The Commonwealth's health care initiative: is it really reform?

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Australia's health care – a broad perspective

To see the context of these initiatives, it is useful to consider the political economy of our present health care arrangements. Good health care comes at a price, and a central political concern is about who pays that price.

Outcomes

Most Australians enjoy good health. We have close to the world's highest life expectancy (just behind Iceland and Japan). We have an impressive record on smoking and on reducing deaths from lung cancer. We are making progress on reducing deaths from heart disease and stroke. We report high levels of satisfaction with our quality of life. And we are doing this while keeping our health expenditure at around the norm of other developed countries, around 10 percent of GDP.[1]

Countering this impressive overall performance, however, are some serious inequities, particularly among indigenous Australians, and as in other countries, health outcomes are closely related to our economic circumstances: economic inequities are reflected in health inequities.[2] Also, our indicators on diabetes and on obesity as a precursor to diabetes and other health problems are very poor.

What we spend

In 2007-08, the last year for which comprehensive figures are available, we spent just over $100 billion on health care. Most of us find it hard to get a feel for such numbers, so I have given them some dimension by expressing them on a household basis. Our health care outlays, shown in Table 1, are $13 000 per household, about $9 000 of which is through our taxes.

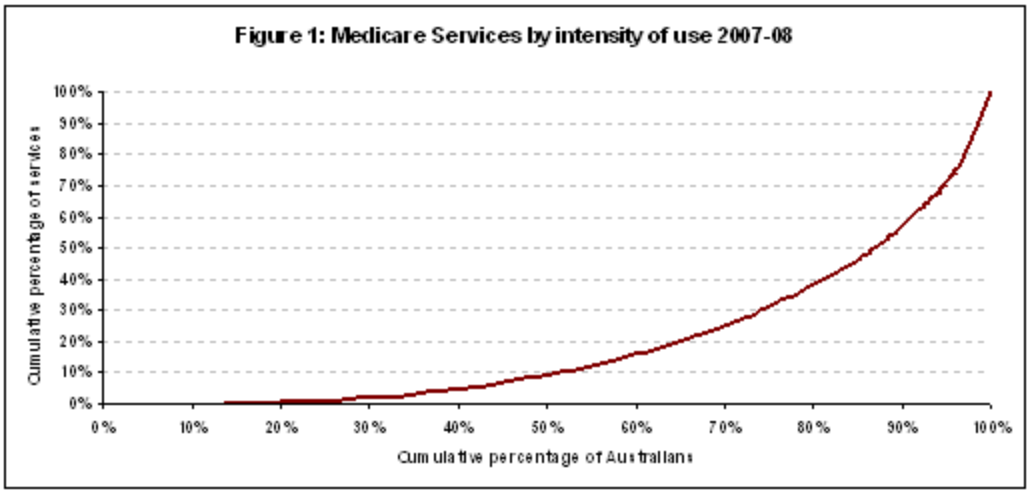
Table 1 Health expenditure 2007-08

	Total $m	Per head $	Per household $
Governments (state and Commonwealth)	71 152	3 346	8 974
Individuals - health insurance	7 862	370	992
Individuals - other	17 416	819	2 196
Other (corporate etc)	7 133	335	900
	103 563	4 871	13 061

Source: Expenditure from AIHW, population and household divisors from ABS.

Health insurance expenditure is net of rebates, which are included under government expenditure

We tend to be unaware of how much we spend on health care for two reasons. First, most expenditure is subsumed in our taxes. Indeed, the 1.5 percent Medicare Levy is a distraction, for it raises only about one sixth of the Commonwealth's health care funding. Second, our use of health care is highly skewed. Most of us, most of our lives, have very little contact with health care. The distribution of health care is skewed towards a few heavy users: in any one year half the population uses only ten percent of Medicare services, while at the other end of the spectrum twenty percent of Australians use sixty percent of Medicare services.[3] (See Figure 1.) It is only if we have the misfortune to suffer a chronic condition or an accident that we become deeply involved with health care during our active lives. Otherwise our experience of health care is likely to be in our dying months or years.



In this regard, it is informative to compare health care with education, another large publicly-funded program. We all experience education in our youth and most of us have some involvement with our children's education through mechanisms such as parents' committees. And in almost every country there are politically active students with a strong stake in education. Health care has no such broad consumer constituency, the only exception being provided by some groups with chronic illnesses who have regular and ongoing contact with health care providers – which means that among consumers, those with chronic conditions tend to command the most policy attention. It is no surprise, for example, that mental illness and diabetes are prominent in the public debate. Also, people's concerns tend to be focused on health conditions with high vividness, such as cancer.

How we spend it

Table 2 shows how we spend that $13 000. Hospitals take nearly 40 percent of our health care expenditure, but from an individual perspective we are probably most conscious of our co-payments for pharmaceuticals and doctor consultations, because these come straight out of our pockets at the time of the service. Hospitals, by contrast, are paid by other parties – by governments in the case of public hospitals and mostly by health insurers in the case of private hospitals.

Table 2 Composition of health expenditure 2007-08

	Total $m	Per head $	Per household $
Hospitals	38 557	1 813	4 863
Medical services	18 338	862	2 313
Medications	26 991	1 269	3 404
All other	19 677	925	2 482
	103 563	4 871	13 061

Source: As for Table 1

Governments, particularly state governments, have a different perspective. A quarter of state budgets is devoted to health care, and two thirds of that expenditure is on hospitals. Hospitals present not only a fiscal concern for state governments; they also present a political concern in the form of emergency department waiting times, surgery waiting queues, and well-publicized mishaps. Certain cases, such as the Bundaberg Hospital deaths, command huge media attention, but there is a background of poor quality control in health care.

A 1995 study of hospital patients in New South Wales and South Australia found that 16.6 percent of admissions were associated with an "adverse event", resulting in disability or a longer hospital stay. These were generally caused by individual or systemic problems in management, about half of which were preventable.[4] In about five percent of all these cases, or almost one percent of all admissions, the patient died as a result of these adverse events. That would indicate about 19 000 preventable deaths a year, not to mention permanent disabilities.[5] Similarly Jeff Richardson of Monash University cites research showing that around 25 patients in Australia die each day from preventable adverse events, suggesting an annual figure of 9 000.[6]

Growth in expenditure

In real terms (that is, in excess of general inflation), health expenditure has been growing at about five percent a year. Some is due to population growth, but even on a per-capita basis real health expenditure is growing at about four percent a year.[7] Some of this growth is due to ageing, some is due to the availability of new technologies and therapies, and some is because health care is intrinsically labor-intensive.

As total expenditure has risen, governments have tried to push costs off to other parties. For the Howard Coalition Government that meant attempts to shift costs to private insurance. For all state and Commonwealth governments that has meant shifting costs between each other – referred to by the cliché "the blame game".

One may believe that in the most rational of all worlds, governments would be concerned with the efficient allocation of resources: for example they would not shift costs on to private insurers if such cost shifting were to result in no outcome other than an increase in the community's total health care costs. But, over the last 25 years, governments have tended to retreat from a wide economic concern for the whole community to a narrow fiscal concern. "Small government", regardless of its wider costs, has become an end in itself.[8]

The government perspective

Governments, therefore, tend to have a particular perspective on health care – a perspective which drives their agenda for "reform". It is likely to be concerned with:

- intergovernmental relations, for health care to date has been a joint Commonwealth and state responsibility;
- hospitals, for they are the largest component of health care outlays;
- cost control, particularly control of what passes through public budgets;
- quality control, for even on narrow fiscal grounds adverse events are problematic;
- the appeasement of interest groups, particularly those on the supply side, for, as explained above, the consumer voice is weak apart from those with chronic conditions.

The Commonwealth's initiatives can be seen largely in that context.

What the Commonwealth has done

The initiatives stem, in part, from the recommendations of the National Health and Hospitals Reform Commission (NHHRC). The appointment of that commission was one of the Rudd Government's first actions upon election.

Most of the Commission's findings and recommendations came as no surprise. It identified inequities in health outcomes, particularly among Aboriginal and Torres Strait Islanders and others living in remote and rural areas. It found gaps in provision, including dental care and mental illness. It noted the stresses on public hospitals, both in their emergency departments and in their ability to provide surgical and medical care. It highlighted practical management issues, including an ageing workforce and slow uptake of information technology – particularly in relation to patient records. Above all, it noted the fragmented nature of health care delivery – although, as I will suggest further on, it failed to come to grips with the root causes of this fragmentation.

The Commission's strongest recommendations were that the Commonwealth should have "full policy and government funding responsibility" for primary health care, and that the Commonwealth should take a stronger role in funding public hospitals, including a move to activity-based funding. That is, hospitals should be funded on the basis on the number and type of services performed, rather than through block grants (usually based on the population in the hospital's catchment). South Australia and Victoria pioneered activity-based, or "casemix" funding and have been the only states to use it.[9]

In addition, the Commonwealth established an expert group to develop a National Primary Health Care Strategy, which reported in 2010.[10] (Just what they meant by the term "strategy" is unclear.) That document put flesh on to the Commission's general recommendation on primary care, including, importantly, the notion of GP Super Clinics which, it envisaged:

> ... will provide a broad range of services that target the health needs of local communities. Patients will be able to access the range of services they need, such as allied health services,

> group education (e.g. for diabetes management), counselling, preventive health services, and specialist outreach in a single, convenient location. Clinics will be open for extended hours, helping to take the pressure off public hospital emergency departments.

The Commonwealth's responses to these, and to other more specific reviews (on ageing, maternity services, payments under the Medical Benefits Schedule, and rural health) have been in the form of a series of initiatives, the most important of which was to take a much more active role in funding public hospitals. These initiatives are detailed in the Government policy document *A National Health and Hospitals Network for Australia's Future*[11], with important policy detail in the Prime Minister's speech announcing the changes.[12]

In a series of agreements with the states and territories (Western Australia is yet to come on board), the Commonwealth will become the majority funder of public hospitals, on a casemix basis, and will take over those aspects of primary care it does not already control – essentially implementing the Commission's recommendations. Management of hospitals will be devolved to local hospital networks.

Hospital funding has commanded policy attention because, over many years, State (and Territory) governments have been legitimately complaining that the Commonwealth has not upheld its share of public hospital funding. The original agreements negotiated with the Whitlam Government envisaged a 50-50 Commonwealth-state funding split. In 2000-01, the Commonwealth had funded 45.2 percent of public hospitals' costs; by 2007-08 this had fallen to 39.2 percent.[13] Over the same period health care was taking an increasing proportion of state budgets, rising from 22 percent in 2000-01 to 26 percent in 2007-08, crowding out other needs, such as education and transport.[14]

Unconditional restoration of funding, even to the 45 percent level was out of the question – that would have cost the Commonwealth an ongoing (and escalating) annual outlay of $2 billion. Instead the Commonwealth will fund 60 percent of the standard cost ("efficient price") of hospital services. This involves a greater Commonwealth funding share, at least partially made up by a clawback of 30 percent of the GST revenue passed through to the states.

This means that the states bear a leveraged responsibility for cost control. If, for example, the standard cost of a procedure is $1000, and the hospital is over budget by 10 percent, with a cost of $1100, the Commonwealth still pays only $600, and the state has to pick up the balance of $500, which is $100 or 25 percent higher than its outlay would have been if the hospital had been able to adhere to the standard cost.

There were other major Commonwealth initiatives. GP Super Clinics are being rolled out (including in Canberra and Queanbeyan), and in the 2010-11 Budget extra funding was announced for health care, including nurse and doctor training, a national performance authority, electronic health records, and more resources devoted to health promotion, illness prevention, and health literacy. One important initiative, largely ignored in the press, is the establishment of a permanent Commission on Safety and Quality in Healthcare. On the revenue and saving side, besides the clawback of GST outlays, there was an increase in the excise on tobacco and savings under the Pharmaceutical Benefits Scheme (PBS). There is a net expansion in funding, but it is difficult to be precise because of the background of normal growth in outlays and the uncertainty about GST revenues.

Given the scope of these changes, the Prime Minister called the initiatives “the most significant reform of Australia's health and hospital system since the introduction of Medicare”.

I do not want to contest that statement. But I do want to ask whether the Commonwealth has overlooked some fundamental problems in our health care programs – problems which have their roots in earlier times when policies were developed in response to needs and conditions at the time, but which have never been re-visited.

To draw an analogy with our health care arrangements, think of an old country homestead which has been shaped over 100 years or more with additions and modifications, some minor, some major, some done in times of plenty, others done in times of stringency, and all reflecting the fashions and technologies of the time. Those who are familiar with the language of public policy will recognize, in this analogy, the ideas of Lindblom who contrasted root-and-branch or comprehensive reform with what he called “muddling through”.[15] We have been muddling through.

Missing – a system perspective

Like the country homestead, our health care arrangements are a mess. They are unbelievably complicated, and the Commonwealth initiatives, if anything, may add to that complication. To continue with the homestead analogy, it has had a major refurbishment, but the old floorplan remains and the new bits do not integrate with the old bits.

The most basic problem is fragmentation in government programs. There are too many disparate programs, and for the most part, these programs are designed around the convenience of suppliers rather than users. They do not join up.

A related problem, which could be seen as fragmentation writ large, is the almost complete separation of private and public hospitals.

We have a set of private insurance subsidies and incentives which does no more than to shuffle queues around, while adding to administrative costs and contributing to health care price inflation. Private health insurance disingenuously combines the worst aspects of socialism and capitalism, while retaining none of their virtues.

And within government programs, we have inconsistent régimes of co-payments.

I will deal with each in turn, but they all come under the general problem that the government and its advisers think about health care as a set of provider-focused programs, rather than as a system.

Fragmentation

Imagine if, when your car needs repairs, you must go to one mechanic for a basic diagnosis and routine service, to another in an entirely different business for specialized service, and to a third type of establishment for major repairs. In addition, the mechanics are not permitted to provide parts; they may specify what parts you need but you must buy them from a

specialized parts stockist – possibly while your car is out of action. The parts stockist has better knowledge about parts than the mechanic, but is not permitted to gainsay the mechanic's specifications. They are all quite separate businesses; in fact there are regulations prohibiting most forms of horizontal integration. Within each establishment only highly qualified mechanics can perform any service on your car; other staff, no matter how experienced, may not do so much as change a light bulb or windshield wiper blade.

Change a few nouns in the above paragraph – for example "mechanic" to "doctor", "parts stockist" to "pharmacy" – and you start to get a picture of our health care arrangements. We have gotten used to them in health care, but, viewed objectively, they are very weird, and user-unfriendly.

The health care industry is burdened with the legacy of ancient customs. The separation of pharmacies from physician's premises, for example, dates to the Holy Roman Emperor Frederic II in 1280. Before there were enforceable laws on trade practices and consumer protection, such separation made sense because it overcame the conflict of interest which can arise when doctors sell profitable medications. It is hard to see its relevance now, however, particularly in view of the Commonwealth's demonstrated powers in controlling pharmaceutical prescribing and pricing. In any case, pharmaceutical firms with their promotions to doctors have found ways around the separation, which by now is like a security fence around an abandoned building.

Our public hospitals date to colonial times, generally as state-subsidized charities for the poor. Doctors worked in public hospitals on an unpaid "honorary" basis – a system of *noblesse oblige*, or as economists would say, they cross-subsidized public patients from high fees imposed on the well-off in doctors' rooms and in private hospitals. Those arrangements held until the middle of last century, when public hospitals became the more inclusive institutions we now know, but we still see remnants of the old culture in the differing remunerations of staff in public and private hospitals.

The Commonwealth, for its part, operates its own major programs – the Medical Benefits Scheme (Medicare) and the PBS – as entirely separate programs, with different budgets, different payments systems and different types of patient co-payments.

This separation of programs is a structure which industrial economists recognize as belonging to another era. There was a time when, for example, auto companies were organized around their input specializations – a casting division for engines, a pressing division for body panels, an assembly division, a sales division etc. Such structures made sense when competitive advantage was based on exploitation of scale economies in manufacturing, but by the end of last century in most industries they had given way to customer-oriented divisions.

It was fifty years ago, in 1960, that Theodore Levitt of the Harvard Business School described such a transformation in businesses, which had previously defined themselves by the products they produced, to defining themselves by the needs they satisfied.[16] Gillette does not make razor blades, it provides services for skin care; Canon does not make cameras, it helps people record images. And so on. This transformation is generally described as moving from a production orientation to a customer orientation.

This transformation was also recognized by governments. In the 1980s the Commonwealth moved its budgetary processes away from an input focus to an output and outcome focus. Health care, however, has remained largely untouched by these transformations. It still has provider-based divisions.

From a consumer's point of view our health care arrangements are a mess, with physical separation of services, duplication of records (consider the number of times a patient must provide her name and address), separation of partial records between different providers, and a lack of continuity of care. There are high search costs, high bureaucratic costs ("transaction costs" in economists' terms), and high risks of conflicting therapies.

From a provider's point of view, however, our program structure could not have been more favorable had the lobbyists designed it themselves. For example the Commonwealth Department has separate divisions for pharmaceuticals, medical services, and private insurers: each provider group has an easily identified point of influence.

In projecting health care expenditure in the *Intergenerational Report*, the Commonwealth's categories are still based on provider categories – hospitals, medical, pharmaceuticals, and private insurance subsidies.[17]

The Commonwealth initiatives retain this structure. The rhetoric is fine: it says health care "should be shaped around the health needs of individual patients...", and that there should be a focus on "prevention of disease and injury and the maintenance of health...", but the actual focus is on hospitals and there is no fundamental program re-structuring. Indeed, the very focus on hospitals tends to reinforce the existing structure. Note, for example, will we have regional *hospital* networks rather than regional *health* networks. Note that the inquiry was called the National Health *and* Hospitals Reform Commission, as if health and hospitals are separate. This is not merely a point of semantics; the title of a commission is subject to deliberation. It reflects the way governments think of health care – as a set of disconnected programs.

There is no doubt, however, that hospitals should not be seen as separate from other aspects of health care. According to the official document accompanying the announcement of the initiatives:

> The Australian Institute of Health and Welfare has estimated that potentially preventable hospitalisations represented 9.3 per cent of all hospitalisations in 2007–08. This equates to approximately 441,000 hospitalisations in public hospitals, with an average cost of about $4,230 per episode of care.[18]

The initiatives are about making our hospitals work more efficiently, and few would quibble with the benefit of doing that. But they seem to be less concerned about making health care as a whole work more efficiently, for our governments do not have a system-wide perspective. In economic terms, the initiatives have been about improving technical efficiency, not allocative efficiency.

One may believe that structure is not a pressing concern among consumers. Medicare's satisfaction rating among the public at 89 percent is high (in fact it was 96 percent two years earlier).[19] But 55 percent of Australians believe there should be "fundamental changes" in our health care system, and a further 18 percent believe the system should be re-built

completely.[20] Among those with chronic conditions, 57 percent of people want fundamental change and a further 20 percent want a complete re-build.

That contrast illustrates a general community perception that while each component of health care works well, they do not come together as a system. The whole is less than the sum of its parts.

There is one tentative move to a patient orientation with the plan for coordinated diabetes care. It's not clear whether this is a precursor to more such programs or simply a reaction to some alarming figures on morbidity, revealing the rapidly rising costs of diabetes. And it's still about coordinating existing disparate programs rather than re-designing programs themselves. (For example, what will be the care of a diabetic who has a car accident?) It's a bureaucratically heavy and therefore costly way to bring care to the patient. I was somewhat surprised to find our local ACT consumer group recommending similar care coordination for people seeking elective surgery, rather than pressing for fundamental program reform.[21]

Private hospitals

We have a weird set of arrangements for funding private hospitals, which are almost entirely separate from public hospitals, and neither the NHHRC nor the Commonwealth has addressed any practical way to integrate them into our health care arrangements.

Private hospitals receive funding mainly through private insurance, and some other third party funders. Also, about 15 percent of patients who use private hospitals pay for the service from their own savings – a point conveniently overlooked by the health insurers, who would like us to believe that without private insurance one cannot use a private hospital. Patients in private hospitals have separate funding provisions with doctors and for pharmaceuticals.

Private hospitals tend to concentrate their services on straightforward elective surgery, while public hospitals pick up all other cases, mainly acute medical care.

There is little reference to private hospitals in the Commonwealth's announcements, presumably because they see them as separate entities. There is, however, one tantalizing statement in the Prime Minister's speech announcing the initiatives. In relation to elective surgery, he said:

> If one of them [the patients] can't get it at their local hospital then the Local Hospital Network will find that person a bed at another hospital within the Network – or with a private hospital if one can't easily be found.[22]

It's hard to see how this will be implemented. Because specialists working on a fee-for-service basis are much more richly remunerated than their colleagues working in salaried positions in public hospitals, it is highly questionable whether private hospitals will supply such services at anything like the "efficient price" applied in public hospitals. Will the Networks contract with the private hospitals, which would mean that the hospitals would be employing the doctors? How will pharmaceuticals be paid for? Will the Government break the restrictions on specialist numbers exercised by the professional colleges, thus reducing the power of specialists to set high prices in private hospitals?

That is not to suggest it is a bad idea. There is every case for bringing private and public hospitals into the same funding stream. The present separation is inconsistent with national competition policy, and, for some conditions, tends to allocate scarce resources to those who have insurance cover rather than to those with the greatest therapeutic needs, and attracts scarce health care professionals away from public hospitals. Subsidized queue-jumping is poor public policy by any criterion.

Private insurance

It would be difficult to design a worse way of funding health care than using private insurance, for it lacks the cost control which can be exercised by a single national insurer, and it lacks the discipline of markets in which people pay for their own services from their own savings.

Health insurance, be it private or public, suppresses price signals – which are the *sine qua non* of markets. The logic "HCF/Medibank Private/MBF will pay the bill" is no different from the logic "Medicare will pay the bill". This phenomenon, known by the quaint term "moral hazard", is a feature common to all insurance, and it results in incentives on both patients and providers for over-use of scarce resources.

Furthermore, shifting funding from public budgets to private insurance may appear attractive to a government concerned with impression management – perhaps wanting to achieve a target size of government spending as a proportion of GDP – but in a wider economic sense it represents no community saving, because what people would save in taxation they have to pay in health insurance premiums, with the extra costs of administration and the loss of cost control which can be exercised by a single public insurer.

The administrative costs are the smaller part of the burden, but they are easily measured: for private health insurance 10.4 percent of revenue is absorbed in administration, and a further 5.1 percent is taken as profit.[23] By contrast the cost to government in collecting taxes and administering Medicare is only 4.0 percent of revenue.[24]

By far the greatest cost of private insurance results from the incapacity of health insurers to control outlays. Because suppliers of health care have strong market power, insurers are weak in the market. If one insurer tries to exercise price discipline on suppliers, there will be others, conscious of their desire to retain their customers, who will be more permissive. There is no reward for keeping costs down. Insurers can easily pass their premium increases on to their members, particularly when those members are supported with high subsidies and tax penalties. Even the economically conservative journal *The Economist* supports this conclusion, pointing out that private insurers lack the market power to control costs.[25]

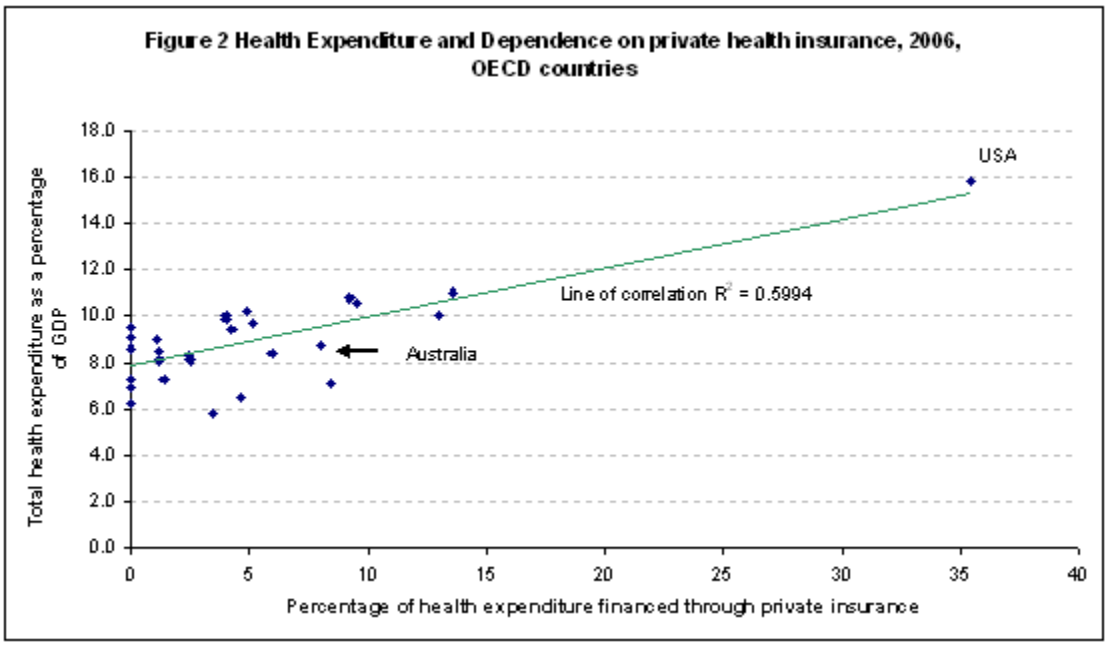
Also, when there are many insurers, no one insurer has any incentive to engage in activities which would reduce demand for health care – activities such as promotion of healthy lifestyles – for these activities have the public good property of non-excludability: one firm's efforts will be mainly to the benefit of its competitors, and no insurer wants to undermine its product by suggesting people don't need to use so much health care .

In a review of Australia's health financing in 2003, the OECD commented:

> Private [insurance] funds have not effectively engaged in cost controls. They seem to have limited tools and few incentives to promote cost-efficient care, and there are margins for some funds to improve administrative efficiency, thereby reducing administrative costs. Private health insurance appears to have led to an overall increase in health utilisation in Australia as there are limited constraints on expenditure growth. Insurers are not exposed to the risk of managing the entire continuum of care. The Medicare subsidy to private in-hospital medical treatment has also reduced funds' accountability for the real cost of private care. Policies to reduce medical gaps have led to some price increase and may have enhanced supply-side moral hazard incentives.[26]

As illustrated in countries with long-established single insurer arrangements, such as the Nordic countries, a single national insurer can reduce moral hazard and keep costs in check by countervailing the market power of suppliers. In relation to contributors, a single insurer is able to insist on uninsurable co-payments if they help reduce excess demand. A single insurer can impose mandatory co-payments to contain moral hazard and to reduce the cost of handling small claims. (In Australia private insurers are permitted to offer "no gaps" policies, heightening moral hazard.) And a single insurer has a strong incentive to invest in activities to reduce demand for health care, as it does not have the "free rider" impediment associated with multiple insurers.

Figure 2, drawn from OECD health data (excluding Greece and Turkey which have incomplete data), shows the relation between countries' total health care funding and their dependence on private health insurance. The relationship is clear: the more that countries try to finance health care through private insurance the higher are their total health care costs. These are all OECD countries with reasonably good health outcomes. In prosperous countries there is no evidence that higher expenditure on health care buys better health care.



In all, private health insurance is an expensive way to share health care costs, not because it's private, but because it's fragmented, lacking the power to overcome moral hazard, and lacking any incentive to provide public goods.

When confronted with evidence that private insurance is more expensive than public insurance, private insurers in Australia respond defensively with three arguments.

One argument is that consumers want choice. Indeed, in most markets, consumers benefit from choice just as they do from price competition. But choice is a benefit only if consumers are offered a variety of products. In health insurance there is little capacity for firms to vary their offerings. If governments are to ensure health insurers provide at least some equity they have to regulate the industry strongly. In Australia health insurers are required to equalize their demographic risk through re-insurance. They may not discriminate against those with pre-existing conditions. They must not offer policies with an excess greater than $500. They must apply standard price penalties based on age ("lifetime rating"). All these regulations mean there is little scope for product differentiation. Choice of financial intermediary, when they all offer the same packages, confers little benefit for consumers.

Another argument is that many consumers want choice of doctor. Those who are admitted to hospital as public patients have to accept care from the doctors on duty, while in private hospitals they can receive care from their own doctor: that choice is reflected in the separation of medical and hospital funding. This argument has validity, but there is no compelling reason why, for conditions where continuity of pre-hospital and hospital care is important (particularly maternity), public hospitals should not be able to offer the same choice.

There is the specious argument, often presented in the media, that without private insurance there would be no "private sector". Emotive terms, such as "socialized medicine" prevail. There is no reason, however, why private hospitals should have to depend on private insurance; as Victorian Premier Jeff Kennett pointed out almost 20 years ago, private hospitals are always free to contract to state governments to provide services for public patients. And there is a Commonwealth model in its payments for war veterans, where the Commonwealth is the sole funder with most hospital services provided by private hospitals.

Then there is the argument that supporting private insurance takes pressure off public hospitals. This justification has glib appeal, but it considers only the demand side, not the supply side, for where demand goes so too do the resources: skilled medical practitioners and nurses will either take their services to private hospitals or will demand more payment from public hospitals, either way putting more pressure on public hospitals. In reality all that our present incentives achieve is a re-shuffle of the queues, with the result that priority treatment, particularly for elective surgery, goes to those with the best insurance cover rather than to those with greatest needs. It's extraordinary public policy for a government to subsidize queue jumping, and it's equally extraordinary for a government to claim it can relieve pressure on public hospitals by offering enticements to take away their professional staff.

Finally, there is an emotive argument that private insurance must be preserved because it is "private", as if there is some intrinsic merit in an activity because it takes place in the private sector – the mirror image of the argument of doctrinaire communism which sees intrinsic merit in state activity. As John Kay, one of Britain's leading economists said:

> ... both supporters and critics of the market economy have often confused policies that are pro-business with policies that are pro-market.[27]

Yet, this simple "pro-private" philosophy seems to be the main basis for supporting private insurance. It has distracted policy attention from the more basic question about the extent to

which we insure. It is taken for granted that we should insure, and that private insurance, regardless of evidence to the contrary, is superior to public insurance. Reflecting this uncritical attitude, the report of the NHHRC, without analysis or logical justification, states:

> We want to see the overall balance of spending through taxation, private health insurance, and out-of-pocket contribution maintained over the next decade.[28]

If the Commonwealth's moves to reduce public hospital waiting lists and to expand the health workforce are effective, and if they can find a way to buy services from private hospitals, there should be less demand for private insurance. Perhaps this is the indirect (and timid) way of reducing dependence on private insurance, which, by any criterion of sound policy, "left" or "right", is desirable.

To its credit, the Commonwealth has buried the NHHRC's suggestion for entrenching private health insurance in what it called "Medicare Select" – a scheme which would have seen compulsory enrolment in private insurance, and it has similarly buried the Commission's recommendation for "Denticare", which would have required dental funding to be churned both through the tax system and through private insurance. The Commission saw private insurance as a "good", without at any point showing how it could add value to health care.

Yet, at the same time the Commonwealth has been trying to increase the incentives for high-income earners to hold hospital insurance – an initiative at variance with its other health policies. Another case of policy fragmentation.

Co-payments

Finally there is the problem of co-payments. There is no consistency in the divisions between free, partially subsidized, and unsupported services. Most co-payments are open-ended, leaving the patient to cover any fee above what the public or private insurer pays; the only significant exception is in the PBS, where co-payments are fixed. Some co-payments are on a family basis while others are on an individual basis. There are welfare provisions and safety nets; most safety nets reset on a calendar year, while we have a 20 percent tax rebate for uninsured services above $1500 which resets on a financial year.[29] It's an extraordinary mess.

Table 3 shows how consumer payments (co-payments and full payments) vary. Individual payments, which are the normal market mechanisms for allocating resources, are inconsistent across different areas of health care. This leads to serious inequities. Someone with a chronic disability who needs ongoing physiotherapy (classified as "other health practitioners") and who needs aids and appliances will have to pay for most of his own health care year in year out, while someone else whose needs can be met in one high-cost hospitalization will pay almost nothing out-of-pocket. Also, there are problems of allocative efficiency, because consumers and doctors recommending therapies are drawn to those areas where the out-of-pocket pain is low – which happen to be hospital services. Even if each part of Australia's health care were to achieve a high level of technical efficiency, different financial incentives in different parts will result in an opportunity cost in terms of forgone allocative efficiency.

One reason for this mess is that different co-payment arrangements reflect the different ideologies, budget constraints, and perceived needs of the times when particular health programs were introduced.

Table 3: Individual payments 2007-08

Area of health care	Individual payments $m	Total payments $m	Individual payments as percentage of total payments
Public hospitals	475	30 817	2%
Private hospitals	337	7 740	4%
Medical services	2 170	18 338	12%
Prescription pharmaceuticals	1 231	8 110	15%
Other health practitioners	1 574	3 373	47%
Dental care	3 944	6 106	65%
Aids and appliances	2 264	2 634	86%
Non-prescription pharmaceuticals	5 185	5 611	92%
All health care	17 798	98 017	18%

Source: AIHW *Health Expenditure* 2007-08

In the postwar years, when Labor tried (unsuccessfully) to bring in a national health scheme and the Coalition established the PBS, real incomes were much lower, life expectancies were shorter, and no-one foresaw the huge potential growth of new health technologies. Real male incomes (brought to 2010 prices) in 1950 were only $20 000 a year, and life expectancy at birth was only 68 years.[30] Drugs on the PBS were free until 1960, and that made a great deal of policy sense at the time. In 1975 when the Whitlam Government introduced Medibank, with a strong preference for free "bulk billed" services and agreements with the states to provide free public hospitalization, real male incomes were still only $40 000. They are now $70 000, and, because of greater female workforce participation, family incomes would have risen even faster. Life expectancy is now 81 years.

The Commonwealth has ducked the issue of co-payment reform. While such reform would possibly result in more generous cover for some conditions, it would almost inevitably see some presently free services attract co-payments. Or it may take the form of a universal safety net, to be applied after a certain threshold of personal expenditure is reached, with allowance for those with constrained means. I personally doubt whether Australians would opt for a completely free tax-funded system, but the basic question of how we should divide health care funding between collective funding and individual funding has never been put to the Australian people: the closest we have come to such a debate is the question whether our collective funding should be through private or public insurance. It is possible that Australians see health care as something they want to share as a principle of "solidarity", or in recognition of the randomness of illness, and are in favor of an entirely free system.

On the other hand, with explanation, and if coupled with a corresponding tax cut and a phasing out of private insurance, it could be possible to introduce some reasonably high level of general co-payment. Such a policy is not without precedent: in the 1987 election campaign the Coalition proposed that people should pay the first $250 of health costs from their own pockets without insurance. Indexing this amount by average weekly earnings brings it to around $700 in today's terms, which would put most Australians into a more market-oriented situation in relation to health care.[31] It was a sound policy, abandoned only because the Coalition parties saw supporting private insurance as more important than bringing market forces into health care.

Conclusion

The initiatives are extensive, but in comparison with other major policy changes, they are not far-reaching. Previous governments have embarked on much more difficult and painful policy changes. The Hawke-Keating Government overhauled industry assistance, abolishing protective tariffs and import quotas, with quite severe consequences for employees and investors in the affected industries. The Howard Government dramatically reformed our indirect taxes. In neither case were there adverse political consequences.

Fundamental health reform should be easier than reform of industry assistance, for in health care, there is no question of anyone presently delivering services losing their livelihood – although some specialists may have to bring their lifestyles back a notch or two. Some bureaucrats in insurance firms and in government health departments may have to find more gainful employment.

The present government made a fundamental mistake at the outset in appointing a commission drawn from people intimately connected with health care provision. In fact, it was chaired by a senior executive in a health insurance firm. The Commission's report is one written by insiders – people highly proficient in their own fields, but who find it difficult to take a broad perspective and to pose fundamental questions. It would have been far better if the government had used the Productivity Commission, with its professional detachment, for this type of inquiry.

At the same time, the Commonwealth Government should have put to the community fundamental questions of the principles which should underpin our health care policies. How do we want to ration scarce resources? Should we try to incorporate distributive welfare into health care programs or should that function be confined to social security programs? How should we divide funding between individual and collective sources?

We could see the 2010 initiatives as a set of necessary but partial changes, to keep the existing structures going for a few more years while we embark on basic reform. Tariff reductions took decades, and indirect tax reform, although brought in over one term, had a basis in earlier fundamental reviews undertaken by the Hawke Government. Health reform will take time, for it will require the government to engage with the community on those difficult questions referred to above.

Because we are now entering, *de facto*, an election period, I want to conclude with a word of caution. I am not alone in finding that the Commonwealth initiatives have fallen short of what may be called fundamental reform. But that is not to provide any endorsement or preference for the policies of the possible alternative government. Their recent proposals on mental illness have merit in that they extend the notion of a user orientation, but their proposal to abolish GP Super Clinics is regrettable, and their proposal to abandon electronic patient records is alarming, in view of the quality problems in health care. Also, their record on private insurance shows a greater concern for privatization than for economic efficiency. We should reserve judgement, however, until all policies are revealed.

Notes

1. A range of data can be found at the Australian Institute of Health and Welfare regular publication *Australia's Health*. The latest 2010 edition is at: http://www.aihw.gov.au/publications/aus/ah10/ah10.pdf

2. See Richard Wilkinson and Kate Pickett *The Spirit Level: Why Greater Equality Makes Societies Stronger* (Bloomsbury 2009).

3. In 2007-08, 51.43% of Australians used 10.24 percent of Medicare services, and 19.11% used 60.58% of services. Figures derived from *Medicare Annual Report* 2008-09 Appendix Table 20.

4. Ross McL Wilson, William B Runciman, Robert W Gibberd, Bernadette T Harrison, Liza Newby and John D Hamilton "The Quality in Australian Health Care Study" *Medical Journal of Australia* Vol 163, 1995.

5. The Wilson study found 4.7 percent of the 16.6 percent died, indicating a death rate of 0.78% of admissions. Based on 4.9 million annual admissions (public hospitals only) that would indicate annual deaths of 38 000. If 51% are preventable, that would indicate a preventable death rate of around 19 000.

6. Jeff Richardson "Steering without navigation equipment: the lamentable state of Australian health policy reform" *Australia & New Zealand Health Policy* # 6, 2009.

7. AIHW *Health Expenditure Australia* 2007-08 AIHW 2009.

8. For a more complete explanation of this phenomenon, see my article "Who's that tugging at our skirts?" *D!ssent* Number 32, Autumn/Winter 2010.

9. The Commission's final report *A Healthier Future for all Australians* (June 2009) and final report (December 2008) can be found at: http://www.health.gov.au/internet/nhhrc/publishing.nsf/Content/nhhrc-report

10. *Building a 21st Century Primary Health Care System*, available at the Government's health reform website http://www.yourhealth.gov.au

11. Also available at the Government's health reform website.

12. See the Prime Minister's National Press Club Speech of 3 March 2010 at http://pmrudd.archive.dpmc.gov.au/node/6534

13. See AIHW *Health Expenditure Australia 2007-08* Table 4.5.

14. See ABS *Government Finance Statistics, Australia* (ABS 5512.0), 2008-09, Table 4.

15. Charles E Lindblom, "The Science of 'Muddling Through'" *Public Administration Review* Spring 1959.

16. Theodore Levitt "Marketing Myopia" *Harvard Business Review* vol 38 #4 July/Aug 1960, Republished July 2004.

17. Commonwealth Treasury *Australia to 2050: future challenges* (*Intergenerational Report*) 2010.

18. Department of Health and Ageing *A National Health and Hospitals Network for Australia's Future* 2010.

19. Medicare Australia *Annual Report* 2007-08.

20. Commonwealth Fund "International Health Policy Survey in Seven Countries" 2007 http://www.commonwealthfund.org.

21. "Call to fund new path for patients" *Canberra Times* 15 June 2010.

22. Prime Minister's National Press Club Speech of 3 March 2010.

23. For PHI administrative costs see the PHIAC *Annual Report* 2008-09.

24. In 2008-09 Medicare processed $27.7 billion of claims in its three main programs, with administrative expenses of $722 million, giving an administrative cost ratio of 2.6 percent. Medicare Australia *Annual Report* 2008-09. To this must be added 1.4 percent for tax collection. *Australian Taxation Office* Annual Report 2008-09.

25. *The Economist* "Clear Diagnosis, Uncertain Remedy" Feb 18th 2010.

26. Francesca Colombo and Nicola Tapay "Private Health Insurance in Australia: A Case Study", *Health Working Papers* No. 8, OECD, 2003.

27. John Kay "The future of markets" 2009 Wincott lecture http://www.wincott.co.uk/lecture2009.htm

28. National Health and Hospitals Reform Commission *A Healthier Future For All Australians* Final Report June 2009, Recommendation 92.

29. See Jennifer Doggett "Out of Pocket: rethinking health copayments" Centre for Policy Development July 2009.

30. Life expectancy in 1946-48 was 66.1 years for males. 70.6 years for females. ABS *Australian Historical Population Statistics* Cat. no. 3105.0.65.001.

31. In the September quarter 1987 Average Weekly Ordinary Time Earnings for full time adults were $445.0 and in the December quarter 2009 they were $1 226.7 (RBA Table G6). Applying this ratio (2.756) brings the $250 payment up to $680.