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

weird funding

largely escaped the disruptions and structural reforms of other industries

technological advances associated with increases in unit costs

strong quality control on inputs and procedures, but less on outcomes
Traditional structure

- Engine casting
- Press shop
- Machining
- Assembly
Contemporary (customer) structure

Car company

- Commercial
- Economy cars
- Lifestyle vehicles
- Luxury cars
Traditional structure

Policymakers and funders

Ambulatory caregivers

Pharmaceuticals

Public hospitals

Private hospitals and insurers
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Who pays for what

Co-payments by service type

- Public hospitals
- Unreferred medical services
- Patient transport
- Private hospitals
- Prescription pharmaceuticals
- Referred medical services
- Other health practitioners
- Dental care
- Aids and appliances
- Non-prescription pharmaceuticals
- All recurrent health care

Co-payment vs. Shared payment
How insurance (public or private) should work

Individual pays fixed $ from own pocket  Insurer bears open-ended risk

How health insurance (public or private) generally operates

“Insurer” pays a set amount  Individual bears open-ended risk
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

close 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

Total health expenditure as a percentage of GDP vs. Percentage of health expenditure financed through private insurance.
Why have separated funding streams?

- Private insurers
  - $11 bn annual subsidy from CW
- State and Commonwealth governments

Private hospitals

Public hospitals

Limited competition
anachronistic structure, organized around suppliers rather than users, and strong barriers to entry

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Fifty years without scrutiny of subsidies

Composition of $11 bn annual subsidy to PHI

- Rebate direct payment: 6.3
- Rebate tax exemption: 3.0
- Exemption from MLS: 1.6
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
anachronistic structure, organized around suppliers rather than users, and strong barriers to entry

weird funding

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technological advances associated with increases in unit costs

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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

- Clarification of issues
- Green paper
- Consultation
- White paper

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

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