Australia’s Balance Between Public And Private Arrangements

by Andrew Podger

The paper by Alain Enthoven provides a very useful review of the potential benefit from greater use of market mechanisms in national health systems. The paper has relevance well beyond the United Kingdom, as many of us grapple with finding an appropriate balance between public and private arrangements. Enthoven’s focus has been on the use of the “internal market,” through such measures as the separation of purchasers and providers and competition among providers. This paper touches also on the potential for more use of what I might call the “external market,” with competition among purchasers and with consumer choice of both purchasers and providers, including the option to contribute financially to supplement taxation-based funding to gain additional benefits.

In considering such market options, it is important to reflect on the underlying reasons for government intervention in health. These include the social objective of ensuring that people can afford high-quality health services when they need them and the reliance we all have on providers and their expertise, particularly with constant developments in technology. Once governments are involved in health insurance, they must grapple with the moral hazard of all third-party payers, as consumers and providers have a shared interest in maximizing services they don’t have to pay for.

In Australia we have limited experience in the use of the internal market and greater experience than the United Kingdom in the use of the external market. Our arrangements are complex, and one would have to be cautious in drawing conclusions from our evidence.

Some Australian states have moved to more formally separate purchasing from providing public patients’ hospital care. Where this has occurred, there is evidence of considerable efficiency gains, particularly through increasingly sophisticated use of output- or case-mix-based purchasing. Victoria, for example, has greatly increased the efficiency of its hospitals by introducing case-mix-based funding, far more so than most other states have. The application of competition among hospitals for public patients has been more limited, with considerable political difficulties in handling any hospital closures that arise (particularly in rural areas). The federal Veterans’ Affairs Department has, however, privatized or transferred to the states all of its former repatriation hospitals and in its new purchasing role has used competition extensively to improve efficiency and service quality.

However, Australia has not experimented with fundholding in the way that Britain has. Acute care financing remains almost entirely separate from primary care financing. But we are experimenting with reward sharing for appropriate use of medicines and of diagnostic services, and with pooling funds across the different streams of care for groups of chronically ill patients.

So far as the external market is concerned, we are second only to the United States among all Organization for Economic Cooperation and Development (OECD) countries in our share of private funding for health. We have a substantial private health insurance market that offers greater choice and amenity for hospital care, including earlier access to elective services. But competition among private providers, and among private purchasers, has only recently shown signs of delivering significant efficiencies. Private health insurers are now putting more pressure on hospitals through competitive bidding (although the use of case-mix adjustment is still by no means universal), and they are beginning to address issues of health service quality and not just compete on the basis of price and secondary issues such as ancillary services.

The limited gains to date from this compe-
tition are the result of a number of factors, including the protection afforded by “community-rating” regulations that require funds to charge common premiums regardless of age or risk (reinsurance arrangements result in the efficient funds’ cross-subsidizing the inefficient), and the political pressures against private hospital closures (funds, for example, must pay a default benefit to members for services in any private hospital, even if there is no contract with the fund). Possibly more important is the power of the medical profession, which has resisted entering into contracts with private hospitals or funds; doctors charge patients over and above what Medicare and the private insurer will cover, with this “gap” undermining the value of the insurance protection supposedly on offer.

Notwithstanding these limitations, we are moving to strengthen the role of private health insurance and to improve the operation of the market. The Australian Competition and Consumer Commission has authority to act against anticompetitive behavior, including by professions such as medicine and law. Changes to regulation of private health insurance, such as the introduction of unfunded lifetime community rating, will reduce the protective impact of the previous legislation. There is also evidence of funds’ addressing the problem of “gaps” and offering more comprehensive insurance products.

Finally, there is the federal government’s new 30 percent rebate on premiums. Although this has been criticized by some as unnecessary assistance to industry, the government sees it as critical to stopping the steady fall in private insurance membership since the introduction of Medicare. Indeed, it may be seen as a move toward the opt-out model Enthoven mentions at the end of his paper, which also allows individuals to top up their national health insurance (a similar proposal has been made in Australia by Dick Scotton). This rebate means that those with private coverage now effectively receive a significant proportion of the risk-related premium subsidy they would otherwise have received if they relied fully on Medicare. There are signs of fund membership stabilizing, and possibly increasing a little, notwithstanding universal access to high-quality services under Medicare. It is too early, however, to predict exactly how the public/private balance will evolve in the Australian health system.

Our arrangements are complex, and the market competition might not yet be delivering all of the efficiencies potentially available because of the underlying problems of market failure and moral hazard. Most importantly, though, they are attracting into the overall health system more dollars than the electorate is likely to accept through taxes alone. The reduced pressure on public choice and public rationing is important, as an increasingly wealthy and well-informed community challenges the inevitable limitations of a fully publicly funded system.

I conclude by posing a few questions about where, in Enthoven’s view, the market is going in the United Kingdom: (1) are PCGs moving away from being regional monopolies, to competing with each other (or with other intermediaries)? (2) Does the blurring of the role of these groups between purchasing and providing (that is, enhanced vertical integration) lead to serious conflicts of interest? (3) If PCGs merge, will they become more powerful than health authorities, and how are each of these evolving?

Andrew Podger attended the seminar to discuss Alain Enthoven’s Rock Carling lecture. He describes the experience as follows: “I [was] very grateful for John Wyn Owen’s invitation to participate in this seminar. However, it [was] a bit surreal for me, sitting in a car in the Australian Goldrush town of Bendigo, late in the evening and in the dark.” Podger participated by cellular phone conference call.