The search for better financing of health care, including that for people with chronic illness

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A wholly state-funded or federally funded system of health care, concentrating on providing integrated services, might circumvent the political blame game

During 2005 and 2006, the bipartisan House of Representatives Standing Committee on Health and Ageing conducted a nationwide inquiry into how the Australian Government could take a leading role in improving delivery of highest quality health care to all Australians.[1] This inquiry received 159 submissions and conducted hearings and interviews in each Australian state and territory. The fractured relations among the state, territory and federal governments that surface when the bills for health care roll in motivated the Committee's choice of title for its report — "The Blame Game".

The Blame Game describes conflict in the division of roles and responsibilities between federal and state governments, and the disconnection between public and private health systems, defining these factors as causes of impaired economic efficiency (which they are), but without linking them to the changing nature and extent of disease in Australia.

Like atheromatous plaques tolerated for years, blame-game policies are now stenosing, blocking effective financial channels for health services to flow to those with chronic health problems. The growing pressure for care of patients with chronic illness makes resolving the blame-gaming of health service financing more urgent than if it were a matter of financial inefficiency alone.

Of course, all health services — acute and chronic — would benefit from abolition of the blame game, but financing care for people with chronic illness should be rearranged as a working example of care across all providers funded from one source. This could reduce the transaction costs that proved problematic with the Australian coordinated care trials.[2]

Three actions now might prevent an infarct in our ability to provide health care in the future.

National agenda

First, we need a national agenda for the future of health care in Australia. This could start from the principal recommendation of The Blame Game: a national health agenda focused on financing health care. However, the agenda should reverse the usual priorities and begin from a concern for health, and only then consider financing arrangements. This would be a splendid prelude to negotiating the next Australian Health Care Agreements (AHCAs) in 2008. An agenda headed by the prevention and management of chronic illness could draw on the National Chronic Disease Strategy (NCDS).[3] The NCDS identified the scope of the problem — chronic illness accounts for 80% of the burden of disease (including mental illness and injury) and for some 70% of health expenditure in Australia.

Other evidence is also at hand to support action. Information flow among care providers is critical to managing chronically ill people across institutions and over time — these problems are being addressed by the National E-Health Transition Authority. Programs of extended primary care are testing ways of serving the complex needs of patients in the community. There are some (although not many) programs of prevention supported in all jurisdictions or collaboratively through the Better Health Initiative.[4] Despite this, no long-term programs engage all sectors of the health and social care system. Pilot projects, most often in general practice and limited in their ability to include specialist, allied health and social care, have flourished briefly, but there has been no serious long-term commitment.

Reform in Australian Health Care Agreements

Second, we need reform in the next round of AHCAs between the Australian Government and the states and territories. These 5-yearly bilateral agreements pledge the parties to public hospital financing. The AHCAs must now build on the developing collaborative spirit of the Council of Australian Governments (COAG), as evidenced in the agreements for the Better Health Initiative. This will not be easy, and to move from the anodyne rhetoric of collaboration to adequately funded action is a big leap. Thus far, there is no indication of sufficient spirit of cooperation within COAG. For example, of the $3.5 billion worth of initiatives in the National Action Plan on Mental Health, many rely on rearrangements of current funding, which might look distressingly like cost shifting. The impact of COAG's national reform agenda on increased workforce participation by reducing morbidity associated with chronic illness will be minor, at around 0.6%.[5]

The AHCAs need a new format, outlining how services are to be provided for people, rather than how hospitals are to be funded. It needs to be recognised that funds for chronic disease management are probably five times too low, given that fewer than 20% of patients leaving hospital and requiring continuing care receive best practice care. Medicare rebates for specialist outpatient services may make the funding process more transparent, but they have negligible impact on the necessary integration of care.

New funding models

Third, we need the other instruments of health care payment, including the Medicare Benefits Schedule (MBS), to be aligned with the way sick people require care. Public hospital funding models are based on episodic care for largely independent health problems, and these models continue to be used despite the knowledge that this is not the case for many people admitted to hospital. Patients with chronic illness require continuing care, often increasing stepwise with the addition of increasing social care over years, and involving multiple health service elements from primary care to hospital and back. Health care for people with chronic disorders should be available from a common fund that is spent in line with agreed principles of best practice. The Better

Health Initiative pays specialists to integrate services for people with cancer, but continues to rely on incentives for general practitioners to integrate services for people with other chronic illnesses.[4] Only medical practitioners can make an MBS claim for case management and care planning, and there are no mechanisms for federal funding for continued and team-based allied health and other interventions to prevent avoidable hospital admissions. Incentives for high quality care for managing chronic disease would be a welcome feature of a reformed MBS.

Conclusion

These three steps — a national agenda, a reformed set of health care agreements, and new approaches to funding community-based care — offer one way forward in confronting the rising tide of demand for care of people with serious and continuing illness in Australia. Blame, as we know, is a poor game to play if the object is to seek improved clinical safety and quality. It serves us no better in developing our health policies for tomorrow.

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