

# Health care in Australia: missed opportunities for reform

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## Summary

Most sectors of Australia’s economy have undergone significant structural change over the last thirty years, but health care has been largely insulated from these processes. Its architecture remains substantially the same as it was in the mid 1970s. What changes have occurred have been partial, in response to specific problems.

Each change has been made in the context of the political ideologies, fashions, and fiscal conditions at the time. Consequently, health care is fragmented, without coherent policy underpinnings. There are programs with universal free entitlements alongside others with strong means testing. There are two separate hospital systems, one nominally “public”, the other nominally “private”, with entirely different funding mechanisms. There are many exemptions from competition, impeding structural change and maintaining privileges for providers. Such fragmentation has been costly, in terms of equity and technical and allocative efficiency.

Only in health funding, specifically in health insurance, have there been significant changes. The balance between private and public insurance has oscillated in line with the ideologies of successive governments, distracting from the more important question of the extent to which health care expenses should be met by individual payments, without the moral hazard of insurance. Economic theory and evidence suggest that the most equitable and efficient way communities can share health care costs is through a single national insurer (generally a government insurer). That does not mean the government need be the major provider of health care, however. There is scope for the private sector to dominate the supply of services and for individual payments to take a stronger role in financing services.

Because Australia has tolerably good health outcomes, with outlays in line with other OECD countries, there is complacency in government circles. There is a failure to recognize the costs of forgone opportunities for reform.

Other countries can draw on Australia’s experience – as a reminder not to allow privatization to become a substitute for economic reform, to manage health care as an integrated system, and to ensure public policy is not captured by provider interests.

The other strong message is that as countries become more prosperous, governments should keep in mind opportunities for funding to be shifted to individuals, without the distortion of insurance. The balance between insurance and individual payments will be influenced by national cultures, and should always ensure there is access to health care for the least well-off.

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### Notes for the reader

#### Australia's government structure

Australia is a federation, with one federal government (the "Commonwealth" Government), six state governments and two self-governing territories – for all purposes they function as two extra states. Australia's constitution divides functions between the Commonwealth and state governments. Two states, New South Wales and Victoria, have 60 percent of the nation's population.

#### Currency

Monetary figures in this paper, except where otherwise indicated, are in Australian Dollars. At the time of preparation the exchange rate was 1,035 Won to the Australian dollar.

## Introduction

Australia's health care industry has no clear division between a private sector and a public sector. Health care is delivered through a wide variety of mechanisms ranging from large publicly listed corporations through to one person general practitioner clinics. In terms of funding health care, the public sector dominates, but in terms of delivering health care the private sector dominates: 70 percent of recurrent health care funding is from the public sector, while about 60 percent of health care is delivered by the private sector. Only in hospitals does the public sector dominate, with most hospital care being provided in hospitals operated by or on behalf of state governments.

To those concerned with the economics of health care, ownership is of less concern than the market structures in which health care providers operate. Almost all health care is provided in highly regulated markets: lightly regulated competitive markets operate only on the fringe of health care, such as non-prescription pharmaceuticals sold in supermarkets. And only a small proportion (18 percent) of health care is paid for by direct consumer payments; all other payments are made by public or private insurers.

A notable feature of the Australian economy over the last thirty years has been a high degree of structural change, generally initiated by the Commonwealth (federal) Government. Australia has dismantled protective tariffs, implemented vigorous competition policy, privatized most public utilities, deregulated the financial sector and fundamentally restructured indirect taxes. Yet health care has remained largely insulated from these changes. Health care is still shielded from the forces of competition policy and has many arrangements which had their policy justifications in past times but which are now quite dysfunctional: an example is the separation of pharmacies from other primary care providers.

Where change has occurred it has done so incrementally, in response to specific opportunities and problems. Health care programs have therefore been shaped by the broad (and shifting) government ideologies and fiscal conditions at the time of their introduction – the “left”/“right” complexion of the government and the state of public revenue determining fiscal tightness or looseness. Consequently, there is little underlying policy coherence in Australia's arrangements; an outside observer will see in coexistence underpinnings of democratic socialism alongside strong preferences for the private sector.

Fundamental reform is impeded by the presence of vocal and well-funded interest groups, particularly among health care providers, and by the inherent conservatism of the industry. Public policy has been distracted from serving the community's interests of efficiency and equity, towards serving the interests of financial intermediaries, medical specialists, pharmacists and others who benefit financially from government interventions.

The main public policy considerations in recent years have related to the role of private health insurance, which, while being small in terms of total health care funding, has been of major policy concern to successive governments, with Coalition Governments (center right coalitions of the Liberal and National Parties) generally favoring private insurance and Labor Governments (center left) favoring public insurance. The present Labor Government, elected in late 2007, made health care reform, particularly improvement of hospital services, a major campaign issue, and appointed a reform commission which reported in mid 2009. So far it

appears that whatever changes do occur as a result of that commission's work will be in the tradition of incremental rather than system-wide initiatives.

Although Australia has health outcomes and expenditures in line with other OECD countries, it has many shortcomings in terms of efficiency (technical and allocative efficiency), and in terms of equity. In part these shortcomings arise from constitutional constraints and the related distribution of responsibilities between the Commonwealth and state governments. But they also arise from the incremental nature of policy development referred to above, from the influence of lobby groups, and from poorly defined policy objectives.

In terms of specific program management, Australia has some practices which provide valuable models for other countries: the mechanism for evaluating and pricing prescription pharmaceuticals provides a case in point. Also, Australia has led the world in some public health initiatives. But in terms of overall system management and governance Australia provides a case study of lessons for other countries – mainly lessons about forgone opportunities and the consequences of poorly developed policy processes and poorly designed organizational structures. (Australia is not alone in finding health care policy problematical, however.)

This paper starts with a broad economic description of Australia's health care from an international perspective. That is followed by a short history of Australia's health care showing how there has developed a fragmented set of arrangements. The third section looks at financing health care and at specific sectors, mainly hospitals, with an emphasis on economic issues of equity, technical efficiency and allocative efficiency. Finally, there are some tentative conclusions which may provide some ideas and warnings for policymakers in other countries.

### Efficiency in health care

There are three main ways in which *technical efficiency* in health care may be improved. First, highly skilled and highly paid professional staff can be better deployed, through reducing administrative burdens and ensuring that there are no work restrictions, such as professional demarcations, which prohibit staff from applying their skills. Second, expensive diagnostic equipment can often be better utilized. Third, administrative procedures can generally be improved, particularly in relation to use of information and communication technology.

*Allocative efficiency* is generally defined in terms of using limited resources to maximize health outcomes. Saving life is one such outcome, but it is a crude one. An outcome of saving life-years is more refined, and it gives more weight to

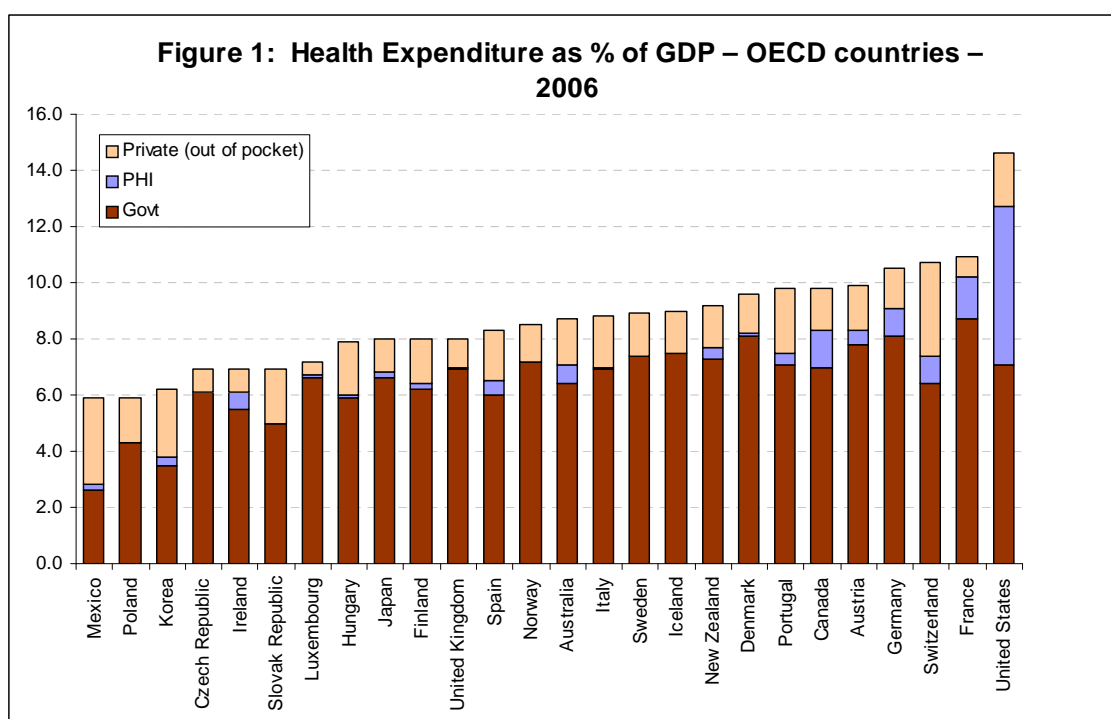
interventions early in life than those which may extend life by only a few months or years. An even greater refinement is in use of "quality adjusted life years" (Qalys), which place more weight on interventions which result in a fully functional life-year than those which leave a patient partially or wholly incapacitated. Qalys incorporate different weights to different levels of incapacity.

An increasing trend is for health care interventions to be subject, where possible, to empirical research on their effectiveness, requiring policy and resulting guidelines to be evidence-based. Such empiricism is formally established in pharmaceutical evaluation, but is not so widely applied in other areas of health care.

## 1. Australia's health care industry and how it compares

### Expenditure

In terms of total health care expenditure as a percentage of GDP, Australia is near the average of OECD countries (8.7 percent in 2006) – an average which is influenced, in part, by very high expenditure in the USA. Figure 1 shows health expenditure for OECD countries, distinguishing between direct private payments, public funding and private health insurance (PHI) funding.



In most countries between 70 and 85 percent of health care is funded by third parties, being some combination of government and private insurers, with the rest being funded through direct consumer payments – either co-payments (supplementing payments by insurers) or full payments without any third party support. (Korea stands out with a high proportion of health care being funded through direct consumer payments). Where countries tend to differ is in the balance between private and public health insurance. The Nordic countries and the UK have almost no funding passing through private health insurance. In some other European countries, such as France, Germany and the Netherlands, most private insurers operate on a mutual not-for-profit basis, while in some other countries, most notably the USA, private insurers dominate and are mainly for-profit corporations. Some countries, such as Canada, restrict private insurance to services not covered by the government insurer (a complementary role), while others allow private insurers to compete with or supplement public insurance.

Australia's funding arrangements are complex, this complexity having built up over time as a result of the incremental approach to health care policies referred to above. Most policy concern, and about three quarters of government funding, however, is with three main programs:

The *Medical Benefits Scheme (MBS)*, also known as *Medicare*, is a Commonwealth program which pays for about 84 percent of medical services, other than those performed in public hospitals. Every procedure has a description and a specific payment known as the “schedule fee”, but medical practitioners are permitted to charge more than the schedule fee if market situations permit, with patients picking up the balance. There are Commonwealth-funded safety nets for those who accumulate a high level of co-payments.

The *Pharmaceutical Benefits Scheme (PBS)*, the other main Commonwealth program, controls the prices of most prescription pharmaceuticals and reimburses most of the cost of prescriptions. Both the producers’ prices and the pharmacists’ markup are controlled. Most consumers are required to pay up to \$33.30 for prescription pharmaceuticals, with significantly smaller co-payments for those eligible for social welfare. As with the MBS there are safety nets for those with high use of prescriptions.

*Public hospitals* are operated and funded by state governments, but about 42 percent of that funding comes from the Commonwealth as tied grants to the states. Under agreements between the Commonwealth and state governments, all public hospital services are provided free, and there is no means testing.

In addition, the Commonwealth, through a system of direct subsidies to private health insurers and tax penalties imposed on high income earners without private health insurance, encourages Australians to hold private insurance. These incentives and penalties apply to individuals; unlike the situation in the USA, and unlike what used to occur in Korea, there is no incentive for employers to finance private insurance for their employees. (In fact, Australia’s tax system generally discourages any form of employee benefits other than direct monetary payments and superannuation.) As at late 2009, 45 percent of Australians held private insurance. People use private insurance mainly to fund accommodation in private hospitals, the gap between the Medicare schedule fee and the fee charged in private hospitals, and other benefits, particularly dental care.

In terms of funding, the sources and main applications of Australia’s health expenditure are summarized in Table 1, with more comprehensive detail in Appendix 1.

Source	Main areas of expenditure	\$ billion
Commonwealth Government	Most medical services (MBS) and prescription pharmaceuticals (PBS), other than those performed and provided in public hospitals, a large share of public hospital funding (which is passed through to state governments) and subsidies for private insurance.	44
State and territory governments	Public hospitals and a number of community health services (some in cooperation with local governments).	24
Health insurance funds	Private hospital accommodation and some other “ancillary” services such as dental care. (Medical services in private hospitals are funded largely by the Commonwealth).	8
Individuals	Co-payments for pharmaceutical and medical services. Full payment for other services such as dental care (unless privately insured), premiums for private health insurance,	18
Accident insurers, foundations etc	A miscellany of services, almost all supplied by private sector providers.	4
Total funding		98

## Australia's health outcomes

One of the most basic revelations from OECD data is that it is difficult to find any significant relationship between health expenditure and health outcomes. All developed countries enjoy reasonably good health; while there are variations in health indicators these are far less than variations in health outlays. Evidence suggests that to the extent that provision of health care contributes to health outcomes, the composition of health facilities is important, with primary care being particularly effective.<sup>1</sup>

Table 2 shows three of the more commonly used health indicators for OECD countries.

	Life expectancy at birth (years) 2005	Rank	Potential life years lost, all causes of death, per 100000 population <70, 2003	Rank	Maternal & infant mortality - deaths per 1000 live births, 2005	Rank
Australia	80.9	4	3 228	6	5.0	22
Austria	79.5	12	3 610	13	4.2	16
Belgium	79.1	18			3.7	9
Canada	80.4	7	3 460	10	5.4	24
Czech Republic	76.1	25	4 548	23	3.4	7
Denmark	78.3	22	3 783	18	4.4	18
Finland	79.1	19	3 767	17	3.0	5
France	80.2	10	3 840	19	3.8	10
Germany	79.4	15	3 545	12	3.9	14
Greece	79.3	17	3 316	8	3.8	12
Hungary	72.8	29	6 784	27	6.2	25
Iceland	81.2	3	2 352	1	2.3	1
Ireland	79.5	13	3 625	14	4.0	15
Italy	80.9	5	3 068	5	3.8	13
Japan	82.0	1	2 838	3	2.8	4
Korea	78.5	21	4 135	21	4.7	19
Luxembourg	79.5	14	3 712	16	2.6	3
Mexico	74.7	27	7 014	28	16.8	29
Netherlands	79.4	16	3 328	9	4.9	20
New Zealand	79.8	11	3 863	20	5.0	21
Norway	80.3	9	3 269	7	3.1	6
Poland	75.1	26	5 651	25	6.4	26
Portugal	78.1	23	4 411	22	3.5	8
Slovak Republic	74.0	28	5 779	26	7.2	28
Spain	80.4	8	3 485	11	3.8	11
Sweden	80.6	6	2 775	2	2.4	2
Switzerland	81.4	2	3 028	4	4.2	17
Turkey	71.4	30			23.6	30
United Kingdom	79.1	20	3 699	15	5.1	23
United States	77.8	24	5 054	24	6.9	27

Source: *OECD Health Data, 2009*

1 Starfield et al 2005, WHO 2008.

Table 2 shows that the USA, which stands out in terms of its outlays on health care, performs poorly on most indicators of health outcomes; Korea, with a much lower outlay on health care, outranks the USA on all three indicators shown in that table.

By most (but not all) indicators, Australians enjoy good health. Possibly that has led to a degree of complacency about reform. But as pointed out by Professor Jeff Richardson of Monash University:

Commentary on health policy reform often commences with an unstated logical error: Australia's health is good, therefore the Australian Health System is good. This possibly explains the disconnect between the options discussed, the areas needing reform and the generally self-congratulatory tone of the discussion: a good system needs only minor improvement.<sup>2</sup>

In terms of life expectancy and years lost from early death among adults, Australia does indeed rank well, but in terms of maternal and infant mortality Australia's rank is poor – almost certainly an influence of high mortality among Aboriginal Australians. Other more specific indicators show similar mixed results.<sup>3</sup> One specific risk indicator is obesity, where, among OECD countries, Australia ranks 24 out of 28 in increasing order of obesity, while Korea shares the number one position with Japan.<sup>4</sup>

Richardson and others also point out, contrary to government rhetoric about equity, that health care resources are not well distributed. Thanks to universal medical, pharmaceutical and hospital schemes Australia does not have the USA problem of an uninsured minority, but there are significant disparities in access to health services. As in other countries Australia has regional disparities: the large cities are more prosperous than the country, and within those large sprawling cities there are regions of comparative poverty. Health care resources, particularly general practitioners and specialists, are similarly poorly distributed. While state governments determine where public hospitals will be located, governments have no power to require private providers to locate in particular areas.

Also there are financial impediments to access. Although many would consider Australia's co-payments to be modest, slightly more than a third of Australians with chronic conditions report that in the last two years they have either not filled a prescription or have not obtained recommended treatment, because of costs.<sup>5</sup>

In addition, the way in which the Commonwealth has structured incentives for people to take private insurance has contributed to inequities, for those incentives are most generous for the well-off, who, with the backing of private insurance, can get priority treatment in private hospitals and therefore first call on scarce resources, while those without private insurance, while being entitled to free care in public hospitals, may face very long waiting times for similar services. (This is not to suggest private hospitals provide better care than public hospitals. While many offer superior comfort, they generally offer fewer services. Those with complex needs are generally better served in public hospitals.)

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2 Richardson 2009.

3 Tiffin and Gittins 2004.

4 OECD Health Data 2005.

5 Commonwealth Fund 2008.



Another aspect of health care, often overlooked, is the quality of care. A survey in 1995 found that there were around 18 000 deaths and 50 000 cases of permanent disability each year associated with adverse events in health care. At least half of these could have been prevented with more rigorous quality control. Around 17 percent of hospital admissions involved an adverse event.<sup>6</sup> To put these figures into perspective, imagine a country with half the population of Korea experiencing a Boeing 747 crash every week.

It is tempting to rationalize such shortcomings on the basis that such problems are manifest to some extent in all developed countries. Such an attitude reflects a culture that would be unacceptable in any other industry. In well-performing industries few firms would be content to gage their performance by using the poor performance of their competitors as a benchmark, and no firm would last long if it had an ongoing (and soluble) problem in quality control.

To return to Richardson's observation, even if Australia does enjoy good health, it is erroneous to attribute good health outcomes solely to the performance of the health care sector. There are many determinants of health. Inequality is associated with poor health; even controlling for any association between poverty and difficulties in accessing health care, economic inequality in itself seems to be a factor leading to poor health.<sup>7</sup> And it is well-known that many public health measures, far removed from health care, can have significant health benefits. Australia, for example, led the world in automobile seat belt legislation; this and other road safety measures such as carefully designed speed limits and strict laws on drink driving, have resulted in a dramatic fall in motor vehicle injuries and mortality. Similarly, in response to the spread of HIV/AIDS, Australia has been vigorously promoting sexual health. Australia was an early adopter of anti-smoking measures; by now only 19 percent of adults smoke, a very low figure by international standards.

## Conclusion, Part 1

There are three policy lessons we can draw from this short analysis of comparative health outlays and of Australia's experience – lessons which may be applicable beyond Australia:

- 1.1 Higher outlays alone do not necessarily buy better health care.
- 1.2 By the standards generally used to evaluate an industry's performance, Australia's health care sector could do much better.
- 1.3 While health ministers and their advisers are very concerned with health care, public health in areas as diverse as road safety and sexual health can have significant benefits, often with low budgetary and community costs.

These are the broad messages we can draw from such a broad analysis. When we look more closely at particular programs there are other messages we can draw, either from positive experiences (such as Australia's evaluation of prescription pharmaceuticals) or from negative experiences (such as Australia's concerns with privatized funding rather than pursuit of economic efficiency). These are covered in the next two sections.

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6 Wilson 1995.

7 Wilkinson and Pickett 2009.

## **2. Australia's mess and how it got that way**

### **Political and constitutional background**

Korea is spared some of the difficulties experienced in federations such as Australia and the USA.

As in some other federations the main role of Australia's central government is to collect and re-distribute funds, either through transfers to states and individuals, or to buy services. Apart from defense assets, the Commonwealth Government has few physical assets and few business enterprises. (Over the 1990s and 2000s the Commonwealth divested itself of airline, banking, telecommunications and many other smaller businesses.)

The Commonwealth is the nation's main taxation authority: it collects 82 percent of all taxes, while the states and territories collect just 15 percent of taxes. State finances are boosted by transfers from the Commonwealth, including all of the revenue collected from the goods and services tax, and specific grants for health care, mainly public hospitals.

Federal systems develop tension between tiers of government, and health care is one of the prime areas of such tension, particularly in Australia because health care is a shared responsibility. The division between Commonwealth and state funding responsibilities is not clear cut: although there is a separation with the Commonwealth responsible for funding medical services and pharmaceuticals and the states responsible for funding and operating public hospitals, there are conflicts and incentives for cost-shifting. For example, if a state can reduce a patient's stay in a public hospital, her care becomes a Commonwealth responsibility on discharge. Conversely, if more people hold private insurance and use private hospitals, there is less demand on state-owned public hospitals – although as demand shifts so does supply, as medical specialists and nurses are attracted away from the public sector, (which is why financial support for private insurance, contrary to government claims at the time it was re-introduced, has not reduced the pressure on public hospitals).

While such intergovernmental problems are peculiar to federations, there is another political issue relating to health care which seems to arise in all democracies – the power of health lobby groups representing health insurers, pharmaceutical firms, pharmacists, doctors, and other health workers. Their voices tend to crowd out the voices of consumers, and they can exert strong political power in resisting change and preserving privilege.

### **The retarding power of health lobbies**

To understand why provider lobbies are so strong, it is useful to consider the way in which consumer interests are normally served in other industries, through the mechanisms of price and quality competition. Those firms which do not adapt go out of business, while others take their place.

In most markets such “creative destruction”, to use the terminology of Joseph Schumpeter, serves consumers well. Pan Am Airlines is long gone, and General Motors is in effective receivership, but there is no shortage of airlines or cars.

In some industries delivering human services, however, such creative destruction does not always apply as easily as it does in other markets. Hospitals are often local monopolies (what economists call “natural monopolies”), and have to stay open, even if their performance is sub-standard.

Also, as pointed out above, most health care is funded by private or public insurance. Insurance, by its very nature, suppresses the normal market discipline of price signals. This is an important point in the debate about privatization. While many privatizations of government industries, such as telecoms, have been associated with an opening of markets to competitive forces, substituting private insurance for public insurance, in itself, does nothing to improve economic efficiency. In fact, as will be pointed out in Part 3, privatization as a means to produce short-term fiscal outcomes can actually come at a high cost. It is too easy for policy makers to consider privatization as an end in itself, without considering the more important issues around market structures and the role of competition.

While price competition in health care is muzzled, so too is quality competition. Health care is characterized by strong asymmetries of information between providers and consumers; providers are much more knowledgeable than consumers. In most markets consumers can compare products and match what is on offer to their needs, but when consumers cannot judge the quality of what's on offer, quality standards tend to fall all around.<sup>8</sup> For safety reasons, therefore, health care is necessarily heavily regulated. Any innovations, such as new drug therapies, must be very carefully evaluated. Consider, for example, the time it takes for a new pharmaceutical to make progress from concept to commercialization, compared with the time it takes for a new piece of entertainment software to make it on to the market.

This means that the health care industry operates in an intrinsically conservative culture, and technical conservatism spills over into economic conservatism. Institutions continue on through time, and their stakeholders gain entrenched power. Work practices and institutional arrangements continue unquestioned. For example, the separation of pharmacies from medical clinics made some sense in times long past when pharmacists carried out chemical experiments and mixed dangerous substances, often somewhat removed from health care. (Possibly the separation can be traced to the Holy Roman Emperor, Frederic II, who directed a separation of pharmacies from physicians' premises in 1280.) Such separation makes little sense now, particularly given the emergence of personalized drug therapies, but the tradition continues. In Australia, although nurses' clinical education has improved greatly over the last thirty years, nurses are still prohibited from carrying out many simple procedures. Another aspect of conservatism in Australia and in many other countries has been a very slow uptake of information technology; paper-based systems still dominate in health care; only recently have there been moves to develop national standards of electronic health records.

Another problem in health care is that most consumers, most of their lives, have very little contact with health care, and therefore have very little incentive to become involved in trying to influence public policy. It is only if we have the misfortune to suffer a chronic condition or an accident that we become involved during our active lives. Otherwise our experience of

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8 Akerlof 1970.

health care is likely to be in our dying months or years, when we have lost the energy and motivation for political involvement.

In this regard, if we 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 university students with a strong stake in education. Health care has no such broad consumer constituency: the only exception is 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. Without strong consumer voices, provider lobbies find it easy to gain the attention of ministers and their advisers.

There is also a subtle professional pressure to concentrate health resources on hospitals. The most professionally challenging and interesting work takes place in large teaching hospitals. Primary health care, by comparison, does not provide the excitement for those who are motivated by being at the cutting edge of new developments. (In this regard academics are no more virtuous; most academics prefer working on research projects with graduate students to teaching first year undergraduates.)

These factors – the federal issues which are unique to Australia, and the structures which give power to provider lobbies – provide the background to Australia's health policy as it has developed over the last half-century, to deliver us a rather messy, fragmented set of arrangements, which by no stretch of the imagination could be called a "system".

### **Development of Australia's health care policies – muddling through**

The political philosopher Charles Lindblom described a policy development process of "muddling through" – an incremental approach to problem-solving which handles only the proximate problems, without seeking system-wide solutions.<sup>9</sup> Further, he distinguished between purposeful incrementalism and disjointed incrementalism. In some cases, policy development proceeds by small steps, but with one end in mind (purposeful incrementalism). In others the processes are not connected (disjointed incrementalism).

Over the last half century or more, health care policy in Australia has proceeded along a disjointed and incremental path. In part this has been because of the conservative power of lobbies, referred to above. It can also be attributed in part to complacency, also referred to above. There have been legal and constitutional impediments to policy reform. Also, because different decisions have occurred at different times, they have reflected changing political fashions, the ideologies of the governments in power, and the fiscal priorities of the time.

Government involvement in health care started with the states; Commonwealth intervention is comparatively recent. State governments have been involved in hospitals for more than a hundred years. In New South Wales and Victoria public hospitals were traditionally operated as state-subsidized charities, while in other states they were owned and operated by the

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9 Lindblom 1959.

governments. In all cases, up to the middle of the twentieth century, public hospitals were provided primarily for those without means, while those who had the means used private hospitals or, in cases, made some payments to the public hospitals. (One state, Queensland, stood out in providing free public hospitalization to all, funded by a lottery tax. While Queensland's system was universal, its quality of care was lower than in other states.) Medical practitioners worked in public hospitals on an unpaid "honorary" basis, effectively cross-subsidizing public hospital services from the fees charged to the better-off patients in private hospitals and in their own clinics.

Before 1939 there were proposals for a national health insurance scheme, but they never developed. Most specific proposals elicited strong opposition from doctors' lobby groups, who valued their independence. The fiscal fashion of the time was not favorable to an expansion of government programs, and by 1939 Australia had other priorities because of developing worldwide military hostilities.

In 1945, when hostilities in the Pacific had ended (for the time being at least), the Labor Government of the time proposed a national health scheme, entitling all Australians, regardless of means, to free medical care – very similar to Britain's National Health Service also being developed at the same time. It faced a constitutional impediment, however, in that the powers necessary to implement such a scheme rested with the state governments. In a special amendment to the Constitution, the Commonwealth obtained those powers, but the amendment included a provision that any such scheme should not involve "civil conscription". The medical lobbies had threatened to campaign against the constitutional amendment on the basis that requiring doctors to work under government direction was analogous to conscription for military service. Hence, that provision was inserted to help ensure the passage of the amendment. (In Australia constitutional amendments have to be approved by referendum, requiring acceptance by a majority of voters in a majority of states.)

When the Commonwealth tried to implement a pharmaceutical benefits act, which would have imposed some minor controls on doctors' prescribing, the medical associations challenged the legislation in the High Court (Australia's highest court), on the basis of the "civil conscription" clause, and won. That victory essentially killed any proposals for a comprehensive health insurance scheme. The restriction on "civil conscription" is still regarded as an impediment to the Commonwealth taking a strong role in controlling doctors' fees.

In 1950, however, a newly-elected conservative Coalition Government managed to enact a pharmaceutical benefits scheme, initially providing free pharmaceuticals (co-payments were a later introduction). It also introduced subsidies for health insurers, which, at the time, were voluntary mutual help organizations, set up and administered mainly by doctors. Commonwealth benefits were available only to those who belonged to a health insurance fund. At the same time the Commonwealth started subsidizing states for providing certain services in public hospitals, such as treatment of tuberculosis. It is notable that although the initiatives of the Coalition Government were similar in some respects to the proposals of the previous Labor Government, particularly in relation to pharmaceuticals, the medical lobbies were far more accepting of such reforms when they came from the Coalition.

Those arrangements remained more or less intact for twenty years. In fact the basic architecture of the Pharmaceutical Benefits Scheme remains unchanged to this day, although its scope has widened immensely as new drugs have come on to the market. In particular it has developed a rigorous system for evaluating prescription pharmaceuticals, in which each proposed new listing of a pharmaceutical is subject to rigorous cost-benefit analysis. Within the constrained budget of the Pharmaceutical Benefits Scheme, administrators calculate how they can maximize the returns from pharmaceuticals, in terms of years of healthy life saved (Qalys). These evaluations are used as bargaining coin in negotiating with pharmaceutical importers and manufacturers. In this way Australia has been able to achieve much lower pharmaceutical prices than those in most other developed countries. Unfortunately however, such a rigorous cost-benefit and evidence-based approach has not been applied in other areas of Australian health care.

By 1968, growing inequities in the voluntary and subsidized health insurance arrangements led the Commonwealth to set up an inquiry into hospital and medical funding. Its recommendations were essentially for a resurrection of a comprehensive national health insurance scheme, as had been proposed in the 1940s. The Coalition was still in office when the inquiry reported, and it introduced a modified scheme which still relied on subsidized voluntary private insurance, while the Labor Opposition adopted as policy the inquiry's proposal for a government-funded scheme.

When, after 23 years in Opposition, Labor again won office in 1972, it tried to pass legislation enacting a government-funded scheme. In terms of public support the Government had no obstacle; its proposals were very popular, but the reaction from medical lobbies and health insurers was hysterical. To this day there are still shrill warnings that any extension of public insurance is a move to Soviet style "socialized medicine".

The Government failed to pass its legislation through the Senate and only in an extraordinary set of events, involving a second election, was it able to get its scheme through Parliament in 1974. Thus was introduced a scheme known as "Medibank", which provided for Commonwealth payments for all medical services, but without price control (because of the "civil conscription" constraint). There were complex arrangements around the fee schedules, allowing for small patient contributions as a matter of course, but there were incentives in terms of simplified billing incentives for doctors who charged at 85 percent of the schedule fee, without a co-payment. Essentially this meant that in professions and regions where there was a high supply of doctors, the schedule fee would operate as a price cap, but in other situations doctors could charge higher fees.

As part of the package the Commonwealth entered into agreement with the states to pay around fifty percent of the costs of operating public hospitals; in return the states were to make public hospitals accessible to all with no charge.

Thus were developed the mechanisms of national medical health insurance (the Medical Benefits Scheme) and free hospitals, which still exist today, but that existence has not been unbroken, for in 1975 the Coalition was again elected and over its seven years in office, it re-introduced tax incentives for private health insurance. Over those seven years it implemented seven different schemes of health funding. By the end of its period in office it had not only re-introduced tax incentives for people to hold private insurance, it had also made it impossible

for patients to obtain any Commonwealth medical benefit unless they held private insurance or were classified by the Commonwealth as “disadvantaged persons”. For most people, other than the most disadvantaged, the risk of having no health cover was such as to make private insurance close to compulsory. Restoration of membership of private health insurance had become the Government’s policy objective; there was no consideration of ways in which more market discipline could be introduced into health care.

Medibank as an institution was converted into a government-owned private insurer – “Medibank Private”. Its role at the time was partly political – to allow people who objected to “private” insurance to enrol with a publicly-owned insurer, and to place some competitive discipline on the privately-owned private health insurers (which, at that stage, were all mutual funds).

Labor was re-elected in 1983, and its platform included a strong commitment to re-introduce universal health insurance. It did so, naming the new scheme “Medicare”. Apart from some minor differences it was (and still is) the same as the old Medibank. Those minor differences relate mainly to what is included in the medical schedules; initially “ancillary” services such as psychology and physiotherapy were excluded, but in recent times they have been brought in to Medicare, albeit with fairly tight restrictions. Dentistry is still excluded, but there are special means-tested dental schemes.

In order to finance the increased fiscal cost of universal health insurance the Government introduced a small tax levy, now 1.5 percent of income, which funds around 17 percent of Commonwealth health expenditure. The Government incentives for private health insurance were abolished, but the Government retained a 30 percent bed-day subsidy for private hospitals up to 1986. (This meant that people without private insurance, who paid their own way in private hospitals, could receive some support).

In 1996 the Coalition was re-elected. Conscious of the overwhelming public support for universal tax-funded health insurance, its election platform included a pledge to “retain Medicare” (without defining just what Medicare was to be). Over the 13 years Labor had been in office membership of private insurance had fallen from around 50 percent of the population to 30 percent. Once again the Coalition re-introduced tax incentives and subsidies for people to hold private insurance. As before, its policies went through several iterations. They started with means-tested subsidies, followed by a tax penalty on high income earners without private insurance, followed by a lifting of the means test, and a regulation called “lifetime rating”, whereby for every year past the age of 30 in which a person fails to take up private insurance, a new contributor must pay a penalty of two percent on the premium. Thus someone taking insurance for the first time at age 55 would pay 50 percent more than someone taking the same package at age 30. “Lifetime rating” is designed to entice the young and healthy to subsidize older and less healthy contributors. These initiatives have once again boosted membership of private insurance, which is now around 45 percent of the population.

Medicare as such was essentially unchanged, but the Coalition Government did introduce a new safety net for people with high out-of-pocket medical expenses. Once people have accumulated \$1100 of co-payments associated with charges higher than the schedule fees, the Commonwealth reimburses 80 percent of that excess. This measure has been of particular

benefit for those using specialist services, for their rates of over-charging have been very high.

When Labor was elected in late 2007 it broke from traditional Labor policy, in that it promised to retain support for private insurance. Health reform, however, was a major part of its platform. Conscious of the political fallout associated with long hospital waiting times, it promised an injection of funds to the states to help them improve hospital throughput, and it threatened to take over public hospitals from the states if they did not improve their efficiency. The newly elected government appointed a commission to examine health policy – the National Health and Hospital Reform Commission – which reported to Government in June 2009. Its terms of reference were constrained: for example, it was not to question the role of private insurance. Its recommendations are in the form of options, ranging from minor changes, with a great deal more emphasis on primary care, through to a scheme of compulsory enrolment in private insurance. (The chairperson of the Commission is an executive from a private health insurance firm.) The present government is already committed to an expansion of primary health care centers, but it has made no indication so far of its reaction to the Commission's other suggestions.

### **Australian health care today**

In at least two important aspects there are ways in which Australia's health care industry differs from other countries' health care industries.

First, Australia's health care policies, particularly in relation to funding, are not firmly embedded. Most countries have stable funding arrangements – so stable that governments cannot change them. The Thatcher Government in the UK, so enthusiastic about privatization, dared not change the basic design of the National Health Service; community resistance was too strong. In the USA the Clinton and now the Obama Administrations have found it close to impossible to reduce the central role of private health insurance. Private health insurers in the USA have spent more than \$US400 million to block meaningful reform<sup>10</sup> – illustrating the danger of allowing any group to gain such privileges as to provide them with the resources to lobby to sustain that privilege.

By contrast, for more than 60 years, Australia's funding arrangements have varied according to the "left/right" political complexion of the Commonwealth Government, and, particularly when the Coalition has been in office, there have been frequent changes within one party's term of office. Whenever significant changes have been proposed, there have been bitter and acrimonious political struggles. This is strange in a country where on so many issues the two main parties have only minor policy differences. Those political fights over health care also help explain why governments, which have been so willing to undertake reform in other areas, have become so cautious in regard to health. Politically, financial market deregulation and tariff reform have been much easier than health care reform.

Second, and related to this ideological volatility, there is no clear agreement concerning the principles which underpin health policy. Some programs, such as public hospitals, embody

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<sup>10</sup> *The Economist* 16 January 2010.



principles of universal free access, while some others, such as the Pharmaceutical Benefits Scheme, involve significant co-payments and targeted means testing. At times governments focus their attention on the total community costs of health care, and at others they are concerned only with the fiscal costs of health care. And while the Commonwealth remains committed to sustaining free public hospitals without any means testing, it is also using tax incentives and subsidies to encourage people to opt out of the shared system and to use private hospitals.

As a result, there is a fragmented set of health care arrangements. Fragmentation is costly: it imposes higher search and transaction costs on consumers, it results in duplication of record-keeping and of diagnosis, and it adds to the risk of conflicting therapies. Evidence shows that integrated services deliver better care at lower cost.<sup>11</sup>

Table 3, showing how consumer payments (co-payments and full payments) vary, reveals another aspect of this fragmentation.

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: As for Appendix Table 1

What stands out is that individual payments, which are the normal market mechanisms for allocating resources, are quite inconsistent across different areas of health care. This leads to serious inequities. For example, someone with a chronic disability whose needs are for ongoing physiotherapy (classified as “other health practitioners”) and for aids and appliances will have to pay for most of his own health care, while someone else whose needs can be met in one high-cost hospitalization will pay almost nothing out of pocket. And there are serious problems of allocative efficiency, because consumers and doctors recommending therapies will be 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 those different parts will result in an opportunity cost in terms of forgone allocative efficiency.

<sup>11</sup> Browne et al, 1999.

When we examine the detail of co-payments, even greater distortions are revealed. People are actually discouraged from taking responsibility for paying for their own hospitalization, for while private insurance is subsidized and supported with tax penalties, those who pay from their own savings receive no such support. Before incentives for private health insurance membership were reintroduced in 1997, 25 percent of admissions to private hospitals were by people funding themselves without insurance. By 2006-07 that proportion had fallen to 12 percent.<sup>12</sup> That retreat from self-reliance has happened because the policy objective of the government has been to support private insurance as an end in itself, rather than to support development of market mechanisms. In doing so they have actually discouraged the development of markets, added to inequities, and discouraged self-reliance.

The way payments are made also contributes to inefficiency. Other than those working in public hospitals, doctors are paid on a fee-for-service basis (under the Medical Benefits Scheme) – a system which carries incentives for over-servicing. Pharmacists are paid on the basis of the number of prescriptions they dispense (under the Pharmaceutical Benefits Scheme), but prescriptions are written by doctors, who have no incentive to control their cost. In most states public hospitals, on the other hand, generally receive block grant funding, a system which makes little allowance for variations in demand.

Dissatisfaction with fragmentation is revealed in polling: 55 percent of Australians believe there should be “fundamental changes” in health care, and a further 18 percent believe the system should be re-built completely. Among those with chronic conditions, 57 percent of people want fundamental change and a further 20 percent want a complete re-build.<sup>13</sup> Those figures, from the Commonwealth Fund, may seem to be at odds with the known popularity of Medicare: in 2007-08 Medicare’s satisfaction rating among the public was 89 percent.<sup>14</sup> But that contrast illustrates a general perception that while each component of health care works well, those components do not come together as a system.

Health care has stood out as being exempt from the market reforms that have occurred in other industries. Over the last thirty years, Australian governments, of both persuasions, have introduced vigorous competition policy. Health care, however, is the only significant industry exempt from competition policy. Professional medical groups still have strong control over the education and accreditation of doctors, particularly specialists – ostensibly in the name of preserving standards, but with the effect of sustaining strong market power. Every state has regulations restricting pharmacy ownership, which mean pharmacies have to be run as independent small businesses; large corporations, which could bring economies of purchasing and administration, are prohibited from owning pharmacies. Price advertising is almost universally prohibited. Most significantly, public and private hospitals do not compete with one another: they have separate funding streams, with public hospitals funded from state governments, while private hospitals are funded from private insurers, the Commonwealth (which pays for most medical and pharmaceutical services), and from individuals. This separation of hospital funding is covered in Part 3.

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12 Australian Bureau of Statistics Bulletin 4390.0 *Private Hospitals Australia*, editions to 2006-07.

13 Commonwealth Fund 2007, 2008.

14 Medicare Australia *Annual Report* 2007-08.

## Conclusion, Part 2

Before we go on to look at specific market and privatization initiatives in Part 3, there are some general lessons we can draw from Australia's experience:

- 2.1 Governments should be clear about their policy principles and objectives, and these should be applied across all aspects of health care. Health care should be operated as an integrated system. This is so basic that it should be self-evident, but it is clear that in Australia, and probably in many other countries, this has not happened, because policy development has been fragmented.
- 2.2 Health care has characteristics which make it easy for lobby groups to exercise influence, while those same characteristics make it difficult for consumers to have a voice. It is easy for policymakers to forget the basic economic principle that industries, including health care, exist for consumer benefit, not to provide economic rent for producer interests.
- 2.3 Insurance, private or public, suppresses price signals. No economic benefits are achieved by shifting insurance from public to private mechanisms.

Related to this third point is the role of direct consumer payments, including co-payments. Australia, like many other developed countries, introduced its main health programs at a time when personal incomes and wealth were much lower. In 1950, when the government was introducing schemes which were free at the point of delivery, the average male wage in Australia was only \$20 000 (in 2010 prices); it is now around \$70 000, and most families now have two incomes. There was a much stronger case for free provision when incomes were low and health care was expensive. If Australia were to design a health financing system from scratch, or if a government had the courage to undertake a comprehensive policy review, there would probably be much more scope for uninsured consumer payments, making use of market signals, while attending to the needs of those for whom such payments would be most burdensome. In this regard Korea, with its high levels of uninsured payments, has an advantage over many other countries.

Also, it should be kept in mind that consumer payments are not incompatible with universalist principles. There is often an assumption that a universal system is necessarily a free system, but the essence of universalism is that all share the same health care facilities, and that resources are prioritized on the basis of clinical needs, rather than ability to pay. Carefully-constructed co-payments which attend to the needs of the least well-off do not violate such a principle of universalism.

### 3. Public policy – privatization or market reform?

#### Australia's hospital sector

Australian terminology can be confusing. A “public” hospital is one in which services are paid for by state or territory governments. Most public hospitals are owned by state governments, but there are other ownership models. In Victoria many hospitals are nominally owned by charitable trusts, with the state government being the dominant or single funder of the trust. Some public hospitals are owned by religious institutions, particularly Catholic religious orders, but are operated on contracts to state governments. In other cases the hospitals are owned by the state government, but are managed by non-government bodies contracted to state governments. There have also been experiments with private for-profit companies entering into such arrangements, but these have not endured. (See below.)

Public hospitals provide an integrated range of services; they employ their own medical staff on a salary or a contractual basis, and purchase pharmaceuticals directly from wholesalers. Most large public hospitals have emergency and accident services and have relationships with universities for clinical training.

Among public hospitals there is a range of different contractual arrangements between governments and hospitals. The two largest states, New South Wales and Victoria, offer contrasting models. New South Wales funds hospitals on a regional basis; each of eight regions within the state is given a budgetary allocation, based on population, with weighting for age and other demographic factors which are likely to affect demand for health services. Victoria, since 1993, has been using casemix funding, based on “diagnostic related groups” (DRGs). Each hospital procedure (e.g. a normal birth delivery, a hip replacement) has a DRG classification, which is linked to a standard cost – the same sort of standard costing as is used in factories and other establishments with a range of products. The system was developed in the USA, and has been modified in Australia. Hospitals are funded on the basis of the number of procedures carried out, with extra funding for providing emergency services and medical training. So far, DRG funding covers only recurrent costs, not capital costs: it is difficult in such arm's length arrangements to provide the mechanisms which will ensure hospitals set aside funds for capital replacement.

A “private” hospital is one which may resemble a public hospital physically, but which operates on a very different funding model. Patients or their private insurers pay for use of the beds, operating theaters and non-health facilities. Medical services are provided separately, and are paid for by a combination of Commonwealth Medical Benefits Scheme payments and “gap” payments (the difference between the schedule fee and the doctor's charge), which may be fully or partially covered by private insurance. Pharmaceuticals are supplied under the Commonwealth-funded Pharmaceutical Benefits Scheme. Richardson has correctly commented that:

Health funds [insurers] and private hospitals are the landlords providing beds and equipment. The Government, not private health insurance, provides the overwhelming proportion of the insurance against the medical costs in these hospitals.<sup>15</sup>

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15 Richardson 2009.

Any outside observer would find these arrangements bizarre. With accommodation, medical, and pharmaceutical services separated, there is no one locus of responsibility within private hospitals; it would be stretching a point to say there is any coherent governance. This separation, in the name of “choice”, is in the interest of maintaining the professional and economic power of doctors.

Most private hospitals operate on a for-profit basis: 165 of Australia’s 289 acute and psychiatric private hospitals are for-profit, and increasingly they are becoming owned and operated by large corporations. The remaining 124 hospitals are operated on a not-for-profit basis, mainly by religious or charitable institutions (which may, separately, operate public hospitals).

In addition to these acute and psychiatric hospitals, there are an almost equal (and growing) number of private “day hospitals”, essentially clinics for same-day minor procedures.

There are some crossovers between the private and public hospitals. Some patients in public hospitals are admitted as “private” patients, which means they have the same complex system of payments as in private hospitals, but generally with their own choice of doctor. Such arrangements are unattractive for public hospitals, as private insurers pay less for public hospital stays than for equivalent private hospital stays, but many patients insist on such arrangements, because they want choice of doctor and the treatments they need are not available in private hospitals. In addition, from time to time state governments purchase services from private hospitals for “public” patients.

The relative size of the two sectors is shown below in Table 4. Among the very large hospitals with more than 200 beds, public hospitals dominate. Public hospitals also dominate at the other end of the size spectrum, in non-metropolitan and remote regions.

	Private hospitals	Public hospitals	Total
Number of establishments	556	768	1324
Episodes of care	3.1 million	4.7 million	7.8 million

Although there is some overlap between the two sectors, they tend to meet different health needs. Around two thirds of all elective surgery is performed in private hospitals, while public hospitals tend to handle people with medical needs and with more complex conditions.

There have been claims and counter-claims about the relative efficiency of the two sectors. A study by the Productivity Commission in 2009 found that, when adjusted for casemix, private and public hospitals have similar average costs per patient, but a different composition of costs. In private hospitals medical, diagnostic and prostheses costs are higher, while in public hospitals general hospital costs (administration, food etc) are higher. Private hospitals have higher labor productivity and shorter length of stay, but this is due in part to different

casemixes.<sup>16</sup> Such research is hampered by an absence of compatible data between and within the two sectors. In fact, throughout Australia's health care industry there are data shortcomings. Medibank, when it was developed in 1974, was meant to incorporate data capture, but this has not happened.

The separation of the two hospital sectors has become somewhat entrenched in Australia. There is an unquestioned policy assumption that private hospitals must necessarily be supported by private insurance, and that public hospitals must necessarily be funded by budgetary allocation. Politicians and lobbyists talk about the "balance" between the "public" and "private" sectors, without distinguishing between funding and provision. Whenever there is a risk of private health insurance membership falling, private insurers warn that the "private system" is threatened with collapse, without considering the possibility that private hospitals could be funded in many ways other than private insurance – from state governments or from direct consumer payments to name two.

### **Privatization of hospitals**

In general, there has been no trend to privatize public hospitals in Australia. The main policy concerns have been in relation to the governance of hospitals and the nature of transactions between funders and providers – the extent to which such transactions have some characteristics of free markets, and the extent to which they have elements of command and control. DRG funding for public hospitals is an example of a market-based approach, which retains the service in public ownership – a reminder that market structures and incentives are more important in achieving efficient outcomes than changes in ownership.

Although many corporations would like to see more privatization, there has been no public support for privatization of Australian hospitals. Specific proposals for privatization of hospitals have always met with strong community opposition, and apart from some small deals relating to rationalizations, there has been no transfer of an existing state hospital into private ownership. There have been experiments with getting the private sector to build, own and operate new public hospitals (with possible transfer back to the public sector at the end of a specified period), but these have resulted in the hospitals being brought back into public ownership well before any contractual period expired.

One well-known such case occurred in New South Wales, when, in 1992, the state government contracted a firm (Mayne Nickless Ltd) to build a public hospital at Port Macquarie, a rapidly growing city about 400 km north of Sydney. This was a build-own-operate project, without any transfer back to the public sector. The Government was to make an initial outlay of \$52 million to the company, and then pay the company around \$47 million a year for twenty years to provide public hospital services.

Construction went ahead, but in the operation phase there were a number of cost overruns, complaints of poor service, and management difficulties. In 2004 the state government bought back the hospital for \$29 million (and absorbed around \$6 million of liabilities).

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<sup>16</sup> Productivity Commission 2009.

Accounts of why the project failed vary. From inception there was strong union and community resistance. The firm itself had some experience in health care, but little in hospital management, and during the contract period it had problems in its other divisions, which led to allegations that it was draining funds from Port Macquarie Hospital to support its other businesses. Some suggest that the New South Wales capitation funding model was to blame: because the hospital offered good quality service it could not cope with the high demand. This explanation is supported by the existence of a long waiting list at the hospital. In addition many economists, including the former state Auditor-General, suggested that the prices paid by the state government were far too high; in effect it was a very expensive way to fund infrastructure, akin to borrowing funds at a very high rate of interest, but keeping the transaction off the balance sheet.

Other states had similar experiences. In 2007 the South Australian Government bought back a privatized public hospital. Just this year the Tasmanian Government has announced plans to buy back a small regional hospital and the Australian Capital Territory Government is negotiating with the Catholic Church to buy a privately-owned hospital from the Church. The Port Macquarie case was the most publicized failure, leaving a sour taste with governments, the public and investors. For now, privatization of state hospitals is off the agenda.

At the same time, however, there have been some co-location initiatives, whereby a private hospital and a public hospital locate in close proximity, and share certain important facilities (with appropriate payments). These are in recognition of the differing and complementary functions of private and public hospitals. Patients in the private facilities whose needs escalate are often temporarily transferred to the public hospital, where there are more professional and physical resources available. These co-located facilities introduce their own problems, in that professional incomes are generally significantly higher in the private hospitals than in the adjoining public hospitals, and there are issues in cross-agency charging.

One small transfer of hospital ownership did occur with little controversy. Until 1994 the Commonwealth owned a number of hospitals for war veterans. By 1992 it owned and operated nine veterans' hospitals, all in state capitals, with a total of 2 500 beds (around 1.4 percent of the nation's total number of beds). Over the period 1993 to 1997 most of these hospitals were transferred to state governments and some were sold to private companies.

The reasons for the transfers and sales were pragmatic. The number of eligible war veterans was falling, and the Commonwealth had been inclined, from the mid 1980s, to move from direct service delivery model to a purchaser-provider separation wherever possible.

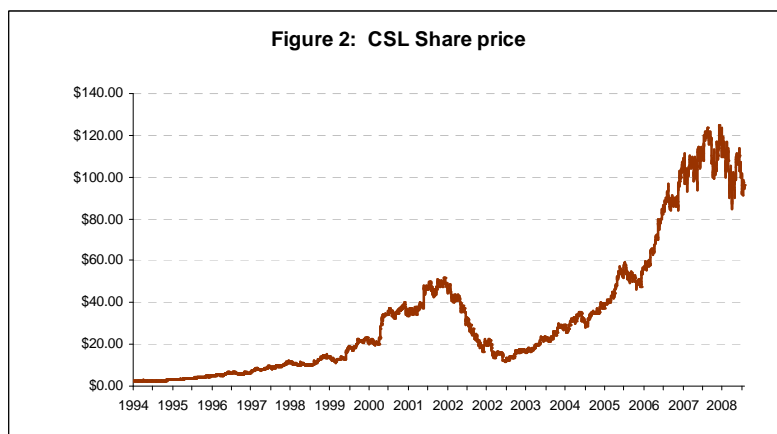
The Commonwealth now operates veterans' health services on a single payer model, with most services provided by private institutions. In the case of hospital services, around 60 percent of services are provided in private hospitals, with the remainder being in state public hospitals (including the former Commonwealth-owned hospitals). What is notable about this initiative is that the Commonwealth, in its veterans' services, has successfully separated payment from service delivery; for this small section of the market it has emulated the system successfully used in countries with single payer national insurance systems which purchase their services from private providers. But in retaining support for private health insurance, it resists applying that model to the broader national programs.

## Commonwealth Serum Laboratories

Within the health care sector as broadly defined, the most significant privatization was of the Commonwealth Serum Laboratories (CSL). CSL was established by the Commonwealth in 1916 to become the primary supplier of vaccines and antivenom products. Vaccine security is a public policy concern common to most countries, and Australia, with its unique and deadly snakes, spiders and jellyfish, needs its own supply of antivenoms – which would not be economical to provide in a private market.

Until 1961 CSL was under close government control, operated as a division within the Health Department. From 1961 to 1991 it operated as a statutory corporation, and in 1991 it became a public company, with all shares owned by the Commonwealth. It was sold in a publicly tendered share float in 1994,

the sale (at \$2.30 a share) realizing \$292 million (after \$7 million of fees and commissions). This was close to the book value of CSL's assets.<sup>17</sup>



When CSL was sold the Commonwealth assumed liability for any legal claims relating to use of CSL products (a high risk in the case of serums) up to the time of sale. It also entered into a ten year contract to have CSL continue developing and making vaccines and antivenoms.

The company's share price, from the time of the privatization, is shown at Figure 2. Certainly the initial modest growth in the share price gives no evidence of an undervalued sale; there was no immediate jump in the share price upon sale. This undoubtedly reflects the benefit of the tender process.

The subsequent rises in share price reflects a growing dynamism within the company, as it sought new markets at home and abroad and developed a wider range of products. In terms of development of an expanding and profitable industry, the privatization would be deemed to have been successful. That still begs the question of whether such expansion could have occurred while the company was publicly owned. Is there some factor, inseparable from public ownership, which suppresses innovation and creativity?

Fiscally, it is harder to evaluate if the sale was beneficial. Professor John Quiggin of James Cook University has factored in the dividends forgone and the cost of contracting the continuing supply of vaccines and antivenoms, and, discounting those costs at the Commonwealth bond rate, calculates that the sale represented a negative net present value to the Commonwealth of \$600 million.

17 Details from Hamilton and Quiggin 1995, CSL website ([www.csl.com.au](http://www.csl.com.au)) and Australian Stock Exchange.



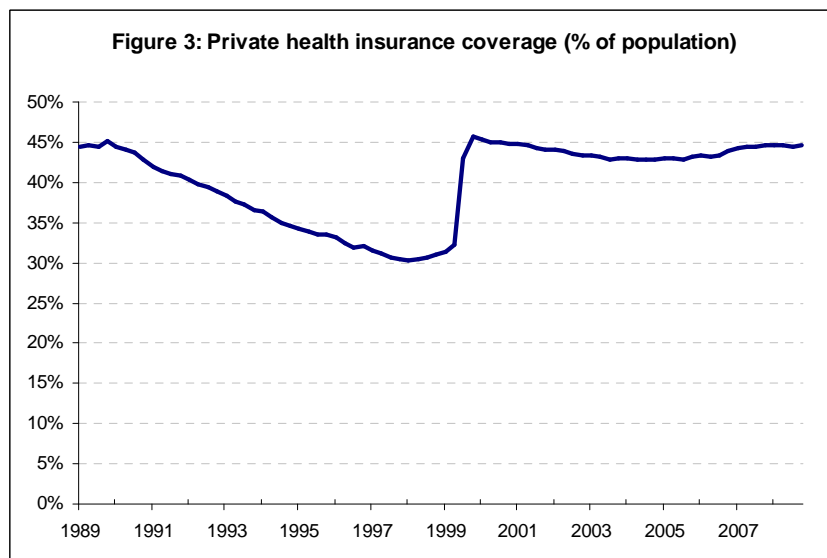
Some will undoubtedly dispute the assumptions on which Quiggin made his analysis, but the important point, in this and other Australian privatizations, is that while the governments involved record the proceeds of such a sale in the public ledger, they do not record all the liabilities associated with the sale, particularly those liabilities which will be realized in future years as governments have to buy in services which they had previously obtained in-house. Such incomplete accounting makes it tempting for governments to sell assets simply to produce politically impressive short-term indicators, such as a reduction in fiscal debt, without revealing the opportunity cost of such transactions.

## Health insurance

The legacy of sixty years of fragmented health policy is a fragmented set of insurance arrangements.

The Commonwealth, through its budget-funded programs, is the dominant insurer. It also still owns a private insurance firm, Medibank Private (See Part 2), but Medibank Private in most aspects is indistinguishable from other private insurers, and is classified as a private insurer. It holds about 27 percent of the private insurance market. Another four firms hold around 60 percent of the market, and the remaining 13 percent is held by another 33 firms. Historically, most insurers were mutual not-for-profit organizations, but recent years have seen a change as insurers have de-mutualized, becoming public companies. (Some other countries discourage de-mutualization, but Australia has no such restriction.)

Recent movements in coverage by private insurance are shown in Figure 3, which reveals the boost in membership resulting from the incentives and penalties introduced by the Coalition Government after its election in 1996. (The uptake was delayed, mainly because the government's initial policy initiatives were ineffective.)



By most measures, private health insurance has been a costly means of financing health care. Although its total contribution to health care funding is minor (eight percent of recurrent expenditure), it results in some system-wide costs, most of which can be avoided by a single national insurer.

One part of these costs relates to administration. Private health insurance is expensive to administer: 10.4 percent of revenue is absorbed in administration, and a further 5.1 percent is

taken as profit. By contrast the cost to government in collecting taxes and administering Medicare is only 4.1 percent of revenue.

But by far the greatest cost results from the incapacity of health insurers to control outlays. As pointed out in Part 2, all insurance, private or public, suppresses those price signals which allocate resources in competitive markets. Once a premium has been paid, the insured service is free or near to free if there is a small co-payment. In the insurance industry this problem, which encourages over-utilization and indifference to prices, is known as “moral hazard”.

Also, 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 hold on to 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. 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.

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.<sup>18</sup>

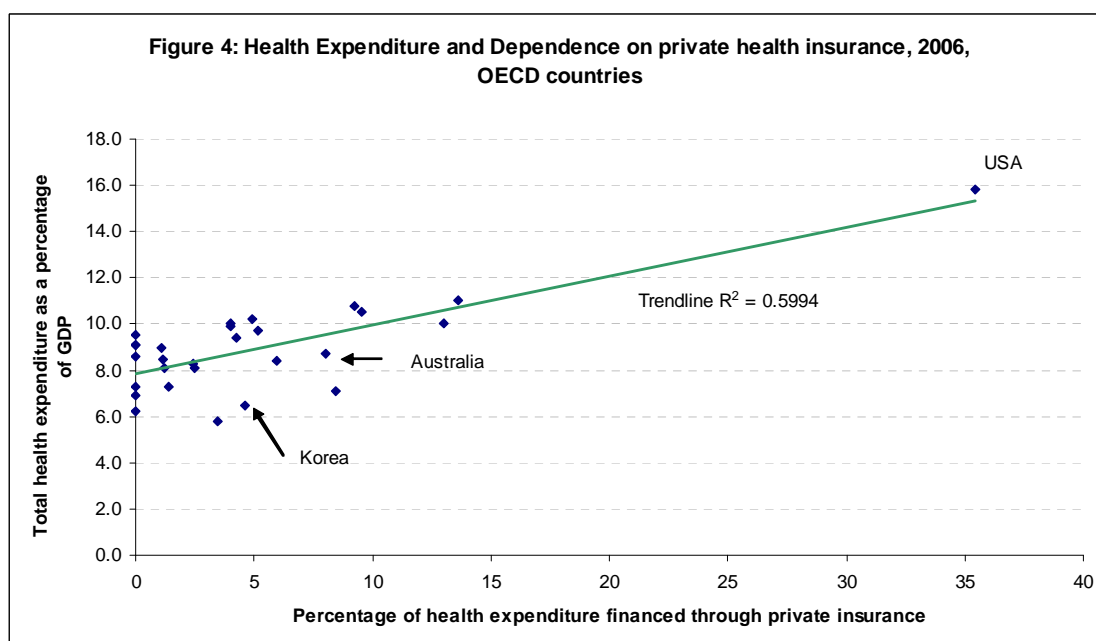
As illustrated in countries with long-established single insurer arrangements, such as the nordic countries, a single national insurer can reduce moral hazard by countervailing the market power of suppliers. In relation to contributors, a single insurer is able to insist on uninsurable co-payments if they help reduce excess demand. 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 4, 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, and as shown in Part 1, in prosperous countries there is no evidence that higher expenditure on health care buys better health care.

Private health insurance is an expensive way to fund health care, not because it’s private, but because it’s fragmented, lacking the power to overcome moral hazard, and lacking any

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18 Colombo and Tapay, 2003.



incentive to provide public goods. This is not to establish a case against private institutions: a country could contract a single private company to provide all health insurance, and, if well-regulated to ensure its policies were equitable, it would probably do at least a good a job as a public insurer, but it is improbable that any government would wish to provide so much monopoly power to a single company.

Naturally, 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. Under Australia’s arrangements, 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.

Another argument is that, given projections on ageing and therefore a high future demand for health care, governments in the future will not be able to collect the taxes to fund public

insurance. But if communities can afford to pay for private insurance, they can even more easily afford to pay tax. Whatever the mechanism used, if communities are to share their health care costs through insurance, they have to pay either through taxes or private insurance. Private insurance, in effect, is a privatized tax. There is no saving and is likely to be a net cost in shifting health insurance off the public budget and on to private insurers.

It is fitting that policymakers should be concerned with the future costs of health care, but the basic question they should be asking is, as the country becomes more prosperous, if more of the burden of health care should be shifted from insurance (public or private) on to people's own resources.

Finally, there is often an emotive argument that private insurance must be preserved because it is "private", as if there is some intrinsic merit in an activity just because it takes place in the private sector. (This is the mirror image of the argument of doctrinaire communism which sees intrinsic merit in state activity.) A variant in Australia is that private insurance must be maintained to support private hospitals – an argument which conveniently overlooks other options for funding private hospitals.

### **Medibank Private**

Finally, there is the case of Medibank Private, still in government ownership. There have been proposals to sell Medibank Private; the Coalition Government proposed a sale in 2006, but that did not proceed. The present Labor Government is silent on the issue; in any event, the recent financial crisis has not been a propitious time to float a government business enterprise on the stock market. Also, there is strong public opposition to privatization. While affection for Medibank Private as a government-owned enterprise, which was a consideration in the 1970s, has dissipated, members now argue that the fund's reserves, accumulated from members' contributions, are essentially their equity. Therefore, the argument goes, the government has no right to sell it because it doesn't belong to the government. "Ownership" is not a clear-cut concept.

### **Conclusion, Part 3**

The main policy messages we can draw from Australia's experience are:

- 3.1 Ownership, in itself, is not a major issue. Of more importance in achieving efficient resource allocation is the condition of the markets in which health care funders and providers operate.
- 3.2 Whether health care facilities are owned in the private or public sector, they should be funded on the same basis and should be permitted to compete with one another.
- 3.3 To the extent that health care costs are to be covered by insurance, the most efficient mechanism is a single national insurer.

## Conclusion

Much of what can be learned from Australia relates to areas where Australia's arrangements have shortcomings. I have not tried to allocate blame to particular governments or individuals; rather I have tried to explain how these shortcomings have arisen through normal political, fiscal and constitutional constraints. Almost all countries find health policy problematic: because of various market failures and considerations of equity, governments are necessarily heavily involved in health care, and they face growing future demand with ageing populations – an issue of particular concern in Korea. Compared with the problems in health care in the USA, for example, Australia's problems are minor.

Some of Australia's problems could have been avoided. In particular, successive governments have been too willing to appease lobby groups and have not capitalized on public support for reform. Australia has a very good record in economic reform, overcoming the protests from vested interests, but Australian governments have been reluctant to apply their experience from other areas to health care. In health care Australia demonstrates the consequences of more than half a century of incremental policy development, and it is manifest in a messy and incoherent set of arrangements, with an unrealized opportunity cost in terms of forgone allocative and administrative efficiency.

Successive Australian governments, particularly those of center-right persuasion, have been too concerned with privatizing health insurance, as if privatization is a benefit in itself, and have not been adequately concerned with economic efficiencies which can result from reform of market structures, including the roles of competition, prices and incentives.

Privatization is not a substitute for market reform, and market reform does not necessitate privatization. Without offering an excuse to Australian policymakers, confusion of means and ends and goal displacement are common problems in public policy around the world.

Also, as in other areas, privatization in health care has been encouraged by accounting conventions which over-emphasize immediate fiscal benefits while hiding longer term fiscal and economic costs.

One problem, not unique to Australia, is a reluctance by policymakers to look on health care as an industry and to apply the normal evaluative mechanisms which are applied to other industries. Such a blinkered view allows the development of an idea that health care should be exempt from the normal economic considerations of efficiency and equity. It's a notion that pushes economic thinking to one side, in the erroneous belief that economics is intrinsically illiberal and dismissive of human welfare.

For a country reviewing its health care industry, Australia's experience can offer some guidance. On the positive side are Australia's mechanisms of pharmaceutical price control and cost-benefit analysis, which could be extended to other aspects of health care. Australia has a good record in public health initiatives, which many other countries have followed. There are public hospitals with standards of clinical care second to none. The main problem is that the components do not come together well; other countries can learn from Australia's failure to manage health care as an integrated system.

The strongest lesson is that policymakers should take a broad view and consider the whole industry. Only in such a way is there likely to be policy coherence and the resulting economic

and equity benefits of integration of programs into one system, underpinned by principles which align with the community's values and priorities.

Another is to keep in mind a very basic principle of economics. That is, in normal competitive markets benefits accrue to consumers. If producers or their employees enjoy abnormally high profits or wages for a sustained period of time, the market is not working well; there is inevitably some diminution of economic welfare.

Policymakers, therefore, should be mindful of the importance of governance and market structures, particularly the role of prices and incentives. The ownership of facilities is a minor issue, but there will always be parties, motivated by the opportunity to extract economic rent, who will seek to convince governments that privatization, in itself, is a legitimate objective of public policy. Also, privatization is not a substitute for reform of government programs; it should not be used as a lazy way of passing off problems to the private sector.

On the issue of financing health care the question of ownership of financial institutions is far less important than issues around the governance and incentives applying to those institutions delivering health care. In most developed countries, the private sector is likely to dominate in the provision of health care.

In financing health care the most important policy question is the balance between insurance mechanisms and direct consumer payments. There will always be the need for safety nets covered by insurance, both for those with high needs and for those with limited means, and to the extent that such mechanisms are provided they are most efficiently and equitably provided by a single national insurer. But the role of direct consumer payments is crucial, and it is too easy for generous schemes, with little or no consumer contribution, to become locked in over time, even as people become more prosperous and are able to afford more care from their own resources.

The cutoff point between direct payments and safety nets will vary from nation to nation. The solution will depend in part on people's comparative valuations of community solidarity and individual choice. It will depend on people's attitudes and behavior in relation to saving and on people's access to informal mechanisms of finance, such as support from families, all of which are relevant in public policy. The articulation of those values is an outcome of a well-developed political process.

## Bibliography

George Akerlof “The Market for ‘Lemons’: Quality Uncertainty and the Market Mechanism” *Quarterly Journal of Economics* 84 (3): 488-500, 1970.

Gina Browne, Jacqueline Roberts, Amiran Gafini, Carolyn Weir, Basanti Majumdar, Susan Watt “Economic evaluations of community-based care: lessons from twelve studies in Ontario” *Journal of evaluation in clinical practice* Vol 5 No. 4, 1999.

Commonwealth Fund *International Health Policy Survey of Sicker Adults 2008*.

Commonwealth Fund *International Health Policy Survey in Seven Countries 2007*.

Both surveys available at [www.commonwealthfund.org/Surveys](http://www.commonwealthfund.org/Surveys)

Jennifer Doggett “Out of Pocket: rethinking health copayments” Centre for Policy Development July 2009, [www.cpd.org.au](http://www.cpd.org.au)

Clive Hamilton and John Quiggin “The privatisation of CSL” *The Australia Institute* Discussion paper 4, June 1995. [www.tai.org.au](http://www.tai.org.au)

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

Charles E Lindblom, “The Science of ‘Muddling Through’” *Public Administration Review* Spring 1959.

Productivity Commission *Public and Private Hospitals Discussion Draft* October 2009. [www.pc.gov.au](http://www.pc.gov.au)

Jeff Richardson “Steering without navigation equipment: the lamentable state of Australian health policy reform” *Australia & New Zealand Health Policy* 6:27 2009. [www.anzhealthpolicy.com/content/6/1/27](http://www.anzhealthpolicy.com/content/6/1/27)

Barbara Starfield, Leiyu Shi and James Macinko “Contribution of primary care to health systems and health” *Millbank Quarterly* Vol 83 # 3 2005.

Rodney Tiffin and Ross Gittins *How Australia Compares* (Cambridge University Press 2004).

Richard Wilkinson and Kate Pickett *The Spirit Level: Why More Equal Societies Almost Always Do Better* Penguin 2009.

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* 1995; 163: pp 458-47.

World Health Organization “World Health Report 2008: Primary health care now more than ever” WHO 2008. [www.who.org](http://www.who.org)

**General Sources of information on Australian health financing and delivery**

National Health and Hospitals Reform Commission [www.nhhrc.org.au](http://www.nhhrc.org.au)

Private Health insurance Administration Council [www.phiac.gov.au](http://www.phiac.gov.au)

Australian Institute of Health and Welfare [www.aihw.gov.au](http://www.aihw.gov.au)



**Appendix. Recurrent health expenditure by source and purpose, \$ billion, 2007-08**

	Government			Total government	Non-Government			Total non-government	Total	
	Commonwealth		State		PHI funds (net of subsidies)	Individuals	Other			
	Direct	PHI subsidies	Sub total Commonwealth							
Public hospitals	11.8	0.2	12.0	16.5	28.5	0.5	0.5	1.2	2.2	30.7
Private hospitals	1.1	1.7	2.8	0.3	3.1	4.0	0.3	0.6	4.9	8.0
Medical services	13.9	0.4	14.3	0.0	14.3	0.8	2.1	1.0	3.9	18.2
Dental services	0.2	0.4	0.6	0.6	1.2	0.9	3.9		4.8	6.0
Other practitioners	0.8	0.2	1.0		1.0	0.4	1.6	0.3	2.3	3.3
Pharmaceuticals	7.1		7.1		7.1		6.5	0.1	6.6	13.7
Aids and appliances	0.3	0.1	0.4		0.4		2.2		2.2	2.6
Community health	0.6		0.6	4.6	5.2		0.2		0.2	5.4
Public health	1.3		1.3	0.8	2.1			0.1	0.1	2.2
Administration	1	0.4	1.4		1.4	0.9			0.9	2.3
Research	2.1		2.1	0.4	2.5			0.2	0.2	2.7
Other	0.5	0.2	0.7	1.2	1.9	0.4	0.5	0.2	1.1	3.0
	40.7	3.6	44.3	24.4	68.7	7.9	17.8	3.7	29.4	98.1

Source: Derived from Australian Institute of Health and Welfare *Health Expenditure Bulletin 2007-08*, Table A6