Health care – a weird industry

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Introduction

Earlier this year I was asked to describe Australia's health care arrangements to a gathering of industry economists at the Korean Development Institute. Such an explanation had to be in a framework familiar to industry economists, covering matters such as industry structure, markets, assessments of efficiency, productivity etc – in the way one may describe and assess the performance of any other industry.

When we examine health care through such a perspective it looks weird. We find an industry:

- with an anachronistic structure, organized almost entirely around the interests of suppliers rather than customers;
- in which customers have become conditioned to the notion that someone else will pay most or all of their bills;
- which has been bypassed by the structural reforms and exposure to competition which have transformed almost all other Australian industries over the last thirty years;
- in which, contrary to the trend in other industries, new technologies have been associated with cost increases;
- with strong quality control on the inputs and procedures, but comparative neglect of gross indicators of quality.

One reaction to such a perspective may be to point out that it is callous to use ordinary industry terms to describe health care, because it is about human services, in which safety has to be paramount. Such considerations hold for many other industries, however, such as airlines and food service. Another reaction is that health care is dominated by highly trained professionals with strong duties of care, but the same considerations hold for civil engineers and airline pilots. Yet another is to point out that there are other industries which depart from textbook models. That is correct, but health care has a concentration of strange practices – practices we tend to take for granted. That's why we should expose them and examine their relevance. Even if they made sense in the past do they serve any purpose now? Who benefits, who pays? What opportunities are we missing?

Just as the industry itself is strange, so too is government policy. Not only have governments been reluctant to modernize the industry and to expose it to the discipline of market forces, but also they have added their own distortions, most notably the use of private insurance to fund certain aspects of health care, thereby increasing costs and shifting resources from where they are most needed.

1. Industry structure – a relic from times past

Imagine if, when your car needs repairs, you must go to one mechanic for a basic diagnosis and routine service, to another in an entirely different business for specialized service, and to a third type of establishment for major repairs. In addition, the mechanics are not permitted to provide parts; they may specify what parts you need but you must buy them from a specialized parts stockist – possibly while your car is out of action. The parts stockist has better knowledge about parts than the mechanic, but is not permitted to gainsay the mechanic's specifications. They are all quite separate businesses; in fact there are government regulations prohibiting most forms of horizontal integration. Within each establishment only highly qualified mechanics can perform any service on your car; other staff, no matter how experienced, may not do so much as change a light bulb or windshield wiper blade.

The health care industry is burdened with the legacy of ancient customs. The separation of pharmacies from physician's premises, for example, dates to the Holy Roman Emperor Frederic II in 1280. Before there were enforceable laws on trade practices and consumer protection, such separation made sense because it overcame the conflict of interest which can arise when doctors sell profitable medications. It is hard to see its relevance now, however, particularly in view of the Commonwealth's demonstrated powers in controlling pharmaceutical prescribing and pricing. In any case, pharmaceutical firms with their promotions to doctors have found ways around the separation, which by now is like a security fence around an abandoned building.

Our public hospitals date to colonial times, generally as state-subsidized charities for the poor. Doctors worked in public hospitals on an unpaid "honorary" basis – a system of *noblesse oblige*, or as economists would say, they cross-subsidized public patients from high fees imposed on the well-off in doctors' rooms and in private hospitals. Those arrangements held until the middle of last century, when public hospitals became the more inclusive institutions we now know, but we still see remnants of the old culture in the differing remunerations in public and private hospitals.

The Commonwealth, for its part, operates its own major programs, the Medical Benefits Scheme (Medicare) and the Pharmaceutical Benefits Scheme (the PBS) as entirely separate programs, with different budgets, different payments systems and different types of patient co-payments.

This separation of programs is a structure which industrial economists recognize as belonging to another era. There was a time when, for example, auto companies were organized around their input specializations – a casting division for all engines, a pressing division for body panels, an assembly division, a sales division etc. Such structures made sense when competitive advantage was based on exploitation of scale economies in manufacturing, but by the end of last century in most industries they had given way to customer-oriented divisions.

It was fifty years ago, in 1960, that Theodore Levitt of the Harvard Business School described such a transformation in businesses, which had previously defined themselves by the products they produced, to defining themselves by the needs they satisfied.[1] Gillette does not make razor blades; it provides services for skin care; Canon does not make cameras; it helps people record images. And so on. This transformation is generally described as moving from a production orientation to a customer orientation.

This transformation was also recognized by governments. In the 1980s the Commonwealth moved its budgetary processes away from an input focus to an output and outcome focus.

Health care, however, has remained largely untouched by these transformations. It still has provider-based divisions.

Recently announced Commonwealth plans to fund 60 percent of public hospital costs through direct payments and to integrate primary care facilities will achieve some service integration, but they will not address the major problems of fragmented patient care. While they describe how hospitals will be brought together, they are short on detail about integrating primary care with hospital care. Nor will they bring private hospitals into the same arrangements as public hospitals. Private hospitals will retain their role as providing the infrastructure of beds and operating theaters for visiting doctors, operating on an entirely different business model to public hospitals, with funding coming from a mixture of subsidized private insurance, the PBS for pharmaceuticals, Medicare, and patient contributions.

From a consumer's point of view our health care arrangements are a mess, with physical separation of services, duplication of records (consider the number of times a patient must provide her name and address), separation of partial records between different providers, and a lack of continuity of care. There are high search costs, high bureaucratic costs ("transaction costs" in economists' terms), and high risks of conflicting therapies.

From a provider's point of view, however, our program structure could not have been more favorable had the lobbyists designed it themselves. For example the Commonwealth Department has separate divisions for pharmaceuticals, medical services and private insurers: each provider group has an easily identified point of influence. In projecting health care expenditure in the *Intergenerational Report*, the Commonwealth's categories are still based on provider categories – hospitals, medical, pharmaceuticals and private insurance subsidies.[2]

If health care were like other industries, we would long ago have seen it re-organized. There are many ways to organize industries along customer divisions. In health care we could imagine divisions around types of service:

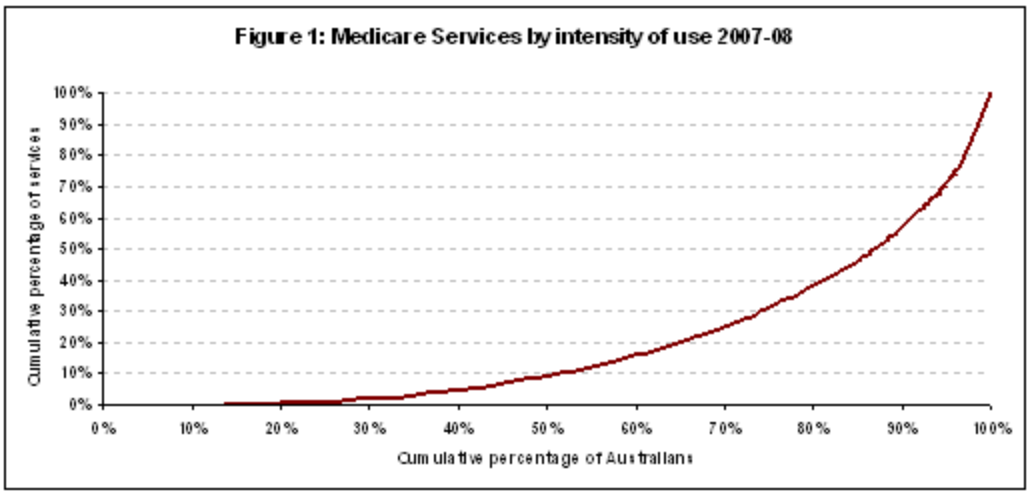
- by type of care – occasional care for the healthy who are light users, chronic care with subdivisions into conditions such as mental illness, and acute care;
- by demographic – mothers and children, adolescents, the aged;
- by region, possibly transcending state boundaries for remote regions;

There is no one best organizational structure, but from a consumer perspective almost any form of customer division is preferable to a provider division.

One reason this antiquated structure has been sustained is that in health care the consumer voice is weak. In most industries consumer interests are served through price and quality competition. Those firms which do not adapt go out of business, while others take their place. Such "creative destruction", to use the terminology of Joseph Schumpeter, serves consumers well.[3] Pan Am Airlines is long gone, and General Motors is in effective receivership, but there is no shortage of airlines or cars. As old firms go, new ones take their place, usually providing better products for consumers.

In some industries delivering human services, however, such creative destruction does not apply as easily as it does in other markets, because the establishments delivering services are fixed in place in relation to the customers. Hospitals are often local monopolies (what economists call "natural monopolies"), and have to stay open, even if their performance is sub-standard. To borrow a term from the global financial crisis, hospitals are "too big to fail".

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. The distribution of health care is skewed towards a few heavy users: in any one year half the population uses only ten percent of Medicare services, while at the other end of the spectrum twenty percent of Australians use sixty percent of Medicare services.[4] (See Figure 1.) It is only if we have the misfortune to suffer a chronic condition or an accident that we become involved with the health care industry during our active lives. Otherwise our experience of 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, it is informative to 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 being 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 and to ensure public policy is dominated by their interests.

2. Muzzled price signals – someone else pays the bill

In health financing, public debate tends to be about the balance between public and private insurance as sources of funding.

This overlooks the underlying assumption that we have been conditioned to expect that someone else will pay all or most of the bill for our health care – be that "someone" the government or a private insurance company.

It is a reasonable assertion, however, to suggest that most of the time, most Australians, could afford to pay for all their health care without any insurance – public or private.

That statement may sound preposterous. Health care is expensive; this year on average we will spend about $5 300 per head or $14 000 per household on health care: those are high amounts for most people to meet from their own resources.[5] As pointed out in the previous section, however, health care expenditure is heavily skewed towards heavy users. Assuming total health care costs are distributed in the same pattern as Medicare outlays, about 60 percent of Australians would incur $900 or less of health care costs in any one year, or about $2 300 per household.[6]

Considering capacity to pay, we find that Australians are reasonably wealthy; an unexpected outlay up to $2 300 (or even higher) should cause no problem for most households. Tables 1 and 2 show Australians' financial wealth by household. Table 1 shows liquid wealth by wealth quintile, and Table 2 shows liquid wealth for selected life stages.[7] On average, people have about $60 000 in liquid assets. Older people, who are heavy users of health care, generally have more liquid assets, even before considering superannuation, which, for people over 60, can generally be considered to be liquid now that preservation rules have been relaxed.

Table 1. Household financial assets by wealth $'000 2005-06

	Household net worth quintile					
	Lowest	Second	Third	Fourth	Highest	All
Bank accounts	3	10	15	25	71	25
Shares, debentures, bonds	0	3	7	16	143	34
Liquid assets	3	13	21	42	214	59
Own businesses		0	2	4	220	45
Superannuation	8	28	40	82	264	85
Total wealth	11	42	63	128	698	188

Source: ABS *Household wealth and wealth distribution 2005-06* ABS 2007

Table 2. Household financial assets by life cycle $'000 2005-06

	Selected life cycle stage (age)					
	Lone person <35	Couple <35	Couple 55-64	Couple > 64	Lone person >64	All
Bank accounts	6	12	42	51	36	25
Shares, debentures, bonds	7	11	55	75	33	34
Liquid assets	13	22	98	126	69	59
Own businesses	3	21	59	92	22	45
Superannuation	16	38	203	107	27	85
Total wealth	31	81	359	325	118	188

Source: ABS *Household wealth and wealth distribution 2005-06* ABS 2007

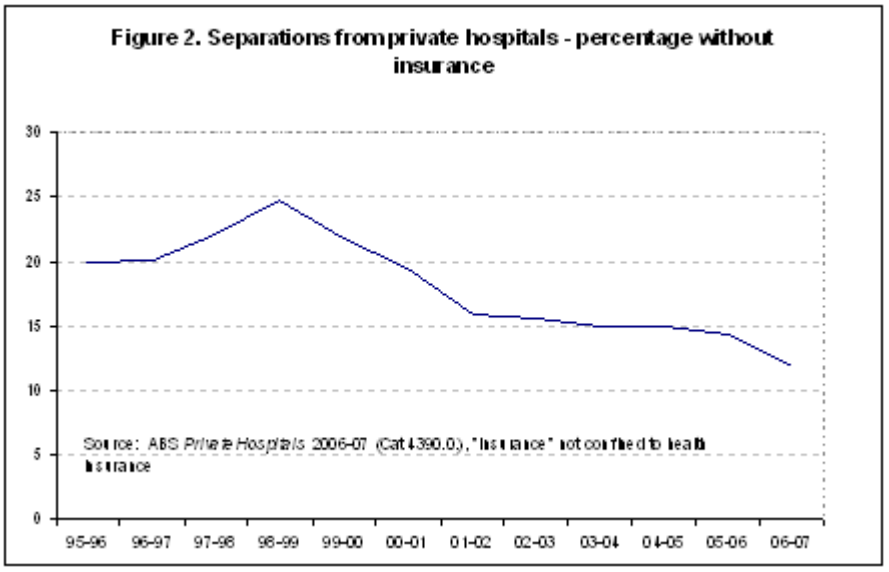
Yet, we persist, individually through private insurance and collectively through government programs, to depend on insurance to cover even our small outlays. Only 18 percent of our recurrent health expenditure is through direct uninsured outlays in the form of co-payments and full payments for services with no insurance coverage.[8] This proportion has remained stable over many years.

Even more strangely we encourage those who can most easily afford to self-insure – that is to finance some of their health care through their own saving – to hold private insurance. Those who buy insurance receive a 30 to 40 percent subsidy, and those with annual incomes above $75 000 are encouraged even more strongly through the one percent Medicare Levy Surcharge (MLS). Because there is a strong correlation between income and wealth, the incentives to hold private insurance are strongest for those who, in the absence of incentives, could most easily afford to pay for small outlays from their savings. Most people with high incomes find that the MLS enticement is greater than the full cost of private insurance. For example, someone with an income of $300 000 has a $3 000 tax break from avoiding the MLS, more than enough to fund even the most expensive insurance policy. Even in the days of high tariff protection we never had such a bizarre form of industry assistance: imagine if the well-off were given a free Holden plus a wad of spending money.[9] Even more strange is the present government attempt to increase the MLS from 1.0 percent to 1.5 percent.

These subsidies mean, for example, that those who pay for their own dental and other ancillary cover, receive no public support, while those who depend on private insurance are subsidized for a large part of their outlays. It's a welfare measure that disproportionately favors the well-off, for there is a clear relationship between membership of private insurance and income. Fewer than a third of those with low income (up to $30 000 in 1995) hold private insurance, while more than 70 percent of those with high income hold private insurance.[10]

Similarly, those who pay for private hospital care from their own savings do not receive the 30 to 40 percent subsidy. Figure 2 shows how uninsured (i.e. self-funded) separations from private hospitals have fallen since the government, between 1997 and 1999, re-introduced

strong incentives for people to hold private insurance. The subsidies were certainly effective in stifling this outbreak of self-reliance.



It is particularly odd that these subsidies were introduced by a Coalition Government, considering that a core plank of the Liberal Party platform is a belief in "the need to encourage initiative and personal responsibility". Why should a center-right government discourage self-reliance? More generally, why should we persist in the practice of using insurance to cover small outlays? Explanations are hard to come by.

One possible explanation is that we tend to demand insurance, even when it is a poor deal. Behavioral economics research shows we pay a high premium to buy out of small risks – a phenomenon known as the *pseudocertainty* bias. For example the higher our income the more likely are we to buy comprehensive car and home insurance, even though, because of the moral hazard and administrative cost of "first dollar cover", policies with high excesses represent much better value for money.[11] A survey by the ABS in 1998 found that by far the strongest reason for holding private insurance was it gave them "security/protection/peace of mind".[12] What this really means is that people buy insurance to buy out of the discipline of market forces, or, in more colloquial terms, they seek to be looked after if not by the "nanny state" then at least by the "nanny corporation".

Another possible explanation is that health care costs are unpredictable. But so too are many other costs. When our cars go in for service we find nasty surprises. Household appliances need replacing at the most inconvenient times. Children of all ages have sudden demands for excursions and textbooks. Older children make sudden demands for accommodation bonds or replacement of a dying car to take them to university. Most people learn to deal with such contingencies, but still seek the comfort of health insurance.

More basically, there is the history of health care to consider, outlined in the previous section. In most countries that could be classified as "developed" in the mid twentieth century, government-funded health insurance dates to the years following to the quelling of conflicts in 1945. In some cases, such as in the UK and the Nordic countries, governments became the

sole insurers, while in others, such as Germany, governments added another layer of insurance supplementing or complementing private not-for-profit mutual insurers.

Australia was involved in these developments, but our government's attempts to establish a comprehensive national insurance system, similar to Britain's National Health System (NHS), met with extraordinary opposition from the local branch of the British Medical Association. (This identification is yet another oddity; to this day some medical lobby groups keep the UK identifier "Royal" in their names.) The government's attempts were thwarted by constitutional provisions which vested relevant powers with state governments, but the Commonwealth was able to get a constitutional amendment passed, giving it powers to provide "sickness and hospital benefits, medical and dental services (but not so as to authorize any form of civil conscription)".[13] That "civil conscription" provision, inserted to quell opposition from the BMA, was interpreted as allowing the Commonwealth to reimburse providers for services, but not to control prices or to direct resource allocation. As a result the Commonwealth, for 30 years after 1946, made only incremental moves towards comprehensive national health insurance. National insurance was on hold until the passage of legislation setting up Medibank, the predecessor to Medicare, in the double dissolution joint sitting in 1976. To this day the Commonwealth has not tried to use any form of direct price control other than in pharmaceuticals.

Over the postwar years the initiatives for national health insurance came from the Labor Party, and were vehemently opposed by medical lobbies, the Coalition parties, and, as they gained privilege, the health insurance funds. When in office Coalition governments wound back or, in the case of the Fraser Government, completely demolished national insurance. Conflicts over health insurance policy in Australia have been bitter, and no other developed country has seen such wide policy swings.[14] In most other countries health financing systems are much more stable than they are in Australia: for example the Thatcher Government dared not undo that country's NHS, and in the USA successive Democrat governments, including the present government, have been unable to change that country's health funding.

The only early national insurance scheme that did get up was the PBS, which was established by the newly-elected Coalition Government in 1950 to provide free pharmaceuticals. Its basic architecture has changed little, apart from the introduction of a five shilling co-payment in 1960. That five shillings equates to about $4 in today's prices. There have been real rises in the co-payment since then – it now stands at $30.30 – but, unlike Medicare which leaves the consumer co-payment open-ended, the PBS co-payment is capped.

In health care, history seems to explain many of the oddities and inconsistencies in our present arrangements. Our various health programs carry the legacy of past policy decisions which were shaped by the fiscal conditions, the economic conditions, the political fashions, and the ideologies of the governments at the time. In the postwar years, when Labor tried to bring in a national scheme and the Coalition established the PBS, real incomes were much lower, life expectancies were shorter, and no-one foresaw the huge potential growth of new health technologies. Real male incomes (brought to 2010 prices) in 1950 were only $20 000 a year, and life expectancy at birth was only 68 years.[15] Free health care made a great deal of policy sense at the time. In 1975 when the Whitlam Government introduced Medibank, with a strong preference for free "bulk billed" services and agreements with the states to provide free public hospitalization, real male incomes were still only $40 000. They are now $70 000, and,

because of greater female workforce participation, family incomes would have risen even faster. Life expectancy is now 81 years.

Therefore there is no consistency in the dividing lines between free, partially subsidized, and unsupported services. Most co-payments are open-ended, leaving the patient to cover any fee above what the public or private insurer pays; the only significant exception is in the PBS. Some co-payments are on a family basis while others are on an individual basis. There are welfare provisions and safety nets; most safety nets reset on a calendar year basis, while we have a 20 percent tax rebate for uninsured services above $1500 which resets on a financial year basis.[16] It's an extraordinary mess.

Table 3 shows how consumer payments (co-payments and full payments) vary. 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 who needs ongoing physiotherapy (classified as "other health practitioners") and who needs aids and appliances will have to pay for most of his own health care year in year out, while someone else whose needs can be met in one high-cost hospitalization will pay almost nothing out-of-pocket. In addition, there are 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. (That is why the present government's hospital initiatives, useful as they are, need to extend beyond shortcomings in technical efficiency into areas of allocative inefficiency.)

Table 3: Individual payments 2007-08

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: AIHW *Health Expenditure* 2007-08

These problems persist because health care has never had the benefit of basic structural reform.

3. Exemption from structural reform – how the industry missed out

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 Government. We have dismantled protective tariffs and quotas, implemented vigorous competition policy, privatized most public utilities, deregulated the financial sector and restructured indirect taxes.

Health care has been largely insulated from these changes. It is still shielded from the forces of competition and, as pointed out above, has many arrangements which had policy justifications in past times but which are now quite dysfunctional. Private and public hospitals have their own funding streams and do not compete with one another. Pharmacists are protected from competition by limits on numbers, ownership restrictions, and protected markets – a set of non-prescription pharmaceutical products ("Schedule 2") which only pharmacies can sell, even though they have no requirement to provide associated professional advice. In medicine, professional colleges restrict the number of places for postgraduate studies. There are entrenched demarcations between professions, with work practice restrictions which, in most other industries, have been relegated to the annals of industrial history.

There are many instances of inefficiencies in health care. The most recent exposure of health care shortcomings relates to hospital productivity. In a study released in 2009, the Productivity Commission found widely varying costs in hospitals between different states.[17] On a casemix-adjusted basis, the cost per separation in public hospitals in 2007-08 varied between $3900 in Victoria up to $5000 in Western Australia.

To obtain a first order estimate of possible savings through better efficiency, it is possible to construct a table based on the assumption that Victoria's cost per separation is the lowest possible cost (a conservative assumption) and that all other states can meet this cost.

Table 4. Possible savings from public hospital efficiency, 2007-08, admitted patients

	Separations of admitted patients	Cost per separation $	Total cost of admitted patients $m	Total cost if costs per separation = Victoria's $m	Saving $m
NSW	1 530 077	4 089	6 256	6 019	237
Vic	1 393 583	3 934	5 482	5 482	0
Qld	867 058	4 406	3 820	3 411	409
SA	379 630	4 177	1 586	1 493	92
WA	476 805	4 976	2 373	1 876	497
Tas	99 157	4 833	479	390	89
NT	92 813	4 833	449	365	83
ACT	84 087	4 833	406	331	76
Australia	4 923 210		20 852	19 368	1 484

Source: Productivity Commission Table 2.6 (separations) and Table 5.2 (costs per separation)
Note that the PC Table 5.2 combines Tas, NT & ACT

That analysis reveals a saving of around 7.1 percent. (The data relates to admitted patients, who incur about 70 percent of the costs of public hospitals.)

Another possible source of saving would ensue if, through improved primary care and public health, hospitalization could be reduced. According to the official document accompanying the announcement of recent hospital reforms:

> The Australian Institute of Health and Welfare has estimated that potentially preventable hospitalisations represented 9.3 per cent of all hospitalisations in 2007–08. This equates to approximately 441,000 hospitalisations in public hospitals, with an average cost of about $4,230 per episode of care.[18]

That is, an additional saving of almost 9.3 percent. I stress "almost" because if both hospital efficiencies and a lower rate of hospitalization were achieved, there would be a slightly lower base of savings. After eliminating the small cross-product, there is a combined efficiency saving in the order of about 15.7 percent. Also, there would presumably be some extra costs in primary and preventative care.

It is indeed extraordinary to find an industry in which, as a first order estimate, there are such clear savings to be achieved. An ideologue with a conservative political bias may say that this is an inescapable inefficiency in an industry so heavily influenced by government policy and with government as the dominant funding source. Such a criticism overlooks tremendous efficiency improvements made in other government utilities, such as postal services, and ignores the fact that while health care funding may be dominated by the public sector, health care delivery is mainly in private hands; the ideologue would need to overlook the fact that the Productivity Commission found no significant difference in productivity between private and public hospitals.

It is not my intention to place high precision on the possible savings to be achieved in health care, other than to point out that they are substantial in a $100 billion industry. It was this sort of back-of-the envelope calculation that set in motion the more comprehensive studies which eventually led to a dismantling of tariff and quota protection.

Those changes in industry policy were difficult. There were large job losses in labor-intensive manufacturing industries. That made the changes very risky for the Labor Government in office at the time. By contrast, given the shortages of health care professionals, health care reform should be painless, for while some administrators may find their jobs threatened, nurses, doctors and technicians need have no fear for their future.

Furthermore, there was no great public clamor for reductions in industry assistance; it was only after tariffs had fallen that people realized they had been paying too much for their cars and clothes. By contrast, there is a widespread feeling that reform of health care 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.[19] Among those with chronic conditions, 57 percent of people want fundamental change and a further 20 percent want a complete re-build.[20]

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).[21] 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.

It is perplexing, therefore, to ask why for the last 35 years, successive governments have avoided subjecting the health care industry to fundamental policy review. The last significant change was the introduction of Medibank in 1974, but, as pointed out above, that was not enduring in the way that other reforms have been. (By comparison it would be hard to imagine a government re-introducing tariff quotas or reverting to the pre GST system of indirect taxes.) Even Medibank was limited in its scope: there was no attempt to integrate medical and pharmaceutical payment systems, dentistry was excluded, and the Commonwealth/State divisions of responsibility remained.

Otherwise policy changes have been incremental, in response to specific problems, best described by the political philosopher Charles Lindblom who referred to a policy development process of "muddling through" – an incremental approach to problem-solving which handles only the proximate problems, without seeking system-wide solutions – a process so unlike the much more fundamental reforms which have taken place elsewhere in the Australian economy.[22]

Successive governments have placed aspects of policy "off limits" for consideration, particularly the role of private insurance. Most significantly, until recently, support for private insurance formed a political cleavage between Labor and Coalition parties, with Coalition parties considering private insurance to be an unquestioned good. On taking office the present government, however, promised to maintain support for private insurance, and it established a commission of inquiry into health care – the National Health and Hospitals Reform Commission (NHHRC) – but the Commission was restrained from consideration of the role of private insurance, and its chairperson was a senior executive of a health insurance firm.

On first sight it may seem natural that in this era governments, faced with fiscal pressure, should favor private insurance over public insurance, but such an assumption needs deconstructing.

Privatization in itself does nothing more than to change the entity holding the equity in a business. Where there have been benefits in privatizations they have flowed from associated market reforms – in particular the opening of competition, and the replacement of free delivery by priced services.

Health insurance however, be it private or public, suppresses price signals – which are the *sine qua non* of markets. The logic "HCF/Medibank Private/MBF will pay the bill" is no different from the logic "Medicare will pay the bill". This phenomenon, known by the quaint term "moral hazard", is a feature common to all insurance, and it results in incentives on both patients and providers for over-use of scarce resources.

Furthermore, shifting funding from public budgets to private insurance may appear attractive to a government concerned with impression management – perhaps wanting to achieve a target size of government spending as a proportion of GDP – but in a wider economic sense it represents no community saving, because what people save in taxation they have to pay in health insurance premiums, with the extra costs of administration and the loss of cost control which can be exercised by a single public insurer.

The administrative costs are the smaller part of the burden, but they are easily measured: for private health insurance 10.4 percent of revenue is absorbed in administration, and a further 5.1 percent is taken as profit.[23] By contrast the cost to government in collecting taxes and administering Medicare is only 4.0 percent of revenue.[24]

By far the greatest cost of private insurance results from the incapacity of health insurers to control outlays. 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 retain 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. Even the economically conservative journal *The Economist* supports this conclusion, pointing out that private insurers lack the market power to control costs.[25]

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.[26]

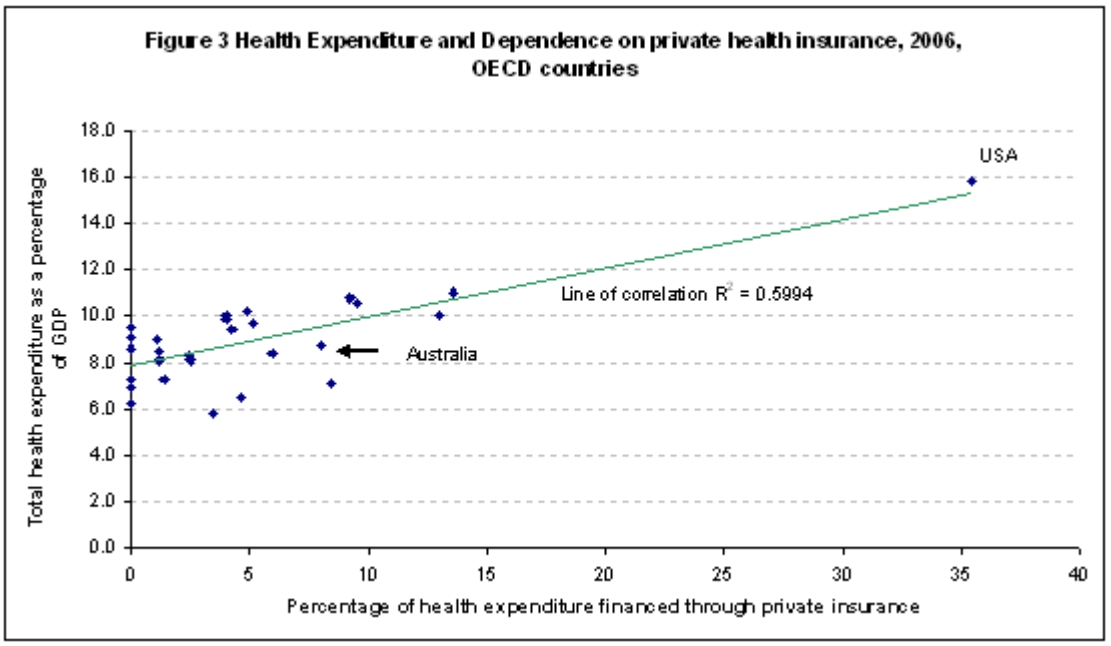
As illustrated in countries with long-established single insurer arrangements, such as the Nordic countries, a single national insurer can reduce moral hazard and keep costs in check by countervailing the market power of suppliers. In relation to contributors, a single insurer is able to insist on uninsurable co-payments if they help reduce excess demand. A single insurer can impose mandatory co-payments to contain moral hazard and to reduce the cost of handling small claims. (In Australia private insurers are permitted to offer "no gaps" policies.) 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 3, 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. 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 share health care costs, not because it's private, but because it's fragmented, lacking the power to overcome moral hazard, and lacking any incentive to provide public goods.

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. 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.

There is the specious argument, often presented in the media, that without private insurance there would be no "private sector". Emotive terms, such as "socialized medicine" prevail. There is no reason, however, why private hospitals should have to depend on private

insurance; as Victorian Premier Jeff Kennett pointed out almost 20 years ago, private hospitals are always free to contract to state governments to provide services for public patients.

Then there is the argument that supporting private insurance takes pressure off public hospitals. This justification has glib appeal, but it considers only the demand side, not the supply side, for where demand goes so too do the resources: skilled medical practitioners and nurses will either take their services to private hospitals or will demand more payment from public hospitals, either way putting more pressure on public hospitals. In reality all that our present incentives achieve is a re-shuffle of the queues, with the result that priority treatment, particularly for elective surgery, goes to those with the best insurance cover rather than to those with greatest needs. It's extraordinary public policy for a government to subsidize queue jumping, and it's equally extraordinary for a government to claim it can relieve pressure on public hospitals by offering enticements to take away their professional staff.

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.) As John Kay, one of Britain's leading economists said in the 2009 Wincott Lecture:

> ... both supporters and critics of the market economy have often confused policies that are pro-business with policies that are pro-market.[27]

Yet, this simple "pro-private" philosophy seems to be the main basis for supporting private insurance. It has distracted policy attention from the more basic question which is about the extent to which we insure. It is simply taken for granted that we should insure, and that private insurance, regardless of contradictory evidence, is somehow superior to public insurance. Reflecting this uncritical attitude, the final report of the NHHRC, without any analysis or logical justification, states:

> We want to see the overall balance of spending through taxation, private health insurance, and out-of-pocket contribution maintained over the next decade.[28]

There has been only one point at which a party contending for government has openly questioned the role of insurance. In the 1987 election campaign the Coalition proposed that people should pay the first $250 of health costs from their own pockets without insurance. Indexing this amount by average weekly earnings brings it to around $700 in today's terms, which would put most Australians into a more market-oriented situation in relation to health care.[29] During the campaign, however, they essentially abandoned this proposal. This is the only time the Coalition has come close to a policy consistent with its platform rhetoric about "self- reliance".

So long as any aspects of health policy remain exempt from policy review, we will make little progress with structural change. Successive governments have tackled what appeared at the time to be entrenched practices, such as tariff protection and centralized wage bargaining, but they have not raised the possibility of bringing in more market mechanisms into health care. Instead, they have accepted without question the notion that all, or almost all, health care costs should be covered by insurance. And they have accepted the notion that, to the extent we do wish to insure for health care, private insurance has a useful role, ignoring its intrinsic

moral hazard and ignoring a wealth of evidence that it raises health care costs without improving health outcomes.

At the time of preparing this paper the Commonwealth is engaged in a series of health policy initiatives, which, in themselves, should overcome some problems in hospital efficiency. As pointed out in Part 1, however, the present government's hospital initiatives will not do a great deal to achieve service integration, and there is no indication that there will be reform of the way private hospitals are funded. The plan to double the number of medical undergraduate places and to increase postgraduate places will overcome many resource problems, but if these extra graduates are not available to public patients, either in public or private hospitals, they will do nothing to reduce waiting times.

What is most extraordinary about these reforms is the time it has taken for these problems to be addressed.

4. High technology – in a cottage industry

In most industries we have seen new technologies bring about dramatic reductions in unit cost. The unaffordable luxuries of yesterday are today's items of mass consumption.

For some goods and services declining unit costs and declining prices can lead to falls in total outlays, while in others they can actually lead to increases in total outlays.[30]

In health care, the consensus view, reinforced by a rigorous study by the Productivity Commission, is that in all, new technologies have resulted in increased costs in health care.[31] Their findings are summarized in one of their conclusions:

> Analysis of the expenditure impacts of some of the major advances in medical technology over the past decade suggests that most have increased net health expenditure:
>
> - For some, the expenditure impact has been unambiguous because they have higher unit costs; complement or add to the existing mix of technologies; or treat an entirely new disease.
> - Others have reduced unit treatment costs or have generated offsetting savings elsewhere in the health system, but have often facilitated significant increases in the volume of treatment.

Health care has traditionally been a labor-intensive industry, but many new technologies, including drug therapies, have high capital or other sunk costs and comparatively low marginal or variable costs. The cost of developing a new pharmaceutical typically runs to hundreds of millions of dollars, while the variable cost per unit is very low; the manufacturing cost of a bottle of aspirin and a bottle of a new anti-hypertensive are not very different. There are similar cost functions for other technologies such as imaging.

Payment systems which rely on a fixed fee per service are not always appropriate for such products. When the manufacturer has a low variable cost but receives a high price which absorbs part of the fixed costs, there is an incentive to over-sell the product. On the other side the public servant or hospital administrator, concerned with containing expenditure, may impose quantitative restrictions on the drug or instrument of diagnostic equipment. Such restrictions result in what economists refer to as "deadweight loss", because the restriction

results in a denial of profit for the supplier and of benefit to the excluded patient – a benefit which would have accrued had the price been lower but still sufficient to cover the variable cost. In health care fee-for-service reimbursement, often kept in check with quantitative restrictions, is the dominant payment method. There must surely be opportunities for smarter purchasing of products with high fixed costs and low unit cost.

The Productivity Commission found that, with the exception of PBS pharmaceuticals and some diagnosis technologies, there is little use of rigorous technology assessment in health care. In fact, in general, while there is a great deal of rhetoric about "evidence based medicine", its application in health care is confined mainly to the PBS. The Productivity Commission also found evidence that new technologies are not being used as cost effectively as they might.

Where there is a huge technology deficit in health care is in the use of the management technologies which have become commonplace in most other industries. We would be very surprised to find that the electricity supplier or airline with which we deal did not keep our details on electronic records and analyzed our habits with customer relation software. By comparison most of the health care industry resides in the industrial dark ages with high dependence on paper-based patient records. It is only in the last few years that there have been moves to develop electronic patient records.

Furthermore, there is a whole class of possible new technologies clustered around the borderline between medical and management technologies, such as those which can monitor certain biometric information and transmit it from home to the person's medical practitioner, or those which can detect a geographical cluster of health-related conditions. Other industries are well ahead of health care in developing the protocols and standards to make best use of similar technologies, such as diagnosis of automobile engines and GPS-linked traffic management.

Another practice which has become commonplace in most industries is the shortening of process time, most notably in what are known as Just-In-Time (JIT) systems. We have become used to rapid despatch of orders with on-line suppliers. Even the conservative book publishing industry is turning to printing on demand. Yet, the health care sector is slow to take up improvements in process time improvements. We do not even have estimates of the number of days people occupy expensive hospital beds, at risk of hospital infections, while they wait for test results to turn around.

To the observer health care is indeed a strange industry. Cutting-edge technologies are used in establishments with cottage-industry management systems. We find similar anomalies when it comes to quality control.

5. Quality control – health care as a health hazard

One of the stormiest political issues in recent times has been the poor management of the Commonwealth's home insulation scheme. One unfortunate outcome of that scheme has been the deaths of four insulation installers.

That figure should set a context for the number of deaths resulting from preventable adverse events in health care. A 1995 study of hospital patients in New South Wales and South Australia found that 16.6 percent of admissions were associated with an "adverse event", resulting in disability or a longer hospital stay. These were generally caused by individual or systemic problems in management, about half of which were preventable.[32] In about five percent of all these cases, or almost one percent of all admissions, the patient died as a result of these adverse events. That would indicate about 19 000 preventable deaths a year, not to mention permanent disabilities.[33]

Similarly Jeff Richardson of Monash University cites research showing that around 25 patients in Australia die each day from preventable adverse events, suggesting an annual figure of 9 000.[34]

It is difficult to estimate a figure with any precision, but it is high. Another perspective on these figures is provided by the 1500 motor vehicle deaths each year. In all cases – insulation, road safety and health care – governments are heavily involved, but policy attention, or at least political outrage, seems to be in inverse proportion to the magnitude of the problem.

What should be of even more concern is evidence that, at a gross level, health care may be far less effective than we have been led to believe. In the current debate about health care in the USA there has been a great deal of concern for the uninsured, most of whom are almost completely shut out of health care, other than emergency room treatment. It has long been known that the uninsured have worse health outcomes than other Americans, but in a recently published piece of research, Richard Kronick of the University of California has compared the health outcomes of the uninsured with those with insurance and with similar demographic and economic characteristics to the uninsured. Kronick finds no significant difference in health outcomes between the two groups.[35] The reasons are subject to argument: it appears that those with access to health care do indeed benefit from care, but that, in aggregate these benefits are offset by the harm suffered by those who experience adverse events.

Such evidence is not conclusive, but if it were manifest in any other industry it would surely prompt a major research effort and urgent development of corrective actions.

It is easy to rationalize high rates of adverse events and deaths. One rationalization is that they occur to people who, almost by definition, are not in the best of health and are likely to be older; it is therefore unreasonable to compare them with deaths resulting from construction or transport accidents, but such a rationalization cannot explain away such high figures. Another is that health care is intrinsically complex; safety cannot be codified in routine procedures supported by high levels of redundancy, as can be done in airlines and similar technologically complex industries.

There are, however, means of making even the most complex operations safer. Todd La Porte of the George Mason School of Public Policy has developed a practical theory of "high reliability organizations", which has been applied to situations as diverse as nuclear power generation and aircraft carrier operations.[36] A culture of reliability is developed when there is trust and open communication, when accidents and incidents are traced back to systemic rather than proximate causes, and when there is more emphasis on tracing causes of problems rather than allocating blame. Such a culture may be thriving in many industries, but it is reasonable to question whether it is common in health care establishments.

Apart from this gross indifference to quality, another weird aspect of health care is that for most procedures, whether they are paid for by patients, private insurers or public insurers, the payment is not contingent on the quality of the service. If, through mild misadventure, a patient has to return to a clinic or a hospital, he or she will probably incur another outlay. Not many industries could get away with such a payment system. Even lawyers have adopted contingency fees for certain cases.

Conclusion

When one attaches the lens of an industry analyst, health care stands out as a very weird industry. Some will argue that the tools used to analyze industries such as motor vehicle manufacturing, airlines, postal services and retailing are not appropriate for health care. Some will claim that health care must necessarily be conservative because of what is stake, but technological conservatism should not provide an excuse for conservatism in business practices – particularly when there is evidence that even on safety issues health care could do far better. There is no compelling reason why health care should be exempt from the sort of examination which is applied to other industries and to related public policies.

It is possible that claims of exemption are based on a fear of what such analysis might reveal. Government policies may be exposed as being ineffective or even counter-productive. Businesses such as private insurance may be shown up as burdensome overheads rather than as value-adding components of health care. Traditions such as professional and business demarcations may be seen as dysfunctional and expensive historical relics. Too much is at stake to allow this industry to go unexamined.

Endnotes

1. Theodore Levitt "Marketing Myopia" *Harvard Business Review* vol 38 #4 July/Aug 1960, Republished July 2004.

2. Commonwealth Treasury *Australia to 2050: future challenges* (*Intergenerational Report*) 2010.

3. Joseph Schumpeter *Capitalism, Socialism and Democracy* Harper and Brothers 1950.

4. In 2007-08, 51.43% of Australians used 10.24 percent of Medicare services, and 19.11% used 60.58% of services. Figures derived from *Medicare Annual Report* 2008-09 Appendix Table 20.

5. Total health care expenditure from all sources in 2007-08 was $98 567 million (AIHW *Health Expenditure 2007-08*, AIHW 2009, Table A3, subtracting public health and research). The same AIHW document reports that over the period 1997-98 to 2007-08 health expenditure, in real terms, has been rising by 5.2 percent a year. Applying this growth and an estimated 3.0 percent growth in the CPI over two years brings the national health expenditure in 2009-10 to $118 billion. Per capita (22.2 million population) that comes to $5300. That comes to around $14000 per household (on the basis of 2.6 persons per household).

6. In 2007-08, 61.40% used 17.12% of Medicare services. (Data as for Endnote 5.)

7. These tables relate to 2005-06. Because they are indicators of financial wealth, I have not indexed them to later figures. Market prices of financial assets over the last four years have been so volatile that indexation may carry little meaning.

8. AIHW *Health Expenditure*, various issues.

9. Such forms of industry assistance are not entirely without precedent. In some states senior public servants have been given locally-made cars as part of their remuneration.

10. ABS *National Health Survey: Private Health Insurance* Cat 4334.0 1998, Table 8. Figures for high income earners are almost certainly understated, for the survey pre-dated the MLS.

11. This is a strong finding of behavioral economics. See, for example, Justin Sydnor "Sweating the Small Stuff: The Demand for Low Deductibles in Homeowners Insurance" University of California, Berkeley 2005. On the general phenomenon of pseudocertainty, see David Kahneman and Amos Tversky "The Framing of Decisions and the Psychology of Choice" *Science* 211, 1981.

12. ABS *Health Insurance Survey* 1998 Cat 4335.0 Table 11.

13. Section 51 xxxiiiA, inserted 1946.

14. For a description of the evolution of Australia's health policies up to 1983, covering the bitter and acrimonious disputes, see Sidney Sax *A Strife of Interests: Politics and policies in Australian health services* (George Allen & Unwin 1984).

15. Life expectancy in 1946-48 was 66.1 years for males. 70.6 years for females. ABS *Australian Historical Population Statistics* Cat. no. 3105.0.65.001.

16. See Jennifer Doggett "Out of Pocket: rethinking health copayments" Centre for Policy Development July 2009.

17. Productivity Commission *Public and Private Hospitals Discussion Draft* 2009.

18. Department of Health and Ageing *A National Health and Hospitals Network for Australia's Future* 2010.

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

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

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

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

23. For PHI administrative costs see the PHIAC *Annual Report* 2008-09.

24. In 2008-09 Medicare processed $27.7 billion of claims in its three main programs, with administrative expenses of $722 million, giving an administrative cost ratio of 2.6 percent. Medicare Australia *Annual Report* 2008-09. To this must be added 1.4 percent for tax collection. *Australian Taxation Office* Annual Report 2008-09.

25. *The Economist* "Clear Diagnosis, Uncertain Remedy" Feb 18th 2010.

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

27. John Kay "The future of markets" 2009 Wincott lecture http://www.wincott.co.uk/lecture2009.htm

28. National Health and Hospitals Reform Commission *A Healthier Future For All Australians* Final Report June 2009, Recommendation 92.

29. In the September quarter 1987 AWOTE for full time adults were $445.0 and in the December quarter 2009 they were $1 226.7 (RBA Table G6). Applying this ratio (2.756) brings the $250 payment up to $680.

30. The movement in total outlays will depend on the relevant demand elasticity. If $\eta < 1$, an decrease in unit price will result in an increase in total expenditure.

31. Productivity Commission Research Report *Impacts of Advances in Medical Technology in Australia* 2005.

32. 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* Vol 163, 1995.

33. The Wilson study found 4.7 percent of the 16.6 percent died, indicating a death rate of 0.78% of admissions. Based on 4.9 million annual admissions (public hospitals only) that would indicate annual deaths of 38 000. If 51% are preventable, that would indicate a preventable death rate of around 19 000.

34. Jeff Richardson "Steering without navigation equipment: the lamentable state of Australian health policy reform" *Australia & New Zealand Health Policy* # 6, 2009.

35. Richard Kronick "Health insurance coverage and mortality revisited" *Health Services Research*, Vol 4 #44 August 2009.

36. Todd La Porte "High Reliability Organizations: Unlikely, Demanding and At Risk" Journal of Contingencies and Crisis Management Vol 4 #2 October 2006.

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