Enough to be called reform?

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Ian McAuley
University of Canberra and Centre for Policy Development
Outline

Health care, a broad perspective

The Commonwealth’s initiatives

Problems skimmed over:
  - fragmentation
  - private hospitals
  - private health insurance
  - co-payments

Conclusion
Outline

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Conclusion
Outcomes

Life expectancy at birth (years)

Turkey
Hungary
Slovak Republic
Mexico
Poland
Czech Republic
United States
Portugal
Denmark
Korea
Belgium
Finland
Greece
Germany
Netherlands
Austria
Ireland
Luxembourg
New Zealand
France
Norway
Canada
Spain
Sweden
Australia
Italy
Iceland
Switzerland
Japan
Outcomes

Potential life years lost per 100,000, population < 70
Outcomes

Maternal and infant mortality -- deaths per 1000 live births
Risk/cost factors

Obesity -- % of population

- United States
- Mexico
- United Kingdom
- Slovak Republic
- Greece
- Australia
- New Zealand
- Hungary
- Luxembourg
- Czech Republic
- Canada
- Spain
- Ireland
- Germany
- Portugal
- Finland
- Iceland
- Turkey
- Belgium
- Netherlands
- Sweden
- Denmark
- France
- Austria
- Italy
- Norway
- Switzerland
- Japan
- Korea
What we spend – $13 000 per household (2007-08)

- Taxes, $8 974
- PHI, $992
- Other individual, $2 196
- Other, $900

Medicare levy trivial – funds only 1/6 of Commonwealth health outlays
Most of us, most of the time, have very little contact with this industry. Consumer voice is mainly about chronic conditions.
How we spend our $13 000 per household (2007-08)

- Hospitals, $4 863
- Medicines, $3 404
- Medical, $2 313
- Other, $2 482
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

Efficient price  CW pays 60%  Hospital cost

Leveraged incentive on states
State payment
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Country homestead metaphor

Legacy of past initiatives, developed in response to needs, fiscal constraints and political fashion of the time. No consistent architecture, no consistent principles.
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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?
A “provider” rather than “customer” structure

Program structure centered on suppliers and funders

Medical (MBS)  Hospital  Drugs (PBS)  Private insurers
Consumer satisfaction

Medicare

Health system

89% satisfaction rating

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

PHI and total health care costs OECD countries

PHI costs more without any improvement in health outcomes

PHI as % of current health care expenditure 2005

Health care expenditure as % of GDP 2007

R² = 0.6126

Australia

Netherlands

USA
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

- Australia
- USA
- Eastern Europe

Expenditure on health -- % of GDP 2006

Life expectancy at birth 2005
## PHI costs and benefits

<table>
<thead>
<tr>
<th>Costs</th>
<th>Claimed benefits</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admin costs &gt; $1 billion p.a.</td>
<td>Choice</td>
<td>Choice of financier – choice without variety</td>
</tr>
<tr>
<td>Lack of capacity to control providers</td>
<td>Save budget $</td>
<td>But cost even more community $$</td>
</tr>
<tr>
<td></td>
<td>Supports private sector</td>
<td>Other ways to finance private hospitals</td>
</tr>
<tr>
<td></td>
<td>Is a market solution</td>
<td><em>False</em> – insurance is non-market</td>
</tr>
<tr>
<td></td>
<td>Takes pressure off public hospitals</td>
<td><em>False</em> – draws resources from public hospitals</td>
</tr>
<tr>
<td></td>
<td>Is “private”</td>
<td>Mirror of doctrinaire socialism</td>
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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”.
Self-reliance quelled

Separations from private hospitals -- percentage self-funded

1987 – Liberal Party proposed first $250 (=$800 in 2010) to be paid without insurance.
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

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<th>Service</th>
<th>Payment Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public hospitals</td>
<td>Free</td>
</tr>
<tr>
<td>Most prescription pharmaceuticals</td>
<td>Set co-payments</td>
</tr>
<tr>
<td>Medical services</td>
<td>Open-ended co-payments</td>
</tr>
<tr>
<td>Privately “insured” ancillaries</td>
<td>Open-ended co-payments – if “insurer” does not bear risk, is it really “insurance”?</td>
</tr>
<tr>
<td>Uninsured services – most ancillaries</td>
<td>No insurance, apart from some means tested services</td>
</tr>
</tbody>
</table>
Haphazard incidence of copayments

Direct consumer payments as % of total expenditure

- Public hospitals
- Private hospitals
- Medical services
- Prescription pharmaceuticals
- Other health practitioners (physiotherapists etc)
- Dental care
- AIDS and appliances
- Non-prescription pharmaceuticals

Incentives to use services with lowest co-payments
Legacy

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

1975  Free hospitals, Medical Benefits Scheme

2010  Male incomes (2010 prices)

$20 000

$40 000

$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
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.

Household financial assets $'000 2005-06

$900 a head (60 percentile) = $2 300 a household
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