The unbearable weirdness of health care

Ian McAuley

Centre for policy development

A paper expanding on the points in this presentation is on my website:
www.ianmcauley.com

Broken or just cracked: can our health system be fixed or does it need to be rebuilt?

On gross indicators doing OK, but inequities, inefficiencies (technical and allocative), future problems

Not a “system” but “a multifaceted web of public and private providers, settings, participants and supporting mechanisms”

i.e. a mess

the legacy of 70 years of policy incrementalism, bits of socialism, bits of markets, bits of cronyism, lots of short-term fixes

No point in re-building, however, without design principles – what do Australians want?

The analyst sees a weird industry:

with an anachronistic structure, organized around suppliers rather than users, and strong barriers to entry

with weird funding

which has largely escaped the disruptions and structural reforms of other industries

in which technological advances have been associated with increases in unit costs

with strong quality control on inputs and procedures, but less on outcomes

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weird funding

largely escaped the disruptions and structural reforms of other industries

technological advances associated with increases in unit costs

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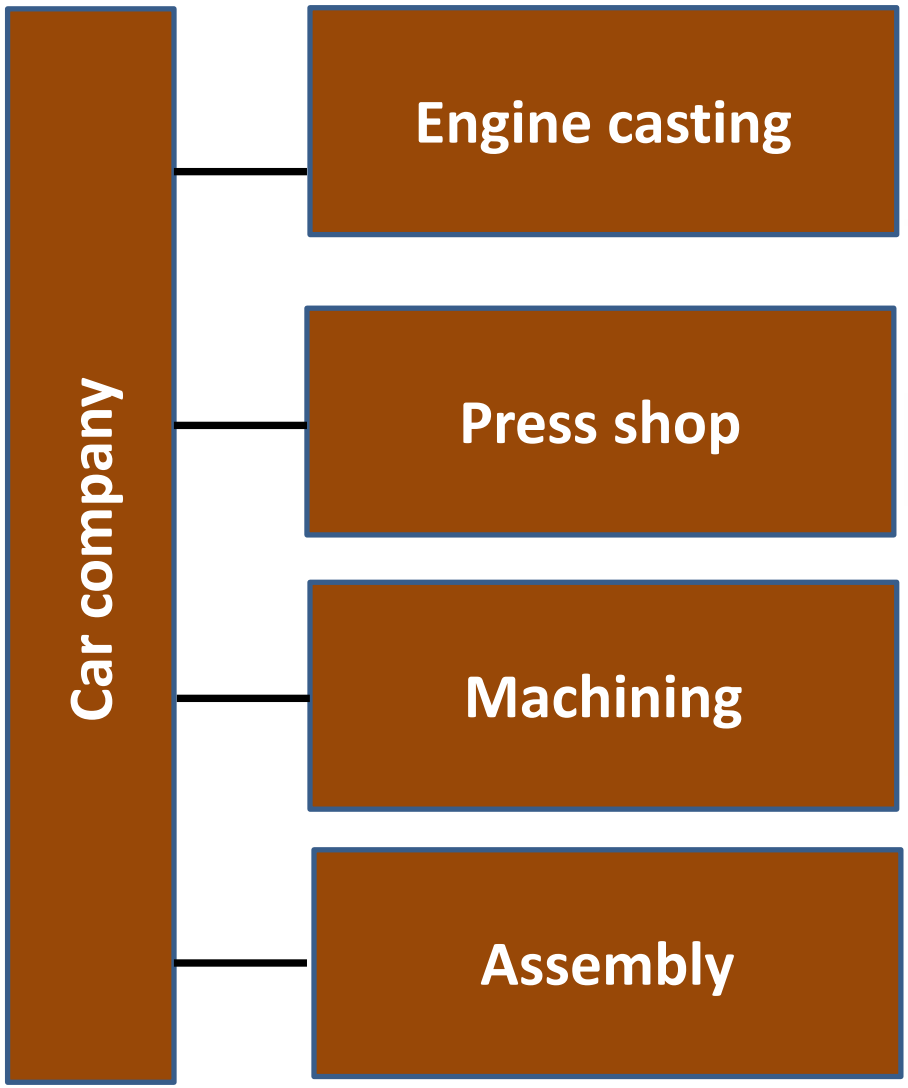
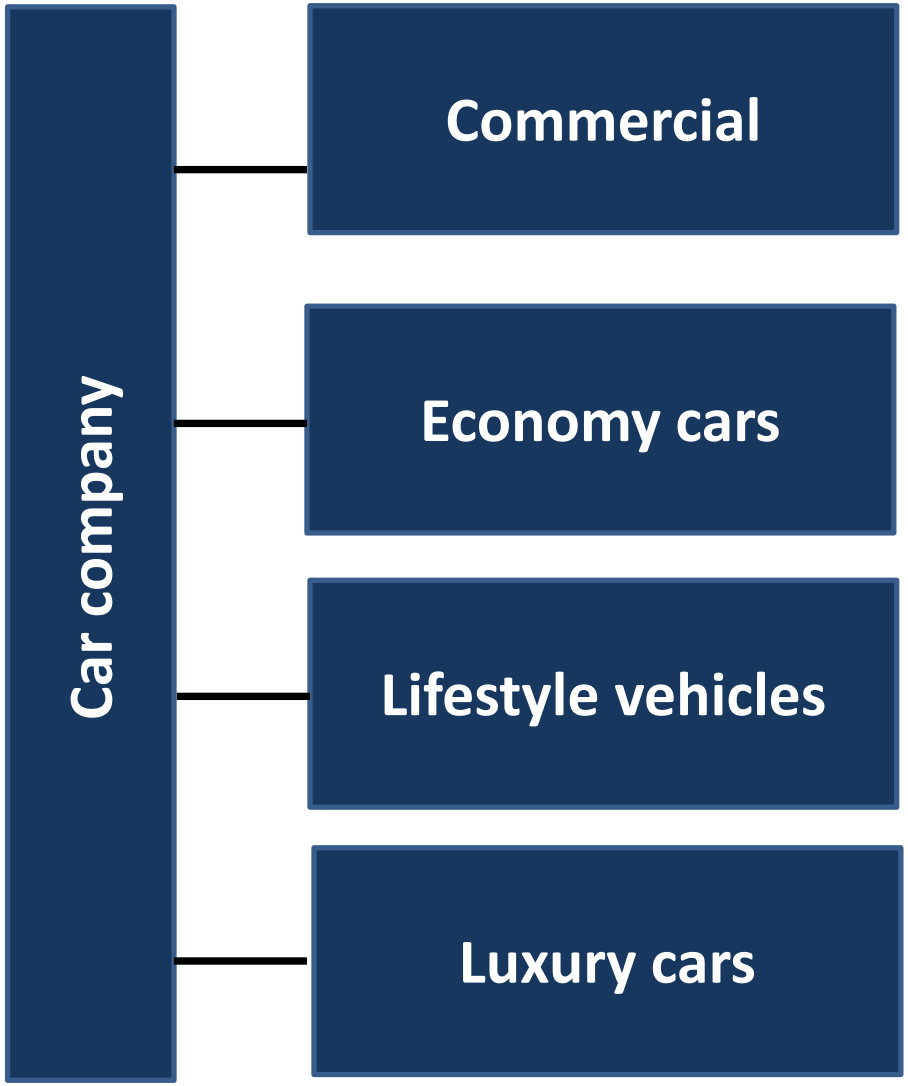
Traditional structure



Contemporary (customer) structure



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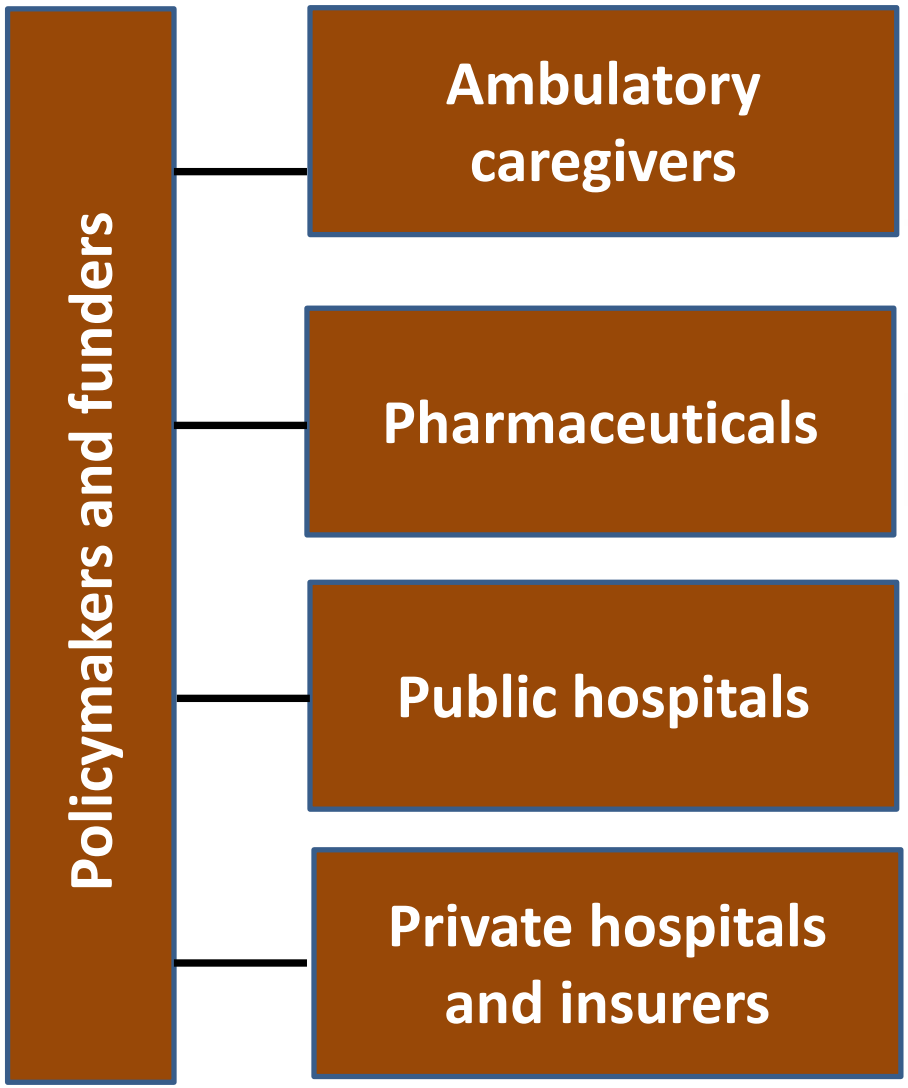

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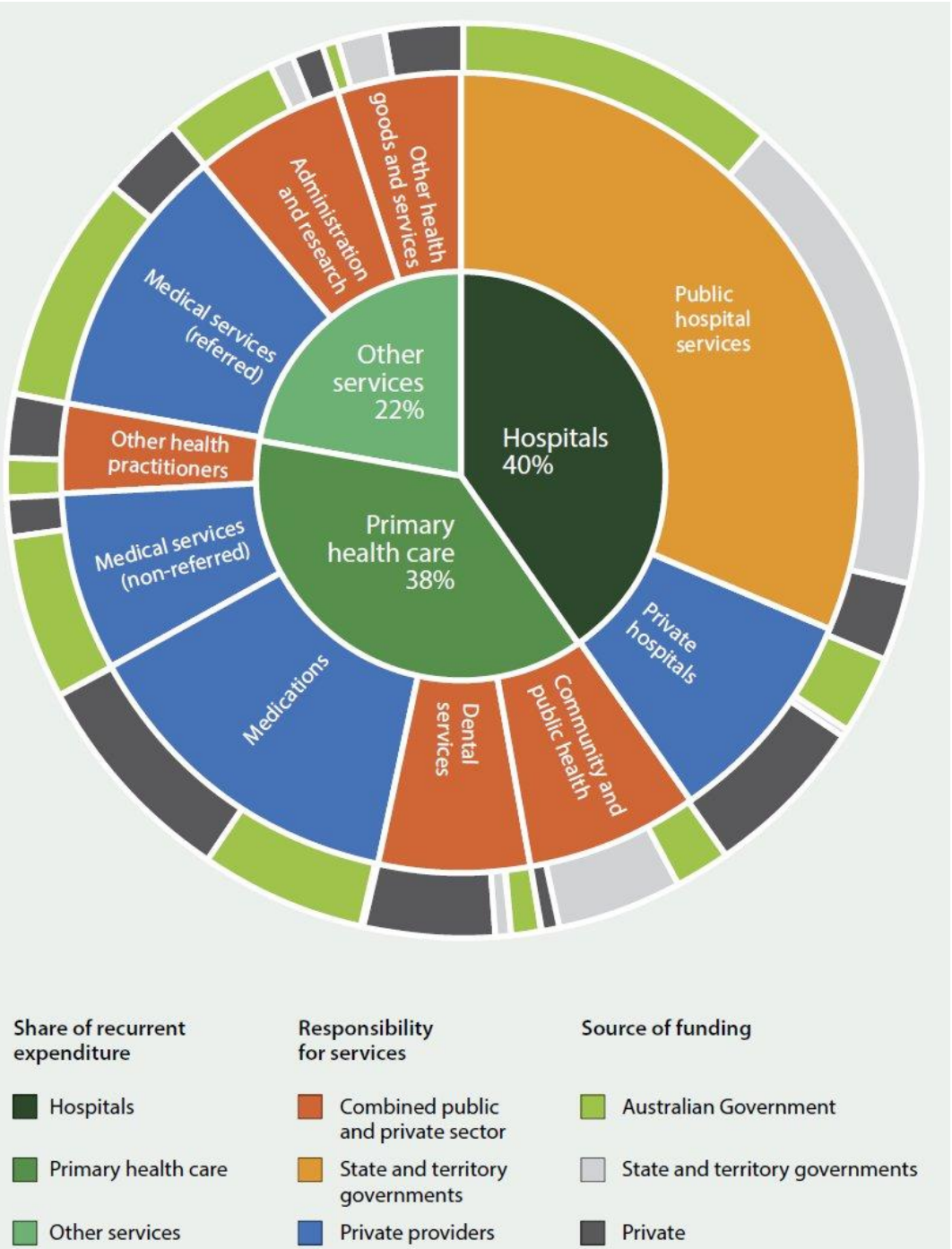
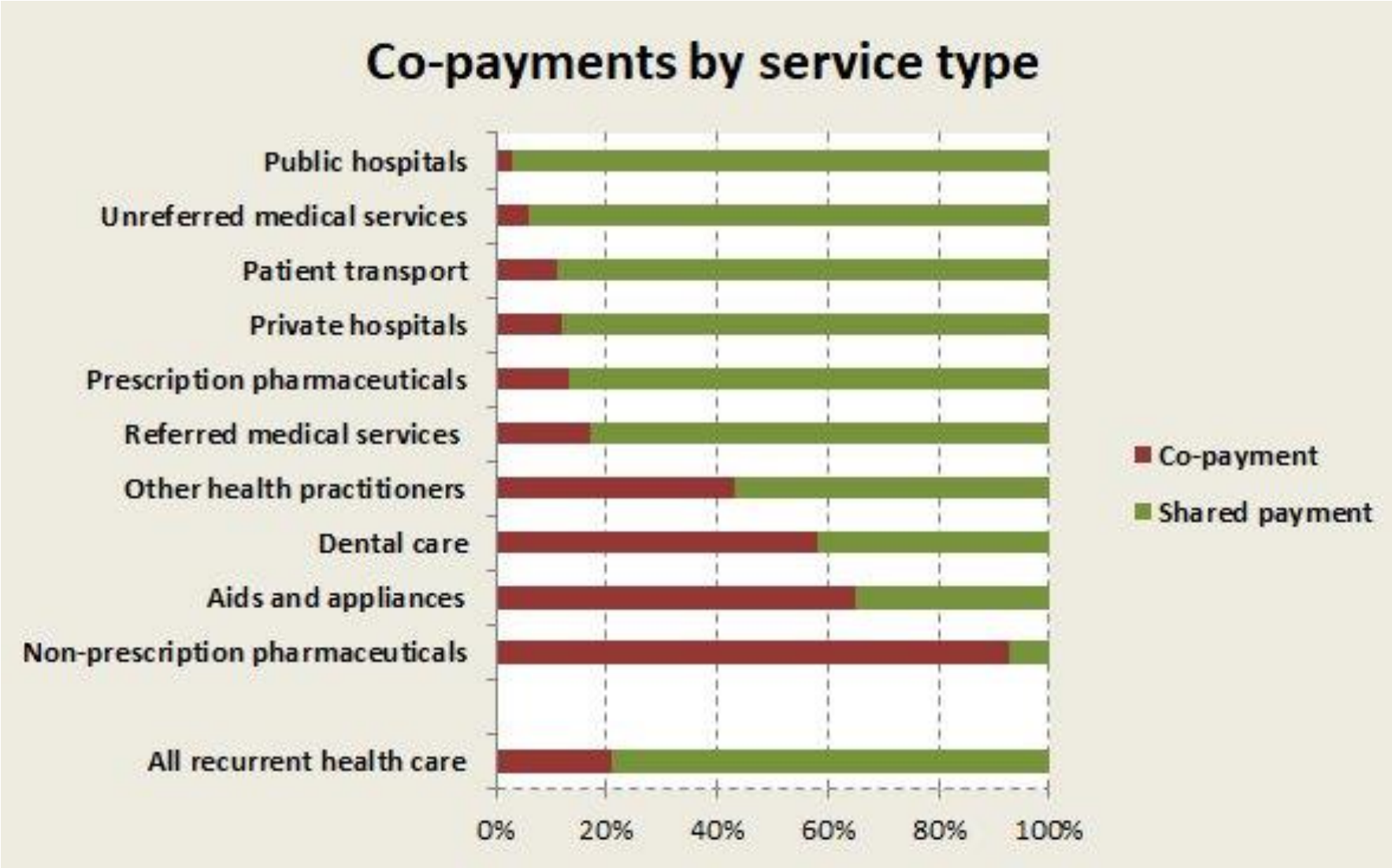

Hospitals 40%
Primary health care 38%
Other services 22%
Public hospital services
Private hospitals
Community and public health
Dental services
Medications
Medical services (non-referred)
Other health practitioners
Medical services (referred)
Administration and research
Other health goods and services
Share of recurrent expenditure
Hospitals
Primary health care
Other services
Responsibility for services
Combined public and private sector
State and territory governments
Private providers
Source of funding
Australian Government
State and territory governments
Private

Who pays for what

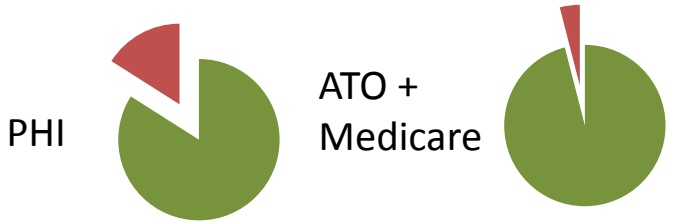


How insurance (public or private) should work

How health insurance (public or private) generally operates

Private health insurance

High-cost and inequitable way to fund health care



High administrative costs

Unable to control providers' prices

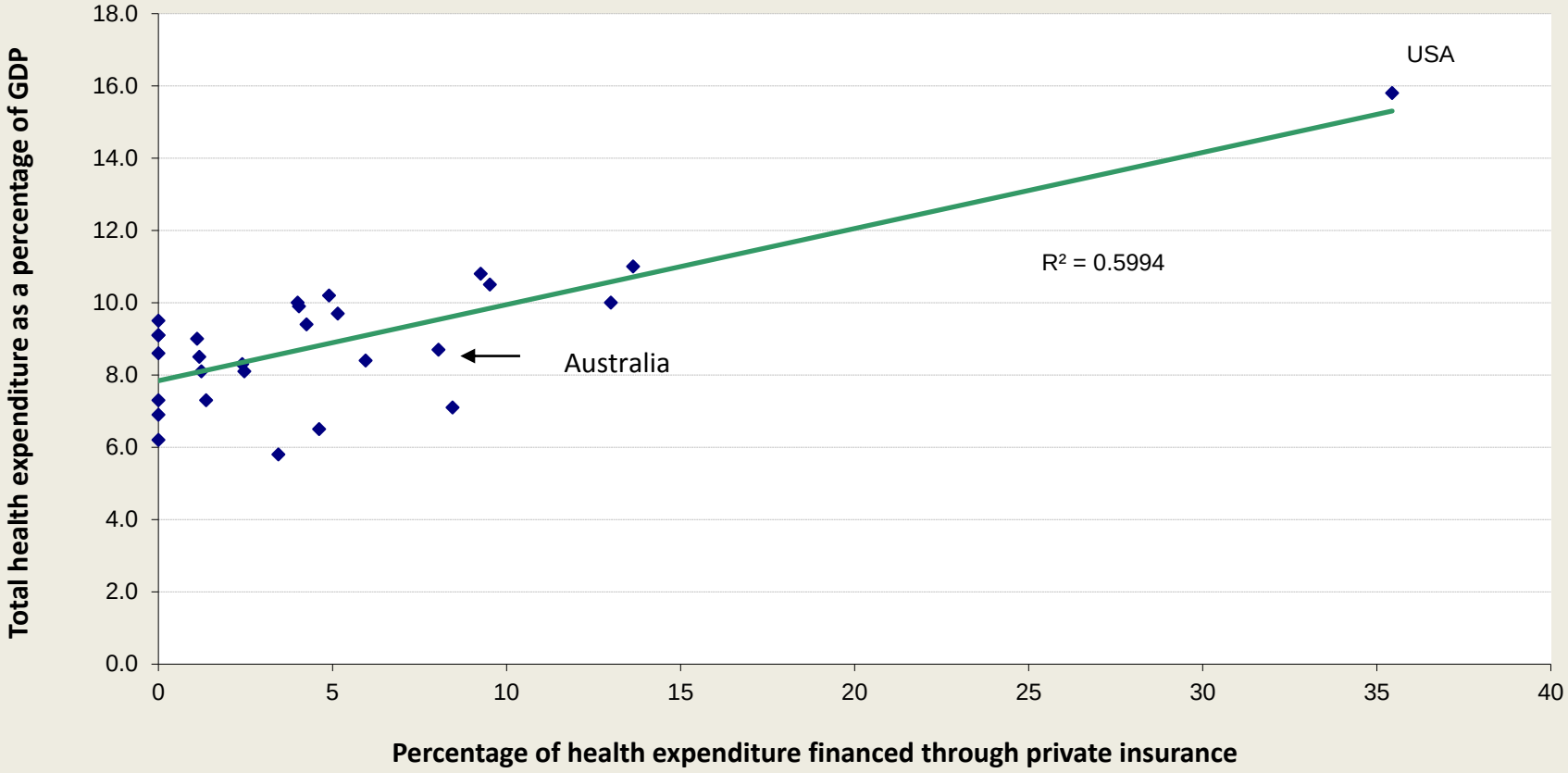
Conflicts:

between premium cost and out-of-pocket costs

control of prices and "choice"

Community rating difficult – ATO does imperfect but better job

Health expenditure and dependence on private health insurance, 2006, OECD countries



Why have separated funding streams?

Private insurers

State and Commonwealth governments

$11 bn annual subsidy from CW

Limited competition

Private hospitals

Public hospitals

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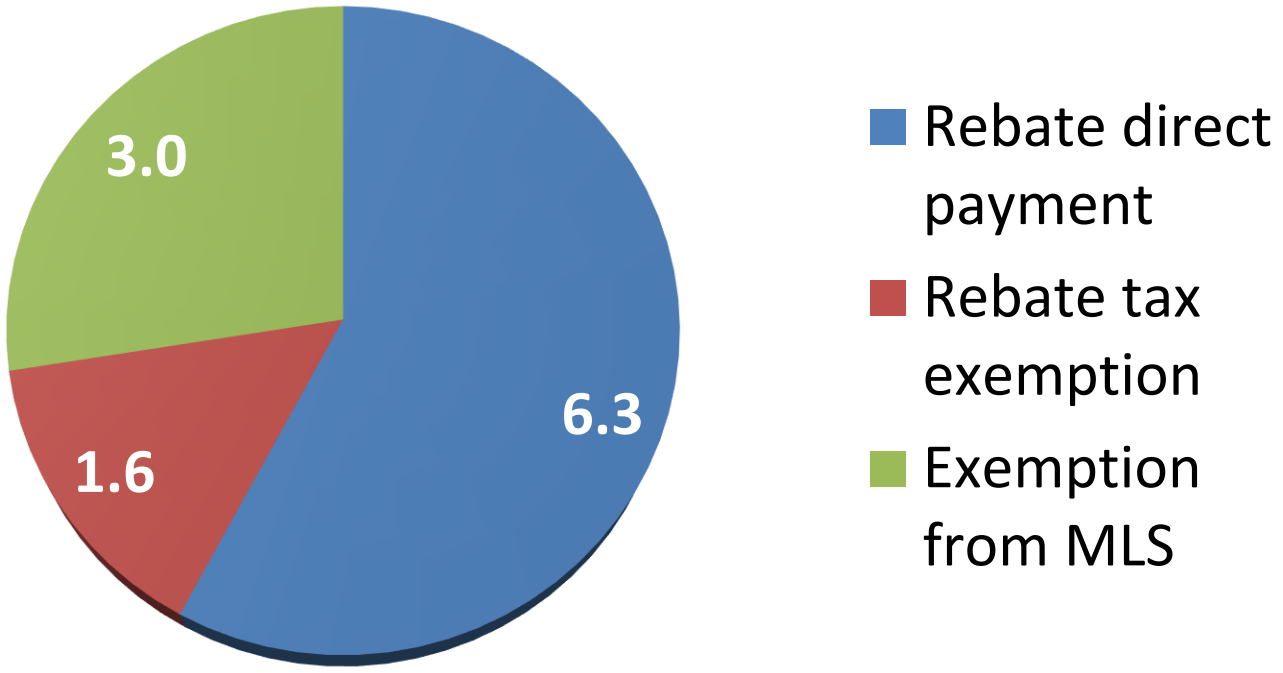
Fifty years without scrutiny of subsidies

Composition of $11 bn annual subsidy to PHI



Fifty years without scrutiny of subsidies

1969 Nimmo Report, basis for Medibank (1974), later Medicare

1999 PC Report on private insurance, on *how* to subsidize PHI, not *whether* to subsidize PHI
"Private insurance is in our DNA" (Abbott)

2007 Health and Hospital Reform Commission – PHI carved out from scrutiny

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Why is new technology not associated with lower unit costs?

Understandable conservatism

Diagnostic technology discovers too much

Payment systems (incl FFS) suited to labour-intensive services

Inadequate use of data capture

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Quality control

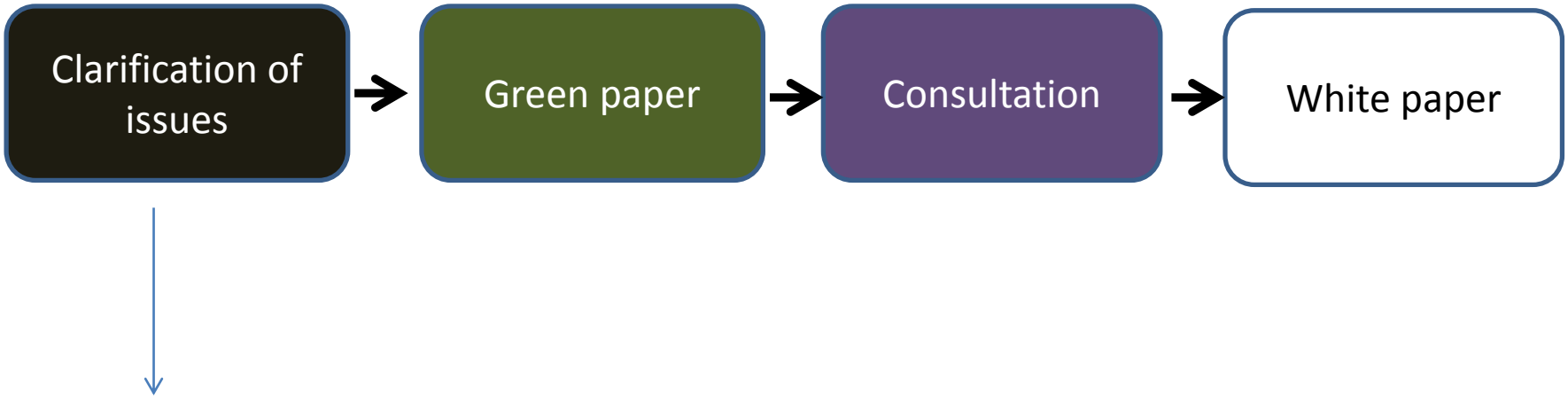
Slow to take up JIT processes

Inadequate use of data

Generally a forensic rather than an inquisitorial approach to incidents and accidents

Rebuild?

First, however, need a design brief



To what extent do we want to share our health care costs?

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