Australia and the United States: "Lessons from Down Under"

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Introduction

It can be a curious experience to be far away from home when something momentous is taking place, and even more so when the outcome of the event may have significant ramifications on your professional and personal lives. To watch it unfold remotely, in unfamiliar surroundings and through the lens of another culture, can be both disorienting and eye-opening. The United States has been gripped throughout 2012 by the Supreme Court decision on the Affordable Care Act (ACA) and the upcoming presidential and congressional elections. All have the potential to redirect the course of reform and the delivery and financing of care in the U.S. as well as significantly alter the health care consumer experience. The oral arguments before the Supreme Court on the individual mandate and Medicaid expansion in late March were closely followed and surprised many pundits and health care experts with the tone and tenor of the discourse. To be on the other side of the world, engaged in a parallel study of systemic efforts around another country's health reform was both a unique moment and a wonderful learning opportunity.

TPG International Health Academy (TPG-IHA) arranges global trade/study missions twice a year to bring U.S. health care executives together with local experts for an in-depth look at the host country's health care system (see TPG-IHA sidebar). In March 2012, a TPG-IHA delegation visited Sydney, Australia to learn more about their two-tiered system and areas of both accomplishment and challenge. The group, shown in the below photo, of 34 high-level delegates represented a diverse cross-section of U.S. geography and health care sectors including executives from delivery systems, health plans/sponsors, financiers, innovators and academics. This TPG-IHA study mission was unique, as we could not entirely disconnect given the major events back home. Many continued to follow the arguments before the Court and that dynamic fostered even more real time comparisons throughout the program.

Even prior to arriving in Sydney, it would be hard to miss the fact that the Australian health care system enjoys admirable results for a fraction of what we spend in the U.S. No matter what a delegate's specific expertise or vantage point was, we could all appreciate what the Australian system seems to have accomplished and how much the U.S. system would have to change to replicate it. The majority quickly locked on to the fact that this country of 22.5 million is able to spend 45% (per capita) of what the U.S. spends on health care and attain superior outcomes in key areas including access to care, life expectancy, screening rates and infant mortality. At the same time, the Australians are not resting on their laurels but undertaking an ambitious platform of specific health reform initiatives.

To help the delegates better understand how the Australian system produces such strong outcomes and to gain an appreciation for the similarities and differences of both countries' ongoing health reform efforts, the TPG-IHA faculty created a targeted and highly interactive curriculum for this mission. The core of the program consisted of a series of presentations and facilitated discussions with a range of Australian experts from settings including health

policy/university, care delivery, government agency, private health insurance, patient advocacy and innovation. The weeklong experience also included tours of Sydney clinics and hospitals and the opportunity for networking and group reflection.

The balance of this white paper will outline key elements of their system that contribute to its success and offer some insight on how Australia achieves better than Organisation for Economic Co-operation and Development (OECD) average outcomes with such limited spend. The paper explores areas of similarity and divergence on the goals and specific strategies for reform that both the U.S. and Australia are currently undertaking. It concludes with thoughts about what the U.S. could learn from the Australians as we move from the recently-concluded battles around the constitutionality of the ACA, through the November elections, and into implementation.

I. How do They do it?

At first the picture in Australia feels very familiar with a laundry list of challenges, current and projected, straight from the U.S. play book. In our opening session, Peter Morris, the First Assistant Secretary from the Australian Department of Health and Aging, presented the group with a detailed overview of the Australian system and key drivers of health reform. His talk focused on how they were trying to mitigate escalating costs due to aging population, rising prevalence of chronic disease and technology proliferation. Mr. Morris also cited workforce shortages and both access and disparity issues for rural and indigenous populations as key areas which local policy experts felt needed to be addressed. As part of the evidence base for the concerns, Mr. Morris presented data on current and projected health care costs (see Chart #1) and it is there that the vastly different starting points first came into view. In contrast to the U.S. where we currently sit at $8,233 dollars per capita spent on health care (per the 2010 OECD Health Data from June 2012), the Australians are concerned about getting to $6,500 by 2040, and just over $9,000 by 2050.It is also relevant to note that their figures also include aged care. It was a major moment to realize just how far apart the two countries are on annual spending even though we are both focusing high levels of energy sorting out how to bend our individual cost trends.

It would be easy to step back and say 'well, you get what you pay for,' so the Australians must be giving up something on results. However, this does not seem to be the case at the aggregate level. The differences in the cost pictures between the two countries became even more compelling as Mr. Morris reviewed a list of Australian health care system achievements. Even within their cost profile, the Australians have strong access to care via Medicare, the tax-financed universal coverage (undocumented migrants are not covered) for public hospital care, most medical services and pharmacy. They have very high rates of immunization and screening, as well as better than OECD average outcomes on key metrics including life expectancy, infant mortality, obesity rates, potential years of life lost and life satisfaction (see Table 1; more details can also be found in the 2011 International Profiles of Health Care Systems Report by the Commonwealth Fund: http://www.commonwealthfund.org/Publications/Fund-Reports/2011/Nov/International-Profiles-of-Health-Care-Systems-2011.aspx).

In trying to assess how they achieve these results, one thing to try and trace is "where is the No." For any system to balance its priorities and resources in a fair and equitable manner, it must

possess a range of mechanisms to help it stay in check. For the Australians, a major element may be the gate-keeping role that the general practitioners (GPs) play within the system. The need for referrals to access Medicare-covered specialist and hospital services is one significant lever to manage utilization. In addition, the Australian system relies on global budgets to pay its public hospitals (67% of all beds) and has a limited national formulary for pharmaceuticals that require government approval after a thorough cost-effectiveness review to add new drugs. They have also been willing to invest in federally-funded prevention programs targeting longer-range population health indicator areas including tobacco usage, cancer screening and vaccinations. The Australians have also been able to embrace, both by the government and the citizens, an explicit two-tier system that encourages people to carry private health insurance as a complement to the public program. As we learned from Dr. Annette Carruthers from NIB, a private health fund, this supplemental coverage allows some relief for the strained public hospital system by giving consumers access to private hospitals. It reduces the queues for elective surgery and has a positive influence on public perception, as those who wish are able to "buy up" into a more patient-friendly model of care where they have more choice of provider, timing and location. The government supports this via a carrots and sticks tax mechanism. They provide premium rebates to those that purchase coverage and have a levy on higher income earners that do not. Currently, about 50% of Australians purchase private health insurance.

Beyond these structural components there may also be some answers in the language they use for their health care system goals; a window into key cultural mechanisms that work in the Australians favor. These goals were presented by Dr. Stephen Leeder, Director of the Menzies Center for Health Policy, who shared that the Australian system strove to be equitable, efficient and of high quality. On the equitable dimension, the language included specific references to fair payments and fair access. As an underlying principle, this speaks to a more communitarian approach than we have in the U.S., and carries an implicit meaning that fair does not and cannot mean full entitlement based on individual wants. Following equity, the goal of efficiency is explicitly linked to value for money. This appears to provide a clear direction to have systems and processes to determine whether a good or service is adding enough to the outcomes profile to justify additional cost.

A final piece of the puzzle worth noting is the consumer perspective. We learned from Sally Crossing, the Director of Health Consumer-New South Wales, that while they see the vulnerabilities and challenging points of the system, patients are strong supporters of it. She used the term "national treasure," and she shared that, by and large, Australians feel lucky to have the health care system that they do, and want a role in making it better. This good will is another important asset and likely contributes to the outcomes and cost picture. So in summary, the working hypothesis would be that the structural and financial components are expressions of these shared goals for the health care system and those, plus the goodwill from the consumer, are all critical parts of how the Australians achieve their highly successful balancing of cost, quality and access.

II. Australian vs. U.S. Health Reform Efforts

The experts that spent time with us were actually quite humble about the Australian health care system and its results. All were very willing to share and discuss the key areas where there is collective understanding that improvement is needed to attain the above-mentioned goals for their healthcare system. There are published core principles for reform as defined by the National

Health and Hospitals Reform Commission (see sidebar for full list) that call out elements including transparency, public voice and responsible spending. While the U.S.'s overarching goals have been to expand access and contain costs, their reform efforts have eight work streams that, at first, seem more narrowly casted. They call out focus areas of mental health, aged care and primary care, as well as having a call for better standards and improved eHealth. When you look at the elements under each reform stream and compare them to core elements of the U.S. reform package under the ACA, you quickly see a high degree of overlap.

Both countries call out the need to simplify and clarify complex accountability structures across federal, state and local levels, and the need to repair fragmentation across provider types through more integrated care models such as patient centered medical homes. There is a push to make health care decisions more local, similar to trends in other countries including Canada and the UK. The U.S. strategies have a stronger public-private mix and are centered on Accountable Care Organizations (ACOs) and some of the bundled/episode payment pilots being supported by the ACA-created Center for Medicare Medicaid Innovation (CMMI). In Australia, they are piloting GP Super Clinics and Medical Locals designed, entities to try and better meet the primary care needs of the population through improved after-hours access and shifting care out of hospitals.

One major difference between the two paths is around how access is treated as a focus of reform. The Australians already have near universal access and are using this reform cycle to improve the access profiles for rural residents and the 2.4% of the population that is considered indigenous. Experts have established clear disparities in both the care received and outcomes for these groups, and are directing effort here to improve those results. In the United States, we still have a larger access gap and the ACA is largely organized around mitigating the uninsured via Medicaid expansion, subsidies and insurance exchanges, and the individual and employer mandates. Now that the bulk of the access expansion provisions of the ACA have been upheld by the Supreme Court, efforts to move toward implementation can continue. Some other areas where the reform paths differ are in the Australian focus on aged care and mental health. They are putting more federal dollars toward specific programs for early intervention, more non-hospital based mental health needs and the aged care system. This includes government subsidized residential care and more options for independent living. Both of these are recognized as important areas in the U.S. but are not currently high on the priority list given the need to deal with the more pressing access and cost challenges we face.

III. Conclusions and Implications for the United States

As we learned over the course of the mission, Australia, like most OECD countries, faces many of the same challenges as the U.S. but enjoys a better starting point from which to craft strategies to respond. While they may not have some of our advantages of economies of scale, it is hard to escape that much of their underlying structure, and therefore success, stems from their more communitarian principles and a legacy of public good will about the system that keeps politicians in line and the focus clearly on outcomes. They have also largely escaped some of the global recessionary pressures weighing on the European Union and the United States. All of these factors are critical points of alignment that serve to stabilize the current Australian health care system and give it the ability to work on reform goals free of the rancor that often characterizes the U.S. environment. That same alignment will not happen overnight in the U.S.

and neither can we rapidly move down the scale and mimic the Australian expenditure profile. What can we take from this experience and bring to our country?

Beyond their amazing results, some interesting things that emerged from our time in Sydney included hearing about the explicit embracing of the two-tiered system by both the government and the populace. There also did seem to be some newly emerging trends toward corporatization of the GPs and consolidation in the private hospital market, especially around same-day facilities and expanded diagnostics. Those that toured the new state-of-the-art Surgery Center in Hurstville frankly felt right at home and got a glimpse of where for-profit healthcare in Australia might be headed. It will bear watching to see what influence that has on the overall system. Finally, we were all touched by the powerful public sentiment, echoed by several visiting experts and a major national study by Menzies-Nous (see chart #2) that the Australian system is something the citizens are very proud of and consider to be a "treasure."

Our reflection and desire to translate what we heard in Sydney did not end once the delegation returned home. As we work toward continued effective operation and improvement of the U.S. health care system, here are three areas of potential focus that stood out after the Australian trade/study mission:

1. **Step up efforts to promote the public's satisfaction and overall understanding of the system:** One thing we learned is that public sentiment counts and that good will can be very helpful in the smooth functioning of the system. Dissention and poor public opinion feed into both the general media and the political realm and can make progress more complex if not impossible. The Obama administration has a second chance at better communicating the benefits of reform now that the majority of ACA was upheld. Polls both before and after the decision showed that a majority of the population wanted all or part of the ACA overturned, so there is much work to be done. For example, a Gallup poll found that 46% of Americans disagreed with the decision on the ACA. They also felt politics played too strong a role, so there is a clear need to decouple the message from the rhetoric so we can move forward. Part of the challenge is the sheer complexity of the system and trying to build understanding and awareness at the population, organizational and individual levels. Utilizing real-life examples and data to tie healthcare to financial well-being and the economy may help, as those are areas of major concern to all Americans.A useful data point may have been found in the recently announced study of the Oregon Medicaid lottery experiment where researchers found that those with regular access to care were more financially stable and less likely to borrow money or stop paying other expenses in order to cover medical bills. We can all share in providing success stories and building understanding and positive feelings in our consumers. Find what is working and talk about it. Find points of clear alignment and work to expand them. The experts in Australia offered us a clear list of their system achievements and the U.S. needs the same type of list.

2. **Consider more explicit cost effectiveness review for new products:** The Australian Pharmaceutical Benefits Scheme (PBS) is an impressive program that clearly has a powerful impact on managing costs in this rapidly growing expense category. Their full assessment and national formulary program would not be a fit for the U.S., but some of the process, emphasis on transparency and deep analytic focus that they employ might be

of benefit if adapted to the U.S. market. Paul Story from the PBS division within the Department of Health and Aging promoted the use of comparative and cost effectiveness research and the advantages of a clear, well defined process of review with no surprises on what was required and how decisions are made. He also touted the relatively short regulatory submission and review timelines--something manufacturers might really appreciate if the FDA could mimic. More available credible evidence (pre-launch and post-market) and consensus on what is needed for review and coverage decisions by private payors in the U.S. would also likely be welcomed.

3. **Continue current efforts to make U.S. health care more local and more integrated**: Sometimes a key lesson learned is that you may, in fact, already be on the right track. Something to potentially take away from Sydney is that our energies in structural and payment reform really do put us all on the same page and that affirmation is a good thing. No matter what happens with the November elections and the fate of the ACA, we should all strive to let the current local market activity on both the public and private fronts play out, especially with PCMHs and ACOs and the range of initiatives around care transitions, disease management and the shift from acute to more integrated care delivery models.

In closing, while the constitutionality of the ACA has been put to rest, the U.S. must still navigate some major turbulence in the policy realm. For those who live and breathe U.S. health care it can be hard these days to be strategic versus reactive. Organizational challenges will persist around where to focus and deploy scarce resources and when powerful forces may still come into play, but this is no time for passivity. Their national motto of "Advance Australia" can also have resonance for the U.S. as we navigate through the election season and beyond. Most importantly, we cannot sit by and wait for perfect clarity or be discouraged that we appear far behind on costs and access.

Overall, there is much to be learned from Australia, even after taking the major cultural differences into account. It would be a mistake to overemphasize our vastly different starting points and the U.S.'s unique ideological challenges and arrive at a place of paralysis. Most developed nations are facing the same challenges of an aging population, rising chronic disease burden, workforce shortages and need to find ways to balance affordability with innovation. Like the U.S., many are working on reform roadmaps that while framed within their own systemic parameters, may include elements that can be recast for leveraging across borders. For those participating in TPG-IHA's London, England mission in September 2012, that session will provide an excellent opportunity to continue the dialogue from the Australian mission and check in on the progress of the NHS reforms. As with the United States and Australia, England has also been trying to move more control and accountability to the local level and to the primary care physicians and the London mission will likely offer a look into their progress and implementation learnings to date.

TPG International Health Academy (formerly The Academy for International Health Studies or AIHS) was founded in 1993. TPG International Health Academy (TPG-IHA) arranges trade/study missions for senior U.S. healthcare executives. Traveling to different countries each year, these missions foster intellectual and cultural exchange. Academy delegates benefit from insights gained from an improved understanding of the global healthcare marketplace.

Each mission consists of academic presentations from university professors, government officials, medical experts and private sector representatives. In addition to four days of interactive classroom discussions, delegates also have ample opportunity to explore the host Country and network with their peers. BCHT's Director and Co-Director have participated on various TPG-IHA missions, including the Sydney, Australia trade/study mission held in March 2012.

National Health and Hospitals Reform Commission

Principles to shape Australia's health system
Published April, 2008

- People and family centered
- Equity
- Shared responsibility
- Strengthening prevention and wellness
- Comprehensive
- Value for money
- Providing for future generations
- Recognise broader environmental influences which shape our health
- Taking the long term view
- Safety and quality
- Transparency and accountability
- Public voice
- A respectful and ethical system
- Responsible spending on health, and
- A culture of reflective improvement and innovation

Group Photo of the Sydney, Australia Delegates

Table #1 - Key Australian and US Metrics - 2010

KEY COMPARATIVE METRICS		
FINANCIAL/OPERATIONAL		
% GDP spent on healthcare	9.1%	17.6%
Per capita HC $$	$3,670	$8,233
% total HC $ = Public	68.5%	48.2%
% total HC $ = OOP	18.6%	11.8%
% total HC $ = Pharma	14.7%	11.9%
MRI units/million pop	5.6	31.6
MD consults per capita	6.5	3.9
Gini Coefficient (measure of income disparity)	.336	.378
HEALTH STATUS/OUTCOMES		
% Population Obese	24.6%	35.9%
Life Expectancy at Birth (years)	81.8	78.7
Potential Years of Life Lost – Males (per 100K)	3,702	6,414
Infant Mortality	4.1	6.1
Tobacco usage (% pop who smoke daily)	15.1	15.1
Alcohol usage (liters/capita)	10.3	8.7
Subjective Well Being – Life Satisfaction (1-10)	7.5	7.2

Source: OECD Health Data, released June 28, 2012

Chart #1 Australian Health Care Spend – Current and Projected

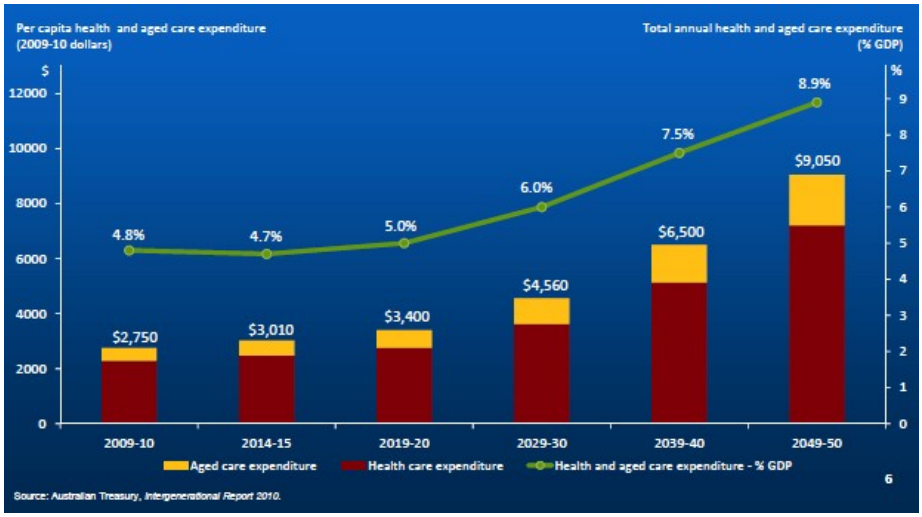
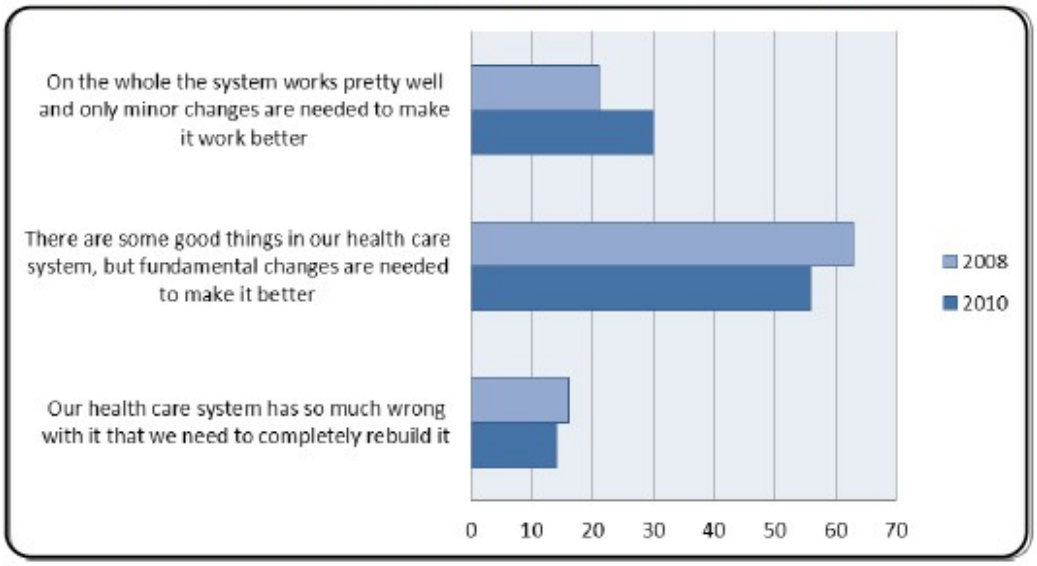


Chart #2 – Australian Perspectives on Health Reform from 2010 Menzies-Nous Australian Health Survey

Figure 6 – "Which of the following statements comes closest to expressing your overall view of the health care system in Australia?" (% of population)



Source: OECD reports