care costs for the health care system or the patient.' N. Zwar and others, *A Systematic Review of Chronic Disease Management*, (Canberra: Australian Primary Health Care Research Institute [APHCRI], 2006), 21.
 - 21 H. Gravelle and others, 'Impact of Case Management (Evercare) on Frail Elderly Patients: Controlled Before and After Analysis of Quantitative Outcome Data,' *British Medical Journal* 334:7583 (6 January 2007), 31–34. The evaluation confirmed the findings of two earlier reviews that 'showed no consistent evidence for the effectiveness of case management in preventing hospital attendances or admissions, reducing health costs, or improving function.' David Oliver, 'Government Should Have Respected Evidence,' *British Medical Journal* 334:7585 (20 January 2007), 109.
 - 22 The University of Auckland, 'Evaluation of Care Plus Programme, New Zealand,' Health Policy Monitor Survey (9)2007, www.hpm.org/en/Surveys/The_University_of_Auckland/09/Evaluation_of_Care_Plus_Programme.html?content_id=251&a=sh&p_ft=new+zealand+care+plus+programme&p_i=0&language=en. For a full evaluation, see CBG Health Research, *Review of the Implementation of Care Plus* (Wellington: New Zealand Ministry of Health, 2006), [www.moh.govt.nz/moh.nsf/pagesmh/5567/\\$File/review-implementation-care-plus.pdf](http://www.moh.govt.nz/moh.nsf/pagesmh/5567/$File/review-implementation-care-plus.pdf), 2. Nevertheless, prominent participants in the Australian health debate claim New Zealand has 'markedly reduced the demand on hospital services by investing in better primary care.' John Dywer, quoted in Mike Steketee, 'Situation is No Accident,' *The Australian* (6 October 2007).
 - 23 Hal Swerissen and Stephen Duckett, 'Health Policy for a Long-Lived Society,' in Allan Borowski, Sol Encel, and Elizabeth Ozanne, eds, *Longevity and Social Change in Australia* (Sydney: University of New South Wales Press, 2007), 167–188; Jennifer Doggett, 'A New Approach to Primary Care,' 23–4.
 - 24 Commonwealth Department of Health and Aged Care, *The Australian Coordinated Care Trials: Summary of the Final Technical National Evaluation Report on the First Round of Trials* (Canberra: Commonwealth of Australia, 2002).
 - 25 Malcolm W. Battersby, 'Health Reform through Coordinated Care: SA Health Plus,' *British Medical*

- Journal* 330:7492 (19 March 2005), 662–665.
- 26 Adrian J. Esterman and David I. Ben-Tovim, 'The Australian Coordinated Care Trials: Success or Failure?', *Medical Journal of Australia* 177 (4 November 2002), 470.
- 27 R. G. A. Feachem and others, 'Getting More for their Dollar: A Comparison of the NHS with California's Kaiser Permanente,' *British Medical Journal* 324:7330 (19 January 2002), 135.
- 28 HMOs like Kaiser Permanente take a lean and mean approach to managed care because they have to compete with other HMOs for the custom of healthcare purchasers (mainly governments and employers) who bargain hard on price. It also has to satisfy individual members, who are demanding customers and are free to move between HMOs if dissatisfied. Competition and choice create the financial incentive to keep costs low while being responsive to patient demand and ensuring fast access to both primary and secondary care.
- 29 N. Zwar and others, *A Systematic Review of Chronic Disease Management*, 13; King's Fund, *Managing Chronic Disease: What Can We Learn From the US Experience?*, (London: King's Fund Publications, 2004).
- 30 R. G. A. Feachem and others, 'Getting More for Their Dollar,' 139.
- 31 Jennifer Doggett, 'A New Approach to Primary Care,' 16.
- 32 B. Firemen and others, 'Can Disease Management Reduce Health Care Costs by Improving Quality?' 'Kaiser achieved considerably better results with similar total resources, because they invested significantly more in primary and preventative care.' Andrew Podger, *Directions for Health Reform in Australia*, paper presented at the Productivity Commission Roundtable on Productive Reform in a Federal System (October 2005), www.newmatilda.com/admin/imagelibrary/images/txo0Rfe65LsO.doc14.
- 34 R. G. A. Feachem and others, 'Getting More for Their Dollar,' 138, 140.
- 35 As above, 140.
- 36 In 2005, the National Chronic Disease Strategy set out a national framework for chronic disease management and prevention, accompanied by five National Service Improvement Frameworks covering asthma, cancer, diabetes, heart disease, and arthritis. Every state government has also initiated a broad-based and integrated chronic disease strategy. NHPAC (National Health Priority Action Council), *National Chronic Disease Strategy* (Canberra: Australian Government Department of Health and Ageing, 2006), 41. Some states have also established new multidisciplinary primary care centres—'GP Plus' centres in South Australia, 'Super Clinics' in Victoria, and 'Health One' centres in New South Wales. This is on top of the existing state-operated Community Health Centres that also provide multidisciplinary services, which the commonwealth partly funds through the \$800 million Public Health Outcome Funding Agreements (PHOFA).
- 37 This may mean that future costs will be lower than they otherwise would be. Earlier detection and treatment might prove the cheaper option compared to the higher cost of providing more complex care if conditions are treated only once they become acute, though this is difficult to judge.
- 38 B. Firemen and others, 'Can Disease Management Reduce Health Care Costs by Improving Quality?,' 73 (emphasis added).
- 39 The 'Day Hospital' model developed as part of the Victorian government's \$42 million Super Clinics project is designed to manage demand for inpatient hospital services, and focuses on the provision of same-day procedures and outpatient and specialist services like chemotherapy and renal dialysis outside of public hospitals in community-based facilities. Victorian Government Department of Human Services, *Annual Report 2006–07* (Melbourne: Victorian Government Department of Human Services, 2007), 28.
- 40 The standard proposal to better integrate the federal health system (and avoid blame and cost shifting and waste and duplication) is a complete Commonwealth takeover of responsibility for health and hospitals. If designed to substitute hospital-based care with community-based facilities, Super Clinics would engineer the much-desired integration of the health system, while minimising the sizeable political obstacles and transitional costs a federal takeover would involve. If privately operated, Super Clinic 'day hospitals' would release a large tranche of the health system from the control of the federal and state health bureaucracies. Arguably, there is more potential for the commonwealth to leverage real health reform by preserving and modifying the federal division of health responsibilities.
- 41 In the UK, for example, 'the plan is to accelerate the transfer of one million appointments, which would in the past have been done in outpatient clinics, into primary care ... [and to] buy mainstream NHS services from independent outfits ... Borrowing from the models of polyclinics in Europe and day surgery centres in the USA, treatment centres were introduced in the UK in 1999 with the opening of an ambulatory care and day-case unit at Central Middlesex Hospital in London. Treatment centres carry out planned or elective work, both diagnostic and therapeutic, in separate premises and with separate staff. Because they perform a high number of procedures as day cases or short stay cases, they reduce the need for hospital admissions. They can be situated in existing hospitals, at independent sites, or in mobile centres. Since 2002, the NHS has also block contracted such services from the

independent sector, in the form of Independent Sector Treatment Centres (ISTCs).’ N. Seddon, *Quite Like Heaven? Options for the NHS in a Consumer Age* (London: Civitas, 2007), 37–39.

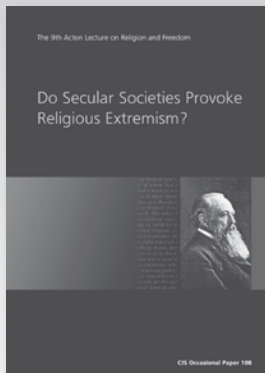
- ⁴² Department of Health and Ageing, *The National Evaluation of the Second Round of Coordinated Care Trials*, Commonwealth Department of Health and Ageing (Canberra: Commonwealth of Australia, 2007), part 3, 494. Emphasis in original.
- ⁴³ GPpartners, ‘GPpartners and Coordinated Care,’ www.adgp.com.au/client_images/171080.pdf.
- ⁴⁴ Department of Health and Ageing, *The National Evaluation of the Second Round of Coordinated Care Trials*, part 3, table 209, 492.
- ⁴⁵ As above, part 3, 486.
- ⁴⁶ As above, part 3, table 202, 486.
- ⁴⁷ As above, part 2, 10.
- ⁴⁸ As above, part 3, 492.
- ⁴⁹ As above, part 3, 469.
- ⁵⁰ As above, part 2, 14.
- ⁵¹ As above, part 2, 25.
- ⁵² As above, part 3, figure 104, ‘Service Utilisation by Service Type—Control and Intervention,’ 467.
- ⁵³ As above, part 3, 481, 489.
- ⁵⁴ As above, part 3, 481.
- ⁵⁵ As above, part 3, 488–489.
- ⁵⁶ As the report suggests. As above, part 3, 488.

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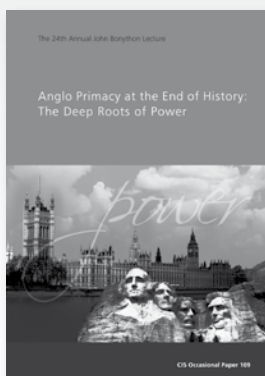


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CIS Occasional Paper 108

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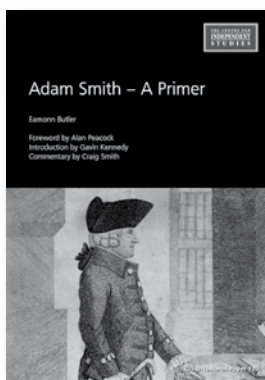
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