Unmuddling the programs of successive governments and recommendations for a fundamental redesign of funding health care

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Summary

In Australia we have an strong record of economic reform – tariff reductions, financial market deregulation, and reform of wholesale taxes to name a few. But it is a long time since we undertook fundamental reform of health care. The most significant changes introduced by different governments have related to the role of private insurance, but even these have been limited in scope. Most changes have been piecemeal and incremental, without any consistent direction.

As a result we have a confusing and user-unfriendly array of health care programs, which do not come together as a coherent system, and which embody incentives unrelated to overall system performance.

We need a fundamental re-design of our arrangements. This will take time, for we need to consult with the community about two fundamental questions. These are to ask (1) the extent to which we wish to take responsibility for funding our own health care as opposed to using pooled funding – namely insurance, and (2) our vision for health care – a shared collective good or "charity" for the poor and indigent.

Once we have settled these questions we need to consider how to provide insurance. While the private sector will always have a strong position in providing health care, private health insurance should have no part in funding health care. It is a very expensive way to fund health care, and, because insurance suppresses price signals at the time of use of a service, it lacks the allocative discipline of normal private markets. If we want price signals to provide the usual benefits of markets, we should have a more rational and consistent set of uninsurable co-payments, designed to bring some market discipline to health care while maintaining access for those of limited means. Larger costs should be covered by a single national insurer.

Also, we need to re-design the programs of health care, away from the present provider or input-based structure, to a consumer or output-based structure, for the present structures militate against program integration and are unresponsive to consumer interests.

Why is health care so difficult?

Australia has an impressive record of economic reform. The Hawke/Keating Government dramatically reduced industry protection, de-regulated financial markets, and introduced competition policy. Both the Keating and Howard Government pursued commercialization and privatization of government business enterprises (airlines, banks, railroads). And with the GST the Howard Government undertook a major reform of indirect taxation and of Commonwealth-state fiscal relations.

None of these reforms were easy. For example conventional wisdom held that it would be impossible for any government, particularly a Labor Government, to reduce industry protection. Many jobs were at stake in industries such as clothing and motor vehicle manufacturing. Unions and industry groups were united in support of tariff and quota protection, and there was no strong push for change from the public or from political parties. Farmers, consumer groups, and the occasional academic economist were the only faint voices calling for tariff reductions.

Politically these changes were difficult: they were what Sir Humphrey would have called "brave" moves. In all cases there were warnings of dire consequences for the governments pursuing these reforms, and there were concentrations of strong opposition. Adding to the Commonwealth's difficulties competition reforms and the GST cut across Commonwealth-state divisions.

But, looking back, none of these reforms have been costly politically. That is not to say they all have ready acceptance, but they have not been the issues which decide elections.

By comparison, health reform should be easy because there is a groundswell of public support for change. There is a widespread feeling that reform is necessary: 55 percent of Australians believe there should be "fundamental changes" in our health care system, and a further 18 percent believe the system should be re-built completely.[1] Among those with chronic conditions, 57 percent of people want fundamental change and a further 20 percent want a complete re-build.[2]

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 (down from 96 percent two years earlier).[3] But that contrast illustrates a general perception that while each component of health care works well, they do not come together as a system. The whole is less than the sum of its parts.

And unlike reforms such as tariff reductions and privatization of government business enterprises, health reform would not result in widespread job losses. The allocative problem in health care is about deploying scarce labour resources – physiotherapists, doctors, nurses and other health professionals – rather than dealing with people with skills no longer required or who are under-employed. Reform would undoubtedly involve some reduction in administrative overheads, in both the public sector and the private sector (including the health insurers), but people in such occupations are mobile. Their skills are generic, and, in any event, as we have experienced in public service cutbacks and in recent job losses in the financial sector, the public shed few tears when they see displaced administrators having to find useful employment. No-one delivering health services need fear for his or her job.

Yet, even though health care reform should be easier than previous economic reforms, we find our governments are timid. It is now 35 years since the Whitlam Government introduced Medibank and 25 years since the Hawke Government re-introduced universal coverage in the form of Medicare. Even these initiatives avoided changing the fundamental architecture of our health care arrangements, such as the separation of hospital, medical and pharmaceutical services into different streams and the division of programs between the Commonwealth and the states.

The Rudd Government in the 2007 election campaign made much of the need to reform public hospitals, but it came to office committed to retain the existing support for private health insurance, thereby essentially ruling out any fundamental change in funding arrangements. It appointed a Commission, the National Health and Hospital Reform Commission (NHHRC), constrained within this commitment to retain the private insurance subsidies. The Commission seems to have taken this as a brief to avoid *any* examination of fundamental issues in health funding for; in both its interim and final reports Commission it has said:

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

(Even so, this statement has not precluded the Commission from proposing a much wider role for private insurance, in its "Denticare" and "Medicare Select" schemes.)

Quite apart from constraints the Commission may have imposed on itself from its inferences about government policy, its very composition virtually ruled out a basic "root and branch" approach to reform, for its members were all "insiders" – experienced and competent within their own fields, but who would have found it difficult to take a broader perspective. Its chair was a senior executive from a major health insurer, and, leaving aside any suggestion of improper behaviour, it is difficult to see how a person with such a background could realize the way in which private insurance distorts resource allocation, or imagine a world in which private insurance may have a diminished role.

The Commission developed a number of uncontentious technical recommendations. Few would disagree with its five priorities areas of health care – improving health outcomes of Aboriginal and Torres Strait Islander people, improved care for people with serious mental illness, support for people living in remote and rural areas, improved access to dental health care, and timely access to quality care in public hospitals. Its emphasis on primary health care is one which would find widespread agreement.

But it has tried to graft these suggestions on to the existing framework of health care programs. For example, although it advocates "a comprehensive primary care platform", it accepts that there should still exist a program separation between medical services and pharmaceutical services (the MBS and the PBS), and is vague on the relationship between primary care and hospital care.

It's not the sort of report we would have expected from a more detached body, particularly one with economic expertise such as the Productivity Commission. The Productivity Commission has been given several references on aspects of health care (most recently on private and public hospitals), but it has never had the opportunity to undertake a comprehensive analysis. In 1997, in its report on private health insurance, the Commission's

final recommendation was for "a broad public inquiry into Australia's health system", including financing, integration of services, the role of co-payments, and the influence of constraints on the operation of market forces – a strong hint that there are problems with looking only at bits of health care, but no government has commissioned such an inquiry.[4]

Our health care arrangements have developed over many decades. Programs have been designed around the priorities and the real or perceived political constraints of the time. The Australian colonies developed public hospitals initially for the "sick poor": only in the twentieth century did they evolve into institutions providing services for everyone, with different funding systems and different means tests (Queensland's hospitals were free right up to the time of Medibank), before Medibank and the Commonwealth-state agreements provided for universal and free access. The PBS had its origins in the 1940s, as a means of giving affordable access to expensive life-saving drugs. The Commonwealth has always been haunted by the battles on the 1940s when its attempts to introduce a comprehensive health care system was defeated by the local branch of the British Medical Association, who battled the Government all the way to the High Court. Between 1972 and 2007 support for private insurance was off and on, depending on whether the government in power was Labor or Coalition. Writing in 1984 Sidney Sax described health policy as emerging from conflicts of ideology, professional values and financial interests; it is the same 25 years on.[5]

Consequently, there is no consistency in program design. For example, the PBS operates within a set of cost-benefit rules which underpin drug availability and pricing – a model of "evidence-based policy" – but cost-benefit analysis is generally absent from other parts of Australia's health arrangements. Rather, the Commonwealth's concern is often with the immediate budgetary cost of program elements, rather than any systematic economic evaluation. The Commonwealth strictly regulates the wholesale price of prescription pharmaceuticals because of the budgetary impact of the PBS, but for non-prescription pharmaceuticals which can be purchased only from pharmacies (S2, "pharmacy only" and S3, "pharmacist only"), and for prescription pharmaceuticals with low wholesale prices, the consumer is left unsupported, paying whatever pharmacies choose to charge in a far from competitive market. In the Commonwealth-state health care agreements public hospitals are required to provide free inpatient services, but the programs run by the Commonwealth are far from free.

While some may talk of a "health care system" we have no system. We have a mess.

Our mess

Consequently, the user of health services experiences an incomprehensible array of disconnected programs, lacking design consistency, with no evidence of any underlying values or principles. To consider co-payments for example:

> We have free public hospitals, but we have to pay $32.90 for pharmaceutical prescriptions. If we have private insurance, generously subsidised by the government, some "ancillary" services such as dentistry are covered (only up to a capped amount, leaving the consumer to pay the open-ended difference), but if we choose to rely on our own savings for our ancillaries or private hospitalisation, we get no support. We may have a nearby "bulk billing" medical clinic, or we may have to make an open-

> ended out-of pocket contribution, the difference depending on where we live. The Medicare safety net has two thresholds, one for the "gap" amount, for which there is a 100 percent refund, the other for out-of-pocket costs, for which there is an 80 percent refund. The Medicare safety nets cut in at $383.90 for the "gap" and at $1 111.60 for the "out of pocket" component, while the PBS safety net cuts in at $1 164.90. These safety nets operate on calendar years, but there is a 20 per cent tax rebate for medical expenses above $1 500 in a financial year, on an individual basis, with different definitions of what qualifies as a medical expense. The Commonwealth provides dental benefits of up to $153.45 per calendar year for each eligible teenager to receive a preventative dental check from a dentist. Some physiotherapy services are covered by Medicare, but different physiotherapy services are covered by private insurers. ...

That's not to mention provisions for certain disadvantaged groups, such as concession card holders, or the complexity of private insurance subsidies (the "lifetime rating" steps, the 35 and 40 percent subsidies for older people, and the levy surcharge).

The above is only a brief outline of the co-payment mess. An excellent description and analysis of co-payments, including practical suggestions for reform, is in the recently released CPD paper by Jennifer Doggett – "Out of Pocket: Rethinking health co-payments".[6]

Co-payments, if properly structured, can serve a useful purpose in bringing some market discipline to health care. Gary Banks, Chairman of the Productivity Commission has said:

> Co-payments can provide a valuable role in constraining inappropriate demand and by marshalling private financing, relieving some of the fiscal strains for government.[7]

But it's doubtful if co-payments as they have arisen in Australia are serving any such allocative function; they are far too complex for anyone to navigate and they have little relation to the value of the service provided. For example, the Medicare Safety Net will be reached by a few high-cost specialist services, but it would take 30 or 40 visits to a GP to reach the threshold.

Surveys by the Commonwealth Fund produce evidence that co-payments, as presently applying, distort people's decisions. There is heavy use of "free" emergency rooms in public hospitals: for example 17 percent of people with chronic conditions have used emergency rooms for conditions treatable by their regular doctor. A third of people with chronic conditions have foregone treatment (doctor's visit, filling a prescription, getting a test) because of cost.[8]

While there are means tests for some programs, there is no system-wide approach to equity. Someone whose needs can be met entirely with medical consultations and pharmaceuticals could pay more than $2000 a year in co-payments, while someone else whose needs require hospitalization may pay nothing at all. One's access to bulk-billing is a lottery determined by postcode rather than any conscious program design. The private health insurance subsidies are bizarre: thanks to the "lifetime rating" steps, the young are expected to subsidize the old (on top of all the other inequitable transfers from young to old); the Medicare Levy Surcharge over-compensates people for holding private insurance; the "no gap" PHI policies result in free services for the insured and price escalation for the uninsured; the well-off with PHI are subsidized 30 to 40 percent for their dental and other ancillary care, while others have to pay the full price.

Fragmentation of our health care services adds to administrative cost. It also has implications for record keeping and therefore safety. There is duplication of records, often paper-based, with serious potential for errors, such as inappropriate medications, misdiagnosis, and duplication of treatment.

Policymakers know about these problems, but they try to solve each problem in isolation, such as the recent measures on ophthalmology, or with deliberately conservative inquiries such as the NHHRC or limited references to the Productivity Commission. Unlike those who guided changes in industry policies, among health policymakers there is an attitude that fundamental change is impossible.

Change is possible

The economist Joseph Schumpeter described the processes of economic growth in capitalist economies as "creative destruction".[9] Big corporations become conservative and sclerotic, but that doesn't matter, for these old firms die and new ones arise. General Motors gives way to Toyota; print media companies are replaced by companies providing on-line content; old brands disappear from our supermarket shelves to be replaced by new ones; Pan Am disappears but there are plenty of other airlines.

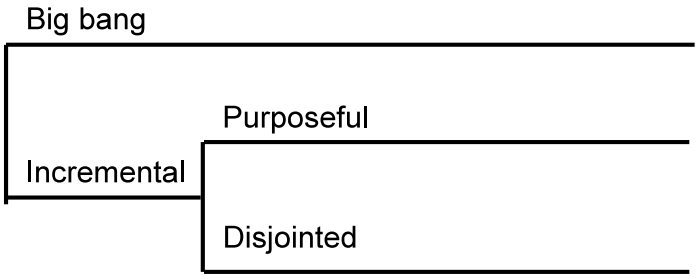
In government services such "creative destruction" is more difficult, often because the services have to continue. There are some initiatives in education, for example, to allow schools to rise or fall in response to parental satisfaction, but in health care, particularly in hospitals, such death and resurrection is a much less realistic business model.

In part this is because of the inherent conservatism of health care – a conservatism which arises from the need for patient safety and the strong professional cultures which health care staff bring to their institutions. The need for conservatism on safety issues easily morphs into a strong resistance to any change: an example is provided by the strong resistance by pharmacists to any changes to the "high street" model of retail pharmacy, detached from other aspects of health care.

Sometimes policy reform can (and must) be on a "big bang" basis. On 1 July 2000 the GST replaced the old wholesale tax. But more commonly reform is gradual, or "incremental" to use the terminology of Yale's Charles Lindblom.[10] In complex systems incremental reform is likely to lessen the risk of unintended consequences; mistakes can be corrected before they become too costly.

Incremental reform has two paths. One is what Lindblom calls "disjointed" incrementalism or "muddling through"; the other is incremental but purposeful, with a clear end in mind. Tariff reform, for example, has been incremental but purposeful – always in the direction of greater trade liberalization. Changes in health care, including the latest proposals from the NHHRC, are better described as disjointed – they make sense in isolation, and within the constraints of limited criteria which may be fashionable at the time, but they have no overall direction or purpose. (The three paths of reform – big bang, incremental purposeful, and incremental disjointed, are shown in Figure 1.)

Figure 1. Reform models



Even if "big-bang" reform is impossible, there can be purposeful, incremental reform. We can do better than"muddling through". To achieve such reform policy makers have to take a system-wide view, to be rigorous in their analysis, and to start by engaging the public in the process. The first step is to ask the public what they want. There are two fundamental questions of values and principles that need to be put to the public:

> To what extent do we want to share our health care costs with other Australians? Do we want to share more or do we want to take more individual responsibility?
>
> and a related question:
>
> Do we want our government programs available to all (a social "solidarity" model) or made available only for the needy (a "charity" model).

There are other issues to be addressed, but these are more of the nature of system design.

The fundamental questions

These two fundamental questions should reveal the community's values, and therefore provide policymakers with a means of building health care reform around a set of consistent principles. To consider each in turn.

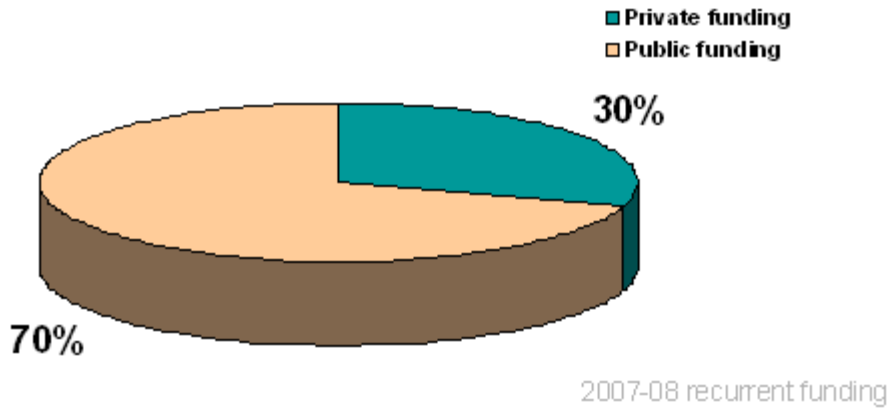
Sharing or individual responsibility?

Most debate on health financing is about the public/private distribution of health care funding. It posits the issues in terms of the "public sector" versus "private sector" – a frame that, in an era of contrived hostility to government, and with a common assumption that the public sector always performs better than government, is bound to lead to the conclusion that the public sector should give way to the private sector.

With such a frame we find that 70 percent of recurrent health funding is from government, and 30 percent from non-government sources (8 percent private insurance, 4 percent other third party payers, and 18 percent individuals). In this frame health funding is dominated by "big government".

Many policymakers use this frame, because their concern is often confined to the fiscal cost of health care; that is the proportion which passes through government budgets. Health insurers too prefer this frame, because it places them in the supposedly virtuous "private" side of the divide.

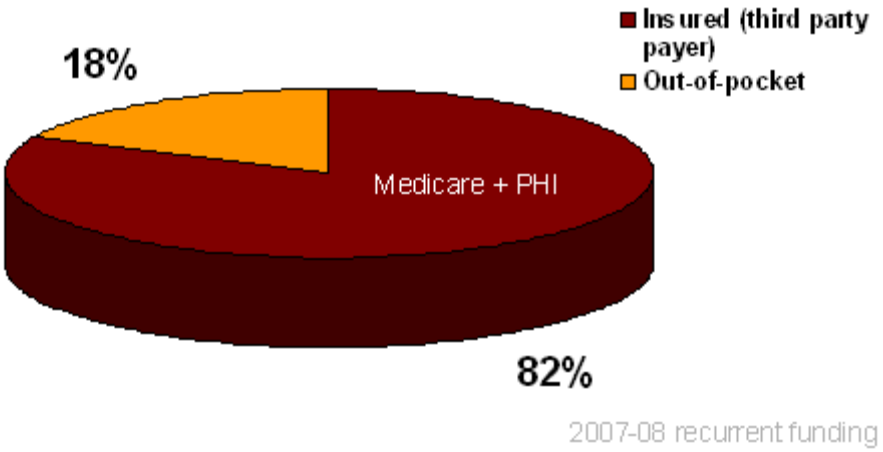
Figure 2. How politicians and lobbyists see health care funding



Such a public/private division, although it dominates public debate, carries little meaning.

Rather, it is of more policy-related relevance to consider what proportion of funding comes from individuals and what proportion comes from third party sources. See Figure 3, which splits health care funding along an individual/shared line, individual payments being out-of-pocket payments and co-payments, and shared funding being all insurance, private and public. On one side is the market with price signals (18 percent), in the other is insurance (82 percent).

Figure 3. How economists see health care funding



Individual payments can carry some of the discipline of market forces, be those payments for non-subsidized drugs, co-payments for medical services, payments for dental services etc. By contrast, third party payments, government or non-government, are outside the discipline of consumer-provider market forces. The consumer's idea "MBF/HBA/Medibank Private will pay for it" is no different from the idea "Medicare will pay for it". Medical practitioners and others, with their patients' interests as a consideration, are likely to recommend services that put no pain on patients' pockets; the answer to the question "are you privately insured?" influences a provider's advice in the same way that public insurance does. (Economists know this phenomenon by the quaint term "moral hazard'.)

Private health insurance belongs on the non-market side of this divide – in the 82 percent of third party payments. Private insurers like to suggest that being "private" they bring some of the benefits of market forces into health funding, but the reality is that insurance is a mechanism, private or public, used by people to buy out of the discipline of market forces. It is a non-market mechanism.

Advocates of private insurance suggest that people who take private insurance demonstrate personal responsibility and self-reliance, but such thinking is deluded, for insurance, by its very nature, is a means of handing over responsibility to another party, be it a government or a private insurer. The "no gap" policies promoted by private insurers offer a complete renunciation of personal responsibility.

It is possible, but unlikely, that the Australian people want completely pooled payments – with services being completely free at the point of delivery. Britain's NHS provides one example, although there are always costs in terms of waiting times.

It is more likely that, in view of our generally rising prosperity and our greater exposure to competitive markets over the years, we would be willing to pay more from our own pockets. That is, without dependence on private or public insurance, provided the markets in which we operate are fair, provided there are provisions for those with limited means, and provided that systems of co-payments do not skew choices away from efficient resource allocation. Sweden, for example, has recently moved from a free system to one with a well-designed set of co-payments, and without the distortion of private insurance (which would dull the market signals of co-payments).

Our main health care programs were introduced in very different times. In the late 1940s when the Commonwealth was trying to bring in universal public insurance and when the PBS was introduced, average annual male earnings, in 2009 prices, were just $20 000. In 1972, when the Whitlam Government was elected with Medibank as a key part of its platform, annual male earnings were just under $40 000.[11] Now they are $70 000. Family incomes would have risen even faster. The argument for free services may be weaker than it was in earlier times.

Some may argue that we should not yield hard-won free services such as bulk-billing or free public hospitals, but the point is that we already have co-payments, and, as pointed out above and in Jennifer Doggett's analysis, they are haphazard in their impact. It should be possible to build a system of uninsurable co-payments with far more equity than at present, with provision for those of limited means.

Even though economic reforms have conditioned Australians to be more accepting of lightly-regulated and unsubsidized markets, there will be limits on the extent to which we want to expose ourselves to health care costs without some form of collective cover. Because high health care needs fall disproportionately on a few people, we will certainly opt for some level of collective cover, and are more likely to seek such cover in health care than in other markets. There is a sound reason why people may be more willing to share health care expenses than they are to share other expenses, for, while there are certain statistical predictors, ill health or injury can strike anyone at any time. We are generally prepared to take more chances in other spheres of our lives than in health care, which is why almost every country, even those with strong individualistic cultures, have widespread insurance mechanisms.[12]

We don't know what Australians want, however. Governments don't know where to put the dividing line between individual and shared responsibility, because the question has never been put to the community. Successive governments have given us free public hospitals and for some access to bulk billing, but they have also given us high levels of co-payments in other areas, all without public engagement. We need an informed debate around the question of individual versus shared funding. The costs and consequences need to be explained to help us make that choice.

If such a question were posed, it would be reasonable to expect those on the "right" of the political spectrum to argue for more individual responsibility, while those on the "left" argue for more sharing, but that has not been the way the debate has been running in Australia, for we're still locked into the public/private frame.

An impediment to a clear "individual vs shared" approach has been the way the Liberal Party has gone along with private insurers to manipulate the debate. Notwithstanding the Liberal Party's policy platform which acknowledges "the need to encourage initiative and personal responsibility", the Coalition in government and in opposition is obsessed with private insurance. It fails to acknowledge that insurance of any kind, private or public, is a way people buy out of individual responsibility. It fails to see that the case against the "nanny state" can equally be made against the "nanny corporation". As pointed out above, its policies of support for private insurance have actually placed the self-reliant, who take personal responsibility for paying for their own private hospital and dental care, at a disadvantage relative to those who are insured. Its support for private insurance is in direct conflict with its own platform. It's as if the Party is gripped by a puerile notion that the private sector is always to be preferred, even if the means of involving the private sector actually distorts the operation of market forces.

And the governing Labor Party seems to be no less confused. It boasts about bulk-billing and is committed to free public hospitals, but at the same time has done very little to bring more equity into the present systems of co-payments.

Sharing or charity?

The related question on values relates to the way we see health care – as a shared system or as "charity" for the needy.

Public funding and provision of health care bring benefits of re-distribution, largely because illness and means are negatively correlated. This often leads observers to evaluate public health care programs only in terms of their redistributive benefits, and to argue that the well-off should be excluded from public programs. The present government's attempt to increase the Medicare Levy Surcharge on high income earners was guided by a notion that the well-off should opt out of the shared public system. Notwithstanding its rhetoric about "social inclusion", its practical vision is of a "gated community" for health care.

Such a charity model confuses the *outcomes* of government programs with their *purposes*. Certainly health care programs have redistributive benefits. So do other areas of public expenditure, including roads, education, policing and almost all other programs. But the purpose of public programs is generally to overcome some market failure.

In the case of health care, there are many market failures and positive externalities which justify public intervention. These include the public good nature of many programs, particularly health promotion, the long-term benefits of childhood and adolescent programs, and information asymmetries between consumers and providers. There is also our demand, referred to above, for some level of collective cover ("social insurance"), for health care costs could be ruinously high for all except the ultra-wealthy. To that extent, we are all potential "charity" recipients.

Many would go further and suggest that health care is something we want to share because of the intrinsic value of sharing. Julian Tudor-Hart, a UK doctor and policy analyst, reminds us of the notion "solidarity" – a notion well-established in mainland European countries but less frequently expressed in the English-speaking world:

> Solidarity is simple, and broadly speaking, true. The simpler we can make it, the truer it can be. Health care is a field in which generosity is a natural behaviour tending to create generosity in return.[13]

In the unlikely event that we were to opt for a completely free system, independent of means, then the question of sharing would hardly arise, for, *de-facto*, it would almost certainly be a shared system. But if we opt for some co-payments or means testing, then the question is central. How do we see health care – as a universal shared good or as redistributive charity?

There is often an assumption that a "universal" health care system is one in which all services are free, but this is a confusion of two policy ideas. A health care system can be "universal" without being free for all. In a universal system we may all share the same hospitals and clinics, but pay differently according to our means. To this extent, for example, our PBS can be described as "universal". But not our hospitals, where we have the "gated community" model, with private hospitals for the insured and well-off, and public hospitals for the remainder.

There is a strong case for everyone to use the same services, even if their payments differ, for the well-off are likely to be those who are most politically active in ensuring quality standards are maintained. It may not matter if they can buy their way into more comfortable rooms while sharing the same medical facilities, but it does matter if, as is presently the case, they have their own hospitals. (Imagine as an analogy if, instead of having first, business and economy class on the same airplanes, we had first class, business class and economy class *airlines,* drifting, over time, to different standards of safety.)

The question of universalism requires community engagement, and careful explanation. Emotive talk of "socialized medicine" has not helped public understanding, and the messages from the government are downright contradictory.

Once those two basic questions are settled, there are specific questions of design, which belong more to technical arenas of benefit-cost analysis and organizational design. Once we decide what proportion of our health care costs are to be shared, we need a mechanism for such sharing. The options are generally private or public insurance.

How to insure – a single public insurer

For those costs people choose to share with their fellow citizens, countries tend to choose public over private insurance, not for some "socialist" reason, but simply in recognition of the fact that, compared with private insurance, public insurance is more administratively efficient, has more power to control service providers' costs, and achieves community rating through the tax system rather than the complex and failed mechanisms of the type that have been adopted in Australia. The business model of private insurance is one which favours expansion; the business model of government services, driven by budgetary pressure and the control of central agencies, is one which favours cost control.

Whenever there is even the slightest hint that private insurance may play a lesser role in funding health care, however, there is a barrage of petulant complaint from the insurers, with three messages:

1. We must not destroy the private sector.
2. We cannot afford Medicare.
3. We must preserve choice.

Just as unions and industry lobbyists contrived arguments to try to stop tariff reform, so too have the health insurers tried to defend their privileged position. But none of these arguments stand up under scrutiny. To examine them one-by-one:

We can (and should) preserve the private sector

No health economist is seriously suggesting we can do away with the private sector's role in delivering health care. Almost all primary care, and a large part of hospital care, is delivered by the private sector. Private hospitals have a strong place in Australian health care, particularly in same-day procedures. And public hospitals have adopted many private sector management practices.

The private insurance industry, supported at times past by suggestive government advertising, likes to create the impression that without private insurance there would be no private hospitals. And, as an extension of this idea to individuals, there is the notion that one must have private insurance to be admitted to a private hospital.

If one accepts such a frame, private insurance appears to be essential for survival of the private hospital system. But there is no reason why private hospitals should not be placed on the same funding basis as public hospitals – most probably on a DRG basis, or on some refined modification of DRGs. (The Department of Veterans' Affairs provides a workable model, with 100 percent public funding, but with most admissions to private hospitals.) There is nothing sacred or essential about the linkage between private insurance and private hospitals.

Before private health insurance membership rose in 2000, 25 percent of admissions to private hospitals were by people funding themselves without insurance. By 2006-07 that proportion had fallen to 12 percent.[14] It's ironic that a result of the Liberal Party's policies was to stamp out this vestige of self-reliance.

We should remind ourselves that while there are many pensioners and others facing financial difficulties, most Australians have a buffer of savings, Even older Australians have on average a comfortable level of reasonably liquid wealth – $230 000 in two person aged (>64) households and $100 000 in single person aged households.[15] The patronising notion that people are too fickle to save for their own contingencies is a self-serving myth perpetrated by the insurance industry.

Private hospitals do not need to be tied to private insurance. In fact, if the Commonwealth paid its subsidies now paid to private insurance direct to private hospitals, this could be an intermediate step towards full activity-based funding, ultimately putting private and public hospitals on the same funding basis. (The Hawke Government unwisely dropped a 30 percent bed-day subsidy it used to pay to private hospitals.) With full activity-based funding there could be genuine intersectoral competition between private and public hospitals.

Policymakers need to think more clearly about the distinction between *funding* of health care and the *delivery* of health care. Contrary to notions which favour private insurance, public funding is quite compatible with private delivery.

If we can afford PHI we can certainly afford Medicare

Even if we can achieve all realizable efficiencies in health care, Australia faces higher health care costs into the future. Even though the impact of ageing is often overstated, it will have an influence, and there is also the issue of demand driven by the availability of new technologies. Private insurers like to suggest that such rises will put unbearable strains on public budgets; some or all of the costs therefore need to be shifted onto PHI.

This argument fails to acknowledge that PHI is essentially a tax – what economists call a "privatized tax". Like official taxes it collects funds from individuals for redistribution among a pool of people. It isn't compulsory, but the penalties applied to moderate and high income earners without PHI are very close to compulsion.

PHI differs from official taxes, however, because it is much more expensive to collect, is under less public scrutiny, and, in spite of attempts to achieve community rating, is

much less equitable in its incidence. If we can afford PHI we can more easily afford public insurance, for PHI is simply a different and more expensive tax.

Policymakers need to look at affordability in wider economic terms than those dictated by narrowly-defined public budgets. It makes no economic sense to save the community $1.00 in official taxes, only to replace it with an imposition of $1.10 in privatized taxes. Narrow budgetary analysis is no substitute for proper cost-benefit analysis, which considers all costs, not just those which pass through the budget – the current obsession of the Commonwealth's *Intergenerational Report*.

What should occupy the minds of policymakers is the question, referred to above, of the division between markets and insurance. It is possible that as prosperity grows people will be more willing to pay more from their own pockets, without insurance. That's the question which should be kept before the Australian people.

Choice of financial institution is meaningless

"Choice" in itself, confers few benefits. We enjoy choice in markets only when products are differentiated; that's how markets work. Choice without variety is meaningless.

We should not confuse choice of insurer with choice of therapy. Private health insurers all offer very similar products; any realistic régime of community rating has to constrain their field of offerings. Insurers cannot even offer the choice of high limits on front-end-deductibles; they are constrained by community rating to limit excesses to $500. Choice of insurer is simply choice between look-alike financial intermediaries.

Consumers value choice of therapy, however, and they already have a large range of choice of ambulatory services under Medicare, although it could be extended. Choice of doctor in hospital is more administratively complex. At present private hospitals, with their reliance on private insurance, achieve this through a far-from-ideal separation of "medical"services (mainly covered by the MBS) and "hospital" services (mainly covered by PHI).

Policymakers could give more attention to continuity of care where people use a combination of ambulatory and inpatient services, particularly in obstetrics. The main impediment to such continuity is program fragmentation; it is not an inevitable outcome of public financing.

In this regard it is useful to comment on the "Medicare Select" proposals being suggested by the NHHRC. That offers "choice" of care managers ("plans"). Consumers would need to choose one manager to look after all their health care needs.

But we exercise choice to our benefit only when we are reasonably clear about what we want. No one knows what their future health care needs will be. Tomorrow I may

> be diagnosed with a serious acute condition such as cancer, or a chronic condition such as diabetes. I may be involved in a car accident. I may live a long and healthy life and die gently in my sleep.
>
> It is absurd, therefore, to suggest that I, or anyone else, should be in a position to make a wise choice about a "plan" for my needs.
>
> That is not to deny the benefit of a care coordinator – someone who can help bring services together. But such coordination, surely, should apply to an individual's health condition. If, say, I am a diabetic who has a car accident, I may want to have a long term relationship with a care manager specialized in diabetes, and a short term relationship with a care manager specialized in accident rehabilitation.
>
> What seems to be implied in the Commission's suggestions is not choice of plans centered on choice of care, but rather, choice of plans centered on choice of financier. In other words it's a mild modification (in terms of means of funding) of the present arrangements, which provide "choice" of look-alike private insurers – choice without variety.

It is hard for policymakers to accept that there are some endeavours in which the public sector can do a better job than the private sector, but health insurance is one such enterprise. We have been heavily conditioned by the notion that somehow the private sector always does a better job – mirroring the obsession in central planning governments which always preferred the public sector. It isn't that public employees are cleverer or more hard working than their private counterparts. Rather, it's about the structures and incentives they face.

Private insurers have no incentive to control cost – they do best when their markets are expanding. They have no incentive to engage in prevention or promotion, for such activities impose a cost on their own firms while conferring benefits on others. And they have little power to stand up to service providers, who can play one insurer off against another. Medicare, if it behaves as a single national insurer, has that power. Unfortunately it has drifted, in recent years, more to a "passive payer" role, and the Commonwealth, over the years, has paid far too little attention to the supply-side of markets: it has been too comfortable to live with the exemptions from competition policy enjoyed by professional colleges and pharmacists.

The original vision for Medicare was as a national insurer rather than a passive funder, and it can revert to that role. The Commonwealth has demonstrated a capacity to be strong on multinational drug companies and on state governments; it can surely do so with other service providers. It can assert its power through many means – competition policy instruments , direct price control, and competing publicly-owned facilities such as health centres. There are different options, which could align with the ideologies of either "left" or "right" political parties.

It is easy for policymakers, however, to be gripped with fear by the supposed power of lobby groups promoting their self-interest. US experience with health insurers, where the insurers are willing to inflict national economic damage in order to maintain their privileges, should

be a warning about what happens when we appease privileged groups. The more we yield, the more resources those groups can muster to thwart change.

Behavioral research confirms that we tend to confuse noise with power. Policymakers hear the din created by the lobbies, but they forget that there are 13 million voters in Australia, many of whom are extremely annoyed by the influence of interest groups. Also, the global financial crisis has reminded us that governments can and do insure against risk; if governments can cover irresponsible financiers for their own folly, surely they can cover ordinary citizens against the more random consequences of ill-health.

Policymakers also need to appreciate that health insurers, even though they try to describe themselves as part of the health care sector, are no more than insurers with a marketing specialization. They are no more part of the health care sector than NRMA is part of the automobile industry. Health insurers are part of the financial sector, a sector which has hardly earned the public's respect over recent times. When previous governments reduced tariffs they had to contend with a public affection for manufacturing – attachments to notions such as "the Australian car". The financial sector has no such reserve of affection to defend itself.

It may take time to engage with the public; engaging with lobbies is far easier and quicker, but it's not the path to reform. That's why the process of reform is necessarily drawn out.

One way to reduce the power of provider interests is to re-structure the programs of health care, for they are presently structured along lines which are ideal for provider lobbies and hostile to consumer interests.

How to organize – a user-friendly architecture

Around 50 years ago a revolution swept through businesses, which changed their organizational structures to reflect customer groupings rather than technologies. A car manufacturing firm would once have had an engine division, an assembly division etc. These structures were replaced by customer-oriented divisions – light vehicles, luxury vehicles etc.

Similarly, about 20 years ago governments in Australia, led by the Commonwealth, started changing program structures and appropriations from an input basis to structures around "outputs" and "outcomes".

Health care programs, however, remain locked into an antiquated input-based structure. The main programs are medical (MBS), pharmaceutical (PBS), and shared Commonwealth/State hospital funding, all reflecting provider interests. Worse, the Commonwealth tends to focus on particular programs when their outlays are growing faster than others. For example, a few years ago, the Commonwealth was panicking about the cost of the PBS, without acknowledging the possibility that growth in drug therapies may be helping save on hospital outlays.

This structure is very consumer-unfriendly. We would find it extraordinary if, when our cars need repairs, we have to go to one establishment for short same-day jobs, to another to get parts, and to a third when we needed more extensive work. But, from a consumer's perspective, that's what our health care arrangements look like. And the private hospital arrangements are even worse; to continue the car repair analogy we would have separate

contracts and would be making separate payments to the mechanics and the garage which provides the workshop space.

Some talk loosely of a health care "system", but it isn't a system by any stretch of the imagination. We have a loosely cobbled-together set of arrangements, designed at different times, reflecting practical priorities and political prejudices of the time they were designed, and designed around suppliers rather than users.

There are various ways a health care system could be designed around users, for example:

by intensity of use – chronic, acute and occasional;

by region – urban, rural, remote etc;

by demographic group – youth, aged etc;

by chronic condition – those with mental illness, diabetes etc

Occasionally there is an attempt to graft a new classification, such as mental health, on to the existing program structure, but it's difficult to achieve good design when the basic architecture is on a different, provider-based, structure.

Of course, any break from a provider-based structure would meet with strong opposition from provider lobbies. But that's a good reason to break the structure, for at present Commonwealth and State health departments have organizational structures which make it very easy for provider interests to find the right point of influence. By contrast, because patients draw on different programs for one condition, consumer groups have no one focussed point of influence.

The NHHRC recognizes fragmentation as a problem, and has some fine words on "connecting care". But it is short on details. It does suggest bringing primary care into health centres where different health professionals would be co-located. But co-location is about as far as it goes. For example, while pharmacists may be located in these health centers, there would remain the present demarkation divisions between medical practitioners and pharmacists. Medical practitioners would still be writing prescriptions, and pharmacists would still be meekly filling them; there is no suggestion of pharmacists working with medical practitioners to be active partners in drug prescribing, and providing a more specialized and therefore stronger line of defence against the promotions of pharmaceutical companies.

Worse, it proposes to add "Denticare" to the existing mess of programs. Rather than simply being added as new items in Medicare, "Denticare" would have its own funding, with complex and costly special arrangements to preserve the role of private insurance in funding dental services. Just why funds should be taken from a low-cost community rated tax system and churned into a high cost health insurance system is not explained.

There is merit in bringing all health care services under one tier of government. At the Centre for Policy Development we have suggested a state-based system, or even a sub-state system of integrated care.[16] As in Canada the Federal Government would still be responsible for setting standards and financing services. As at present the Commonwealth would still be responsible for negotiating with powerful service providers (such as pharmaceutical

companies), and attending to national educational needs. There would need to be developed protocols for centralization of some shared services, particularly if there is sub-state regionalization, and for dealing with mobile consumers, but these are all surmountable technical issues. We have also suggested that the main locus of health care funding and delivery should be in integrated primary care centres – not only because primary care is generally more cost-effective than hospitalization, but also because such centres, growing from the ground up, would allow new and more efficient and user-friendly work practices to emerge.

Conclusion

I am not suggesting health reform is easy. Major reform of public policy is never easy – ask those who were involved in the GST and tariff reforms, or those who are engaged in the CPRS and the current review of our tax system. We can expect to hear the strident voices of self interest, and threats of dire consequences if we break from present arrangements.

But the cost of not reforming, of continuing with disjointed solutions to every small problem, or of appointing constrained commissions of inquiry are far greater. In particular, if we allow the financial sector to become more entrenched in our health care arrangements the costs could be ruinous, as US experience is showing.

We need to come to a more equitable and efficient way of distributing our expenses between pooled and individual funding. To the extent that we want to pool, the case for a single national insurer is overwhelmingly strong, but we must not be scared off such a reform by fear campaigns. To the extent that we want to be self-reliant, we should be able to operate in fair and open markets which are not manipulated by provider interests or distorted by private insurance. And we need fundamental organizational change to make the sector more responsive to consumers' needs, rather than to providers' wishes.

After all, isn't that what markets are about?

Notes

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

2. Commonwealth Fund "International Health Policy Survey in Eight Countries" 2008 http://www.commonwealthfund.org.

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

4. Industry Commission (now the Productivity Commission) *report Private Health Insurance* 1997.

5. Sidney Sax *A Strife of Interests: Politics and policies in Australian health services* George Allen & Unwin 1984.

6. Jennifer Doggett "Out of Pocket: Rethinking health co-payments" CPD 2009.

7. Gary Banks *Health Policy Oration 2008*, Menzies Centre for Health Policy, John Curtin School of Medical Research, ANU, Canberra, 26 June www.pc.gov.au.

8. Commonwealth Fund 2008, op. cit.

9. Joseph Schumpeter *Capitalism, Socialism and Democracy* Harper Brothers 1942

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

11. Historical wage and CPI data from the Reserve Bank Australian Economic Statistics 1949-50 to 1994-95. (RBA 1996). Later data from ABS, Figures rounded, and do not reflect minor definitional changes.

12. The philosopher John Rawls posits the notion of an "original position", being the thought experiment in which people are asked to suggest the constitution of a society if they do not know their own place or opportunities in that society. For our future health needs, we are all in an "original position". John Rawls *A Theory of Justice* Harvard University Press 1971.

13. Julian Tudor-Hart *The Political Economy of Health Care* Policy Press 2006.

14. ABS 4390.0 *Private Hospitals Australia*, editions to 2006-07.

15. ABS 6554.0 *Household Wealth and Wealth Distribution* 2005-06.

16. See the CPD publications: Fiona Armstrong, Tim Woodruff, David Legge and Rod Wilson "Putting Health in Local Hands" CPD 2009 and, under CPD authorship "A Health Policy for Australia: reclaiming universal care".