Private Cover is Costing an Arm and a Leg

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Rudd's health reform package is short on detail — but if the Opposition can put sound economic management ahead of political opportunism, real change can be achieved, writes Ian McAuley.

In only a few days the Rudd Government's health reform initiative has been overlaid with misinformation and confusion.

Some of the misinformation is mischievous: the Opposition Leader has gone out of his way to paint the scheme as costly when, in fact, the policies should actually save money because they are about achieving efficiency in healthcare. Of course, healthcare costs will rise in the future but if we make savings now, that rise will be less burdensome. Another political misrepresentation has been the claim by Shadow Minister Hockey that the policy "doesn't add one single bed", as if this is a shortcoming. In fact, the Government's intention is to make better use of existing hospital places for Australia already over-uses hospital services.

Some of the confusion is based on a simple misunderstanding. We have been conditioned to expect governments to address healthcare problems by spending money. Sometimes they spend public money and sometimes they try to lever private funds — as the Howard government did with private insurance — but as any economics student knows, when resources are fixed, more money does not bring forth more resources. Another million or billion dollars does not immediately create a new orthopaedic surgeon or a qualified nurse. Instead, extra funds fuel price inflation, which is one reason why medical and hospital costs have been rising at almost 4 per cent above general inflation. (This inflation is manifest both in public budgets and in private insurance premiums.)

Predictably, no state government has shown enthusiasm for the reform package, but it would be foolish to give an early endorsement when there is still a great amount of detail to be negotiated.

Put simply, the proposals, outlined in the Prime Minister's Press Club Speech and detailed in this lengthy document, are designed to improve the efficiency of hospital care and to integrate this care with other aspects of healthcare.

There is certainly scope for improving hospital efficiency. According to the Productivity Commission, the cost per patient in public hospitals varies from $4000 in Victoria to $5000 in Western Australia. This is why the Commonwealth is changing the way it supports states for hospital funding from simple block grants to a method based on Victoria's system, whereby funding is tied to activity. Under this system, the Commonwealth will make a standard payment (called the "efficient" cost) for treating a fracture, another for a normal delivery and so on. The Commonwealth will fund 60 per cent of the efficient cost, with the states to pick up the other 40 per cent, plus any variance over the efficient cost — giving state governments a strong incentive to economise.

"Casemix funding", as it is known, has its critics, because it pays for services rather than outcomes, but by any criterion of fiscal management, it is superior to open-ended funding.

Even greater savings may be realised if people can be kept out of hospital in the first place. If, through better primary care, preventable hospital admissions could be eliminated, the annual savings would be almost $2 billion. The Commonwealth recognises this, and as a first step it will bring all primary care — presently split between Medicare, special state clinics and public hospital outpatient services — under Commonwealth control. With integration there will be less incentive to shift cost and responsibility, less bureaucratic duplication, more seamless access by patients, and less risk of conflicting therapies.

The policy is short on detail about how primary care and hospital care will be integrated, however. Its practical measures, such as the establishment of Local Hospital Networks to manage regional clusters of hospitals, simply state that the networks "will be obliged to work with local primary health care providers". The passive voice omits important detail — who will enforce the obligation? Several commentators have already said that the policy is too hospital-centric.

The policy overlooks other inconsistencies and discontinuities in health programs. Bringing public funding more under Commonwealth control makes sense, but integrating public funding, in itself, does not make the delivery of healthcare more patient-friendly. For many years the Commonwealth has operated the Medical Benefits Scheme (Medicare) and the Pharmaceutical Benefits Scheme as separate programs, with different co-payments and different safety nets; should not the Commonwealth start by integrating its own programs?

Will we still have free hospital outpatient services alongside Medicare services, with their high and open-ended co-payments? Has the Commonwealth thought through the consequences of continuing to provide free care in public hospitals while most primary care services attract co-payments? There is a great deal of detail to be sorted out.

The biggest loose end, however, relates to private hospitals. Private hospitals provide 40 per cent of all episodes of hospital care. These are mainly simpler cases, but nevertheless private hospitals are an essential part of Australia's healthcare. The Prime Minister, in his Press Club speech and subsequent interviews, has said that if people cannot get care in a public hospital, then the Local Hospital Network will find them a bed in a private hospital. (In the official policy document, the only mention of private hospitals is the weak statement "networks will also collaborate with local private hospitals".)

This commitment is tantalising. At present private hospitals have their privileged stream of funding through heavily subsidised private insurance. Rather than providing integrated care they offer a platform for health service providers, in particular specialist medical practitioners. Thanks to subsidies to private insurance, the Commonwealth's generous Medicare safety net provisions, and the availability of "no gap" cover, private hospitals and specialists do very well out of privately insured patients.

Much of the attraction of private insurance is that it allows people to jump the queue. If such queues can be significantly reduced (they will never be eliminated), and one can be admitted to a private hospital as a public patient, most of the attraction of private insurance will be lost.

Is it possible that the Government finally understands what health economists have been pointing out ever since the Howard government re-introduced subsidies for private insurance? That is, that private insurance is a very expensive and inequitable way to share healthcare costs and that it does nothing to ease pressure on public hospitals.

Even as membership of private insurance has risen from 30 per cent of the population to 45 per cent, waiting lists have remained, because where the money has gone, so too have the resources. A generously over-funded private sector has attracted medical specialists and other professionals away from public hospitals. As Paul Gross said on the ABC's 7:30 Report on the day the policy was announced:

> "I can just imagine a situation with a hip replacement where we depend on an orthopaedic surgeon and what the Government will do in promising access to a public hospital bed for that particular procedure is to assume that there will be an orthopaedic surgeon on tap who will be willing to accept the fee that will now be paid from an activity-based efficient costing coming from Canberra when he is earning six times that amount in the private sector for doing the same job."

"Six times" may be an exaggeration of the price premium, but Gross illustrates the problem, and it's a problem of the Government's own making — although, in justice to the present Government, it is one it inherited from its predecessor.

Of course, the Local Hospital Networks could yield to the private hospitals' demands and pay inflated rates, but that would blow out the state governments' budgets. That's not likely to happen.

There is much to be gained from bringing private hospitals into the funding mainstream. The present situation in which private and public hospitals do not compete with one another is inconsistent with Commonwealth competition policy, and the split between the "gated community" of private hospitals for the well-off and public hospitals for the hoi polloi conflicts with the Government's notion of "social inclusion". But to achieve this integration, the Government must unwind its subsidies for private insurance, and the Opposition must put sound economic management ahead of political opportunism.