

Health Care in Australia: Missed opportunities for reform

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Development



Outline

Introduction – funding and delivery

Health care in Australia – industry performance

Australia's mess and how it got that way

Public policy – privatization or market reform?

Conclusion

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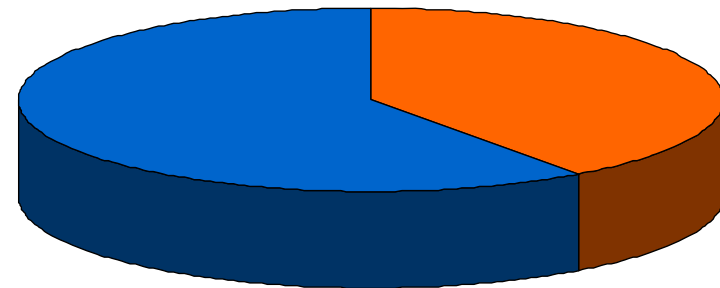
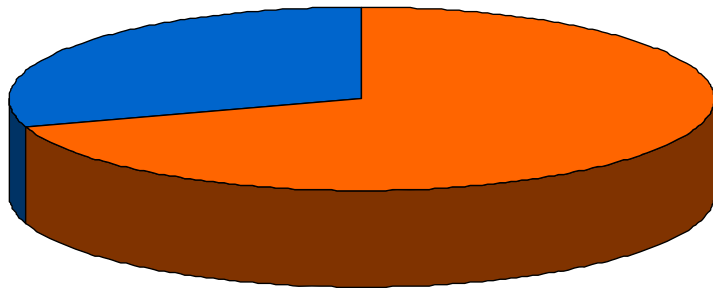
Conclusion



Public-private split

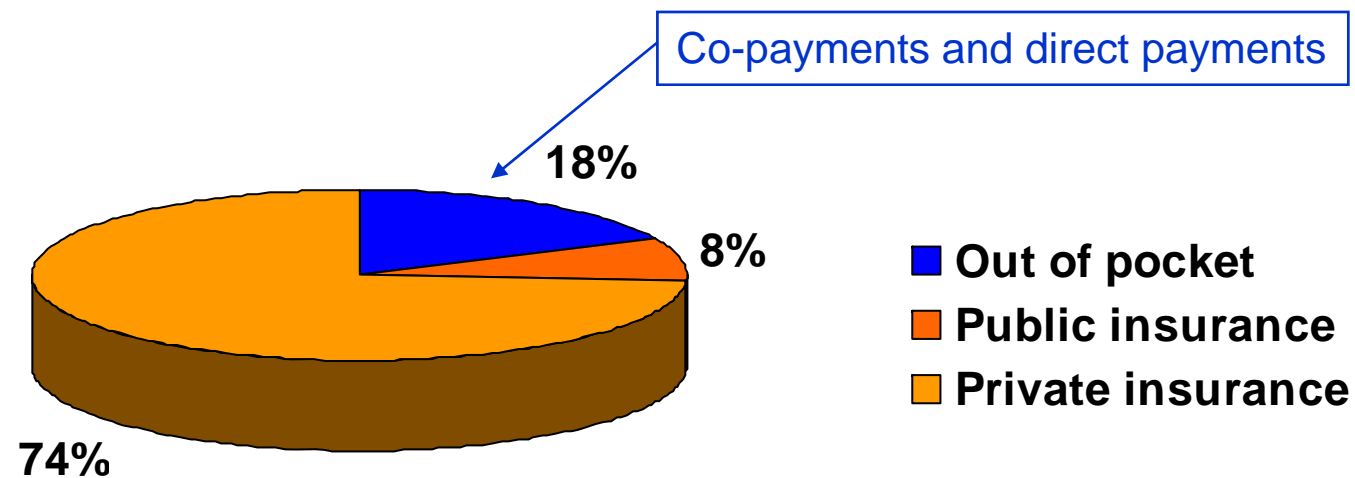


Funding health care 70:30 \longrightarrow *Delivering* health care 40:60



Insurance – out-of-pocket split

Insured and out-of-pocket transactions



Australia's main programs

1. **Medical Benefits Scheme -- Commonwealth**
funds 84% of cost of medical services
2. **Pharmaceutical Benefits Scheme -- Commonwealth**
funds prescription pharmaceuticals
3. **Public hospitals – State**

Universal programs, with some means-tested payments. Public hospitals free.

Commonwealth subsidies to private insurers.

Not compulsory but highly subsidized for high income earners.

Sources and applications of \$

Source	Main expenditure	\$ billion 2007-08
Commonwealth govt	Medical services, prescription pharmaceuticals (other than in public hospitals), PHI subsidies, transfers to states for public hospitals	44
State govts (8)	Public hospitals, community health centers	24
Individuals	Co-payments, full payments for some services, PHI premiums	18
Other		4

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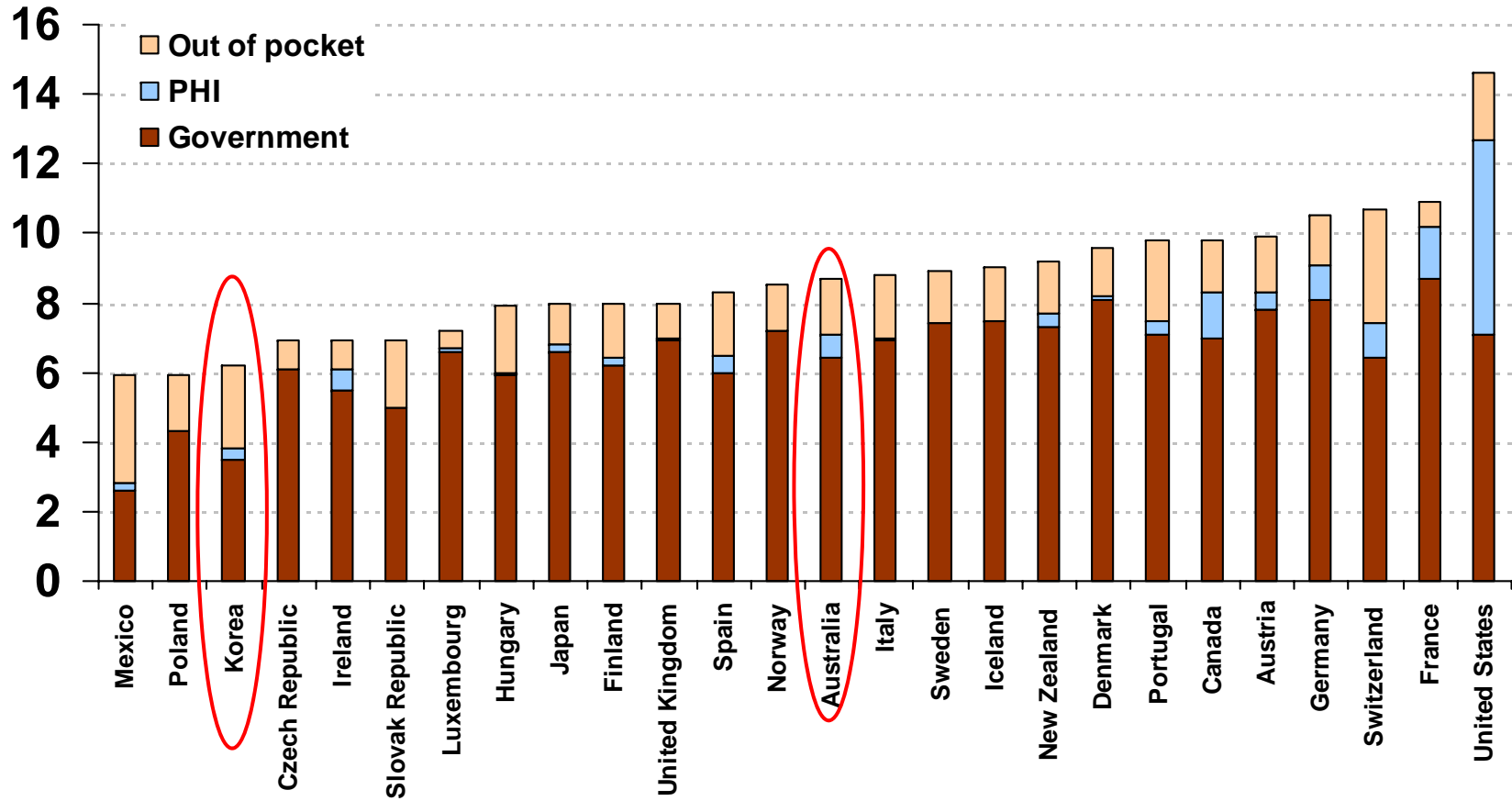
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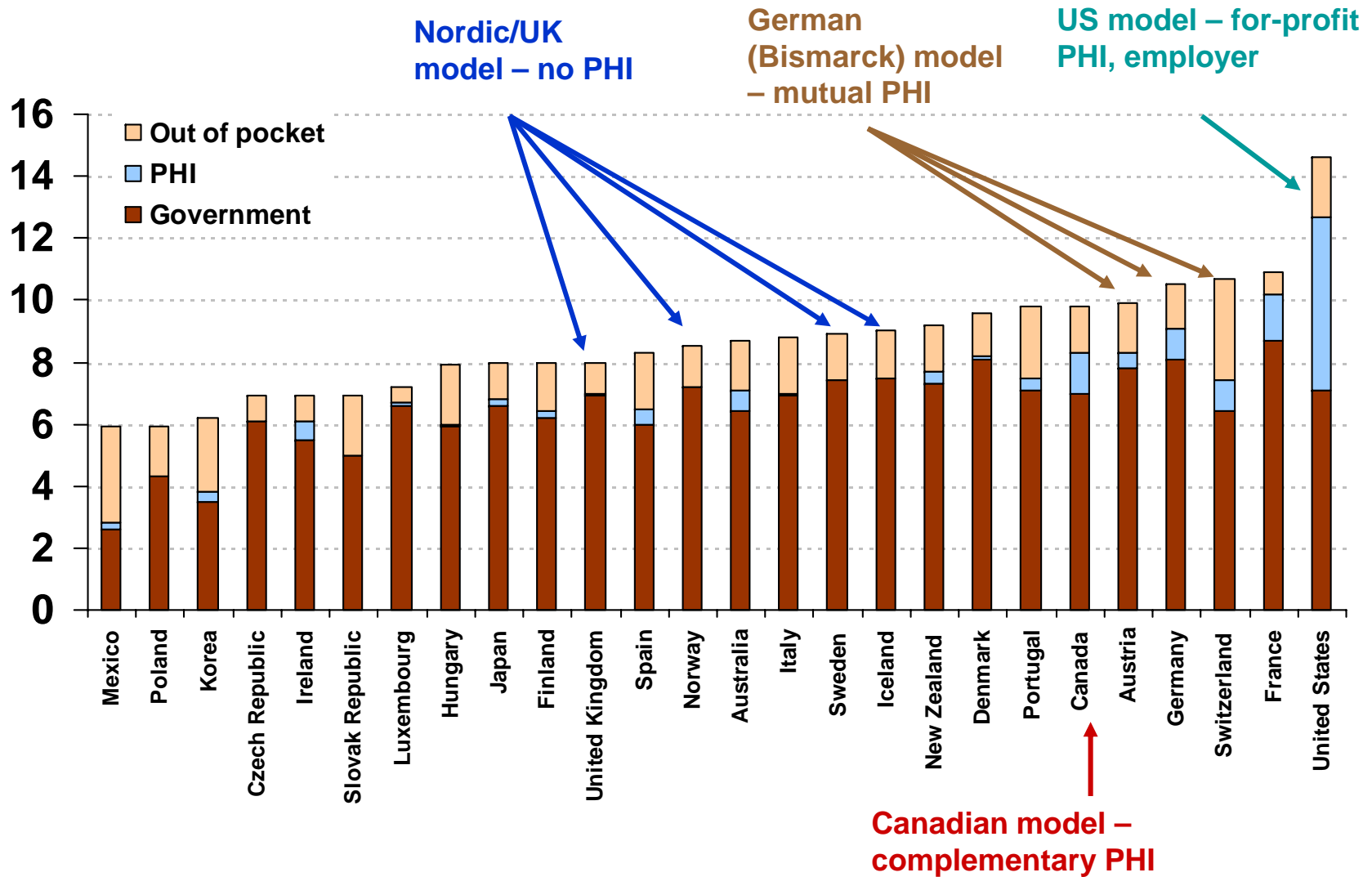
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Health care expenditure % GDP

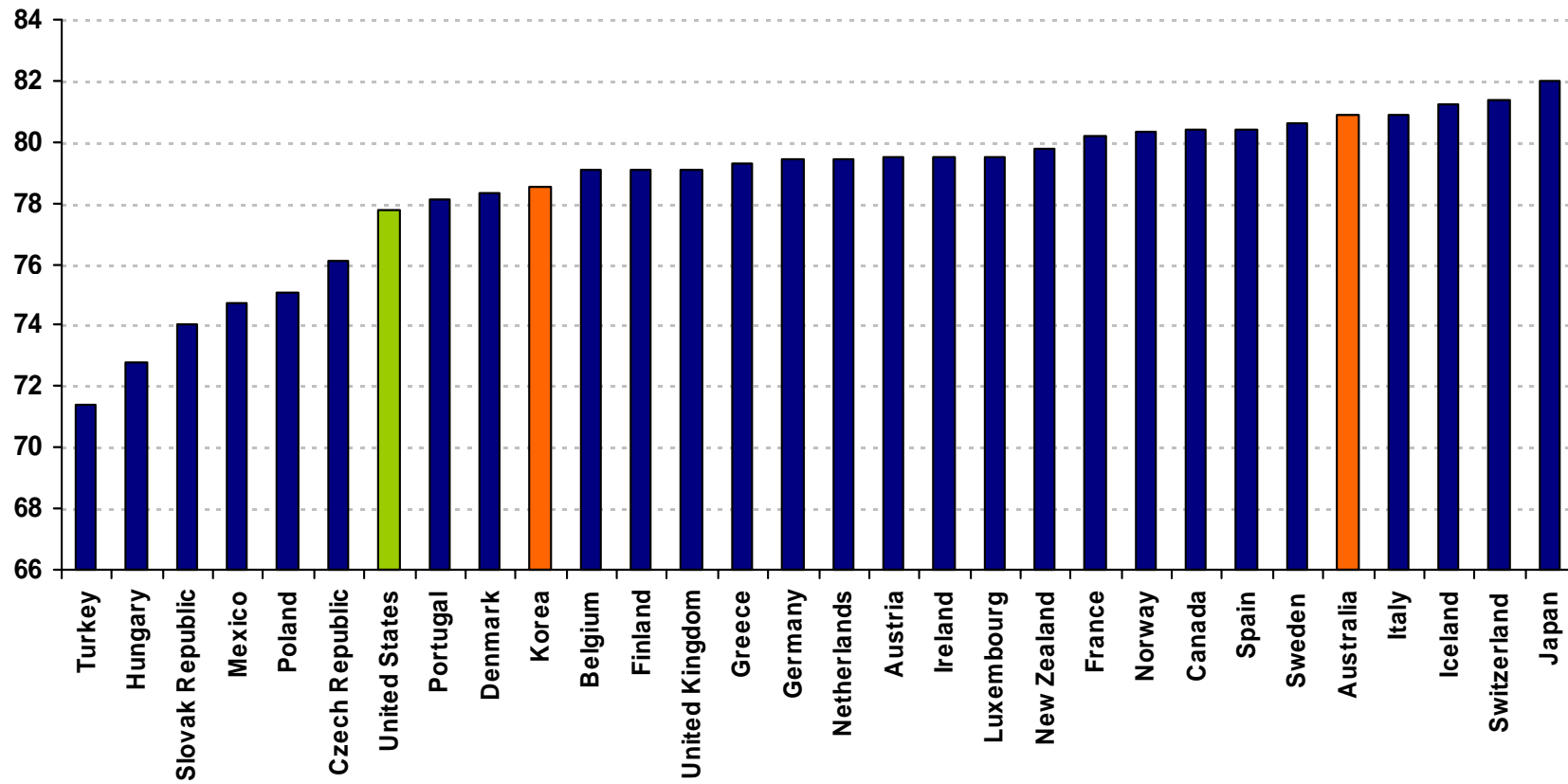


Models of financing health care



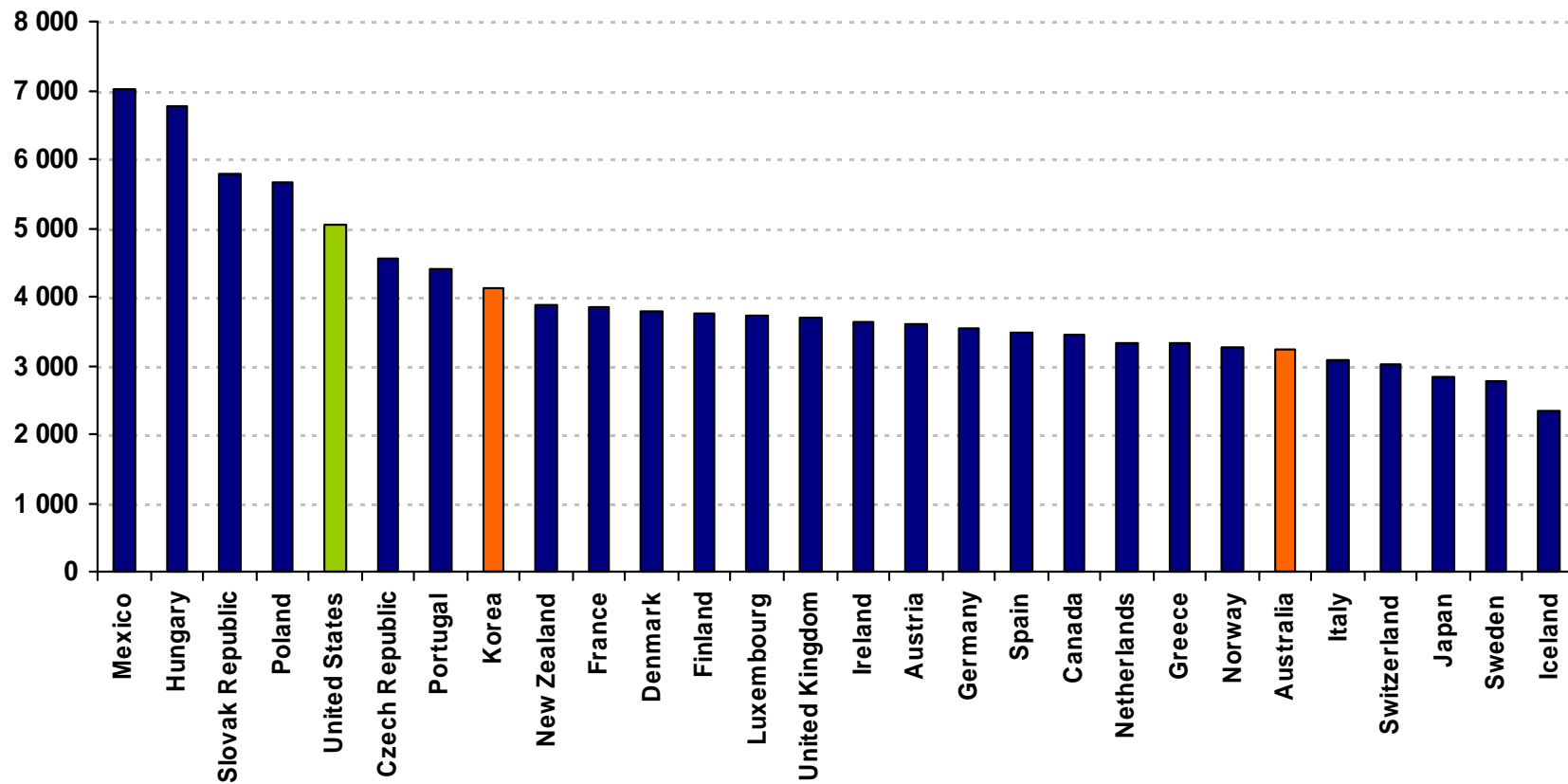
Outcomes

Life expectancy at birth (years)



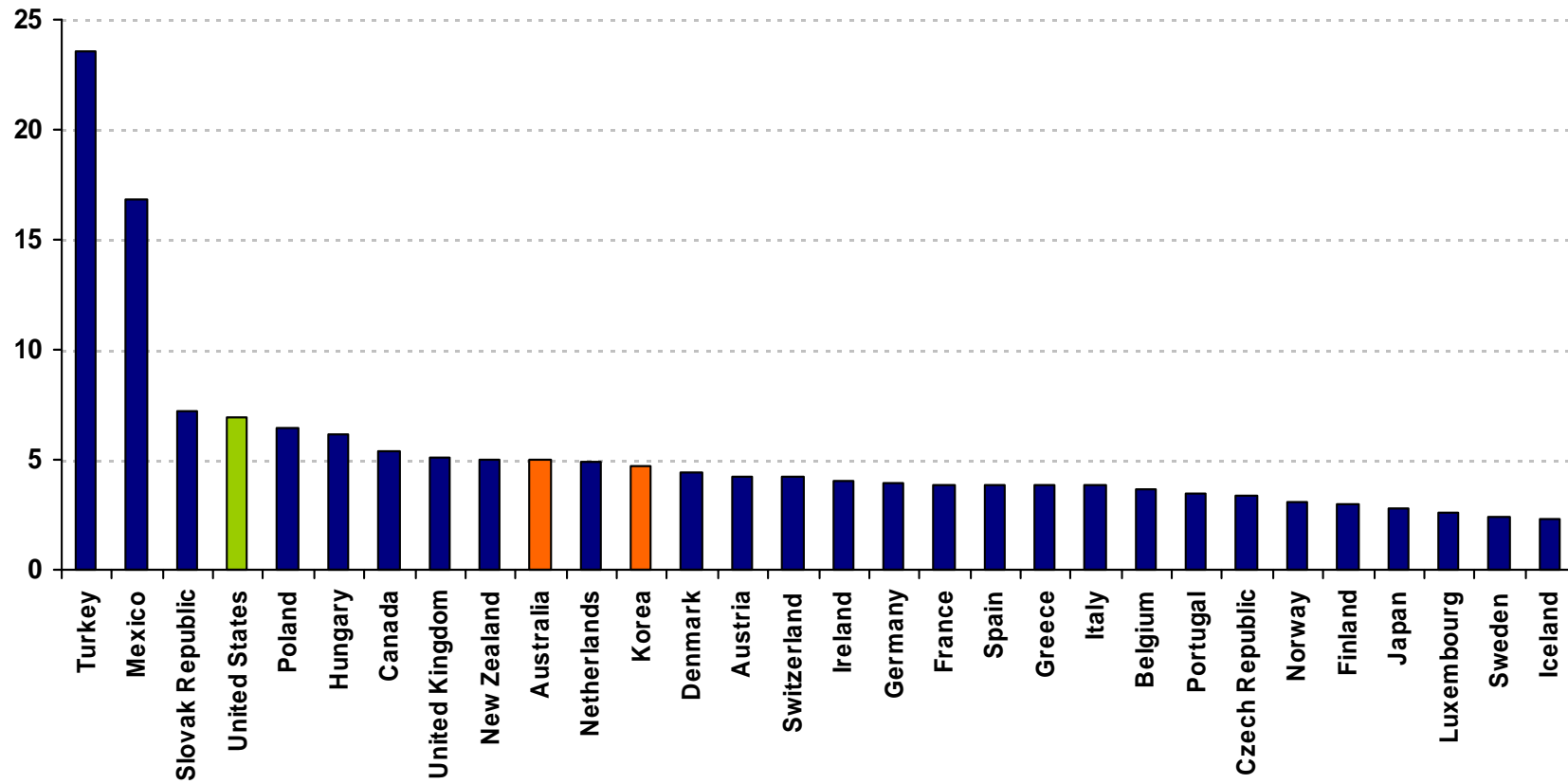
Outcomes

Potential life years lost per 100 000, population < 70



Outcomes

Maternal and infant mortality -- deaths per 1000 live births



Outcomes

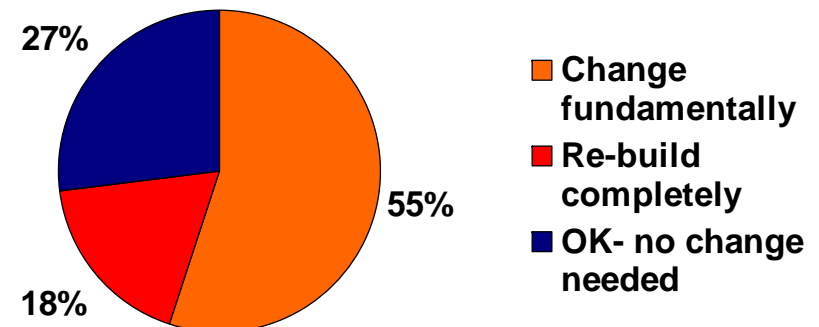
Quality

In Australia 18 000 deaths, 50 000 permanent disabilities each year, half of which preventable

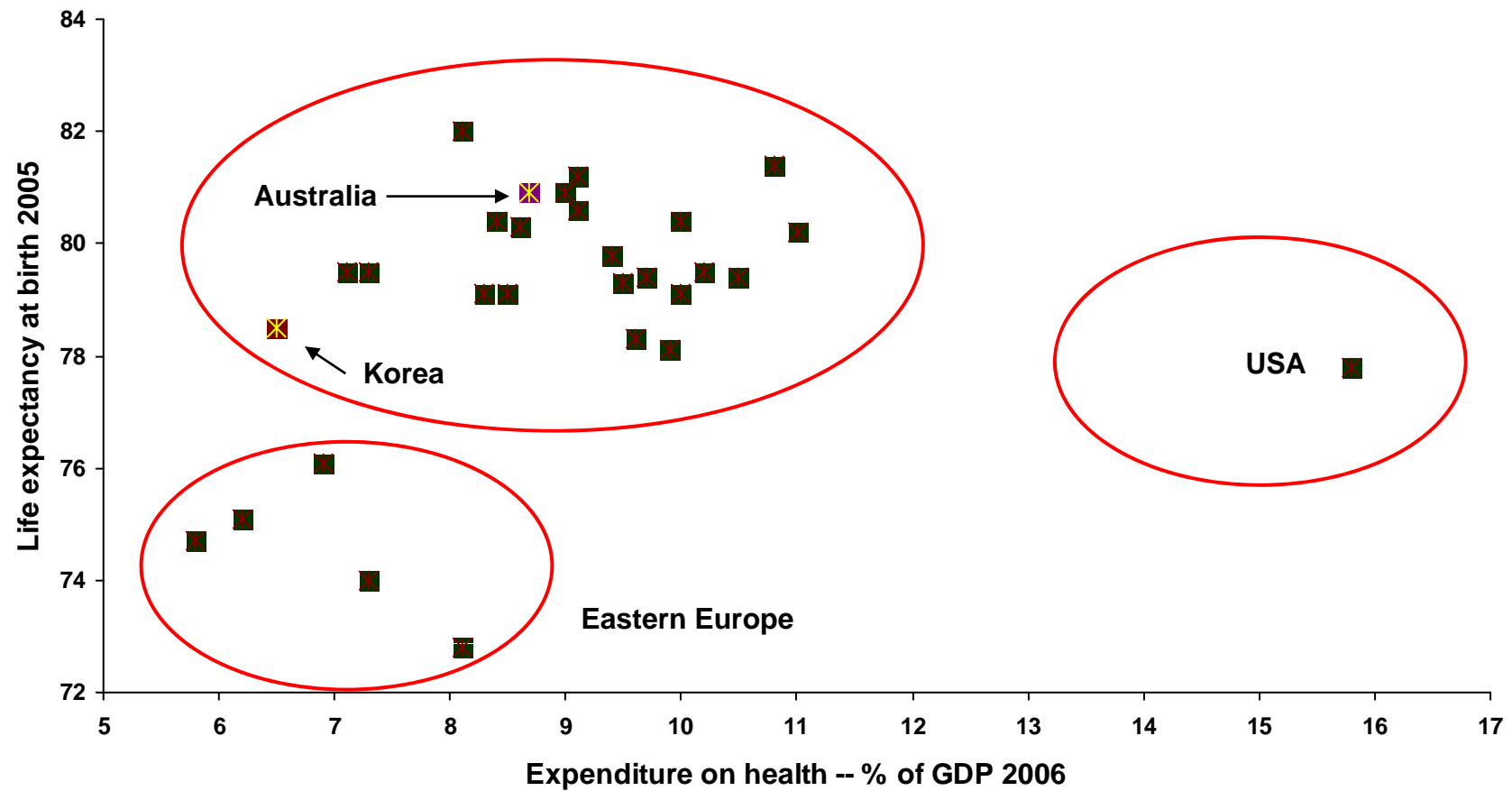
Consumer satisfaction

Satisfaction with individual elements, dissatisfaction with whole

Consumer attitudes

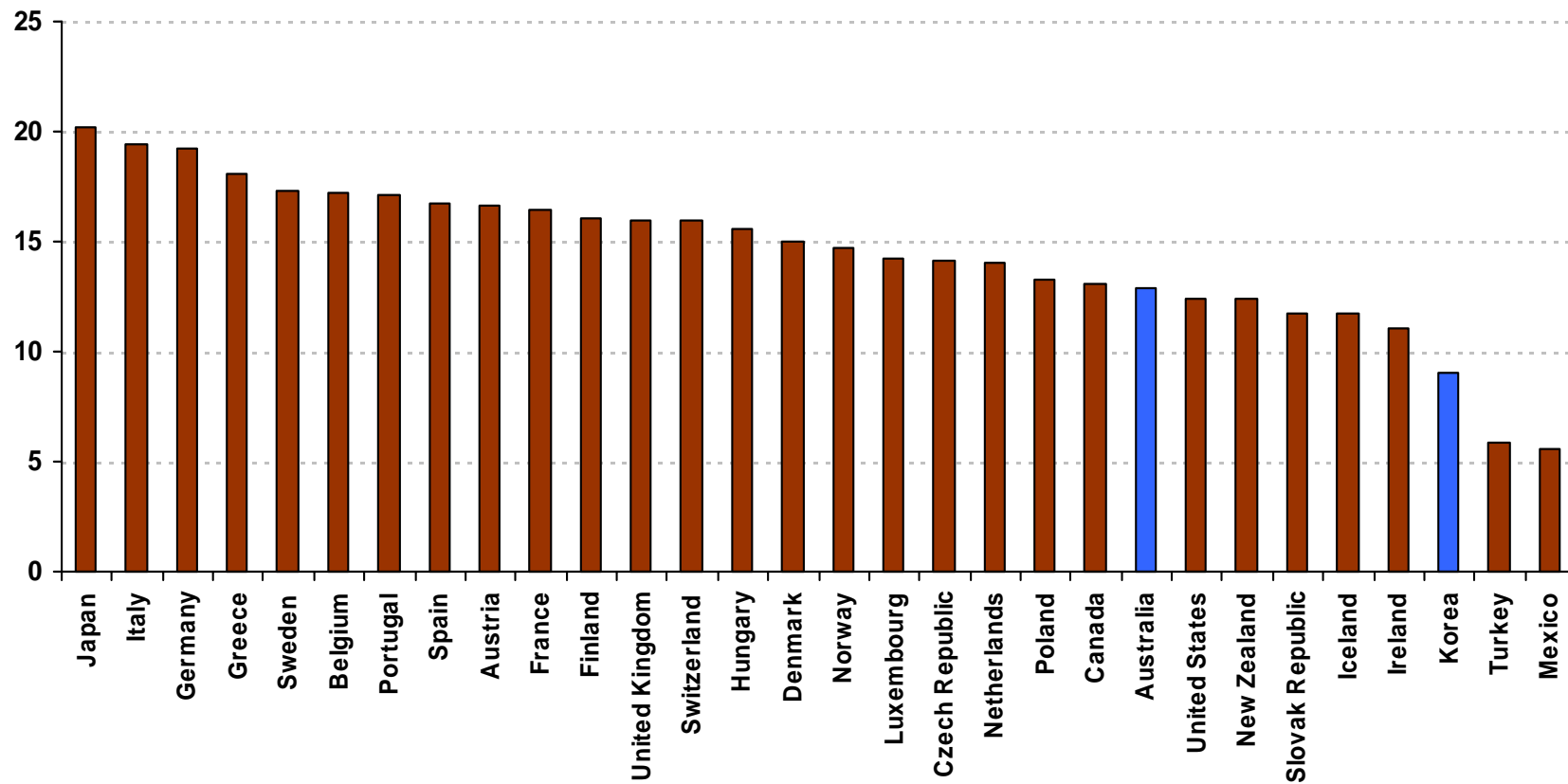


Expenditure on health and life expectancy



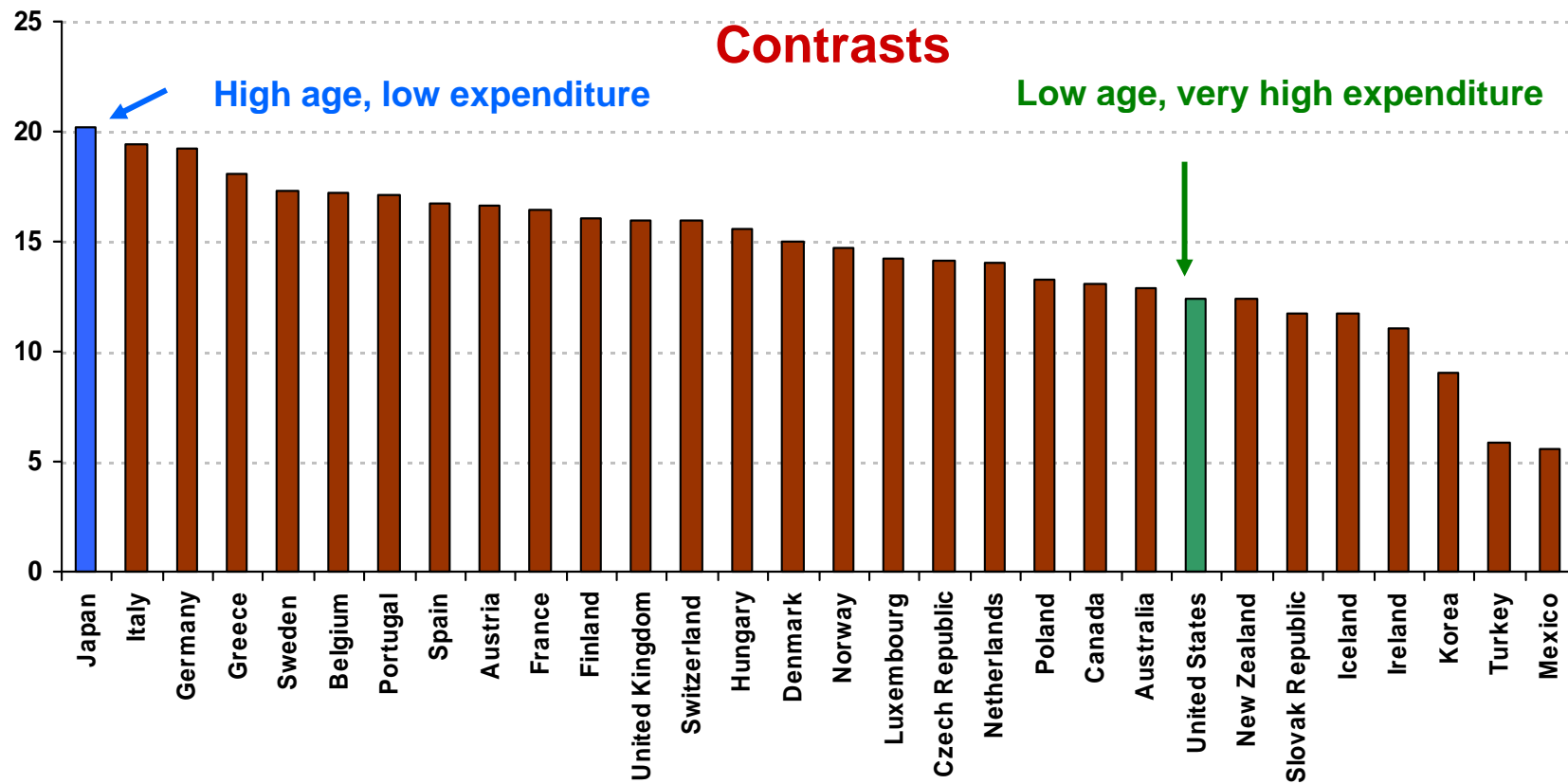
Risk/cost factors

Percentage of population ≥ 65



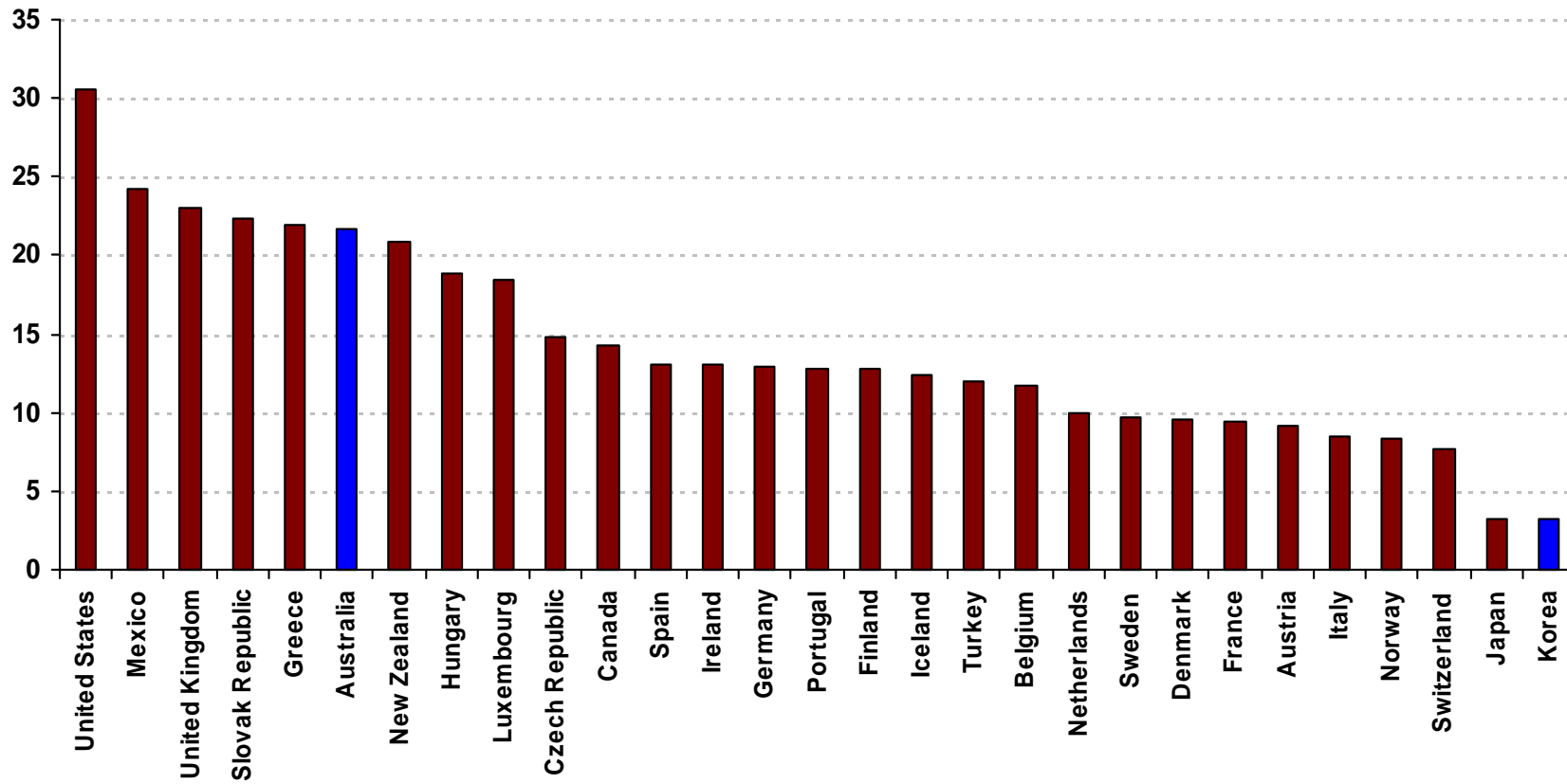
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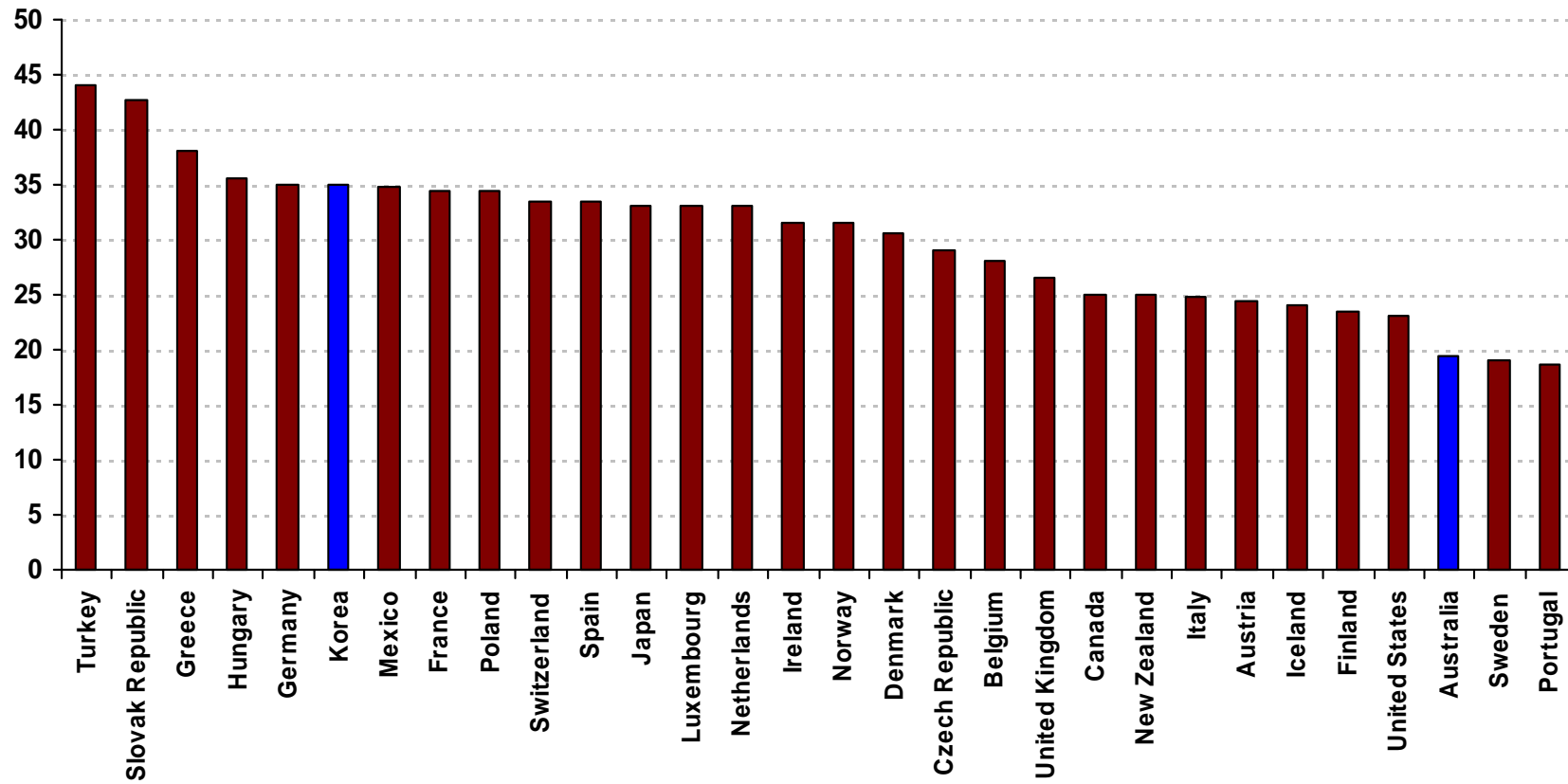
Risk/cost factors

Obesity -- % of population



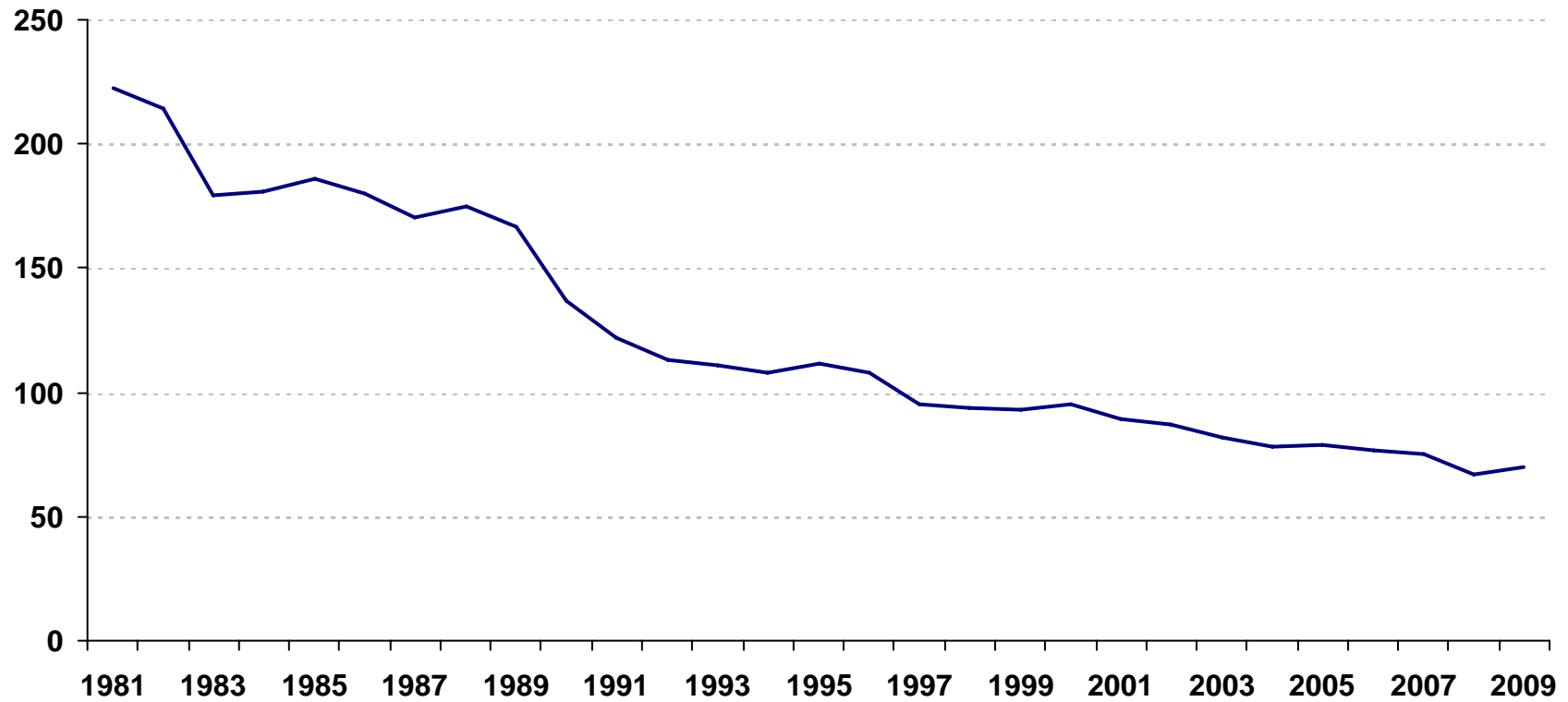
Risk/cost factors

Smoking -- % of adult population



A health success story

Road fatalities per million population



Determinants of health

Health care

All other factors

social inclusion

smoking

sexual health

road traffic safety

education

diet

etc

Within developed countries, no strong evidence of link between expenditure on health care and population health

Industry report card

High cost

Mixed outcomes

Capacity for quality improvement

Areas of technical inefficiency

poor use of staff resources, poor use of information technology

Significant shortcomings in allocative efficiency

lack of program integration, poor incentives, lack of price signals

Consumer dissatisfaction

Why is health care left out?

Australia's record in structural change

tariff reductions

finance market deregulation

redesign of indirect taxes

competition policy

reform of utilities

Health care largely exempt, only significant changes in private-public insurance mix

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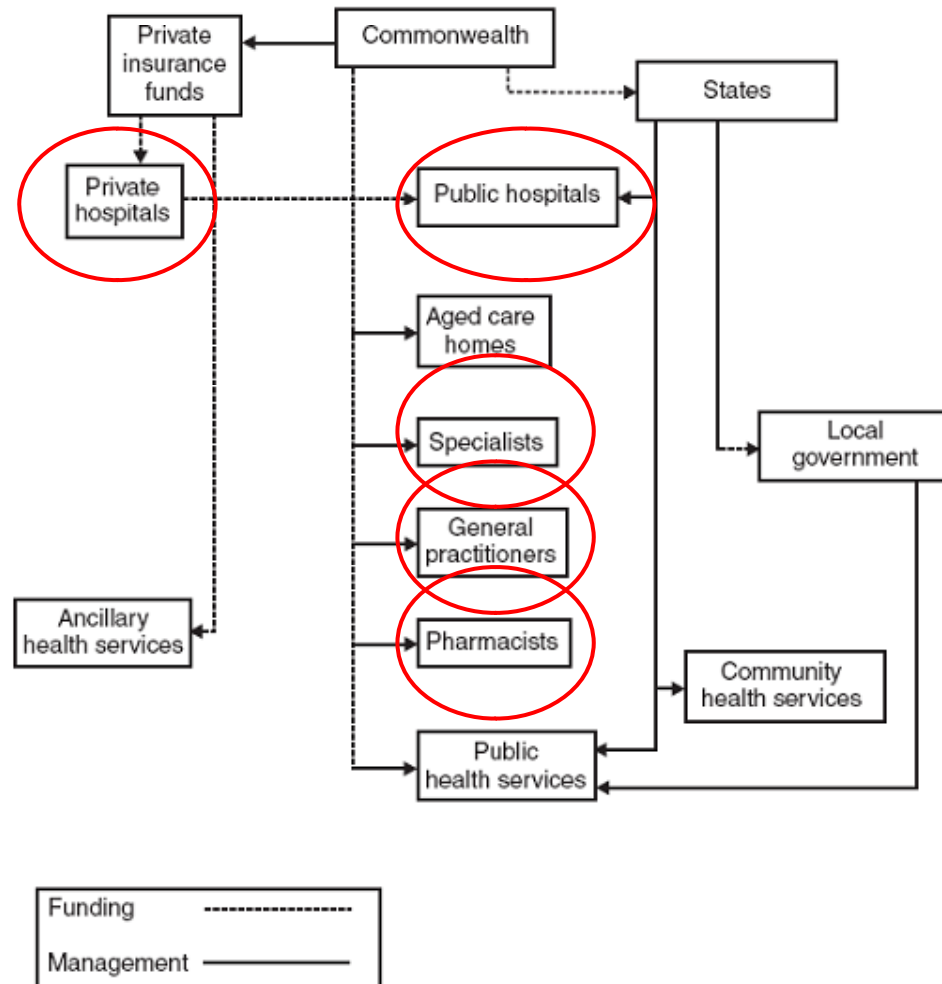
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OECD description of Australia

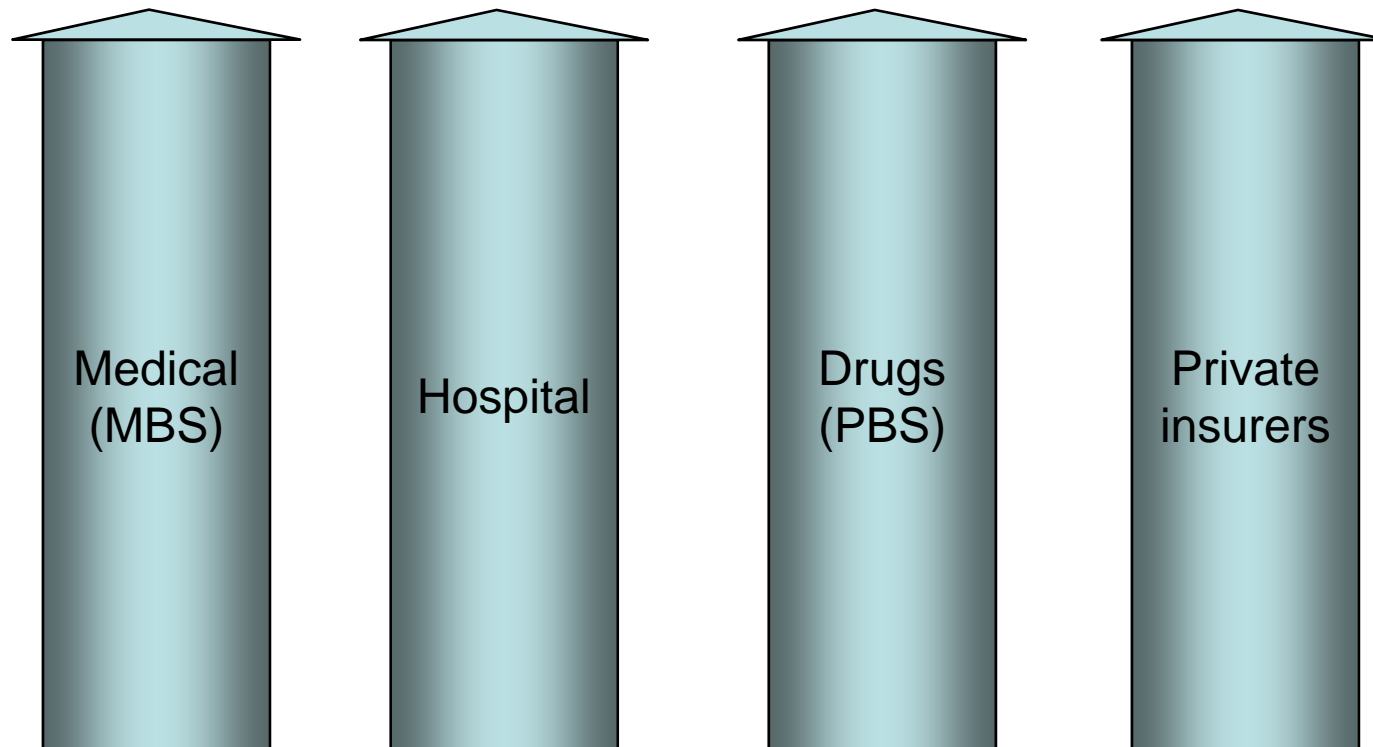


Simplified, and leaves out individual funding

Note provider focus

A “provider” rather than “customer” structure

Program structure centered on suppliers and funders



How the mess developed

Policy process

- incremental decision-making over 65 years
 - attending to immediate problems but not system design
 - policies reflect political ideologies, fashions, and fiscal conditions when developed
- appeasement of provider lobbies
- specific Australian issues – federal system, constitutional constraints
- means-ends confusion in funding – private health insurance as end in its own right

Private insurance

Historical struggles between main political parties

Coalition (center-right) – private insurance

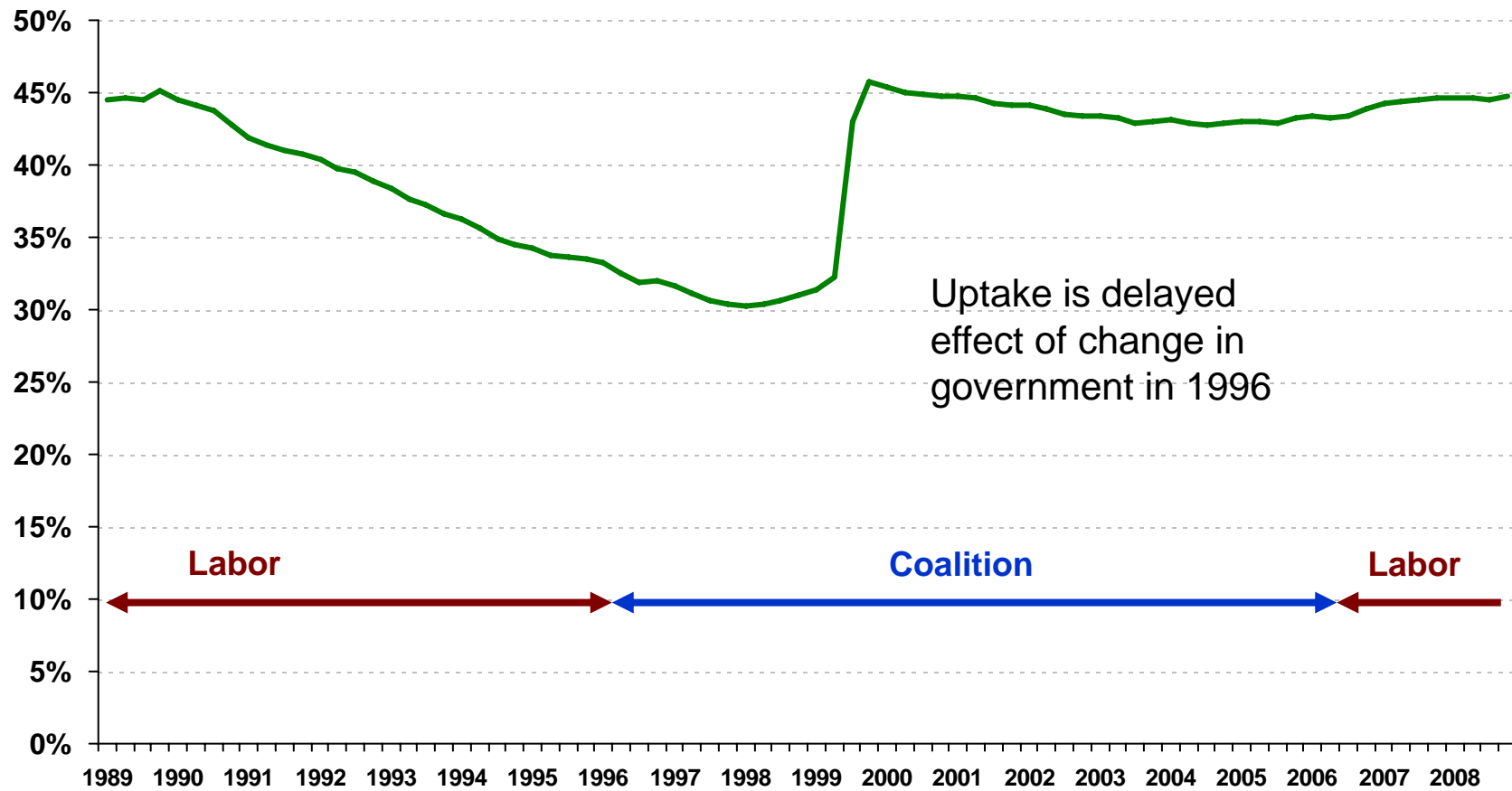
Labor (center left) governments – tax-funded public insurance

Over-riding political imperative, however, to retain government programs

Private insurance is used to support accommodation in private hospitals, gaps between prices charged and Commonwealth medical payments in hospitals, and ancillary services (dentistry etc)

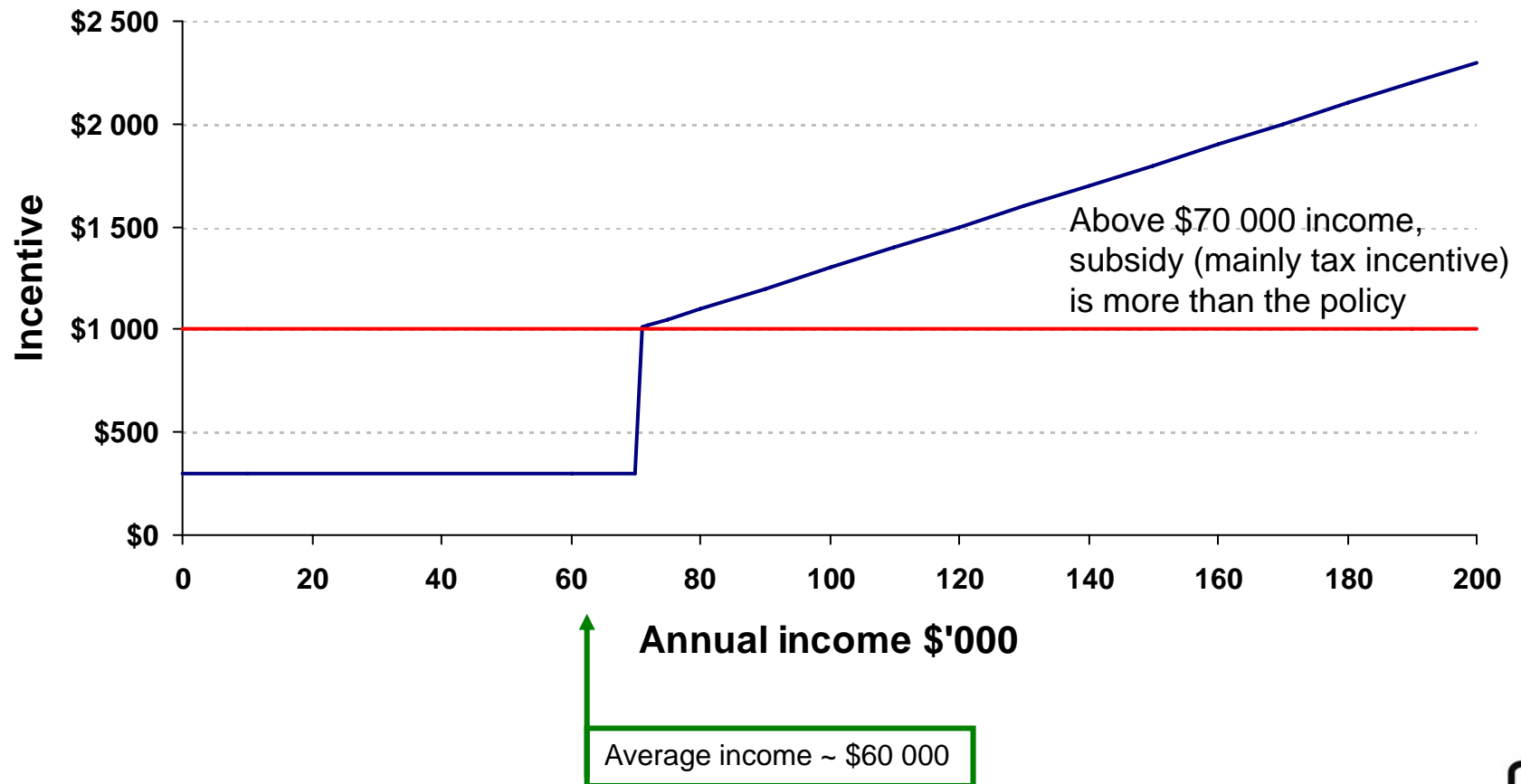
Purchased by individuals, encouraged by subsidies and tax incentives

Private insurance coverage



Private insurance incentives

Financial incentive to hold a \$1000 PHI policy



Dual hospital systems

Public

Free, without means tests
Funded by states

Integrated services –
medical, pharmaceutical,
rehabilitation etc

Private

Patient billed, medical services
and pharmaceuticals paid by
Commonwealth under separate
programs, accommodation and
gaps paid by individual, mostly
with support of PHI.

Separate services, no
one locus of
responsibility

Insurance inequities and inefficiencies

PHI gives well-off first call on medical resources
re-allocation is not on basis of medical needs

PHI subsidies not available to self-insured
well-off subsidized more generously than others for medical care,
dentistry etc

No competition between private and public hospitals

Inefficiencies in fragmentation

Consumer-unfriendly, fragmented

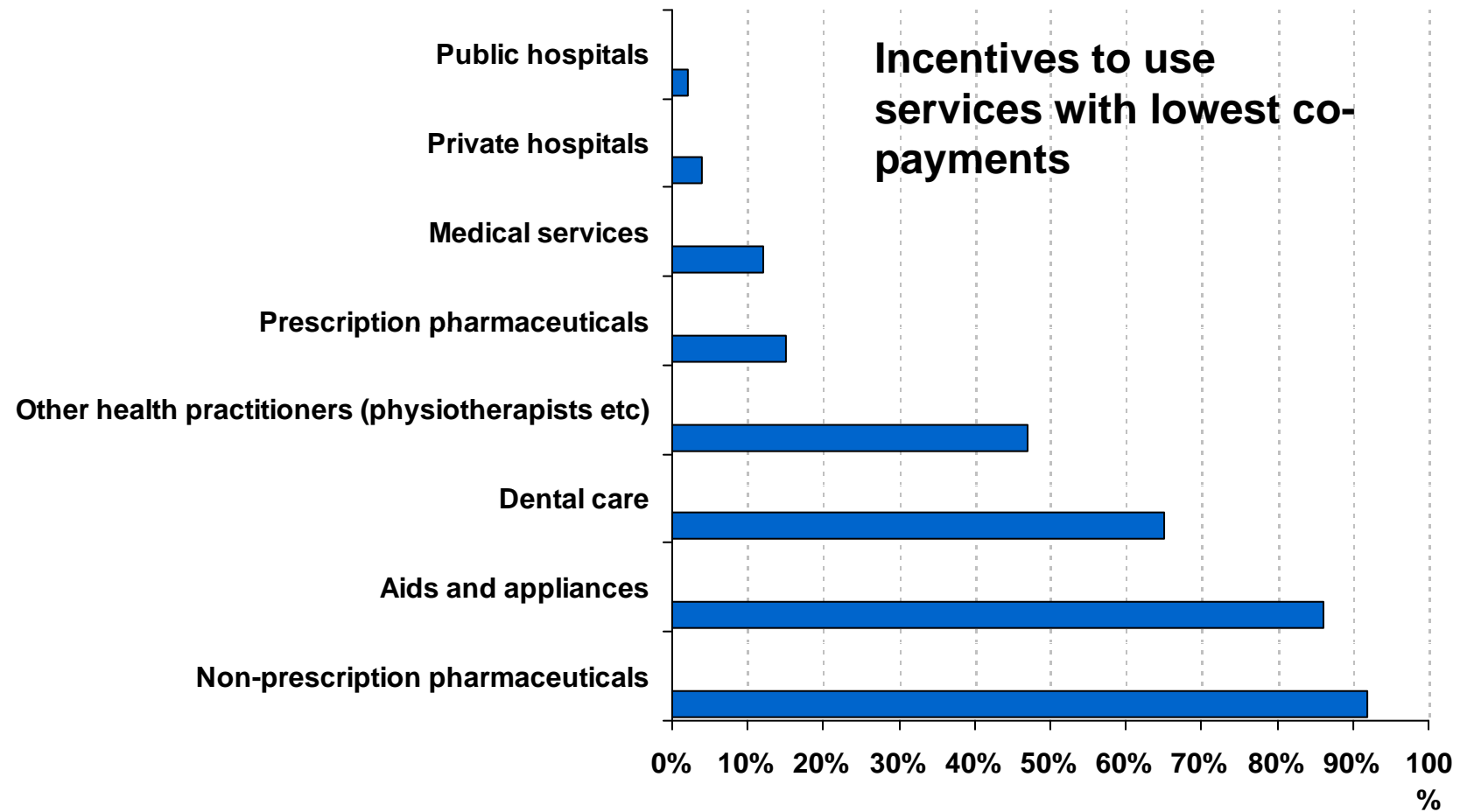
search and transaction costs

duplication of record-keeping and diagnosis

risk of conflicting therapies

Allocative inefficiencies because of inconsistent price signals to consumers

Direct consumer payments as % total expenditure



Legacy

Male incomes (2010 prices)

1950 Free pharmaceuticals, heavily subsidized medical services through PHI (European countries introducing free health care)

→ \$20 000

1975 Free hospitals, Medical Benefits Scheme

→ \$40 000

2010

→ \$70 000

Policy lessons from Australia's mess

Beware of fragmentation through series of disjointed “reforms”

Keep a consumer focus

do not be distracted by provider lobbying

design programs around consumers, not providers

Review direct payments as national incomes rise

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Public and private hospitals

Distinction not based on *ownership*, but on *funding*. Public hospitals are funded by state governments, private hospitals from other sources.

	Public hospitals	Private hospitals
Ownership	By state governments, charities funded by state governments, or charities on contract to state governments	Charities, private corporations
Teaching	In larger hospitals	No
Emergency services	In larger hospitals	No
Specializations	All services, complex cases	Elective surgery, simpler and routine cases
Size and locations	Full spectrum – large hospitals in cities, small hospitals in country	Tend to be medium-sized, large cities only

Relative size

	Public hospitals	Private hospitals	Total
Establishments	768	556	1324
Expenditure \$ billion	31	8	39
Episodes of care (million)	4.7	3.1	7.8

Public hospitals handle the difficult, more complex cases

Hospital reform

State hospitals are the only large part of health delivery in government control/ownership

There is no strong evidence that private hospitals more efficient – similar average costs (adjusted for casemix)

Reform is more concerned with
improving technical efficiency
funding mechanisms – casemix funding

There is no appetite for privatization following bad experiences

Privatization case study

Port Macquarie Hospital (1992)

built, owned and operated by private for-profit company, with block grant at outset and ongoing payments for serving public patients

Bought back by state government in 2004

public complaints

management difficulties

cost over-runs

poor funding model

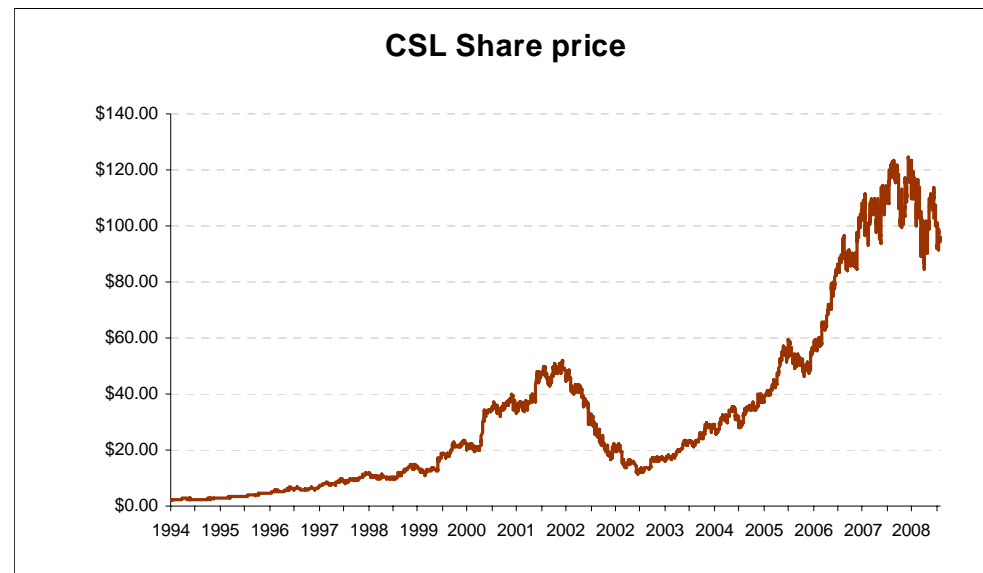
Similar problems in other states, buy-backs

Privatization case study

Commonwealth Serum Laboratories

Transition from close
government ownership
to stock exchange
listed public company

Commercially successful,
but was it too
expensive?



Privatization lessons

Privatization:

is a lazy way to improve operating efficiency

results in no benefits in itself

is not a substitute for reforming markets – price signals, competition, incentives

can look politically attractive because government accounts do not record liabilities associated with privatization

Private health insurance

Is an expensive way to share health care costs:

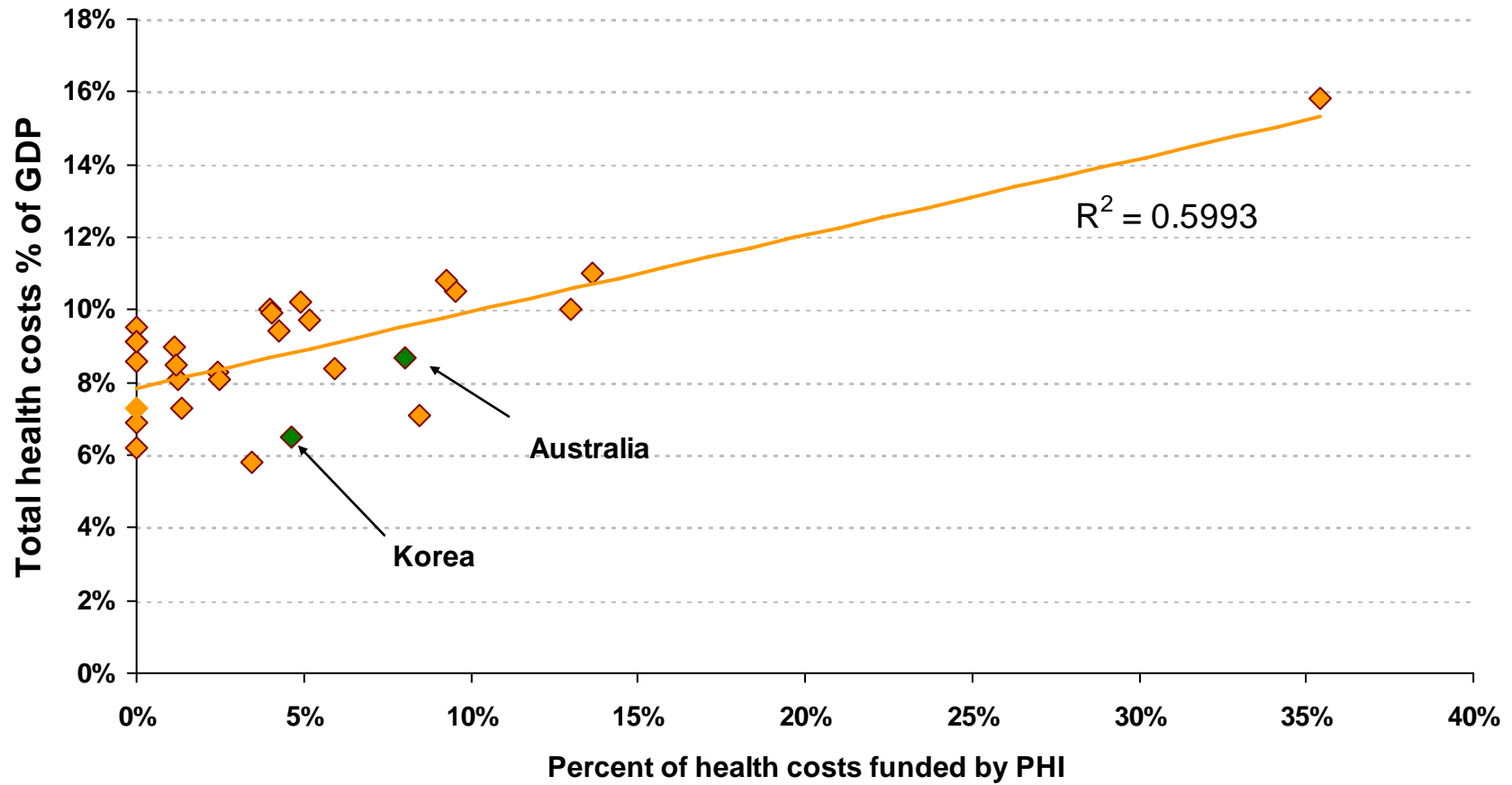
administratively expensive compared with single tax-funded insurer

lacks control on service providers' costs – weak in the market

lacks incentive to reduce demand – “free rider” problem

Problem is not that it is “private”; rather it lacks the power of a single insurer

Private insurance and health care costs



Private health insurance

PHI is an expensive way to share health care costs

A single national insurer has more power:

- to control moral hazard
- to allocate resources where they are most needed
- to preserve equity
- to countervail the power of service providers

Claims of benefits of PHI

Provides choice – but only choice of financier, necessarily highly regulated

Provides choice of doctor – valid when continuity of care is needed, but single insurer can do that

Saves taxes – but PHI is essentially a privatized tax

Supports the private sector – but so too does a single insurer in most countries

Is “private”, therefore preferable to public – a mirror image of the Soviet claim that public is intrinsically more virtuous

What a single insurer is *not*

It is not “socialized medicine”

It is not a universally free system:

a single insurer provides the safety net of insurance – high and uninsurable co-payments have a place, and will be more effective in reducing moral hazard than privatizing insurance

a system is universal if all share the same facilities, even if their payments differ

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Learn from Australia:

Attend to market structure, governance and incentives; privatization is a secondary issue.

Do not exempt health care from industry policy; attend to market failures and inequities without compromising efficiency.

Attend to allocative efficiency – technical efficiency is easier.

Subject programs to cost-benefit analysis.

Ensure health care is structured around consumer interests, not provider interests.

Keep health care integrated and have consistent policies.

Use direct payments to help allocate resources; to the extent health care costs are shared, do so through a single national insurer.