CENTRE FOR POLICY DEVELOPMENT
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Enough to be called reform?

Presentation to Crawford School Policy Forum
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Ian McAuley
University of Canberra and Centre for Policy Development

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Outline

Health care, a broad perspective

The Commonwealth's initiatives

Problems skimmed over:

- fragmentation
- private hospitals
- private health insurance
- co-payments

Conclusion

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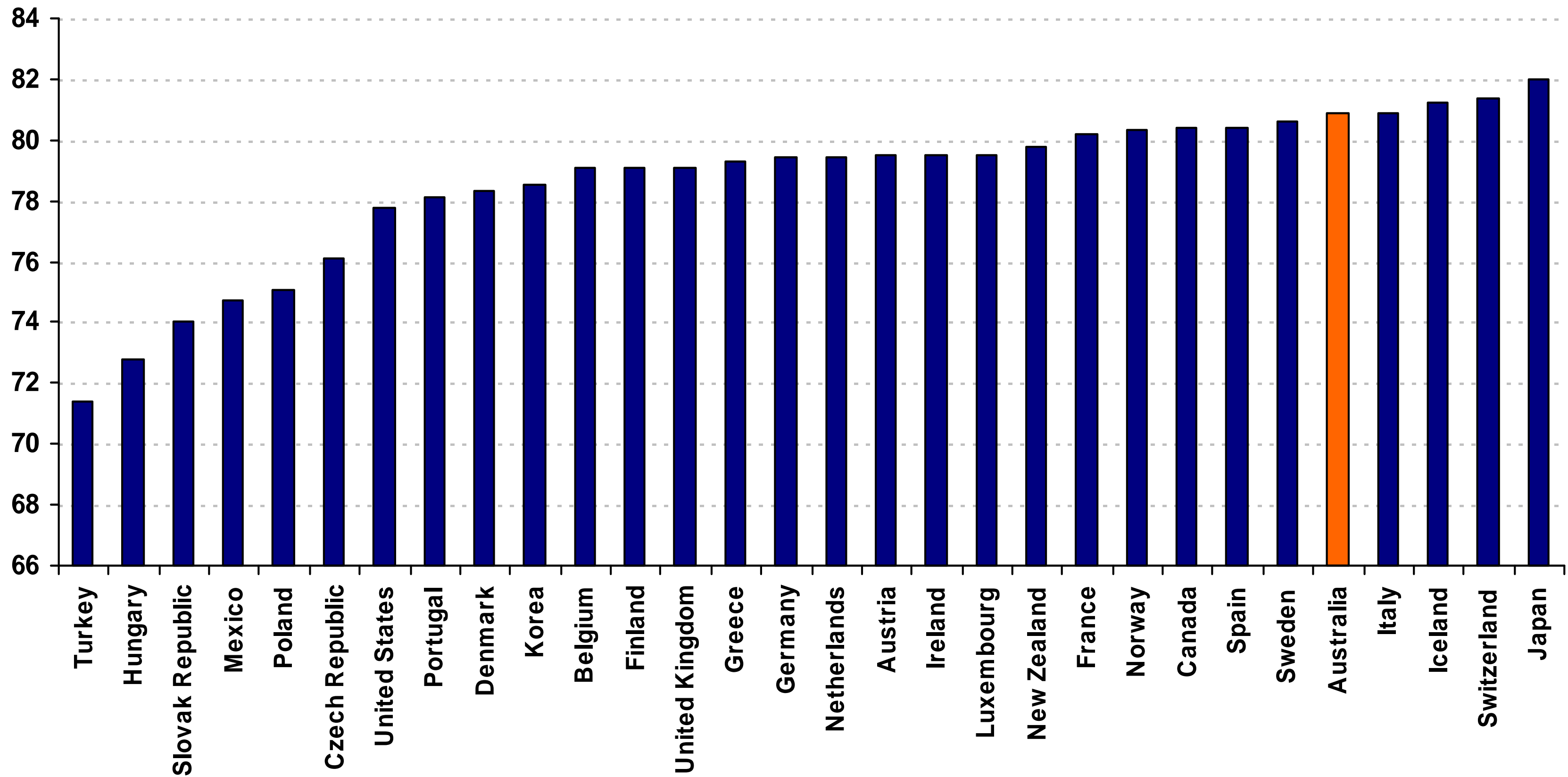
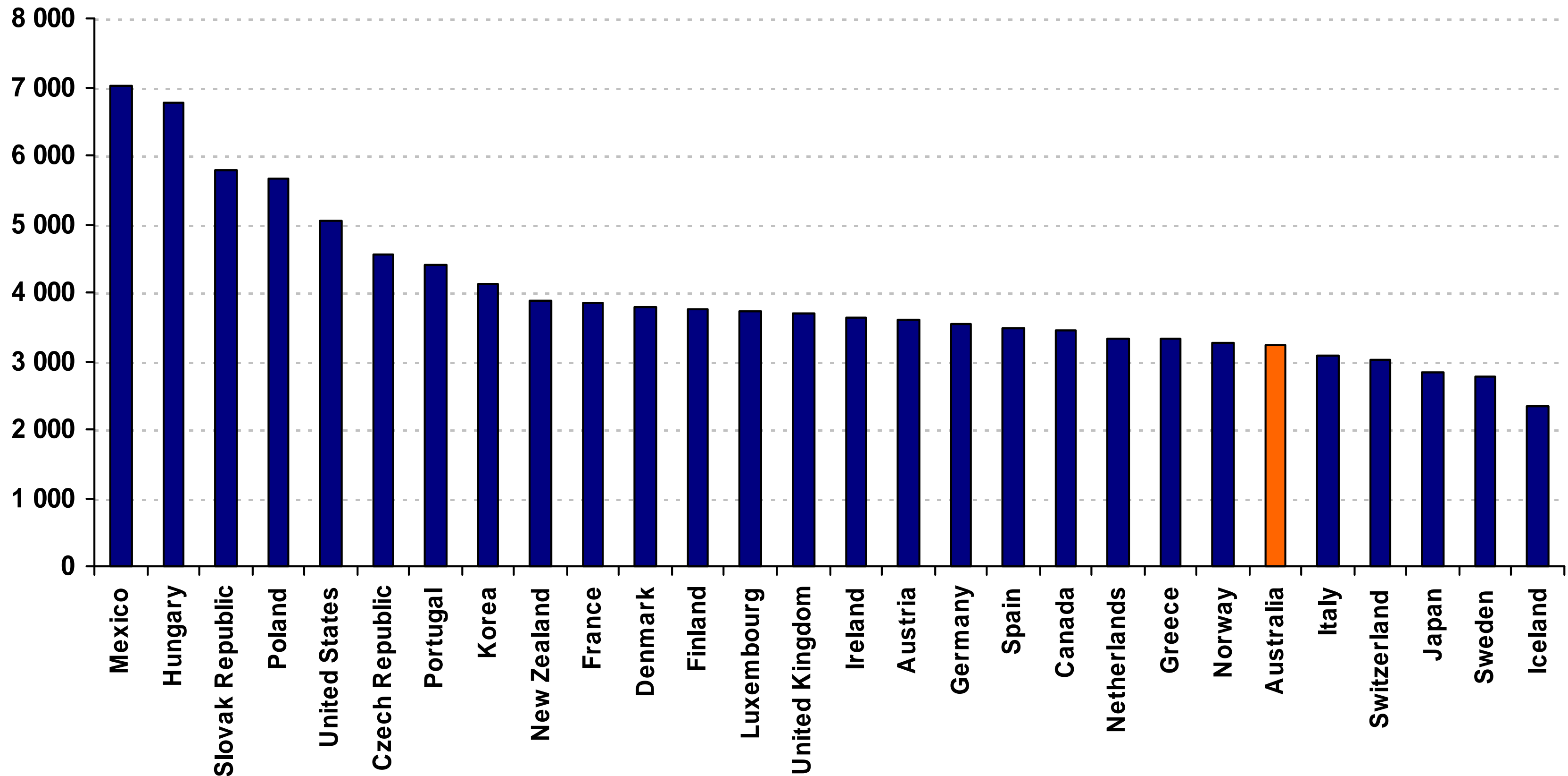
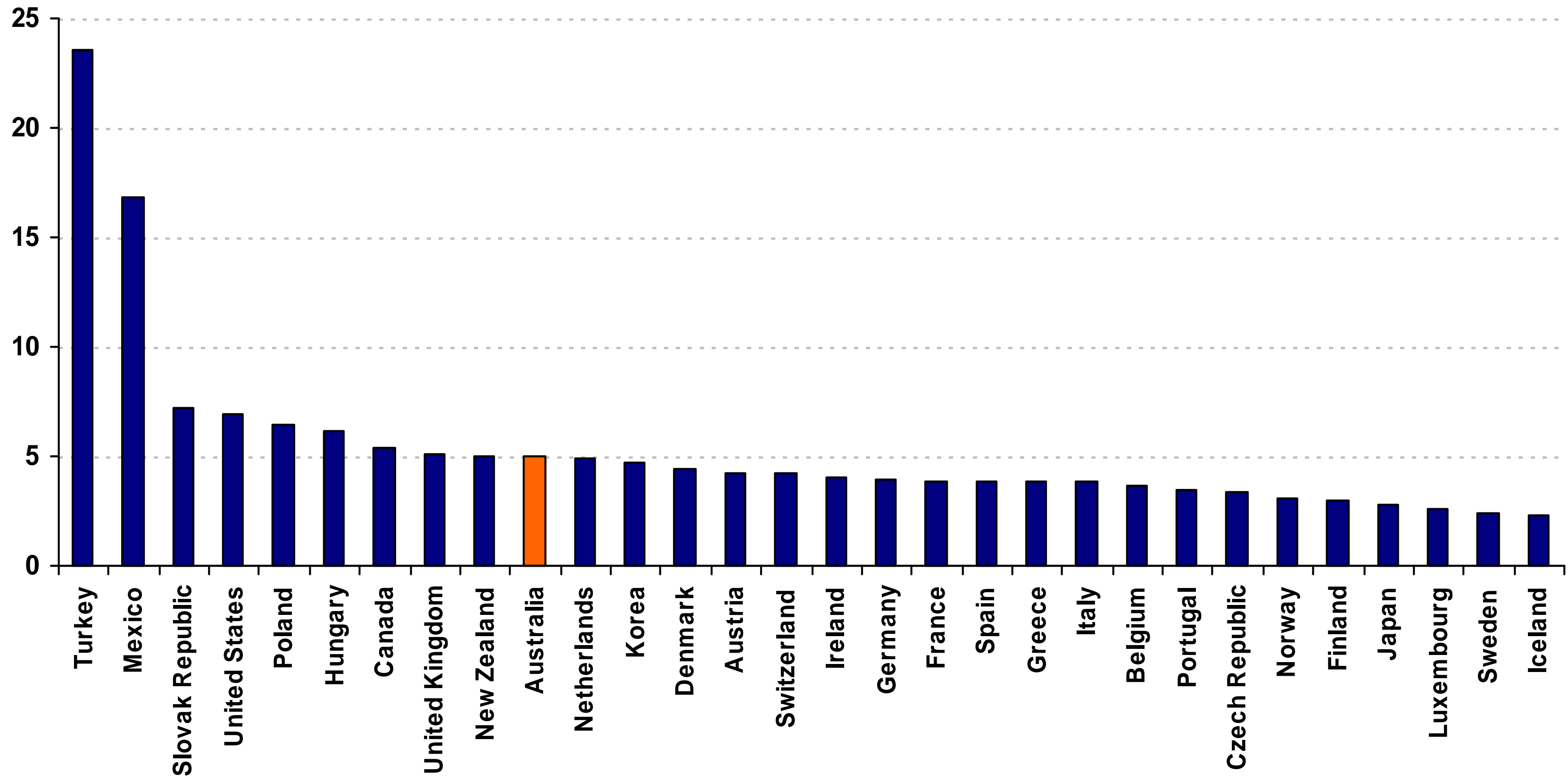
Outcomes



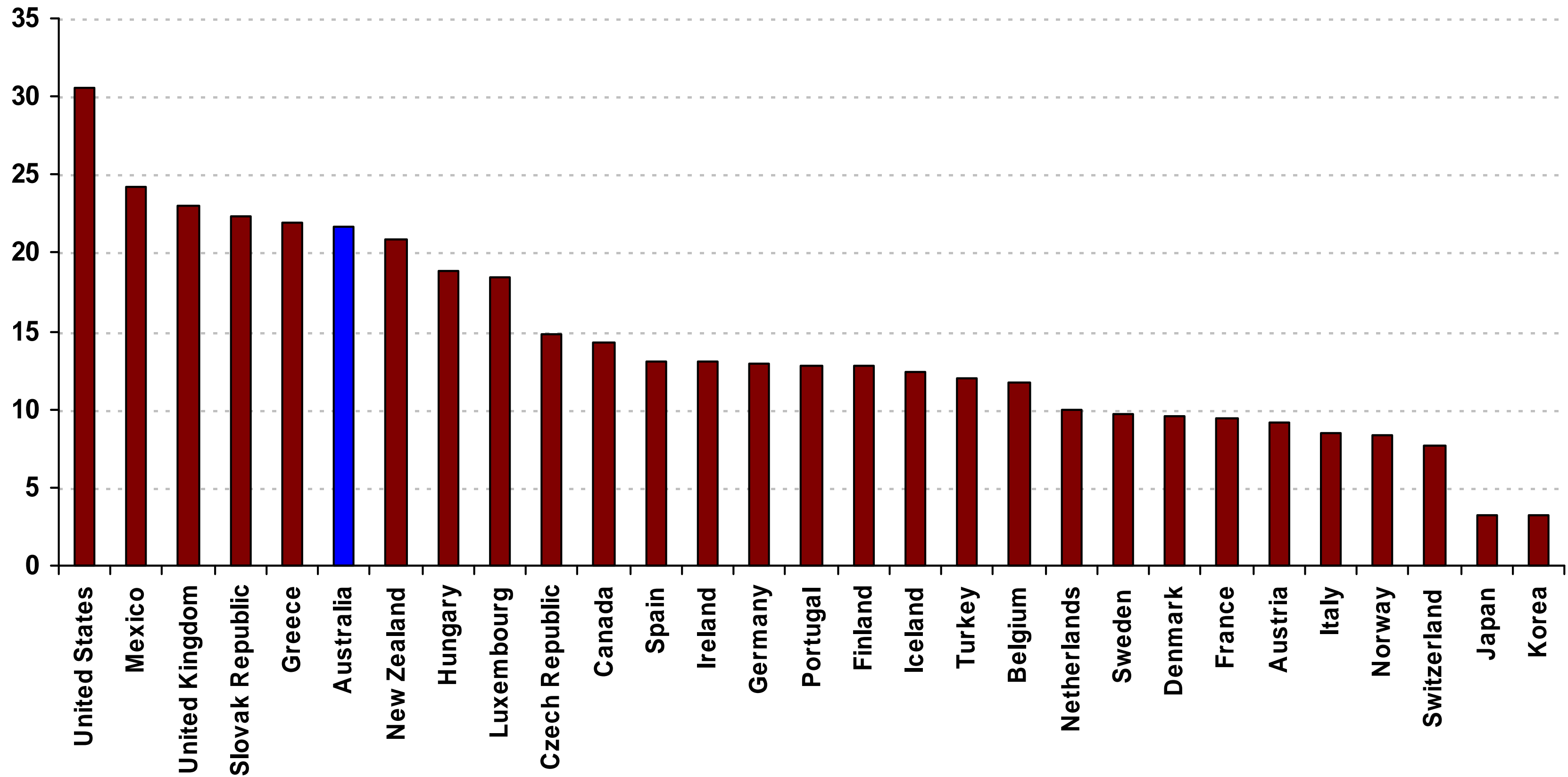
Outcomes



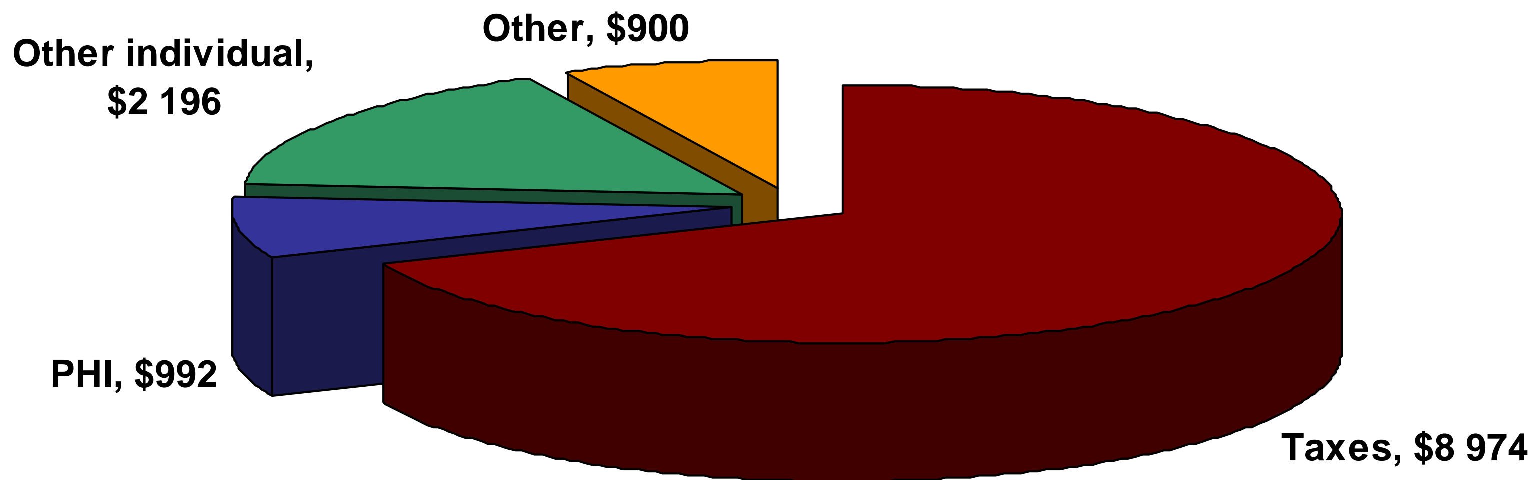
Outcomes



Risk/cost factors

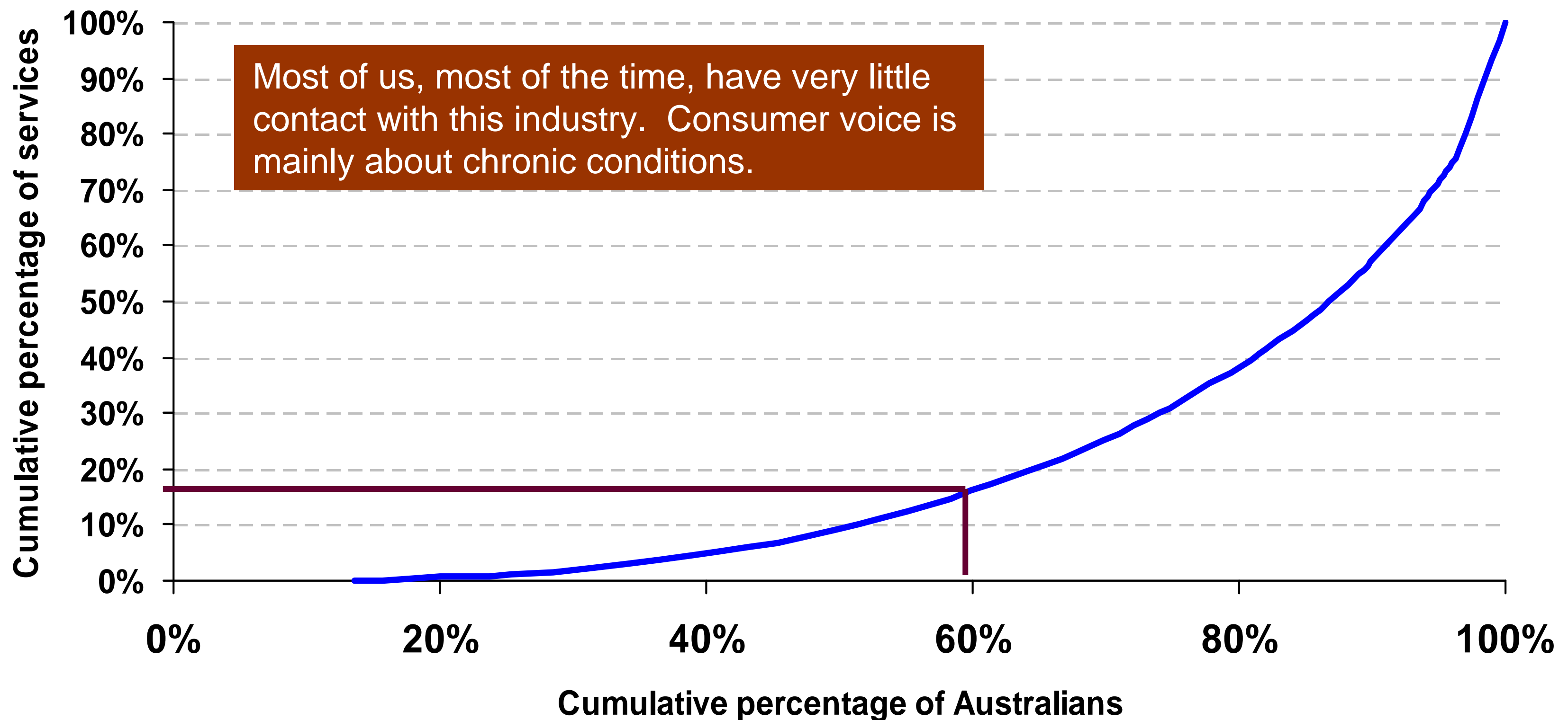


What we spend – $13 000 per household (2007-08)

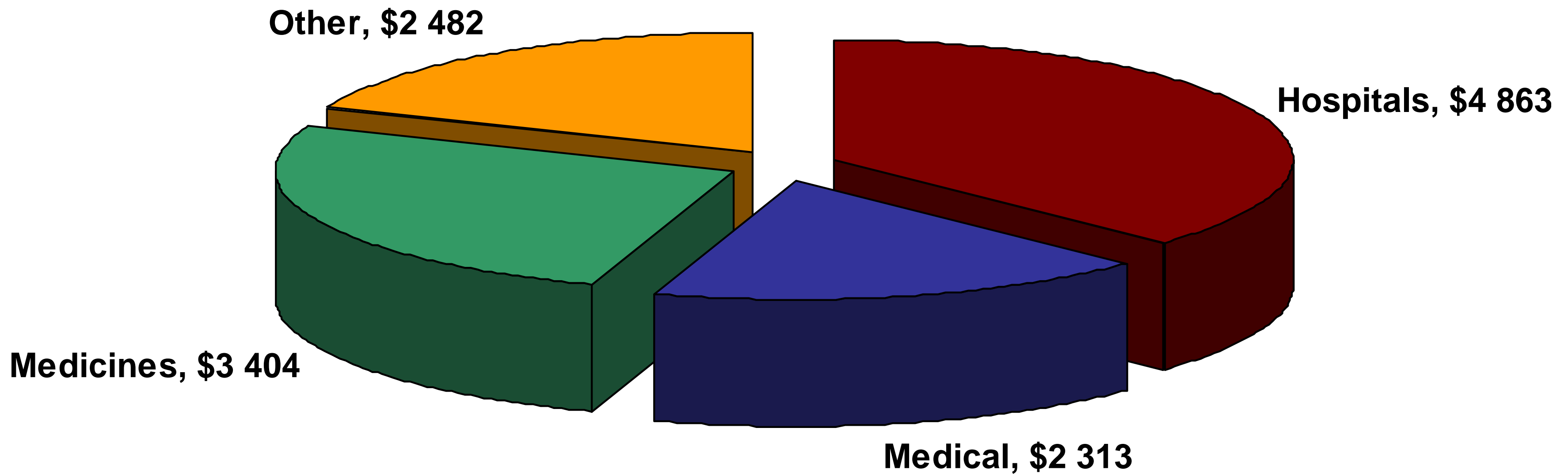


Medicare levy trivial – funds only 1/6 of Commonwealth health outlays

Skewed use



How we spend our $13 000 per household (2007-08)



Quality performance

Adverse events:

Between 9 000 and 19 000 preventable deaths a year

1 500 motor vehicle deaths

= 20 Boeing 747 crashes

Evidence that iatrogenic risks offset much of therapy benefits

Expenditure growth

Australia like other countries struggling to keep health care expenditure at ~ 10 percent of GDP

Growing at 5 percent in real terms, or 4 percent per capita, driven by:

- ageing
- new opportunities – “technology”
- expectations

Government concerns

- intergovernmental relations;
- hospitals;
- cost control, particularly fiscal costs;
- quality;
- appeasement of interest groups, particularly on the supply side, and consumer groups with chronic conditions

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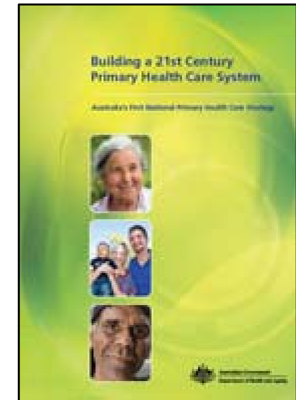
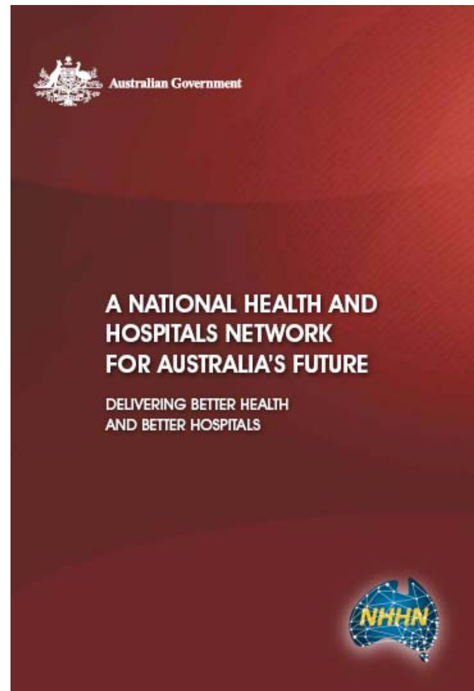
Ageing
Maternity services
Rural health
MBS schedule

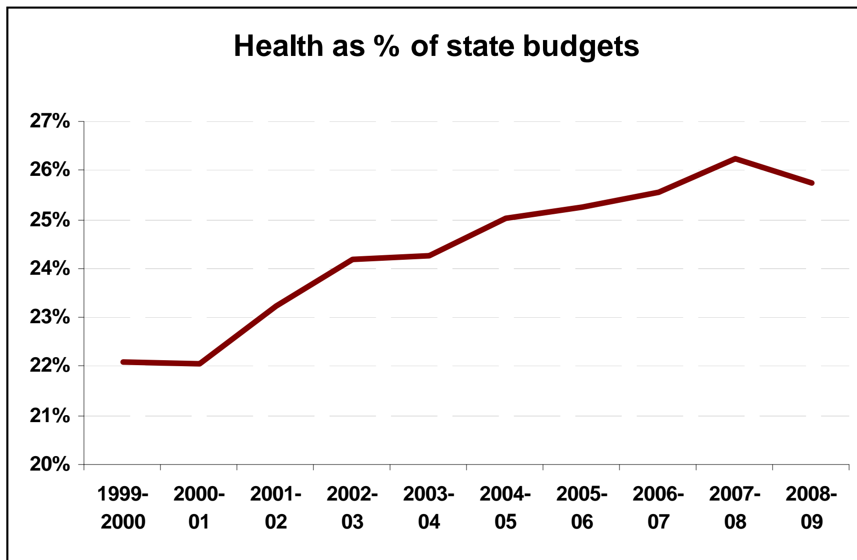


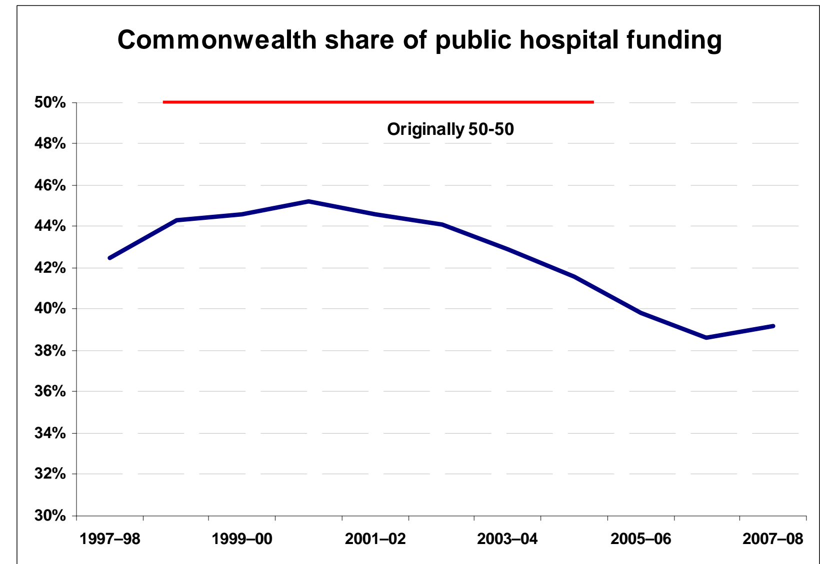


Initiatives

- Commonwealth to fund 60% of hospital services
- Commonwealth to take full responsibility for primary care
- GP Super Clinics
- $ for nurse and doctor training
- a national performance authority
- electronic health records
- more resources devoted to health promotion, illness prevention, and health literacy
- commission on safety and quality in health care
- increase in the excise on tobacco
- savings under the Pharmaceutical Benefits Scheme

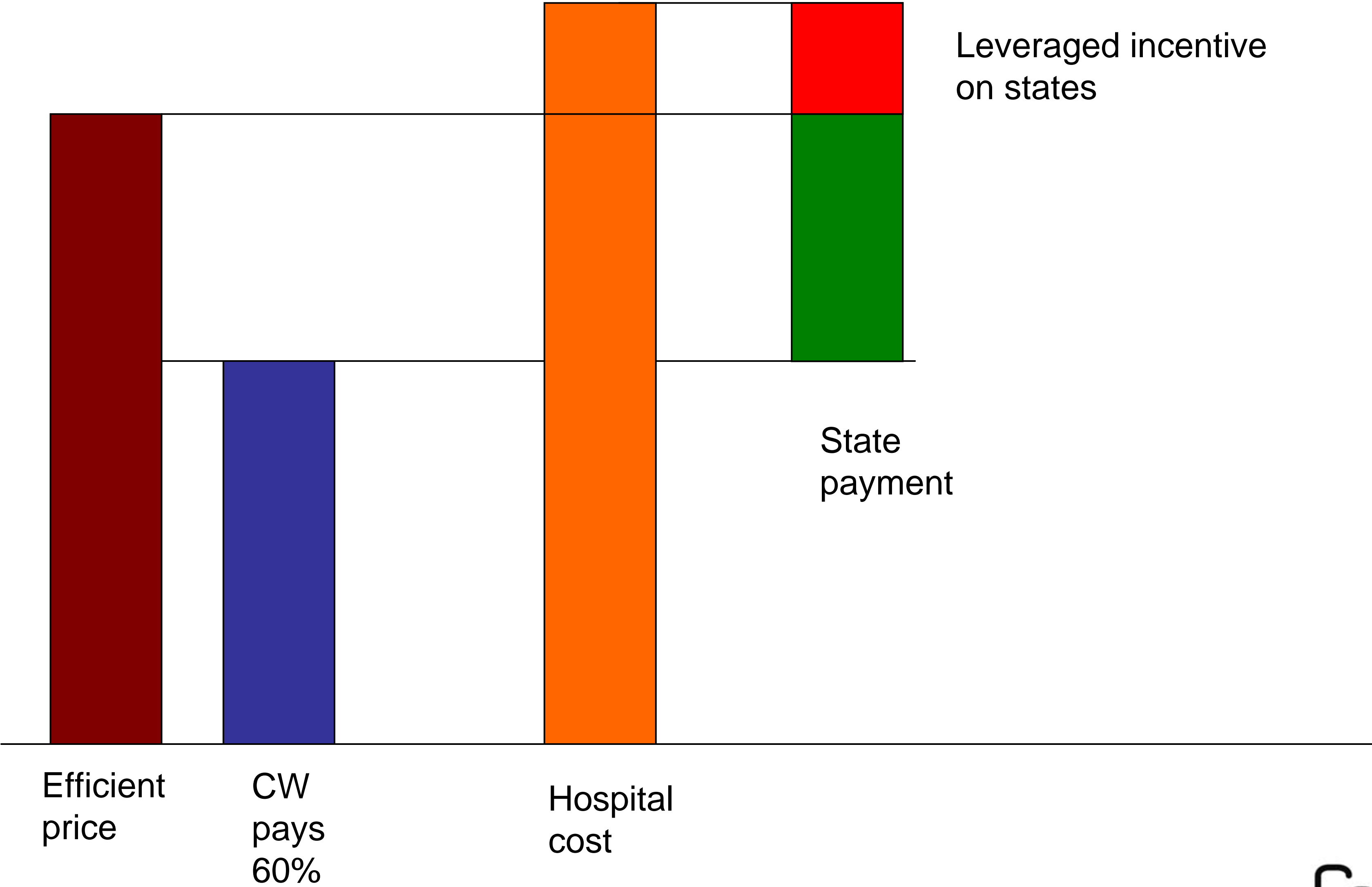
Intergovernmental perspective





Challenge for Commonwealth – restore funding while containing costs

Cost sharing mechanism, with incentives



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Country homestead metaphor

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Consumer perspective

- physical separation of services
- duplication of records
- separation of partial records between different providers
- lack of continuity of care
- high search costs
- high bureaucratic costs (“transaction costs”)
- high risks of conflicting therapies
- demarkation disputes

New bureaucracies to deal with fragmentation?

Call to fund new path for patients

By Peter Jean

Governments should fund advocates to help patients – including those waiting for elective surgery – navigate their way through the health system, according to a patient lobby group.

ACT Health is reviewing the way it communicates with patients on the elective surgery waiting list after *The Canberra Times* revealed last week that a 75-year-old intellectually disabled man suspected of having prostate cancer had been waiting more than a year for an operation he had had been told he required within a fortnight.

The Health Department admitted last week that elective surgery patients were sometimes not informed if they were moved from one urgency category to another.

Health Care Consumers' Association of the ACT executive director Darlene Cox said many patients needed help from an independent person other than their GP to ensure care was properly coordinated.

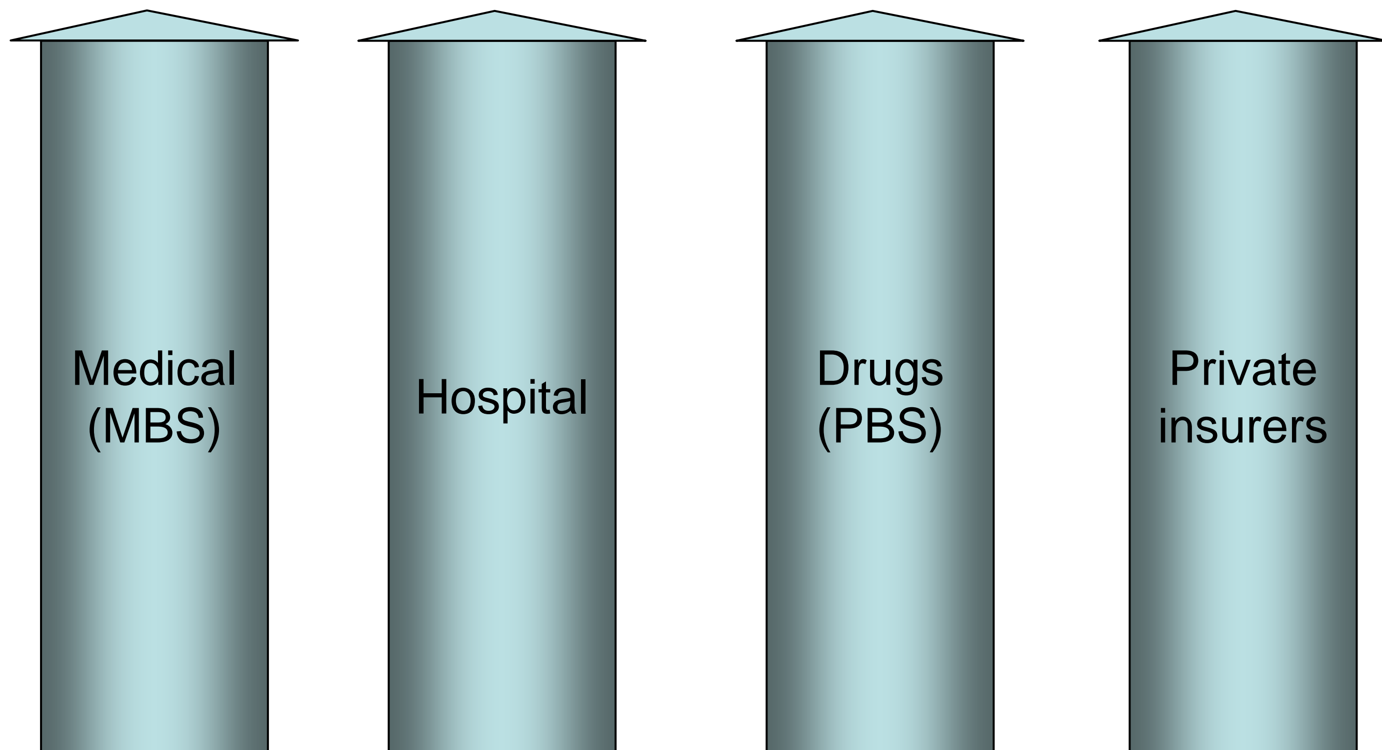
SUPPORT: Darlene Cox backs independent help.

"That role is a really big issue and it's a thing that often is talked about when we're talking about elective surgery," she said.

"You might call them a patient navigator, a system navigator. The role of that person is around recognising the needs of the whole person and providing them with the information to optimise their outcome."

Canberra Times
15 June 2010

A “provider” rather than “customer” structure



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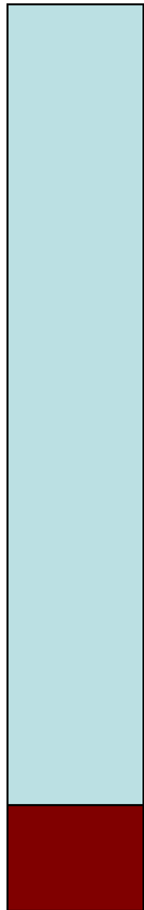
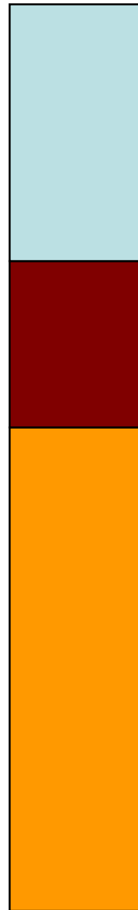
Consumer satisfaction

Medicare



89% satisfaction rating

Health system



18% want a "complete rebuild"

55% want "fundamental changes"

Focus on hospital technical efficiency

Technical efficiency addressed:

In different states public hospital costs vary from $3900 per separation (Victoria) up to $5000 (WA)

Potential savings

Allocative efficiency

Potentially preventable hospitalization 9% of all admissions

Generally a need to reduce hospitalization

Rhetoric OK, but no evidence of integration

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Private hospitals

Initiatives largely about public hospitals, private hospitals still separated

- different funding – separate medical, pharmaceutical, accommodation payment systems
- different specialization

High payments for specialists in private hospitals draw resources from public hospitals. It will be difficult for networks to purchase services at efficient price

Specialists exempt from competition policy

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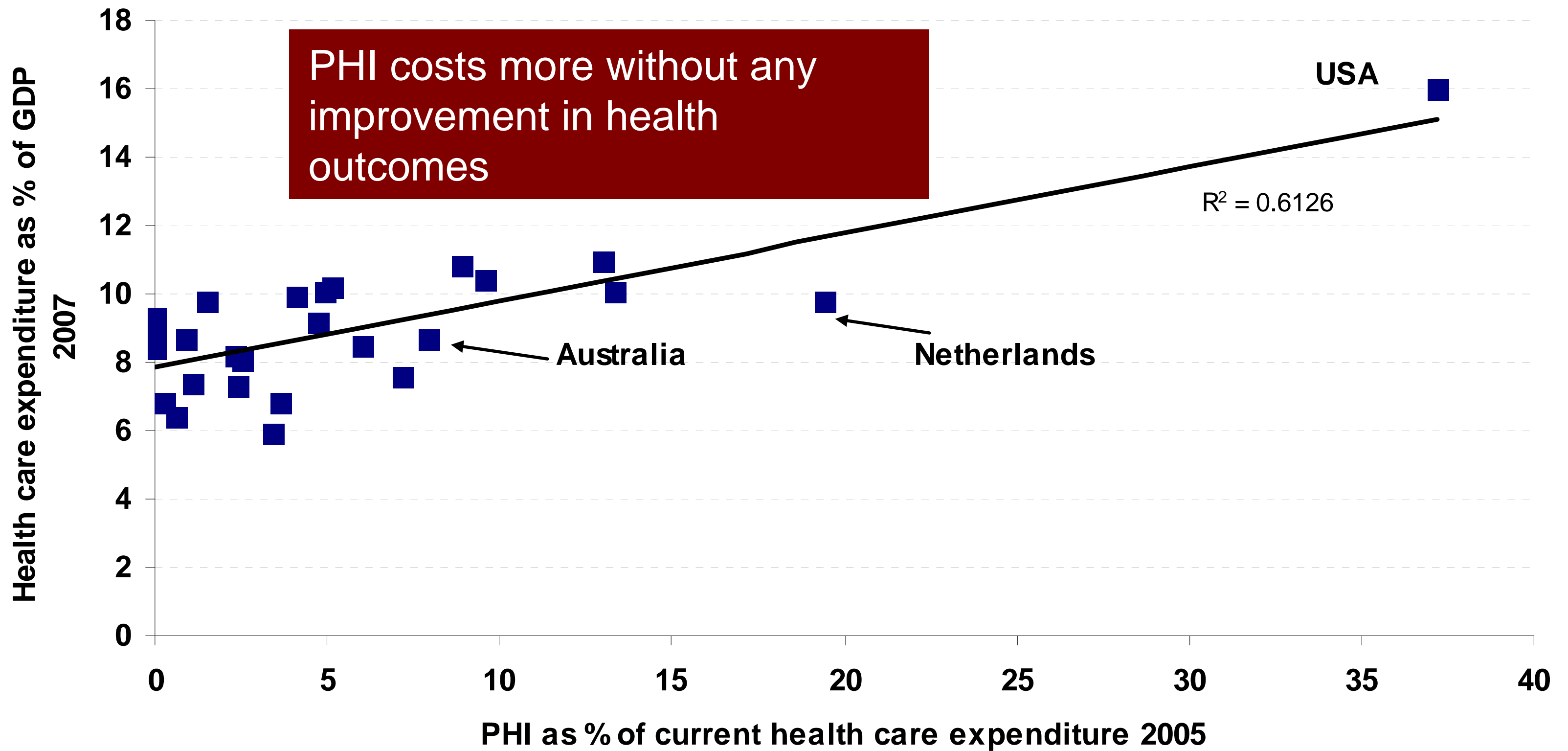
Higher cost, no better outcomes

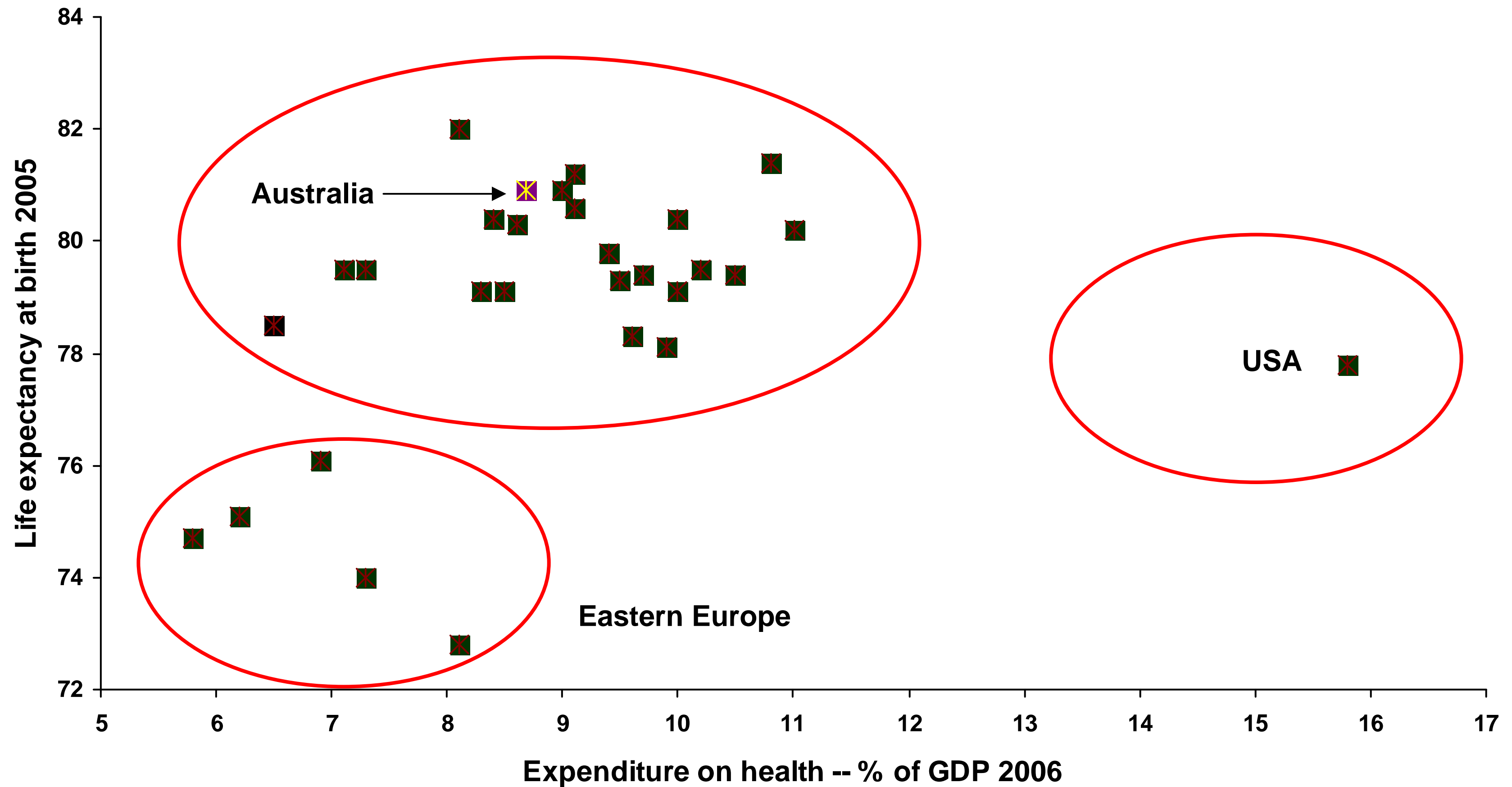


Evidence

"Countries with social health insurance systems [which she has defined as non-government] generally have higher health expenditures than tax-funded systems"

Mary Foley

Expenditure on health and life expectancy



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PHI costs and benefits

Costs	Claimed benefits	Comment
Admin costs > $1 billion p.a.	Choice	Choice of financier – choice without variety
Lack of capacity to control providers	Save budget $	But cost even more community $$
	Supports private sector	Other ways to finance private hospitals
	Is a market solution	False – insurance is non-market
	Takes pressure off public hospitals	False – draws resources from public hospitals
	Is “private”	Mirror of doctrinaire socialism

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Insurance is *not* a market mechanism

"…. both supporters and critics of the market economy have often confused policies that are pro-business with policies that are pro-market."

John Kay

The "insurance" assumption

Left – the government

Right – Private insurance

Insurance is *not* a market mechanism; it's the means we use to buy out of the discipline of markets. All insurance, public or private, is burdened with moral hazard. Notion "Medicare will pay" is the same as the notion "MBF/Medibank Private will pay".

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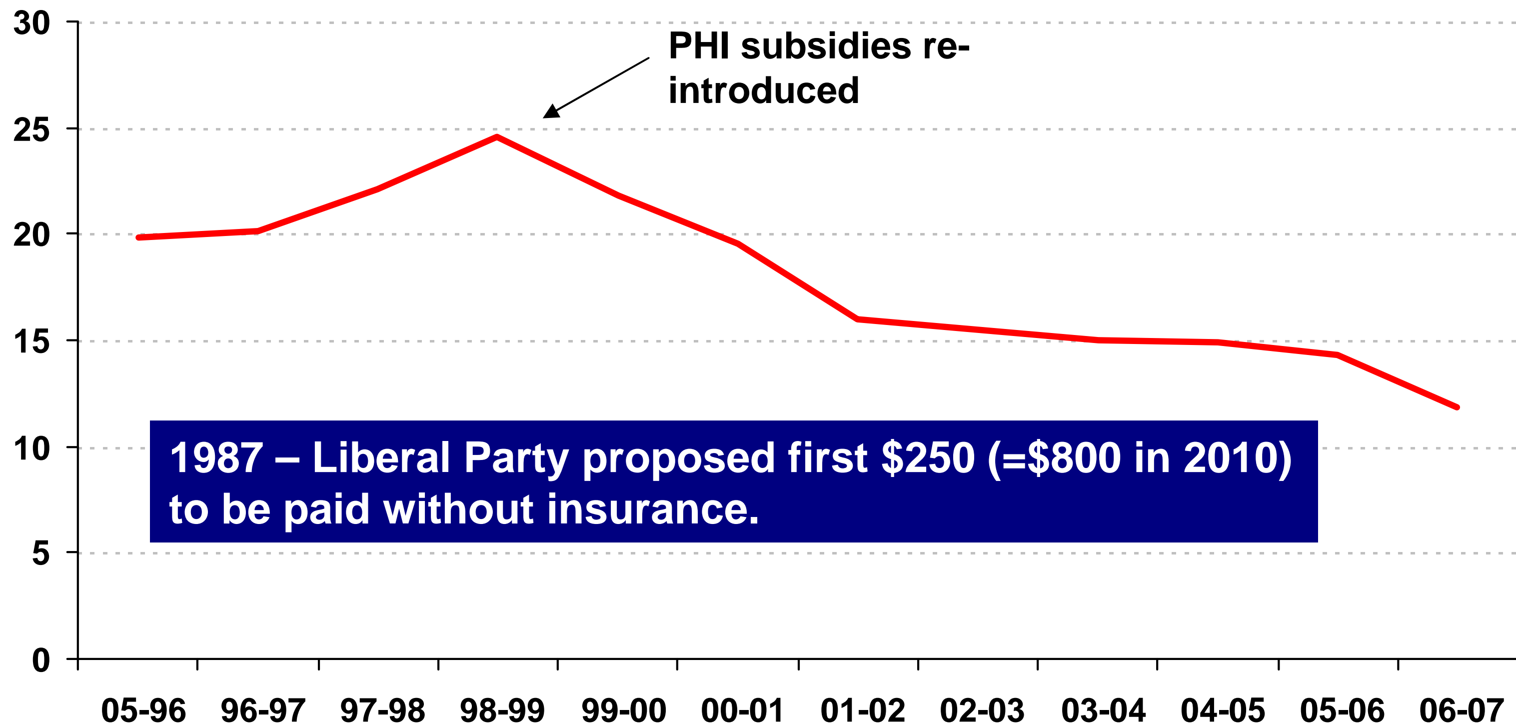
Self-reliance quelled



OECD

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.

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Inconsistent copayments

Public hospitals	Free
Most prescription pharmaceuticals	Set co-payments
Medical services	Open-ended co-payments
Privately “insured” ancillaries	Open-ended co-payments – if “insurer” does not bear risk, is it really “insurance”?
Uninsured services – most ancillaries	No insurance, apart from some means tested services

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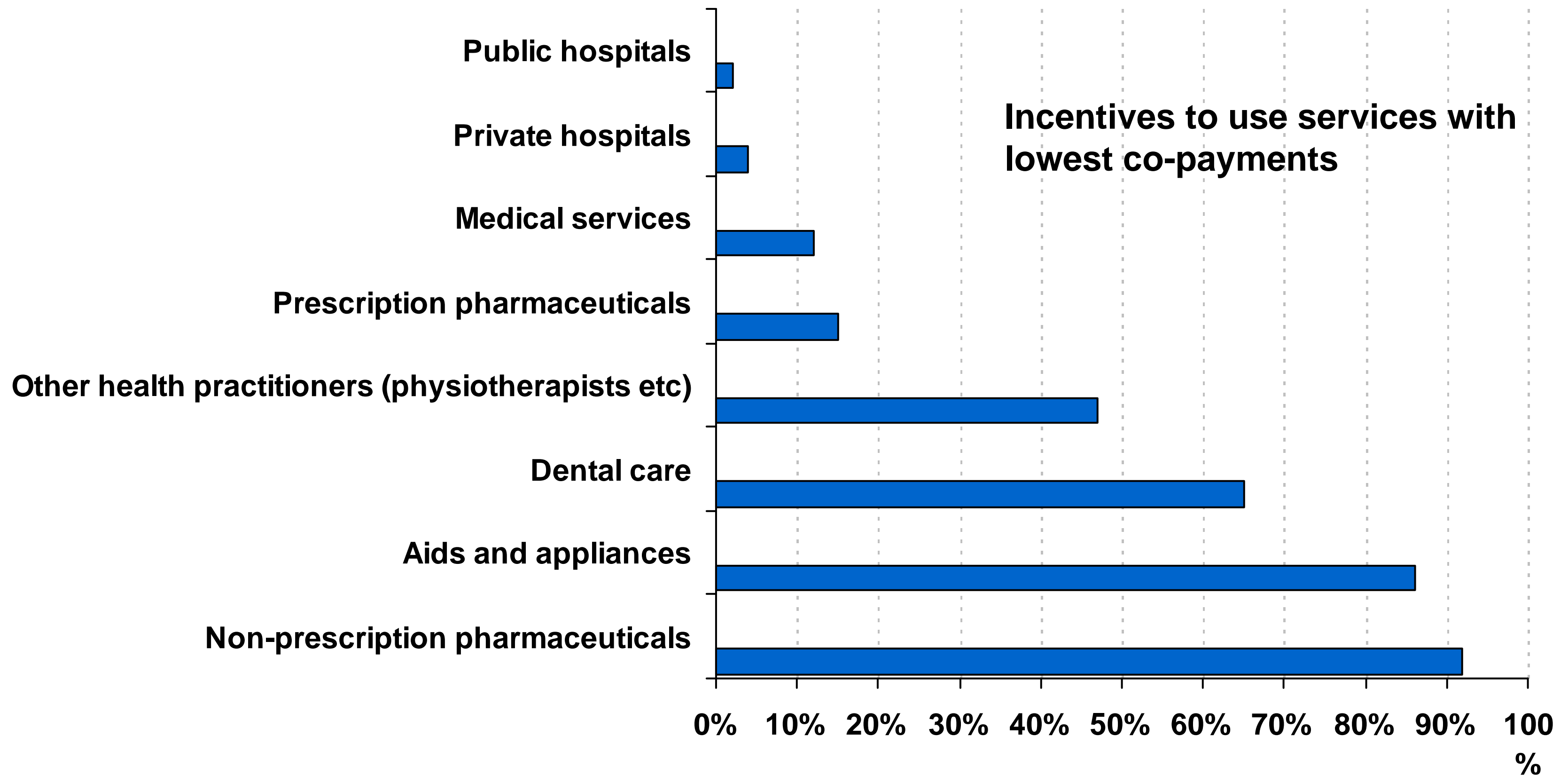
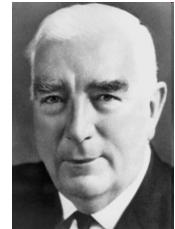
Haphazard incidence of copayments



Legacy

Male incomes (2010 prices)

1950 Free pharmaceuticals, heavily subsidized medical services through PHI (European countries introducing free health care) → $20 000



1975 Free hospitals, Medical Benefits Scheme → $40 000

2010 → $70 000

Policy principles

Question which should be raised is not “public/private”, but the balance we seek between individual and shared funding (insurance)

When we reframe this way, the secondary question is how we should pool funding

PHI is a poor means of sharing:
- hard to control costs and utilization
- hard to achieve community rating
- administratively expensive c.f. tax
- cannot provide public goods

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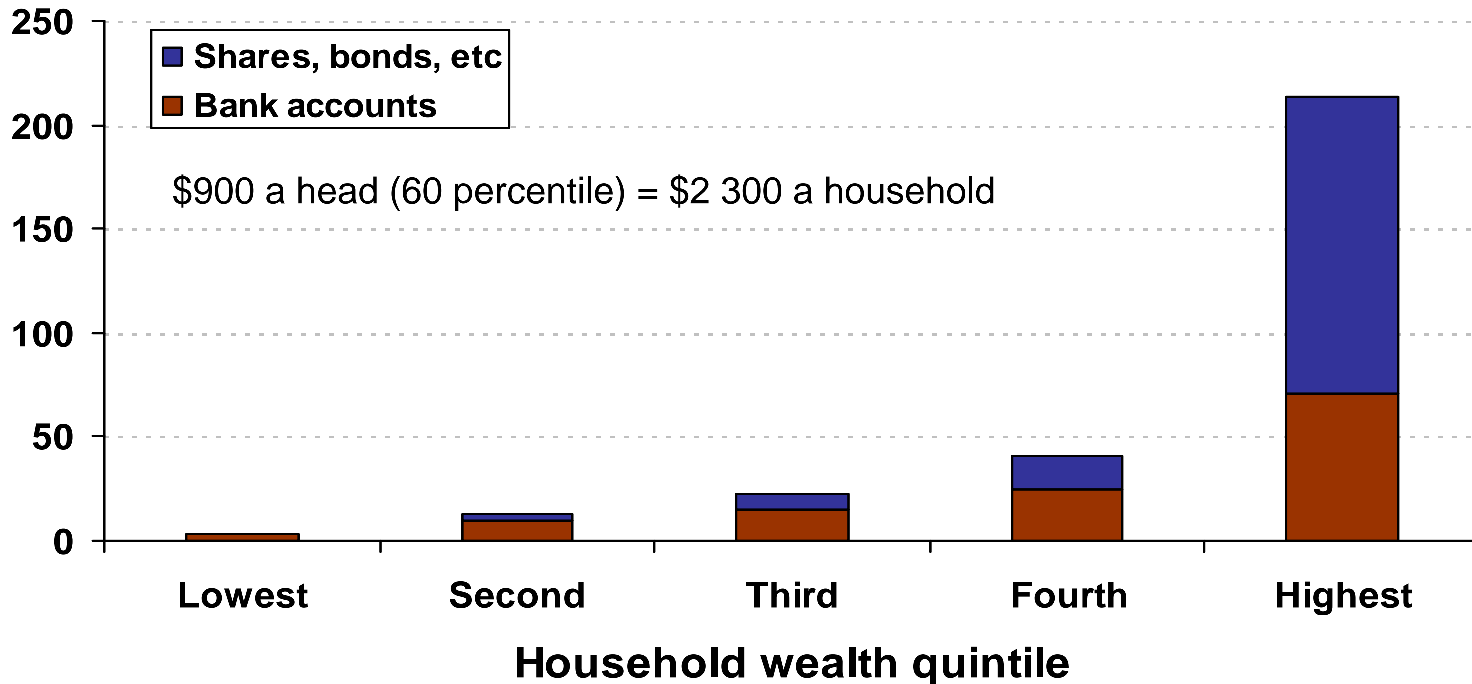
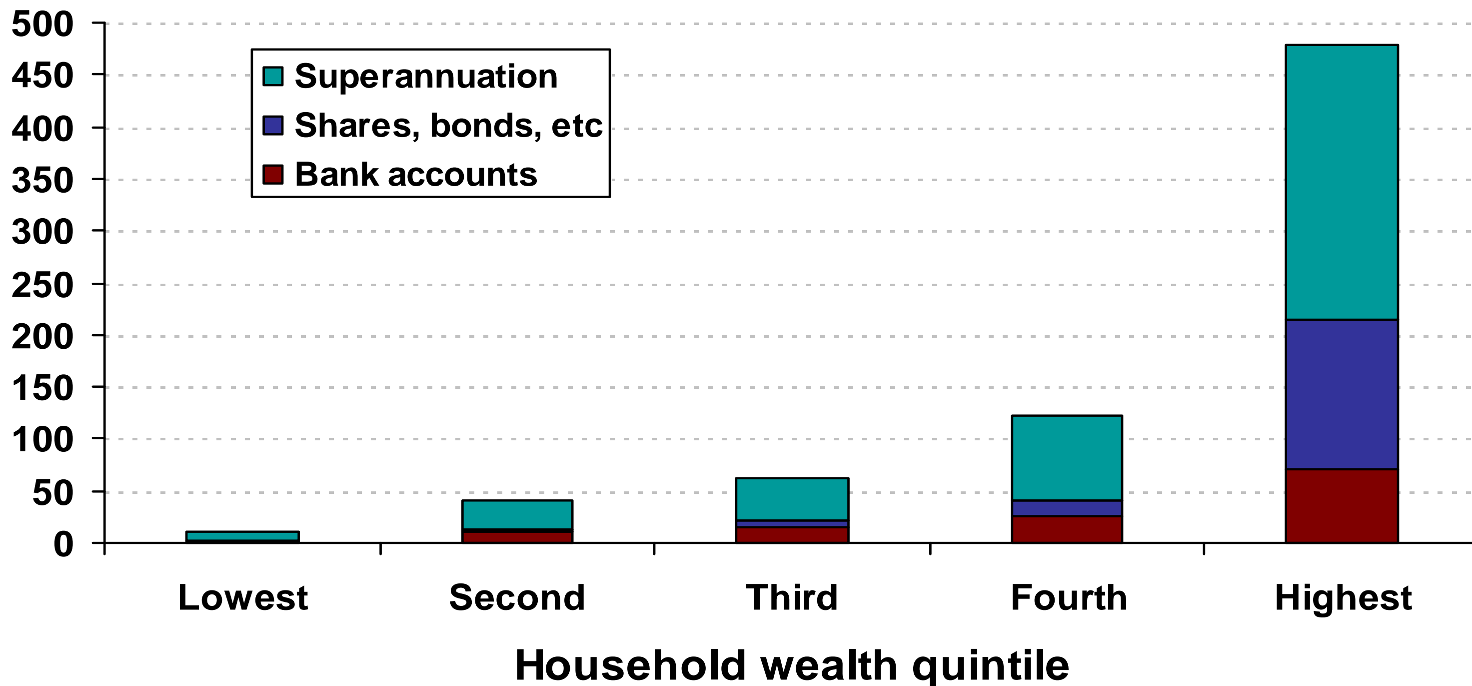
Someone else will pay the bill

But most Australians, most of the time, could pay for all of their health care costs without any insurance, public or private.



Someone else will pay the bill

Financial assets even higher when superannuation included – liquid for those > 60



Why not more market transactions?

"... a guiding principle of any reform should be to put the consumer, not the insurer or the government, at the center of the system. I believe if the government took on the goal of better supporting consumers – by bringing greater transparency and structural reform to the health-care industry, and by directly subsidizing those who can't afford care – we'd find that consumers could buy much more of their care directly than we might think ..."

David Goldhill

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Report card

Poor process – “insider” reviews, lacking capacity to take detached perspective

Too much about “government” concerns, esp fiscal control, rather than community concerns

All useful improvements, but leave intact a dysfunctional architecture

Australia has appetite for significant reform – tariffs, GST etc – such reform takes time and engagement on values

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