



# A HEALTH POLICY FOR AUSTRALIA

RECLAIMING UNIVERSAL HEALTH CARE

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RETHINK PAPER NUMBER 1

MAY 2007

ISSN 1835-0119

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|  |    |
|--|----|
| Main points  | 3  |
| Foreword   | 4  |
| Between complacency and panic                      | 5  |
| Messages from stakeholders                         | 6  |
| Policy responses - incremental and fragmenting     | 10 |
| Principles as the basis for policy                 | 11 |
| From principles to a design brief                  | 13 |
| Rationing and funding                              | 14 |
| A single national insurer - needs based allocation | 16 |
| The border between insurance and direct payments   | 17 |
| Coherence in program design                        | 19 |
| Public or private - not a core question            | 20 |
| Primary care as the focus of delivery              | 21 |
| Is it all too hard? Not really                     | 23 |

### ABOUT THE CENTRE FOR POLICY DEVELOPMENT

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### ABOUT THIS PAPER

*A Health Policy for Australia: Reclaiming universal health care* is the first paper in the CPD's *ReThink* series. *ReThink* papers chart the path from short-term ad-hoc 'reforms' to long-term, systemic renewal based on consistent principles, widespread citizen participation and a realistic understanding of how we live now.

This document was subject to an extensive peer review process. Thanks are extended to all who contributed their feedback and ideas, and especially to Jim Birch, Peter Brooks, Jennifer Doggett, John Dwyer, Carol Gaston, Kerry Goulston, Don Hindle, Jill Iliffe and Steve Leeder. Opinions expressed remain those of the authors.

# A HEALTH POLICY FOR AUSTRALIA

## RECLAIMING UNIVERSAL HEALTH CARE

### Main points

This paper proposes significant reform of Australia's health policies, to restore universalism, and to achieve improvements in both equity and efficiency.

Its main recommendations are:

- » to focus program delivery in primary care health centres, providing an integrated range of services
- » to move to a single, universal insurer (but not necessarily provide universal "free" services)
- » to organise health care programs around the needs of users – fundamentally re-shaping programs and budgetary allocations
- » to rationalise user payments so as to achieve equity and not distort resource allocation
- » to provide and fund services on the basis of therapeutic need
- » to retain Commonwealth responsibility for funding and standard setting, and deliver programs through joint Commonwealth/state administrations
- » to involve citizens in health care to counter the strong lobbies of service providers
- » to focus Ministerial concern more on health than on health care.

### Media information

**Ian McAuley**, CPD fellow, and **John Menadue AO**, CPD Chair, are available for comment on the points raised in this paper and their wider work in health policy reform. It may also be possible to speak to other contributors.

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## FOREWORD

The short-termism of successive governments has given Australia a set of health policies which are increasingly complex, inequitable, inefficient and incoherent.

Opportunistic initiatives, such as the subsidisation of private health insurance, cost-shifting between governments, arbitrary imposts on users, and protection of vested provider interests are putting our health care arrangements under stress. So too is neglect, particularly neglect of fundamental efficiency reforms and of longer term workforce issues.

That stress is manifest in many ways – in misallocation of scarce health care resources (particularly away from prevention and primary care), in administrative inefficiency, and, above all, a loss of universalism.

This ReThink paper proposes basic reforms. Rather than the “patch ups” which have characterised health policy for many years, it suggests a fundamental re-design. We can use the same health care resources that we have at present in both the private and public sectors, but we can employ them more efficiently and effectively.

Universalism should be restored and embedded. A universal system is not only fair; it is also the most affordable in terms of private and public spending, as is clear from the examples set by countries with universal systems. An important aspect of citizenship is that we should all use the same high standard health care services, rather than a “two tier” set of services.

Unfortunately, those with vested interests, or a lack of policy imagination, often assert or assume that “universalism” means some form of nationalised medicine. This is a mischievous inference. Universalism simply means that regardless of means or location, all have access to the same professional staff, clinics, pharmaceuticals and other resources. Whether those are provided in the private or public sector is another question, as is the division between funding through taxes or through direct out-of-pocket payments.

The private sector should maintain a strong role in the provision of services, but there are problems when private financial agencies – health insurance funds – become involved in the funding of health care.

To the extent that we share our health care costs, we should do so through a single national insurer. Private insurance should be confined to peripheral services where its presence does not distort equity or resource allocation.

This paper outlines the architecture of a reformed health care system – it does not move into detailed design. A great deal of public consultation and detailed research is required before that stage can be reached. But, because our present arrangements contain so many technical and allocative inefficiencies, a great deal of reform can be achieved without any additional public or private funding. We have an unusual opportunity to improve both equity and efficiency without having to make difficult trade-offs between the two. It is time to seize that opportunity.

## BETWEEN COMPLACENCY AND PANIC

It is tempting to be complacent about Australia's health policies. In indicators such as life expectancy and many morbidity figures Australia is among the healthiest of all OECD countries. Along with Japan and the Nordic countries we are among the top of the league tables. Most indicators of life expectancy and morbidity continue to show improvement. There has been tremendous progress on reducing the burden of circulatory diseases, for example.

Similarly, many lifestyle indicators are positive; few developed countries have rates of smoking as low as Australia's, and we have been a world leader in AIDS programs. Road fatalities and injuries, while still higher than some other countries, are on a long term downward trend.

We have achieved this while keeping costs under control. At 9.7 percent of the GDP our expenditure is near the OECD average, and is well below the US figure of 15.0 percent: twice Australia's per-capita expenditure. (In spite of such high spending the US' health indicators are only on a par with those of the poorer OECD countries.) In terms of workforce to population ratios we are better supplied with medical practitioners and nurses than the US, Canada and New Zealand.

Yet, hardly a day goes by without a bad news story about dire health care problems. Waiting times, crowded emergency departments, a lack of resources in rural areas and adverse events in hospitals grab the attention of the tabloid media. The Commonwealth raises concerns about ever-growing outlays under the Pharmaceutical Benefits Scheme, and we are being made more aware of obesity as a health problem, where our performance on the league tables is among the worst. Conflicts over funding between Commonwealth and state governments sit in the background as a perennial problem.

There will always be problems in health care; it is unrealistic to expect there to be adequate resources to meet all potential demands, and, as in any complex system, there will be some level of error. Government funding agencies will always feel pressure from treasury departments on the one side and from service providers on the other.

But there is an unacceptable level of complacency relating to health and health care. Politicians and public servants believe the system is basically in good shape, at most conceding that perhaps a few Commonwealth/state coordination problems need fixing. This perspective overlooks the more serious problems of dual responsibility and general program fragmentation. They may concede that private health insurance may perhaps need fine tuning, while overlooking the tendency for a service provided free at the time of delivery to be over-used. This problem, referred to by economists as "moral hazard", is inherent in all insurance, particularly private insurance.

Those who are complacent about the status quo also ignore our greatest shortcoming, which is inequity in health outcomes. For a nation claiming first world status, and which celebrates its economic achievements, the fact that poorer Australians have worse health outcomes than wealthier Australians is a disgrace, indicative of major policy failure. Some health inequities relate to inequities in access to health care programs (discussed below). Many others relate more widely to factors such as diet, exercise, stressful or physically dangerous occupations, and the general stresses associated with exclusion, poverty and a lack of autonomy in people's lives.

**health care expenses for even moderately serious illnesses and injuries are too large and uncertain for most individuals and households to manage**

Health policy has been dominated by *health care* policy, rather than a concern about the many ways in which government policies can affect health – which would be the focus of a *health* policy.

Economic progress is a means to an end, and that end is the wellbeing of all Australians. To the extent that we are failing to address health inequities, our public policies are failing; there is little point in “economic progress” achieved at the expense of wellbeing.

Discussions with those involved in health care, and examination of published research and data, reveal no reason for complacency - but no cause for panic either. Panic is a poor basis for public policy. It directs attention to the immediate manifestations of problems rather than their underlying causes, and it can lead to a sense of helplessness and despair.

The general message is that we could achieve much more with the resources we already have, if only they could be deployed more efficiently. We have a set of health care programs which generally run well in themselves, but which do not come together into a coherent system. Furthermore, while there is a great deal of innovation and there are many centres of excellence, the overall story is one of conservative inertia and waste.

Reform, when it occurs, is only at the margins, rather on the basic structures, which have their origins in different times when there were different health care needs and different health care technologies.

More broadly, we can achieve a great deal if we shift our policy focus away from curative hospital and related high-cost programs (important as these are), towards earlier interventions, particularly primary care, and towards the lifestyle and social determinants of poor health.

## Messages from stakeholders

Many problems require attention. Those raised by the users of the existing system and their advocates in consumer groups include:

### *Health of Indigenous Australians*

Problems are manifold, and include substance dependence, domestic violence, diet and lifestyle-related diseases, and a lack of access to primary care. There is a pattern of Indigenous people, particularly in remote regions, requiring high-cost hospital care (with associated discomfort, risk of infection, slow or incomplete recovery, and the pain of separation) when earlier and lower-cost primary care would have avoided the need for hospitalization.

### *Mental health*

The most frequently mentioned problems are a lack of integration between service providers (emergency wards, private psychologists, mental health crisis teams, psychiatrists etc), poor understanding of mental health among many health care professionals, and the lack of Medicare funding for many useful services. While the Commonwealth is addressing some of these problems, more needs to be done.

### *Access, affordability and equity*

These are three different but closely-related problems. Access problems often relate to affordability, but in many cases they relate to the geographical distribution of resources

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(particularly in rural, remote and outer-suburban regions). From a user perspective waiting times for elective procedures are an access problem (from a system perspective they may be seen as a workforce problem). And when some enjoy easier access than others for the same conditions, there is a clear inequity problem. For those who need high level services the appropriateness and quality of that care can be subject to the personal preferences of GPs, who, through their referrals, are the gatekeepers of health care services, and who have an understandable inclination towards medical therapies. The most-often cited affordability problems relate to the difficulty of finding bulk-billing practitioners and the price of prescription and non-prescription pharmaceuticals. Those with high-cover private insurance get free access to dental and other “ancillary” services, while others, whose taxes are subsidising private insurance, have to rely on their own cash resources or go without.

### *Complexity of services*

There are different eligibility criteria for different government programs. Aged care and health care programs have sharp and artificial demarcations. There are requirements to gain access to certain services through different “gateways”. Different service providers keep different records. And there is misinformation (for example the notion that only the privately insured can use private hospitals). Complexity leads to delays in treatment and therefore a greater than necessary incidence of serious conditions developing before treatment commences.

Professionals raise the above concerns as well as other issues, including:

### *Perverse incentives*

There are many instances of these, such as the structure of Medical Benefits Scheme payments encouraging short consultations and encouraging procedures over other services, limited Medicare coverage of services such as physiotherapy and psychology, and general incentives to provide high-cost and insured services rather than low-cost and uninsured services.

### *Quality and safety*

There is a high level of preventable death and morbidity, particularly in hospitals, resulting, in part, from a failure of integration between providers and the use of antiquated data management. Some professionals are concerned that there is less than consistent quality in medical practices.

### *Efficiency and work practices*

Almost all people delivering direct services, particularly in hospitals, cite poor management, high and often pointless bureaucratic requirements, rigidities in work arrangements (e.g. not catering for those staff needing flexibility), primitive and unreliable record-keeping systems (often paper-based), generally poor use of information technology, and rigid demarcation issues, as root causes of inefficiency. These problems are not confined to the “private” or “public” sector; rather, many arise because of the lack of integration between different service providers.

### *Work pressure and work dissatisfaction*

Country GPs, specialists in hospitals, nurses and many others point out that they are working under great pressure. Their work is open-ended – they can never satisfy all

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**Burnout is an ever-present risk, and many quit the profession or retire early because of workload or professional dissatisfaction.**

demands, and they end up working very long hours. This may seem anomalous in a country with reasonable professional to population ratios, but these ratios are raw numbers. Our workforce is not well-distributed between public and private hospitals. Professionals find that much of their time is occupied by bureaucratic demands from governments, private insurers and hospital managers. Many feel professionally devalued, particularly when they are being micro-managed by hospital administrators and ministerial staff. Burnout is an ever-present risk, and many quit the profession or retire early because of workload or professional dissatisfaction.

#### *Externally-imposed bureaucratic overheads*

As well as those which have a day-to-day impact, mentioned above, these include overlapping Commonwealth and state bureaucracies, and the overheads of private health insurance. (The bureaucratic cost of private insurance is \$900 million a year, or 9.8 percent of turnover, which is more than twice the expense incurred by Medicare and the Australian Tax Office in collecting and distributing health care finance).

#### *Broader workforce issues*

Besides demarcation problems, which result for example in under-utilisation of nurses, there are the general problems of a workforce which is ageing and is not well distributed geographically.

#### *Rent-seeking behaviour*

Economists in particular refer to certain restrictive practices resulting in economic “rent” (essentially high cost and excess profit associated with restrictive trade practices). These include the exemption of retail pharmacy from competition policy (manifest in high prices and restricted hours of service) and the restrictions in access to postgraduate medical training imposed by the professional “colleges”.

#### *Politicisation*

Headline-grabbing incidents, particularly in public hospitals, receive political attention. At the Commonwealth level vocal lobby groups including health insurers, retail pharmacists and medical specialists, have secured privileges at the expense of the public interest.

Those concerned with public policy tend to raise wider concerns, covering:

#### *A lack of integration or even co-ordination between programs*

This goes beyond the problem of the Commonwealth/state division. Even within the Commonwealth, for example, the Pharmaceutical Benefits Scheme (PBS) and the Medical Benefits Scheme (MBS) are run as different programs with different criteria relating to safety nets and co-payments.

#### *An inappropriate program structure*

The dominant programs – the PBS, the MBS and hospitals are centred on inputs. This leads to panics such as those concerning PBS expenditure – even though use of pharmaceuticals helps reduce costs elsewhere in health care and the wider economy. A system with a user-based structure would be more responsive, more efficient, and would more appropriately trace costs according to purpose.

### *Long term cost pressures*

Many policy advisors are concerned with the long-term cost pressures associated with an ageing population. (Others point out that Australia's population won't reach the age structure of some European countries for many decades, and that there is no reason to see high health expenditure, in itself, as problematic.)

### *Imbalanced resources*

There is too much emphasis on hospital care, and too little on primary care. There is too much emphasis on medical interventions generally and too little on public health and on the health impacts of government non-health policies. Apart from pharmaceutical evaluation, there is far too little cost-benefit analysis underpinning policy development, leading to a bias in resource allocation towards hospitalisation at the expense of lower cost therapies, cure rather than prevention, and conditions affecting the aged rather than those affecting the young.

### *Cost-shifting*

Governments, particularly the Commonwealth, are too concerned with their own outlays, rather than the community's outlays on health care. Governments do not take a system-wide view of health care and therefore do not try to promote system-wide efficiency. Governments, under fiscal pressure, cost-shift between each other (Commonwealth and state) and on to users.

### *A fiscal obsession rather than an economic concern*

Governments try to solve problems by spending public funds (e.g. rural incentives) or providing incentives for private expenditure (for example private insurance) without regard to the availability of physical resources. Furthermore, at both a Commonwealth and state level, the fiscal demands of health care programs tend to crowd out other programs such as prevention and public health.

### *Inequities*

Partly because of funding fragmentation there are many inequities. Some services are free (e.g. public hospitals), some have capped-co-payments (e.g. the PBS), some have open-ended co-payments (e.g. medical services) and others have no public support (e.g. non-PBS pharmaceuticals). Incentives for private health insurance are structured in a way that favours the well-off, encouraging them to opt out of sharing their health care resources, and giving them priority access to scarce services, all of which means shifting others down the queue.

### *Loss of universalism*

This is related to the above, but is more basic. Starting around 1990 the Commonwealth has progressively redefined publicly-provided health care in terms of social welfare, rather than a shared system. Quite recently a state premier has suggested that patients with private insurance should not use public hospitals.

### *Inefficiency in resource allocation*

Besides the over-emphasis on hospitalisation there are distortions caused by the emergence of a "two tier" hospital system. Private health insurance has exacerbated the moral hazard of health care delivery and has directed services, particularly "ancillary

**Starting around 1990 the Commonwealth has progressively redefined publicly-provided health care in terms of social welfare, rather than a shared system.**

services”, towards the privately insured and away from those who pay from their own financial resources and from those reliant on public hospitals.

### **Policy responses - incremental and fragmenting**

One response would be to suggest remedies for each of these problems, in turn. In fact, that is the approach which tends to be adopted in government programs and in proposals from opposition parties.

This incremental process has brought us a patchwork set of arrangements, resulting from interventions designed to address the pressing problems of the day.

Worse, successive governments, particularly Commonwealth governments, have brought competing ideological interests to health care. There is nothing wrong with political ideologies; ideological conflicts are part and parcel of a vigorous democracy. But in health care no government has ever applied a consistent ideology. Labor governments have tended to favour free provision of health care, but their vision has been tempered by the constraints of budgetary processes; as a result Medicare schedules, for example, have never extended to dentistry. Coalition governments would be expected to prefer market solutions, but that preference has been displaced by a fondness for private health insurance, regardless of its tendency to distort markets.

Each successive government tends to leave large parts of the programs of previous governments intact. Thus, Labor in office has been reluctant to abolish private insurance, and the Coalition has been reluctant to abolish bulk-billing. Both parties, although rhetorically committed to competition policy, have been reluctant to take on interest groups whom they consider to be powerful – pharmacists, medical specialists, and health insurers in particular. The result is a set of programs, some “socialist”, some “market”, and many lacking any ideological basis other than a wish to serve the needs of privileged interest groups.

Governments of both persuasions have tended to confuse health with social welfare programs. Universalist principles and welfare principles therefore come into conflict. Thus we have a mixture of services which are free to all users (such as public hospitals) and services which are heavily means-tested. And while politicians may talk about universalism there is always the quiet suggestion that government programs should be only for the poor or “indigent”.

It is therefore impossible to find or even to infer any coherent set of principles in our present health policies, particularly on the issue of health care funding. Some services are provided for free while others receive no government support. Some services are covered by tax-funded insurance, but at the same time there are incentives for people to opt out of sharing and into private insurance. Politicians talk of “universalism” and a “commitment to Medicare” while encouraging the development of a two-tier hospital system. Politicians talk about “individual responsibility” while encouraging people to hand responsibility over to health insurance corporations. Governments, particularly Coalition governments, speak vaguely about the virtues of the private sector, but in only a few areas of health care is there a degree of market competition; in general health care has been cosseted from market forces. Labor politicians sing the praises of bulk-billing, while supporting high co-payments for pharmaceuticals.

Rather than continuing down our historical path of incremental change, which leads to ever-expanding complexity, distortion, inequity and general confusion, we need a fundamental re-design; in the terminology of public policy reform should be “root” rather than “branch”. The starting point should be a clarification of the principles which govern and tie health policy together. This is the subject of the next section.

## PRINCIPLES AS THE BASIS FOR POLICY

This paper does not attempt to present a detailed blueprint for the re-design of Australia’s health policies. Rather, it suggests a set of principles which should underpin health policies. A great deal of community consultation and technical design is necessary before the details can be specified.

To draw an analogy, *A Health Policy for Australia: Reclaiming universal health care* can be considered as an initial “architectural brief”. Prior to the renovation of an old building a brief provides a starting point; before users and other stakeholders provide details of their specific needs, and before architects, engineers and cost estimators undertake the detailed design.

Partly because of our legacy of incremental interventions, Australia’s health care policies lack the coherence and stability that can be found in other countries. Britain’s National Health Service (NHS) and the set of arrangements in the US are far more embedded and immutable than ours. The Thatcher Government never managed to undermine the basic universalist principles of the NHS. In the US, in spite of the clear failures of its private insurance based system, even Democrat governments have found reform to be impossible. By contrast, there is more opportunity for fundamental re-design in Australia.

CPD’s first *CommonSense* paper, [Reclaiming Our Common Wealth](#), articulated the need for a clear values base to provide consistency and coherence in public policy. The values of citizenship and fairness should underpin Australian health policy, articulated through principles which ensure that our health care system is:

### (1) *Universal*

“Universalism” means one system, accessible to all. As citizens we should all use the same health care system. Poor and rich should have access to the same health care services from the same providers. (This contrasts with the present government policy of encouraging a segregated two tier system.) A universal system is not necessarily a free system; the poor and rich may pay different amounts to have access to that universal system, but the well-off and the poor should not have separate providers (the “charity ward” notion of health care). All should share the one, high quality system. This need not be a monolithic service: it could be predominantly private, predominantly public, or mixed.

### (2) *Coherent*

From the patient’s perspective there should be one seamless system, rather than a plethora of disconnected programs. Programs should be designed around patients’ needs, not the legacies of historical divisions.

### (3) *Flexible*

Universalism should not preclude a high degree of individual choice, consistent with

**Australia’s health care policies lack the coherence and stability that can be found in other countries.**

therapeutic wisdom. The term “choice” has become trivialised to refer to the choice between look-alike private insurers, or between private and public hospitals (as if ownership is more important than the types of service offered). The other dimension of flexibility is that the system should respond as people’s needs change, and as new technologies become available.

(4) *Equitable*

One way of achieving fairness is through universal taxpayer funding, with all services free at the point of delivery. But that is only one way, and not necessarily the best way of achieving fairness. Free service provision, particularly of some of the so-called “ancillary” services, results in a degree of moral hazard and exacerbates the problem of queuing, which in itself is costly to users. On the other hand some user charges can discourage use; research shows that charges for initial consultations can result in people not seeking low-cost early stage treatments. Methods of payments are discussed in the next section.

(5) *Allocatively efficient*

Allocative efficiency is about ensuring that resources are directed to where they are most needed – another aspect of fairness. In health care that means resources should be directed, through market mechanisms or through direct controls, to where they can do the most therapeutic good. That is in contrast to allocation on the basis of ability to pay, which may be acceptable in some markets but not in health care. A systematic cost-effectiveness approach to health care would almost certainly see more emphasis on primary care rather than hospitalisation, more emphasis on early intervention, and more emphasis on caring for people in poverty.

(6) *Technically efficient*

Technical efficiency is about ensuring outcomes are achieved at the lowest possible cost while also meeting quality standards. It is met through sound general management practices and quality management. Health care needs to be seen as an industry; it is too easy to use the argument that “health care is different” to justify restrictive work practices and policies which privilege providers at the expense of users. This is not an illiberal view. Rather, it is an acknowledgement that our interests as users and taxpayers are to obtain the maximum benefit from our limited resources.

(7) *Designed on the basis of subsidiarity*

Subsidiarity is the principle which states that matters ought to be handled by the smallest (or the lowest) competent authority. Some matters are appropriately handled on a national basis; these include the establishment of standards and the concentration of bargaining power to counteract the power of global pharmaceutical firms and other powerful service providers. In fact, some matters, such as pandemic risk, are best handled globally rather than nationally. But the fundamental design principle should be subsidiarity, with authority delegated to those closest to users unless there are strong reasons for higher level intervention.

(8) *Responsive*

At present health care policy is highly responsive to the whims of Executive Government and to the pressure of lobbyists, but is too unresponsive to users’ needs. Management should be removed from day-to-day government influence, while the influence of users must be strengthened.

Those are the principles behind a health care policy, but a health policy should be about more than health care; it should be about health, or wellbeing. A sound health care system is essential, but not adequate to ensure our health. The determinants of health are many, mostly lying outside any specific “health” portfolio responsibility.

The delivery of health care programs needs to be separated from the wider health portfolio and put at arm’s length from day-to-day ministerial control. (More explanation of structure can be found in the section on program design below.)

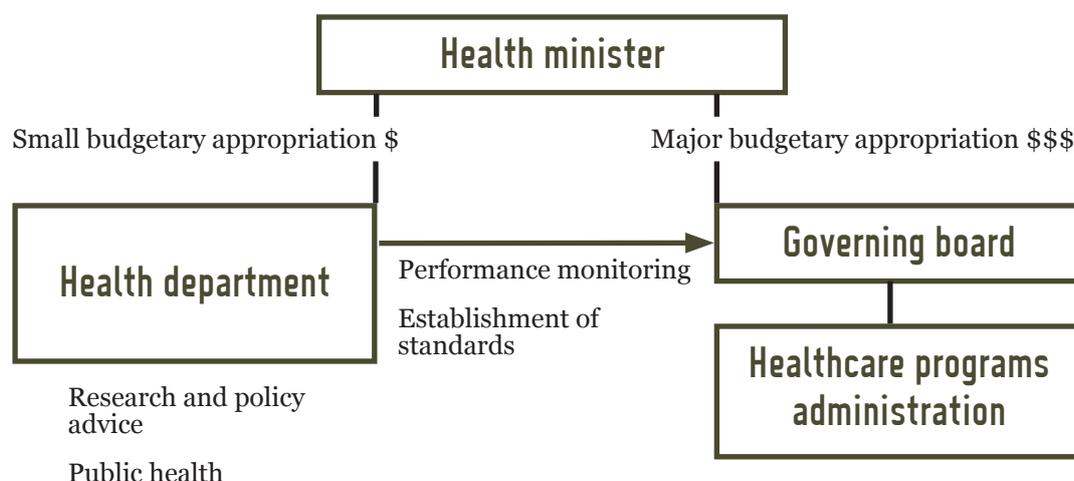
Health care programs will always make a large call on public budgets, and that is why separation is required, so that bureaucratic and ministerial attention can turn to health rather than health care programs. Health ministers, at both Commonwealth and state levels, should provide a voice in all policy proposals, not just those with a direct health focus. A health minister should have the same authority as a treasurer. Education, child care, spatial planning, housing, immigration, trade (particularly relating to intellectual property), population, transport, taxation and social security, employment and environment are just some of the policy areas that should involve the health portfolio, as well as the public good aspects of health such as lifestyle promotion, health education, quarantine, immunisation and research.

Such a reform needs to be part of a wider reform of public administration which sees more policy integration between agencies – what some refer to as a “joined-up government” approach, in contrast to the present devolved portfolio arrangements.

## FROM PRINCIPLES TO A DESIGN BRIEF

The principles we have articulated above are general, and a health care system which is consistent with those principles could take many different shapes.

### A health portfolio



## Rationing and funding

Prices are the normal means of rationing scarce resources to meet most of our needs. In no developed country is the delivery of health care left to the market, however. For a start there are many instances of market failure in health care, the most prevalent being what economists refer to as information asymmetry. That is, the providers of health care know more – much more – than the users of health care, and those who provide the diagnosis are usually those who provide the service.

The other reason health care is not left to the market is that for most of us there is no way of planning for our health care needs. While we may be able to make reasonably sound predictions about our need for housing or our children's education, none of us can estimate our future health with anything like the same level of certainty.

When it comes to health care not even the most extreme ideologue would advocate a laissez faire policy approach. Even the US has its federal programs – Medicare for the aged and Medicaid for the “indigent” (which programs are becoming just as costly as some countries' universal systems). People are naturally risk-averse when it comes to health care, for while we may be prepared to take chances and to rely on the mechanisms of competitive markets in other areas of our lives, in health care we have little capacity to predict what lies ahead. Therefore we choose to use some form of insurance to fund all or part of our health care. And people tend to see health care as a “solidarity” good – one we choose to share as part of our social contract as citizens.

In most developed countries health insurance is provided through a single national insurer, usually a government agency funded by taxes. Private insurance has an attraction to those who dogmatically prefer private mechanisms over public mechanisms, but it has intrinsic problems, as US experience shows and as is becoming obvious in Australia. From data provided by the OCED, which compares health care funding among member countries, it is clear that the higher the proportion of health care funding which is met through private insurance, the more people have to pay for their health care, through taxes, insurance premiums and direct outlays. And a more expensive system does not buy better health care. The main effect of private insurance is to drive up prices without buying better quality.

Insurance, by its very nature, is a means of buying out of the discipline of market forces. Insurance carries the problem known as “moral hazard”. That is the tendency to over-use a service because it is covered by insurance. It is not such a problem in home or auto insurance – the presence of insurance doesn't give us an incentive to indulge in house fires

### *Pharmaceutical incentives*

Development of a new pharmaceutical involves huge expenditure on research and clinical trials, while production and distribution costs of pharmaceuticals are comparatively small.

That cost structure provides a strong incentive to expand sales to cover these fixed costs; once research and development costs are covered each extra prescription is almost all pure profit.

Similarly, because of the attraction of high volume sales, pharmaceutical firms prefer to develop drugs for which there is an ongoing need in a large market – such as anti-hypertensive medications – rather than drugs which have a once-off use such as vaccinations or curative drugs, and they are not at all attracted to conditions with few sufferers.

**When it comes to health care not even the most extreme ideologue would advocate a laissez faire policy approach.**

or car accidents. In health care, however, there are often many options; whether to seek treatment at all, whether to use a high intensity or more modest intervention, whether to change lifestyle or to use expensive remedial therapies. Worse, those giving advice – medical practitioners – have a natural bias to intervention, and in many cases a financial incentive to provide high-cost services, particularly when services are provided on a fee-for-service basis.

Moral hazard is heightened by the nature of some services, particularly pharmaceuticals, for which there is a huge incentive to expand markets (see box on page 14).

For those reasons, moral hazard is a particularly strong problem in health insurance. There is no difference in the logic “MBF will pay for it” and “Medicare will pay for it”, and service providers, knowing that their services will be funded by insurers, can exercise strong market power. Therefore, when there is insurance of any form in operation, there will always be more demand than supply, and unless that insurer has strong market power, service providers will be free to raise the price of services. And the higher the price of services, the more incentive there is for people to insure. That’s why private insurance brings none of the benefits one may usually expect from privatisation; rather it is associated, as in the US, with price inflation and with health care access based on the generosity of one’s insurer (usually employer-financed), rather than need.

### “Use it or Lose it” - Moral hazard in private insurance



In Australia there has been a deceptive campaign to establish the notion that without private insurance the “private system” would collapse. But as is illustrated further on, there can still be vigorous private sector involvement in health care delivery without the need for private insurance.

Private insurance is inappropriate for funding important health care services, not because it is “private”, but because it invariably fragments and distorts the allocation of scarce health care resources, usually at the expense of equity and efficiency. It is not as if private insurance firms are dishonest or exploitative. Rather, it’s that by its very structure, a private health insurance industry is unable to provide health care efficiently or equitably. Private insurers are weak in a market dominated by powerful service providers. Try as

they may to control premiums, they have to accept the prices demanded by those service providers. And there are intractable problems in trying to devise a fair means of paying for private insurance; successive government attempts to achieve “community rating” in private insurance have all been problematic.

A single national insurer can overcome the moral hazard of health insurance, because it can use its concentrated purchasing power to keep the price of insured services in check, and to ensure that scarce resources are allocated in accordance with therapeutic needs rather than the generosity of different people’s insurance schemes. It can also ensure that, through the taxation system, its costs are shared fairly. (A single national private insurer could theoretically be a private firm, but there would be huge problems of monopoly regulation.)

Whatever the insurance arrangements, the problem of the supply/demand imbalance remains. Where private insurance is used the problem is manifest in inflation and inequitable access. Where national insurance is used the problem is manifest in waiting lists.

### A single national insurer - needs based allocation

The case for a single national insurer rests mainly on the principle of allocative efficiency. That is, that resources should be allocated on the basis of therapeutic need, rather than on the user’s ability to pay (usually through access to high insurance cover) or on the basis of service providers’ financial incentives.

“Need” is a difficult concept, for as long as there are any constraints on resources, there are trade-offs to be made. It certainly does not mean that priority should be given to where the complaints are loudest, or where the problems are most manifest. Overcrowding in hospitals, for example, does not necessarily indicate a need for more hospital places: it may indicate a need for better primary care or expanded nursing home services.

One interpretation of needs is that health care resources should be allocated where they achieve the best outcome in terms of quality-adjusted life years. Indeed, this is the approach already taken to evaluate prescription pharmaceuticals for inclusion on the PBS.

Such a criterion may seem to be incontrovertible; it would almost certainly see more emphasis given to child and adolescent health, for example, because such interventions give more life extension than interventions directed at older people. But this criterion may still come into conflict with other plausible criteria. There may be a strong belief that less weight should be given to helping those whose conditions result from lifestyle choices, such as smoking. The notion of “quality-adjustment” is an open one. There are point scoring mechanisms in health economists’ handbooks, but these involve subjective judgements; do they reflect community values?

For this reason needs-based funding is not a purely technical issue. There has to be strong and ongoing community engagement to ascertain how people see their health care needs. Already pharmaceutical firms, pharmacists and professional lobbies have a strong influence in ensuring that their interpretation of “needs” is incorporated into health care programs. To countervail these pressures a strong community voice is essential.

**By its very structure, a private health insurance industry is unable to provide health care efficiently or equitably.**

## The border between insurance and direct payments

There is no reason a single national insurer should provide all services free to all users. Too often we assume a single national insurer like Medicare is also a provider of free services. This assumption tends to give universalism a bad name, for it is easily associated with a lack of cost control.

Some will argue strongly for a universal free service, but co-payments have crept into and have become part of our health care programs. For example the PBS provided free drugs until 1960, and until around 1990 universal bulk-billing was far more prevalent than it is now. Many services, such as physiotherapy and dentistry, are paid for without any support by the sixty percent of Australians without private insurance. It would be politically naive to expect any government to fill the place presently occupied by direct payments and co-payments (currently around 20 percent of all health care expenditure, or \$2 000 a household).

These co-payments, however, have been introduced without any coherence and therefore inequities and perverse incentives abound – as documented in the first part of this paper. Some services, such as public hospital services, are free. Some, such as pharmaceutical benefits, are capped by the government. Some, such as the co-payments for medical services below the safety net thresholds are open-ended; the public subsidy is fixed, leaving the user to bear an open-ended risk. Some, such as the medical safety net provisions are proportional to the price of the service. Some safety nets are set on a family basis, others on an individual basis.

It would be hard to sustain an economic case or even a political case for the universal free provision of health care. Universal free care would pose significant problems around the boundary of paid and unpaid services (should gym membership be free, should cosmetic dentistry be free?). Co-payments, if well-structured, can help people make better choices, and they can provide some relief on public budgets. But, so long as the use of health services is skewed, with a small proportion of the population requiring a great amount of services, they will never form the lion's share of health care funding.

Where there are co-payments (a shorthand to include safety nets and direct payments), we strongly suggest the following design criteria:

- » that they be controlled by the government, rather than left open-ended to be set by service providers. The question of whether the PBS co-payments are too high or too low is an open one, but the notion of a capped co-payment as used in the PBS is a sound one;
- » that there be only one channel of collecting co-payments, with one set of criteria, rather than the separate channels operating at present;
- » that their level relate to means, including people's access to liquidity;
- » that means-based compensation be separated from service delivery, rather than having service providers check the welfare status of users;
- » that co-payments be structured in a way not to distort resource allocation on the basis of needs;
- » that "gap insurance" – insurance to evade co-payments – be prohibited. If co-

**Co-payments, if well-structured, can help people make better choices, and they can provide some relief on public budgets.**

payments are to have any economic role in allocating resources according to need, it is essential that they be allowed to function. Otherwise, as is happening now, priority will go to those with the highest insurance cover.

Many of those consulted in the research for this paper referred to the need for health care to be funded through one channel. A single national insurer would provide a single channel for insured services. It could also be the administrator of co-payments. Under such a model the insurer (Medicare or its replacement) would pay for all services at set rates, and would collect co-payments from users. In that way strong price control would be maintained, and the medical surgery would not have to be an agent for the welfare system.

But there may be other means of putting these principles into effect. A great deal of economic behavioural research needs to be brought to bear on system design, and there needs to be widespread public consultation on co-payments. Is our present overall level of 20 percent co-payment about right or should it be at some other level? Should co-payments be proportional to the cost of services or should they be fixed per service or episode? Should people be expected to pay for all of their expenses before a safety net cuts in? If so, where should safety nets cut in and should they be individual or family based? How should means tests be applied – to take account of wealth, income, or long term needs? Should there be some services, such as screening, quarantined from co-payments? How should use of discretionary services be controlled?

#### *Why so tough on private insurance?*

Prohibition of gap payments may seem a heavy-handed approach. After all, governments do not intervene to prohibit full cover auto or house insurance.

There are two reasons the analogy with general insurance does not hold. First, there is less moral hazard with auto or house insurance than with health insurance. Even for those with full cover, house fires and auto accidents are risky and costly. Second, building services, new cars and crash repairers are not in short supply. My decision to re-build a house or buy a replacement car does not deprive you of access to those same products and services.

There are some products and services related to health care in plentiful supply. Upgrades to private rooms in hospitals and gymnasium membership are examples of services where private insurance could continue to function. But, because these services are discretionary and reasonably low cost, it is unlikely many people would see a need to use insurance to pay for them.

It is important to put these questions to the public, for they have not been visited for a long time. When countries developed universal health care systems in postwar years (Australia was a late starter in 1975) incomes and wealth were lower, therapeutic choices were fewer, interventions which we now consider as basic were very expensive, and life expectancies were lower. To a postwar reformist government a universal free system was seen to be the obvious public policy solution (against strong opposing forces). But most Australians are now much more prosperous in terms of income and wealth, there is a greater acceptance of market systems generally, and we are more aware of the extent of control we have over our own health and therefore the amount of choice that is left in our hands.

If we do not re-address these questions, at their most basic level, the remnants of our free services will continue to be eroded in a piecemeal way, with clumsy, high-cost and inequitable interventions such as subsidies for private insurance, arbitrary safety nets, and inconsistent and inequitable co-payments. When some services are free at the point of

delivery and others, often of greater effectiveness, have to be paid for, there will inevitably be waste and inequity. Free services involve rationing by bureaucratic intervention and queuing, both of which are politically costly and ultimately threaten the viability of those services. It is surely better to have rational and affordable prices built into our arrangements than to have governments responding to funding problems through ill-considered and haphazard cost-shifting.

Putting these questions requires a government (and an opposition aspiring to government) to refrain from the temptation to put up highly specific proposals for reform. And they require us to re-shape the way we think about our choices. In a process of ongoing deception (or perhaps just lazy thinking), governments have led us to believe that the choice to be made is between the private and public sectors, and that the only way the private sector can survive is through private insurance. The fact that 40 percent of Australians have private insurance is taken as an indication of its popularity, but this argument is specious, for Australians have had to be bludgeoned into taking private insurance. (It's akin to saying that if people are paying money to an extortionist they must like the extortionist.) The case for a single national insurer is clear; the more basic question is the extent to which we want our services covered by insurance.

**The case for a single national insurer is clear; the more basic question is the extent to which we want our services covered by insurance.**

## Coherence in program design

At present, reflecting the legacy of past practices, programs are designed around service provision and funding channels – medical, hospital and pharmaceutical services being the main divisions.

This is an ancient structure, based on inputs to health care. Rhetorically, governments have abandoned input-based funding, but in health care it has been sustained without question. Add the complexity of Commonwealth/state divisions, and it is clear how the arrangements have become so user-unfriendly. Even simple cases, such as a minor sports injury, can require a user to access to a large number of different programs.

A more integrated system would have programs designed around classifications of users, perhaps by age (given the strong link between age and use of health care services), or by types of service (chronic, acute, occasional), or by region. Whatever primary categorisation is chosen, it will be sub-optimal from certain perspectives; there is no perfect organisational structure.

When people are asked about priorities there is often a confusion of categorisation. Some call for attention to remote or outer-suburban users (geographical categorisation); some call for particular attention to those with chronic needs (categorisation by condition); some call for resources to be directed to indigenous people (categorisation by ethnicity), or the poor (categorisation by means), or the old or young (categorisation by age). In community consultations there needs to be serious explanation of the pros and cons of different arrangements, and an explanation of the risks if programs are designed around overlapping and inconsistent categorisations.

Governments will always be tempted to be seen to be plying largesse on particular groups, but each such special program adds to bureaucratic complexity and creates problems for users whose conditions do not coincide with program boundaries. Does a young person with a mental health condition use a mental health program or a youth program, for

***Aged-care services***

The other clumsy Commonwealth/state demarcation in present health policies relates to aged-care services, particularly residential care. Ability for delivery of health services is to pass to joint Commonwealth/state bodies, it makes sense for the health care component of aged care similarly to pass to these bodies.

In high level care separation of health and residential services is difficult, but it should be possible for the Commonwealth and states to come to an accounting arrangement whereby the Commonwealth would continue to fund the residential component of nursing homes.

example? Furthermore, proliferation of special programs is not compatible with needs-based allocation.

One solution to this problem is a two-stage geographic allocation. Prime administrative responsibility could lie at the state level, and within the states health services should be regionalised.

The Commonwealth should retain responsibility for collection of revenue and its distribution to the states, according to demographic factors reflecting needs. It should retain responsibility for research, setting standards for services, setting standards for user records, performance monitoring, and negotiating prices with

service providers with strong market power, particularly pharmaceutical firms (as it does now). Standard-setting and monitoring should cover not only clinical effectiveness and safety, but also equity. The Commonwealth should also use its powers under competition policy to remove costly protections for pharmacists and medical specialists.

In each state there should be a body responsible for health care program administration and distribution of funds, under joint Commonwealth/state control. This structure is deliberately conservative; it would be hard for any government to change the ground rules, which would make it possible for the system to become more embedded and less subject to ideological whims. Because there would be only one channel of funding for these bodies they would have no incentive for cost-shifting, and they would be responsible for integrating services in their respective states.

Within states there needs to be regionalisation of services, with funds delivered along needs-based demographic lines, and with local advisory bodies providing advice and feedback. State and local regionalisation formulae would have to allow for re-balancing to account for regions with unforeseen needs and for services provided to people out of their own region.

The only compelling case for special services outside such a model is for services for indigenous people, particularly those living in remote regions. Their needs are high and often of a different nature to those of people living in more settled areas, and their settlement patterns do not fit neatly into a regional structure.

**Public or private - not a core question**

The question of “public” or “private” health has been a distracting one, weighed down with emotive ideological content.

While the provision of insurance is a government function, the private/public division of service provision is not a particularly important issue, as long as all Australians have access to the same services. Public agencies can provide free or charged services. Private

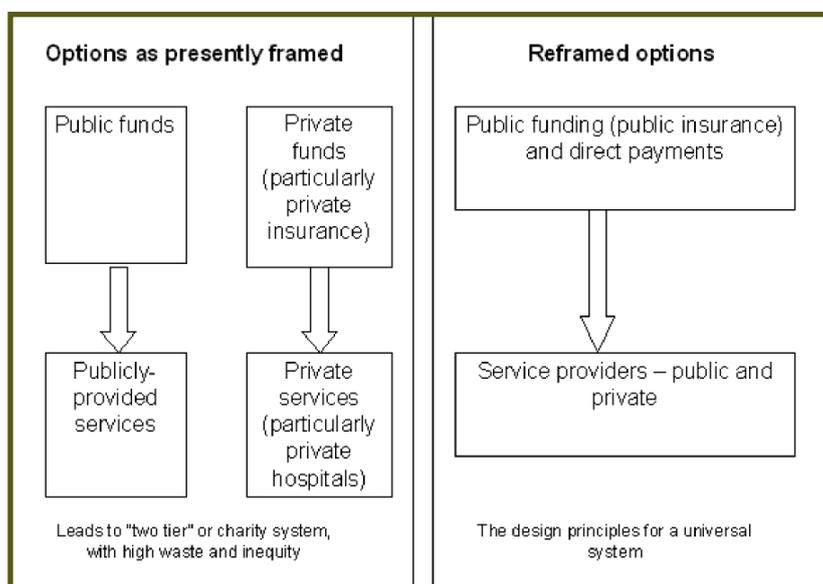
**The case for a single national insurer is clear; the more basic question is the extent to which we want our services covered by insurance.**

firms, on contract to governments, can provide free services. Public ownership, in itself, does not ensure that corporate behaviour will be any different from what happens in privately-owned firms (Medibank Private is a case in point). Technical questions of ownership and governance can be answered once more basic policy principles are resolved.

What is needed is a reframing of the way health care is funded and provided – that we stop thinking of a “public/private” division but instead see funding and provision as separate policy questions.

In particular, there need be no practical distinction between private and public hospitals. Both could receive funding on the same basis, and would become truly competitive with each other. The only difference for private hospitals is that their funding would be similar to that provided to public hospitals (on a “Diagnosis Related Group” basis, which pays a set fee depending on the user’s condition, thus avoiding any incentive to “cherry pick” highly profitable services), and they would be expected to provide medical services within that funding. They would be part of a truly universal system, abolishing the present absurdity of private hospital users having separate contracts for “hospital” and “medical” services.

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## Primary care as the focus of delivery

The practical mechanism of a re-designed health care system should be program delivery through primary care health centres.

These should be large enough to justify the provision of a range of services – medical practitioners, physiotherapists, psychologists, pharmacists, dentists, occupational therapists, and other health professionals. They would provide some of the day care services and home care services presently provided by hospitals. They would be the first port of call for all services other than those emergencies which clearly require hospitalisation. In all regions there would be one or more centres large enough to justify 24 hour operation. These centres would form the gateways to other specialist services – a function presently carried out by GPs – drawing on the expertise of teams of health professionals.

There is a partial precedent for this model in the health centres set up by the Commonwealth in the 1970s, but those were largely confined to poorer regions (particularly in Victoria), and came to be seen as an extension of the social welfare system. They also became embroiled in intense battles concerning salaried versus fee-for service medicine, and in ideological conflicts over “private” or “public” medicine.

By and large, these health centres would be stand-alone businesses. The question of ownership would be resolved on a case-by-case basis. There are many possible ownership models – cooperatives, employee-equity, public ownership (including local government), private businesses. The only necessary condition is that ownership by large publicly listed corporations be prohibited. (There is a precedent at present in the regulation of pharmacy ownership, but this as too limiting a model for health care centres.)

The centres should be truly universal. Their density may be greater in poorer regions, but this would be due to greater needs and transport disadvantages dictating a lower catchment population, rather than any notion that they are a ‘poor person’s service’.

The question of fee-for-service versus salaried service is not easily settled. Each system has its vehement defenders and detractors; in reality each has its virtues and drawbacks. There is no reason why a health centre could not provide both types of contract. Whatever the internal remuneration practices, the health centres would receive payment from the responsible Commonwealth/state body on the basis of the services rendered to the user (similar to rolling together the PBS and Medicare schedules).

Outside the health centres primary care services would continue to be provided. Some specialised services would require a catchment population much larger than those appropriate for a general primary care centre. And some medical practitioners and others would continue to operate in small practices. They would still receive the same payments as the health centres, but over time the professional and financial attraction of working in larger, more integrated practices would have its appeal.

And this is not to neglect hospitals and other residential services, such as aged-care services, respite services and palliative care services. We would expect the pressure on hospitals to ease for five reasons:

- » health centres would provide many services presently provided by hospitals, particularly minor accident and emergency services;
- » bureaucratic reform would be a prime function of the Commonwealth/state bodies responsible for program delivery and funding. Reducing layers of administration, improving information systems, and making better use of professional workers all leads to greater efficiency;
- » because private hospitals would be operating on the same basis as public hospitals they would not be drawing away scarce resources for procedures with little therapeutic benefit;
- » most of what are currently known as hospital “outpatient” services, such as rehabilitation, would be carried out by health centres;
- » early intervention in primary care, and an overall focus of health policy on wellbeing, rather than simply on program delivery, should ease some pressure throughout the system.

## IS IT ALL TOO HARD? NOT REALLY...

This paper proposes a radical change in our health care arrangements. Is it all too hard? Is it politically attractive? Or are we locked into an ongoing process of muddling through, with more and more layers of incremental change?

Thirty years ago it was accepted wisdom that Australia would never abandon tariff protection. Yet we did, and the impetus came from a Labor Government, traditionally the party of protection. That decision had little political cost for Labor. More recently, a Coalition Government fundamentally overhauled our rickety sales tax system, changing state funding arrangements in the process, without any apparent electoral cost.

Health care reform should be far easier than these changes. For a start, we do not have the problem of institutional inertia that has made health care reform almost impossible in the USA. And, unlike the changes in industry policy, no person or firm providing health care services need fear becoming unemployed or going out of business. That is not to say the transition would be painless: significant reform could see many administrators, in both the public and private sectors, left without a role.

Perhaps the most politically appealing aspects of this proposal are the establishment of integrated services in health centres, the simplification of co-payments, and the money people will save when they realise that they do not need to hold private insurance to be assured of high quality service.

These reforms require goodwill in relations between the Commonwealth and states. Unless there is a rare alignment of political vision between all governments, it is hard to see them being achieved in one move. But it should be possible for reform to commence with an agreement between the Commonwealth and at least one state. In fact, there would be merit in a trial before other states come on board.

Most importantly, there is no need for a trade-off between equity and efficiency. Our current set of arrangements (it would be preposterous to call it a “system”) fails on both grounds. Policy-makers can have it both ways, and make some budgetary savings as well. For example, if the Commonwealth were to subsidise private hospitals directly, rather than passing its support through private insurers, it could save \$2.7 billion a year while still paying private hospitals \$1.2 billion, which is the amount they presently receive through the private insurance subsidies. This would free up nine percent of the Commonwealth health care budget while improving equity in health care. Many commentators have suggested that at least a twenty percent improvement in hospital efficiency is achievable. Even a ten percent improvement would result in a saving of \$2.0 billion a year.

Therefore, there is no need for any immediate extension of public funding. Of course health care needs will continue to grow, but with improved system design it will be possible to contain expenditure growth to a lower level than under present policies.

CPD authors will present some alternative models to stimulate thinking – just as an architect may present a series of sketches of alternative ways to realise a client’s brief, particularly when a client is thinking in a way excessively constrained by past experience. To this end we invite readers to submit their own sketches and designs.

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PUBLISHED BY THE CENTRE FOR POLICY DEVELOPMENT, MAY 2007  
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