Markets and medicine: Financing the Australian healthcare system

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Introduction

In early 2010 the Commission on the Education of Health Professionals for the 21st Century (the Commission) convened to outline a strategy for advancing healthcare towards a system that provides "universal coverage of the high quality comprehensive services that are essential to advance opportunity for health equity within and between countries." [1] The strategy focuses on the education of health professionals to empower their capacity as agents of social transformation. [1] This paper endeavours to encourage medical students to think critically and ethically about the consequences of different modes of health finance on the equity of the Australian healthcare system. In doing so, it contributes to this project of health professionalism in the 21st century.

Health finance may seem of little relevance to aspiring or practicing health professionals. However, it is an important determinant of how and to whom medical services are delivered and a critical aspect of Australia's response to the increasing resource demands of the healthcare system. Rising costs are attributable to a variety of trends including innovative but expensive technology, an ageing population, and increasing prevalence of lifestyle associated disease. Policy makers continue to debate the most effective funding methods to achieve effective use of resources, quality services and equity within the healthcare system.

A central issue continues to be the appropriate financial contribution of the private and public sector. Scandinavian countries and Japan rely predominantly on public spending, which accounts for 80.8-84.7% of total spending on health. Others, most notably the United States, have opted for more extensive private contribution, where public spending accounts for 46.0% of total spending (all data from 2008). [2] Australia is somewhere in between, relying on 69.7% of total spending from public funds with the private contribution making up the balance. More than 25% of total private spending is through private health insurance funds. Other private sources, mainly out-of-pocket payments made by individuals, contribute the remainder (data from the 2008-2009 financial year). [3]

The middle road approach has not excused Australia from the private/public healthcare debate. In recent years the debate has focused on the pro-private policies introduced by the Howard government in the late 1990s that reversed the decline in the number of people with private health insurance. [4-6] At the time of writing, the 2011 Federal budget, which includes substantial private/public health finance reforms, is being actively debated in Parliament and the press. [7]

The purpose of this paper is to encourage a greater understanding of the role of private healthcare and its impact on the public system through examination of two important reforms of the late 1990s: the 30% rebate; and Lifetime Health Cover. These are evaluated in terms of influence over uptake of private health insurance (PHI), government health spending and equity. This is followed by an evaluation of the effects of post-reform uptake of PHI on the healthcare system. This highlights the limits of PHI membership to reduce public spending and to relieve pressure on public hospitals. It also exposes PHI and pro-PHI policies as a source of inequity within the Australian healthcare system. Finally, the implications for medical students of the analysis are highlighted. The Commission has proposed a central role for health

professionals in achieving equitable and effective healthcare systems. Thus, this paper responds to these emerging aspects of medical practice and challenges students to engage in a new kind of health professionalism.

To change the direction of the Australian healthcare system, it is helpful to know where it came from. With that in mind we begin with a brief history.

History of the Australian healthcare system

Healthcare in Australia is provided through interdependent public and private sectors that provide both equivalent and complementary services. This organisational structure is contingent on the health policies introduced in Australia since the 1950s.

Government regulation of PHI in Australia began in 1953 under the National Health Act, which strove towards universal coverage through subsidy, tax deductions and regulation of PHI. Regulation required insurers to (i) accept all applicants, regardless of their personal characteristics such as age, gender or health status; and (ii) offer community-rated premiums that did not reflect the person's risk status. In July 1975, the Whitlam-led Labour government attempted to achieve universal coverage through the introduction of Medibank. Under Medibank, doctors could opt to bill government instead of charging patients. It also provided free hospital care through state run public hospitals. [8] However, the central features of Medibank, including universal coverage, were dismantled over the following five years by the newly elected Liberal-National coalition government. In 1984, the then Labour government introduced Medicare as the national universal health insurance program; a function it continues to perform today. [8]

Medicare provides cover for primary health care, ambulatory services and inpatient care in public hospitals. It is funded through federal tax revenue and 1.5% levy on taxable income. [8,9] Private healthcare and insurance continues to exist in parallel and provides complimentary ancillary services not covered by Medicare, such as dental, physiotherapy and some equivalent inpatient services also covered by Medicare. Private patients enjoy certain benefits over Medicare including choice of consultant, shorter waiting lists and private accommodation in private hospitals. [10] Government regulation of PHI continues to reflect the mandates of the 1953 Act.

The precedent of PHI in Australia prior to Medicare and influence of

vested interest groups ensured that it remained an integral component of the national healthcare system. [8,11] However, in the years following the introduction of Medicare and the large premium increases of the late 1980s and early 1990s [9] PHI membership steadily declined (see Figure 1) and Medicare replaced the private health insurance industry as the largest funder of healthcare in Australia.

In response, an influential lobby composed of private sector interest groups, including private hospitals, insurance funds, and State governments, emerged. They argued that declining membership threatened the viability of the private sector and that previously privately insured patients would overwhelm public hospitals. [12] However, data from the late 1990s indicates that public hospital activity (measured in patient days per capita) had decreased compared to a marginal increase in private hospital activity. [8,13] Nevertheless, governments of the 1990s accepted the threat as legitimate and responded with a variety of reforms designed to increase PHI membership and enhance industry sustainability. Two reforms introduced by the Howard led Liberal-National coalition government coincided with a substantial uptake of PHI beginning in March 2000 (Figure 1) and are of particular interest. [14]

1. A 30% rebate on PHI premium payments for both hospital and ancillary cover introduced in December, 1998. This was designed to promote PHI membership by increasing affordability.
2. The lifetime health cover was introduced July 1, 2000. This enabled insurers to increase premiums 2% p.a. for anyone taking out health insurance after the age of 30, to a maximum of 40%. It was designed to encourage a younger membership and keep individuals enrolled; reducing so called 'hit-and-run' membership.

Considering the shift in PHI membership and the considerable public spending associated with the 30% rebate it is helpful to examine the impact of these policies in greater detail before considering the relative benefits of increased PHI membership.

Costs and effects of pro-PHI policies on uptake of PHI

Figure 1 demonstrates increased uptake of PHI membership following the introduction of the 30% rebate and lifetime health cover reforms. However, closer analysis reveals that the introduction of a lifetime health cover, and not the 30% rebate, should be credited for the increased uptake. Several authors draw attention to timing of each intervention. [14,16-19] Figure 1 shows the substantial increase in membership appears to be much more closely associated with the lifetime health cover deadline in July 2000 than the 30% rebate. These initial observations were corroborated at the time by survey data that evaluated health insurance purchasing behaviour and intentions. These data predicted only a small increase in PHI membership in response to the 30% rebate. [20] More recently, empirical estimates using econometric modelling confirmed that the rebate was unlikely to induce significant uptake of PHI. [21]

Beyond questions of efficacy, several other concerns are worth mentioning, including the cost and equity of the 30% rebate. In 2008/09 annual government spending on the PHI rebate reached $3.6 billion. [3] This cost increases each year in proportion to the annual increases in insurance premiums. [22] Considering the substantial and increasing annual spending the government should expect to save money through reduced use of public hospitals. Assume temporarily that the introduction of the 30% rebate was effective, overlooking the evidence to the contrary presented above. Increased PHI membership should shift patients and costs to the private sector and reduce pressure on the public system. However, in the years following its introduction researchers estimated that no more than 16.5-20% of the annual cost of the rebate was recovered through such a shift, a poor return on investment. [14,23]

Equity is also a legitimate concern. Figure 2 demonstrates that wealthy Australians are more likely to purchase PHI than poorer Australians. [24] This income gradient is problematic if equity is to be attained across the health system. All privately insured Australians are eligible for the 30% rebate regardless of income status. Consequently, the rebate disproportionately benefits wealthy Australians. [10,14,17] Furthermore, PHI covers a variety of ancillary services. This means that the 30% rebate effectively subsidises services not covered by Medicare, including dental, optical, physiotherapy, and chiropractic services. [14,17] Since wealthier Australians are more likely to hold PHI they effectively receive subsidisation of these services. Poorer Australians,

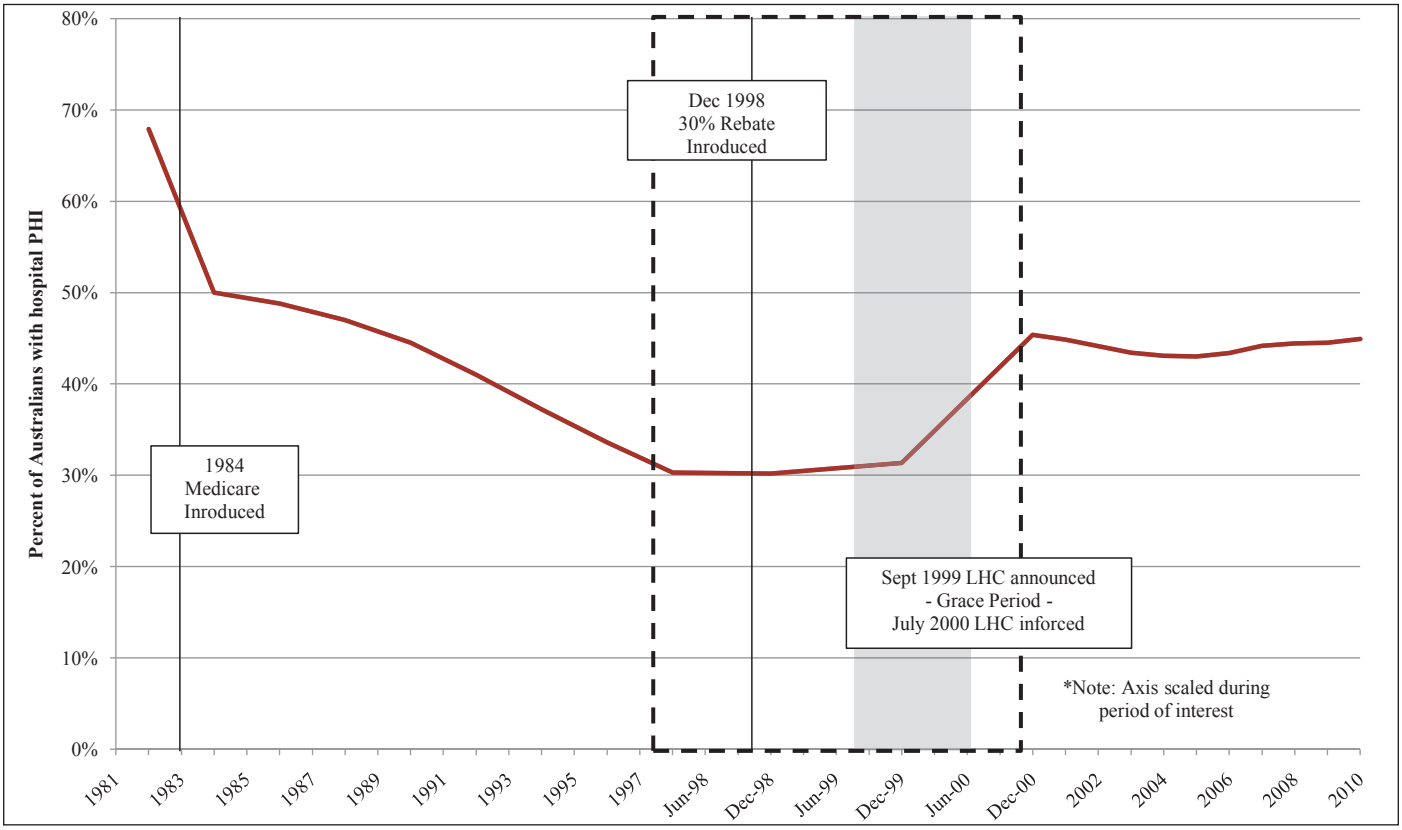

Figure 1. *The percentage of Australians with hospital private health insurance over the past 25 years. Adapted from [14,15].*

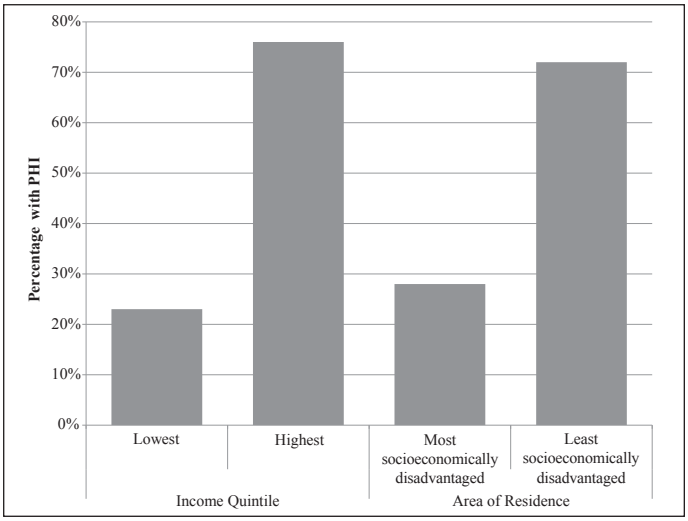

Figure 2. *Comparative percentage of Australians with private health insurance depending on income quintile and area of residence. Adapted from [24].*

unable to afford PHI, are left paying out-of-pocket or going without.

Through the 30% rebate, the government spends several billion dollars a year to sustain a sector that by its very nature compromises the equity of the Australian healthcare system. These resources could be better allocated to improve the public option available to all citizens. [25] Nevertheless it was included in the platform of reforms that caused considerable uptake of PHI.

Effect of increased PHI membership on public healthcare

Prior to the introduction of the main reforms discussed above, the 1997 Industry Commission report identified a variety of objectives met by the private Australian healthcare sector, [26] including:

1. Encouraging private funding to relieve pressure on the public purse; and
2. Relieving pressure on the public system.

The effects of increased PHI membership following the reforms can be used to evaluate the extent to which the private sector accomplishes these objectives.

Government health spending

The effect of increased PHI membership on government spending can be evaluated in terms of relative contribution of the federal government and health insurance funds to total health spending. Table 1 demonstrates that the proportional contribution of total health spending made by the government remained relatively constant during the period of reform. Furthermore, the increased uptake of PHI, although possibly associated with slowing the decline, has not increased the proportion of total spending contributed by health insurance funds. [14]

The absence of a strong relationship between increased PHI membership and increased contribution to overall health spending made by health insurance funds contradicts policy designed to increase PHI membership. This further supports the previous conclusion that the substantial spending on the 30% rebate should be redirected to the public sector to enhance the equity of the healthcare system.

Pressure on the public system

The second objective suggests that if more people are utilising private services, there will be less pressure on the public system, leading to reduced waiting periods for elective consultations and procedures. However, studies have failed to detect any change in wait times for these services following the uptake in PHI. [28,29] Several explanations have been proposed.

First, holders of PHI are still entitled to public services and may use each sector strategically to minimise cost and wait times. [30] This may be exacerbated by the fact that there has been a concurrent increase in uptake of PHI with large co-payments that encourage use of the public system for more services. [14] Indeed, some PHI members may not utilise private services at all and instead enrol in PHI simply to avoid the tax surcharge on high income earners. [14]

Second, consistent with the intention of the lifetime health cover reform, PHI uptake was greatest among young individuals. [17]

Table 1. *Relative contributions (in percentile) to total health spending over the past fifteen years. Some rows may not add to 100% due to rounding. Data ranging from 1998/99 - 2008/09 sourced from the Australian Institute for Health and Wellbeing report Health Expenditure Australia 2008-2009. [3] Data ranging from 1992/93 - 1997/98 sourced from the Australian Institute for Health and Wellbeing report Health Expenditure Australia 2002-2003. [27]*

	Government			Non-Government			
Year	Federal Government	State/territory and local	Total	Health Insurance funds	Individuals	Other	Total
1992–93	43.6	23.4	66.9	11.4	16.8	4.9	33.1
1993–94	45.1	21.3	66.4	11.0	16.9	5.6	33.6
1994–95	44.8	21.6	66.3	10.7	17.1	5.9	33.7
1995–96	45.2	22.0	67.2	10.5	16.0	6.3	32.8
1996–97	43.7	22.9	66.7	10.4	16.7	6.3	33.3
1997–98	44.4	23.8	68.2	8.8	16.7	6.3	31.8
1998–99	43.3	23.7	67.0	8.0	17.3	7.8	33.0
1999–00	44.3	24.9	69.2	6.9	16.7	7.3	30.8
2000–01	44.4	23.3	67.7	7.1	18.0	7.2	32.3
2001–02	44.0	23.2	67.2	8.0	17.5	7.2	32.8
2002–03	43.6	24.4	68.0	8.0	16.7	7.3	32.0
2003–04	43.6	23.6	67.2	8.1	17.5	7.3	32.8
2004–05	43.8	24.0	67.7	7.7	17.4	7.1	32.3
2005–06	42.8	25.3	68.0	7.6	17.4	6.9	32.0
2006–07	42.0	25.8	67.8	7.6	17.4	7.2	32.2
2007–08	43.2	25.5	68.7	7.6	16.8	6.9	31.3
2008–09	43.2	26.5	69.7	7.8	16.8	5.7	30.3

Relatively speaking, young individuals are not major consumers of healthcare services in either system and are likely to make fewer claims on their policies. This shift favours industry sustainability but is unlikely to take any pressure off the public system. [14]

Finally, supply of healthcare resources, especially human resources, is limited and stable in the short term. Every patient treated privately tends to consume human resources that could otherwise be utilised in the public system. Indeed, evidence suggests that for any specialty, as the proportion of surgeries performed privately increases so does the wait list in the public sector. [31]

Implications for the health system and health professionals

The failure of the private sector to control public spending and pressure on the public system despite substantial uptake of PHI highlights the complexity of the relationship between parallel private and public sectors. Hurley *et al.* [10] emphasise that sustainability of the private sector depends on the quality of healthcare it offers. Crucially, when a public and private sector operate in parallel, the public sector must be inferior to the private, or there will be no incentive for individuals to pay for private services that are offered free of charge in the public system. [10] Considering wealthy Australians are more likely to hold PHI, this implies a two-tiered model of healthcare is unavoidable and presents a clear threat to the equity of the Australian healthcare system. Indeed, wealthy Australians tend to have access to better healthcare and have better health outcomes. [32,33] These realities constitute a central challenge to the role of the private sector within the Australian healthcare system.

Despite these persisting inequities, change is possible but requires leadership and commitment. The Commission argues that health professionals are privileged because of the time and effort spent training, and the investment by families, society and public financing. We therefore have an obligation to act on behalf of our investors, educate ourselves, think critically and ethically, and become advocates for effective and equitable health systems. [1]

The present aim is to challenge students to critically examine the financial policies and mechanisms of the Australian healthcare system with specific attention to the implications for equity. In doing so, this paper highlights emerging aspects of medical practice and contributes to the project outlined by the Commission to educate health professionals to "mobilise knowledge, and to engage in critical reasoning and ethical conduct." [1] Such an education empowers us to become agents of change within the health system who strive for a more equitable future. [1]

Conclusion

In an effort to challenge medical students to engage in a new health professionalism outlined by the Commission on the Education of Health Professionals for the 21st Century, this paper provides a critical evaluation of the health finance system in Australia. This evaluation centred on the effects of two pro-PHI reform platforms introduced in the late 1990s. Despite contributing to substantial uptake of PHI, these reforms failed to relieve pressure on the public system or control public costs. Through evaluation of these reforms a critical analysis of private health finance and service delivery has also emerged. The analysis revealed the complex relationship between activity in the private sector, insurance and delivery, and the pressure felt by the public healthcare system. Moreover, the evidence presented provides a cautionary discussion about the real limits of parallel private healthcare. Most concerning are the persisting socioeconomic inequities within the Australian healthcare system. This discussion provides some insight into the complexities inherent in the public/private debate, prepares medical students for informed engagement with these issues, and in turn contributes to a new health professionalism of the 21st century.

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Conflict of interest

None declared.

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