

**Financing Health Care:
Short Run Problems, Long Run Options**

**Paper presented to the Health Reform Forum
Melbourne Business School 19 September 2002**

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ACKNOWLEDGMENTS

The Health Economics Unit of the CHPE is supported by Monash University.

The Program Evaluation Unit of the CHPE is supported by The University of Melbourne.

Both units obtain supplementary funding through national competitive grants and contract research.

The research described in this paper is made possible through the support of these bodies.

Table of Contents

1	Introduction	1
2	Short Run 'Problems'	1
2.1	Private Health Insurance	3
2.2	Pharmaceutical Benefits Scheme (PBS)	8
3	Long Run Problems	10
4	Options for Reform	11
4.1	Instruments	11
4.2	Managed Competition	14
4.3	Regional Budget Holding	16
5	Discussion	18
	References	19

List of Tables

Table 1	Pharmaceuticals and other medical non durables,	2
Table 2	Recurrent expenditures, source of funds (\$ billions current)	3
Table 3	Private hospital services	3
Table 4	PHI expenditure and revenue	5
Table 5	PHI Areas of expenditure and subsidy	7
Table 6	Ratio of likelihood of receiving a service following admission to	7

List of Figures

Figure 1	Private Health Insurance	2
Figure 2	Size of Sectors	2
Figure 3	Percent population covered by a hospital insurance table,	4
Figure 4	Cost and scripts for NSAIDs	9
Figure 5	PBS expenditure from 1992 to 2001	9

List of Boxes

Box 1	Stages of the Reform Process	16
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Financing Health Care: Short Run Problems, Long Run Options

1 Introduction

This paper addresses two broad issues. First, what are the problems facing the Australian health care system (Medicare) and how successfully have these been identified and addressed? Secondly, does Managed Competition/Managed Care represent a more rational path for Medicare to follow? The overarching assumptions behind the analysis are, first, that reform should be driven by quantitatively large problems and, secondly, that policies which do not address such problems are likely to be counter productive if only in terms of their opportunity cost—the energy and resources devoted to second, not first, order problems.

In Section 2 below two recent concerns are addressed, namely, the role and financing of private health insurance (PHI) and pharmaceuticals. It is argued that the response to both of these problems has been inappropriate: policies do not represent parts of a long run coherent plan for achieving either an efficient or equitable health system.

In the third section it is argued that significant problems exist with Medicare and it is a reasonable hypothesis that a restructuring of the scheme to align incentives and objectives will increase the likelihood of achieving objectives. It is, however, possible to effect significant changes within the Medicare framework. The choice between these broad strategies cannot be determined on the basis of a priori reasoning alone. An assessment must be made of the *quantitative* response of key parameters. Debate over system reform should therefore identify these parameters and evaluate the empirical and other evidence relating to their magnitude. Part of this process depends upon the identification of system objectives and surprisingly little attention has been given to this question.

2 Short Run ‘Problems’

The two issues which have received greatest public attention in the past three to four years are the role of Private Health Insurance (PHI) and the cost of pharmaceuticals. In discussing these, two caveats are immediately necessary. The first arises from the fact that both PHI and the PBS are components of a wider health system. Consequently, the sub-sectors should be evaluated in terms of their effect upon the wider health system and the extent which they contribute to the achievement of health sector objectives. The caveat is important. It implies, for example, that the size of the subsidy or the absolute level of expenditure upon pharmaceuticals should not be an immediate concern if the increased use of drugs reduced health care costs elsewhere. Likewise, PHI is not simply a vehicle for the elimination of risk. Rather, it is a source of revenue for other health services. The structure of health insurance creates incentives for particular behaviours, and the most important criterion for assessing PHI is the effect it has upon health system performance and the magnitude and importance of these effects.

The second caveat, which follows from the first, is that costs and the change in costs should be compared with the overall size of the health sector. Despite the exuberance of the debate, PHI in 1999/2000 contributed only 7.1 percent of health sector revenues (see Figure 1). In the same

Figure 1 Private Health Insurance

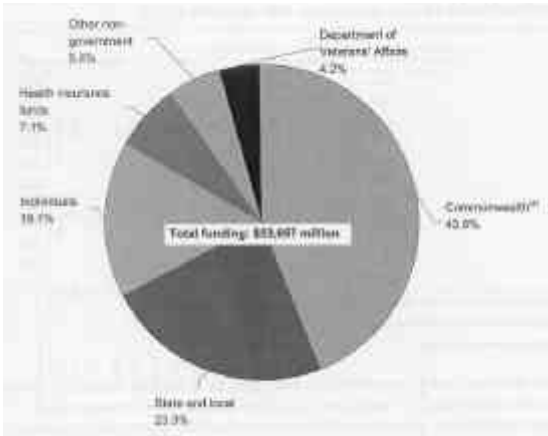
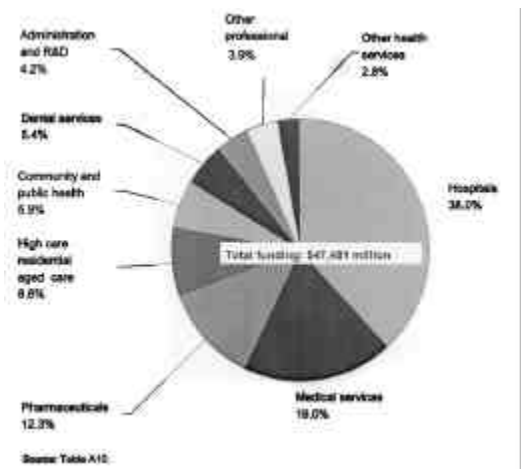


Figure 2 Size of Sectors



Source: AIHW Health Expenditure Bulletin

The importance of international comparisons should not, however, be overdrawn. Virtually every health system has problems and it is clear that Australia, like most other countries, could significantly improve the operation of the health system. This more general issue is discussed in Section 3.

2.1 Private Health Insurance

The widely known story about the events leading to recent PHI policy initiatives is simple, logically consistent and for the most part wrong. It is that because of the existence of a ‘free’ alternative—public hospital care—the membership of PHI declined until 1998; that this led to a decreasing use of private hospitals which, in turn, put pressure on public hospitals and that this was the reason for increasing hospital queues. This (incorrect) sequence of events was widely interpreted as indicating a crisis in Medicare and the commonly accepted solution was to reverse the decline in PHI in order to take pressure off the public hospitals.

Table 2 Recurrent expenditures, source of funds (\$ billions current)

Year	Total Expenditures	Hospitals		Expenditures		Individuals
		Pub	Priv	Gov	PHI	
1989/90	26.8	8.2	1.7	18.3	3.1	4.5
1998/99	47.5	14.0	4.0	33.0	4.8	8.5
% change	77.2	70.7	135	80.3	54.8	88.8

Source: AIHW Health Expenditure Bulletin

Note: \$4.8 b = gross revenue unadjusted for the rebate.

Table 3 **Private hospital services**

	% of Total	
	Separations	Bed Days
1985/86	25.9	21.9
1989/90	26.7	22.0
1995/96	30.5	26.3
1999/00	34.3	28.1
Increase	32.4%	28.3%

Source: Butler 1999; Bloom 2002

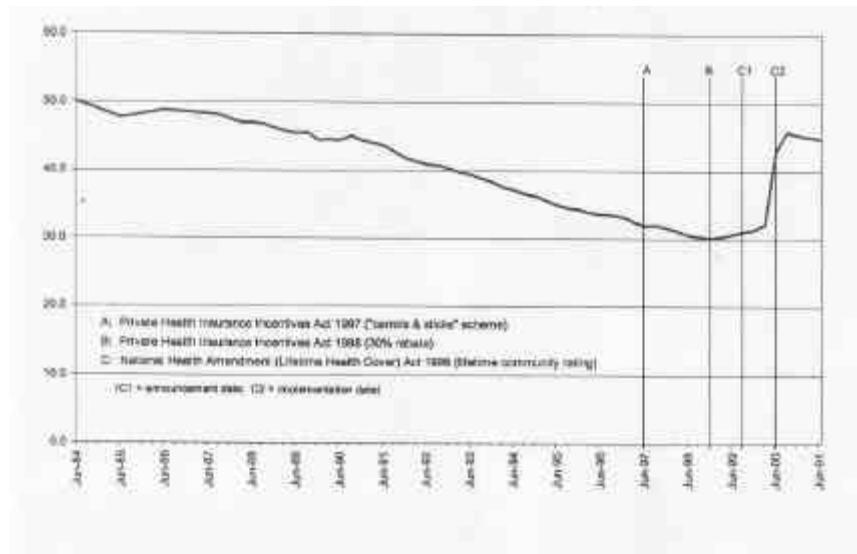
Some of the relevant evidence is presented in Tables 2 and 3. Between 1989/90 the revenues raised by PHI rose by 54.8 percent. Private hospital income increased by 135 percent—almost double the rate of growth of public hospital expenditures. From 1985/86 to 1999/2000 private hospitals increased their share of hospital separations from 25.9 to 34.3 percent—that is, private hospitals increased their share of separations by 32 percent. This evidence unambiguously contradicts the explanation commonly given for hospital queuing. Rather, queuing has occurred in public hospitals for two main reasons. First, there is a shortage of some specialists and priority has been given to private, not public, patients. Secondly, State governments have imposed severe budgetary limits on their hospitals. In Victoria, for example, the acute care budget between 1991/92 and 1994/95 fell by 8 percent in normal terms despite a 12 percent increase in unit costs and a 21 percent increase in standardised throughput (Richardson 1999).

This evidence suggests that subsequent policies were not designed to avert the collapse of the public system but to preserve or expand PHI as a social objective in itself.

In the past 5 years there have been three main policy changes with respect to PHI: (i) in July 1997 the Private Health Insurance Incentives Scheme (PHIIS) introduced tax subsidies for low income households and tax penalties for high income individuals and families—those with incomes above \$50,000 and \$100,000 respectively—who failed to purchase PHI; (ii) in September 1998 the tax subsidy was replaced by a ‘30 percent rebate’ for all PHI irrespective of the recipient’s income; and (iii) in September 1999 ‘Lifetime Community Rating’ was announced to become effective from July 2000. For those purchasing PHI before the age of 30 and maintaining PHI there is now a lifetime discount on the insurance premium. The discount is reduced by 2 percent per annum for each year beyond the age of 30 at which a person purchases PHI.

The policies have been spectacularly successful. As shown in Figure 3 membership increased from 30 to 45 percent. In a careful analysis of this change Butler (2001) demonstrates a very uneven contribution from the three policies. The PHIIS had little or no impact. The 30 percent rebate probably increased membership from 30 to 32.2 percent. Almost all of the effect—the increase from 32 percent to 45 percent coverage—is attributable to the introduction of lifetime tables.

Figure 3 Percent population covered by a hospital insurance table,
Australia June 1984 to June 2001



Source: Butler 2001

While the policies have successfully increased the membership of PHI, they have created an industry which, along with the echidna and platypus, could be the Australian entry into an international ‘Strange but True’ contest. As individual and family incomes rise above the threshold, the effective price of PHI (direct price less subsidy less surcharge avoided) now falls and quickly becomes negative—individuals and families are effectively paid to purchase the product—they are left with a higher net income if insurance is purchased! PHI is probably unique in the world in being supported by a subsidy which depends upon the purchase of a particular product. It is similar to the introduction of a tax on the incomes of those

who fail to buy an Australian made car in order to promote the automobile industry.

Next (and possibly offsetting some of the apparent inequity of paying the wealthy to take out PHI) people with private health insurance may be substantially out of pocket in a way that does not happen if there is no health insurance—the financial risk is greater with, than without, health insurance if it is used! This is also likely to be unique in the world. The third and most successful policy to encourage PHI also has a bizarre dimension. Insurance is normally intended to reduce the anxiety associated with risk. In the present context it is the risk of needing private health care and being unable to pay for it without insurance. Before the introduction of lifetime policies this anxiety arose because of the risk facing individuals and families in the next 2 to 5 years. But the introduction of lifetime tables means that families must now consider the next 20 to 30 years and the success of the policy is almost certainly due to the fact that it increases the very thing which insurance is intended to reduce, namely, anxiety associated with the future.

The change in PHI income and membership has undoubtedly increased hospital expenditures in the private sector. An alternative policy would have been to increase public hospital expenditures by an amount equal to the subsidy. Using this as a benchmark PHI is not very efficient. As shown in Table 4, PHI revenues increased from \$4.8 billion to \$7.1 billion between 1998 and 2000. However hospital benefits paid by PHI rose by only \$1 billion. As the subsidy in 2001 was approximately \$2.3 billion only 43 percent of it flowed through to additional hospital expenditures. The full cost of the different policy measures in 2001 was probably closer to \$3.8 billion (Segal 2002). This implies that only 26 percent of the total subsidy was spent on hospitals. Most of the remainder was spent on activities which are outside the public national health scheme. If the subsidy has been allocated by PHI companies pro rata then only 58 percent of it would be spent upon hospitals (public and private) 5 percent would be spent on medical services and the remaining 35.1 percent would be spent on services not included in the national health scheme for other patients (see Table 5).

Table 4 PHI expenditure and revenue

	Pop Cover (%)	PHI income \$b	PHI Hospital Benefits \$b
1998/99	30.1	4.8	2.8
2002 (est)	44.9	7.1	3.8
Increase		2.3	1.0
Subsidy			
30%			2.3
Full (Segal) ¹			3.8
Change in Hospital			
÷ 2.3b			0.43
÷ 3.8b			0.26

Source: PHIAC, Annual Reports

¹ Segal, Australian Financial Review, includes cost of exemption from Medicare Surcharge; 30% rebate; coverage of medical, pharmaceutical costs due to higher use of services.

Table 5 PHI Areas of expenditure and subsidy

	Expenditures 1998/99 ¹ \$b	%	Pro rata allocation of subsidy \$b 2001
Recurrent	4.06	100.0	
Hospitals	2.35	57.9	1.33
Medical	0.21	5.2	0.12
Other Professional	0.20	9.1	0.21
Drugs/Appliance	0.17		
Dental	0.56	13.7	0.32
Admin	0.50	12.3	0.28

¹ Health Expenditure Bulletin

The impact of the PHI policies upon public hospitals has not been properly analysed. There are, however, grounds for believing that it may have been perverse. In the simple, but wrong analysis of PHI outlined earlier, an increase in the number of private hospital patients would reduce the 'pressure' upon public hospitals and thereby decrease the length of queues. However the logic of this argument is incorrect. Queues depend upon the balance between supply and demand. While it is true that a transfer of patients to the private sector will reduce the demand for public services, a transfer of doctors between the sectors to meet this demand will decrease the supply of doctors for public patients.

Table 6 Ratio of likelihood of receiving a service following admission to private and public hospitals after AMI, 1995/97

	Private Hospital Patients : Public Patients to		Private Patients in Public Hospitals : Public Patients to	
	Angiography	Revascularisation	Angiography	Revascularisation
Within 14 days				
Men	2.20	3.43	1.77	1.53
Women	2.27	3.86	1.57	1.81
Within 3 months				
Men	2.24	3.43	1.53	1.23
Women	2.28	3.34	1.49	1.32
Within 12 months				
Men	2.16	2.89	1.42	0.97
Women	2.22	2.84	1.48	1.10

Source: Victorian Inpatient Minimum Dataset, Robertson & Richardson 2000

Table 6 presents some of the miniscule evidence relevant to this issue. In sum, it indicates that patients admitted to private hospitals after a heart attack are 2 to 4 times more likely to receive an intensive procedure (angiography, revascularisation). This implies that an expansion of the private sector will increase the number of these procedures which will require a disproportionate transfer of doctors from the public to the private sectors. If this pattern were generally true and, for example, a 10 percent transfer of patients was accompanied by a 20 percent transfer of doctors, then the expansion of the private hospital system would increase, not decrease excess demand and queuing in the public sector. This scenario is highly plausible. Doctors have a

strong financial incentive to give a larger number of more complex services in the profitable fee-for-service, private sector than in the less profitable, salaried or sessional, public sector.

2.2 Pharmaceutical Benefits Scheme (PBS)

Since government intervention became unfashionable in the 1970s economists have been quicker to identify regulatory failure than regulatory success. Thus, for example, despite the *prima facie* evidence that the PBS had been, for a number of years, spectacularly successful in their price negotiations with pharmaceutical companies, few have noted this fact and the Industry Commission (1996) was sparing in its praise! With the vigorous use of its monopsonistic power, Australia's health authorities drove down the price of the pharmaceuticals it purchased to almost 50 percent of the average price in other countries (Industry Commission 1996). Until 1993 negotiations were essentially ad hoc (although economic data had previously been provided to the Pharmaceutical Benefits Advisory Committee—PBAC). Since 1993 companies seeking to have their drugs listed on the PBS have been required to submit a formal economic evaluation (which must follow a detailed methodological protocol). The Australian regulation was the first such requirement in the world. Similar legislation was subsequently passed in Canada, New Zealand and the United Kingdom.

The submission of a cost effectiveness analysis does not, in itself, increase the governments negotiating power. While it will eliminate highly cost ineffective drugs—those with lower effectiveness for high cost—it could, perversely, lead to an increase in the final price of highly cost effective drugs. Pharmaceutical companies which are aware of the cost effectiveness of their product and will have an incentive to inflate apparent costs when drugs are highly effective in the knowledge that they will still appear to be cost effective. Consistent with this, the negotiated price of more recent drugs has been closer to the world average price. The outcome, however, may reflect learning by those purchasing drugs in other countries who have observed the lower Australian prices.

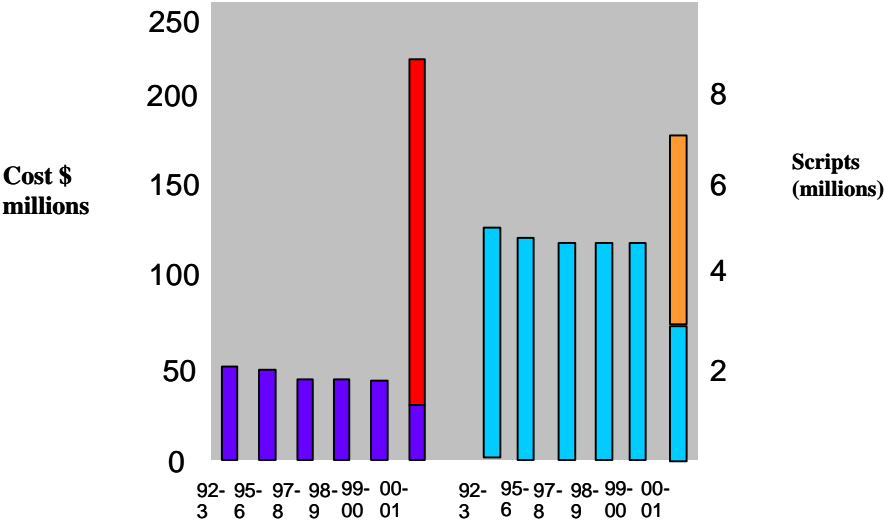
The regulatory framework of the PBS now has four separate, and separately administered, stages. First, drugs are examined for safety and efficacy by the Therapeutic Goods Administration and, when successful, drugs are registered. Secondly, the Pharmaceutical Benefits Advisory Committee examines the costs and benefits of a drug and recommends rejection or adoption and, in the latter case, an appropriate price. Thirdly, the Pharmaceutical Benefits Pricing Authority recommends a price to the Commonwealth Minister for Health who, it is believed, always accepts this price. Finally, drugs are dispensed by regulated Pharmacists and for a regulated fee for the Pharmacist.

In principle, the present framework is a good one. It combines rigorous economic evaluation with a capacity for authorities to exercise discretion at all stages. A retrospective analysis of 355 consecutive submissions to the PBAC between January 1991 and January 1996 indicated that the PBAC normally rejected drugs with a cost per life year greater than \$76,000 and were unlikely to reject drugs where the cost per life year was less than \$42,000. Between these two values the committee exercised a degree of discretion as might be expected depending upon specific contextual factors.

The framework does not, of course, guarantee successful regulation and problems may arise for at least three reasons. First, it is possible that the market for a particular drug might be significantly greater than anticipated and, consequently, realised expenditures might exceed the

expected level. This ‘problem’ does not, itself, indicate a defect in the framework. If the cost effectiveness of a drug is favourable then a larger market indicates that greater than anticipated benefits are being obtained. If this results in a global budgetary problem for government then the threshold at which any drug is accepted should be incrementally increased until a satisfactory budget outcome is achieved.

Figure 4 Cost and scripts for NSAIDs



Source: Segal et al 2002a

The second and more serious problem is that, as with any regulatory process, the regulators may be ‘captured’. The recent and highly publicised experience of the anti inflammatory drug Celebrex is consistent with (but does not ‘prove’) the hypothesis of regulatory capture. As reported in The Age (02/02/2001) the PBAC recommended that Celebrex be priced at \$1.00 per day with a halving of the price once an agreed number of scripts had been issued. Despite this, and for the first time, the government accepted a pricing authority recommended price 20 percent higher than the recommendation. No quantity discount was negotiated. Announcing the listing of Celebrex, Health Minister Dr Michael Wooldridge foreshadowed expenditures of \$54 million per annum. In the event, realised expenditure was \$232 million. As shown in Figure 4 this caused a dramatic increase in the national bill for non steroidal anti inflammatory drugs. Adding to the *prima facie* evidence of capture, three of the members of the PBAC publicly expressed concern over the growing political influence of the drug industry which now has a representative on the five member pricing authority.

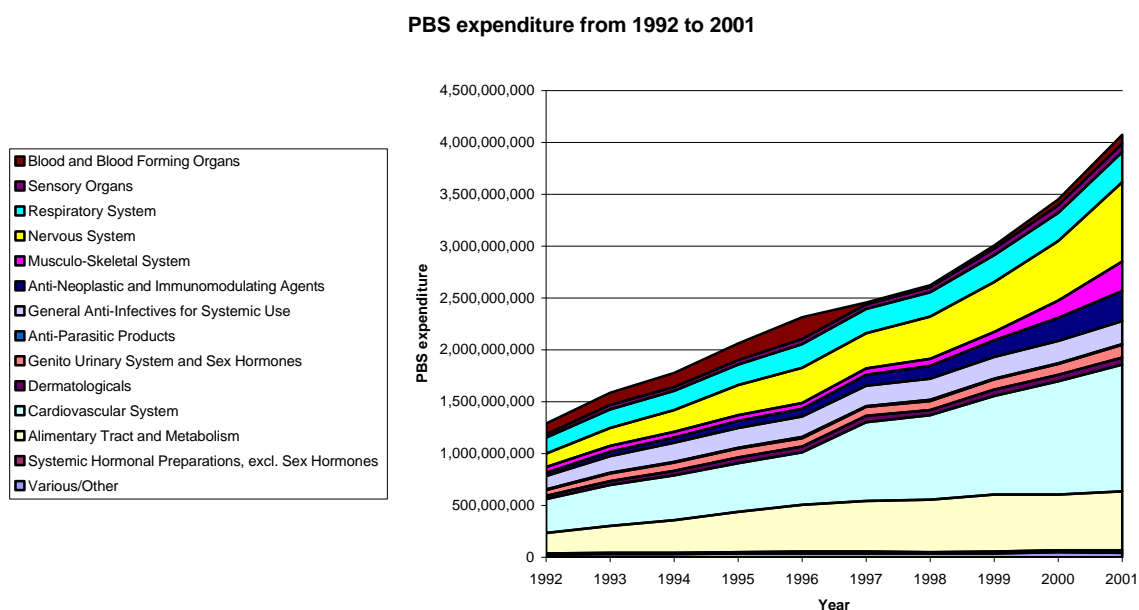
Regulatory capture cannot, however, satisfactorily explain the ten year trend in pharmaceutical expenditures. These are shown in Figure 5 which indicates a significant growth, not simply in drugs of the muscular skeletal system (which includes Celebrex) but a growth in all drug categories, and particularly, those of the cardiovascular system. The figure suggests that expenditures have been driven by new technologies, a trend which is likely to continue as biotechnology and research into the human genome is translated into a new generation of pharmaceuticals.

The third and most worrying weakness in the PBS system is its reliance upon doctors to prescribe drugs only when the clinical indicator (blood pressure or cholesterol level etc) has reached the threshold suggested by the PBAC. It is believed that doctors commonly ignore these

recommendations and prescribe drugs even when the clinical indicators suggest that the drug is 'cost ineffective'.

An ad hoc option for ameliorating this third problem is to increase the capacity of the Health Insurance Commission to analyse proscribing patterns and to counsel doctors with clearly deviant prescribing habits (as it does with medical services). A second desirable but ad hoc policy is the provision of additional resources to the PBAC to re-examine a larger number of currently listed drugs and to target those with rapid expenditure growth. The process should result in a revision of the clinical indicators and possibly the delisting of drugs where the benefit is lower than the possibly increasing threshold at which drugs are listed.

Figure 5 **PBS expenditure from 1992 to 2001**



Source: HIC Annual Data

These palliative measures are unlikely to have a significant impact while the economic incentives are perverse. Doctors have no reason for withholding drugs whenever they have positive value for their patients. This suggests the need for a restructuring of the payment system and, more specifically, the adoption of a system in which pharmaceuticals are treated as an input into the production of a service—pharmaceuticals should be 'bundled' with the doctors consultation. Experience in the UK, US and New Zealand suggest that the provision of a pharmaceutical budget to a 'GP Budget Holder' may have beneficial effects upon prescribing practises. This, however, is only one example of the need for a comprehensive re-evaluation of the incentives which have evolved haphazardly in Australia over time.

3 Long Run Problems

In addition to ‘problems’ of PHI and pharmaceuticals, Medicare is widely believed to suffer from structural problems which will prevent it from coping with a number of formidable problems which it will shortly confront. Some of these problems/structural weaknesses have been significantly exaggerated. These include the following:

- (i) **Cost.** Cost effectiveness and not cost per se should be the criterion for inclusion or exclusion of services. If benefits exceed costs then economists should be advocating increased expenditures. (Spending 30 percent of GDP on health care—as once projected by the US Health Care Financing Agency—would be highly desirable if it extended life expectancy to 130 years of excellent health—something HCFA did not, unfortunately foreshadow). Increased expenditures on cost effective interventions should be no more a problem than the increased share of GDP devoted to recreational travel or restaurants.
- (ii) **Technology.** Identical arguments apply to technology as to the cost of health services. The most important caveat is that with inappropriate incentives the control of ‘cost ineffective’ technologies may be difficult.
- (iii) **Cost Shifting.** All else equal, cost shifting between levels of government is irrelevant for the population if the same services are provided to the same patients. (A minor caveat arises from the different sources of tax revenue.) Cost shifting becomes a problem only if the service mix is distorted, services curtailed or if the quality of government management is eroded because of its focus upon cost shifting rather than costs and outcomes.
- (iv) **Duplication of Government Functions.** The extent (or existence) of this has never been documented. The complete removal of the Commonwealth Department of Health and Ageing would have a relatively trivial impact upon system costs—about 0.6 percent of health expenditures or about 1 percent of total government health expenditures.

Lack of service coordination is often cited as a problem with Medicare. In principle this could be a serious deficiency resulting in the inappropriate use of services and the failure to substitute more for less cost effective types of care. The magnitude of this problem does not, however, appear to have been documented and the concern arises primarily from a consideration of present structures, not observed outcomes.

Quantitatively Large Problems: Despite these cautionary comments about the extent of Medicare’s problems, it undoubtedly has large scale and documented deficiencies and it is these which should be the drivers of long run reform. Three problems stand out.

- (i) **Technical and productive inefficiency in the form of avoidable adverse events.** This is ranked first because of the scale of the problem. The Quality in Australian Hospital Study, after revision, reported a 10.6 percent adverse event rate (Thomas et al 2000), which, by extrapolation (to the results of the 1995 QAHC study), implies 11,500 deaths and 32,000 permanent disabilities.
- (ii) **Allocative inefficiency, both geographic and between disease groups.** The magnitude of this problem is also enormous as revealed by small area variation in the delivery of different services (Richardson 1999). It is also likely to be significant between disease groups and disease stages since there has been no attempt to date to base the allocation

of resources upon the cost effectiveness of alternative interventions. (See Table 6 for the case of AMI).

- (iii) Equity. The variations noted above in (ii) represent differences in access to and use of health services by different populations. Aboriginal health is amongst the worst in the world.

The last two problems are both a direct consequence of the present funding system.

4 Options for Reform

4.1 Instruments

Empirical evidence suggests the following conclusions with respect to the effectiveness of alternative policies.

Options for reform vary from a series of ad hoc measures to a comprehensive overhaul of the system. A number of the former are listed in Table 7. Evidence concerning the most important ad hoc options is summarised below.

Table 7 **Ad hoc Solutions**

Problem	Marginal Programs	
QA	Financial incentives for QA	✓✓
Effectiveness of interventions	Normative copayments	✓✓
	Normative DRG	✓✓
	GP Division Budget Holder	✓✓
Pharmaceuticals/pathology	ie capitation payments to include drugs, diagnostics, other	✓
SAV	Normative DRGs	? ✓
	Capitation payments to regional agents	✓✓
	Rural loadings on HIC benefit	✓

- Budget Caps: This has been the most effective form of cost control to date. Examples include the world-wide capping of hospital budgets from the mid 1970s (Victorian experience is, perhaps, the most dramatic example).
- Provider Incentives: Evidence is limited but consistent with expectations. In particular, a recent study by Gravelle et al (JHE 2002 p324ff) suggests that the limited incentives built into the budget holding experiment in Britain—the ‘Thatcher Reforms’—may have had a very significant affect upon hospital referrals. There was a 30 percent reduction in referrals for cataracts—the procedure studied.
- The Physical Availability: Unsurprisingly control of supply reduces utilisation. This has been a major policy instrument in US HMOs.
- Copayments: Patient copayments reduce demand. There is a one-off effect. Evidence contradicts the belief that patients will drop ‘unnecessary’ services. (This was a major finding from the Rand Health Insurance Experiment).

- **Countervailing (Monopsonistic) Power:** This appears to be highly effective and associated with a concentration of spending. Perhaps the best example is the Australian PBAC which once reduced prices to 50-60 percent of the world average. It suggests the desirability of large purchasing units and a separation of the purchaser and provider.
- **Consumer Information (Empowerment):** While arguably an end in itself there is little evidence that information per se will have much effect. Data by Chassin reproduced in Table 8, reveals a startling outcome. The State of New York has published mortality rates by hospital and by doctor since 1989. The market shares of the hospital with the worst (standardised) outcome and the best (standardised) outcome each year were unaffected by the publicity. Neither individuals *nor Managed Care groups* responded to this information.
- **Privatisation:** There appears to be no evidence from within the hospital sector world-wide to demonstrate the advantages of the privatisation of hospitals. It must, therefore, be concluded that advantages are either very marginal as compared with other magnitudes in the health sector or non-existent. Regulatory energies expended on privatisation ventures have a high opportunity cost with respect to other more fruitful areas of reform.

Table 8 Market share for hospitals with lowest and highest CABG mortality in New York State 1989-95

Year	Lowest Mortality	
	Year before named as lowest	Year after named as lowest
1989	16.7%	16.3%
1990	14.6	15.2
1991	1.6	1.4
1992	3.6	3.5
1993	14.2	13.0
1994	13.1	13.3
1995	4.0	4.4
Year	Highest Mortality	
	Year before named as highest	Year after named as highest
1989	7.8%	9.1%
1990	6.8	6.9
1991	8.4	7.8
1992	3.2	3.1
1993	10.6	10.8
1994	0.5	0.5
1995	6.8	6.2

Source: Chassin 2002, *Health Affairs* 21:4 p47

4.2 Managed Competition

In a series of influential articles Scotton has adapted the Enthoven proposal for Managed Competition to the Australian health system (Scotton 1999a, b; 2002; National Health Strategy 1991). For the reasons argued by Scotton the proposal appears to represent the best (and possibly only) option for the use of market competition which overcomes the manifest problems of simple competition and also achieves equity and the social objectives which are the *raison d'être* for government intervention in the health sector.

Clearly Managed Competition has both potential advantages and disadvantages. The balance between these depends upon three broad classes of consequences and the magnitude of each of these is unknown.

Table 9 HMO/MC Review of the Literature

Attribute HMO Result	Attribute			
	Quality of Care (overall)	Mortality	Morbidity	Process
Favourable	16	9	4	11
Mixed	13	11	9	11
UF	18	7	3	8
Total	47	27	16	30

Source: Miller and Luft 2002, *Health Affairs* 21:4 Tables 1, 3

Table 10 Managed Competition and Non Competitive (RHAs)

Potential Advantages	Regional Health Authority	Managed Competition
Costs/Quality of care	?	??
Simplifies Commonwealth/State roles		
Rationalises public/private division	-	
Maintains/increases countervailing power	?	?
Maximises chance of allocative efficiency		
- removal of program banners		
- evolution to Managed Care		
- incentives for best practice	-	
- allows comparison, benchmarking		
Provides consumer choice	-	
Equalises access/expenditures per person		
Harnesses private sector dynamism		
- experimentation		?
- market driven incentives	-	?

Key

likely/effect/small

very likely/effect large

? effects/meaning uncertain

Costs: In the USA Managed Care has had a major impact upon costs. The growth of US health expenditures plateaued in the early 1990s but appears to have returned to its trend from about 1998. The ratcheting down of the trajectory is generally attributed to the spectacular growth of Managed Care. However this experience cannot be generalised. US expenditures are so huge

that cost cutting was relatively simple. The ‘economies’ were primarily achieved by reducing provider incomes. In countries like Australia there is less scope for this strategy.

In the Australian context Managed Care might well be inflationary. If the most effective competitive strategy was the marketing of expensive technologies—as occurs in the US hospital sector—then Managed Competition might be counter-productive with respect to cost control. The UK evidence with respect to hospital referrals from budget holding practices cited earlier suggests that budget holding in Australia might likewise substitute lower cost procedures for hospital care. The likelihood of this happening and the magnitude of the savings are hard to predict and particularly at the aggregate level. Providers excluded from one scheme may generate demand elsewhere.

Table 11 Disadvantages: Managed Competition and Non Competitive RHA

Potential Disadvantages	Regional Health Authority	Managed Competition
Administrative costs rise		
- contracts	X	XX
- marketing	-	XX?
- admin of budget holder	X	X
CE Threatened by		
- cost shifting	na	X
- cream skimming	na	X
- misleading marketing (→↑T) ‘cost attractiveness’ not effectiveness		XX
May create multi tier system		
- suborns public system	-	XX

Key

X likely/effect/small very likely/effect large ? effects/meaning uncertain

Quality: In principle, budget holders in the Managed Competition model might seek to increase or maintain their market share through the provision of a higher quality product. Consistent with this many US Managed Care groups have introduced protocols, at least some of which are evidence based. Further, if medical practitioners resisted the introduction of evidence based medicine then non government groups may be more willing to coerce this form of practice. (Reinhardt has labelled this practice ‘bounty hunting’: sub-contracting to the private sector activities which the government sector is unable or unwilling to undertake). However, to date, the evidence from the USA is not encouraging. Recent evidence collated by Miller and Luft (2002 Health Affairs, 21:4) supports the results of their earlier two surveys. This is that, overall, US HMOs are neither better nor worse than other schemes with respect to quality. Key results are summarised in Table 9.

Results in the table are disappointing for those who believe that Managed Care may be a vehicle for improving health outcomes. They are, however, consistent with the observation of Chassin (2002) cited earlier that Managed Care organisations in New York were unwilling to act upon objective evidence and based decision making upon the judgement of medical advisors.

The effects of the introduction of a non-competitive vertically integrated network for Veterans in the USA is summarised in Segal et al (2002a). The improvement in health outcomes over a short period was astonishing and illustrates the potential importance of system reform. However, as

the base level of health and health servicing for US veterans was almost certainly inferior to the health and health services of the average Australian, the results are not directly transferable.

Equity: Two elements of equity would be affected by the introduction of Managed Care in Australia. The first of these would follow directly from the payment of a risk adjusted premium to a health fund. This would equalise payment across the country for persons in the same risk category. This could have a potentially favourable impact upon under-serviced populations. The negative impact upon currently over-serviced populations would need to be phased out slowly. The second affect would be the introduction of a multi tier system. As noted earlier there would be a direct trade-off between the achievement of egalitarian objectives and the extent to which particular schemes could offer genuinely better quality health services. This trade-off appears to be inescapable: either Managed Care offers significant choice or it does not. If the choice relates to health then health service inequalities will occur.

4.3 Regional Budget Holding

The chief uncertainties and potential disadvantages of Managed Competition arise from the competitive and private sector elements of the scheme. The pooling of funds and rationalisation of expenditure patterns by a single regional budget holder are unproblematical. A similar budget holding authority is envisaged in the Scotton model for members of the population who do not actively opt out of the public scheme. This suggests that the introduction of regional budget holders may simultaneously represent the first stage of a phased introduction of Managed Competition but also a reform of the existing Medicare scheme which would be independently important even if the structural reforms proceeded no further (Segal et al 2002b). In Tables 10 and 11 the two options of Managed Competition and a regional health authority are contrasted. The various stages of this proposal are listed in Box 1.

In the initial time period, t_1 , funds would be transferred from State and Commonwealth sources to the RHAs. (If this was politically infeasible then sensible system reform including the option of Managed Competition would be highly problematical.) The number of these regions should be limited. For example there may initially be 3-6 in NSW and Victoria; 3-4 in Queensland, SA and WA and 1-2 in Tasmania, NT and ACT, a total of 18-30 for Australia. In this initial stage the population should be largely unaffected as payments would continue to private doctors and hospitals on the present basis. There should be complete underwriting of the experience of the regions as the purpose of the introductory stage would be the establishment of the RHAs and their administrative functions.

Initially, patients should retain the right to visit any Australian doctor or public hospital. However the cost of the consultation or inpatient episode should be debited to the regional budget. Subsequently increasing copayments (decreasing reimbursement) could be considered for doctors and hospitals not accredited to the region.

To avoid inequity the regional budget should be adjusted downwards as the population with private insurance rose. The appropriate quantum per private member would be the expected cost to the RHA averted due to PHI. This would depend upon the likelihood of hospitalisation and its cost. While this calculation would be, initially, problematical, any error would be averaged over a large population and there would be no problem analogous to the cream skimming which occurs in a private scheme receiving an inaccurately calculated risk adjusted premium.

Box 1 Stages of the Reform Process

t_0 :	Methodology and Cost	(a) current regional spending (b) expected spending (c) public saving due to PHI
t_1 :	Pooling	(a) regional authorities ($n = 15$) receive a single budget (b) initially 100 percent reimbursement of overspending (c) reimbursement of providers as occurs presently (d) HIC a possible agent (e) public hospital reimbursement by DRG
t_2	Early Transition 1	(a) regional budgets adjusted 5 percent per annum towards 'expected value' determined by a risk population based framework (b) regions permitted to alter specified relationships (eg limited preferred provider contracts but preservation of 'default payments'; employment of allied health personnel; introduction of integrated information, QA system)
t_3	Late Transition 1	(a) regional budgets set equal to the 'expected budget' (b) flexibility and discretion increased eg no or low default payment for non-contract providers; elimination of high risk (low quality) hospital departments; construction of (Kaiser style) vertically integrated clinics. Possible integration with aged services (c) assessment of final transition
t_4	Transition 2	(a) private sector 'carve outs': transfer of full budgets per person to registered accredited groups, regulated as in the Scotton proposal (b) ongoing review of performance (see Scotton)

In the initial period regions with above average utilisation of services would receive a higher budget per capita. The adjustment to the 'expected budget'—the budget based upon population, age, sex and risk—would need to be graduated through time.

During this period and the next RHAs could be given increasing flexibility with respect to service delivery and service contracts. In particular, preferred provider arrangements should become possible, not simply with individual doctors but with departments of particular hospitals. An explicit objective should be the closure of clinical units within hospitals where outcome is sub-standard. Progressively, the 100 percent underwriting by government should be replaced by a government reinsurance arrangement which, as with the Reserve Bank reserve function, gives powers to the reinsurance agency to impose conditions upon overspending regions.

Subject to the provision of the defined core services RHAs should have maximum flexibility to alter service delivery arrangements.

A decision concerning the final transition to the Scotton model of Managed Competition (t_4) should be made after a careful assessment of performance and experience with the non-competitive model.

5 Discussion

Perversely, to this point the paper has ignored the issue of social objectives. As the WHO forcefully (and bravely) asserted in its World Health Report 2000, health systems may have multiple goals and it is hazardous to recommend reforms without first establishing system objectives (which are unlikely to be those nominated by the WHO or to have the importance weights used in the WHO Report).

It is clear that different groups in the community seek different outcomes from the health sector and these objectives may conflict. Health systems do not simply produce health; they redistribute resources from the healthy wealthy to the poor and sick. It might be expected, therefore, that the former group would prefer a scheme which embodies a smaller cross subsidy (for example, medical savings accounts). The latter group is likely to prefer a national scheme, financed by progressive taxes and with equal benefits to all social classes. Governments and Departments of Finance are likely to favour cheap schemes. Medical providers universally prefer schemes which embody medical dominance and minimise countervailing power from the purchases of medical care.

Can subsidies to private health insurers or the private sector generally be justified? The answer is undoubtedly, 'yes'. The private sector offers a degree of 'choice' and it allows resource allocation to be determined, in part, by the individual's willingness and ability to pay. It is clearly the government's role (and not that of an economist) to decide whether or not these objectives should be pursued. However it is possible to analyse and quantify the benefits of the particular model of 'choice' currently offered and the extent of the redistribution of income from taxpayers generally to those with PHI.

At best, the measures taken to encourage PHI represent a lost opportunity for invigorating private health insurers and goading them into the sort of entrepreneurial activities which economic theory and proponents of the market argue will occur in the private sector but, to date, have been almost totally absent from PHI¹.

The role of social values may also be decisive in determining whether or not the option of Managed Competition is pursued. The essence of Managed Competition is that the population is offered a choice between health schemes and this is almost certain to result in a multi tier health system. While, in principle, the different tiers could simply reflect *the pattern of preferences* it is more likely that it would reflect social class and income (albeit with the possibility of cross over for some individuals). If this outcome was unpopular then there would be a potential trade-off between equity (equal access and care) and (possible) efficiencies. Even if efficiencies could be demonstrated, Managed Care might be unsuitable if it sufficiently violates social objectives.

¹ Examples include data systems for patients/clinicians EBM included in doctor's software; information to patients including quality of hospitals; multi purpose clinics - coordination service for chronic/elderly; incentives for health promotion; quality initiatives
Policies could 'empower' PHI various ways: link subsidies to above; measures; end the default payments; reduce the number of funds; encourage service delivery in groups; increase fund exposure to risk arising from high provider incomes and inappropriate work patterns.

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