CENTRE FOR POLICY DEVELOPMENT
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Health care: Re-framing our thinking

Presentation to fourth biennial national health reform summit
March 2009

UC

The NHHRC Report

Timid, cautious

- mainly builds on existing policy proposals
- accepts architecture of existing arrangements
- not strong on economics

Generally well received by interest groups, presumably because it doesn't scare the horses

Assumes no appetite for reform

- compared with
  - Howard Government's GST/state financing changes
  - Hawke/Keating Government tariff reductions
- reform should be easy in an industry with a shortage of labor; only those in unproductive overheads need fear change

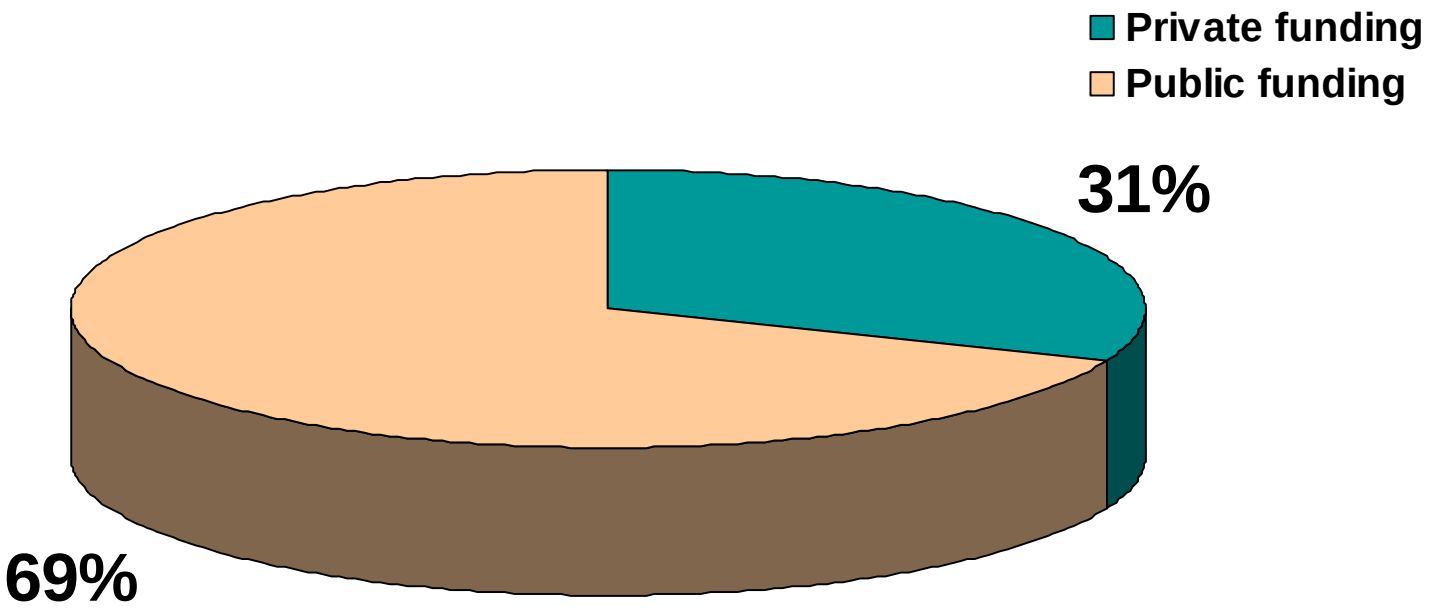
The NHHRC Report

Reason for caution:

- conflicts of interest?
- caution with a new government?
- a “deficit of imagination”
  - difficult for people intimately involved in health programs to look at it with detachment, from the outside
  - hard to re-frame, to consider fundamental reform

Re-frame 1: Not public/private, but sharing/individual

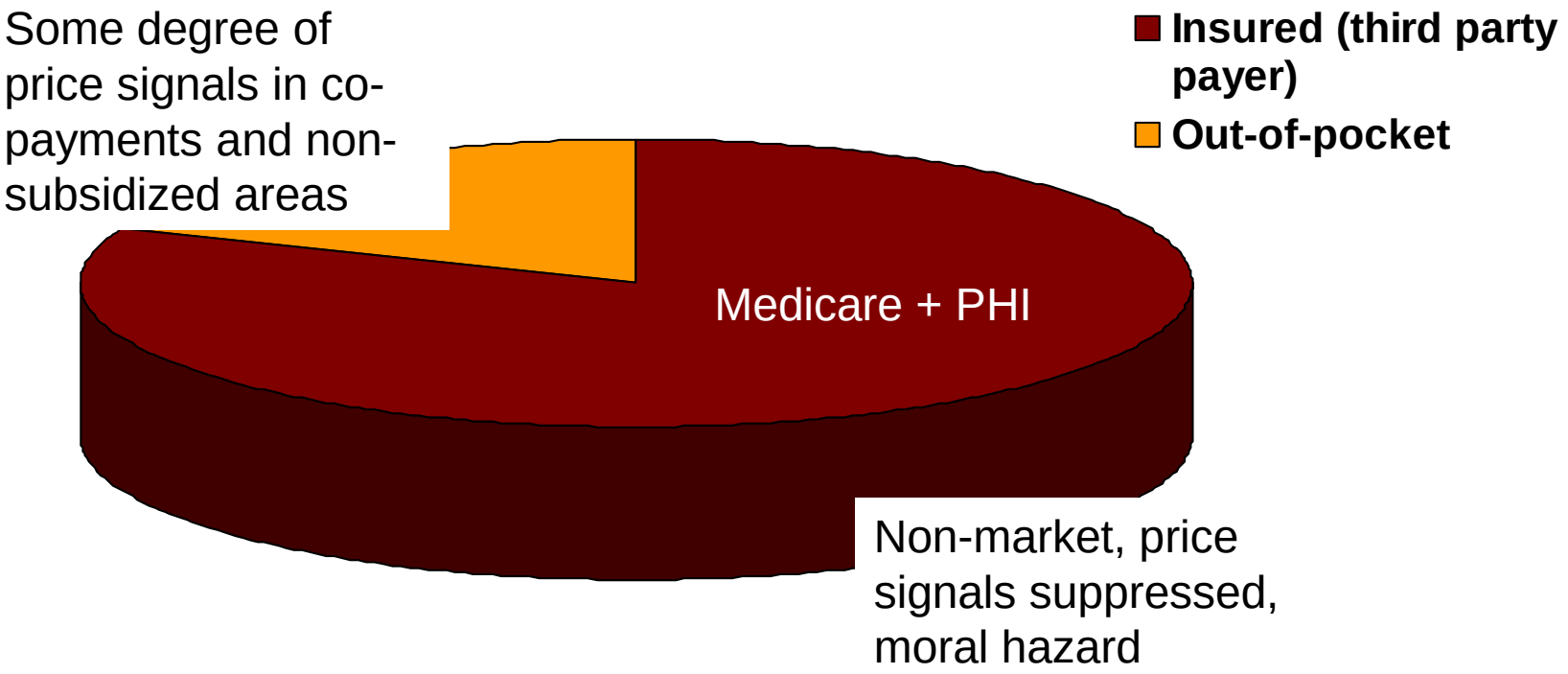
How politicians and lobbyists see health care funding



2006-07 recurrent funding

Re-frame 1: Not public/private, but sharing/individual

How economists see health care funding



2006-07 recurrent funding

Re-frame 1: Not public/private, but sharing/individual

Private health insurance is *not* a market mechanism

Attitude “MBF/HBA/ Medibank Private will pay for it” is no different from attitude “Medicare will pay for it” (“moral hazard”)

People buy insurance to avoid the discipline of markets.

PHI is an escape from individual responsibility, an acceptance of dependence on the nanny corporation.

Re-frame 1: Not public/private, but sharing/individual

Use it or Lose it !

Time is runnig out !

If you are in a health fund and have optical cover and you have not made a claim for glasses or contact lenses this year, time is fast running out to do so.

Maybe you need a pair of prescription sunglasses? Glasses for the computer? Or what about that spare pair of reading glasses?

In many cases we can make a complete pair of glasses for the same amount as you get back from your health fund. So you might not even be out of pocket.

Don't put it off any longer.

Re-frame 1: Not public/private, but sharing/individual

Private insurers cannot control costs

> They [private insurers] are going to be faced with a huge tsunami of costs for the ensuing twelve months, over which they have no control. They have to go to their fund members and say "we need more money".
>
> **Michael Armitage, 29 February 2008**

… are locked into "illness model"

Perhaps insurers would like to emphasize responsibility, self-reliance to reduce overall claims

But marketing relies on myths and exploitation of irrationality to accentuate risk and dependence:

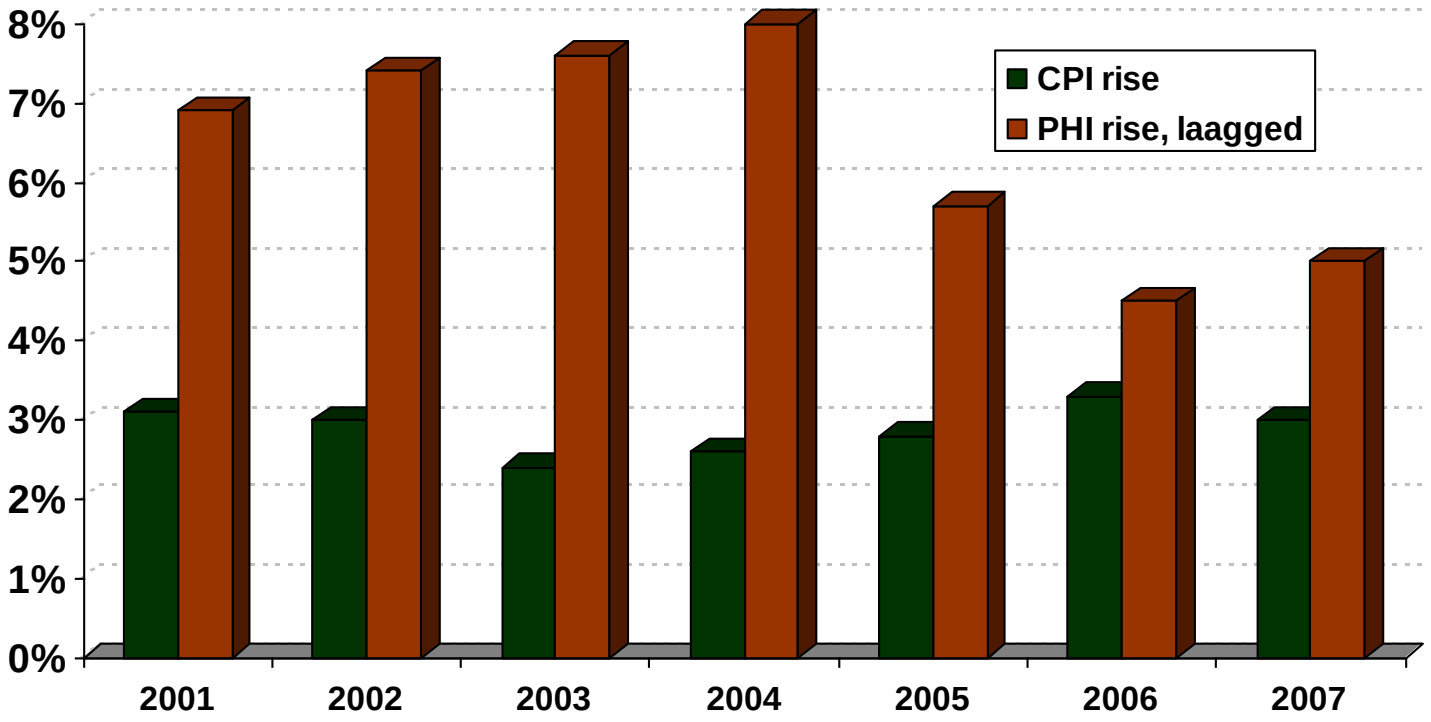
- You are likely to get ill
- You need PHI to use a private hospital
- Medicare cannot look after you

… have no incentive to provide public goods

prevention, promotion

Re-frame 1: Not public/private, but sharing/individual

Original 30% rebate now absorbed in real price rises



Re-frame 1: Not public/private, but sharing/individual

Question which should be put to Australian people not “public/private”, but the balance we seek between personal and pooled funding

When we reframe this way, the secondary question is how we should pool funding

PHI is a poor means of pooling:
- hard to control costs and utilization
- hard to achieve community rating
- administratively expensive c.f. tax
- cannot provide public goods

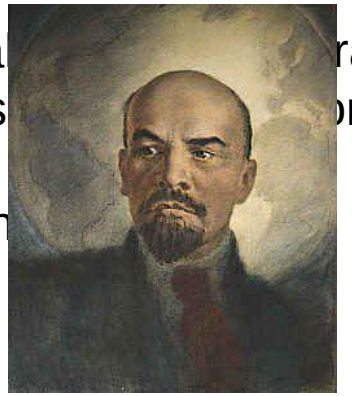
Re-frame 1: Not public/private, but sharing/individual

Misrepresentation an impediment to clear thinking. Opposition to PHI often misrepresented as:

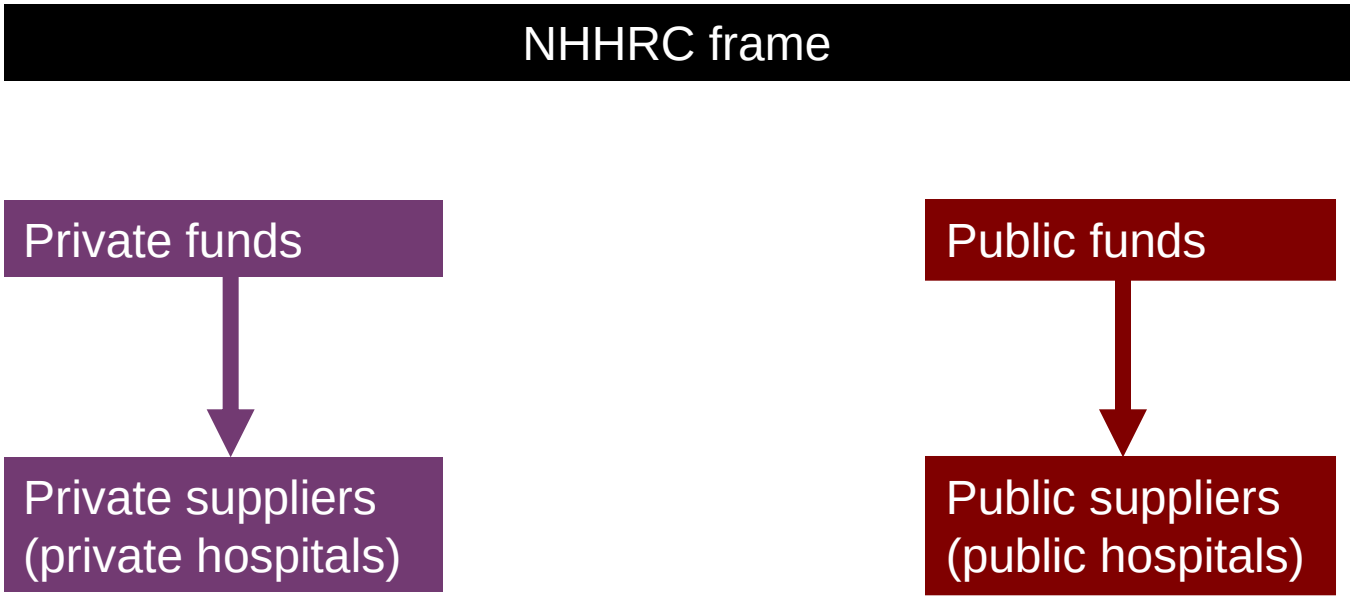
a “socialized” health care system;
ignores private delivery, public funding

a free system;
there is a strong case for price signa ral
hazard, a distortion caused by all ins r private

a system without choice;
a single insurer can offer choice of th



Re-frame 2: Think of funding and delivery separately



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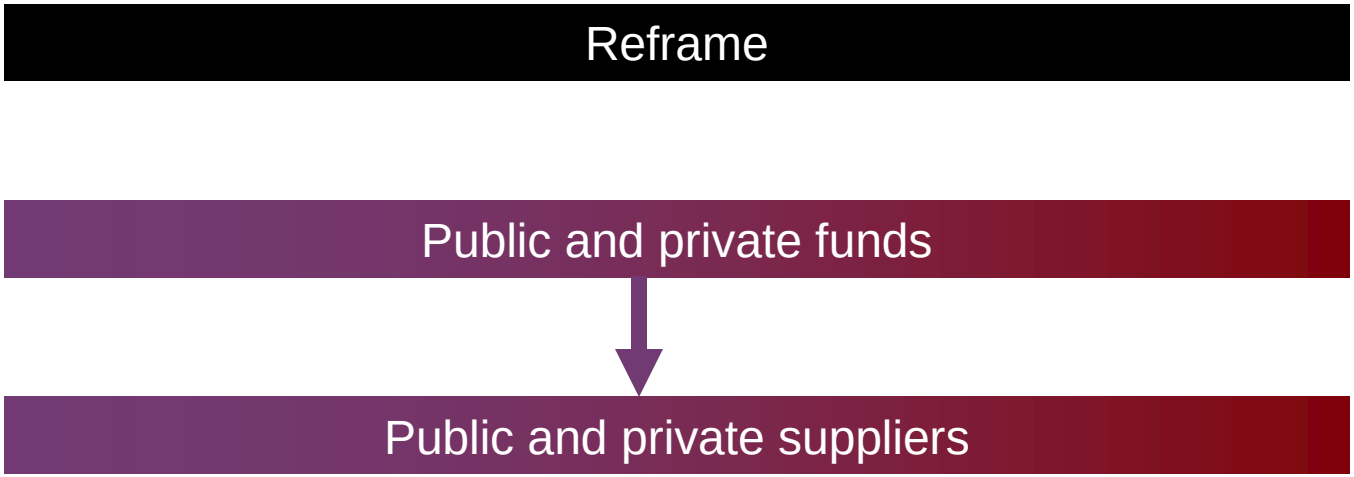
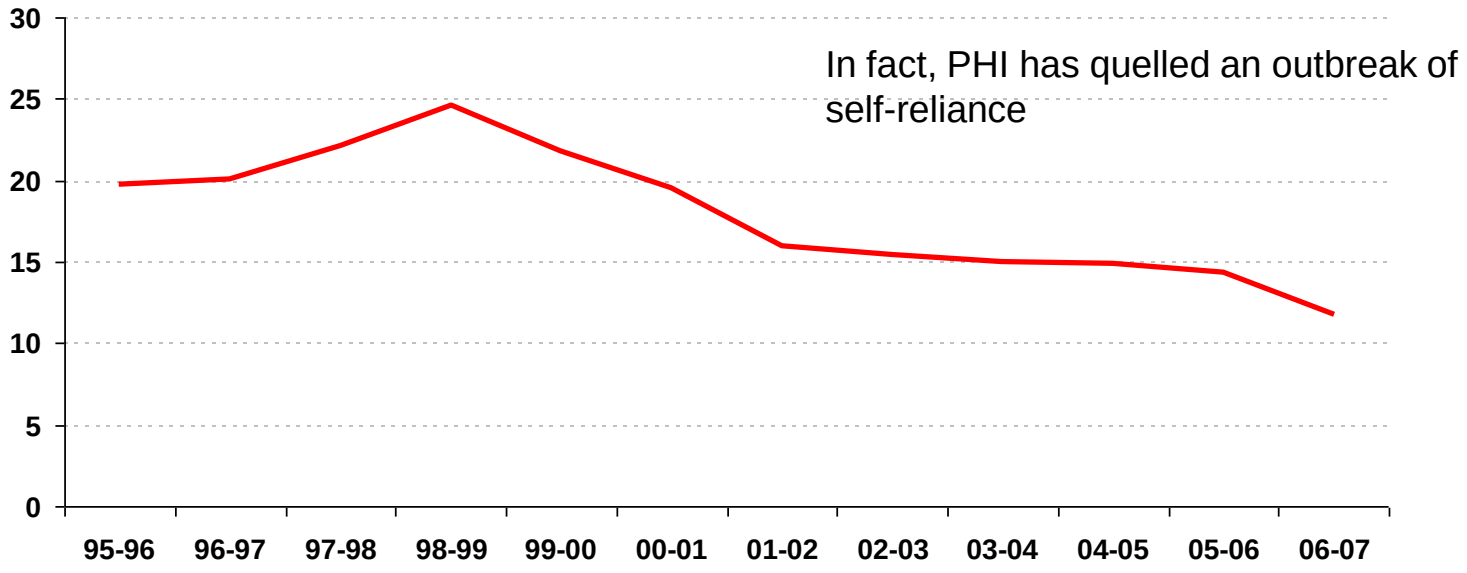


A funder – provider split, well-established in other areas of government policy, and well-established in Department of Veterans' Affairs

Re-frame 2: Think of funding and delivery separately

Commission seems so entrenched in one frame that they think of PHI as only way to get access to private hospitals

Private acute care hospitals: percent of separations without insurance



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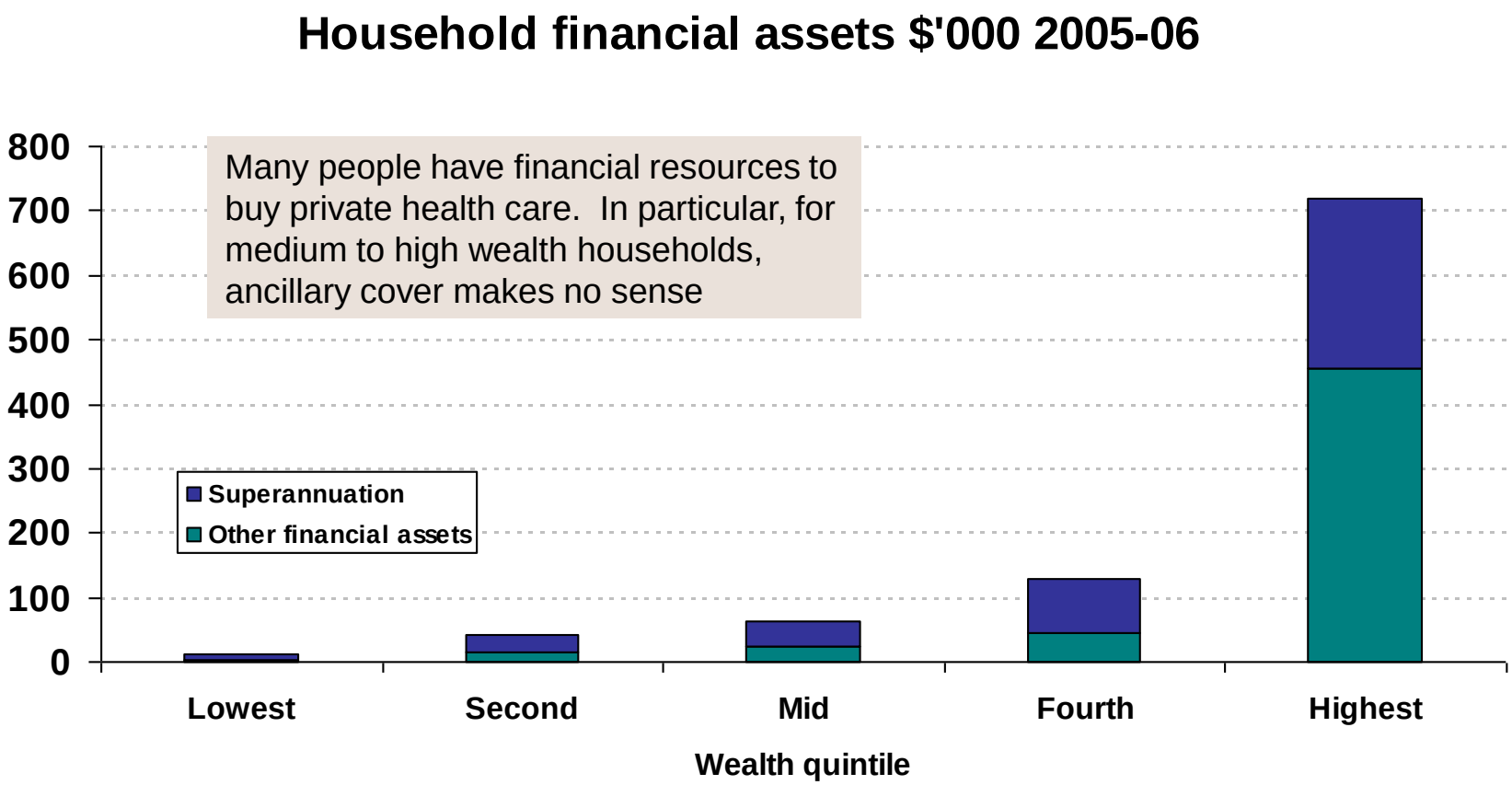


Re-frame 3: Think of all costs, not just budgetary outlays

Economic concern is total cost of health care, particularly the collective burden

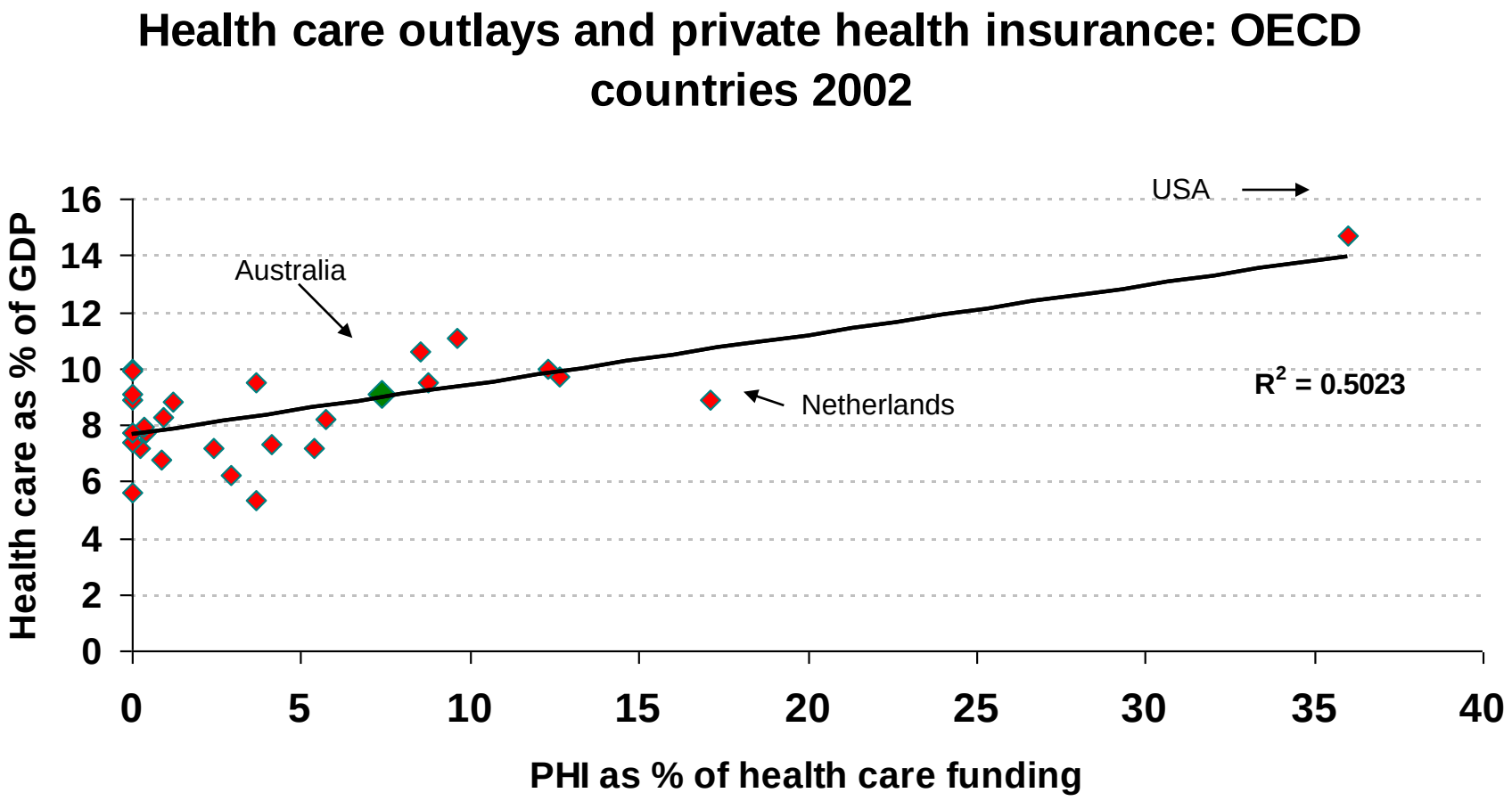
- no point in reverting to privatized taxes such as PHI if they:
  - cost more to collect than official taxes
  - result in inflation and misallocation of scarce resources
  - are less equitable than official taxes

If we can afford PHI, we can more easily afford taxes

Principles of cost-benefit analysis are to consider all costs over all time incurred by all people

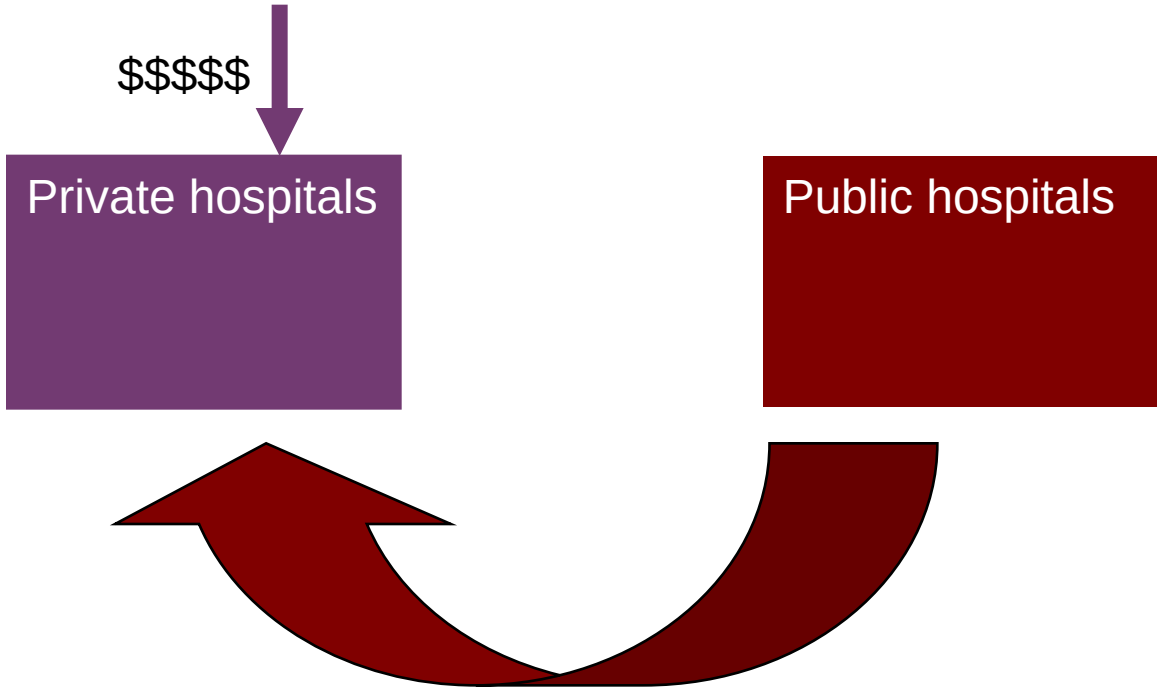
- but government, in budgetary process, esp *Intergenerational Report*, considers only fiscal costs
- finance has displaced economics

Re-frame 3: Think of all costs, not just budgetary outlays



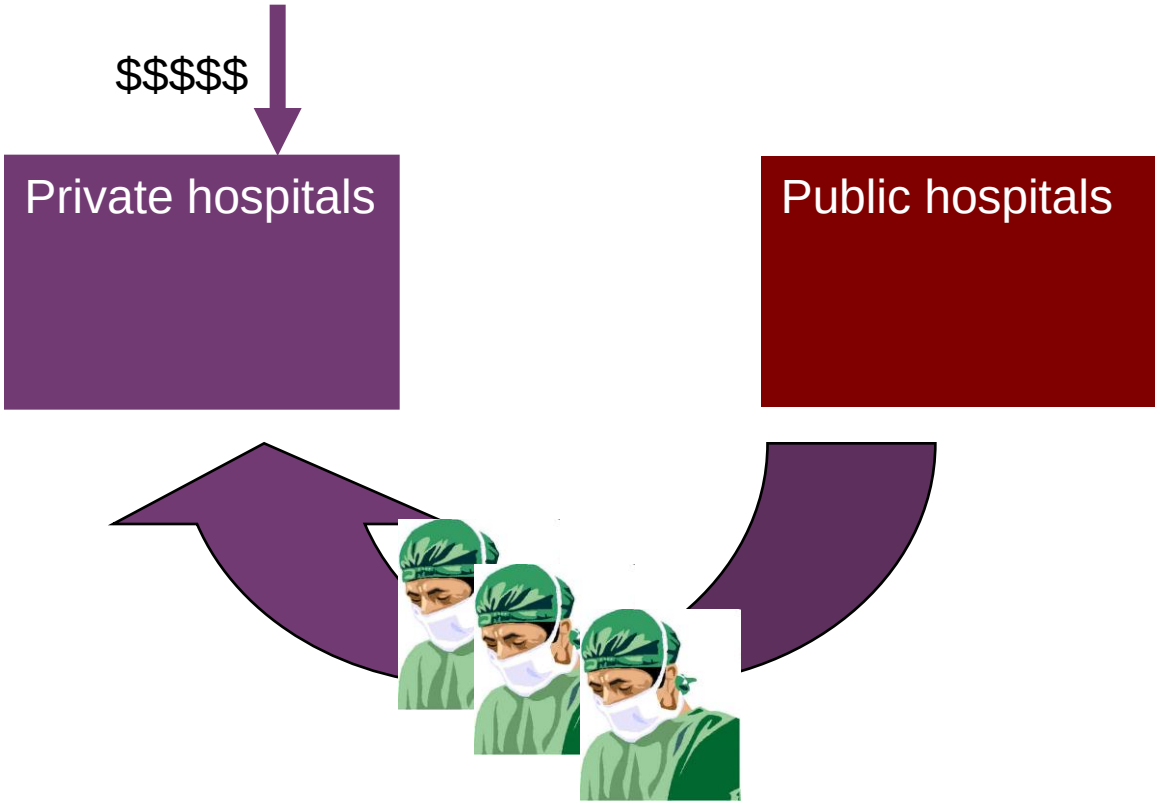
Re-frame 4: Think of resources, not just $

Impaired thinking: “Take pressure off public hospitals”



Re-frame 4: Think of resources, not just $

Reality: “Take resources *from* public hospitals”



Reframe 5: Think sharing, not charity

We don’t prohibit the rich from using our public roads.

In economists’ terms roads are practically non-excludable. Health care is morally non-excludable.

Re-frame 5: Think sharing, not charity

Health care has re-distributive benefits, but that doesn't mean it's a charity function.

Almost all public goods have re-distributive benefits. Their justification lies in market failures and in desire for collective sharing of some costs

for reasons of social solidarity
because of "original position" in health care

Re-frame 5: Think sharing, not charity

Private insurance – the gated community

Medicare – for the “indigent”

Re-frame 6: Think universal access, not “free” for all

What we have

Separate, over-*subsidized* private hospitals, offering more “choice”

Universal free hospitals

Calling a two-tier system “universal” is like saying we are all entitled to use the Salvation Army soup kitchen

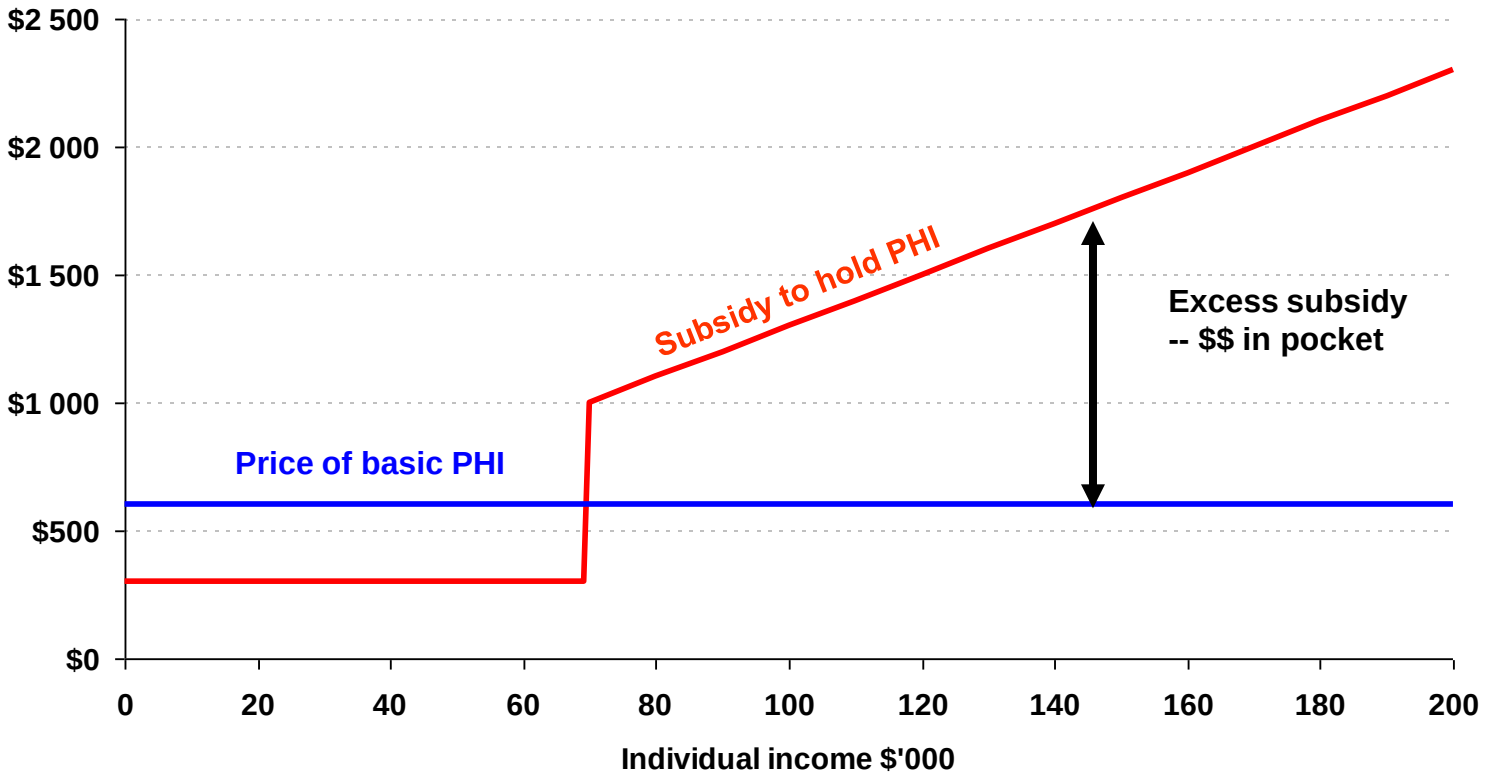
Possibility

One high quality system, used by all, with choice.

Different payments depending on means

Re-frame 6: Think universal access, not “free” for all

A government committed to “social inclusion” encourages social *exclusion*



Re-frame 6: Think universal access, not “free” for all

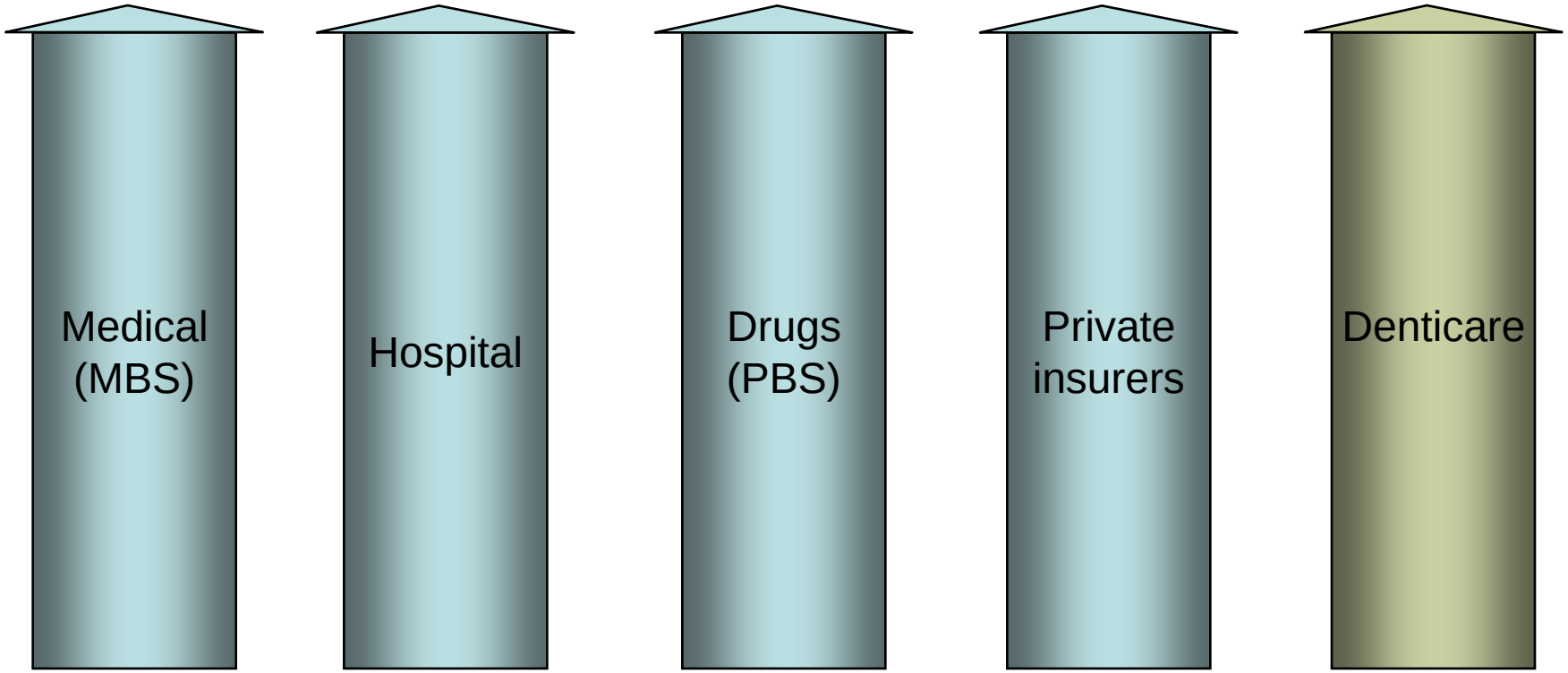
Free PHI plus a reward for exclusion

+

+ free advertising

Re-frame 7: Think of the customer before the supplier

Present program structure, centered on suppliers and funders



Re-frame 7: Think of the customer before the supplier

Think of car repairs – different locations and payment systems for
- parts
- minor repairs
  - separate payments for mechanics and use of premise
- major repairs

Proposals for health centers involve co-location, but not integration
- e.g. pharmacists would still not be prescribing partners

Re-frame 7: Think of the customer before the supplier

Possible program structures, centered on suppliers and funders

By need for care
- chronic
- acute
- occasional

By demographic
- aged
- adolescent etc

By condition
- mental illness
- cardiovascular etc

Ideas for mental health etc commendable, but trying to graft new programs on to old structure.

Re-frame 8: Think of one tier of government, not necessarily a Commonwealth takeover

Many models to achieve integration:

e.g. State as focus of delivery, with Commonwealth providing pooled funding, standards, negotiations with drug companies

Re-Frame 9: Don’t think of an equity-efficiency tradeoff

When there is waste there is scope for improvements in both equity and efficiency

Conclusion

The Commission has failed to notice that a large and expensive financial intermediary has been inserted as an overhead in our health care arrangements:

at a time when the failure of the financial sector to atend to the public interest has become very evident

Conclusion

Commission was wrong mechanism for reform

Still possible to put to Productivity Commission – more detached, more economic expertise