

Research Insights

Is COVID-19 opening the fault lines in our healthcare system?

While a number of temporary solutions to the COVID-19 pandemic are in place to fix emerging fault lines in the funding and organisation of health care, these solutions need to be permanent to help ensure future resilience and sustainability of the healthcare system.

Fault lines emerge among the COVID-19 crisis

As the healthcare system prepares for an unprecedented test of its resilience, it is useful to begin to reflect on some of the lessons that could be learned that might influence future reform initiatives. Compared to other countries, many think Australia has one of the best healthcare systems in the world, while others suggest that it is not a 'system' at all and that it could be much more integrated.

The fault lines in our system are deep, yet they usually remain ignored, forgotten about or seem too hard to change until there is a crisis that opens them up for all to see. There are two major fault lines within the system that have emerged because of the coronavirus crisis and are receiving short-term patches but should be translated into long-term solutions.

Key Insights

1 New funding models for GPs to support online consultations

The fee-for-service funding model used in Australia is one straight from the 19th century, with a nod to the middle ages. It is very clear it has been unable to cope as General Practitioner (GP) groups clamour for additional Medicare Benefits Schedule (MBS) subsidies that will enable online or telephone ('telehealth') consultations and support general practices to stay open without the risk of spreading the virus. Though this is just being announced as a temporary measure, it has taken months to get in place while the virus spreads. Using telehealth not only helps support efforts to stop the spread of COVID-19 but is also much more convenient for many patients with a range of problems as they could save an hour or more of their time on a visit to the GP.

The increased convenience of telehealth is likely to lead to an increase in demand for GP services and therefore costs, which may concern the government. Patients could book an appointment for very minor conditions compared to before, which will likely lead to another Medicare cost blowout in the current fee-for-service system. The cure is clear guidance and protocols when booking appointments, or reserving online consultations for those who are less mobile or in greater need of care.

Under careful regulation, the government can ensure online services are not exploited by the for-profit corporate sector as was the case with urgent after-hours care items.ⁱ

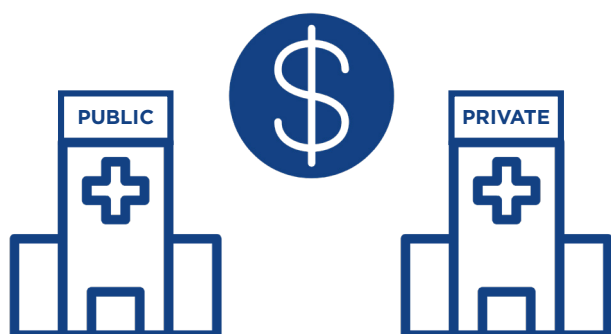
This cure also involves a more resilient funding model—one that is less prone to cost blowouts and involves less red tape allowing GPs to consult with patients however they see fit when circumstances deem this necessary, rather than being concerned about how they will get paid. The best designed funding models are blended where fee-for-service is combined with a fixed annual payment per patient (called a capitation payment).ⁱⁱ This will reduce Medicare cost blowouts whilst giving doctors the flexibility to provide more appropriate care. This is being trialled in the Health Care Homes program for patients with chronic disease but could be introduced for the whole population to reduce the constraints of the fee-for-service system in providing appropriate care for patients.ⁱⁱⁱ



2 Pooling the funding of private and public hospitals

The second wide-open fault line is the division between public and private hospitals. Governments announced on 26 March 2020 that all non-urgent elective surgeries would be cancelled in both the public and private sectors. Private hospitals have already begun to lay off nursing staff and talk about closures at a time when skilled staff are needed most.^{iv} While public hospitals are preparing to bear the brunt of the coronavirus, only on 1 April 2020 was agreement reached that private hospitals will receive some funding from Federal and State governments in exchange for lending some of their capacity to assist in the pandemic. Though public hospitals are always busy and at capacity, it seems obvious that patients displaced (and on waiting lists) from public hospitals should be treated using the excess capacity of private hospitals. Fewer patients in private hospitals funded by private health insurance means increased profits for private health insurers (PHIs) who won't have to pay for all that care not taking place. Private health insurers have already announced that they will postpone the 1st of April premium rises for members, so they are using a little of their windfall gains to help out those who have private health insurance.

The longer-term impact of the virus on the private sector is unclear. A different funding model for both public and private hospitals may have made the whole sector more resilient, encouraged much earlier cooperation across the divide, and enabled resources to be moved quickly across the divides to respond to the pandemic with little additional cost. Repurposing private health insurance subsidies was suggested in 2015 but shelved—even though some insurers quietly concurred.^v The current agreement to directly fund private hospitals (rather than via PHIs) could be a testbed for existing PHI's subsidies to be redirected to pay private hospitals. Such reform means that funding issues wouldn't get in the way of an effective and coordinated response to the pandemic.



How to make the healthcare system more resilient

The ideas of resilient health care need to be applied to how we redesign the system overall—including how we view payment models and funding mechanisms, and how the different parts of the system relate to each other. Resilience is a system's capacity for flexibility, robustness and adaptability in response to changing circumstances so that performance is maintained.^{vi} Resilience is usually defined at the micro-level, for example patient safety on the frontlines, the flexibility of healthcare workers or the way clinicians continuously navigate the system, rather than whether the many moving parts of the system work effectively together.^{vii}

Healthcare mostly exhibits high levels of resilience. This is especially the case on the frontlines of care, where clinicians and clinical teams have always worked around complex patient problems and bridged the many gaps in the system to bring about good quality care for the majority. Yet paradoxically, at the same time, the healthcare 'system' in Australia is too fragmented in the way it is funded and organised—adding to the complexity and degree of difficulty in delivering safe high-quality care under pressure. Longer-term reforms would help in future times of crisis as well as under typical circumstances. We need a healthcare system where patients don't fall through the cracks and the provision of appropriate care is supported, and not hindered by the way the system is financed and organised.

This coronavirus is teaching us many things, but we know one standout lesson for the future: this is unlikely to be the last event of its type. These are challenging times that without a doubt will occur again in tandem with major climate events (such as bushfires and floods) and as new bacterial and viral infections emerge. They will place enormous pressure on healthcare services and frontline healthcare workers who are risking their lives, yet finding their hands are tied by a disjointed 'system' that reduces the speed and agility of response. Fixing these fault lines should be a key reform priority once the coronavirus is under control.

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