

# Are current primary health care funding arrangements getting us where we want to go?

Jane Hall

Research Excellence in Finance and Economics of Primary  
Care

Centre for Health Economics Research and Evaluation  
University of Technology Sydney

# Payment for face to face contact



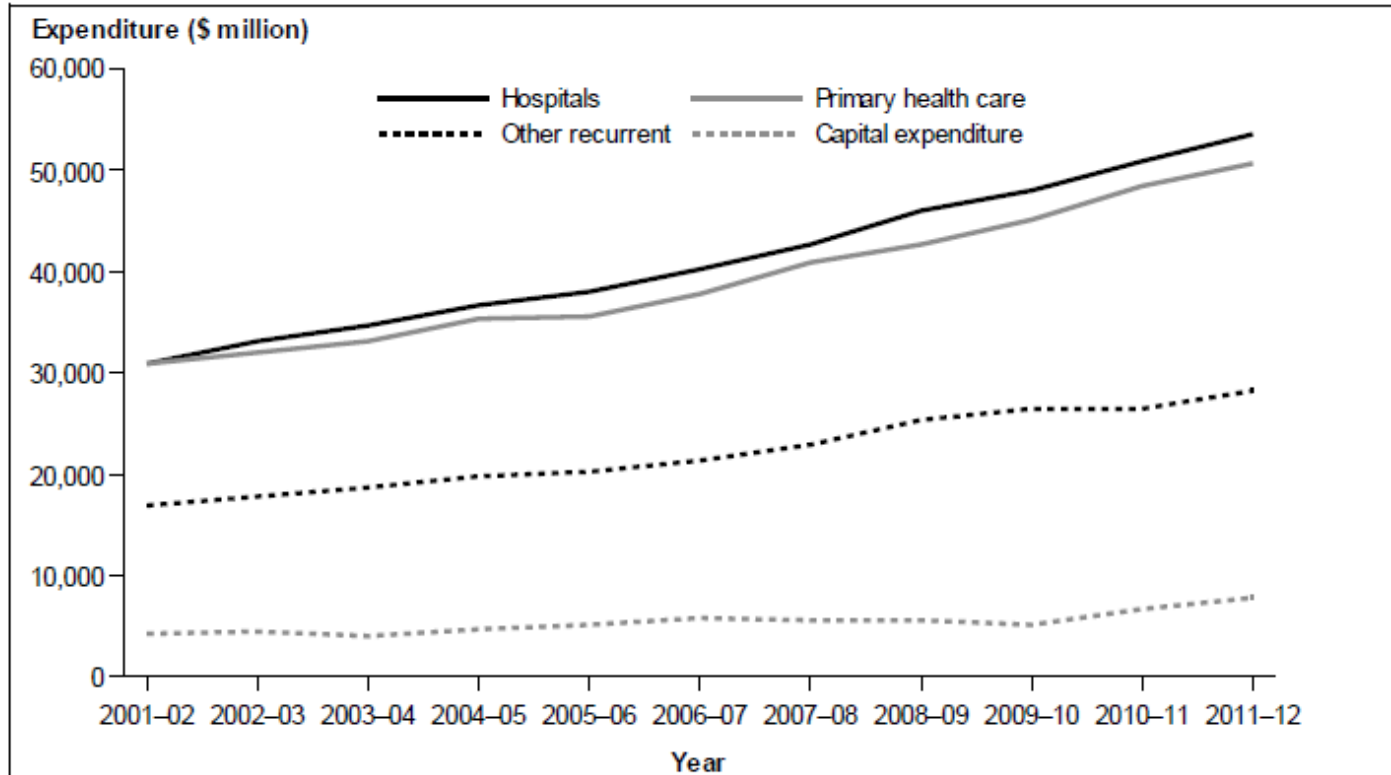
# The Status Quo



## ➤ Medicare funding

- Transactional based funding, focused on the occasion of service.
- Based on historical models of care.
- “One size fits all” physicians and patients.
- Has achieved high coverage, and patient acceptance
- Known to encourage volume, unknown effects on quality

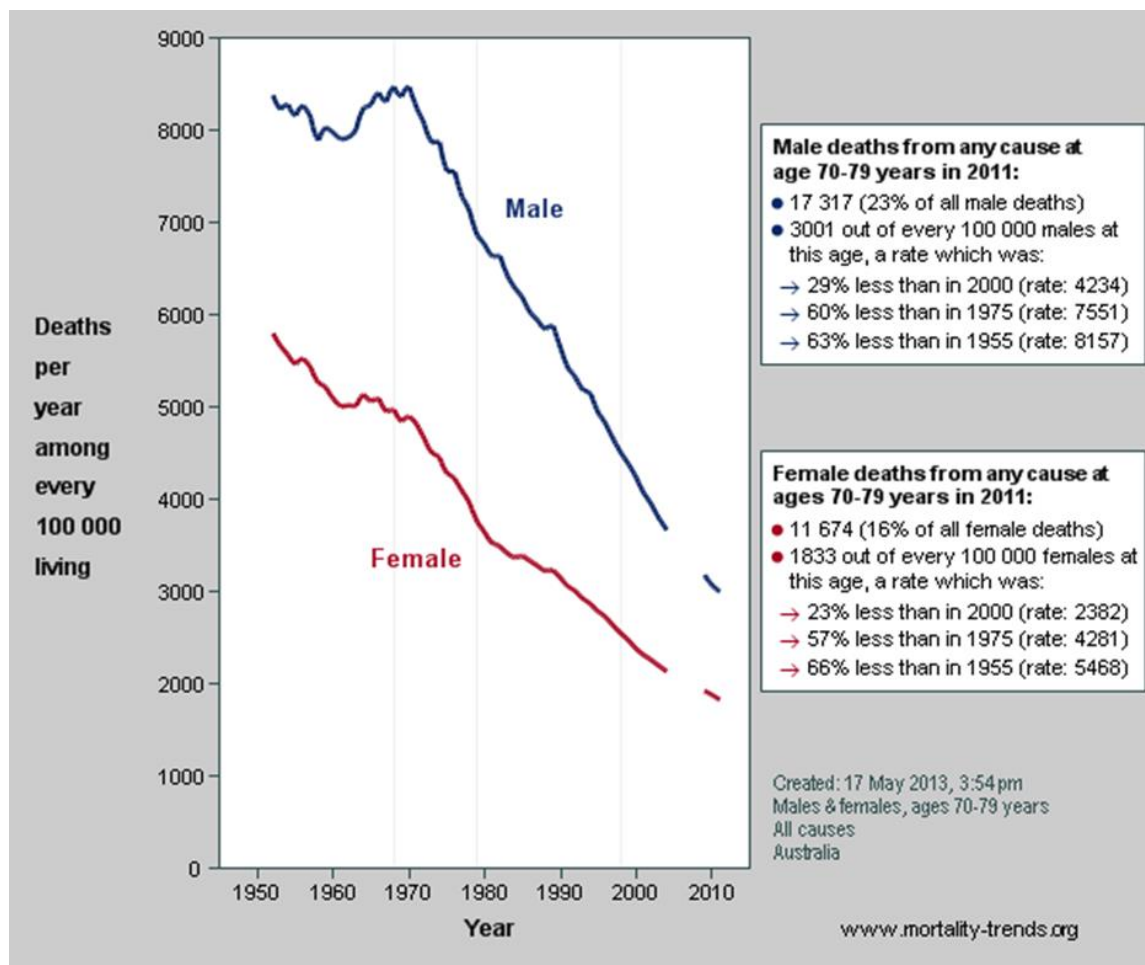
# Cost of primary care



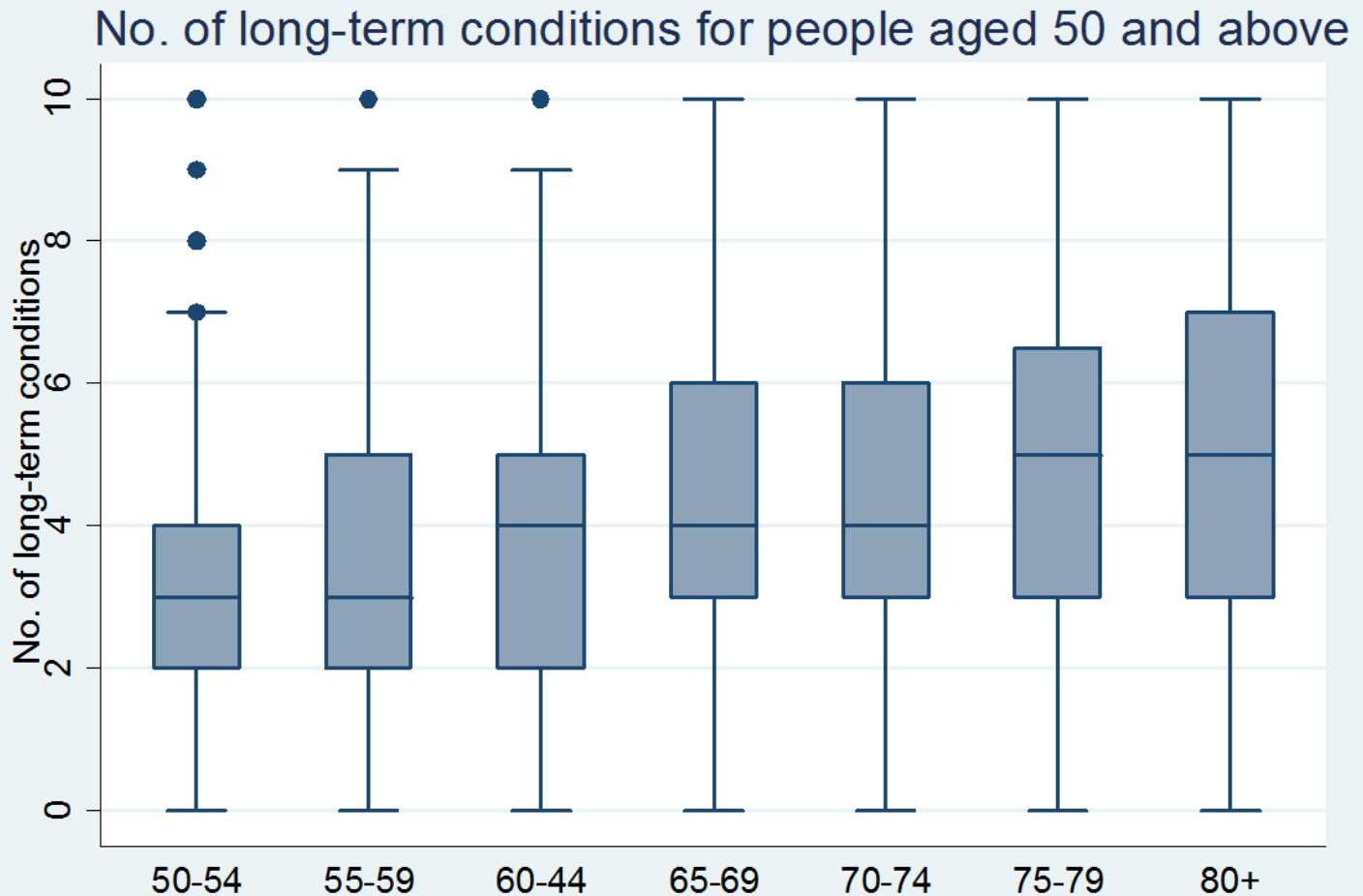
Source: Table A1.

**Figure 2.1: Total expenditure on health, by broad area of expenditure, constant prices, 2001-02 to 2011-12 (\$ million)**

# Changes in death rates Australians 70-79

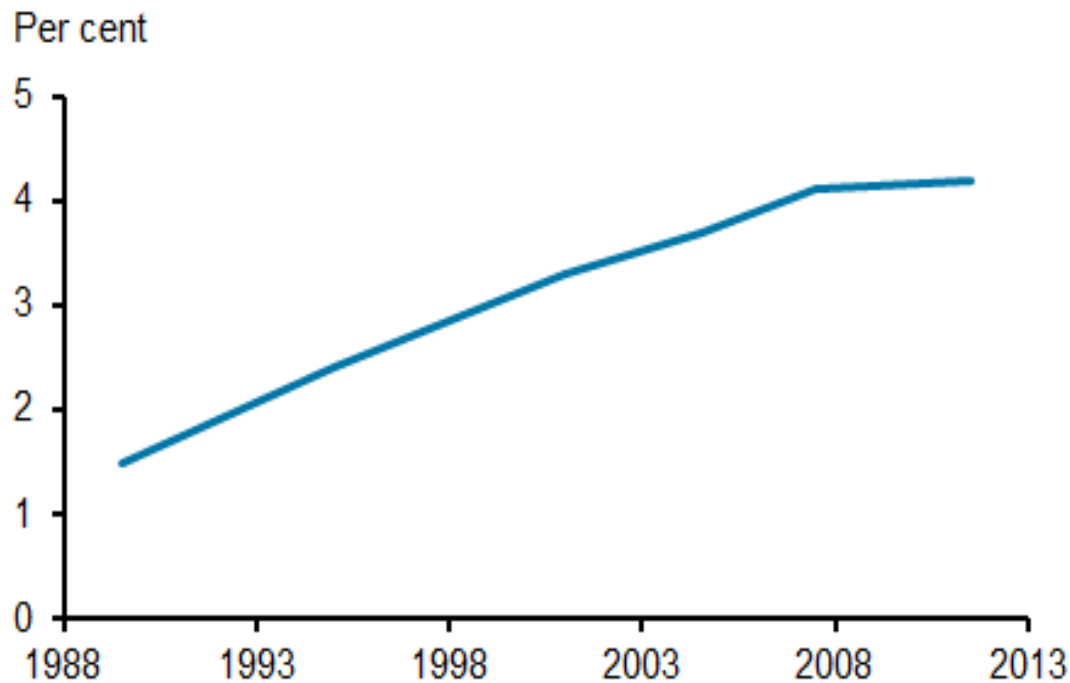


# Age brings chronic illness



Source: NATIONAL HEALTH SURVEY 1995

# Diabetes in Australia over 25 years



AIHW 2014 analysis of  
ABS NHS data

# Detection and treatment of Type II diabetes

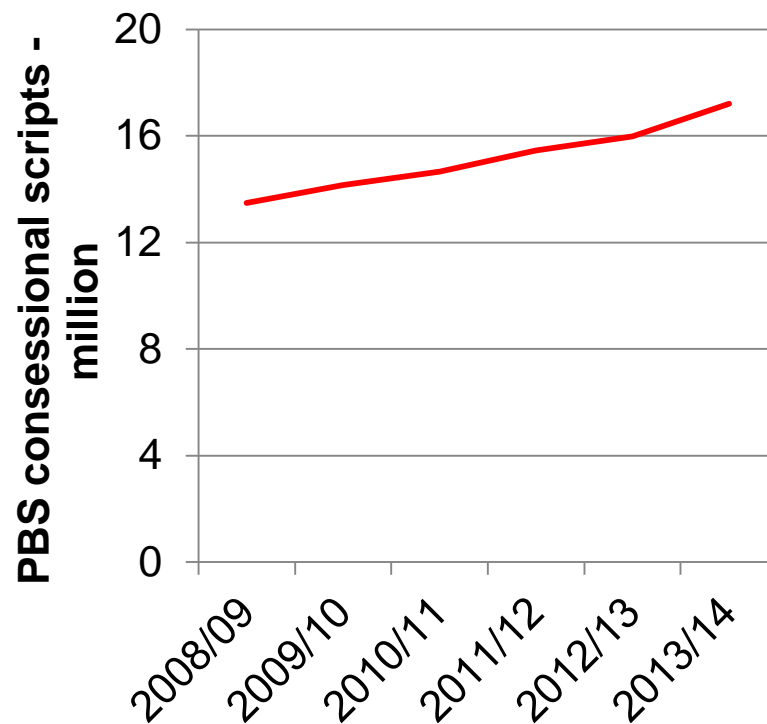
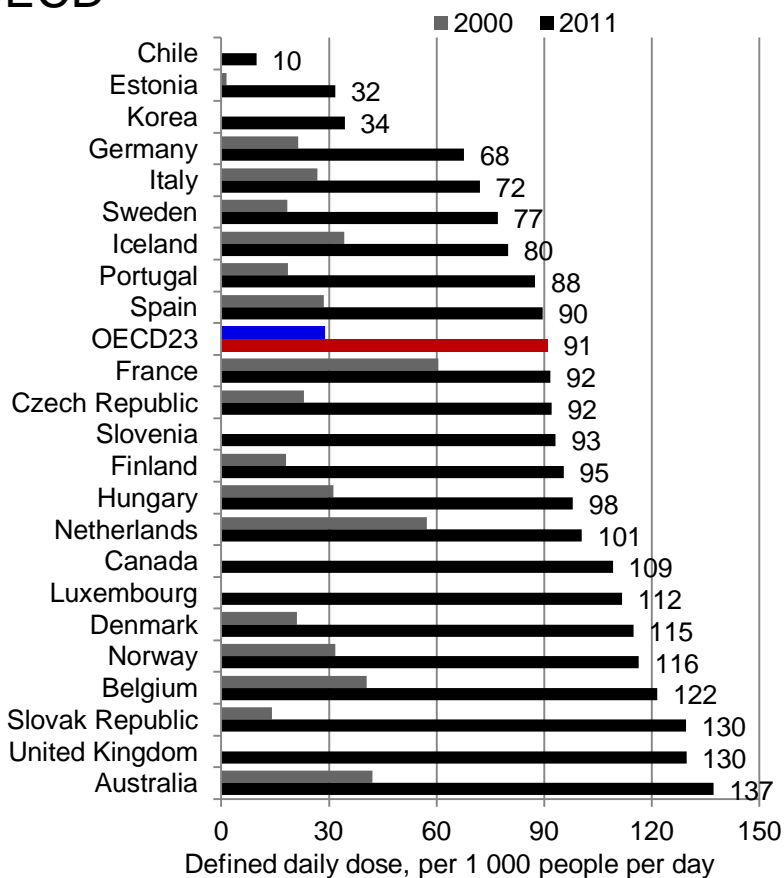
	Then	Now
Diagnosis	Emergency presentation of severe insulin deficiency	Primary care monitoring detects pre-diabetes and mild deficiency
Treatment	Animal insulin – only Large unwieldy syringes	Multiple synthetic agents Small devices
Monitoring	By doctor, blood tests and return visit	Self at home
Complications	Drug reactions Kidney failure Vision loss	Rare Preventable/ transplants Preventable
Quality of life	Repeated ED visits Loss of driver's licence	Largely unimpaired



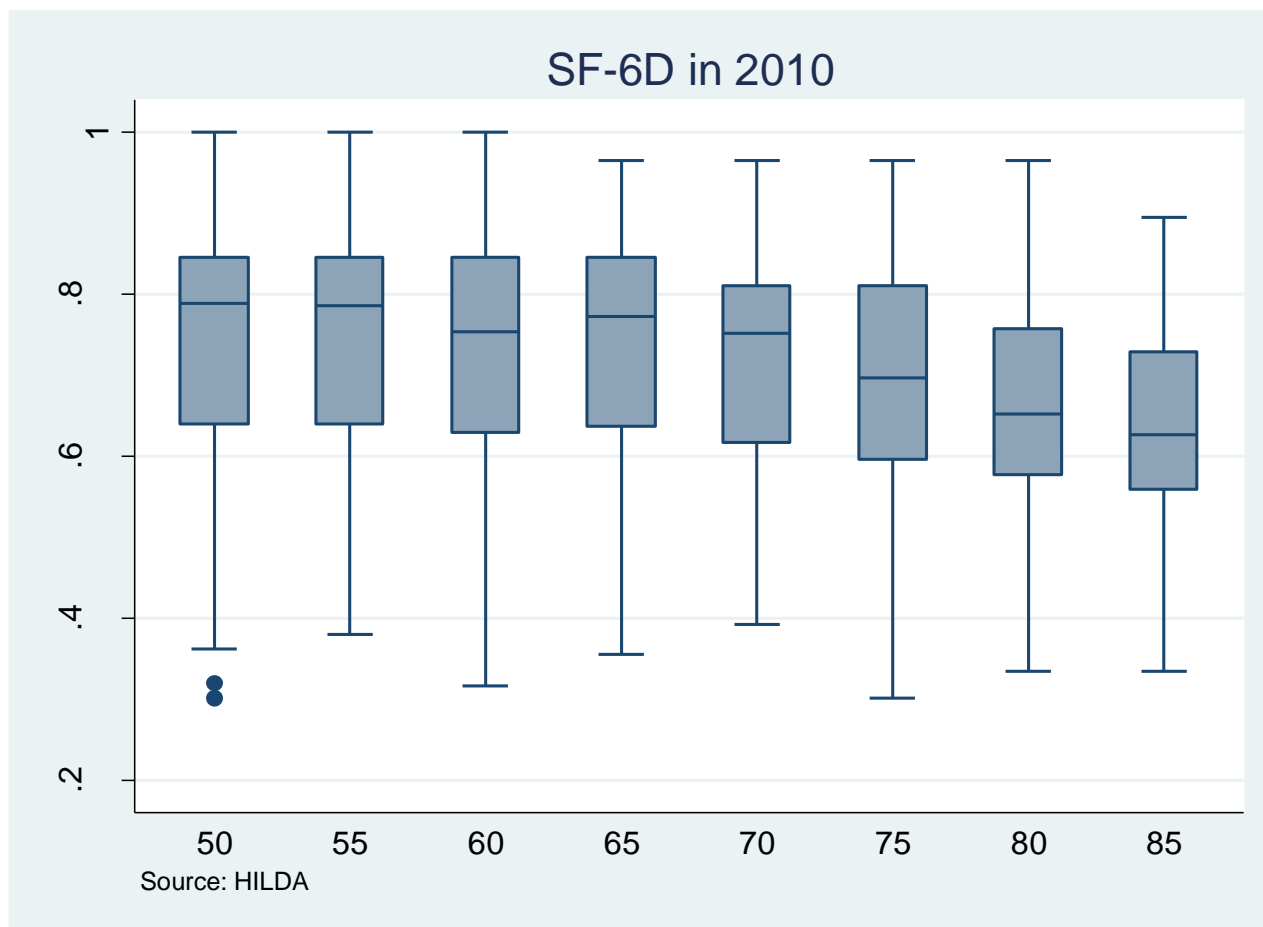
# Anti-cholesterol medications

Australia is the highest consumer in the OECD

and growing, following recent guideline recommendations



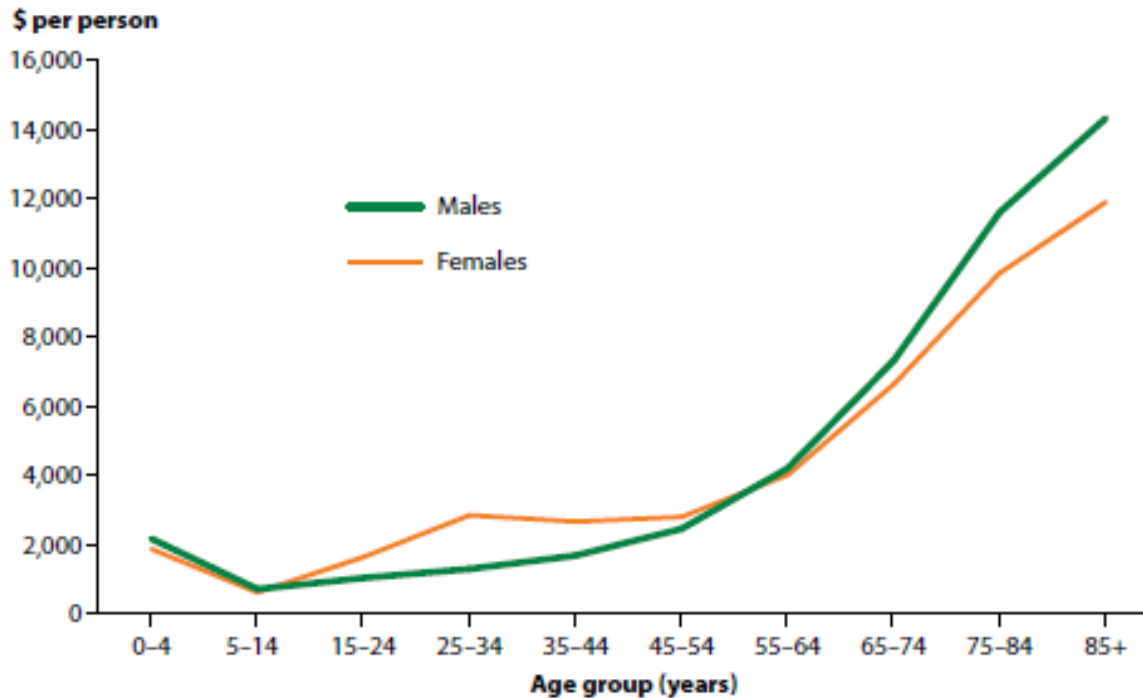
# Variation in health status by age



# Health care expenditure by age

AIHW 2014

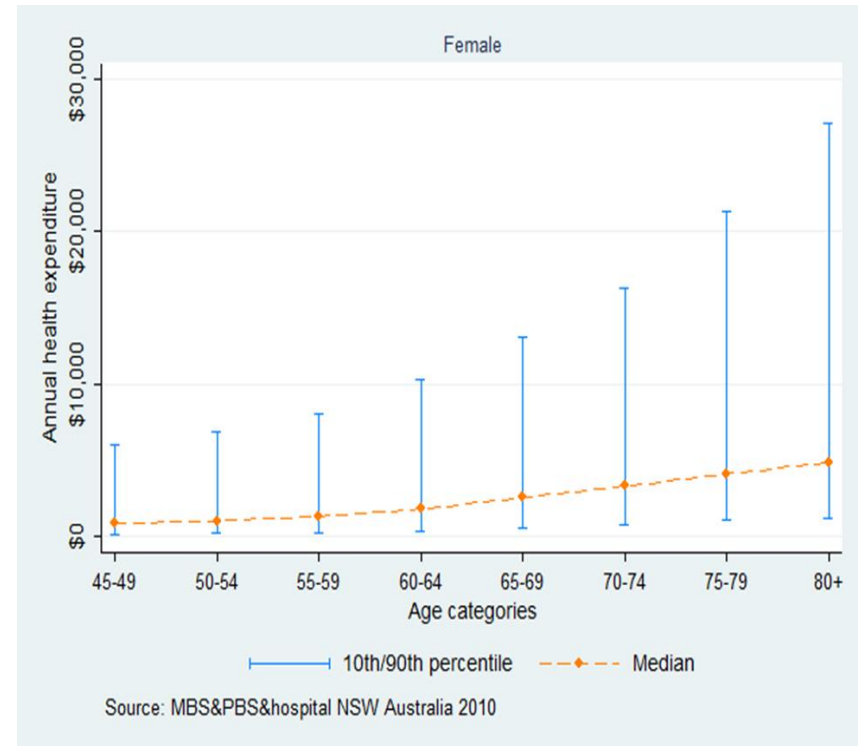
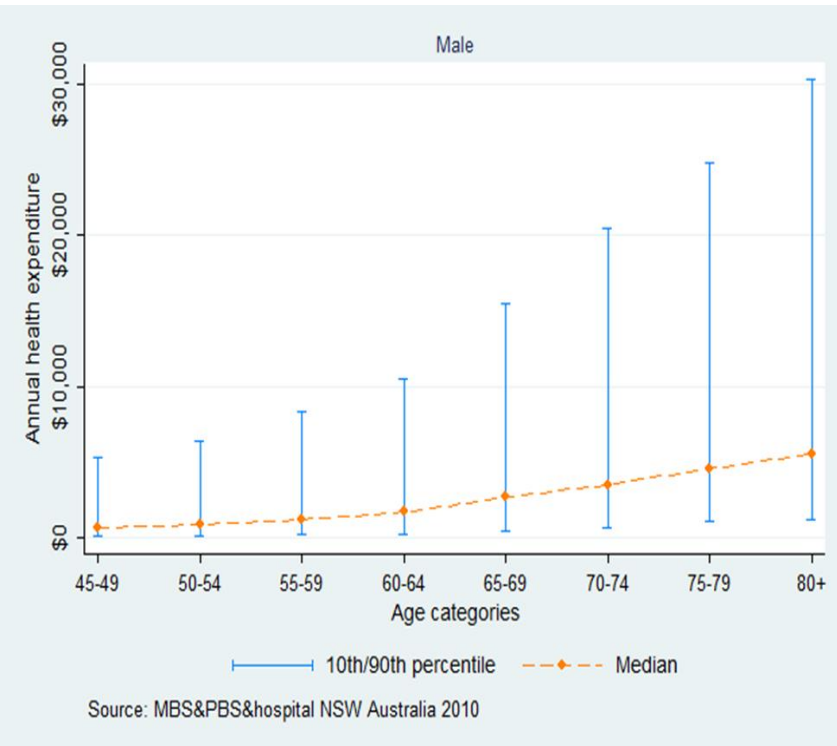
**Figure 2.10**



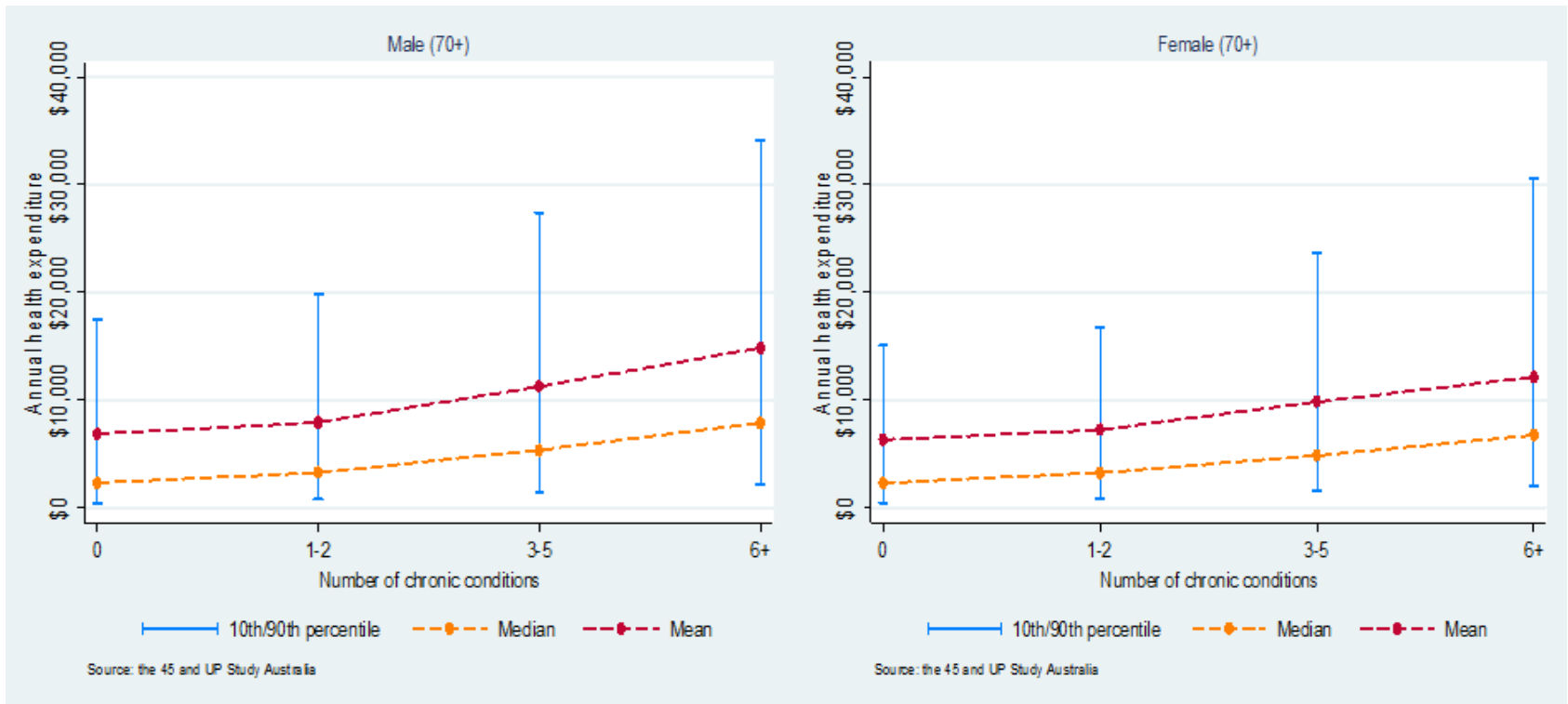
Source: AIHW disease expenditure database.

**Allocated health expenditure per person, by age and sex, 2008-09**

# Health care spending by age



# Expenditure by chronic conditions



# Summary

- Age is not destiny
  - Wide variation in health status even at older ages
- Prevalence of chronic conditions is rising
  - Diagnosis and treatment are changing
- No of chronic conditions associated with age and increased costs
  - also with increased variability
- Variation is the big story

# Financing and funding health care

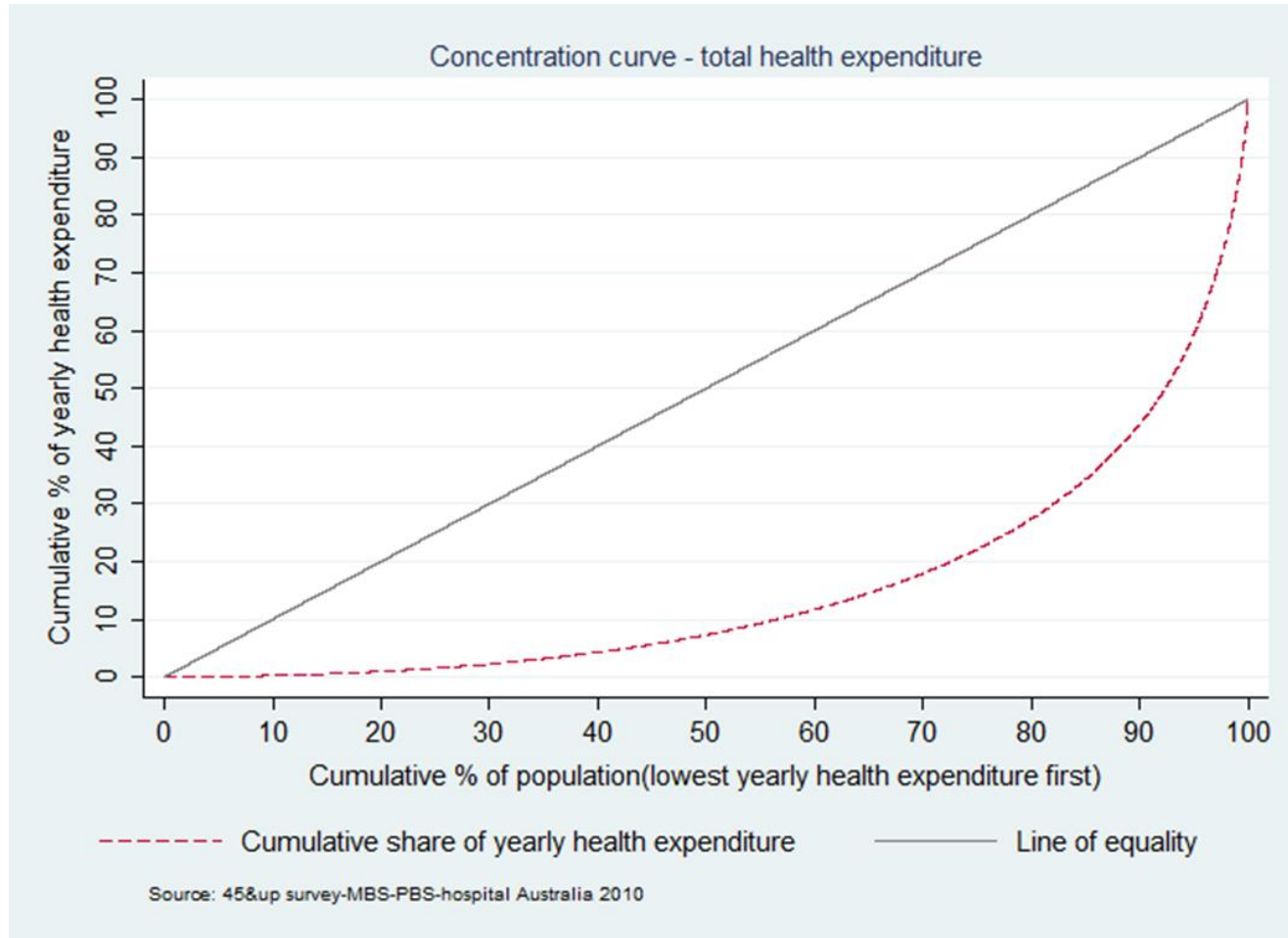
- Financing – raising the funds to pay for health care
- Funding – how we pay providers
- Third party payers separate financing and funding

# Challenge for financing

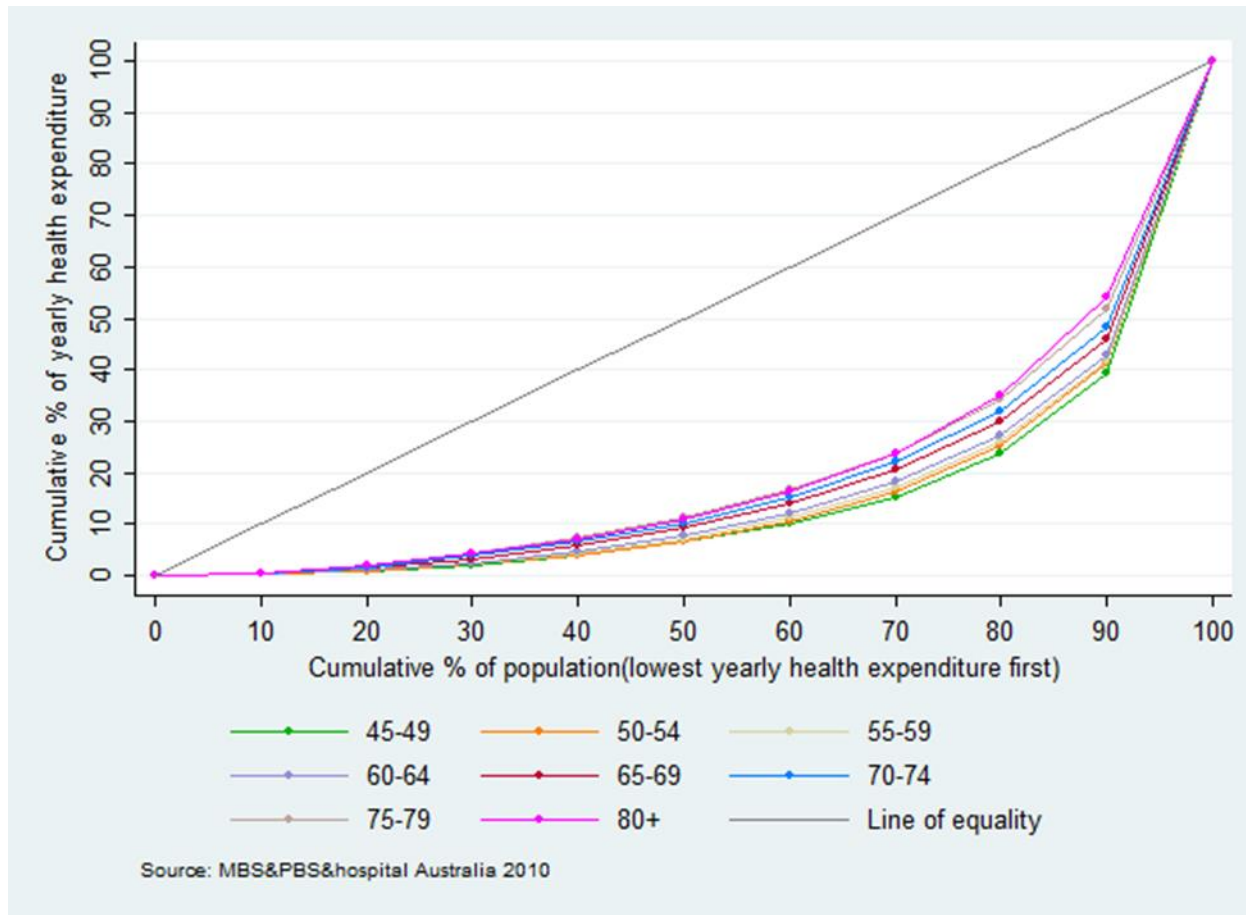
- Prevent people not getting care because they cannot afford it and reduce financial risk for those who can
- Ensure financial viability of providers
- Risk management



# Concentration of health care spending



# Pattern remains by age



# Why are some people big spenders?

- Uncertainty – unlucky to be sick
  - Severity of illness
  - Poor response to treatment
  - Condition is expensive to treat
- Use more services
- Use higher priced services
- Don't ameliorate risk
  - Opportunities for early intervention are missed

# Insurance changes the risk - Moral hazard

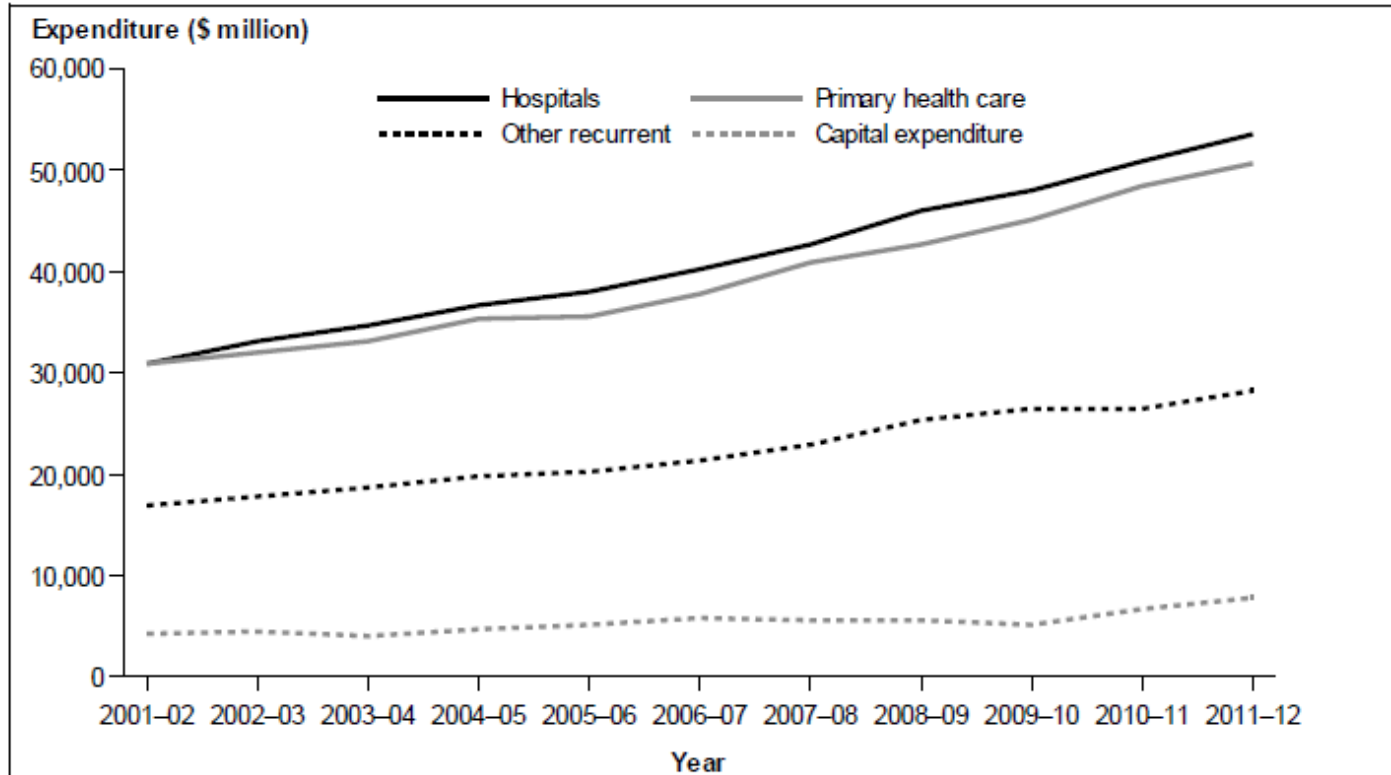
## ➤ Providers/system

- Underinvestment in services that are not insured
  - Including prevention
- Lack of efficiency
- Failure to innovate

## ➤ Consumers

- More risky behaviour
- Over use of services
- Acceptance of high cost alternatives

# Cost of primary care

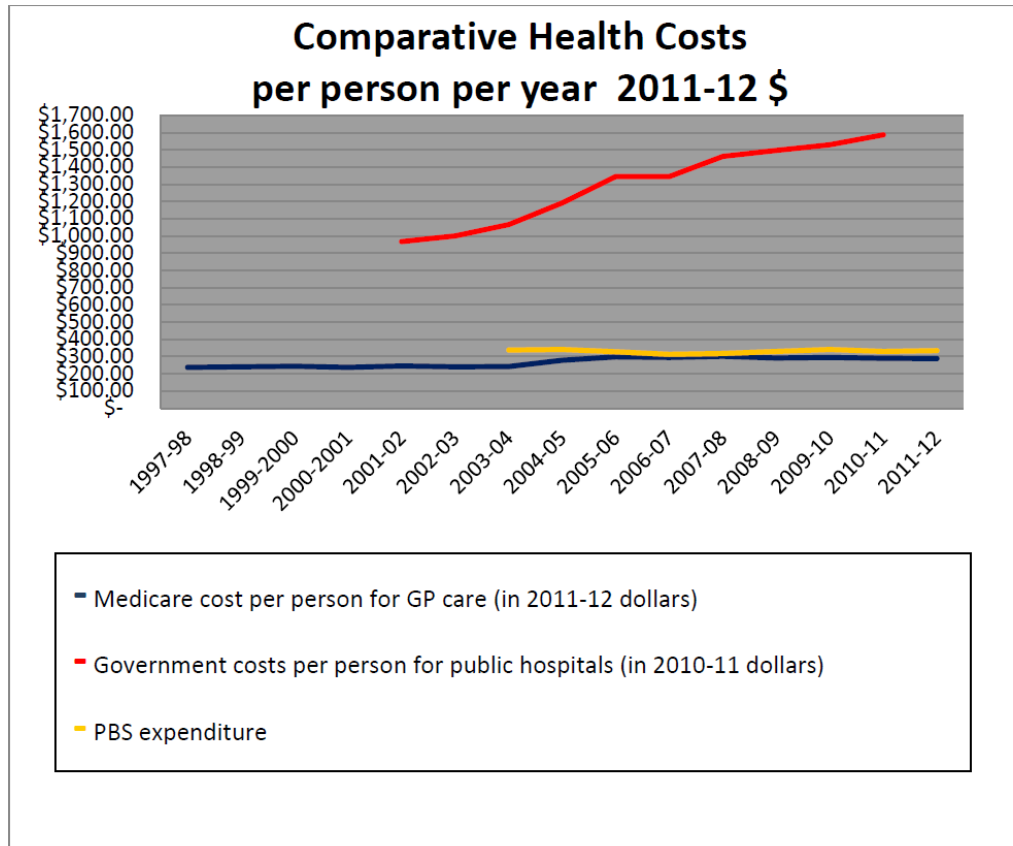


Source: Table A1.

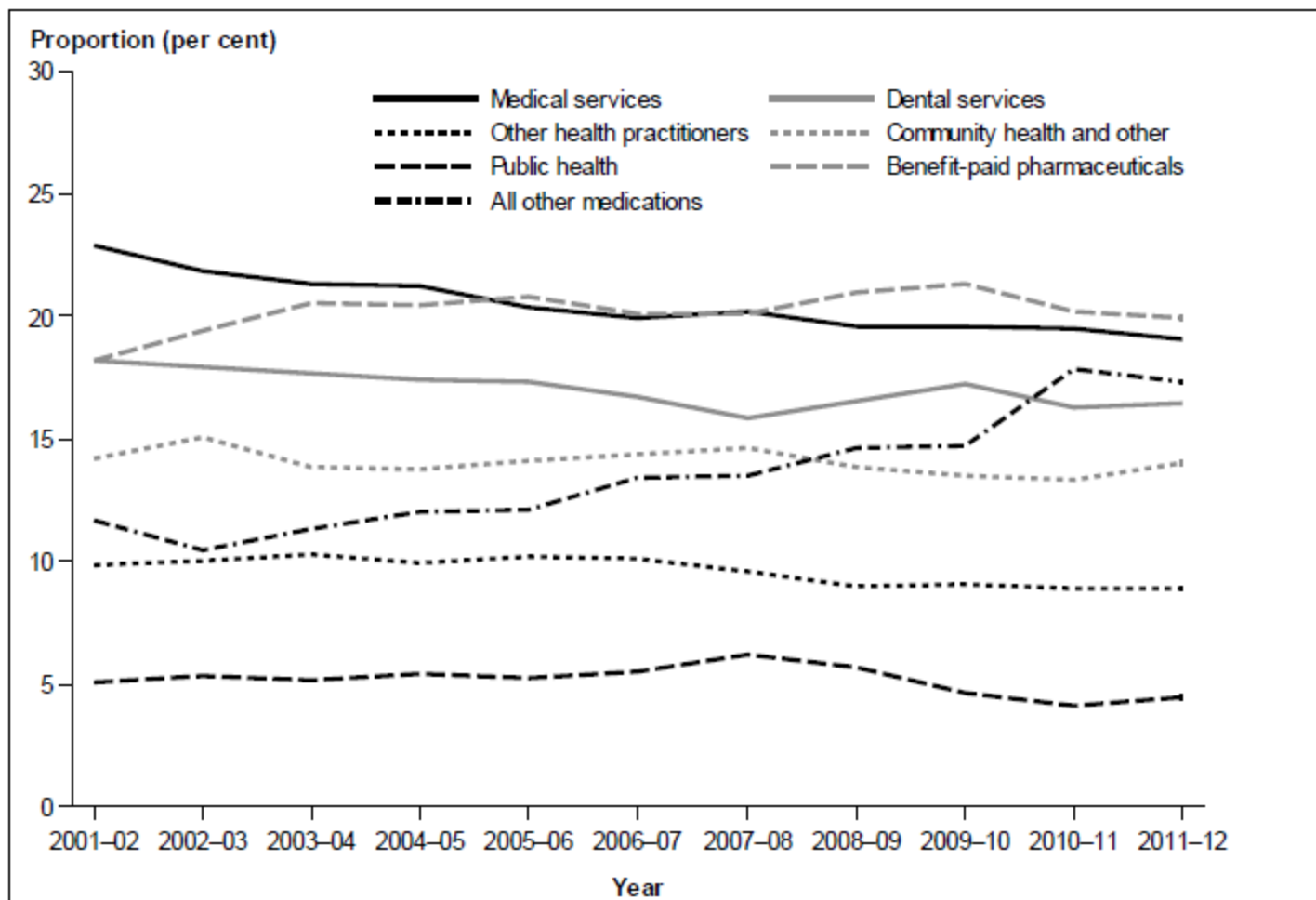
**Figure 2.1: Total expenditure on health, by broad area of expenditure, constant prices, 2001-02 to 2011-12 (\$ million)**

# RACGP view of health care cost increases

Figure 1: Comparative Health Costs per person per year 2011-12



# Cost components: AIHW 2013



Source: Table A30.

**Figure 4.6: Share of total funding for primary health care, by area of expenditure, constant prices, 2001-02 to 2011-12 (%)**

# Cost per consultation

- Level B consultation                      \$36.30
- Additional costs
  - Other treatment 53.9 per 100            \$13.50
  - Prescriptions 83.2 per 100            \$34.90
  - OTC 9.4 per 100                         \$ 0.99
  - Pathology 47.1 per 100                 \$ 9.42
  - Imaging 10.3 per 100                 \$10.30
  - ED 0.4 per 100                         \$ 1.20
- Almost 2:1



# Aims – primary care

- Improve health care for all Australians, particularly ... inequitable outcomes
- Keep people healthy
- Prevent illness
- Reduce the need for unnecessary hospital presentations
- Improve the management of complex and chronic conditions

# What is missed

- Ensure services provided are value for money
- Ensure efficient production
- Ensure referrals and additional costs are efficient and effective
- Enhance innovation

➤ *“Improving the productivity of health services is a fiscally and economically superior way of meeting health needs while containing costs than simply adjusting the quantity or quality of services provided.”*

➤ *Prod Comm 2013*

# Disclosure

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*The information and opinions contained in it do not necessarily reflect the views or policy of the Australian Primary Health Care Research Institute or the Commonwealth of Australia (or the Department of Health).*

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