Addressing the Needs of an Aging Population in the Health System: The Australian Case

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Abstract—Although smaller as a proportion of total population than Western Europe or Japan, almost 15% of Australia’s population is aged 65 years and over and expected to increase to nearly 22.5% by 2050. Health policy makers in Australia have tried multiple approaches to address the growing health care needs of an aging population and the related burden of noncommunicable conditions (NCDs). We assess how these interventions—in primary care, hospital services and private health insurance—have influenced outcomes and draw inferences from their successes and some of their main difficulties. Among the key lessons from the Australian experience, also relevant for the Asia Pacific region, are the challenge of aligning financial incentives in a mixed public-private health care and financing system and the difficulty of reforming a medically-centered primary care model to one that integrates care across a range of dimensions, including the services of allied health professionals and long-term care services. The clearest specific policy lessons for the region include the suggestions that public subsidy of private health insurance is unlikely to be an efficient approach to reducing the health-related cost burdens of aging populations, and that countries should build alternatives to fee-for-service payment mechanisms into their plans for achieving Universal Health Coverage. Australians might look to the experience of other countries in the region for additional models of coordination between national government and sub-national divisions and for approaches to reducing the disadvantages faced by minority groups in the health system.

INTRODUCTION

Australia, like most high-income countries, has a large and growing elderly population. Although smaller as a proportion of total population than Western Europe or Japan, almost 15% of Australia’s population is aged 65 years and over and expected to increase to nearly 22.5% by 2050. The rising population share of the elderly has been driven (as elsewhere) by two major factors: a decline in adult mortality rates along with lower fertility rates. A 65-year old...
Australian male could expect to live about 12.5 additional years in 1960, whereas in 2015, a 65-year old male could expect to live for 19.5 additional years (the corresponding numbers for females are 15.7 years and 22.3 years, respectively). Total fertility rates have declined from 2.9 in 1973 to 1.9 in 2013.

Australia’s greying population has led to considerable policy analysis and discussion, most often in connection with its economic consequences. In 2013, the influential Productivity Commission assessed the likely future economic impacts of aging in Australia and analyzed policy options to address the associated fiscal dimensions. The Commission was particularly concerned about a lowering of the growth of labor force participation rates and overall a decline in labor supply, along with a reduction in labor productivity and national incomes. Due to these trends in economic outcomes, the Commission projected an increase in the fiscal burden related to expenses for health services, aged care and pensions in future years. The health care sector was singled out for special attention, as the Productivity Commission considered it to be Australia’s greatest future fiscal challenge, with the share of public spending on health in GDP expected to rise sharply, from its current level of 6.5% to 10.8% in 2060, but the Commission was concerned that governments had failed to respond with timely action.

In 2005, the Commission reported that timely action to address the consequences of demographic change could avoid the future need for ‘big bang’ policy interventions later. Over eight years later, the discussion of the possible opportunities and policy challenges presented by an aging population seems to have waned.

Our focus in this paper is the Australian health sector, and how it has addressed aging-related issues thus far. Contrary to what the Productivity Commission report suggested, health policy makers in Australia have tried multiple approaches to address the growing health care needs of an aging population and the related burden of noncommunicable conditions (NCDs). Our goal is to assess how these interventions have worked to influence outcomes and draw inferences from their successes and their main difficulties. The experience with these interventions can provide important lessons for health policy steps that future Australian policy makers might consider. Moreover, an analysis of the Australian experience can serve as a guide for countries in the broader Asia Pacific region, many of which are currently grappling with the related challenges of NCDs and aging, and others that are likely to face these challenges in the future. As elsewhere in the region, the Australian interventions were undertaken in a climate of significant health sector resource constraints; and Australia has struggled with ensuring affordable services to groups that are geographically remote or especially disadvantaged, such as its indigenous populations, a factor in common with other Asia Pacific countries.

The interventions that will concern us fall into three broad areas of health sector activity: primary care provision, hospital services, and private health insurance. The first two account for the vast majority of health services provided and supported by public sector health funds in Australia, but our emphasis will be on elements that are of particular relevance to aging populations, including the prevention, management and treatment of chronic conditions. Private health insurance is included because it is a key mechanism through which Australia has sought to ease the burden on public funds for health, while seeking to ensure that the public funds for health provide a safety net, and because many countries in the Asia Pacific region—such as Philippines, India, Malaysia and others—rely extensively on private health insurance financing for health.

BACKGROUND ON AGING AND THE AUSTRALIAN HEALTH SYSTEM

The Australian health system is a mixed two-tiered system with a universal publicly funded tier, known as Medicare, which subsidises primary care and fully funds hospital care, and a voluntary (subsidized) private health insurance tier, which provides coverage for private hospital care and ancillary (non-General Practitioner) primary health services.

Primary care provided by medical practitioners is financed through Medicare and out of pocket (OOP) payments (private health insurance is prohibited from covering these and certain other services). The Medicare Benefits Schedule (MBS) specifies a fee-for-service and reimburses 85% of that fee. Medical practitioners are not required to adhere to the fee but can set their own price without restriction. Consumers pay the difference between the scheduled fee and the practitioner’s fee. Policy initiatives in 2004–5 provided incentives to restrain price to the scheduled fee known as ‘bulk-billing’, such as: direct reimbursement from Medicare, avoiding individual billing; a $5 ‘bulk-billing bonus’ for each bulk-billed service for those aged under 16 (2004); and an increase in the reimbursement rate from 85% to 100% of the Medicare schedule fee for bulk-billed services. More than 80% of General Practitioner (GP) consultations are currently bulk-billed, with the highest rates for children, low-income groups including those receiving government welfare payments, and people living in urban areas. Primary care is
also provided by directly state funded community health services, and by independent providers of allied health services such as dentistry and physiotherapy that are paid for out of pocket or via private health insurance.\(^8\)

The Commonwealth (national) government retains most revenue raising powers while States (and Territories) have responsibility for public health and health service provision, and so rely on financial transfers.\(^7\) The division of responsibilities between State governments and the Commonwealth government is understood to undermine cohesive national reform. Some coordinated policy measures have, however, been successfully negotiated, most notably through the National Health Reform Agreement (NHRA) of 2011. These include the requirement for cost-effectiveness evidence for pharmaceutical reimbursement through Medicare (since 1993) and for medical procedures (since 1998), and the gradual introduction of activity-based payment for public hospital funding, which began in Victoria in 1993 and was expanded to all states as part of the 2011 NHRA.\(^7\)

Another key policy issue of the Australian health system is the disadvantage experienced by the indigenous population. Although indigenous populations account for only about 3% of Australia’s population (and 3.4% of its population), improving their poor health status and high burden of non-communicable diseases has remained a longstanding policy objective.\(^9\) Aboriginal use of services covered by the MBS and the pharmaceutical benefits scheme (PBS) under Medicare has historically been significantly lower (<40%) than that of other Australians.\(^10,11\) In contrast to the usual division of Commonwealth government financing and State government administration of health care, the Commonwealth government directly administers an Aboriginal primary health care program that provides funding for Aboriginal health services across the country, and this has been an important mechanism for more equitable health financing. Aboriginal community-controlled health services (ACCHS) grew out of the civil rights movement that campaigned for the constitutional changes of 1967 (recognizing the equal status of Aboriginal Australians) and were established from 1971.

Besides the direct provision of services through ACCHS, specific Aboriginal health policy also began to be developed from the early 1970s. Since 1995, the main vehicle for this has been Framework Agreements signed off by members of Commonwealth and State governments and representatives of the ACCHS and the Aboriginal and Torres Strait Islander Commission (ATSIC) regional councils. These have developed regional plans for Aboriginal health and statements of intent, including for extending access to health care, increasing resource allocation for Aboriginal health, joint planning and increased accountability. Alongside these developments, measures to increase enrollment of the Aboriginal population in Medicare and improve utilization rates of the enrolled have included relaxing the bureaucratic procedures for enrollment, reimbursing services provided by nurses and Aboriginal health workers (in contrast to the mainstream system in which only doctors’ services are reimbursed), and removing co-payment requirements under PBS. Although these measures have led to per capita spending for indigenous Australians that is higher than non-indigenous populations, this is probably insufficient to reflect the former’s greater level of need. Moreover, Medicare spending is driven by the availability of doctors and their scarcity in rural and remote parts of Australia is a major driver of continued regional inequity in funding.

**Aging and its Implications for the Australian Health System**

Aging populations can influence health systems in multiple ways. These include firstly, increased use of health services by older age groups. Fig. 1 shows that hospitalization rates among Australians 65 years and older are more than four times their younger counterparts, among both indigenous and non-indigenous populations. Available data also show that the share of patients 65 years and over in GP visits increased...
from 27.9% in 2006–7 to 30.7% in 2015–16. A person over 65 in Australia makes over 10 visits to a GP annually, more than double the rate of under-65 individuals, so growing numbers of elderly will continue to account for a growing share of health services in future years.13

Health service requirements of the elderly are also more complex because of their high levels of multi-morbidity. Data from the Australian Health Survey (2014–15) show that the share of Australians reporting three or more chronic conditions was 29.3%, almost double that of the 45–64 age group, and nearly 12 times that among Australians in the 0–44 age group (Fig. 2). Within the 65+ age-group, differences in multi-morbidity rates were small, whether considered by remoteness of location or socioeconomic status. However, data from the Australian Health Survey also show that in the 45–64 age group, multi-morbidity rates (three or more chronic conditions) are highest among individuals living in the poorest areas and in more remote areas of Australia. This is a good proxy for multi-morbidity rates among Australia’s indigenous population, who have a life expectancy that is lower by 10 years compared to the non-indigenous population.14

Rates of multi-morbidity were proportionately higher in the 65+ population attending general practice compared to other age-groups. Results from a large study of patients visiting GPs in Australia suggest that almost 70% of the patients over 65 years of age had three or more chronic conditions. The most common cases of multi-morbidity involved some combination of hypertension, hyperlipidaemia and osteoarthritis. Obesity was not included as a condition in this analysis but affected 28.6% of patients attending a GP.15 Increased number of visits by older people with multiple morbidities have implications for pressures on general practice, as such patients are likely to require more extensive management (and coordination) than the conditions presented by younger patients. There are also implications for patients across the lifespan who may find their access to general practice squeezed, or expertise in their conditions limited. The younger age groups (0–4 and 5–14) are those for which decreases in share of patient visits to general practice are largest and general practitioners may become less expert in their conditions over time.

Disability is also an important issue related to aging that requires health system response, in combination with other social support measures. Fig. 3 reports data from disability surveys periodically carried out by the Australian Bureau of Statistics (ABS) showing that rates of severe activity limitations among the elderly, while declining slowly over time, are much higher than among their younger counterparts. People with disabilities are likely to face more difficulty in accessing health services. They are also more likely to need health care as chronic conditions tend to be correlated with disability. The Australian Burden of Disease study identified cardiovascular disease, neurological conditions (e.g., dementia), musculoskeletal disorders and respiratory conditions (such as asthma and COPD) as among the major causes of non-fatal burden of disease in the country.16 People with disabilities need support with activities of daily living, and this is provided, in Australia, through a mixture of residential care, community-based support and the family.17 However,
because of their health care needs, coordination between social support and medical services is also needed.

How has Australia performed with respect to an aging population with a significant burden of chronic illness? In a recent survey of adults in 11 high-income countries, 14% of the Australian respondents reported cost-related access problems, about the average for the 11 countries sampled; and generally, Australia was placed in the top half of the ranking for indicators of access, including availability of specialists and after-hours care. Responses by Australian adults with chronic conditions also suggest that Australia was among the better performers, although there were obvious issues of concern: 24% of adults with a chronic condition did not discuss their goals and priorities of caring for their condition in the preceding year with a health care provider, and 26% did not discuss their treatment. 18

However, focusing on patients with greater need, including individuals with multiple chronic disease morbidities, suggests challenges not apparent from a survey of adults alone. In a 9 high-income country survey among patients identified with a higher level of need (individuals with three or more chronic conditions or that needed help with activities of daily living), 19% reported cost-related problems with access to health services (second worst after the US); 11% reported an unnecessary emergency department visit; 32% reported problems with care coordination (behind the best performing France and Netherlands); and 13% thought a medical mistake was made (third worst after Sweden and Switzerland, and alongside US) in their treatment. On the positive side, 84% of the high need patients reported having a treatment plan (second best after US). 19

To get at the views of primary care providers, a 10-country survey of primary care practices found that 85% of Australian primary care practices reported being well prepared to manage patients with multiple chronic conditions (just after Germany, Netherlands and Norway). However, less than 50% claimed to be well prepared to manage the needs of patients with dementia or patients who needed long-term home care services. Only 18% of primary care practices reported they would be notified if a patient were discharged from hospital or Emergency Department (second worst after Sweden); and only 45% reported coordinating care with community care providers (one of the poorer performers). Overall though, almost 50% thought that the health system was working well with only minor changes needed; and generally Australian physicians were less dissatisfied and stressed than primary care doctors in the other countries included in the study. 20

RESULTS

Our results are presented in three sub-sections, focusing on primary care services, hospital services, and private health insurance.

Reorienting Primary Health Services to Address Aging in Australia

The structure and financing mechanisms of the Australian system show multiple limitations in its capacity to adapt to the demands of an aging population with multi-morbidities. The division of primary care into its three elements (general practice, state-funded community health services and independent allied health services) presents a challenge for integration and for the development of primary care teams. The three are funded by separate mechanisms, being directly publicly funded (community health services), privately funded (allied health services), and publicly subsidized through Medicare (GP services).
One attempt to improve integration of primary care has been the reorganization of general practice governance.7 The 2011 NHRA established 61 Medicare Locals replacing 108 Divisions of General Practices as the coordinating and oversight bodies of general practice in defined catchment areas. These were intended to facilitate access to allied health care, identify underserved groups and ease transitions between hospital and community.8 The Medicare Locals were later replaced by 31 Primary Health Networks. One of the drivers of this last reform was the objective of ensuring more private sector involvement in primary care governance, and most Primary Health Networks were awarded to consortia of Medicare Locals and private health insurers.8 Their role is to improve effectiveness, efficiency and coordination of care delivery through the commissioning of services.21

Both reforms (the establishment of Medicare Locals and the subsequent move to Primary Health Networks) have involved centralization of functions and this has been unpopular with general practitioners.22 This centralization has allowed less scope for direct participation by GPs, and the Medicare Locals, for instance, were considered less aware of local needs, especially of rural practices, from their mainly urban locations. Other studies report attempts by individual Medicare Locals to improve primary care provision, but it cannot be concluded that this is representative across Medicare Locals.23 In any event, the bulk of primary care funding continued to support fee-for-service visits even after both reforms were in place and this may be the critical factor in constraining integration.8

Primary care integration has also been encouraged by the chronic disease management initiative, instituted in 2004. Under this initiative, new items were added to the Medical Benefits Schedule to enable GPs to refer eligible patients to allied health professional services in private clinics, with the costs subsidized by Medicare: up to five allied health consultations were permitted per patient per year.24 The initiative also provided for reimbursement of specific services provided by registered nurses on behalf of GPs.25 New referrals flowed to physiotherapists and podiatrists in the largest numbers as a consequence, followed by dieticians.26 However, the uptake of the program has been low over the years, with the average GP preparing 22 chronic disease management plans per year.24 This is despite some evidence that patients are enthusiastic about the approach and of population-level effectiveness in increasing the regularity of GP service utilization in the population aged over 65.27,28 One study found that women patients with two or more chronic conditions and patients from metropolitan areas had a higher probability of being offered a multidisciplinary team care arrangement, implying greater difficulty in encouraging these for men in rural areas.29 Others have suggested that the problems of coordination have to do with more practical concerns and relate to the poor understanding of Medicare provisions and associated software options, and shortage of appropriately trained nurses.30

Studies also suggest a move away from general practitioners working alone and providing episodic opportunistic care toward greater focus on prevention and early intervention, and structured chronic disease management within multidisciplinary care team approaches.25 The 2012 Australia Medicare Local Alliance National Survey indicated that the number of registered nurses working in general practices was increasing, as was the proportion of practices employing a registered nurse. Nevertheless, current financial incentives still emphasize physician-led primary care, as only general practitioners can claim the reimbursements, and that team care requires further delegation of authorities than current arrangements permit. A study of two super clinics in New South Wales and Victoria suggests that these problems affect multidisciplinary case management in such settings more generally.31 A lack of meaningful support for transformation of care models, and the lack of effective incentives for collaborative care in fee-for-service billing arrangements were identified as the factors hindering the achievement of the initiative’s objectives. Donato and Segal argue that a successful model of reform will require a “meso-level” organizational structure, capitated single fundholding arrangements, blended payment methods for reimbursing providers, the establishment of a national quality and performance framework, and development of primary care infrastructure.32

Perhaps secondary to the problem of integration of multidisciplinary inputs into primary care is the problem of an adequately preventative approach, which is also undermined by a fee-for-service funding model. In 1999, cost reimbursement for health assessments for Australians aged 75 years and over was introduced under Medicare to promote early identification (secondary prevention) of symptoms and precursors of chronic conditions. This resulted in a 6-fold increase in the number of health assessments between 1999 and 2009. Moreover, data for up to 2008–9 show that the 75–84 age group made greater use of the assessments than the 85+ age group and that women in the latter age group made greater use than men.33 The most disadvantaged populations have similar or higher levels of uptake of the extended primary care services in total (which include both chronic disease management plan services and the health assessments).34 Overall though, only about one-fifth of the eligible population has received a health assessment.
Indigenous Australians were initially entitled to reimbursement for the assessment at age 55 and later at any adult age, given the earlier age of onset of chronic disease in this population and higher rates of infectious disease. While the health assessments had not been widely taken up by 2004 in the general population of Aboriginal and Torres Strait Islanders, and assessment rates were lower among older than among younger people, uptake has since increased sharply, from 7.4% in 2006–7 to 32.5% in 2013–14. Unfortunately, a direct comparison with the non-indigenous population is not possible as a change in Medicare reimbursement categories after 2010 makes it difficult to identify the use of health assessments by people aged 75 years and over in the non-indigenous population.

Aging and the Australian Hospital System

The main issue for the hospital system in responding to the aging of the population is the avoidance of unnecessary admissions and unnecessarily long lengths of stay. Both issues are related to coordination of hospital services with the primary care system and other community support structures.

Unnecessary admissions arise when a problem has not been managed appropriately in primary care whether because vaccination has been missed, poor management of complications has resulted in an emergency warranting hospitalisation, or because of adverse drug effects that could have been avoided through better monitoring or awareness of drug interactions.

The Australian Institute of Health and Welfare estimates a national rate of 25.2 potentially preventable hospitalizations (PPH) per 1000 population that is distributed across vaccine preventable conditions, selected chronic conditions and selected acute medical conditions. This rate has been increasing slowly between 2010–11 and 2014–15, possibly reflecting the growing prevalence of chronic conditions. The rate of PPH among indigenous Australians is almost three times that among non-indigenous populations, and is higher among individuals belonging to the lowest socio-economic status (SES) category compared to the group belonging to the highest SES category (Fig. 4). Although not shown in the chart, there is considerable inter-state variation, with Northern Territory having the highest PPH rates (50.2 per 1,000), compared to Tasmania with the lowest rate (19.0 per 1,000).

Increasing age and increasing number of medications are strong predictors of potentially preventable hospitalizations, partly due to adverse drug effects. The problem is estimated to be particularly acute for those suffering from diabetes, only one in five of whom are estimated to receive best practice care. The incidence of diabetes complications resulting in potentially preventable hospitalizations in the indigenous population is four times that of the rest of the population. Because this problem originates in primary care, the policy reforms discussed in the previous section are among those that aim to tackle it. The issues of unnecessary extra length of stay in hospital and readmission after discharge relate in part to the transitions between hospital and primary care, and more generally those of coordination and continuity of care between hospital care and primary care. Podger suggests that the Australian system does not manage well the frail elderly who need hospital care, resulting in excessive numbers of admissions and readmissions.

The division between Commonwealth and State responsibilities is often identified as the root of continuity of care problems in the interface between primary and hospital care. For example, it has been suggested that the efforts by the commonwealth government and states to shift healthcare costs to each other have adversely affected coordination of...
care, particularly affecting patients with chronic and complex conditions. However, a recent influential study of the Australian health system notes that problems in this interface appear equally or more seriously in countries with unitary systems, using evidence from the 2014 Commonwealth Fund survey focused on the experience of older adults. Thus the issues may be more fundamental ones in the cultures of primary and hospital care and relevant to a wide range of contexts.

Recognition that there are significant problems in the transition between hospital and primary care, particularly for older adults, prompted the “transition care” program, introduced in 2005. It has been estimated that 12% of all general medical admissions are complicated by functional deficits, with the problem concentrated among older age groups. The transition care program is intended to support the transition from hospital to residential care or community of older patients as they are discharged from hospital. The majority receive services in their own home, and the services include home help and personal care, rehabilitation including physiotherapy and occupational therapy, nursing care and case management over an 8- to 12-week period. The intention is to minimize inappropriate extended hospital stays and unnecessary residential care.

Available data suggest an uneven distribution of access to the transition care program across Australia. For those who achieve access, the program has been evaluated as contributing effectively to improvements in quality of life for older frail people, with the magnitude of the gain associated with the intensity of the intervention. While it was not assessed as being capable of generating cost savings for the health system, it was estimated to have some impact on reducing hospital readmissions and preventing or delaying residential care admissions. An analysis of the client experience found that many recognized the contribution of the program to their recovery, but they also found their situation, sometimes requiring a recognition that they will not return to their previous level of function, disempowering. Fragmentation of service delivery, lack of control of the client over the services delivered, and uncertainty about future support were identified as the issues whose resolution would increase benefits from the program.

In part, the difficulties of transition relate to the availability of residential aged care. Podger, writing in 2006, pointed to about 2,000 elderly people in hospital awaiting residential aged care. There have been significant developments in the residential aged care system in the last decade in Australia which are considered outside the scope of this review. Given the various influences on the numbers of elderly awaiting residential care, including the transition care program, epidemiological and demographic change as well as residential aged care provision, it is unclear how that number might have changed, although a recent inquiry heard that the problem remains extensive.

**Private Health Insurance in Australia**

The introduction of Medicare in 1984 was followed by a decline in private health insurance. Private health insurance contributed 20.1% of the total health expenditure in 1982–83 but had fallen to contributing only 6.9% by 1999–2000. The private health insurance coverage level was subsequently stabilized by a series of measures including public subsidies, a means-tested Medicare levy surcharge applied through the tax system to high income earners who fail to take out private health insurance, and a lifetime surcharge on the community rating applied to those who fail to take out private health insurance by age 30 on a sliding scale.

There are two critical issues for private health insurance markets that are related to aging. The first is the increased average risk profile in the population and its implications for market equilibria in which adverse selection is balanced relative to other factors. The second is its implication for the use of private services by the better off (including the wealthier elderly) thereby serving an equity objective by better directing public subsidies toward the poorer groups (including the elderly poor).

One set of scholars has suggested that it is not just the risk characteristics of individuals and the associated issue of adverse selection that drive the equilibrium in the Australian health insurance market. Other factors, particularly risk aversion among individuals, have helped create a demand for private health insurance among the healthier populations and prompted preventive behaviors, both counteracting adverse selection and helping constrain private health insurance premiums. This view is not universally held. The perception that the post-1984 Australian market was in an adverse-selection-driven “death spiral” was what prompted the Howard government’s reforms to private health insurance introduced between 1997 and 2002. Data from Australia’s Annual Health Surveys suggest that private health insurance coverage has slowly increased over several years following the reforms. Moreover, richer individuals tend to have significantly higher levels of private health insurance than their poorer counterparts.

The reforms to private health insurance had a price. The costs of tax rebates and concessions introduced in this period have been estimated at over AUD 5 billion, whereas the cost of the surcharge for late enrolment in private health insurance (known as “lifetime cover”) is privately rather than publicly
incurred. However, this conclusion has been partly challenged by analyses of individual-level data rather than the aggregate-level data that the earlier authors relied on. In particular, analyses using individual-level data have been used to suggest that for single enrollees, the tax rebate reinforced the effect of the lifetime cover provisions. For families, though, the conclusions reached are the same as the earlier studies. The effect of the tax rebate reduced the effectiveness of the lifetime cover to the extent that it reduced the future surcharge associated with late enrolment. However, a recent study that also used individual-level data from the Australian Health Survey explored the effects of the jump in tax rebate on private health insurance that occurs at ages 65 years and 70 years, and found no effects on private health insurance coverage in these groups.

In relation to constraining use of public services, earlier research suggested that the effect of the Howard-era reforms was principally to increase coverage rates among the young, and is unlikely to have resulted in lowering utilization pressures on public hospitals. Private health insurance did not significantly shift users from public to private services, and a major continuing problem is the lack of incentives to use private health insurance within the public insurance system. About 50% of PHI policies have deductibles or exclusions that require policy holders to pay out of pocket when using hospital care, creating a disincentive to use private health insurance in public hospitals where treatment is otherwise free. The only positive incentive to use PHI in a public hospital is the right to choose the treating doctor, and this was considered important by only 25% of those surveyed. Since public hospitals have incentives to attract revenues through PHI, one strategy frequently employed is to ensure that no private patient is paying out-of-pocket by covering those costs. Studies also show that privately insured individuals get a better mix of services in public hospitals: they are more likely to see a specialist instead of a general practitioner and get their own choice of doctor (and better service quality) in public hospitals. Recent data from the Australian Institute for Health and Welfare also show that privately insured patients in public hospitals had half the length of waiting times for surgeries than their publicly funded counterparts, which raises concerns about equity. Then there is the behavior of hospitals themselves. Data on inter-hospital transfers for Australia suggests cream-skimming, in that sicker patients are much more likely to be transferred from private hospitals to public hospitals, relative to transfers of patients from one private hospital to another, and from public hospitals to private hospitals.

The conclusion from this literature is that despite the high costs of the Howard reforms of private health insurance (PHI), they have failed to contribute to cost control in the public system as intended even as the effects of population aging on the public system continue to grow. If PHI is to play a role in cost containment, then further reforms will be needed to ensure that the hospital costs of those privately insured are covered through the private insurance system. Many commentators consider that the subsidies provided to PHI would be considerably better invested in the public system. Equity may improve too, given that PHI coverage rates are higher among the better off, and that treatment, even within the public system, varies by PHI status.

CONCLUSIONS

Aging is emerging as a significant policy concern on the radar of policy makers in the Asia Pacific region, and Australia’s long experience with health systems policies addressing aging and NCDs can potentially provide lessons for countries in the region given important contextual similarities. The public-private mix of the Australian health system has characteristics in common with systems of countries such as India, Malaysia, Mongolia and Philippines, where segmentation of health services by population group that predominantly uses them is common. In India, like Australia, revenues are concentrated at the national government level and responsibilities for delivery exist at the state level. Issues arising from a mix of centralized and decentralized governance also arise in countries without formally federal systems but with uneven distribution of revenue and responsibility between national and provincial governments as in China and Indonesia. The public insurance programs in India that fund hospital services in both public and private hospitals are likely facing similar issues of patient-shifting across hospitals as have been seen in Australia. In common with Australia, countries in the region face the challenge of reforming a medically dominated primary care system with better-balanced use of multidisciplinary inputs to support health across its multiple dimensions. The more general problem is how to rebalance the system away from a model based on the treatment of individual diseases and over-dependence on hospitals. Policy concerns about addressing the distinct health needs of vulnerable, minority and...
indigenous populations and challenges of access to health services in rural and remote regions are also something Australia shares with many other countries in the Asia Pacific.

Among the key lessons that the Australian experience provides is the importance of aligning financial incentives in a mixed public-private health care and financing system and the difficulty of reforming a medically-centered primary care model to one that integrates care across a range of dimensions, including the services of allied health professionals and long-term care services. The clearest specific policy lessons for the region include the suggestions that public subsidy of private health insurance is unlikely to be an efficient approach to reducing the health-related cost burdens of aging populations, and that countries should build alternatives to fee-for-service payment mechanisms into their plans for achieving Universal Health Coverage. In the Australian context, it has been argued that primary care practitioners are, by definition, patient-focused (not disease-focused) and that the governance of primary care systems needs to recognize that disease-oriented quality standards, bases for payment and practice guidelines are consequently often inappropriate. Replacing fee-for-service payment systems with alternatives that provide better incentives for integrated care and preventative interventions is desirable, rather than waiting until after they have become entrenched.

In applying these lessons for developing policies toward aging populations in the broader Asia Pacific region, one must also acknowledge important gaps and differences with the Australian situation. Australia has not been particularly effective in closing the gap between health outcomes between the indigenous populations and the rest, despite multiple strategies over many years. As a high-income country, Australia’s budgetary challenges are less pressing than many of its regional counterparts, and policy priorities (e.g., economic growth and poverty reduction) may also be different. In the context of service delivery, many countries have invested little in nursing and allied professions relative to Australia, with Australia starting from a stronger position to develop team-based primary care than most. Finally, Australia is not confronted by an unfinished infectious disease agenda and the consequent tension between investments in maternal and child health and in the health of older populations that confront other countries in the region.

Nevertheless, the Australian experience underlines that the challenges facing health systems in a rapidly aging region are not dichotomized between its richer and poorer countries. There is a great deal of opportunity for learning across countries in relation to the experience of policies and policy change from the past, and perhaps even greater opportunities as the challenges of aging populations become more acute throughout the region and the range of policy experimentation widens and deepens.

DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST

No potential conflicts of interest were disclosed.

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