What are we doing to ensure the sustainability of the health system?

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Executive summary

Health care expenditure has been steadily rising in Australia in recent decades, just as it has in many countries around the world. Increasingly, governments are becoming concerned about how this level of public spending will be sustained. Many are looking for ways to contain the growth in health care expenditure, or ‘bend the cost curve’.

Burgeoning health expenditure is a difficult problem to solve because there are a myriad of factors driving up health costs, and most of them are rooted deeply in a complex health system where much of what happens is beyond the reach of government. Simple technical solutions such as imposing tighter constraints on government spending, or using monetary incentives to change health professionals’ or consumers’ behaviour are unlikely to work on their own because they do not grapple with important political dimensions of the problem. Governments, for example, need to find ways of slowing the growth in health care expenditure without adversely affecting health outcomes, particularly for people who are already in poor health. Governments also need to affect change on the ground where health care services are delivered. This can be difficult because many health care providers operate in the private sector beyond the direct control of governments.

Despite the challenges, most governments use a range of policy tools to help control the growth in health care expenditure. This paper identifies some of the main ones used in Australia:

• deciding which health care interventions will be publicly funded;
• changing the way health care providers are paid;
• imposing costs on individuals;
• constraining the capacity of the health system; and
• encouraging competition.

The paper assesses how effectively each of these tools is being used in Australia, and it outlines some potential options for reform.

Key policy tools for containing health expenditure

Deciding which health care interventions will be publicly funded

One of the main tools governments use to control health expenditure is to ensure that public funds are used only to fund the most clinically effective and cost effective health care interventions. Formally, this process is known as Health Technology Assessment (HTA). Currently HTA processes in Australia operate within discrete sectors of the health system rather than across it. The assessment process for new drugs, for example, is completely separate from that for new medical procedures. Currently, most assessments are done on new technologies or interventions; existing ones, even if they are out-dated or ineffective, continue to be funded except in relatively rare circumstances.

To remedy these problems in HTA, policymakers could consider establishing a single HTA agency capable of systematically assessing the clinical effectiveness and cost-effectiveness of all types of
new and existing health care interventions. Under these arrangements, it should be possible to compare the effectiveness of different types of interventions for the same health conditions. Some consideration should also be given to implementing mechanisms to ‘de-fund’ or ‘disinvest’ from the least effective interventions.

**Changing the way health care providers are paid**

The way health care providers are paid also has an impact on health care expenditure. Some payment methods provide incentives to ‘over-service’, while others provide little incentive to deliver high quality care. Australia currently relies heavily on provider payment methods considered by the World Health Organisation to be the least effective ways of curbing expenditure growth: fee-for-service payments and activity-based funding (ABF) both provide strong incentives to increase the volume of care delivered and therefore overall expenditure.

To help contain health expenditure, policymakers could consider supplementing or combining fee-for-service and ABF methods with others that are better able to constrain expenditure growth (examples include fixed budgets and salaried employees). It will be important that these new methods are also accompanied by reforms that strengthen systems for monitoring performance so that they do not have a detrimental impact on the quality of care.

**Imposing more costs on individuals**

Many governments try to curb health care expenditure growth by imposing costs on individuals; these costs are commonly known as co-payments. Most countries are shifting away from using co-payments as a means of financing health care, but Australia continues to rely heavily on them. Even though Australia has a system of safety nets in place to protect people from excessively high out of pocket costs, evidence is now emerging that the cost of care is stopping some people from using necessary health services. Because this is neither equitable nor efficient, policymakers should consider undertaking a high-level review of Australia’s co-payment and safety net policies. As well as considering technical issues such as access, entitlements and benefit levels, this review should also canvass and debate alternative co-payment policy proposals.

**Constraining the capacity of the health system**

The overall capacity of the health system has a powerful influence on expenditure growth. Capacity is determined to a large degree by the number of health care facilities and the number of health workers practicing in the system. Reforms to the way health workers are trained and registered in Australia have recently been implemented, but it is too soon to assess their impact on expenditure growth. Australia’s health infrastructure decision-making processes, however, have received relatively little attention. There are currently multiple health infrastructure funding processes in operation, which makes it difficult, if not impossible, to monitor the impact of infrastructure funding decisions on health expenditure.

To help control health expenditure growth, governments could consider consolidating the various infrastructure decision-making processes in Australia and making them more transparent. To make further advances in the health workforce area, governments will need to continue to find new ways of working together on areas of shared responsibility.
Encouraging competition

Competition is a key driver of efficiency and innovation in many sectors of the economy but it is contentious in the health sector because there are so many areas of market failure. While competition does exist within the Australian health system, in many areas it is limited.

There are many potential options for encouraging competition in health care but past experiences here and overseas demonstrate that competition policies do not always deliver the anticipated benefits. To design and implement effective competition policies in health care, policymakers first must acknowledge the differences between health care and other markets.

Some options in medical services are to encourage greater role substitution (for example, using nurse practitioners or physicians’ assistants where appropriate). Another is to give the government a greater role in training medical specialists, and make the process more transparent.

Australia’s health insurance system should be considered as a priority for reform because it has an overarching influence on competition between providers and in service delivery. The key issue in health insurance is to resolve long-standing questions about the role of private insurance in the context of Medicare. A number of proposals for insurance reforms already exist, and include options such as: promoting managed competition between insurance funds, re-allocating existing public subsidies for private insurance to other areas such as to patients in the form of vouchers, private hospitals in the form of bed subsidies, or directly to public hospitals.

Introduction

Health care expenditure has been steadily rising in many countries around the world. In Australia, total expenditure on health care is now in excess of AUD120 billion a year, and in 2009-10 accounted for 9.4 per cent of Gross Domestic Product (GDP), up from 7.6 per cent in 1997.\(^1\) In the United States (US), health expenditure increased from 13.4 to 16.0 per cent of GDP over this period. In the United Kingdom (UK), it increased from 6.6 to 8.4 per cent, and in Canada, from 8.8 to 10.1 per cent.

In most wealthy countries there is some debate about the merits of spending more and more on health care. Proponents on one side of the debate argue that spending more than approximately USD1000 per person per year on health care delivers only marginal benefits in health status because most of the major advances in health care have already been made. Wealthy countries’ spending on health care far exceeds this amount.\(^2\) In 2007, for example, health expenditure per person in Australia was AUD 4732.\(^3\) It was AUD 10,352 per person in the US, AUD 4249 per person in the UK, and AUD 5343 in Canada.\(^4\)

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4. Ibid, p.419.
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Proponents on the other side of the debate argue that the marginal benefits from additional health expenditure in wealthy countries are worthwhile because reducing small risks of ill health to very small risks is all that is possible for most people, and health care in wealthy countries has shifted away from increasing longevity to improving quality of life. Others argue that the benefits of additional spending on health care mostly outweigh the costs because higher expenditure on technology improves access to health care — that is, it makes new treatments available to more people.

Additional spending on health care tends to be easier to justify in the private sector than it is the public sector. In the private sector, higher spending on health care largely results in higher prices or incomes for suppliers. It can also lead to employment growth and higher wages. Although higher expenditure in the public sector may also have the same effect, it is largely financed through taxation increases, so it can be difficult to justify politically.

This paper leaves questions about the absolute level of health spending aside. Instead, it focuses on government spending on health, in particular federal government expenditure, and considers the fiscal sustainability of the health system. Put simply, fiscal sustainability in public finances means that governments must be able to pay for all their financial obligations without making radical adjustments to taxes or shifting the burden of debt onto future generations. To achieve fiscal sustainability, governments must be disciplined when making decisions about spending. They must promote the efficient operation of government and balance the allocation of resources across sectors with the aim of achieving the best value for money. Significant threats to fiscal sustainability include an increase in the size of the dependant population and/or economic downturn because of their impact on government revenue, particularly through taxation receipts, and demand for social welfare services.

Governments in many advanced economies are becoming particularly concerned about the fiscal sustainability of their health systems. It must be pointed out though that increases in health expenditure should be expected. This is because health spending, in economic terms, is considered a superior good (these are goods that are both scarce and have a high price), and the proportion of spending on superior goods tends to increase along with incomes. The problem with this (expected) growth in health expenditure is that over time, large and persistent gaps have opened up between it and economic growth. This has primarily been because of rapid advances in medicine and technology, past successes expanding access to care and the ageing of the population. According to The Treasury’s 2010 Intergenerational Report, health care will consume about two thirds of the projected increase in government spending over the next 40 years if current trends continue.

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5. S Lewis, S Leeder, op. cit., p. 271.
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In Australia, health care expenditure over the last decade (1999–00 to 2009–10) has been growing on average by 5.3 per cent a year, while average annual economic growth (in real GDP) has been substantially lower at 3.2 per cent a year. Compared with other countries though, Australia has been reasonably successful in containing the growth in health expenditure. Between 2000–01 and 2006–07, the average annual growth rate in Australia for total health expenditure per person was 2.9 per cent. It ranked in the top third of OECD countries on this measure of cost containment.

What can be done?

At the moment, most commentary on health expenditure in Australia tends to speak in general terms about the need to improve sustainability without providing any concrete plans for action. Or, at the other extreme, discussions tend to overplay the significance of small-scale reforms on the sustainability of the health system.

There are however five key mechanisms currently used in Australia to slow growth in health care expenditure. These mechanisms, which are not unique to Australia but used commonly around the world, are:

- deciding which health care interventions will be publicly funded (commonly known as Health Technology Assessment);
- changing the way health care providers are paid;
- imposing costs on individuals;
- constraining the capacity of the health system; and
- encouraging competition.

The challenge of constraining health expenditure

Containing growth in health care expenditure is particularly challenging for governments because the system itself is so complex that it is difficult to govern effectively. The core activities of health care—providing care to individual patients—happen in private and in settings that are often beyond

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10. AIHW, *Health expenditure Australia 2009-10*, op. cit
11. Organization for Economic Co-operation and Development (OECD), OECD, *Health expenditure, total health expenditure, average annual growth rate per capita*, website data online, viewed 9 June 2011, [http://www.oecd.org/document/16/0,3343,en_2649_34631_2085200_1_1_1_1,00.html](http://www.oecd.org/document/16/0,3343,en_2649_34631_2085200_1_1_1_1,00.html); Some analysis of this data was carried out to calculate average annual growth rates for the period 2001–01 to 2006–07.
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the direct control of governments. Some publicly funded health care programs are demand driven—the Medical Benefits Scheme (MBS) and Pharmaceutical Benefits Scheme (PBS) for example—making it difficult for governments to control overall expenditure. And in Australia, federal, state and territory governments, the non-government and private sectors each play a role in financing and delivering health care (for a brief overview of Australia’s health system see this report from the Australian Institute of Health and Welfare\(^ \text{14} \)). Because the federal government is only one player in this complex health system, its ability to control overall expenditure has limits.

At the broadest level, total government expenditure on health care is determined by the volume of health services provided and the price (the government) pays for them. It follows then that governments seeking to slow the growth in public expenditure can intervene by slowing growth in the volume of services provided or the price paid for them, or both. In practice, it is difficult for governments to design, and even more difficult for them to implement, policy solutions that meet these objectives. Slowing growth in health care expenditure (or ‘bending the cost curve’ as it is referred to by experts) is not a simple policy problem that can be solved with technical solutions. Ultimately, it is a political problem. There are three main reasons why.

First, to slow expenditure growth, governments need to develop policies that reduce the growth in the use of unnecessary health services, not necessary ones. If governments reduced the volume of necessary, or essential, health care services it would have a detrimental impact on health outcomes in many cases, and would likely increase the cost of care. Restricting access to cancer screening tests for at risk groups or immunisations, for example, would be a false economy because it would mean that more people would probably end up with cancer and vaccine-preventable diseases, and they are generally more expensive to treat than to prevent.

The problem for policymakers is that because there is so much uncertainty in health, in many cases it is difficult if not impossible to define what constitutes necessary and unnecessary care. Treatments once thought to be unnecessary can, over time, become widely regarded as necessary, so definitions are not static. As a result, much of the decision-making on what constitutes necessary health care is left to health professionals. Health professionals, however, cannot always be certain about the causes of ill health in an individual, and therefore they cannot be sure if a treatment will be effective. Governments sometimes get directly involved in decisions about what constitutes necessary care but it can lead to controversy. The most recent example of this was the controversy over the Government’s decision to defer listing some new drugs on the Pharmaceutical Benefits Scheme, even though they had been recommended by the independent Pharmaceutical Benefits Advisory Committee.\(^ \text{15} \)

Second, to contain total health expenditure, governments can slow the growth in prices for health goods and services. This, too, is difficult to do because price is an important determinant of providers’ incomes. Imposing limits on price growth in countries like Australia is particularly difficult

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because many health services are delivered by the private sector (for example, privately practicing General Practitioners (GPs), medical specialists, allied health professionals and private hospitals) and the private sector is free to set its own fees. Governments can attempt to exert some influence over prices in the private sector by controlling the benefits it pays under the Medical Benefits Scheme (MBS), but its influence through this means is relatively indirect.

And finally, when implementing measures to slow health expenditure growth, governments need to ensure that they do not exacerbate the inequalities in health status that exist in every country. Most governments in developed countries recognise that there is a ‘social gradient’ in health where people at the lower end of the socioeconomic spectrum are in poorer health and have a much higher risk of contracting just about any disease than those at the upper end of the spectrum. These disparities do not just exist at the extremes. Pioneering research in the 1960s found that even amongst different ranks of British civil servants, a social gradient in health was apparent. This social gradient means that governments have to consider the impact of cost control policies on different socioeconomic groups, which makes policy development and implementation a much more complex task.

The task of constraining health expenditure is made even more complex because it is impossible to separate the political and policy dimensions of the problem. To illustrate, decisions made about health technology assessment or health infrastructure have direct implications for what the government considers ‘necessary’ health care and can exacerbate inequalities in health (if the government decides, for example, not to fund a particular service that is available privately). It is also impossible to disentangle many of the key mechanisms for containing health expenditure. Decisions made about co-payments, for example, have an influence on the way providers are paid as well as competition in the health sector.

The main contribution of this paper is to briefly assess how effectively each of the five mechanisms outlined above are used in Australia to control health expenditure. It also outlines some potential areas for future reform. The paper is broad in scope so it does not provide a detailed analysis of every issue raised. Because the paper focuses on cost containment mechanisms rather than sectors of the health system, it does not address some issues even though they are important: the pricing of generic drugs under the Pharmaceutical Benefits Scheme and competition in the diagnostic imaging sector are two examples. Instead, the paper aims to stimulate a discussion on the sustainability of the health system by outlining some options for reform.

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Key mechanisms for controlling health expenditure growth

Deciding which health care interventions will be publicly funded

One of the key mechanisms governments have for controlling health expenditure is to decide which health care interventions will attract public subsidies and which will not.\(^\text{18}\) This decision-making process is called Health Technology Assessment (HTA), and is formally defined as ‘a multidisciplinary field of policy analysis...[that] studies the medical, social, ethical, and economic implications of development, diffusion, and use of health technology.’\(^\text{19}\) The term ‘technology’ refers to more than just medical devices; it also includes pharmaceuticals and vaccines, diagnostic tests, surgically implanted prostheses, medical procedures and public health interventions.\(^\text{20}\)

In Australia, there are three main organisations involved in HTA: the Pharmaceutical Benefits Advisory Committee (PBAC), Medical Services Advisory Committee (MSAC), and the Prostheses and Devices Committee (PDC). A brief overview of the roles of each of these organisations can be found in Appendix A.

In the past, Australia led the world in the use of HTA.\(^\text{21}\) It gained this reputation during the 1990s when it pioneered the use of economic evaluations as part of the approval process for pharmaceuticals. In more recent times, a number of criticisms have been levelled at Australia’s HTA processes. They were articulated most clearly by the Productivity Commission in its 2005 report on the impact of advances in medical technology, and by the Department of Health and Ageing in its 2009 Review of Health Technology Assessment in Australia. Both reports highlight a number of issues but there are three key ones that merit discussion.

Australia’s approach to HTA has been criticised for being fragmented across sectors of the health system with separate assessment processes and assessment criteria in place for pharmaceuticals, medical services and medical devices.\(^\text{22}\) Fragmenting HTA processes and organisations leads to some degree of duplication, making the process more costly and therefore less efficient. This is not the case in some other countries where one agency is responsible for assessing all health technologies (for example, the UK’s National Institute for Health and Clinical Excellence and the Canadian Agency for Drugs and Technologies in Health).\(^\text{23}\)


\(^{19}\) International Network of Agencies for Health Technology Assessment (INAHTA), Health Technology Assessment, HTA Resources, Definitions, INAHTA website viewed 2 December 2010, [http://www.inahta.org/HTA/](http://www.inahta.org/HTA/)


\(^{23}\) DoHA, Review of Health Technology Assessment in Australia, op. cit.
HTA processes in Australia are also fragmented across levels of government with separate, often ad hoc, processes operating at the state and territory and local level (for example within area health services) in addition to those at the federal level. This fragmentation of HTA across levels of government is inefficient because it means that assessments of the same technologies can be duplicated in several jurisdictions at additional cost, and widespread access to new, more clinically effective and cost-effective interventions can be slowed down.

As with many other countries, the main focus on HTA in Australia is on assessing new technologies before they are put into practice or onto the market. Very few resources are invested in assessing the clinical effectiveness and cost-effectiveness of existing technologies, both relative to new ones and in their own right. When post-market surveillance of new health technologies in Australia is conducted, it tends to focus on safety issues despite the fact that, according to the United States Institute of Medicine, there are many existing health interventions that scientific studies have shown to be ineffective or harmful. Such interventions include: episiotomies for routine births, the use of supplemental oxygen for premature babies, traction treatments for low back pain, and spinal manipulations to treat migraines. By continuing to fund less effective or even ineffective interventions, governments get less value for money in health care. If the problem is widespread, it undermines the sustainability of the health system.

In recent years, the Australian Government has recognised the importance of reviewing existing technologies as part of the HTA process and has introduced the MBS Quality Framework to help review the evidence around the safety, clinical effectiveness and value of existing MBS items. The Comprehensive Management Framework for the MBS announced in the 2011–12 Budget confirms the government’s commitment to reviewing existing technologies, but it is not yet clear how extensive or quick the review process will be. Under the MBS Quality Framework, just four reviews of existing MBS items had been conducted by mid 2011; the outcome of these reviews were not publicly available at the time of writing.

In Australia there is relatively little investment in processes that compare the effectiveness of different health technologies, so it is difficult to adjust, or even remove, government benefits for health care interventions over time. Recent controversy over changes to the MBS benefits for cataract surgery and vitamin D tests demonstrate how difficult it can be to adjust benefits. In both

25. OCED, Value for Money, op. cit.
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In these cases, claims were made that the benefits paid for these health care interventions were well in excess of the cost of delivering the service and as such, lower benefits were justified. Because of the outcry from doctors and others over the proposed changes to cataract benefits, the Government was forced to compromise and agreed to reduce the benefit by 10 to 15 per cent rather than the 45 per cent originally proposed. The proposed changes to benefits for Vitamin D tests, along with other pathology tests, are now expected to be reviewed as part of the Government’s new Quality Framework.

Another key criticism of HTA processes in Australia is that they lack a strategic, systematic and integrated framework. In some other countries, the UK for instance, HTA organisations have a needs-based approach, which allows them to set their own priorities for HTA assessment. Under this approach, HTA can be more closely aligned with national health priorities so that new interventions with the most potential benefit can be assessed first. In Australia, priorities for assessment of health technologies tend to be led by applicants (that is, the manufacturers or developers of the technology), and it operates on a first come, first served basis.

Options for reform

There are a number of potential options for reforming HTA in Australia. The most substantial one is to consider establishing a single independent agency for HTA. By establishing such an agency, it would also be easier to implement other potential reforms, such as developing an overarching framework for HTA, undertaking more comparative effectiveness research and exploring options for ‘disinvesting’ some health technologies. Each of these options is examined in brief below.

There are several international precedents for the establishing a single HTA agency. Examples include the National Institute for Health and Clinical Excellence (NICE) in the UK, the German Agency for Health Technology Assessment, and the Canadian Agency for Drugs and Technology in Health. Although they all operate slightly differently, each of these agencies operates at arm’s length from the government to assess and review the full range of pharmaceutical, medical and health services interventions.

One of the key advantages of a single HTA agency is that it is easier to develop and apply an overarching approach to HTA where the same basic approach and criteria is used to assess new and


33. DoHA, Review of Health Technology Assessment in Australia, op. cit.

34. T Jackson, op. cit.

35. Ibid.
existing health technologies. It would also be possible to set minimal effectiveness thresholds that all health care interventions must meet in order to be eligible for public subsidy; this proposal is currently being debated in major international medical journals such as the British Medical Journal. At present in Australia, the PBAC, MSAC and PDC all use different assessment process and criteria for determining what constitutes effectiveness. Academic experts have been calling for a unified approach to assessment and have done some of the preliminary work needed to advance in this direction.

Establishing a single agency may also make it easier to evaluate the effectiveness of different health care interventions designed to treat the same health problem. This work is known also as comparative effectiveness research, and expanding its role in HTA in Australia is another key reform proposed by some, including academic experts in the field. Because it is not feasible to evaluate the effectiveness of all existing health care interventions, comparative effective research needs to be targeted. A group of Australian researchers have developed a framework that could be used to systematically identify existing practices that are not very cost-effective. Some of the criteria for assessing whether an existing health care intervention should be re-evaluated include: new evidence on safety, clinical effectiveness and/or cost effectiveness; major geographic variations in care; major variations in care amongst providers, technological developments, or; public interest or controversy. The US government has recently invested $US1.1 billion in comparative effectiveness research through the American Recovery and Reinvestment Act (2009), with substantial allocations going to the Agency for Healthcare Research and Quality and National Institutes of Health. At present, there do not appear to be any plans to invest in a national comparative effectiveness research program in Australia.

The final potential option for reform is to begin identifying existing health technologies that should no longer receive public funding, a process known as ‘disinvestment’. Most governments find it difficult to reallocate public funding for existing health care services—even if they are only marginally effective—because outcry can be high when funding cuts for health care interventions are proposed. A recent example is the outcry from the Australian Medical Association (AMA) over the proposed reductions to MBS rebates for mental health plans prepared by GPs; the measure was


40. Ibid.
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outlined in the 2011–12 federal Budget.41 The Senate Community Affairs Committee is currently conducting an inquiry into this as well as other proposed changes in mental health.42

Some researchers argue that a dedicated program of disinvestment should be considered in Australia so that scarce resources can be reallocated to more clinically effective and cost-effective interventions.43 These researchers also outline criteria that could be used to identify existing interventions that may not be cost-effective (they can be found in this article from the Medical Journal of Australia44). Such a program, especially if rolled out across the health system, could lead to significant savings. A recent study published by a group of clinical pharmacists in Victoria found that when they introduced a program for pharmaceutical prescribing and dispensing based on the principles of disinvestment, the area health service saved $3.2 million over a four year period without any adverse health outcomes.45

Changing the way health care providers are paid

The way health care providers are paid—not just the amount they are paid—is an important determinant of total health expenditure. Providers include individual health professionals such as GPs, medical specialists, and physiotherapists, as well as organisations such as hospitals and community health centres. They are paid in a variety of ways, including:

• salaries;
• fee-for-service payments (providers are paid according to the number of services delivered);
• diagnosis related groups (DRGs)/activity-based funding (ABF) (providers are paid a fixed fee per patient that takes into consideration the complexity of the patient’s condition);
• capitation payments (providers are paid a fixed amount based on the number of patients they are responsible for);
• per diem payments (providers are paid a daily fee for each patient treated); and
• budget allocations (where a lump sum is used to fund a pre-defined range of health services and activities).46

44. Ibid.
Increasingly, providers are also being partly remunerated under pay-for-performance or payment by results schemes. Under these schemes, financial rewards are paid to providers who meet specific performance benchmarks. Because these schemes are usually only used in conjunction with other payment systems, they are not considered further in this paper.

According to the World Health Organization (WHO), the payment methods with the most potential for containing health expenditure are salaries, budgets and capitation payments. The downside of these payment mechanisms is that they can be associated with low productivity, low quality care, under provision of services and cost shifting. In contrast, ABF, fee-for-service and per diem payments tend to encourage providers to increase the volume of services delivered, sometimes at the expense of quality care. These payment methods also do not provide any incentives to contain costs unless there is also a fixed budget or price signals to consumers, such as co-payments. Many countries use a combination of payment mechanisms to compensate for the weaknesses of any one particular method.

In Australia all these payment mechanisms are used to varying degrees. More details on the provider payment systems used in various sectors can be found in Appendix B. Public hospitals are currently paid using a combination of ABF and fixed budget allocations. This combination will continue under the National Health Reform Agreement, but it is likely that more public hospitals and public hospital services will be funded through ABF as a result of the reforms.

The expansion of ABF in public hospitals is likely to have several effects. As with all volume based payment systems, ABF will create incentives for providers to increase activity levels. While this may be necessary to satisfy unmet demand for care, it will also require additional expenditure. As a balance, ABF will also create strong incentives for providers to deliver services more efficiently (or outsource them to providers who can), thereby containing expenditure growth.

It is difficult to predict what the overall impact on public hospital expenditure growth will be, but several experts have argued that the expansion of ABF is unlikely to have a substantial impact overall. According to one US expert from the Dartmouth Institute for Health Policy and Clinical Practice, the new funding arrangements proposed in Australia, ‘will do little to rein in soaring health costs,’ and, ‘other measures will be needed to ensure growth does not overwhelm state and federal budgets’. One of the co-architects of Medicare, John Deeble, also an experienced hospital administrator, explains that ABF is a useful analytical tool, but not a panacea for getting more value out of the health system. This is largely because ABF will not be used as the only funding method for public

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Hospitals; many will continue to be paid, at least in part and some almost completely, through block grants.

Health economist, Jeff Richardson, also a supporter of ABF, agrees that, ‘there is no reason to believe that it [ABF] will have a major system effect’. He says that this is because ABF will not better balance the mix of primary, secondary and tertiary services, nor will it ensure quality or reform in public hospitals, better integrate programs or improve access to care. Because of this, governments are likely to continue to rely on existing mechanisms that are unrelated to provider payments to contain expenditure growth; the most common ones are capacity constraints created by workforce and bed shortages.

In the areas of medical services, the federal government has only a limited capacity to control expenditure through provider payment mechanisms. Fee-for-service dominates in medical services, and the government has very little control over fee levels (the government has control over the level of patient subsidies provided through the MBS, but not medical fees). Past attempts to make substantial shifts away from fee-for-service payments in Australia have always failed, lending support to the notion that fee-for-service practice is now so well entrenched in Australia that there is no realistic chance of it being replaced by alternative payment mechanisms. Because of this, governments have tended to avoid reforming provider payments and have relied instead on other mechanisms for controlling expenditure growth. Patient co-payments are the main one used and they are discussed in the following section.

Options for reform

Australia relies heavily on provider payment mechanisms deemed by the WHO to be the least effective means of curbing expenditure growth. Some health experts have singled out fee-for-service for criticism, arguing that it is not well suited to preventing and managing chronic diseases. They explain that fee-for-service payments encourage health professionals to focus on acute management of symptoms rather than preventing disease or managing the symptoms effectively over time. The Government made a small attempt to move away from fee-for-service practice in the 2010–11 Budget with its Coordinated Diabetes Care initiative. However after strong protests from the AMA,

52. Many doctors object to the idea that they are paid by the Government as they provide private services on a fee-for-service basis. Eligible patients are then reimbursed in full or part through the MBS. Despite these objections, it is difficult to argue that ‘bulk-billing’, which accounted for 74 per cent of all GP services provided in 2009–10, is not a form of direct payment to doctors from the Australian Government.
rxIkJQ.7ITFV1jeEvrRrERACiZGLwG5jZ/7jRI9QWmEkhiAzUjSiZagbGjqaZWqvsDRRFb-
LQVS9Mbel1p._&sig=AHIEtbTcXbWysJC3Py5SLS2_zbrzpG2kSfA
the Government announced that it would scale it back to a pilot program running over three to four years.  

The Government also made some subtle changes to funding arrangements for mental health services in the 2011–12 Budget by investing in community-based services and programs (for example Early Psychosis Prevention and Intervention and headspace centres) where staff may work outside the fee-for-service Medical Benefits Scheme. Although these changes to funding arrangements are small in the overall scheme, they may have an impact over the longer-term if experts can show that they have contributed to tangible improvements in health outcomes for people with chronic illnesses.

To drive further efficiencies and put tighter constraints on expenditure growth in Australia, it is likely that governments will have to consider combining fee-for-service practice and ABF with other mechanisms for controlling expenditure. It is likely, for example, that public hospitals paid through ABF will continue to have a fixed budget for non-emergency services. Another potential option for constraining cost growth would be to encourage more health professionals to work as salaried employees, for example in hospitals or primary health care facilities. Proposals along these lines however are likely to be controversial.

Imposing costs on individuals

Co-payments, also called out-of-pocket payments or user fees, are payments for medicines and health services made by an individual at the point of care. Co-payments are commonly used to finance health care, particularly in poorer countries. They are a viable means of containing government health expenditure because they shift some or all of the costs of health care onto the individual, and they introduce a price signal that, in theory at least, can lead to a reduction in the demand for unnecessary services. According to the RAND Corporation’s landmark experiment on the relationship between health care costs and utilisation in the 1970s and 80s, the problem with co-payments in practice is that they lead to a reduction in the use of all health services, not just unnecessary or discretionary ones.

The WHO has also expressed concerns about the use of co-payments, labelling them a relatively blunt instrument for controlling costs. It highlights some of the potential negative consequences, including that they:

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- tend to discourage people from using health care services when or before they need them (for example preventive health checks and health promotion services);
- can cause some people serious financial hardship either by imposing high co-payments for one off events or small co-payments over a period of prolonged illness;
- are the least equitable form of health funding because they are regressive (the rich pay the same amount as the poor for any particular service); and
- make it impossible for an individual to spread the costs over a lifetime.

In Australia, individuals’ contributions (or co-payments) accounted for approximately 17.5 per cent of total health expenditure in 2009–10.\(^9\) There has been very little change in the proportion of health expenditure sourced from individuals over the last decade (see Table 1 in Appendix C for trend data over the last decade). However Australia’s reliance on co-payments appears to be at odds with trends in other countries. In most OECD countries over the last decade, the proportion of total expenditure coming from individual co-payments has been decreasing; nearly all the other countries not following this trend are transition economies.\(^6\) Figure 1 in Appendix C shows the change in the percentage of health expenditure financed through co-payments between 1997 and 2007 for 22 OECD countries.

A lack of consistency is another key problem with co-payment policies in Australia. At present, some health services in Australia are fully subsidised by the government (bulk-billing medical services and public hospital care), so there is no co-payment. Some health services require a set co-payment (prescription pharmaceuticals), some require an open ended co-payment (ancillary allied health services covered by private insurance), some require proportional co-payments (medical services once the safety net reached), and some attract no government subsides at all (dental and allied health services that are not covered by insurance).\(^6\) These arrangements can create perverse financial incentives to use some services in preference to others: for example, people may choose to go to a public hospital emergency department, which is free at the point of care but more expensive, in preference to a GP who charges a co-payment.

Successive governments have attempted to mitigate some of the negative consequences of co-payments by establishing safety nets for people on low incomes or with exceptionally high out-of-pocket costs. There are currently two main safety net schemes to assist people with out of pocket costs, one for prescription medicines (the PBS Safety Net) and the other for out of hospital medical services (the Medicare Safety Net).\(^5\) Although these safety nets aim to ensure that cost does not prevent people on lower incomes from accessing necessary health care, there is mounting evidence to suggest that they are not completely effective.

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60. Organization for Economic Co-operation and Development (OECD), *Health data 2010, Frequently requested data*, OECD website, viewed 29 June 2011, [http://www.oecd.org/document/16/0,3343,en_2649_34631_2085200_1_1_1_37407,00.html](http://www.oecd.org/document/16/0,3343,en_2649_34631_2085200_1_1_1_37407,00.html)


62. Individuals can also claim a Net Medical Expenses Tax Offset of 20 per cent of medical expenses over $1500.
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An Australian Bureau of Statistics (ABS) survey in 2009 on patient’s experiences of health care found that a substantial number of people were deferring or forgoing treatment because of the cost.\(^6^3\) The survey found that in the previous year, concerns about the cost of care meant that:

- 1 in 16 people delayed or sacrificed treatment from a GP;
- 1 in 11 people delayed or did not fill a prescription; and
- 1 in 10 people delayed or sacrificed treatment from a specialist.

A report published by the Australian Institute of Health and Welfare in 2011 found that the cost of dental care (which is predominately provided in the private sector) was also preventing a significant number of people from accessing necessary services.\(^6^4\) It found that concession card holders were less likely than non-concession card holders to:

- make a dental visit in the 12 months prior to the survey;
- visit a private dentist;
- visit for a check-up;
- receive a scale and clean; and
- report that they usually visited a dentist once a year, or that they usually visited for a check-up.

It also found that concession card holders were more likely than non-cardholders to receive a dental extraction, they were more likely to report that they avoided or delayed dental care due to cost, or that cost had stopped them receiving recommended dental treatment.

The cost of pharmaceuticals also seems to be a barrier to accessing health care for some people. An investigation into the costs and use of pharmaceuticals in Australia in 2005 found that the 24 per cent increase in co-payments at that time led to reductions in the volume of essential medications dispensed, despite the existence of a safety net.\(^6^5\) The decrease in volume was greatest for social security beneficiaries, suggesting that the co-payment increase had a greater impact on this group of low-income people.


Despite evidence that the cost of health care prevents some people from using necessary health care services, it is difficult to prove that this then goes on to have a detrimental impact on health outcomes. In an attempt to understand the relationship between the cost of care and health outcomes, researchers from the Menzies Centre for Health Policy surveyed a group of GPs in western Sydney. They found that most GPs surveyed said that they treated patients who found it difficult to afford health care. Some of these patients experienced deteriorations in their health because they had not been able to afford necessary treatment, some were admitted to hospital and, in rare circumstances, some even died.

In recent years, some aspects of Australia’s safety net arrangements have been criticised explicitly on equity grounds. In its 2009 review, the Centre for Health Economics and Research and Evaluation (CHERE) highlighted some serious problems with the Extended Medicare Safety Net (EMSN) scheme. Most importantly, it found that the EMSN had not led to a decrease in co-payments for patients. Instead, it had the unintended consequence of driving up medical fees, which advantages providers, not patients. There were some reports at the time suggesting that medical fees increased because the AMA was advising its members on how to exploit the new arrangements. When the CHERE looked into this they estimated that since the EMSN was introduced in 2004, it had been directly responsible for an almost 3 per cent increase in fees each year; this is over and above the rate of inflation. These fee increases meant many patients were paying higher co-payments, even those who qualified for the EMSN, because the EMSN only reimburses patients for 80 per cent of their out of pocket costs.

The CHERE review also found that there were some major inequities in the distribution of EMSN benefits. It found that 55 per cent of the EMSN benefits were going to the most privileged geographical areas of Australia and less than 3 per cent was going to the most disadvantaged areas.

In an attempt to address some of the issues identified by the review, the Australian Government made some changes to the EMSN scheme in the 2009–10 Budget.

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70. Department of Health and Ageing, Changes to the Extended Medicare Safety Net in the 2009-10 Budget, MBS Online website, Fact sheets, viewed 29 June 2011,
for a small number of MBS services where there was evidence that doctors had substantially increased their fees over a short period of time. Examples include some obstetric and assistive reproductive technology services, and some types of cataract surgery. Some commentators, however, have raised doubts about whether benefits caps will be effective in the long-term because this solution does not address the fundamental problem that governments can only control benefit levels, not doctors fees.  

**Options for reform**

It is clear from this analysis that by continuing to rely on co-payments to control health expenditure to the extent that it currently does, Australia is going against an international trend. This, along with evidence that co-payments are making it difficult for some people on low incomes to access necessary care, suggests that co-payment and safety net policies in Australia need to be reviewed.

A number of specific policy proposals on co-payments have been made, including issuing people with a Health Credit Card so they could pay for health care without any upfront payments, and lowering or eliminating co-payments for people with chronic diseases. Additional options would no doubt be canvassed as part of a broad review of co-payment policies.

**Constraining the capacity of the health system**

The capacity of Australia’s health system to provide services is another important determinant of health care expenditure. Two key ways governments can contain the growth in health care expenditure is to limit the number of new health care facilities built, or limit (or fail to adequately increase) the number of new health care professionals trained. Decisions about the capacity of the health system are rarely made explicit, perhaps because they can be very controversial, but these decisions are made routinely by governments at the federal and state levels. The following section considers in more detail how decisions about infrastructure and workforce supply are made in Australia.

**Infrastructure funding**

Most government health infrastructure funding in Australia is spent on public hospitals. While the Commonwealth is the majority funder, the states and territories also contribute funds from their own revenue. State and territory governments are responsible for making most of the decisions about capital investment in public hospitals.

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73. There is also considerable private sector infrastructure financing in the areas of general practice and private hospitals.
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There are various methods of funding health infrastructure in Australia. Some Commonwealth funding for public hospitals is provided to the states and territories as part of the National Healthcare Agreement.\textsuperscript{74} There are also a number of National Partnership Agreements between the Commonwealth and states and territories that include some infrastructure funding. Examples include the Hospital and Health Workforce Reform, Improving Public Hospital Services, and Elective Surgery Waiting Lists partnership agreements.

The Commonwealth also provides infrastructure funding through the Health and Hospitals Fund (HHF). It was established in 2008 as part of a broader infrastructure funding program (it also includes other areas such as transport and broadband, higher education and vocational education and training facilities).\textsuperscript{75} Through the HHF, the Commonwealth invests in:

- major health infrastructure programs that will make significant progress towards achieving its health reform targets; and
- makes strategic investments in the health system that will underpin major improvements in efficiency, access or outcomes of health care.

The HHF is administered by the Commonwealth Department of Health and Ageing. So far, it has held four funding rounds for infrastructure projects and has made grants for a wide variety of projects including: public hospitals, research facilities, general practices, medical centres, patient and carer accommodation, operating theatres, dental clinics and dialysis units (a list of the projects funded can be found here).\textsuperscript{76}

The Commonwealth also provides health infrastructure funding though other mechanisms, including:

- A grants scheme for general practice infrastructure. In the 2010–11 Budget, the Government announced an additional infrastructure funding program for general practice—the Primary Care Infrastructure Grants Scheme worth $355.2 million over 4 years.\textsuperscript{77} These grants are specifically for the establishment of GP SuperClinics.

- Ad hoc budget measures for capital equipment such as diagnostic imaging machines such as Magnetic Resonance Imaging (MRIs), Positron Emission Tomography scanners (PET scanners) and Computed Tomography Scanners (CT Scanners).

- A number of small-scale infrastructure funding grants made available by the Department of Health and Ageing as part of other programs.

In recent years, the government has also begun to invest in the infrastructure needed to develop and expand e-Health in Australia. e-Health involves the use of electronic communication and

\textsuperscript{75} Department of Health and Ageing (DoHA), \textit{Health and Hospitals Fund}, DoHA website, viewed 29 June 2011, \url{http://www.health.gov.au/hhf}
\textsuperscript{76} Department of Health and Ageing (DoHA), \textit{Health and Hospital Fund}, DoHA website, viewed 1 July 2011, \url{http://www.health.gov.au/}
information technology in the health sector and aims to improve the safety, quality, equity and sustainability of the health system by ‘transforming the way information is used to plan, manage and deliver health services’. It is anticipated that e-Health will drive down costs in the longer term by improving the way information and knowledge are shared and facilitating remote access to health professionals. In the 2010–11 Budget, the Government allocated $446.7 million over two years to establish the key components of a national personally controlled electronic health record.

It is evident that there are many different funding streams for health infrastructure at the Commonwealth level. The states and territory governments also have separate process, but they are not considered in this paper. What is lacking is a publicly available consolidated record listing all the ways health infrastructure is funded in Australia.

Workforce supply

Governments have a substantial influence over the supply of health care workers. In the past, for example, governments have capped the number of places for medical students in universities and subsequently raised them when data suggested there were workforce shortages in some professions. Governments also exert considerable influence over the number of training places in universities for nurses and other allied health professionals.

It is well known that Australia, along with many other countries, currently has a serious shortage and maldistribution of health care workers. Shortages are particularly acute in professions such as nursing, dentistry, midwifery, and clinical psychology, and are set to worsen over time as labour markets tighten, the population ages and community expectations for care grow.

In theory, workforce shortages act as a constraint on health expenditure growth: fewer health professionals on the public payroll should mean lower health care costs. In practice, however, workforce shortages can lead to inefficiency and waste in the health system and drive up costs in the longer term. When there are workforce shortages, rather than waiting to the most appropriate health professional, people may go to see whoever is the most accessible, even if they are not able to provide the care they need. Choosing to wait to see the most appropriate health professional may also lead to problems if necessary treatment is delayed. There is evidence, for example, showing

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that timely access to mental health prevention services and harm reduction interventions amongst drug users is more cost-effective in the long-run than delaying access to care.\(^2\)

According to a 2005 Productivity Commission investigation into the health workforce, Australia has had problems in the past with workforce planning.\(^3\) The Commission found that there were significant problems recruiting and retaining health care workers in Australia because many health professionals felt they were unable to fully develop and utilise their skills once in clinical practice. It also found that Australia’s extraordinarily complex and rigid health workforce regulations made it difficult to develop effective policy and adjust to changing demands. In particular, the Commission highlighted that there were multiple and overlapping roles for governments with regard to the health workforce, which often resulted in poor coordination on key issues such as workforce planning. The Commission also pointed out that there were a plethora of bodies involved in accrediting health workforce education and training programs and registering health professionals, and that regulatory arrangements were often rigid and overly influenced by professional bodies. Because of this, it has been difficult to accurately project the numbers of health care workers needed in the future and respond with an adequate increase in supply.

The Commission made recommendations designed to improve projections regarding Australia’s health workforce. Since then, Health Workforce Australia (HWA) has been established. It is a statutory body responsible for providing a skilled, flexible and innovative health workforce through its work in: workforce planning, policy and research; clinical training; innovation and reform of the health workforce; and the recruitment and retention of international health professionals.\(^4\) Establishing a national, co-ordinated approach to health workforce planning and regulation will hopefully help governments to better match anticipated demand for health professionals with supply.

Options for reform

It is evident from the discussion above that there are numerous health infrastructure funding processes in place in Australia. The key problem with the existing arrangements is that each of these processes appears to be operating in isolation, making it impossible to monitor the impact infrastructure spending on overall health expenditure. As a result, some priorities for reform could include:

- identifying all the health infrastructure decision-making processes that currently exist;
- examining whether some of these processes could be streamlined or consolidated; and
- establishing a system for tracking total health infrastructure spending.

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Once established, these reforms would help policymakers to identify areas of need and prioritise them as areas for investment. It would also allow governments to track the impact of infrastructure funding decisions on health expenditure growth over time.

The health workforce shortages that have persisted in Australia in recent years are likely to have reduced pressure in the short-term on health budgets and expenditure, but it is possible that it also has had a detrimental impact on access to care and health outcomes in the longer-term. Recent reforms such as the establishment of HWA may lead to a more unified approach to health workforce planning over time but there are some early signs that significant improvements might still be some time off.

In February 2010, several state governments indicated that they wanted to back away from a 2008 COAG deal that would see Commonwealth and state and territory funds pooled for clinical training and then administered by HWA. Some states objected to the idea of HWA administering the funds and providing advice to them in an area they were already managing. Tensions were eventually resolved by agreeing to scale back the role of HWA so that it planned but did not administer funding for clinical training.

While it is too soon to tell whether HWA will be able to resolve some of the structural problems underpinning persistent workforce shortages and maldistribution in Australia, it is likely that the longstanding problems governments have working together in shared areas of responsibility will continue to have an impact on the work of HWA. The focus of future reforms should be to address this challenge.

Another option for reform is to investigate the potential cost savings associated with role substitution. Role substitution occurs when some tasks traditionally performed by one health professional group are transferred to another one—for example, a nurse practitioner, physician assistant or allied health professional takes on some roles traditionally performed by a doctor. Expert commentators in the US have called for reforms along these lines as part of a suite of reforms design to curb expenditure growth. They argue specifically for amendments to the scope of practice laws that would allow the greater use of nurse practitioners, physician assistants, and community health workers, and changes to provider payment arrangements (for example to US Medicare) that would encourage the use of allied health professionals. Although the National Health Workforce Strategic Framework, which was endorsed by key stakeholders and all health Ministers in 2004, recognises that the creation of new workforce roles or realignment or existing ones may be

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needed to make optimal use of health workforce skills in Australia, there have been no major changes along these lines to date.\textsuperscript{88}

Overall, it appears that the key factors affecting the capacity of Australia’s health system have been given little consideration in the past. This may change with the development of a national approach to health infrastructure investment and health workforce planning.

Encouraging competition

Increasingly governments around the world are using competition as a key tool in health care.\textsuperscript{89} Competition incentives work to influence different aspects of health care, for example the price of goods and services, the quality of care, or market share. Competition incentives can be applied to various ‘actors’ in the health system, including, doctors, nurses, managers, patients and insurers.\textsuperscript{90} They can also be applied to different processes within the health system, such as financing, the production side of health care, or the mechanisms used to allocate resources.

In theory, competition can help contain the growth in health care expenditure by driving down costs, improving efficiency, stimulating quality improvements and driving innovation.\textsuperscript{91} Those that support competition and the use of market mechanisms in health care tend to oppose direct public sector regulation such as controlling prices, the capacity of the health system and health care utilisation. They argue that regulation creates health systems that operate inefficiently, respond to providers’ rather than patients’ interests, establish barriers to innovation and reform, and encourage uniformity rather than quality improvement. Pro-market advocates also argue that stimulating competition is beneficial because it shifts the balance of power in the health system towards consumers (or patients) and away from providers, such as hospitals and medical practitioners.\textsuperscript{92}

Despite the potential benefits of competition in health care, some remain sceptical. Critics argue that because the market for health care is very different from markets for other goods and services, it is not appropriate to simply adopt pro-market mechanisms, such as competition, even though they are used extensively in other sectors of the economy.\textsuperscript{93} They point out that there are numerous areas of market failure in health care—for example, major information asymmetries between

\begin{thebibliography}{99}

\bibitem{89} OECD, \textit{Achieving Better Value for Money in Health Care}, op. cit.


\end{thebibliography}
providers and patients and the many externalities in health care. Because of the extent of market failure in health care the benefits of competition are often not realised (some of the main areas of market failure are outlined in Figure 2 in Appendix C).

This paper considers competition in the Australian health system between hospitals, medical services and insurers. Competition also occurs between suppliers of health products such as pharmaceuticals and medical equipment and diagnostic imaging services providers but these sectors are not considered in this paper.

Hospitals

In the hospital sector, there is some competition between public and private hospitals but it is inextricably linked to competition amongst health insurers, which is discussed below. People choose to use private hospitals over public ones for a range of reasons; some are that they provide the option of choosing your own doctor and the possibility of private room accommodation or shorter waiting times for elective surgery.94 Some people also choose private hospitals based on perceptions about the quality of care and service provided.

Although there is some genuine competition between public and private hospitals in Australia, it is limited by several factors. Private hospitals do not provide the same range of services as public hospitals. Emergency departments, for example, are uncommon in private hospitals and few private hospitals provide highly specialised treatments such as transplant and burns services. As a result, the competition between public and private hospitals for patients occurs largely in the market for elective surgery, but even then some argue that it is limited because:

- the two funding streams—Medicare and private insurance—operate in relative isolation, with most privately insured patients treated in private hospitals; and

- there is competition for scarce resources, in particular health professionals, which means that resources tend to be shifted to the sector with the most money and activity.95

Genuine competition in the hospital sector is also limited because patients that choose to use private hospitals currently have access to only limited information about the quality of hospital services that can assist them to make an informed decision (this problem also applies to public hospitals). The recently established MyHospitals website provides some data that patients can use to inform their decisions but it currently provides only very limited information on the quality of care (in hospital infection rates for staphylococcus aureus bacteraemia, or golden staph), and none on waiting times for elective procedures.96 Over time, the website may help foster greater competition on quality of care if it publishes more performance data for individual public and private hospitals.

The establishment of the National Health Performance Agency may also help foster greater

competition in the hospital sector. It will be responsible for publicly reporting on the performance of health care providers, clinical safety and quality performance standards, adverse events and patient satisfaction.\(^97\)

The structural barriers to competition within the hospital sector are compounded by the fact many surgeons practicing in both sectors have financial incentives to delay surgery in public hospitals, which results in patients moving into the private sector.\(^98\)

**Medical services**

Competition also occurs to a degree between health professionals. Unlike in other countries, the market for GP services in Australia is not restricted by geographic area or insurer; patients are not required to enrol with a practice in their local area or seek treatment only from doctors associated with a particular insurance fund. Instead, a patient’s choice of GP is influenced by factors such as waiting times, convenience, out of pocket costs and reputation. Similar factors influence a patient’s choices when seeking treatment from allied health professionals, many of whom also work in the private sector.

According to industry analysts, *IBISWorld*, there is a moderate level of competition in the market for GPs in Australia.\(^99\) They point out that because GPs tend to operate within confined areas, none have a very large market share, or in more technical terms, there is low market concentration. This is particularly the case in rural and remote areas where there are often major workforce shortages. However, market concentration in the general practice sector is increasing as more and more large practices are established that offer a range of medical and allied health services. Some doctors have expressed concern about the impact of this trend on competition in the sector.\(^100\) They are worried in particular that in large practices, referrals will be made only within the practice. Some have also argued that the establishment of government funded GP SuperClinics in recent years is a threat to genuine competition in the market for GP services.\(^101\)

GPs in Australia also face some competition from other health care professionals, such as nurse practitioners, psychologists and physiotherapists. However the extent of competition is limited because relatively few services provided by non-medical health professionals attract benefits under the MBS, and there are strict regulations preventing role substitution (discussed earlier). Strong resistance to the introduction of physicians’ assistants in Australia, even though they have been used

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100. Ibid.
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for more than 40 years in the US, illustrates the point. Another example is the low number of midwives registering with Medicare to provide collaborative obstetric care. Seven months after the scheme began only 21 out of 42,000 registered midwives had entered the scheme. Many complained that they were unable to find a doctor willing to enter into a collaborative agreement with them.

The market for medical specialists in Australia is even less concentrated than it is for GPs with the vast majority of medical specialists practicing alone or with one other medical specialist. Just as in general practice, however, there is evidence that practices are amalgamating in some areas, vision and orthopaedic services for example. IBISWorld has assessed the level of competition in the medical specialist market to be low and the sector has been criticised in the past by the Australian Consumer and Competition Commission (ACCC). IBISWorld points out that medical colleges have the capacity to reduce competition in certain specialty areas because they control the number of new entrants into the market (doctors must pass exams set by the relevant medical college to practice in that area). The ACCC made a number of recommendations about specialist training after investigations in 2003 and 2005.

Competition in the market for both GP and medical specialist services is also limited by the lack of information on health professionals’ performance and outcomes; most patients rely on recommendations, particularly from their GP or other health professionals, to make their choice. It is not clear yet whether the National Health Performance Agency will publish any information on the quality of care delivered by individual practitioners, as is done in some other countries. Competition between medical practitioners based on price is also limited because the complex array of subsidies and safety nets mean that price signals are muted.

Health insurance

There is a degree of competition in Australia’s health insurance market between Medicare (Australia’s compulsory, tax-funded health insurance scheme) and the private health insurance sector. Although Medicare is compulsory, private insurance coverage rates have hovered around 43

106. IBISWorld, Specialist Medical Services in Australia, op. cit. 2010
107. ACCC, ACCC proposes surgical college reform to help address surgeon shortage, op. cit.; ACCC, Review of Australian Specialist Medical Colleges, op. cit.
per cent since 2000; in December 2010, 45 per cent of the population had private health insurance and 52 per cent had ancillary cover.\textsuperscript{108}

In reality though, genuine competition between public and private insurers is limited because Medicare is compulsory and private insurers are prevented from covering some services, for example GP services. Private health insurance plays a role in supplementing (or topping up) coverage provided by the public system: for example, in private hospitals, private insurance can cover the gap between the doctor’s fee and the medical benefit provided through Medicare.\textsuperscript{109} However private health insurance in Australia also duplicates coverage provided through the public system (Medicare) to a much greater extent than it does in most other countries.\textsuperscript{110} For example, both Medicare and private insurance provide coverage for inpatient hospital treatment. Competition, to the extent that it does exist, occurs mainly in the field of elective surgery.

Within the private health insurance sector, there is competition between funds for market share. Funds compete based on insurance products, premium prices, benefits, and service. Compared with many other countries, competition between funds in Australia is limited and government intervention is high.\textsuperscript{111} The government provides a substantial rebate to people who purchase private health insurance. It has strict regulations concerning capital reserves and financial solvency. It sets minimum benefits levels, controls premium increases and the product range that funds offer. Private health insurance funds in Australia are also prevented from discriminating between people on the basis of their health, their age (other than age at entry for Lifetime Health Cover), gender, race, sexual orientation, state of health, religion, or the size of their family.

One of the main reasons funds cannot easily break free from this regulatory environment is that they only have a limited capacity to control the factors driving up premiums. According to a 2005 Access Economics report, the private funds are essentially passive payers in the insurance market as they simply pass through to members the costs they incur, for example private hospital accommodation charges and medical fees. Even though there is some evidence that funds are beginning to take a more active role by focusing on prevention and health outcomes, in a free

\begin{itemize}
\item \textsuperscript{110} Organisation for Economic Co-operation and Development (OECD), Private health insurance in OECD countries: The OECD health project, OECD, Paris, 2004, viewed 29 June 2011, \url{http://www.oecd.org/document/10/0,3746,en_2649_37407_33913226_1_1_1_37407,00.html}
\end{itemize}
market, some of the smaller funds with lower capital reserves would struggle to remain financially viable if they were forced to compete.112

Even though there are a relatively large number of private health insurance funds in Australia, competition within the private health insurance sector is also limited by high market concentration (that is, a few funds have a very large market share). In July 2010, there were 35 private health insurance funds operating in Australia, but only five of them had a market share of five per cent or more.113 Between them, these five funds accounted for 84 per cent of the private health insurance market.

The government’s private health insurance regulator, the Private Health Insurance Administration Council, claims that despite the high degree of market concentration, competition is strong in the Australian private health insurance market.114 IBISWorld assesses the degree of competition within the sector as moderate, arguing that the structure of the industry itself imposes limits on competition.115 Others argue that competition between funds in Australia has been deliberately stifled so that other objectives can be met, objectives such as ensuring that: subsidised private health insurance is accessible to all, regardless of health status (the long-established principle of ‘community rating’116 is an important example); contributors are fairly treated, and; funds are prudentially managed.117 The low number of new commercial insurers entering the market since Medicare was introduced in 1984, and low numbers of people switching funds lends some support to the claim that competition is constrained in the private insurance sector in Australia. To illustrate, in the March 2011 quarter, only 0.6 per cent of policy holders switched funds.118

According to IBISWorld’s analysis, consolidation in the form of mergers in the private health insurance market is likely to increase over the future.119 Merging is one way funds can lower costs because larger funds are in a better position to bargain with providers over the price of services. To ensure profitability into the future, funds will need to continue to find ways of lowering costs but they will also need to raise premiums because the industry is under significant pressure. According to IBISWorld, however, the scope for doing both is limited.

114. Ibid.
116. Under community rating all members of an insurance fund are charged the same premium regardless of their health status.
119. IBISWorld, Health Insurance in Australia, op. cit.
What are we doing to ensure the sustainability of the health system?

Options for reform

Promoting the idea of greater competition in health care is contentious. Because there are so many areas of market failure in health care, pursuing competition without regard for the uniqueness of health and health care systems can be detrimental.120 The OECD has explained that there is no other sector of the economy that challenges the traditional assumptions of neoclassical economics more so than health, so it is hard to sustain an argument that the application of pure market principles is what is needed in health care.121

In health care the challenge is to identify proposals that accept the basic premise that the health sector is different but also stimulate competition in ways capable of delivering benefits for the system, patients and those that work within it.122 Countries that have attempted to introduce market-oriented reforms offer some instructive lessons. Some of them have found that: increasing competition has often required greater national regulation; implementation has been difficult (as it tends to be with all health care reforms) and has often led to conflicts between policy objectives, such as equity, efficiency and effectiveness; and the costs associated with increasing competition have been much higher than expected.123

Despite the challenges, ignoring the role of competition in health care is not a realistic option, particularly in countries like Australia where the private sector plays a significant role in the delivery of health services. In the area of medical services, to stimulate competition there may be merit in considering greater role substitution. Introducing physicians' assistants in Australia is one potential option that has already been outlined.124 There may also be merit in returning to some of the ACCC’s recommendations about medical specialists' training.125 In particular, consideration could be given to making the training and accreditation process more transparent and expanding the government’s role in it. Another option floated by the ACCC is to shift medical specialist training into the university sector.

120. See Appendix C for examples of market failure in health care.
121. OECD, Achieving Better Value for Money in Health Care, op. cit.
125. Australian Competition and Consumer Commission (ACCC), ACCC proposes surgical college reform to help address surgeon shortage, media release, 6 February 2003; ACCC, Review of Australian Specialist Medical Colleges, op. cit.
Stimulating competition in the hospital sector depends substantially on reforming Australia health insurance arrangements (discussed below). However, as an initial step, it seems likely that competition between hospitals would be enhanced if people had access to more comprehensive and timely performance data on individual hospitals, both public and private. Consideration could also be given to making some performance data for individual practitioners publicly available.

In the insurance sector, one important area in which such reforms could be focused is in resolving the tension between Medicare and the private health insurance system—an overarching structural issue that has a significant impact on competition in other parts of the health system.

According to the OECD and the Industry Commission (the Productivity Commission’s precursor), these unusual health insurance arrangements in Australia have endured because successive governments have continued to introduce policies that support universal access under Medicare and voluntary, community-rated private health insurance.\(^{126}\) To date, governments have paid little attention to the challenges of operating a mixed insurance system and resolving the tensions between the public and private insurance schemes that inevitably result when there are two, overlapping insurance systems in operation.\(^{127}\)

There are a number of potential options in the area of health insurance. One is to set Medicare and the private health insurance funds up in direct competition with each other. Proposals along these lines have been made in the past, most recently by the NHHRC in the form of Medicare Select. Medicare Select is a form of managed competition between a public insurer and private insurers.\(^{128}\) The proposal was largely based on a managed competition scheme outlined in 2002 by Dr Richard Scotton (one of the architects of Medicare).\(^{129}\) Another option is to redirect subsidies for private insurance to private hospitals themselves.\(^{130}\) In contrast, some, including the Commonwealth Treasury, have argued that subsidies for private health insurance could be redirected to public hospitals.\(^{131}\) Yet another option is to provide funding for health care to patients directly in the form of vouchers.\(^{132}\)

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Conclusion

Improving the sustainability of Australia’s health system is not an easy task. There are major challenges associated with reforming a system where both the federal and state and territory governments share responsibility for health. These challenges are compounded by the fact that health care is plagued by uncertainty and inequity, and many key health care activities, such as service delivery, are beyond the direct reach of governments.

Compared with many other countries Australia’s health system is relatively efficient and effective, and successive governments have been reasonably successful at containing the growth in health expenditure. However, future governments are likely to be under more intense pressure to slow the growth in health care expenditure as demands and expectations for health care continue to rise. To ensure the fiscal sustainability of the health system in the future, governments will need to do much more than they have in the past. Ad hoc, sector by sector reforms are unlikely to be enough.

This paper identifies some of the key mechanisms for controlling expenditure growth and examines how effectively they are being used in the Australia health system. It outlines some potential options for reform as a starting point for discussion; they are by no means the best or the only options available. It will only be possible to evaluate the relative merits of these and other reform proposals by embarking upon a broader discussion on the sustainability of the health system where the focus is on performance of the system as a whole. It is not clear where responsibility for advancing this agenda should lay — with the federal Department of Health and Ageing or Treasury, the Council of Australian Governments or the new National Health Performance Authority. It is clear, however, that the agency or organisation that takes responsibility for improving the sustainability of the health system will have plenty of work to do.
Appendix A

Health Technology Assessment agencies in Australia

**Pharmaceutical Benefits Advisory Committee**

The PBAC makes recommendations to the Minister for Health and Ageing about which new medicines should be listed for public subsidy through the Pharmaceutical Benefits Scheme (PBS). The PBAC considers both the clinical effectiveness and cost effectiveness of medicines. When the Committee began to incorporate economic evaluations of new medicines into its evaluation process in 1993, it was considered to be a world leader in the field.

**Medical Services Advisory Committee**

MSAC was established in 1998 to make recommendations to the Minister for Health and Ageing about which new medical services or procedures should be listed for public subsidy through the Medical Benefits Scheme (MBS). Like the PBAC, MSAC considers both the clinical and cost effectiveness as part of its evaluation. It also has a role in assessing the safety of new medical services or procedures.

**Prostheses and Devices Committee**

The PDC differs somewhat from PBAC and MSAC in that it is concerned with the benefits paid by private insurers for prosthetic devices such as cardiac pacemakers and defibrillators, cardiac stents, hip and knee replacements, and intraocular lenses. It also considers human tissue implants such as human heart valves, corneas, bones (part and whole) and muscle tissue. The PDC provides advice on which prostheses should be included on the Prostheses List, and what benefits should be paid by insurers. The PDC was formed in 2004.

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Appendix B

Provider payment systems

Public hospitals

At present, the federal government does not fund public hospitals directly but indirectly via agreements made with the states and territories. The states and territories pay hospitals using a combination of activity-based funding and fixed budget allocations (it varies from state to state and within states) using funding received from the Commonwealth as well as own-source revenue. Hospital funding arrangements are set to change with the introduction of activity-based funding, scheduled to begin from July 2012. Despite this, many smaller public hospitals will still be funded using a combination of activity-based funding and fixed budget allocations.

The majority of staff in public hospitals are salaried employees, including many doctors. Some doctors, however, are paid using other mechanisms. Visiting medical officers enter into contracts with public hospitals and are either paid on a fee-for-service basis (using the Medical Benefits Schedule of fees) or sessional basis (under these arrangements, doctors receive a fixed fee for providing services for a set period of time).

Medical services

Most general practitioners (GPs) in Australia charge a fee-for-service. Patients then seek reimbursement for all or part of the fee through the Medical Benefits Scheme (MBS). GP services therefore are also partly funded from patient contributions, or co-payments. Many GPs, however, choose to bulk-bill the services they provide, meaning that they are paid directly by the federal government on the condition that they do not charge the patient a co-payment.

In the 2010–11 federal Budget, the Government proposed the introduction of a capitation payment for GPs providing services to diabetic patients. Under the arrangements proposed, diabetic patients would enrol with a general practice, and the general practice would receive an annual lump sum payment for every enrolee, to be used to fund routine patient care as well as any additional specialist services needed, such as podiatry. Following objections from the Australian Medical Association (AMA), the Government decided to postpone the changes until at least 2014 and instead agreed to pilot an alternative scheme recommended by the AMA.

Most medical specialists also charge a fee-for-service, and like GPs services, a patient co-payment is also often required. These arrangements apply to medical specialists providing services to private patients out of hospital, as well as to private patients in public and private hospitals.


Pharmaceuticals

Prescription pharmaceuticals are largely provided through privately owned and operated community pharmacies and public and private hospitals. The Australian government funds community pharmacies in three main ways:

- by subsidising the cost of eligible prescription medications through the PBS;
- through the Community Pharmacy Agreement, which is a budget allocation over a 5 year period to pay community pharmacies for dispensing PBS medicines (dispensing fees are a type of fee-for-service payment) and providing other pharmacy programs and services, such as medication management services; and
- through the PBS Safety Net, which allows general patients who spend more than the threshold amount on prescription medications to receive them at the concessional rate for the remainder of the calendar year, and concessional patients to receive them free.

The Australian government also indirectly funds pharmaceutical products and services provided in public hospitals through the Australian Health Care Agreements. Public hospital pharmacists are employed on a salaried basis.

The Australian government, therefore, pays for pharmaceutical services using a mixture of payment mechanisms: salaries, fee-for-service, and budget allocations.

Table 1: Total funding for health expenditure, by source of funds as a proportion of total health expenditure, 1997–98 to 2007–08 (per cent).

<table>
<thead>
<tr>
<th>Year</th>
<th>Australian Government</th>
<th>State/territory/local</th>
<th>Health insurance funds</th>
<th>Individuals</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997-98</td>
<td>42.1</td>
<td>25.3</td>
<td>9.5</td>
<td>16.3</td>
<td>6.8</td>
</tr>
<tr>
<td>1998-99</td>
<td>43.3</td>
<td>23.7</td>
<td>8.0</td>
<td>17.3</td>
<td>7.8</td>
</tr>
<tr>
<td>1999-00</td>
<td>44.3</td>
<td>24.9</td>
<td>6.9</td>
<td>16.7</td>
<td>7.3</td>
</tr>
<tr>
<td>2000-01</td>
<td>44.4</td>
<td>23.3</td>
<td>7.1</td>
<td>18.0</td>
<td>7.2</td>
</tr>
<tr>
<td>2001-02</td>
<td>44.0</td>
<td>23.2</td>
<td>8.0</td>
<td>17.5</td>
<td>7.2</td>
</tr>
<tr>
<td>2002-03</td>
<td>43.6</td>
<td>24.4</td>
<td>8.0</td>
<td>16.7</td>
<td>7.3</td>
</tr>
<tr>
<td>2003-04</td>
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<td>23.6</td>
<td>8.1</td>
<td>17.5</td>
<td>7.3</td>
</tr>
<tr>
<td>2004-05</td>
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<td>24.0</td>
<td>7.7</td>
<td>17.4</td>
<td>7.1</td>
</tr>
<tr>
<td>2005-06</td>
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<td>25.3</td>
<td>7.6</td>
<td>17.4</td>
<td>6.9</td>
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<tr>
<td>2006-07</td>
<td>42.0</td>
<td>25.8</td>
<td>7.6</td>
<td>16.8</td>
<td>6.9</td>
</tr>
<tr>
<td>2007-08</td>
<td>43.2</td>
<td>25.5</td>
<td>7.6</td>
<td>17.2</td>
<td>5.7</td>
</tr>
<tr>
<td>2008-09</td>
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<td>25.1</td>
<td>7.8</td>
<td>17.2</td>
<td>5.0</td>
</tr>
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<td>2009-10</td>
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<td>26.3</td>
<td>7.6</td>
<td>17.5</td>
<td>5.0</td>
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</tbody>
</table>

Source: Australian Institute of Health and Welfare (AIHW), Australia’s Health 2010, AIHW, Canberra, Table 8.4, p. 414. ‘Other’ largely includes funding from injury compensation insurers.
What are we doing to ensure the sustainability of the health system?

Figure 1: Change in proportion of health expenditure (per cent) financed through co-payments, selected OECD countries, 1997–2007.

<table>
<thead>
<tr>
<th>Country</th>
<th>Change in proportion of expenditure from co-payments</th>
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</thead>
<tbody>
<tr>
<td>Australia</td>
<td>+1.1</td>
</tr>
<tr>
<td>Austria</td>
<td>-0.1</td>
</tr>
<tr>
<td>Canada</td>
<td>-2.1</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>+3.5</td>
</tr>
<tr>
<td>Denmark</td>
<td>-2.5</td>
</tr>
<tr>
<td>Finland</td>
<td>-2.6</td>
</tr>
<tr>
<td>France</td>
<td>-0.1</td>
</tr>
<tr>
<td>Germany</td>
<td>+3.1</td>
</tr>
<tr>
<td>Hungary</td>
<td>+5.6</td>
</tr>
<tr>
<td>Iceland</td>
<td>-1.9</td>
</tr>
<tr>
<td>Ireland</td>
<td>-1.2</td>
</tr>
<tr>
<td>Japan</td>
<td>-2.2</td>
</tr>
<tr>
<td>Korea</td>
<td>-13.4</td>
</tr>
<tr>
<td>Mexico</td>
<td>-2.2</td>
</tr>
<tr>
<td>New Zealand</td>
<td>-1.3</td>
</tr>
<tr>
<td>Norway</td>
<td>-2.7</td>
</tr>
<tr>
<td>Poland</td>
<td>-3.8</td>
</tr>
<tr>
<td>Slovak Republic</td>
<td>+17.9</td>
</tr>
<tr>
<td>Spain</td>
<td>-2.4</td>
</tr>
<tr>
<td>Switzerland</td>
<td>-1.7</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>-2.4</td>
</tr>
<tr>
<td>United States</td>
<td>-2.4</td>
</tr>
</tbody>
</table>

Appendix C

Box 1: Examples of market failure in health care

Examples of market failure in health care

- Many health services are public goods. A public good is one that people cannot effectively be excluded from using, and one that when used by one person does not become less available to others. Population-based health promotion programs (for example campaigns to increase physical activity) and research and development (for example into new treatments) are examples. If left to the market, public goods tend to be under-supplied because people usually prefer to wait until they are provided free of charge instead of paying for them.

- There are many externalities in health. Externalities are benefits and costs that arise from particular health interventions that extend beyond the patient and provider to other parties. Immunisation against contagious diseases is an example. The presence of externalities in the market for health care means that some services will be under-utilised as individuals can benefit without purchasing the services themselves.

- Insurance can lead to inefficiencies because markets can create moral hazard (where people take less care of their health in areas where they are insured), lead to adverse selection (where those who take out insurance are more likely to use it than the general population) and risk aversion (where insurance companies are unwilling to offer cover to high-risk people or small populations where it is difficult to spread the risk).

- Information asymmetries often exist because the providers of care have much more information and knowledge about a health service, its potential outcomes and quality than the consumers do. This means it is possible for providers to encourage patients to use services beyond what is optimal or necessary.

- The quality of health care data is often poor. In many areas of health care, there is no, or poor quality, data on the inputs, activities and outcomes of health care. Where data is available, there is often such large variation that it impossible for patients to use it to make informed decisions about which provider to choose.
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