HEALTH CARE IN AUSTRALIA: LESSONS FROM DOWN UNDER

by Stuart Altman and Terri Jackson

Prologue: Australia's approach to the financing of health Care, as in most industrialized nations, rests on an important but ever-changing dynamic between the public and private sectors. While publicly financed Care dominates, the ready availability of private insurance provides a counterpoint that compels the government to be accountable for its policy actions. As authors Stuart Altman and Terri Jackson underscore in this paper, government must demonstrate in its efforts to restrict spending for health services that it is not imposing excessive restrictions on access to Care. Australia, given its geographic distance from the United States, is not a country to which close attention has been paid on these matters. But its health care reform story is a fascinating one, given that it has reflected changing opinions about what its system should ultimately be. Altman, an American economist, and Jackson, a doctoral student, teamed up to provide a glimpse of reform developments Down Under. Politically, both Australia and the United States have strong private physician communities and private health insurance lobbies, and federal and state government interests that often conflict. Within this framework, Australia has managed to construct a publicly financed health insurance system with a privately financed alternative. Altman is dean of the Florence Heller Graduate School for Advanced Studies in Social Welfare at Brandeis University. He studied the Australian system during several extended visits to that country. Altman has been an active player on the U.S. national health policy stage for two decades. He was an architect of the Republican Nixon administration's national health insurance proposal, which featured a requirement that employers provide their workers financial protection against illness, an approach that now resonates with Democrats. Jackson, an Australian resident, is currently a Pew Charitable Trusts Scholar at Brandeis working on a doctoral degree.
As the United States grapples with its twin problems of growing inequities in access to health services and an uncontrolled rate of growth in health care spending, comparisons with health systems developed by other industrialized countries serve two purposes. They give a snapshot of how the U.S. system compares with others, and they permit analysis of policy strategies that might work in the United States.

This article makes the case that, as does Canada, Australia provides a useful point of comparison for U.S. health policymakers. The three nations share common historical links to Great Britain, similar standards of living and economic development, and high standards of medical and hospital care. Australia and the United States both have long histories of private health insurance. The medical profession in both countries is well organized and politically influential; this results in a health policy arena that is highly visible and politically contentious.

In contrast to Canada, Australia’s health financing reforms have had to accommodate powerful private hospital and health insurance industries. Further, Canada’s reforms had the benefit of a decade to settle in before the worldwide escalation of health expenditures in the mid-1970s and 1980s while Australia has been forced to wrestle with the difficulties of reorganizing financing arrangements and extending access in the face of political concerns about rising costs of health care.

The major political parties in Australia differ on the appropriate roles of the public and private sectors in health care, but both parties accept a need for balance. Maintaining this balance has proved difficult without creating perverse outcomes in other areas of the health system, in nonhealth government expenditure, or in the economy as a whole. Nevertheless, the system appears to be working, and U.S. policymakers could learn from the decisions made to maintain this balance.

Some Comparisons

In 1989, Australia spent 7 percent of its gross domestic product (GDP) on health, in contrast to the U.S. figure of 11.8 percent. What is more, over the past fifteen years, relative health spending in Australia has remained fairly stable at its current level, while the U.S. rate has steadily increased. Exhibit 1 shows the divergence in these expenditure patterns in selected countries. Some of this difference is explained by the faster growth of Australia’s GDP, which in turn has allowed for larger increases in absolute expenditure. But Australia still spends less than half the U.S. per capita amount on health services. Compared on the basis of purchasing power parities (PPPs), Australia’s per capita expenditure in 1989 was $1,032, and that of the United States, $2,354. Exhibit 2 compares the
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Exhibit 1
Health Expenditures As A Percentage Of Gross Domestic Product, Selected Countries, 1970-1989

<table>
<thead>
<tr>
<th>Year</th>
<th>United States</th>
<th>Canada</th>
<th>Germany</th>
<th>United Kingdom</th>
<th>Australia</th>
</tr>
</thead>
<tbody>
<tr>
<td>1970</td>
<td>7.4%</td>
<td>7.2%</td>
<td>5.9%</td>
<td>4.5%</td>
<td>4.9%</td>
</tr>
<tr>
<td>1975</td>
<td>8.4</td>
<td>7.4</td>
<td>8.2</td>
<td>5.5</td>
<td>5.5</td>
</tr>
<tr>
<td>1980</td>
<td>9.3</td>
<td>7.4</td>
<td>8.5</td>
<td>5.8</td>
<td>6.5</td>
</tr>
<tr>
<td>1985</td>
<td>10.6</td>
<td>8.5</td>
<td>8.4</td>
<td>6.0</td>
<td>7.0</td>
</tr>
<tr>
<td>1986</td>
<td>10.8</td>
<td>8.8</td>
<td>8.5</td>
<td>6.0</td>
<td>7.0</td>
</tr>
<tr>
<td>1987</td>
<td>11.1</td>
<td>8.7</td>
<td>8.6</td>
<td>5.9</td>
<td>7.1</td>
</tr>
<tr>
<td>1988</td>
<td>11.3</td>
<td>8.6</td>
<td>8.9</td>
<td>5.9</td>
<td>6.9</td>
</tr>
<tr>
<td>1989</td>
<td>11.8</td>
<td>8.7</td>
<td>8.2</td>
<td>5.8</td>
<td>7.0</td>
</tr>
</tbody>
</table>


Comparison of mortality and utilization measures for the two countries' allocation of health dollars.

Comparison of mortality and utilization measures for the two countries belies the conclusion that Australians are content with a cheaper but inferior system. Life expectancy at birth is similar. In 1985, Australian males could expect to live 72.3 years, and their American counterparts, 70.8 years. Australian women had a' life expectancy of 78.8 years, and American women, 78.2 years.' Over recent years, infant mortality as a

Exhibit 2
National Health Expenditures, Proportion By Object Of Expenditure, Australia And United States, 1986

<table>
<thead>
<tr>
<th></th>
<th>Australia</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Percent</td>
</tr>
<tr>
<td>Hospital care</td>
<td>$ 6.79</td>
<td>44.7%</td>
</tr>
<tr>
<td>Physician care</td>
<td>2.69</td>
<td>17.7</td>
</tr>
<tr>
<td>Dental care</td>
<td>0.73</td>
<td>4.8</td>
</tr>
<tr>
<td>Other professional services</td>
<td>0.53</td>
<td>3.5</td>
</tr>
<tr>
<td>Drugs and sundries</td>
<td>1.18</td>
<td>7.8</td>
</tr>
<tr>
<td>Eyeglasses and appliances</td>
<td>0.26</td>
<td>1.7</td>
</tr>
<tr>
<td>Nursing home care</td>
<td>1.36</td>
<td>9.0</td>
</tr>
<tr>
<td>Other health services</td>
<td>0.37</td>
<td>2.4</td>
</tr>
<tr>
<td>Administration and insurance</td>
<td>0.54</td>
<td>3.6</td>
</tr>
<tr>
<td>Public health activities</td>
<td>0.54</td>
<td>3.6</td>
</tr>
<tr>
<td>Medical research</td>
<td>0.19</td>
<td>1.3</td>
</tr>
<tr>
<td>Total</td>
<td>$15.18</td>
<td>100.1%</td>
</tr>
</tbody>
</table>


Note: These comparisons have some limitations because of differences in concepts and definitions.

\(^a\) Millions of Australian dollars.

\(^b\) Millions of U.S. dollars.
percentage of live births has hovered around 1 percent in both countries.\(^5\)

Health services measures are also comparable, with Australia recording slightly higher levels of service provision despite the system’s lower cost. For example, in 1986, Australia supported 5.1 acute hospital beds per thousand population, compared with 4.1 in the United States.\(^6\) Australians received 1.35 bed days of hospital care per capita in 1985-1986, while Americans received 0.95 bed days of care per capita.\(^7\) This reflects the slightly longer average length-of-stay in Australia (in 1986, 6.6 days, versus 6.5 in the United States) as well as a higher hospitalization rate in Australia (in 1985, 205 discharges per thousand population, compared with 148 for the United States).\(^8\) Interestingly, while the hospitalization rate is higher in Australia, one of the most visible political issues there is the growing waiting lists for nonemergency hospitalizations. Another political concern about the Australian health system is the slowed growth in the introduction of expensive medical technology.\(^9\)

Differences between the two health systems are apparent in the degree of specialization of the medical work force and in patterns of medical care. For example, general medical practitioners made up 72.5 percent of the Australian physician work force in 1986, but only 11.9 percent in the United States.\(^10\) Australia has fewer physicians per 100,000 population (186) than the United States (217).\(^11\) Nevertheless, Australians have more physician contacts per person per year than Americans have (6.4 compared with 4.6), no doubt attributable in part to the wider access afforded by Australia’s health system.\(^12\) Surgical rates show no consistent patterns between the two countries. U.S. physicians perform more tonsillectomies, hysterectomies, lens procedures, cholecystectomies, and coronary artery bypass operations, while Australian physicians perform more appendectomies, mastectomies, and exploratory laparotomies.\(^13\)

One striking difference in the two countries is physicians’ level of remuneration. In 1987, Australian physicians earned less than one-third (31 percent) the annual amount earned by their American counterparts, down from 41 percent in 1983.\(^14\) Compared with average earnings in each of the two countries, physicians in Australia earn 2.2 times the average salary rate, while U.S. physicians earn 5.4 times the average salary.\(^15\) These differences are partly explained by the smaller proportion of specialists in the Australian system, but they also reflect the price control system (“rebate schedule”) for medical services in place since the early 1970s.

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**Medibank To Medicare**

A widespread impression of Australia’s health care system is that it changes every fifteen minutes. This impression derives from Australia’s
politically turbulent 1970s and its parliamentary system, which combines both legislative and executive authority in the governing party and allows political actors more latitude to enact legislative programs with fewer of the checks and balances of a congressional system such as in the United States. Nevertheless, it appears that both major parties support the basic structure of the Australian health system, although this support has not been tested by a change in leadership at the federal level since 1983.

**Political background.** The major parties in Australia are the Labor party, with historic roots in the trade union movement, and the Liberal party, which is the main conservative party. A government formed by a coalition of the Liberal party and the smaller Country party held office at the federal level from 1949 until 1972. Labor’s election victory in late 1972 led to the establishment of Medibank, a compulsory and universal health insurance system many of whose features are incorporated in the current Medicare system. Opposed by the organized medical professions and by non-Labor state governments, full implementation of the program in all states was delayed until October 1975, when the last state signed a Medibank agreement to accept the carrot of fifty-fifty hospital cost sharing with the federal government. In December of the same year, Labor was defeated by the Liberal/Country coalition. In the election campaign, the leader of the Liberal party promised to maintain the popular new Medibank system, despite his party’s former opposition. The promise lasted less than a year, with changes in October 1976 heralding a series of policy changes that had effectively dismantled Medibank by the time Labor again won office in 1983.

**Medibank revisions.** The major modifications to Medibank were designated as Medibank II, III, and so on, but while the program retained the original name, it came to look quite different with each of the conservative government’s revisions. These changes both supported the ideological views of the government in power and formed part of its macroeconomic strategy. Changes were justified in terms of freedom of choice (of private insurance as an alternative to Medibank) and of reintroducing markets into health care. They also had the added value for the Liberal government of moving health care spending off budget. Over the eight-year term of the conservative coalition parties, the patient copayment was increased, first to 25 percent of the government-mandated “schedule fee” for each item of service, and later to 60 percent, with a ceiling of twenty dollars per item. After September 1981, free admission to public hospitals was again restricted to pensioners and welfare beneficiaries, with federal funding penalties for states that failed to reach commonwealth revenue targets because they maintained universal access to free hospital care. In the same set of changes, government
subsidies for medical and hospital charges were made available to members of private health insurance funds. Over these eight years, the role of private insurance changed from providing only supplemental coverage, to serving as an alternative to the public system, to functioning as sole agents for the administration of government health care subsidies. It is important to understand that, unlike in the United States, only a very small proportion of private insurance in Australia comes through employment. For the most part, individuals and families purchase their own private insurance with after-tax income and varying degrees of government subsidy, which are generally much lower than in the United States.

A prominent issue in the 1983 election was the government’s frequent changes to the health insurance system. Labor promised to restore the essential features of Medibank I, changing its name to Medicate to avoid confusion with the later Liberal versions of Medibank. On coming to office, the new Labor government began reconstructing Medibank/Medicare, which was officially introduced in February 1984.

Medicare today. Medicare provides universal, income tax-financed health insurance coverage for both inpatient and ambulatory care. Medicare is partly financed by a 1.25 percent federal income tax, the “Medicare levy,” which goes mostly to pay for physician services. In addition, hospital expenses are paid for separately by the states and financed from various federal and state revenue sources.

Through Medicate, patients are entitled to free care in public hospitals (similar to U.S. not-for-profit hospitals), in community centers, and from those private physicians who accept assignment of benefits for nonhospital outpatient care. For primary care, most physicians in a community participate in the Medicare program. For outpatient specialist care and inpatient physician services, a Medicare patient must accept treatment by a salaried physician or one assigned by the hospital.

Australians who purchase supplemental health insurance are entitled to care in private hospitals where patients have a choice of physicians. They are charged a fee to cover the full cost of the hospitalization. (Until 1986, private hospitals received a subsidy from the state for a portion of their expenses.) Private patients also can be admitted to a public hospital and can select their own physician. Their insurance can cover the cost of a private room, and they, or their insurance funds, are liable for physician charges in excess of the Medicare fee level. For private patients in public hospitals, an extra bed-day accommodation fee is charged.

Private health insurance. Premiums for private health insurance are set at individual and family (double the individual) rates. They vary in cost depending on the kinds of additional benefits included (for example, private room, dental, and chiropractic). Insurers are prohibited from
offering differential premiums based on health status or claims experience (no experience rating). Premiums are taxed as a fringe benefit when paid by employers. Thus, there is no artificial incentive for employers or employees to include health insurance as part of an employment package, and very few employers offer this benefit. What is surprising from an American perspective is that there appear to be no discounts for the efficiency of group purchases.

The percentage of the population who take out private coverage varied widely through the 1970s, as benefits available under Medibank were altered from year to year. With the introduction of Medicare in 1984, the proportion of the population subscribing to private supplemental insurance dropped sharply from 65 percent to about 45 percent today. Most supplemental insurance is sold by Blue Cross-type organizations based in each state, but some commercial plans have been approved by the federal government as registered medical benefits organizations, and the government markets its own supplemental insurance plan, Medibank Private.

The Hospital Sector

One notable difference between the Australian and U.S. health systems is the role played by public hospitals. In contrast to the United States, Australian public hospitals are major providers of care across class and income categories. They play a role similar to that of the U.S. not-for-profit hospital and accounted for over 75 percent of bed days in Australian acute care hospitals in 1986. Public hospitals in Australia are the major teaching institutions and research centers of excellence.

Public hospitals are most often incorporated as charitable, nonprofit organizations, run by a lay board of management. One state, New South Wales, has instituted area boards, which have responsibility for public hospitals, community health centers, and other public health facilities within a geographical area. Although appointments to these boards are increasingly under state government control, the nominal independence of the boards (subject only to the little-used sanction of dismissal by the Minister for Health) creates for each hospital a power base independent of the state government. As budget pressures have increased, boards and administrators have become more actively involved in the political process surrounding the setting of budgets and in using the media to garner public support for their negotiating positions.

Public hospitals are a responsibility of state government and funded by grants from the federal government, state government tax revenues, and fees from privately insured patients. In better times, a hospital’s budget was based on historical costs, increased for inflation and for any expansion
or improvement in services approved by the state. More recently, however, state governments have faced unilateral reductions in federal funding and in turn have placed greater cost-control pressures on hospitals and area boards. These fiscal pressures have resulted in the desire by public hospitals to expand their private patient base. The total size of each hospital’s budget, however, is controlled by the state, and increases in revenue from private patients often result in reductions in state revenues for public patients. Therefore, the potential growth in private patients is kept in check. If budget tightening continues, states could be forced to let public hospitals keep more of the increased revenues from private patients. This could set up a scenario whereby the number of public patients is further restricted (via increased waiting lists) and could promote the growth of two-class medicine.

Hospitals are encouraged to rationalize the use of expensive services such as neonatal intensive care beds through areawide coordination. Such expenditures require the approval of state health authorities, as is true of all capital funding for installation of major new medical technologies, construction of new public hospitals, and major renovations. Unlike in the United States, borrowing for major capital projects is done by the state and included in an overall state capital budget. The availability for capital expenditures in health care competes with capital expenditures for other public needs and is limited in its total size for each time period.

New South Wales, which includes Australia’s largest city, Sydney, has led the country in the use of restricted capital to force hospital role delineation and consequent rationalization of services. Victoria, Australia’s second most populous state, has pioneered the use of “health service agreements” with public hospitals. These make the amount hospitals receive conditional on their achieving specified levels of output, such as case-mix-adjusted discharges, and negotiated levels of certain elective surgical procedures for which there are waiting lists. Better collection of hospital data and the introduction of more sophisticated measures of hospital output such as diagnosis-related groups (DRGs) are expanding state health authorities’ ability to monitor cost containment.

States also regulate licenses for new private hospital beds, thus giving state health authorities some control over the location of new private beds and over total bed supply. But with the pressure to hold down government expenditures and the ready availability of private capital, beds in private hospitals have increased by 6.4 percent in the past four years, while beds in public hospitals have declined by almost 11 percent. The balance between the supply of public versus private beds is one of the key fulcrum points in the Australian system. A decline in the availability of private beds adds pressure on state governments to increase
public expenditures or face longer and longer waiting lists. A shift toward private beds increases the waiting time for Medicare patients and moves the system back toward its pre-1984 state. To maintain a balance between public and private beds, the 1988 commonwealth/state Medicare agreement includes provision for penalties in the hospital funding formula. These penalties apply to states that decrease the proportion of public hospital bed days below 53 percent (the national average is 55 percent) and/or increase the proportion of private inpatient medical services more than 2 percent faster than the national average. These penalties were designed in part to prevent states from shifting the costs of salaried hospital physician care onto the federal budget. The commonwealth subsidizes the fees of private physicians via Medicare, whereas the states pay the cost of salaried hospital physicians through the hospital budget.

The penalties also discourage states from creating a situation in which public beds are restricted and private beds expanded, thus forcing patients into purchasing private insurance to avoid long delays in receiving hospital care. If the coalition (conservative) parties regain control of the federal government, these provisions could be replaced with incentives to increase the supply of private beds.

### Physician Reimbursement

Except for a few salaried physicians (in public hospitals and community health centers), physicians are reimbursed by fee for service. The government-mandated medical fee schedule used by Medicare sets the upper limit for third-party reimbursement. Most physicians accept the scheduled rate, or close to it, even for private patients. Private insurance by law may not be sold to cover extra-billing above the “scheduled” fee. This prohibition makes any extra-billing very visible to the patient and reinforces Australian patients’ long-standing resentment of physicians who charge substantially above the government’s set fee.

The Medicare payment or rebate is calculated as a percentage of the scheduled fee: 75 percent for services in the hospital and 85 percent for out-of-hospital services. Benefits assigned directly to the physician (“bulk billing”) are paid by Medicare at these lower rates. As noted earlier, Medicare patients, at no additional cost, can avail themselves of services by those physicians who accept assignment. When physicians do not accept assignment, the patient (and/or insurer) must claim the rebate and be liable for the gap between the scheduled fee and the rebate. For out-of-hospital care, the rebate amount is adjusted so that the maximum gap payment for any item of service is twenty dollars, but there is no cap on in-hospital copayments for private patients. Supplemental insurance,
called “gap” insurance, is sold to cover these copayments, but again, coverage of extra-billing above the scheduled fee is prohibited.

A 1946 constitutional amendment to broaden the federal government's powers in the field of health (previously limited to quarantine and other public health measures) was adopted with an explicit prohibition on the "civil conscription" of physicians. This restriction on federal powers was intended to frustrate the governing Labor party's goal of establishing a national health service based on salaried rather than fee-for-service medical practice. The civil conscription provision bars the commonwealth government from restricting medical practice to salaried remuneration. Nevertheless, 23 percent of practicing physicians are employed on a salaried basis, primarily in public hospitals, community health centers, and school medical services. The civil conscription provision has also been interpreted as prohibiting the government from imposing a national fee schedule for all physicians. To preserve this independence, private physicians routinely charge above the government fee schedule, but in many cases the difference is very small, since private insurance cannot reimburse for fees above the government schedule.

The restriction on insurance coverage for extra-billing has led to growth in the number of physicians willing to accept assignment at government rates. The assignment or bulk-billing rate for physician services has risen steadily since Medicare's introduction, from 45.2 percent of services in 1984-1985 to 5.1 percent in 1986-1987. The rate of bulk billing is highest among general practitioners (60.2 percent of services) and lowest among specialists such as anesthesiologists (5.3 percent). Many physicians bulk bill in all cases, while others administer their own form of means test, accepting assignment only for recipients of government pensions or welfare benefits. When a physician does not bulk bill, the patient must claim the rebate (85 percent of scheduled fee, 75 percent for inpatient services) from Medicare, pay the gap out of pocket or from insurance, and pay any extra-billing out of pocket.

To qualify for the maximum reimbursement of the fees of a specialist in private practice, Medicare patients must get a documented referral from a general practitioner (GP). GPs make up the majority of the physician work force, and because of this two-tiered referral system, Australians tend to develop loyalty to a GP. Services provided by GPs represented 54.9 percent of all medical services in 1987, and when the on-referral diagnostic specialties of pathology and radiology are removed from the calculation, this rises to 73.7 percent of all medical services.

The fee schedule has always included a differential rate between specialists and GPs. Recently, an intermediate tier was added, which uses a crude relative-value/complexity scale for office visits, increasing the
relative reimbursement for services that entail the use of cognitive medical skills. Reimbursement on this new rate is restricted to members of the College of General Practice, who must undertake continuing education and submit to forms of peer review to maintain membership.

In contrast to physician reimbursement in some Canadian provinces, Australia has no mechanism for setting limits on the total volume of claims, and thus the system is vulnerable to upcoding of visits and procedures and the unbundling of a visit package into a number of procedural claims. The problem is addressed to some extent by the Health Insurance Commission’s Fraud and Overservicing Division. This unit screens claims data to identify high-end outliers, who are then subjected to further scrutiny, including clinical review. Most cases of suspected overservicing result in the physician’s being cautioned, but recalcitrant offenders face both revocation of license and criminal prosecution. This system does not address the subtler problem posed by the cost effects of more routine upcoding and unbundling that may define the standard nonoutliers, which the Canadian expenditure cap attempts to discourage.

Until recently, physician fees were set through the national system of wage arbitration courts, which govern labor relations in Australia. Before a judicial arbitrator, physician groups would present a case for increasing the fee schedule by a certain percentage. The government would make its case, invariably for a lower percentage increase. The arbitrator could make independent inquiries, and from this process, a fee determination was made, which was legally binding on both parties. These relatively civilized arrangements have broken down with continuing conflict between the commonwealth government and the Australian Medical Association (AMA). Medicare rebates and the fee schedule from which they are calculated are now set unilaterally by the commonwealth government. The AMA maintains its own recommended fee schedule, which physicians are free to follow for nonassigned payments.

Care of public patients in public hospitals is now performed by salaried or sessional physicians. Prior to Medibank/Medicare, such care was available on a means-tested basis in public hospitals and performed by “honorary” staff who served for no pay as a quid pro quo for admitting rights for their private patients. Resident physicians were paid a salary during their training and provided much of this free care.

Medibank originally aimed to remove the stigma of being a public patient by eliminating the means test for free care and by paying nonhospital-based private physicians a sessional rate for attending to hospital patients in both inpatient and outpatient clinic settings. These state payments to private physicians continue today under Medicare. The added incentive for a private physician to see Medicare patients in the
hospital is for the privilege of admitting their private patients to public hospitals. Physician services in outpatient clinics are also reimbursed by the hospital on a sessional basis. Thus, most specialists now derive income from sessional payments as well as from fee-for-service practice; only a very few maintain practices totally outside the public hospital system.

The Challenges Ahead

The health stories that hit the front pages and thus trouble governments in Australia deal with waiting lists and the high level of physician militancy. Both of these are attributable, to some extent, to strategies of cost containment pursued by state and commonwealth governments. It is charged that both governments have taken cost containment too far; that public hospitals are underfunded and consequently must ration care. Medicare’s supporters contend that by limiting the introduction of cost-increasing technologies and the availability of hospital beds, Australia has been able to avoid the excesses readily apparent in the U.S. system. They argue that some amount of restraint is necessary to allow the system to prospectively equate the benefits of added spending for health to the costs of forgone alternative spending. What is “rationing” to one side of this argument is “avoidance of waste and duplication” to the other.

Waiting lists for elective surgery in public hospitals are the most frequent targets of Medicare critics. Occupancy rates in private hospitals are considerably lower than those in public hospitals (62 percent, compared with 71 percent for public hospitals in 1985-1986). However, there has been a steady decline in subscribers to private insurance since Medicare’s introduction in 1984. With increasingly tight state budgets and excess capacity in the private hospital system, some policymakers are advocating the reintroduction of public subsidies for private insurance. Recent evidence suggests that as a result of government’s controls on the introduction of new diagnostic and treatment technologies, private hospitals with the ready availability of private capital are now adopting these technologies more quickly than the public sector. Over time, this development may change the respective roles of the two sectors, even with no changes in the incentives to take out private insurance.

But do waiting lists really signal a serious problem? A recent Australian Institute of Health report highlights the problems that arise from compilation of the lists by private physicians rather than by hospitals or state health authorities, with the high likelihood that patients would appear on more than one list. Physicians have broad discretion in determining which patients are put on the list and at what stage of their illness; this may allow the profession to tailor perceived waiting list crises to longer-
term political strategies. In Australia, the line is a fine one between a booking list for routine elective surgery and a waiting list.

A second difficulty arises from the pecuniary, in contrast to the political, interests of physicians who control waiting lists. A.J. Culyer argues from British experience that physician employment in both the public sessional sector and in the private fee-for-service sector is a crucial factor in the production of waiting lists in that country: “A combination of part-time salary in the NHS plus private practice provides a direct incentive to generate NHS waiting lists in order to bolster the demand for care in private beds.”

Australia’s system of employing most specialists in both the public sessional and private fee-for-service systems leaves it vulnerable to these same incentives.

The waiting list controversy illustrates the larger problem of introducing a public health insurance scheme in the face of sustained resistance by an organized and militant medical profession. Australia, and particularly New South Wales, has experienced a number of strikes and boycotts by medical specialists in the past decade. The 1985 New South Wales strike won increased sessional rates for physicians in public hospitals, restoration of wider private practice opportunities, and additional commonwealth funds for capital equipment in teaching hospitals. The latter concession was to reduce budgetary pressure on states and allow them to ease restrictions on capital equipment expenditures. The AMA was given a formal role in approving proposed state expenditure of these funds.

One of the costs of holding the lid on health expenditures in a publicly funded system is the heightened level of political conflict generated by health care financing issues. Yet despite the wide publicity given to the public hospital waiting list crisis and to physician dissatisfaction, a recent opinion poll found that 71 percent of Australians support Medicare.

Another source of controversy is debate on the balance in funding between the federal and state governments. The current Medicare Agreement includes penalties on states that seek to shift their obligations to provide public hospital inpatient treatment onto the private sector. Such shifting can occur either through states running down their public hospitals and encouraging increased use of private hospitals or through moving the cost of salaried inpatient medical services onto Medicare by encouraging use of public hospital beds by fee-paying private patients.

State health politics reflect the same ideological divisions as the federal level, but with the additional complication that states tailor their policy responses to cooperate with or frustrate the party in office at the federal level. Over the past fifteen years, states have developed more sophisticated mechanisms for planning bed supply across the public and private sectors, using borrowing controls on public hospitals and licensing con-
trols on private hospitals to achieve the politically desired balance. Faced with declining financial assistance from the federal government and heightened media criticism of public hospital strikes and waiting lists, health policy has become a major state political issue in recent years. Differences in philosophy and behavior between the federal government and state governments have been less of an issue in the United States but could accelerate if the United States were to adopt a more extensive public financing system, jointly funded by federal and state funds.

Lessons From Down Under

The feature that most distinguishes the Australian health system from the U.S. system is Australia’s large system of publicly funded hospitals that includes the premier-quality institutions in the country. While the public hospital system predates 1973, the use of various means tests to qualify for free care in such institutions or to receive free or heavily subsidized physician services left many Australians with limited protection prior to Medibank. Attempts by conservative governments to rectify this situation with the aid of subsidies for private health insurance protection, while of some help, still left big gaps in protection and an unhappy electorate. If the Australian experience is any guide, it suggests that U.S. proposals for a national health plan that focus entirely on market reform of private insurance and government subsidies for individuals to purchase private insurance will end up far short of the mark.

It is very unlikely that the United States will embrace a predominately public system such as Canada’s. Therefore, the more likely political outcome is an enlarged public sector coexisting with a sizable private sector. The Australian model in the U.S. context would come closest to making a modified form of a state-administered Medicaid program for hospital care and a federal Medicare plan for physician services available to all Americans. As in Australia, the term Medicaid would need to be changed to wipe out the welfare connotation. Private health insurance coverage would continue and would probably be used extensively, but with reduced amounts of government subsidy, such as elimination or reduction of the tax exemption for employer-sponsored plans.

The United States could modify the Australian model and make the system more private by adopting some of the Medibank changes. These might include greater restrictions on who can qualify for free care under the government plan, reduced freedom of choice of physician and hospital services under the government plan, and limits on government payments to hospitals and physicians. These limits on the publicly funded program could be combined with various subsidies for private coverage.
In Australia, these included more extensive tax exemption for the purchase of private insurance and a partial government hospital subsidy for all privately insured patients or for those with very large expenses.

One should remember, however, that the more restrictions placed on the public plan, the more the government plan begins to resemble a limited welfare program and not a national health insurance system. It is hard to imagine that such a system would receive wide support in the current U.S. political climate. Nevertheless, following Australia’s example, it is possible to construct an adequate governmentally financed health system coexisting with an extensive privately financed plan for those who wish to opt out of the public system.

Physician reimbursement is another arena in which the Australian government has sought to influence the mix of public and private financing and service delivery. The long-standing fee schedule pricing system has given public insurers (Medibank/Medicare) a tool to keep increases in medical incomes in line with wage increases in the rest of the work force. The prohibition on insurance for extra-billing has been an effective means of limiting physicians’ ability to break out of fee constraints by passing fee increases on to private patients and in turn to health insurance premiums. This has also prevented a bidding war between the public and private sectors in terms of which sector is able to provide better-quality (or at least higher-paid) medical care.

The current federal Labor government has also used the fee schedule to retain physicians in general practice and to counter some of the financial incentives to specialization. Through their control of funding to salaried physicians in community health centers and hospitals, both state and federal governments have expanded or contracted public-sector alternatives to private fee-for-service practice.

The cost containment strategies used in Australia are quite simple in comparison to those tried in the United States. Three mechanisms appear to dominate Australia’s cost containment strategy: (1) control of hospital budgets at the state level with the growing use of area authorities (restricted multiple payers); (2) control of capital expenditures, also at the state level, with tight controls on publicly financed capital and more limited restrictions on private expenditures; and (3) physician fee controls by the federal government with indirect limitations on extra-billing.

What is of particular interest to an outside observer is that while all three mechanisms appear to be effective, they permit more flexibility than do the tight restrictions imposed, for example, in Canada or suggested by some in the United States. In the case of Australian hospital revenues, while states approve the total budgets of public hospitals and control the flow of public funds, they do permit private patients in public hospitals
and at times allow some private patient revenues to supplement a hospital budget. Therefore, there is neither a strict single-payer system nor the existence of large numbers of payers and uncontrolled budgets.

A similar situation exists in controls on capital formation. While the flow of public funds is strictly controlled, private funds can be spent for both new facilities and equipment. Such private spending is indirectly limited through licensing regulations, but such restrictions have at times been less restrictive. Finally, physicians are permitted by law to extra-bill above the Medicare fee schedule, but an indirect restraint is imposed by not permitting insurance coverage for such extra-billing.

**Conclusion**

The Australian government has the legal mechanisms to restrict most spending for health services, particularly public spending, but because of the extensive amount of private insurance, there exist a number of supplements to limited public funds. What should be of special interest to the United States is when and how much the governments of Australia—federal and state—choose to use these private funds and the political ramifications of opening the system to more private use.

The existence of a large private delivery system and the ready availability of private insurance allow the government to cut back public expenditures knowing there is a broad-based safety valve for needed health services. But, the Australian government also knows that its own public system is being judged against the quality and success of the private system. If the government wishes to maintain a publicly financed system, which seems to have a broad base of support, it must demonstrate to the electorate that it can provide acceptable services without excessive restrictions. Such tension or competition does not exist to the same extent in countries such as Canada or the United Kingdom, which operate financing systems that are much more dependent on public funds. It is very likely that those same tensions would exist in any national health insurance system adopted in the United States, where a more balanced mix of public and private funds will almost surely prevail.

There clearly are major differences between the Australian and U.S. health financing and delivery systems; these differences are historical in origin and are not likely to be changed by any politically acceptable plan in either country. Nevertheless, Australia’s similarities to the United States in the size and importance of the private sector in health care financing and provision, and in the politics of broadening access during a time of political sensitivity to public-sector spending, make it a fruitful source for future U.S. health policy studies.
NOTES

2. Ibid., 113, Exhibit 5.
4. Ibid.
7. Mathers and Harvey, Hospital Utilization and Costs Study, 91, Table 5.5; and Census Bureau, Statistical Abstract, 103, Table 161.
8. Mathers and Harvey, Hospital Utilization and Costs Study, 134, Table 6.8; 97, Table 5.10; and Statistical Abstract, 103, Table 161.
11. Ibid., 136, Table 7.13; and Census Bureau, Statistical Abstract, 97, Table 149. Latest comparable data are for 1981.
13. Ibid., 118, Table E.8. Comparisons are for 1980. Rates are not adjusted to account for the age structures of the two populations.
15. OECD Secretariat, “Health Care Expenditure and Other Data,” 192, Table H.5.
17. Under a number of circumstances, these same benefits may be available to public patients. State governments occasionally contract with private hospitals to treat Medicare patients as a way of providing better geographical access for public patients, or to relieve waiting lists for particular procedures. In addition, public hospitals generally allocate private rooms to seriously ill patients whose conditions could not be satisfactorily treated in a shared ward. Medicare patients admitted by a specialist physician whom they have consulted in an outpatient department will most likely be treated by that same specialist when admitted as an inpatient.

19. Mathers and Harvey, Hospital Utilization and Costs Study, 87, Table 5.1.


22. The fee schedule is organized according to “items of service,” similar to the Current Procedural Terminology (CPT) schedule used for U.S. Medicare reimbursement.

23. Patients are also protected from catastrophic copayment burdens by a $150 (Australian) annual limit. Thus, when a patient has spent to this limit, he or she becomes eligible for 100 percent reimbursement of the scheduled fee, and the direct-billing rate for these patients increases to 100 percent.


25. Ibid., 122, Table 6.28 (using Health Insurance Commission data).

26. Ibid.

27. Ibid., 119, Table 6.25 (using Health Insurance Commission data).


30. Mathers and Harvey, Hospital Utilization and Costs Study, 87, Table 5.1.


