Occasional Papers: Health Financing Series
Volume 4

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Foreword

Much of the public focus on Australia’s health care system is around issues of how to best provide high quality, accessible care at a reasonable cost. That is a discussion well worth having. Yet frequently that discussion is polarised around arguments about whether the health system as a whole, or at least important components of it, are ‘in crisis’ or ‘unsustainable’. Concerns about public hospital waiting lists and the affordability of private health insurance are two examples of this manifestation. Against that, there are also many ‘good news’ stories about health: exciting new medical and pharmaceutical breakthroughs, or gains in public health through successful immunisation campaigns being examples.

The fascination about health issues and the debate about priorities and approaches are understandable and necessary. At one level, birth, sickness and eventual death are aspects of life that confront all of us. We want the best for our families and more generally for society as a whole. At another level, almost one in every twelve dollars spent in Australia is directed at health care. The point is that we all have a keen interest in good health and in finding ways of better achieving it.

In Australia, we have a health system that serves us well, and compares well, on many key indicators, to overseas systems. While there is room for improvement, the complexity of the system makes it difficult to agree on where improvements are needed, what trade offs we are prepared to make in order to gain these improvements, and what changes will deliver the results we seek. Hence the presence of as many, if not more, ‘solutions’ in the debate as there are stakeholders.

This series of papers—coming out of the Department’s Health Financing Project—is intended to contribute to the debate by providing data and analysis that is not generally easily accessible. The papers are by no means the last word on the subject; they do not seek to cover all perspectives, for that would be too big a task. This is the fourth volume in the series and examines the evolving roles of the public and private sectors in funding and delivering health care in Australia. Other papers in the series will consider particular aspects of health financing and related issues.

We hope that you will find the papers a useful contribution to the debate.

David Borthwick
Deputy Secretary
December 1999
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This paper, “Public and Private – In Partnership for Australia’s Health” explores the impact of public and private sector participation in the funding and delivery of health services and market based approaches, including competition, on the overall objectives of the health care system: good health, low cost, equity and satisfaction.

Current arrangements

Health care funding and delivery in Australia currently involve both the public and private sectors in a complex, interwoven relationship. Although there has always been a significant private sector participation in health service delivery, there have been some changes in the balance between public and private health service delivery, with a move towards more private sector involvement particularly through the private sector provision of publicly funded services under contractual arrangements. However, funding arrangements have remained fairly static with the public sector continuing to have the bulk of funding responsibility.

The private sector and competition

Competition has been identified as a strategy that could encourage greater efficiencies in the health care system in order to keep future health care expenditure sustainable. However, caution must be taken to ensure that the overall objectives of the health care system are not undermined in a competitive market. Factors, such as the conflict between short-term profit motives and the quality of service provision, information asymmetry between consumers and providers, and the under-supply and maldistribution of medical specialists have the potential to jeopardise overall health objectives. Government intervention is arguably justified to overcome these failures of the health care market.

The effectiveness of competition in the Australian health care system is limited by the fact that there are only a few areas of service provision where the public and private sectors actually compete against each other. The acute care hospital market is the most significant of these. Even then, there are many areas where they do not overlap in terms of specific service provision. For example, emergency admissions are almost solely the responsibility of public hospitals, whereas elective surgery for private patients is predominantly the domain of private hospitals. For the areas in which public and private acute care hospitals do overlap, it is not yet possible to identify any difference in the quality of health outcomes.

Two recent developments in contracting arrangements have the potential to increase competition and therefore the efficiency of acute care hospitals:

- private hospitals contracted to provide public services; and
- private health insurers contracting with private hospitals for the delivery of private patient services.

Both of these developments are too recent to assess their efficacy.
Future directions

In relation to the funding of services in the future, evidence suggests that it is more efficient and equitable for basic health care to be primarily funded by the public sector, however there will continue to be a legitimate demand for additional services which can be privately funded.

In relation to the provision of services, the sector of service delivery is less important than the nature of the funding arrangements, which can be improved by more active purchasing of services rather than passive indemnity arrangements. There is an opportunity to learn more from the growing number of funders who are defining, monitoring and evaluating services in the contracting environment, including private sector funders.

There is room for improvement in our current health system in relation to all of the objectives of the health system but in particular in terms of the efficiency, coordination and integration of services. One of the primary reasons for introducing competition into service delivery and increased private sector involvement in a market-based health care system is to achieve improvements in both allocative and technical efficiency. However, information asymmetry, moral hazard, the scope for supplier-induced demand and the existing boundaries between disjoint funding sources all work against improvements in efficiency.

Resource allocation through pooled fund-holding arrangements has the potential to improve health outcomes and consumer satisfaction by facilitating the substitution of more appropriate services and providing the opportunities for coordination and integration of services. The role of fund-holder could be either a public or private responsibility.

Fund-holding is still relatively new in most countries and there are many issues to be tested and refined in terms of exploring whether it is possible to develop an appropriate fund-holding model for the Australian context. Ultimately, it would be necessary to ensure that the benefits derived from such a model would not undermine the benefits inherent in the current health system, that they would not be outweighed by the cost of any transition and that they would not undermine the other objectives of the health system.
Introduction

Many countries, including Australia, have identified four key objectives for their health care systems: the achievement of good health for the community, low cost, equitable access, and satisfaction for consumers and providers (Department of Health and Aged Care, 1999c).

There is considerable flexibility in the choice of health funding and service delivery mechanisms to achieve these objectives, and this is reflected in the wide range of approaches adopted around the world. Governments have also recognised the need to effectively manage the forthcoming changes to health care needs and delivery methods, which are being driven by factors such as the development of new technology and the ageing of the population.

Many countries are exploring whether there are ways of restructuring or reorganising their health funding and service provision arrangements to enhance the objectives of their health system. Within the international context, there are several recurring themes in this health reform agenda. Two of these are explored in this paper:

- what is the impact of public and/or private health funding and service delivery on the objectives of a health system; and
- to what extent can market-based approaches, including competition, be used to improve the efficiency and effectiveness of a health care system.

The mix of public and private sector funding and service delivery in Australia and most other countries has evolved over time and involves a hybrid of arrangements across different areas of the health system.

Chapter 1 details the current public and private sector responsibilities in health funding and health service delivery in Australia. In this paper, the term ‘public’ is used where any level of government provides the funding or employs the service providers. The term ‘private’ is used to refer to all non-government activities whether involving an institution or an individual. Sectoral interaction varies, with one sector having primary responsibility for the funding and/or delivery of some types of care while for other types the responsibility is shared. The sector(s) funding the care and the sector(s) delivering the care do not necessarily coincide.

Chapter 2 considers the impact that competition and the public-private mix can have on the objectives of a health system. It examines the nature of the health market, the special nature of the consumption of health care, and the extent to which competition and/or private sector involvement might help the health care system meet its objectives.
Much of the current health system reform in other countries has centred on market-based solutions to improve efficiency and effectiveness. Progress along this reform model varies. For example, the US embraced full market-based reform and now must identify the appropriate interventionist role for Government to ensure health services are of satisfactory quality; other countries with strong pre-existing regulatory regimes are incrementally introducing market-based policy in the hope that their own blend of government intervention and market-based reform will deliver better efficiency and cost-containment without compromising the quality of, or access to, health care.

Overseas evidence suggests market-based systems may help improve the objectives of a health system by:

- producing goods of the level(s) of quality that meet consumers’ preferences;
- being more consumer-focused in the provision of services;
- offering products at competitive prices;
- increasing allocative and technical efficiency;
- increasing the appropriateness of service delivery; and
- reducing the overall cost of the health system.

However, the same evidence also suggests that market-based systems can have unintended consequences which might have a negative affect on the objectives of a health system, such as:

- increased costs as more expensive services are expanded or services are duplicated to attract more funding;
- increased transaction costs;
- continued provider power in some circumstances due to information asymmetry and public preference for local level providers over large fund-holders who are seen as remote from the populations they serve; and
- a reduction in efficiency if providers use contracting arrangements that focus solely on reducing expenditure rather than rewarding efficiency (Bruce and Jonsson, 1996).

Many of these concerns result from the tensions between fund-holders and providers that will inevitably arise in a market-based system where fund-holders seek to buy more services for the same amount while maintaining or improving quality and providers seek to maximise their income. The final effects of these tensions remain to be seen, but it is clear that ‘competition as a free-standing strategy is not a panacea for achieving efficiency, effectiveness and economy in the use of resources’ (Bruce and Jonsson, 1996, p107).

Meanwhile, finding the most appropriate application of market-based policy appears to be the major issue on the agenda of international health care reform and is also the basis of the reform agenda in other areas of Australian government policy. There is currently some incremental reform around these issues occurring in the Australian health system. Chapters 3 and 4 and a series of case studies examine some of these reform initiatives and explore some of the potential and actual consequences of their introduction.
Chapter 3 considers acute hospital care, including in-hospital medical services. This is the component of the Australian health care system that attracts the greatest health expenditure and it is the area in which there is the greatest overlap between public and private sector funding and service delivery.

Chapter 4 briefly considers areas of the health care system in which the roles of the public and private sectors have changed recently, such as hearing services and pathology services, and the lessons to be learnt from community-based general practice which is an area in which the private sector dominates service delivery.

Chapter 5 outlines the evolution of the fund-holding role, and its implications for the private sector, and the impact of competition reform, and then summarises the key conclusions of the paper.
1. Australia’s health care system

An appraisal of Australia’s health care achievements, using standard measures of life expectancy, infant mortality, prevalence of communicable diseases and incidence of coronary heart disease, shows that, overall, the health status of the Australian population has improved over time and compares well with other highly developed countries. Some sectors of the population, however, continue to have relatively poor health status. These represent different levels of socioeconomic status, geographic location and ethnicity. The Aboriginal and Torres Strait Islander communities, in particular, have substantially higher levels of morbidity and significantly shorter life expectancy than the non-indigenous population.

In addition to some shortcomings in meeting the current objectives of the health care system, Australia must also prepare for the different demands on health care funding and delivery that are likely to arise in the future.

The health status of the Australian population is directly affected by the health care system, that is, the delivery of services by trained professionals for the treatment or prevention of illness, as well as other broad responsibilities outside the health care system which are usually met by government, for example, sewerage, water quality, quarantine and disaster management.

This paper will consider Australia’s health care system and how the public and private sectors interact within it.

Health care in Australia represents a significant investment, accounting for $47.3 billion, or 8.4 per cent of gross domestic product (GDP), in 1997–98 (AIHW, 1999a, p.2). Effective management is essential to ensure that this investment meets current and future health care objectives.

The mechanisms chosen to fund and deliver health care services are important factors in the effectiveness of Australia’s health care system.

Funding of health care

The funding of health care is defined as the provision of funds to:

- pay individual or institutional health care providers for the delivery of health services to individuals, communities and the wider population; and
- reimburse individuals who have already purchased health care services.

In this paper, the funding arrangements are defined as public or private according to the source of funding. It should be noted that funding from one source may be paid out through another source; for example, the Federal Government 30 per cent rebate on private health insurance represents public funding, although it is usually paid out by private health insurers in the form of lower premiums.
The public funders are the Commonwealth Government and the State and Territory Governments. Private funding falls into two key areas: funding by organisations such as private health insurance funds and workers’ compensation schemes; and individuals’ contributions to their own care.

Trends in health care outlays

Australia’s expenditure on its health care system is increasing. In real terms (1996-97 dollars), health expenditure increased from $33,751 million in 1989–90 to $46,544 million in 1997-98. During this period, annual real growth varied between 2.3 per cent and 5.3 per cent (AIHW, 1999a, p.1). See table 1.

Average per capita expenditure on health care services increased from $1,993 in 1989–90 to $2,497 in 1997–98 (in 1996-97 constant prices) at an average per person annual real growth rate of 2.9 per cent (AIHW, 1999a, p.20). See figure 1.

Australia’s health care services expenditure as a proportion of GDP is generally similar to that of other advanced Western economies (AIHW, 1998b, p18). Expenditure increased from 7.5 per cent of GDP in 1989–90 to 8.4 per cent in 1997–98. See table 1. The growth that occurred corresponds to periods of negative GDP growth, not acceleration in expenditure on health services.

Table 1: Health care expenditure 1989–90 to 1997–98

<table>
<thead>
<tr>
<th>Year</th>
<th>Expenditure ($m)*</th>
<th>Growth over previous year (per cent)</th>
<th>Expenditure 1996-97 ($m)</th>
<th>Growth over previous year (per cent)</th>
<th>Proportion of GDP (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1989–90</td>
<td>28,800</td>
<td>–</td>
<td>33,751</td>
<td>–</td>
<td>7.5</td>
</tr>
<tr>
<td>1990–91</td>
<td>31,270</td>
<td>8.6</td>
<td>34,524</td>
<td>2.3</td>
<td>7.9</td>
</tr>
<tr>
<td>1991–92</td>
<td>33,087</td>
<td>5.8</td>
<td>35,513</td>
<td>2.9</td>
<td>8.2</td>
</tr>
<tr>
<td>1992–93</td>
<td>34,993</td>
<td>5.8</td>
<td>37,077</td>
<td>4.4</td>
<td>8.2</td>
</tr>
<tr>
<td>1993–94</td>
<td>36,787</td>
<td>5.1</td>
<td>38,593</td>
<td>4.1</td>
<td>8.2</td>
</tr>
<tr>
<td>1994–95</td>
<td>38,967</td>
<td>5.9</td>
<td>40,278</td>
<td>4.4</td>
<td>8.2</td>
</tr>
<tr>
<td>1995–96</td>
<td>41,783</td>
<td>7.2</td>
<td>42,421</td>
<td>5.3</td>
<td>8.2</td>
</tr>
<tr>
<td>1996–97</td>
<td>44,279</td>
<td>6.0</td>
<td>44,279</td>
<td>4.4</td>
<td>8.3</td>
</tr>
<tr>
<td>1997–98</td>
<td>47,267</td>
<td>6.7</td>
<td>46,544</td>
<td>5.1</td>
<td>8.4</td>
</tr>
</tbody>
</table>


*current dollar value
Sector distribution of funding

The contribution of the public and private sectors across all aspects of health care is best described as a continuum from totally publicly funded to totally privately funded, with most areas of health care receiving funding from both sectors. The funding roles remained relatively stable over the past decade since there were no major changes in Government health policy to alter the amount or proportion of health funding contributed by the public sector.

The private sector’s contribution to total health expenditure in Australia is proportionately quite high compared to other Organisation for Economic Cooperation and Development (OECD) countries. See figure 2.

**Figure 1: Real health services expenditure per person, 1989-90 to 1997-98**

![Figure 1: Real health services expenditure per person, 1989-90 to 1997-98](image)

**Figure 2: Public and private health expenditure in OECD countries as a proportion of total health expenditure**

![Figure 2: Public and private health expenditure in OECD countries as a proportion of total health expenditure](image)

*Private health care can cover quite different components of health sector funding and delivery across these countries.*
Between 1989–90 and 1996–97 the proportion of health funding contributed by the public sector remained steady at about 68 per cent. Recent policy shifts, including the introduction of the Federal Government 30 per cent rebate on private health insurance in 1999, are expected to increase the Commonwealth’s contribution by about three per cent.¹

### Table 2: Sector contribution to health expenditure 1996–97

<table>
<thead>
<tr>
<th>Area</th>
<th>Total ($m)</th>
<th>Proportion (per cent)</th>
<th>Public share ($m) (per cent)</th>
<th>Private share ($m) (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public acute hospitals</td>
<td>11,973</td>
<td>27.0</td>
<td>10,920 91.2</td>
<td>1,053 8.8</td>
</tr>
<tr>
<td>Private hospitals</td>
<td>3,493</td>
<td>7.9</td>
<td>354   10.1</td>
<td>3,139 89.9</td>
</tr>
<tr>
<td>Other institutional</td>
<td>4,026</td>
<td>9.1</td>
<td>3,064 76.1</td>
<td>961 23.9</td>
</tr>
<tr>
<td>Medical services</td>
<td>8,198</td>
<td>18.5</td>
<td>6,713 81.9</td>
<td>1,485 18.1</td>
</tr>
<tr>
<td>Other professional</td>
<td>1,407</td>
<td>3.2</td>
<td>203    14.4</td>
<td>1,204 85.6</td>
</tr>
<tr>
<td>Pharmaceuticals</td>
<td>5,056</td>
<td>11.4</td>
<td>2,729 54.0</td>
<td>2,327 46.0</td>
</tr>
<tr>
<td>Other recurrent</td>
<td>7,443</td>
<td>16.8</td>
<td>3,946 53.0</td>
<td>3,498 47.0</td>
</tr>
<tr>
<td>Capital</td>
<td>2,683</td>
<td>6.1</td>
<td>1,711 63.8</td>
<td>972 36.2</td>
</tr>
<tr>
<td>Total</td>
<td>44,279</td>
<td>100.0</td>
<td>29,640 66.9</td>
<td>14,639 33.1</td>
</tr>
</tbody>
</table>

Source: AIHW, 1999a, p.38.

The private sector contributes, on average, 33.1 per cent of funding across the health care system, but the contribution varies considerably in different parts of the system. Public hospitals and medical services are substantially funded by the public sector, while private hospitals and allied health care (other professional services) are funded privately (AIHW, 1999a, p.38). See table 2.

### Public sector funding

The Commonwealth Government and the State and Territory Governments use a range of mechanisms to fund health care in Australia, including:

- the allocation of funds from general revenue through grants to individual providers or patients, for example, the Medical Benefits Scheme (MBS) and the Pharmaceutical Benefits Scheme (PBS);

¹ Assuming other trends continue, the introduction of the Federal Government 30 per cent rebate on private health insurance will reduce the proportion of funds contributed by private health insurers from more than 11 per cent to less than eight per cent, the lowest level since the introduction of Medibank in 1975–76. The effects of this policy change will not be observed until the 1998–99 figures are available.
• the provision of grants to States and Territories, usually calculated on the basis of historical throughput, for example: hospital funding grants or other special purpose payments for specific health programs; and
• in some cases, the provision of output-based funding for specific services, for example, funding provided by some States to the operators of public hospital services.

These mechanisms ensure that entitlement and access to publicly funded health care is independent of the individual’s ability to pay.

Through these mechanisms, the public sector funds:
• public hospital services;
• community-based services, including all of those bulk-billed\(^2\) by practitioners and a proportion of those not bulk-billed;
• a proportion of the cost of most prescribed pharmaceuticals;
• optometry services;
• some dental care; and
• population health activities (described in more detail below).

The balance of funding between the Commonwealth Government and the State and Territory Governments has changed over time. Between 1989–90 and 1996–97 the proportion of funds contributed by the Commonwealth increased marginally from 43.5 per cent to 48.1 per cent (AIHW, 1999a, p6) as a result of several changes, including:
• increases in Commonwealth funding through the Department of Veterans’ Affairs;
• increases in Commonwealth funding for pharmaceuticals, medical services and public hospital services (Department of Health and Aged Care, 1999b); and
• a two per cent decrease in the State contribution to total recurrent expenditure following the first year of the 1993–1998 Medicare Agreements.

**Private sector funding**

A substantial proportion of funding for the health system comes from private sector sources, principally individuals (52 per cent) and private health insurers (34 per cent) (AIHW, 1999a, p.36). Private health insurance is subsidised by indirect payments from individuals in the form of premiums which are themselves subsidised by a 30 per cent Rebate from the Commonwealth Government. The remaining private sector contribution to health funding comes primarily from compensable payments. See table 3.

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2 When bulk-billing, practitioners recover charges for the Medicare service directly from the Health Insurance Commission and the patient is not required to make any payment.
Table 3: Private sector components of recurrent health expenditure 1995-96

<table>
<thead>
<tr>
<th>Area</th>
<th>Total private sector ($m)</th>
<th>Individuals (per cent)</th>
<th>Health insurance funds (per cent)</th>
<th>Other sources* (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public acute hospitals</td>
<td>1,053</td>
<td>8.4</td>
<td>34.2</td>
<td>57.5</td>
</tr>
<tr>
<td>Private hospitals</td>
<td>3,139</td>
<td>9.2</td>
<td>77.6</td>
<td>13.2</td>
</tr>
<tr>
<td>Other institutional</td>
<td>961</td>
<td>86.4</td>
<td>9.7</td>
<td>4.0</td>
</tr>
<tr>
<td>Medical services</td>
<td>1,485</td>
<td>55.1</td>
<td>15.4</td>
<td>29.5</td>
</tr>
<tr>
<td>Other professional</td>
<td>1,204</td>
<td>65.4</td>
<td>18.7</td>
<td>15.9</td>
</tr>
<tr>
<td>Pharmaceuticals</td>
<td>2,327</td>
<td>96.5</td>
<td>1.9</td>
<td>1.6</td>
</tr>
<tr>
<td>Dental</td>
<td>2,157</td>
<td>71.9</td>
<td>27.6</td>
<td>0.4</td>
</tr>
<tr>
<td>Other recurrent</td>
<td>1,341</td>
<td>34.8</td>
<td>53.4</td>
<td>11.8</td>
</tr>
<tr>
<td>Total</td>
<td>13,667</td>
<td>51.8</td>
<td>34.4</td>
<td>13.8</td>
</tr>
</tbody>
</table>

* Includes workers’ compensation and compulsory third party motor vehicle insurers, as well as other sources of income.

The private sector funds a wide range of health care services, including:

- private patient services in public and private hospitals (principally through private health insurance);
- the gap between the MBS rebate and fees charged for privately provided medical services (principally from individuals, but insurance funds contribute where the medical service is part of a private patient hospital episode);
- pharmaceuticals (principally from individuals); and
- services provided by allied health professionals including dental services, optometry products (for example, spectacles and contact lenses) and ambulance services (again, principally through private health insurance).

As shown in table 3, sources other than individuals and private health insurers, primarily workers’ compensation and compulsory third party motor vehicle insurance, contribute significantly to the private funding of public acute hospital care (57.5 per cent), medical services (29.5 per cent) and other professional services (15.9 per cent).

There were no significant changes in the balance of funding between the private sector groups in the period 1989–90 to 1996–97. The proportion of funds contributed by individuals to total recurrent health expenditure averaged around 17.2 per cent from 1989–90 to 1995–96 (AIHW Health Expenditure Database, November 1998, unpublished data) and fell slightly to 17.0 per cent in 1996–97 (AIHW, 1999a, p.38).

There are 41 not-for-profit private health insurance funds and three for-profit private health insurance funds in Australia (PHIAC, 1998, table 1). In both 1996–97 and 1997–98 they contributed around $4.1 billion (PHIAC 1997, table 5; PHIAC 1998, table 6). The proportion of the population with health insurance declined from 45.5
per cent to 30.9 per cent between 1989–90 and September 1999 (PHIAC 1998 and PHIAC 1999b). For-profit private health insurers covered 11.9 per cent of the insured population in 1997–98 (PHIAC 1998, table 8). Despite the declining membership, the proportion of funds contributed by all private health insurers remained steady, averaging 11.8 per cent (Department of Health and Aged Care 1999b, table 3), due to an increase in premiums. Data from the Private Health Insurance Administration Council show an 89 per cent nominal increase in premiums per person from $393 in 1989–90 to $744 in 1996–97 (PHIAC 1998). Over the same period the Consumer Price Index increased by 20.3 per cent (ABS 1999e, p5).

The Industry Commission’s 1997 inquiry into private health insurance concluded that almost three-quarters of the increase in premiums over the period 1989–90 to 1994–95 was due to increased benefits per bed day, and that this in turn was driven by:

- a shift of private patients from public hospitals (at nominal benefits) to private hospitals (over 27 per cent of the total increase);
- increased private hospital charges (13 per cent of the total increase); and
- a decreased average length of stay in private hospitals, leading to a smaller number of days over which to distribute one-off theatre costs (20 per cent of the total increase).

The Commission concluded that the underlying factors of ageing and adverse selection contributed about one-quarter of the increase in premiums (Industry Commission 1997, pp195-255).

Expenditure on population health activities

Population health covers a broad range of activities, involving: describing the health of populations and the determinants of health; developing, implementing and evaluating population health interventions; and developing appropriate population health infrastructure to undertake this work. Population health activities have been very successful in improving the health of populations, some examples of these activities are: childhood immunisation;

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3 The average cost of individual claims has risen. The total insurance benefits paid out by health insurance funds per average single member increased from $462 in 1989–90 to $779 in 1997–98. The majority of this increase was in hospital benefits, which increased from $358 to $701 during this period; ancillary benefits rose from $174 to $268. This rise is particularly noticeable for hospital services: private health insurance funds are paying out for an increasing number of private hospital episodes because more members are choosing to use private hospitals rather than public hospitals and the cost of accommodation in a private hospital is almost double that in a public hospital. The total amount of private hospital benefits paid by funds increased from $1,586,016 in 1991–92 to $2,213,104 in 1997–98. There was a corresponding decrease in the amount of public hospital benefits paid by health insurance funds from $538,673 in 1991–92 to $273,030 in 1997–98.

4 There is an increasing trend for private health insurance coverage to be skewed to higher risk, older persons who are making more claims. The proportion of health insurance funds’ members aged over 65 years rose from 11.6 per cent in 1991–92 to 14.9 per cent in 1997–98 and accounted for 46 per cent of total benefits paid. This trend is greater than the increase in the proportion of persons over 65 in the population which has increased from 11.29 per cent to 12.17 per cent over this period (PHIAC, 1998, p23).
screening programs such as for breast cancer; HIV/AIDS prevention; water quality monitoring; legal reform; intersectoral work on reducing road accidents; and identification of the determinants of health such as the impact of income disparity.

Under Australia’s constitution, state and territory governments are responsible for most population health functions, such as monitoring water quality, education campaigns, immunisation amongst others, as well as undertaking policy and strategy coordination.

The Commonwealth Department of Health and Aged Care primarily develops national policy and coordination and provides funding to state and territory health departments and some non-government organisations for population health activities. At times, with the agreement of States and Territories, the Department undertakes direct population health programs.

Local government and non-government bodies such as State and Territory cancer councils and health promotion foundations/councils and the National Heart Foundation also undertake population health activities.

In recent years it has been difficult to discretely identify expenditure on population health programs. In 1997-98 however a new expenditure category for population health, 'Public health services' has been included in the Government Finance Statistics (Government Purpose Classification). Estimates of expenditure for 1997-98 in this category, show that total expenditure on population health by all levels of government in Australia was $714.5 million. This represents a share of 1.6 per cent of total recurrent health expenditure in the same year. By source of funds, Commonwealth direct-expenditure on population health is 15.8 per cent of total population health expenditure. Commonwealth grants to the States comprise 19.9 per cent of total government expenditure on population health. State expenditure on population health, net of Commonwealth grants is 59.1 per cent of total population health expenditure, and Local Government expenditure makes up the remaining 5.2 per cent of total expenditure on population health.

Private sector expenditure on core population health functions is minimal and while there are opportunities to increase the level of private sector input into population health, observations show that this is usually not stimulated by market-driven forces due to the required collective nature of population health action and the time lag between intervention and outcomes (Shiell and Carter, 1999). Some private health insurers are providing ‘incentives’ for people to take up population health activities. An example of this is some insurers offering special coverage arrangements for people who undertake preventative health measures. In Germany, legislation requires that the new privatised health insurance bodies spend one per cent of their funds on public health. Hence the positioning of government in the area of population health remains important, with scope for new innovations on providing incentives or regulations to facilitate population health action.

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Delivery of health care services

In this paper, the sector delivering a health care service is defined as that sector with which the consumer comes in contact when receiving the service. In some circumstances, the distinction between public and private sector service delivery is not clear; for example, in public hospitals, private sector medical practitioners provide some medical services and the public sector provides all accommodation, operating theatres, nursing and allied health services.

General trends in the delivery of health care services

There has been an overall increase in the numbers of medical services, prescriptions and episodes of hospital care (see table 4):

- the number of medical services provided under MBS increased by 27.0 per cent from 156,579 in 1991–92 to 198,800 in 1996–97 (Department of Health and Aged Care, 1998, p31);
- the number of PBS prescriptions increased by 33.5 per cent from 92.47 million in 1991–92 to 123.43 million in 1996–97 (AIHW, 1998a, p225); and
- the number of public hospital separations increased by 23 per cent from 1991–92 to 1996–97. Over the same period the number of private hospitals separations increased by 39 per cent (AIHW, 1999, table 4.1; AIHW, 1998, table 3.1).

There have also been changes in how services are provided. This is most notable in the hospital setting, where there has been an increase in the number of same-day procedures and a decrease in the average length of stay.
Table 4: Change in service delivery patterns 1991-92 to 1995-96

<table>
<thead>
<tr>
<th>Health service</th>
<th>1991–92</th>
<th>1995–96</th>
<th>Percentage change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public hospital separations^ (’000)</td>
<td>2,937</td>
<td>3,568</td>
<td>21.5</td>
</tr>
<tr>
<td>Private hospital separations^ (’000)</td>
<td>1,120</td>
<td>1,577</td>
<td>30.3</td>
</tr>
<tr>
<td>Private market share(%)^</td>
<td>29.2</td>
<td>30.6</td>
<td>4.8</td>
</tr>
<tr>
<td>Public hospital same-day(%)^</td>
<td>29.3</td>
<td>39.7</td>
<td>35.5</td>
</tr>
<tr>
<td>Public hospital average length of stay^</td>
<td>5.2</td>
<td>4.6</td>
<td>-11.5</td>
</tr>
<tr>
<td>Private hospital same-day(%)^</td>
<td>33.9</td>
<td>48.9</td>
<td>44.2</td>
</tr>
<tr>
<td>Private hospital average length of stay^</td>
<td>4.0</td>
<td>3.7</td>
<td>-7.5</td>
</tr>
<tr>
<td>Medical services per capita∗</td>
<td>9.0</td>
<td>10.7</td>
<td>18.9</td>
</tr>
<tr>
<td>PBS prescriptions per capita∗</td>
<td>5.8</td>
<td>6.8</td>
<td>17.2</td>
</tr>
</tbody>
</table>

* Changes in the utilisation of Medicare services over time should be interpreted with caution as such changes could represent structural change to the MBS, population growth, net migration, ageing of the population, cost shifting, addition of new items to the MBS or changes in Medicare coverage due to Government policy.


Sources: Australian Institute of Health and Welfare health expenditure database; Australian Bureau of Statistics, CGC, Department of Health and Family Services, published data.

**Allocation of service delivery responsibility**

The State and Territory Governments’ provision of the majority of public hospital services is the public sector’s most significant health service delivery role. State and Territory Governments are also primarily responsible for the delivery and management of publicly provided community health services.

The private sector’s role in delivering health care is also significant and includes, for example, provision of:

- services in private hospitals;
- almost all primary and specialist medical care;
- most allied health services; and
- some population health care, for example, immunisation programs.

Generally, each aspect of health care delivered in Australia has been predominantly the responsibility of either the private sector or the public sector. The most important exception is the provision of hospital services, in which both sectors play a substantial role.

The number of available acute hospital beds per 1,000 population varies significantly between States, but in each State there are almost twice as many available public hospital beds as available private beds. Nationwide, in
1996-97 there were 3.1 available public hospital beds and 1.2 available private hospital beds per 1,000 population (AIHW, 1999, table 3.1).

There are differences in the distribution of private hospitals between States and between different rural and regional areas. Generally, large for-profit private hospitals are located in suburbs in capital cities and areas which have high rates of private health insurance (that is, areas with higher average incomes). The private hospitals in these locations often compete with each other for medical specialists and patients. However, overall, 67 per cent of private overnight facilities and 74 per cent of available private hospital beds are located in capital cities, which contain 64 per cent of the population (ABS, 1999b, p12; ABS, 1999f).

The private-public structure of the health workforce provides a proxy measure of the respective contributions of both sectors in delivering various types of health care.

In 1996, 45,342 medical practitioners practised as clinicians, 41,116 (90.7 per cent) of whom provided services through Medicare (AIHW, 1998d, p3). Subgroups of this workforce, particularly medical specialists, are likely to practise in both public and private sectors, so valid estimates of the private-public contributions are difficult to obtain. The AIHW (1998d, p3) has reported that, in 1996, 19,948 practitioners, or 41.8 per cent of all practising medical practitioners, worked in public hospitals as their main, second or third job. Specialists in training and non-specialist hospital practitioners, who make up 20 per cent (9,081) of the workforce, are based principally in the public sector. Specialists, on the other hand, undertake a greater mixture of public and private work, with 58.7 per cent of this workforce undertaking some work in public hospitals in 1996. General practitioners, who comprise 45 per cent of all clinicians, practise predominantly in the private sector (AIHW, 1998d, p3).

According to the AIHW overview Australia’s nursing workforce (AIHW, 1998e) there were 265,753 registered and enrolled nurses in 1997, of whom around 218,000 were working as nurses. The Australian labour force survey of nurses showed that, in 1996, 103,331, or 47 per cent, were employed in public hospitals. Nurses also worked in other public settings including 10,425 in community health centres and 15,873 in public nursing homes. The total percentage of employed nurses working in the public sector was 59 per cent. The private sector employed 28,729 nurses in private hospitals, 6,720 nurses in private medical rooms and 18,081 in private nursing homes (AIHW 1998e, pp44-45).

Of the 13,479 practising pharmacists in Australia in 1995, almost 80 per cent (10,722) were working in the private sector as community pharmacists. There were 1,950 hospital or clinic pharmacists (14.5 per cent of the total), working primarily in the public sector. Industrial pharmacy, pharmacy administration, research and education employed 755 pharmacists (AIHW, 1998f, p1).

Private employment also dominates most other allied health workforces. Between February 1997 and August 1998, the number of persons employed in dental services positions in the public sector fell slightly from 2,100 to 1,900, while the number of persons so employed in the private sector increased from 18,300 to 22,700 (ABS, 1999d, unpublished data). In the same period, the number of persons employed in technical pathology positions in
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the public sector increased slightly from 900 to 1,100 and the number employed in the private sector rose from 5,900 to 6,900 (ABS, 1999d, unpublished data). The public sector increased slightly from 900 to 1,100 and the number employed in the private sector rose from 5,900 to 6,900 (ABS, 1999d, unpublished data).

There is a complex intersection between public and private health settings, and between publicly and privately employed health professionals, as illustrated in table 5.

Table 5: Health professional employment by sector

<table>
<thead>
<tr>
<th>Working in public sector health care setting</th>
<th>Publicly employed health professionals</th>
<th>Privately employed health professionals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaried medical officers in public hospitals</td>
<td>Visiting medical officers in public hospitals</td>
<td></td>
</tr>
<tr>
<td>Nursing staff, allied health professionals in public hospitals and community health centres</td>
<td>Self-employed GPs working from community health centres</td>
<td></td>
</tr>
<tr>
<td>Medical and paramedical staff in community health centres</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Working in private sector health care setting</th>
<th>Publicly employed health professionals</th>
<th>Privately employed health professionals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses privately employed in the community</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaried medical officers, nurses and allied health professionals in private hospitals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visiting medical officers in private hospitals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GPs and specialists in private surgeries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacists in community pharmacies</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Changes in allocation of responsibility

Over the past decade there have been noticeable changes in the mix of public-private responsibilities for delivering health care. Many of these reflect the Commonwealth Government’s and State Governments’ moves to reduce their ‘hands-on’ role in service delivery and increase reliance on private sector organisations to provide publicly funded services:

- the private sector has an expanding role in providing public hospital services. This ranges from the provision of some outsourced services (for example, pathology, laundry and catering) for State Government-operated hospitals to the entire management, operation and ownership of a public hospital. The Commonwealth has also contracted out hospital and other allied health services for veterans to private sector hospitals and other service providers;

- a range of State Government-funded for-profit and not-for-profit providers now supply a significant proportion of community health services (for example, community nursing services); and

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6 This category of pathologists may also include registered medical practitioners who are employed as pathologists, resulting in a possible overlap of the numbers of this workforce and the medical workforce discussed above.
a reduction in the public sector provision of some services, such as public hospital outpatient and pharmaceutical services, has resulted in an increase in services provided by private sector self-employed medical practitioners and pharmacists.

At the same time, public sector service provision has been affected by changes in utilisation patterns, including, for example:

- reductions in private patient services in public hospitals; and
- moves from public sector institutionalised health care to more community-based health care, leading to an increase in both for-profit and not-for-profit private sector services.

Governments have also moved to operate some public health services in a business-like manner to provide a return to government and to allow the private sector to enter the market. Examples of this trend include:

- the private sector provision of health services that previously operated as public sector monopolies and the corporatisation of government business enterprises, for example, hearing services and government medical officer services; and
- parts of public hospital services, such as pathology services, that are now operating on a commercial basis.

Summary

Funding and service delivery by the public and private sectors are interwoven and consumers or patients often are unaware of the sectoral contributions. Health care in Australia may be:

- publicly funded and publicly delivered (for example, State Government-owned public hospitals);
- publicly funded and privately delivered (for example, community-based medical services subsidised under the Medicare system);
- privately funded and privately delivered (for example, community-based allied health services, including dental and physiotherapy and private hospital care—medical services provided in private hospitals are however publicly funded under the Medicare system); and
- privately funded and publicly delivered (for example, services for private patients in public hospitals of which medical services are also partially publicly subsidised under the Medicare system).

Some health professionals may deliver services under all four funding-service delivery arrangements.

The roles of the public and private sectors in funding and delivering health care have evolved over time. The funding roles remained relatively stable over the past decade since there were no major changes in Government health policy to alter the amount or proportion of health funding contributed by the public sector. There were, however, some shifts in the balance between the private and public sectors in terms of health service delivery, with expansion of the private sector. The public sector continues to carry the majority of the funding responsibility for health services while the private sector is responsible for the majority of health service delivery.

Table 6 summarises the funding-delivery combinations that now operate in Australia’s health care system.
Table 6: Funding and delivery of health care in Australia

<table>
<thead>
<tr>
<th>Responsibility for delivery of health care*</th>
<th>Responsibility for funding of health care</th>
<th>Principally public sector</th>
<th>Mix—both public and private sectors</th>
<th>Principally private sector (mutual, for-profit organisations, individual contributions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principally public sector</td>
<td></td>
<td>Medicare hospital patients*</td>
<td>Private patients in public hospitals (declining)*#</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Public health initiatives</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health research</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mix—substantial contributions from both sectors</td>
<td></td>
<td>Veterans’ health care*</td>
<td>Aids and appliances (large individual contributions to funding; increasing tendering of operations to private sector)</td>
<td>Australian Hearing Services*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Commonwealth Rehabilitation Service</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Ownership and investment in infrastructure and assets</td>
</tr>
<tr>
<td>Principally private sector (includes for-profit and not-for-profit)</td>
<td></td>
<td>Ambulatory medical services, eg general practitioners, specialists</td>
<td>Private patients in private hospitals*</td>
<td>Dental, other allied health services (mostly individual contributions with some private health insurance)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pharmaceutical services</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nursing services provided in the community</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: The numerous different arrangements for public-private funding and service delivery would be more accurately depicted along a continuum from totally public to totally private but, for convenience and brevity, have been allocated here to distinct categories.

* Components of health care for which delivery is moving from the public to private sectors.

# Although the public-private delivery pattern for this care is changing, the public funding contribution is fixed through the funding of medical services under MBS.

The lack of homogeneity within each sector also contributes to the complexity of this system. The public sector comprises different levels of government while the private sector includes organisations that may be for-profit or not-for-profit as well as private citizens who contribute to the cost of health care through point-of-service payments.
2. Competition and the health sector

In the past decade, governments of all levels and persuasions have noted that effective competition provides flow-on benefits in the form of efficiencies and consumer focus.

This chapter first examines competition theory in the general context of the Australian economic and health care systems and then discusses the constraints on the scope for competition in the health care sector, outlines the differences between the public and private sectors and examines what the Government can do to address problems with the operation of the market.

Competition theory

Pure competition theory is based on a range of assumptions, including:
- that no one supplier can dominate the market and, as a result, affect the market price; and
- that consumers:
  - have sufficient information to make informed decisions about the value of competing products;
  - are the best judges of what will maximise their own utility;
  - act in ways that reflect their preferences;
  - have predetermined tastes; and
  - make rational, economic-based decisions.

Where these assumptions hold true, the market remains contestable; that is, open or potentially open to all suppliers, who must continually improve their service and/or product to maintain their market share.

In the health care market, however, some of the underlying assumptions of consumer behaviour do not hold true and the market is not always fully contestable.

In an ideal market, effective competition between suppliers drives economic efficiency and ensures the effective allocation of resources to production. In pure competition theory, the market:
- is consumer-focused, since the quantity and quality of goods and services produced will accord better with consumer demand; and
- produces goods and services as efficiently as possible and sells them for the lowest price conducive to a reasonable profit.

Effective competition is closely linked to the market’s contestability, that is, the extent to which existing suppliers perceive themselves to be open to new competition from potential, rather than actual, market entrants. A contestable market can produce efficiencies and benefits for the consumer even if there is only one supplier.
Competition theory from the Australian viewpoint and the National Competition Policy (NCP)

The 1993 report of the National Competition Policy Review (the Hilmer report) advocated micro-economic reforms to existing markets to improve competition in a number of traditionally closed environments.

The Hilmer report found that in the absence of competition there were fewer incentives for suppliers to continually improve the quality and efficiency of production. The report nominated several matters as targets for reform, including greater responsiveness to consumer needs, development of innovative services, clarification of objectives and better evaluation and monitoring of outcomes.

On 25 February 1994, the Council of Australian Governments (COAG) agreed to adopt the principles of competition policy set out in the Hilmer report and on 11 April 1995 the Commonwealth, States and Territories entered three formal agreements to implement the National Competition Policy (NCP). The NCP’s key objective is to develop a more open and integrated Australian market that limits anti-competitive behaviour. It focuses on the operation and products of existing suppliers and the structure and ownership of players in the industry in question.

All levels of government have responded proactively, undertaking a range of activities across various sectors to create a more competitive environment for Australian industries.

In line with the NCP's recommendations, governments are assessing their own business activities as part of an initiative to review and reform public monopolies. This is aimed at improving performance and creating contestability. The NCP aims to make government business activities competitively neutral, that is, to remove their special advantages over private enterprise by subjecting them to the same obligations, including compliance with regulations and the payment of taxes and charges. The NCP also emphasises the need for governments to review regulations that might limit competition.

This focus on increasing competition is set against a political philosophy in most Australian jurisdictions of decreasing government involvement in service delivery. For example, the National Commission of Audit (June 1996 p10), recommended that governments should only be involved in activities where:

- their involvement is essential to achieve specific social objectives;
- there is clear evidence of market failure; or
- there is a high risk the private sector on its own would not perform adequately.

It was also noted that the need for government involvement in service delivery changes over time as the maturity and competitiveness of markets increases.
Application of competition to health

It is now generally accepted that health care resources are limited and not all health care wants can be satisfied. The World Health Organisation (WHO) recently supported the concept of ‘new universalism’ in the provision of health care. In its annual report, WHO stated that ‘universal coverage means coverage for all, not coverage of everything’ (Brown, 1999, p1305). The health care sector competes with other sectors for resources and is not the only determinant of the population’s health status. It is therefore important that the resources devoted to health care are used as effectively and efficiently as possible. This becomes an even greater imperative given that there is no natural limit to health expenditure. Population growth, the ageing of the population, excess supply, growing expectations and the luxury good nature of health care services (in the sense that consumption increases more than proportionally with income) will lead to an ever-increasing national health bill.

Most Organisation for Economic Cooperation and Development (OECD) countries anticipate that their health expenditure will increase as a proportion of GDP in coming years.

Effective competition is one strategy to encourage greater efficiencies in the health sector and ensure that total health outlays remain sustainable. Such competition must, however, be developed and implemented in such a way that it does not undermine the primary objectives of the health care system.

Some of the conditions required for effective competition in the health sector had, until recently, been given low priority. Suppliers of health care services, for example, are still working to identify clear objectives and product priorities. Governments are becoming more skilled in identifying the type and quality of health sector products for which they negotiate contracts, but specification of the product is still often ill-defined and difficult to measure. In addition, the fundamental basis of the product varies considerably. Health care for chronic conditions is a markedly different product to health care for acute conditions, which, again, is different from health care for general conditions and preventive health.

Various forms of competition now have a greater impact within the health system, including, for example:

- competition and contestability between different public sector operators;
- competition between operators in the private sector; and
- competition between public and private operators.

There have been some advances, principally at the State level, in developing more competitive environments across different areas of the health sector, for example:

- the identification, in Victoria, of more than 300 clinical and non-clinical activities which were to become competitively neutral by mid–1998;
- the requirement for full cost principles to be applied to the provision of health services in New South Wales since July 1998;
- competitive tendering for some non-clinical activities in the Australian Capital Territory; and
- corporatisation of both Commonwealth Government and State Government health business activities.
Despite these advances, however, anti-competitive behaviour still prevails in certain areas of the health system. In particular, the Australian Competition and Consumer Commission (ACCC) has identified:

- potentially anti-competitive mergers within the pharmaceutical, pathology and radiology sectors;
- restrictive actions by medical specialist colleges in accrediting hospitals for specialist training positions and engaging in trainee selection processes; and
- collective action by the medical profession to prevent medical purchaser-provider arrangements or to penalise those practitioners who enter such arrangements.

At the same time, some parts of the health system are, by their very nature, the responsibility of the public sector. These include ‘public goods’, that is goods that are non-excludable and non-rival in consumption and therefore have no market value in the ordinary sense. An example of a public good in health is the control of contagious diseases. In addition, the public sector has generally taken responsibility for those parts of the health system which are subject to externalities or factors caused by others which may affect the health and welfare of individuals, such as promoting immunisation.

**Issues that affect the scope for competition in the health sector**

The underlying characteristics of an ideal market are not always present in the health care market, for various reasons, including:

- information asymmetry;
- lack of price signals and moral hazard;
- adverse selection;
- supply-induced demand and supplier-induced demand;
- restrictions on providers’ access to the market;
- restrictions on consumers’ access to the market;
- the absence of competitive neutrality;
- market domination;
- training, distribution and retention of the workforce; and
- restrictions designed to limit growth in government outlays on health.

**Information asymmetry**

According to economic theory, consumers in competitive open markets have sufficient information to make informed decisions about the type, quality and price of the products they intend to purchase. They are also assumed to have access to products from a range of competing suppliers.

The same considerations do not necessarily apply in health care. Health care information is possessed predominantly by the providers of health care. Most individual consumers of health care only seek information on their health when prompted by their personal experience and acknowledgment of a problem with their health.
status. They will then often have difficulty accessing and understanding technical medical information and therefore may be unable to differentiate the quality and effects of different health care treatments.

Consumers may also prefer the advice of their practitioner and be unwilling or unable to seek additional information or make decisions that challenge that advice. Conversely, individuals may feel so vulnerable and anxious to address their health concerns that they have preconceived expectations of treatment. This explains, for instance, the often inappropriate demand for antibiotics to treat colds and flu.

**Price signals and moral hazard**

In open markets consumers choose between competing products offered at different prices on the basis of their preferences and available budget.

In the Australia health care sector, price signals may range from minimal or zero in the public sector to higher, often unpredictable, levels in the private sector, despite the fact the quality of services may be similar in both settings.

It is often argued that the absence of price signals leads to higher and excessive consumption of health products. Evidence from the PBS, where copayments are applied systematically, suggests price does affect consumption, although the appropriateness of that resulting decline in consumption on health outcomes is less clear (McManus et al, 1996). The lack of price signals elsewhere in the system and the lack of any financial benefit for those who consume less provide little incentive for prudent consumption.

Imprudent consumption is exacerbated by the difficulty consumers have making rational, economic-based decisions on health care. Most are unwilling to put a hypothetical limit on personal expenditure to recover good health; however much complex health care is beyond the budget of individual consumers and will be accessed only through a system of health insurance.

In the context of health insurance systems, the term ‘moral hazard’ is used to describe the set of circumstances where consumers seek to obtain health care treatment that may be unnecessary or unwarranted because they do not have to pay for the full cost of these services. Where a third party, such as a government or an insurer, distorts price signals by paying for health care, providers and consumers, together and individually, may instigate more services than consumers would demand if they had to pay, or partially pay, for them.

**Adverse selection**

The private health insurance market experiences adverse selection, in which only those most likely to use health services take out insurance. This reduces the degree to which risks are spread and increases the cost of insurance. The situation is exacerbated in countries like Australia, where voluntary private health insurance coexists with universal health care provision. Those with a low risk of health service utilisation may decide the public system will provide adequate service should they need it.
Supply-induced demand and supplier-induced demand

Medical practitioners act as gatekeepers for most of the Australian health system. Under this arrangement, they are providers of advice on health care services that may be required and are also the potential suppliers of these future services.

Mechanisms for the provision of independent advice, as exist in other markets, have yet to be developed for consumers of health services in Australia. This situation exacerbates the information asymmetry between consumer and provider.

There is considerable evidence worldwide of variations in clinical practice that are unrelated to the features of the patient or their condition (Richardson, 1998). This suggests care is based on practitioner training, preferences and motivation, rather than evidence-based best practice (Henry and O’Connell, 1996). In addition, service use growth rates over time correlate more closely with increases in doctor numbers than with population growth (AMWAC and AIHW, 1999, p31).

Although a range of programs have defined funding conditions (including definitions of the range and, sometimes, quality of services) and prices to be paid, most funding is still based on throughput or fee-for-service. Under these arrangements, practitioners benefit from prescribing or recommending further services for the consumer, because they usually prompt extra visits to the referring practitioner and therefore additional income. Practitioners therefore have limited incentive to restrict the number of immediate and referred services provided to consumers.

At the same time, consumers have little reason to question the necessity of extra services: they do not have to meet the costs and they want to ensure they receive the best possible care. This is exacerbated by the growing availability of an increasing range of health technology.

All of these factors can lead to both supply-induced demand which is the tendency for equipment and facilities to be used because they are available and supplier-induced demand which is the tendency for practitioners to promote the use of their services.

The Commonwealth Government has introduced capped funding agreements with some professional provider groups, in an attempt to create incentives for providers to more carefully consider the appropriateness of the services they provide. Under some State Government contracts with private hospital operators for the provision of public patient services, funding is provided based on capped population budgets rather than on throughput. See case study 1. This also introduces some incentive for hospitals to reduce unnecessary services and provide services as efficiently as possible.

Other government strategies to limit supply and supplier-induced demand have had only limited success. These strategies include capping funds for specific health programs, limiting the total number of services that can be provided in particular circumstances, and restricting the number of facilities through licensing requirements (for example, limiting the number of beds available or limiting the number of private pathology collection centres).
Historically, private health insurers have taken a very limited role in influencing the overall efficiency and effectiveness of health care services. Excessive or unnecessarily expensive services provided to the privately insured often result in large payments by insurers and substantial out-of-pocket expenses for consumers when providers charge well in excess of the scheduled fee. The introduction of contracting arrangements, under which private health insurers and hospital providers agree on the prices for a defined set of services, provides an incentive for hospitals to work more closely with doctors to ensure that services are appropriate and efficient. In contrast, private health insurers do place limits on less essential ancillary services, limiting the amount that can be claimed for such services. Providers of these services (for example, some optometry chains) have responded by introducing more competitive pricing and innovative, consumer-focused products.

Supplier-induced demand can also result from defensive medicine, which arises out of the fear of litigation and leads to the referral of patients for a greater number of diagnostic assessments than is necessary. Defensive medicine reduces the allocative efficiency of the health dollar, but, as pointed out in the 1995 Review of Professional Indemnity Arrangements for Health Care Professionals, it can also be beneficial to the patient through, for example, better record-keeping and enhanced information (Department of Human Services and Health, 1995; Hancock, 1993).

**Providers’ access to the market**

In open, competitive markets, suppliers must present their product as good value for money to potential consumers, who have the opportunity to choose among competing products. Suppliers must ensure that their overall investment in products is financially sound and sustainable in terms of income. In such a market there would be no regulatory restrictions on the number of suppliers able to operate. Those who develop, market and price products well will succeed, whereas those who fail to do so may be forced out of the market.

In contrast, limited access to training and the large investments required have limited free access to the health care market in Australia.

New entrants to the medical specialist services market are limited by education and training prerequisites and the limited number of training positions offered by professional colleges. Undergraduate and postgraduate training positions for medicine, dentistry and physiotherapy are also limited and entry is highly competitive. Generally speaking, however, there are greater opportunities for individuals to become providers of other health services such as nursing and allied health.

In theory potential corporate suppliers of health services have open access to some parts of the health system (for example, hospitals and pathology services). In practice, however, the high initial investment required to become a serious market competitor means that, in Australia, there will be relatively few organisations able to become corporate providers of health services without the backing of other private investors.
Consumers’ access to the market

Consumers will seek different types of health care depending on their health problems: the types of services sought by those with relatively minor conditions and those with major chronic and acute conditions may be quite different. The scope to choose between competing service providers and the effect of information asymmetry on consumers’ behaviour in the market are likely to vary depending on the type of health care sought. For example, individual consumers generally do not make decisions about acute care, which is usually stochastic and expensive.

Health care is rarely a normal, predictable commodity that can be bought and sold through the usual market arrangements. Circumstances where consumers have an urgent need for health care deny them the opportunity to research and assess the relative merits and value of potential suppliers.

Consumers must also consider that suppliers of health care services can not guarantee beforehand that the service will produce the intended health outcome. There is always some associated risk, particularly with surgical procedures. That risk varies with such factors as the urgency, complexity, or invasiveness of the procedure, and the age and general health of the consumer. There is information asymmetry between the consumer and provider of health services in their knowledge of the potential risk and likely outcomes of the health service being provided.

Unlike private health insurers, individual consumers are small players in most areas of the health service delivery market and lack the purchasing power to influence the market. In health care, it is primarily as consumers of general practitioner services, in the relatively competitive general practice market, that individuals are able to exercise choice and affect the price and availability of the product. The continuing high level of bulk-billing is an indication of the effectiveness of consumers’ market power. Under Medicare, consumers’ access to other medical services is restricted. For example, specialist fees are only reimbursed through MBS if the consumer was referred to the specialist by a general practitioner or another specialist. In addition, consumers require a specialist’s referral to use a hospital for elective surgery and, on most occasions, it will be the specialist who nominates the particular hospital the consumer will attend. Where consumers do have a choice, they generally act on precedence or loyalty to, for instance, a familiar local public or not-for-profit hospital.

Consumers’ access to services is also restricted by the regional maldistribution of providers. In areas where there are few providers, there is little scope for improved efficiency or quality of services as a result of competition.

Competitive neutrality

Public and private sector health care providers have generally not experienced the same benefits and restrictions on their operations. Public sector health services have historically had the benefit of immunity from a range of taxation charges applied to private-for-profit services, for example, fringe benefits tax, wholesale sales tax, land sales tax and stamp duties. On the other hand, private sector employers do not have the burden of some public-sector obligations such as higher rates of employer superannuation contributions that public sector employers have to pay.
Governments have now given greater recognition to the importance of competitive neutrality and are seeking to put public and private sector service delivery on a level playing field. For example, Government tendering processes in Victoria have adjusted the bids of public sector tenders to account for the financial value of competitive advantages and disadvantages. Similarly, competitive neutrality in the pathology industry is enhanced by Commonwealth Government fee supplementation for the private sector, although it has been argued that this encourages States to cost-shift through the privatisation of their pathology services.

Market domination

The public sector is currently the largest source of funds in the health care market. A service provider that dominates a particular market wields considerable power in controlling the cost of the inputs required to produce services. Where a single body is responsible for buying the majority of such inputs on behalf of many service providers (for example, a State Government body that purchases pharmaceuticals for all publicly funded hospitals) it can exert considerable buying power to drive down the price paid. Other smaller players seeking to buy those same inputs, for example, individual private hospitals, can exert far less influence on prices. Similarly, where the public sector is the sole funder of particular services for the population, such as the Commonwealth Government as funder of pharmaceuticals through the Pharmaceutical Benefits Scheme, the Government is also able to use its monopsony power to reduce prices.

The structure of the industry

Suppliers in a competitive market may seek to increase their competitiveness through structural change; for example, horizontal or vertical industry integration. Private pathology service suppliers have undergone such integration recently.

The appropriate level of integration for a more competitive and efficient market is dependent on the size of the market. Consumers will benefit from integration when service providers that are large enough to influence the cost of their inputs pass on some of the gains to their customers with a view to maintaining or increasing market share. Integration can, however, reduce the number of competing service deliverers to one or two, creating a monopoly or oligopoly and reducing the scope for consumers to influence the operation of the market.

The desirable number of suppliers for the Australian health system is the subject of debate, similar to recent debates over the appropriate size of the telecommunications, media, airline and supermarket industries.
The training, distribution and retention of the workforce

The health care workforce requires a considerable investment in education and training. Responsibility for such training is met by governments, specialist colleges and other training bodies.

The length and complexity of training programs do not facilitate easy adjustment to meet changing health care delivery and consumption patterns and there will usually be a delay of some years before new market demands are satisfied by changes in the availability and skills base of the workforce.

Planning and maintenance of the health care workforce must be based on estimates of future workforce participation patterns to account for those individuals who choose to practise part-time or leave the health care workforce altogether.

Governments are also concerned to ensure that self-employed health professionals, such as medical practitioners, are well distributed. Since such workers can choose where they practise, there is no assurance that the level of competition will be improved by increasing the size of that workforce.

Effect of competition on overall health outlays

Effective competition in the health system may reduce the unit cost of individual health services, but it does not affect the total number of services or the type of services provided, which are also important factors contributing to total health expenditure. These decisions largely remain the responsibility of the medical profession.

Governments have attempted to overcome this dilemma with a range of strategies. For example, although greater privatisation of pathology services increased competition within that sector, resulting in higher levels of direct billing of services at or below the scheduled fee, total expenditure on pathology services continued to increase. The Commonwealth Government negotiated with the pathology profession to cap the total available funding for its services to address the potential impact on expenditure of an increased number of suppliers. Such agreements are designed to cap total Government outlays by encouraging providers to reduce the incidence of unnecessary services. If successful, this strategy could contain Commonwealth outlays on health in key high cost areas of the health system.

Differences between the sectors

Competition in the health sector, between and within the public and private sectors, can result in varying outcomes that may be beneficial or detrimental to the overall objectives of health care.

Government measures to address market failure in the health care system can be more fully appreciated if they are considered within the general philosophical context of public sector intervention in the free market.

The public and private sectors have fundamentally different operational perspectives on delivering and funding health care. The public sector has traditionally taken an egalitarian, non-competitive approach to funding and
delivering health care. Public accountability and readily accessible additional funding make the public sector both bound and able to focus on the provision of equitable and high quality care irrespective of profitability. This has resulted in the public sector providing services that are, in some cases, not profitable; for example, to impecunious consumers and those in remote and rural areas. By contrast, private sector involvement in the health system is generally based on a more liberal, profit-maximising perspective. It has been argued that this could result in services of compromised quality, although it can also be argued that, in a perfectly competitive market, private operators must ensure quality to maintain their market share. The private sector’s approach has also been criticised for concentrating on short-term profit at the expense of long-term health risks, although the health system in general focuses more on health care than health prevention.

Perceived differences in the underlying philosophical positions of the public and private sectors lead to a range of stakeholder perspectives on the preferred mix of public and private sector funding and service delivery in the health care system.

In particular, consumers tend to trust the public sector and want to be sure that there are sufficient protective mechanisms in place to ensure that, where the private sector is involved in the funding or delivery of health services, it provides equitable access and high quality health care.

The for-profit, not-for-profit differences

It is important to recognise that the private sector is not homogeneous; it comprises for-profit and not-for-profit organisations, which some would argue have completely different values and philosophies influencing their involvement in the health system.

The key definition of a not-for-profit organisation is one that ‘does not distribute its net earnings to individuals who exercise control over it such as members, officers, directors or trustees’ (Gray, 1986, pp7-8).

The involvement of not-for-profit organisations in the funding and delivery of health services has been, and continues to be, substantial, most notably in the areas of hospital services and mutualised private health insurance funds. They also provide a diverse range of health services such as community care, aged care, palliative care, extended care, acute care and research and training.

Traditionally, the incentives and objectives of for-profit and not-for-profit organisations were considered so different that it was believed that there was a fundamental difference in their behaviour and operation. Recent observable changes in the not-for-profit health sector, however, indicate more similarities than differences between not-for-profit and for-profit organisations.

Their goals often differ more in degree than in substance, since not-for-profit organisations are not prohibited from earning profits or surpluses and indeed must recover sufficient revenue to ensure their financial viability and to cross-subsidise their other social welfare activities; for example the subsidisation of community-based counselling services and those less-profitable hospitals within a particular not-for-profit hospital group or chain.
This has led to the evolution of not-for-profit organisations into large commercially focused employers with an increasing emphasis on sound financial management and raises some doubt as to the extent of their non-profit motive.\(^7\)

It is to be noted that some not-for-profit hospitals are also actively tendering with State Governments to provide hospital services for public patients (see case study 1). At the same time, some not-for-profit bodies are involved in horizontal integration across other areas of the health system (for example, private health insurers that own and/or operate private hospitals and allied health services). The business motive of not-for-profit organisations in some circumstances is to make a profit. Many not-for-profit hospitals, for instance, are owned by doctors and therefore provide a means by which they can increase their income through self-referrals. Indeed, it is possible for such a not-for-profit hospital to operate at a loss or just break-even while the doctors who own the hospital can still make considerable profits from the medical services they provide at the hospital. In this example, a not-for-profit body, in effect, behaves like a for-profit organisation.

Since World War II, not-for-profit bodies have increasingly derived income from private charges rather than donations and government grants. The change in the charitable characteristics of these bodies has had some drastic consequences. For example, some church organisations have highlighted emerging tensions between:

- the theological/moral underpinning of the church and the traditional moral position to treat workers fairly and equitably; and
- the church’s role as an employer in the contemporary industrial environment in which individual workplace agreements and competition between workers abound.

Recently, not-for-profit hospitals, like their for-profit counterparts, have undergone vertical integration by entering into multi-institutional arrangements and/or partnerships, with a view to gaining economies of scale and greater access to capital. Examples include partnerships and joint ventures between: St Vincent’s and Mercy Private; Mercy and Mt Alverna; Holy Spirit and Sisters of Charity; and the establishment of Catholic Health Australia (Spring, 1999). Some believe that such amalgamations are required to enable not-for-profit institutions to continue to operate effectively and efficiently and without government assistance. Not-for-profit hospitals have adopted more aggressive marketing strategies in an attempt to increase their market share and have introduced efficiency measures to make them more competitive with for-profit hospitals.

Conversely, there has been a change in the market behaviour of for-profit bodies. Increased consumer focus by this sector and attempts to project a more egalitarian public image, with a view to increasing the long-term

\(^7\) There has been debate about the merits of a market in which the religious not-for-profit sector has to ‘compete’ to provide services with the for-profit sector. Melbourne City Mission has pointed out that churches are spending significant amounts of money to win tenders (for example, tendering to provide public hospital services), funding which traditionally was channelled back into providing more services for those in need. At the same time, the competitive environment of tendering for limited government funding has resulted in what some have described as a less cooperative not-for-profit sector in which churches no longer work for the common good, share information and network, but rather keep information to themselves to assist in possible tender bids against other not-for-profit and for-profit competitors (Radio National interview transcript, “The ‘Re-engineering’ Non-Profit”, Life Matters, 26 February 1999).
profitability, are further blurring the differences between the not-for-profit and for-profit sectors in the public mind.\(^8\)

The pace of change embraced by the two sectors varies; for example, the for-profit private health insurance sector has recently made considerable advances in developing more innovative private health insurance packages and negotiating these with the medical profession. In addition, industry restructuring through integration and amalgamation is more advanced among for-profit service deliverers than the not-for-profit service delivery industry.

**When might governments intervene?**

There is substantial evidence that health care markets fail to operate efficiently when left to their own accord (Rice, 1998). In such circumstances the key objectives of the health care sector may be jeopardised. For example, the United States health system has high overall expenditure but relatively poor coverage.

Governments intervene in response to the various forms of market failure. It has been noted that ‘regulating private insurers to rule out some consequences of competitive health insurance markets and regulating public health care systems to rule in some consequences of competition might be interpreted as a process of ‘convergence’ between both kinds of programs’ (Wasem, 1995, p91).

Some examples of government intervention and the reason for this intervention include:

- to provide equitable access to affordable health care services across the population. Medicare, universal public health insurance which is funded by means of progressive taxation arrangements, addresses vertical inequities, ensuring that all citizens have access to an affordable level of basic medical care. Many other government interventions occur as a result of this intervention. For example, some government interventions aim to limit aggregate government expenditure by capping the supply of services or restricting public funding to a limited range of services, thereby effectively limiting in the range of services that can be afforded;
- to address horizontal equity concerns, governments have actively encouraged medical practitioners to practise in less popular areas (for example, rural and remote locations) through incentives and providing additional funding for community service obligations for services provided to these areas. There are, however, areas where government intervention has failed to produce equity, the most prominent example being the provision of health services for Aboriginal and Torres Strait Islander communities;

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\(^8\) There has been recent discussion about the double bind that the not-for-profit sector is in. Traditionally not-for-profit organisations became involved in welfare services to provide services for those who otherwise would not have access to them, thus enhancing equity. This role has diminished with the emergence of a public health system safety net. Meanwhile, under the current paradigm, not-for-profit organisations are tendering to provide outsourced government services and the government is deciding who should have access to these services and at what cost (usually under a 'user pays' arrangement). This throws into question the original purpose of not-for-profit organisations’ involvement in health and welfare funding and service delivery; that is, responsibility for safety net decisions has shifted away from these bodies and back to the public sector.
to regulate the distribution of health care across different health care settings and geographic regions. For example, some State Governments regulate beds in private hospitals;

to address the problem of adverse selection and ensure that the populations’ health risk is shared equally across the public and private funders. As a result of private health insurance regulation, private health insurers must allow all people to take out health insurance, regardless of health risk, under the principle of community rating. In respect of private health care, the Government also regulates the price of private health insurance to ensure that it is affordable, the floor price of private hospital services through the default bed-day rate and the range of privately provided services which private health insurers can pay for;

to ensure the quality of services provided by health professionals, State and Territory Governments are responsible for regulation of the health labour force including ensuring that they meet minimum education and training requirements. The private sector also has some responsibility in setting the education and training requirements for health workforces. The professions also provide technical advice on the quality and appropriate standards of service provision through such mechanisms as peer review, professional development, defining best practice, clinical guideline development and evidence-based medicine;

to improve consumer satisfaction and increase accountability, most Governments have introduced independent health complaint mechanisms and health ombudsmen to hear consumers’ concerns about their health care;

to ensure minimum safety standards for other aspects of the health system. For example, the Therapeutic Goods Administration assesses the efficacy of pharmaceuticals and therapeutic devices before they are allowed onto the Australian market;

to minimise the effect of negative externalities on individuals’ health, for example, by banning smoking in public places to minimise the risk that non-smokers will suffer from lung cancer due to other people’s smoking; and to maximise positive externalities, for example, by promoting immunisation because high immunisation rates confer greater protection for the whole community;

to ensure that health goods and services, which will improve both social and economic wellbeing and which would be under-consumed if left to individuals’ willingness to pay, are made available. For example, programs that promote healthy diets, safe sex practices, and cessation of smoking. The benefits of such strategies are long-term and as such may be relegated to lower priority if left to the responsibility of private funders; and

to enhance the future capacity of the health system by funding training and research. Generally there are insufficient short-term financial gains in funding these activities to stimulate private sector contributions. As such, there are concerns that, for example, the increased privatisation of hospital pathology services has reduced levels of research and training in the pathology field. Private sector involvement in research is limited to areas with shorter-term profit potential; for example, new drug technologies. In 1994–95, public funding of research comprised 72 per cent of all such funding. The private not-for-profit sector contributed 16 per cent and the private for-profit sector contributed 12 per cent (Wills 1998, p150). However, it would be possible for governments to intervene in another way, for example by regulating or prescribing a mandatory funding contribution from the private sector to fund health research and development.
Summary

Health sector markets fail for a variety of reasons:

- the private sector does not generally provide those health products that are public goods because they are unable to derive a commercial return from doing so;
- some goods and services which benefit individual and community health are likely to be under-consumed if left to individuals’ willingness to pay;
- individuals’ health care requirements are unpredictable but often essential;
- public and private insurance systems lack price signals and therefore the influence of price on consumer demand is distorted;
- only those most likely to use health services are likely to pay for voluntary health insurance, which results in a high-risk insurance population;
- service providers usually decide consumers’ level of access to the market and funders’ ability to influence decisions about individual service provision is limited;
- supplier-induced demand promotes inefficient allocation of resources;
- there is considerable information asymmetry between service providers and consumers about health diagnosis, management and treatment;
- entry to the market for health care providers is controlled;
- there is an undersupply of some categories of service providers;
- the distribution of service providers varies across regions, limiting competition to particular locations; and
- differential tax and legislative treatment of private and public sector operators in some areas creates an uneven playing field.

There is a high level of government intervention in the health system in Australia to overcome this market failure and help achieve the objectives of the health care system.

In a perfect market, competition results in increased efficiency and increased quality, innovation and consumer-focus in services or products. There are, however, few areas of the Australian health system where the public and private sectors actually compete. The most notable areas of competition are the funding and delivery of hospital services and areas of health care where public sector health organisations have been corporatised and now compete with private sector counterparts.

Although the health market differs from perfect markets in some very significant ways, there are nevertheless some areas in which competition in the health sector occurs and has had an observable impact. This is explored in the next two chapters.
3. Competition and acute care hospitals

The most significant competition between the private and public sectors in the Australian health care market is for the delivery of services in acute care hospitals. The acute care hospital sector delivers a large number of different services at a cost of $14.4 billion per year, or 37.1 per cent of the total Australian health budget.

The complex arrangements between the funders of acute hospital services (for example, governments and private health insurers) and other health service providers (for example, individual specialist practitioners and institutional managers) are not matched anywhere else in the health care system.

The provision of services and the mechanisms for accessing those services in acute hospitals are inextricably linked to the funding and delivery arrangements under which those services are provided.

Any analysis of competition between and within the public and private acute hospital sectors must consider the interaction of many factors, including:

- competition among providers;
- competition between funders;
- government intervention in the private health insurance market; and
- competition from the consumer’s perspective.

**Competition among providers**

Public hospitals, private hospitals and specialist medical practitioners are the major providers interacting and competing to deliver services in the acute hospital sector.

**Public hospitals**

The major players in the public hospital arena are the State and Territory Governments and Catholic hospitals that provide services to public patients (in this paper, data on public hospitals include all hospitals that treat publicly funded patients, regardless of the hospital’s ownership).

Australia’s public acute care hospitals represent a substantial capital investment. In 1997–98 there were 734 public acute care hospitals, with a total of 55735 available beds (AIHW, 1999, p23). Generally, these hospitals are an

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9 True competition between public and private funders cannot operate while there is not the option to select private health insurance instead of Medicare. However, consumers do choose between Medicare only or Medicare plus private health cover and, to that extent, there is competition between these two alternatives.
ageing asset and will require costly and difficult rebuilding and replacement in the coming decade to cater to the changing geographical distribution and service needs of populations.\textsuperscript{10}

State and Territory Governments have implemented a range of strategies to address these changing needs. These strategies have included moving components of hospital care to other community settings, relocating major hospital services to highly populated outer metropolitan areas and networking hospitals and other health services to create links with a range of other health facilities. Some of these changes have produced more cost-effective arrangements for the continuing care of hospital patients.

In the past, the Department of Veterans’ Affairs has provided services to war veterans in purpose-built Commonwealth-operated repatriation hospitals, but these services have been contracted to other public and private hospitals over the past two decades (see Department of Veterans’ Affairs case study 2).

In addition, State and Territory Governments have negotiated with some private not-for-profit hospitals to provide public services. State and Territory Governments are also now tendering for the private sector to build infrastructure and/or operate publicly funded hospitals, while privately owned and operated hospitals are entering contracts to provide services for general public patients. Case study 1 examines some of these changes in the delivery of publicly funded hospital services.

**Private hospitals**

In 1997–98, there were 492 private hospitals operating in Australia, comprising 294 acute overnight facilities, 23 psychiatric hospitals and 175 freestanding day hospitals (ABS 1999b, p3). Together these accounted for about 33 per cent of all hospital admissions and 31 per cent of occupied bed-days and employed about 42,000 full-time equivalent staff (APHA, 1999, p2). In the same year, private hospitals generated revenue of about $3.5 billion (ABS 1999b, p10).

Historically, private hospitals in Australia were owned by individuals or small companies. Mergers and acquisitions in the past five years have seen the consolidation of stand-alone and small institutions as private sector organisations have sought to maximise their revenue and minimise their costs.

Most private hospital owners now fall into one of the following groups:

- large corporate operators;
- Catholic operators (including four large orders and a number of independents—there has been amalgamation among Catholic operators);
- other religious operators;

\textsuperscript{10} Under the Commonwealth Government’s incentives package in Schedule E of the 1993-98 Medicare Agreements, considerable rationalisation and rebuilding of hospitals has been undertaken.
• private health insurance funds, in particular MBF and AXA Australia Health Insurance;\(^{11}\) and
• other for-profit and not-for-profit independent operators, such as community-based organisations, bush hospitals and community hospitals.

The nine largest hospital groups among the large corporate operators and the Catholic operators control 45.4 per cent of the national private hospital market (APHA, 1998, p3).

More than half of all private hospitals are run on a for-profit basis. The number of for-profit private hospitals rose from 174 in 1993–94 to 180 in 1997–98, while the number of not-for-profit private hospitals decreased from 155 to 137 over the same period (ABS, 1995, p8; ABS, 1999b, p13). The not-for-profit sector, however, continues to play a significant role in the delivery of private hospital services in Australia, accounting for 49 per cent of private hospital beds (APHA, 1998, p3) and 48 per cent of private hospital separations (ABS, 1999b, p15). Major players in the not-for-profit private hospital sector include St John of God Health, Sisters of Charity Health, Mercy Health and Aged Care, Little Company of Mary and Wesley/St Andrews (Spring, 1999).

Under arrangements with State and Territory Governments, 22 not-for-profit private hospitals, including seven major teaching hospitals, provide about 3,000 beds for public patients.

**Competition to provide services**

There is competition amongst medical practitioners and competition among hospitals to provide private patient services.

*Competition between medical practitioners*

Patients must consult a medical practitioner before they are admitted to a hospital, except when they need emergency care. Through this referral process, medical practitioners play a key role in determining demand for elective hospital services.

In the public sector, general practitioners (GPs) refer patients for assessment by a specialist in a hospital outpatient clinic before they are admitted.

In the context of the private sector, however, specialists compete for patient referrals from GPs and other specialists. Practitioners may potentially refer to a limited group of fellow practitioners on the basis of criteria other than competence and skill. The Australian Competition and Consumer Commission (ACCC) has noted anti-competitive and illegal price-fixing arrangements between local practitioners (Fels, 1998). The ACCC is concerned that such arrangements reduce the incentive for practitioners to compete on the basis of price or quality.

\(^{11}\) Some private health insurance funds appear to be divesting their private hospitals in an attempt to separate the roles of purchaser (through private health insurance operations) and provider. This could also be a response to the recent fall in the profitability of private hospitals.
Competition between medical practitioners is also affected by under-supply in many specialties outside the major metropolitan centres and in the public sector (AMWAC and AIHW 1999, p61). The limited number of training places that specialist colleges accredit has contributed to this situation. In locations with only one specialist, there is no incentive for that practitioner to seek consumer loyalty through better quality or lower-priced care. In many rural locations there are no local specialists, forcing consumers to travel for care. Most consumers of specialist services thus have little opportunity to compare or affect the value of services offered by other practitioners.

The problem of specialist shortage is not a new one. This shortage is particularly pronounced in certain disciplines (anaesthetics, orthopaedics, dermatology, rehabilitation medicine, geriatric medicine, ophthalmology, urology and ear, nose and throat surgery) and certain areas of the health system (public hospitals, rural and remote areas and outer metropolitan areas).

The specialist workforce could be expanded by increasing the number of training positions or recruiting suitably trained and experienced specialists from overseas. Recruitment of overseas-trained specialists is complicated by the fact that their training and experience might not match Australia’s requirements.

While the Commonwealth has few direct levers to control the supply of the medical workforce, significant progress has been made since the inception of the Australian Medical Workforce Advisory Committee (AMWAC) in 1995. The AMWAC arrangements were put in place partly in response to the ‘A Cutting Edge’ report on the surgical workforce (Baume, 1994). The State and Territory Governments have also been encouraged to fund additional registrar positions in teaching hospitals for particular undersupplied specialties.

Among AMWAC’s roles is the development of tools to describe and manage medical workforce supply and demand. AMWAC also oversees the establishment and development of data collections and analyses and reports on those data to assist workforce planning.

AMWAC has also conducted reviews of the specialist medical colleges. Generally, there has been a good response to the recommendations of the reviews, with a number of colleges increasing the number of training positions and/or trainees in programs (orthopaedics is a notable exception). However, even if in adequate supply, there is no guarantee that specialists will practise in areas where there is the greatest need. In fact, present trends indicate that while the AMWAC process may redress the undersupply of specialists over time, the current maldistribution is likely to continue.

While the cooperation of the colleges has generally been forthcoming, there is little that the Commonwealth can do to sanction those colleges that do not comply with AMWAC recommendations. Although the potential investigation by the Australian Competition and Consumer Commission has spurred many of the colleges into action, some disciplines remain defiant in their refusal to implement AMWAC recommendations. This intransigence is largely a feature of the colleges’ monopoly on specialist training and recognition. Therefore, any attempt to increase the specialist workforce in Australia needs to be cognisant of this college stranglehold.
The report ‘Trainee Selection in Australian Medical Colleges’ (the ‘Brennan report’) was commissioned by the Medical Training Review Panel in response to junior doctors’ concerns about a lack of transparency in specialist medical colleges’ selection processes. While the report concluded that there is insufficient evidence to support allegations of systematic malpractice by the colleges, strong perceptions remain that selection and appeals processes are not transparent and independent.

The appeals processes, however, are more contentious, with the principles of independence and access being of key importance. The process should not only be fair and independent, but also appear to be so. For example, while appellants should be responsible for bearing some costs associated with the hearing, access to appeals processes should not be determined by the capacity of the appellant to bear unnecessary and burdensome costs.

**Competition between hospitals**

There are both similarities and differences in the structures, *modus operandi* and services of public and private hospitals. As such, some components of acute hospital care are open to competition, while others are likely to be available from only one sector.

There has been little competition in the provision of acute, emergency treatment because in many locations public hospitals have been the only facilities to offer such services. The private sector’s role in providing this type of care is, however, increasing which could lead to more competitive purchasing of these services from private hospitals by State governments and privately insured consumers.

In the case of elective procedures, on the other hand, practitioners have primary responsibility for selecting the institution on behalf of patients. The 1997 TQA Research report on health care in Australia (Quints and Marks, 1997) showed that doctors determined the institution in 64 per cent of private hospital admissions. In cases where consumers independently choose a hospital, their choice is influenced by loyalty to established acute care hospitals, which in many cases are public hospitals. In response to these two factors, private hospitals compete for medical practitioners and thus admissions on the basis of what their facilities can offer them, rather than what they can offer the patient. Private hospitals offer specialists access to new technologies, office space and consulting rooms. Public hospitals compete for specialists by offering private patient rights, teaching and research facilities and kudos for working in highly recognised institutions. The undersupply of practitioners in some specialties gives them considerable bargaining power and enables most to select hospitals that offer them attractive positions. Co-located public and private hospitals are another potential strategy for attracting practitioners to both hospitals.

For-profit private hospitals have faced some competitive disadvantages in attracting specialists. They have not been able to offer employees the fringe benefits tax-exempt salary packaging that has been available to not-for-profit private hospitals and public hospitals. These hospitals must therefore offer higher salaries and wages, which place pressure on their staffing budgets. The implementation of the Federal Government’s goods and services tax package will bring the position of all private and public hospitals closer by decreasing fringe benefits tax advantages for not-for-profit private hospitals and public hospitals.
Comparison of private and public hospital services

Areas of overlap in the services provided by public and private hospitals provide the potential for competition. Public and private hospital services may be compared on the basis of efficiency, price, mix of services, access to services, quality of care and barriers to entry.

Efficiency

From 1996–97 to 1997–98 public hospital separations increased by 3.5 per cent and private hospitals separations increased by 6.4 per cent (AIHW, 1999, table 4.1). The larger increase in private hospitals is due in part to the increase in the number of same-day procedures that has resulted from new day surgery facilities.

Several factors complicate more complex comparisons of the efficiency of public and private sector hospitals. There are key differences in the mechanisms by which they manage service provision. Private hospitals charge on a fee-for-service basis, while public hospitals generally operate with capped budgets which have been determined using a combination of historic data and casemix measures.

In 1997-98, public acute hospitals provided 3.7 million separations accounting for 15 million patient days. Over the same period private acute hospitals provided 1.8 million separations accounting for 6.0 million patient days (AIHW 1999, table 4.1). Overall the private sector provides around 33 per cent of all episodes in hospital, 30 per cent of all bed days, 26 per cent of medical episodes and 23 per cent of obstetrics care.

A comparison of public and private hospital efficiency levels based on average costs across all DRGs is difficult since public and private hospitals cater to different populations and exhibit different casemix profiles. Similarly, the validity of average DRG cost comparisons is questionable because cost data is derived from different information in each sector.

The efficiency of a hospital system can, however, be measured by the number of bed days it uses to provide particular types of services. This is often measured as the average length of stay (ALOS) for particular services or DRGs. In 1997–98, ALOS for all inpatient services was 4.0 days in the public sector and 3.3 days in the private sector. When data on same-day services were excluded, the 1997–98 ALOS was 6.4 days for public hospitals and 6.2 days for private hospitals (AIHW, 1999, table 4.1).

For some DRGs public hospitals have shorter lengths of stay and, for others, the private hospitals do. When the total casemix profile is considered for each sector, private hospitals are more efficient, in terms of bed days, for the range of DRGs they provide and similarly for public hospitals. In fact, if all other factors were held constant and public hospitals undertook the range and quantity of DRGs performed in 1997-98 in the private hospital sector with all other factors being held equal, they would need an additional 0.2 per cent of days overall. Similar data for 1995-96 suggests that public hospitals were previously more efficient in providing the range and quantity of DRGs offered by both sectors.
However, the picture is more complicated if particular types of care are excluded. Private hospitals have a longer length of stay than public hospitals for obstetric cases, perhaps due to different consumer expectations. If these are excluded, the relative efficiency of private hospitals is increased. In contrast, public hospitals have a much longer length of stay for psychiatric episodes. If these are also excluded, public hospitals are more efficient than private hospitals in providing the range and quantity of DRGs performed by either sector. It is unclear whether the differences for psychiatric care are due to differences in types of patients (e.g., severity) or differences in treatment for the same patients (that is, efficiency).  

Expenditure per patient separation is another measure by which public and private sector hospitals can be compared. State Government cost control measures have been remarkably successful in public hospitals. Between 1989–90 and 1995–96, real recurrent expenditure on public acute hospitals grew by two per cent per annum, while between 1991–92 and 1995–96 public patient separations in those hospitals grew by an average of 8.4 per cent per annum. This represents an annual average productivity gain (in relation to admitted patient care) of 4.2 per cent for each one per cent growth in funding. By comparison, private hospitals’ real recurrent expenditure grew by 8.4 per cent and patient separations grew by six per cent, representing an average annual productivity gain (in relation to admitted patient care) of 0.7 per cent for each one per cent growth in funding (Department of Health and Aged Care, 1999, unpublished).

Occupancy levels are another measure by which to compare public and private hospitals. Public hospitals usually operate at close to full occupancy for acute inpatients (this does not apply in all rural hospitals) and have a waiting list system for elective surgery, which is undertaken as emergency and critical care workloads allow.

In contrast, the average occupancy rates for private hospitals between 1995-96 and 1997-98 have remained stable at around 70 per cent (ABS, 1999b, p.14). Occupancy levels in private hospitals vary considerably at different times of the week due to short ALOS, which reflects the high proportion of shorter-stay elective procedures in their case load, and the scheduling of surgery and post-surgery care for weekdays more often than weekends. For example, in 1992–93, the average occupancy rate in private hospitals was 73.4 per cent from Monday to Friday and 54.4 per cent over the weekend.  

Private hospitals have implemented a considerable range of reform strategies to improve their efficiency and ensure their continued viability. The most significant macro-economic reform strategy is vertical integration and horizontal integration undertaken to maximise market strength and maintain control of revenues as they pass through the health system.

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12 Source data from Australian Institute of Health and Welfare, Australian Hospital Statistics 1997-98. Error DRGs and those with less than five separations in either sector have been excluded from the analysis.

13 It may be concluded that a hospital that is consistently operating at less than full occupancy is functioning inefficiently, but it is not valid to conclude that a hospital that is always at full capacity is efficient. Hospitals can certainly operate at full capacity but have unnecessarily low throughput as a result of the inefficiencies affecting each episode of care.
Horizontal integration strategies have included the moves by hospitals, particularly not-for-profit facilities, to develop informal collaborative relationships and/or group bargaining positions. This strategy amalgamates market share and therefore maximises bargaining power in negotiations with private health insurers. This approach is currently being tested through the authorisation process in the Trade Practices Act with the Australian Competition and Consumer Commission.

Such reform strategies also increase private hospitals’ attractiveness to practitioners and allow them to participate in service delivery partnerships with governments (see The Provision of Public Hospital Services, case study 1).

Integration is also occurring through the amalgamation of private hospital services and other private health services, for example:

- Health Care of Australia is the largest private hospital manager and the largest private pathology provider;
- Australian Hospital Care is developing strength in private hospital services in Melbourne and South-East Queensland, acquiring beds from other private hospitals and integrating with other services through alliances rather than acquisitions; and
- Ramsay Health Care Group is a leading private operator of psychiatric hospitals and a major operator of medical hospitals.

The private sector has also pursued numerous micro-economic reform strategies:

- business operations are becoming cost-focused and more efficient to maximise returns;
- enhanced information systems have been developed to benchmark costs and improve efficiencies. The use of casemix in these systems provides operators and private health insurers with a better understanding of hospital costs, benchmarking and comparisons. Hospitals that use expensive high-tech equipment also benefit since the costs of those assets are properly assessed against the specific procedures for which they are used and are recovered in the prices charged for such services;
- agreed case payments and episodic payments have been developed with private health insurers to replace per day rates. This encourages private hospitals to base funding on average costs of outputs, to increase technical efficiency and to substitute more cost-effective services where clinically appropriate;
- co-location with public hospitals allows the sharing of human and technological resources and access to emergency public hospital services. Not-for-profit private hospitals have co-located with public hospitals for some time, but the trend for co-location of for-profit private hospitals and public hospitals has only recently developed;
- niche markets (that is, areas of specialisation that are less subject to competition) have been established. Private hospitals are now introducing high-tech acute care procedures that generally increase the length of stay and therefore generate greater overall remuneration. There has also been a sharp increase in the number of standalone day surgeries, which offer services that are more likely to be affordable for those who do not have private health insurance cover and are prepared to pay the full cost of their treatment as a private patient;
• accident and emergency units have been developed to operate as a referral mechanism for longer-term acute care. Industry sources have suggested that up to one-quarter of all patients attending private hospital emergency units are subsequently admitted as inpatients;¹⁴
• value-added services such as consulting suites and on-site radiology, pathology and medical centres are being used to increase returns and attract medical staff; and
• partnership arrangements between the public and private sectors are being developed, representing one of the most significant expansions of the role of private hospitals. These arrangements include:
  – management contracts for the provision of public hospital services by private operators; and
  – contracts with government to provide services for general public patients or specific groups of publicly funded patients, such as veterans.

In addition, a range of other strategies are being used by private hospitals to increase their market-share including:
• treating non-resident full-paying patients;
• fostering better relationships with tertiary institutions with a view to establishing credentials in a particular specialty thereby encouraging practitioners who trained at those hospitals to refer patients back to the hospital in the future; and
• competing with public hospitals by offering much shorter elective surgery waiting times.

**Price**

Price is the major factor by which consumers differentiate public and private hospital services.

Under the Australian Health Care Agreements (AHCAs), the Commonwealth Government and the State and Territory Governments jointly fund free public hospital care which is accessible to all Australians. Patients receiving private patient care in either private or public hospitals are usually charged on a fee-for-service basis and are partially reimbursed through the Medical Benefits Scheme (MBS) for the cost of medical services provided by practitioners during their hospital stay. Other components of a private patient service, including accommodation charges and the remaining medical expenses, must be met through private health insurance and/or out-of-pocket payments.

Specialists usually charge well over the MBS fee for their services (AMWAC and AIHW, 1999, p37). While 80 per cent of GPs bulk-bill (AMWAC and AIHW, 1999, p28), relatively few specialists do. A small number of the most competitive specialties, such as pathology and diagnostic imaging, have bulk-billing rates of over 65 per

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¹⁴ Regulation of the type of services that can be covered by private health insurance does not cover outpatient services, including accident and emergency. Therefore, privately insured patients using these services who are subsequently admitted are often charged for accident and emergency care as part of their inpatient treatment. Patients who use accident and emergency services and are not then admitted are unable to claim the cost of these services under their private health insurance cover. This creates a disincentive for consumers to use these services and for hospitals to provide them.
cent, but the rate for the majority of specialties is very low. For example, bulk-billing rates for anaesthetists, radiation oncologists and obstetricians and gynaecologists is less than 20 per cent (AMWAC and AIHW, 1999, p28). The limited supply or undersupply of specialists in many areas (AMWAC and AIHW, 1999, p61), referral patterns and information asymmetry ensure many practitioners face little competition for clients. The prices charged by practitioners are a major factor in the overall cost of health care and lead to most of the out-of-pocket expenses paid by patients.

These out-of-pocket expenses, combined with private health insurance premiums, represent a major disincentive for patients to choose the private hospital option (Quints and Marks, 1997, p246).

Private health insurers and private hospitals have negotiated contracts that ensure all hospital charges are covered by insurance. Indeed some private health insurers (Medibank Private, AXA Australia Health Insurance and now MBF) compete on price by selectively tendering with a limited number of hospitals. Private specialist practitioners, however, have resisted contracting with private health insurers and in most cases consumers are still subject to considerable out-of-pocket expenses for their medical services. Specialists are less vulnerable to pressure from private health insurers because reimbursement from private health insurers comprises a relatively small proportion of their income and they have been unreceptive to proposals that they enter into contract arrangements. If private health insurers had responsibility for the payment of all charges, including medical charges, they might be in a better position to negotiate with all providers (hospitals and doctors) and develop a real ‘no-gaps’ product for members. Discussion about the impact of the price of private health insurance is covered in more detail later in this chapter.

**Mix of services**

There are key differences in the casemix profiles of public and private hospitals\(^\text{15}\). The top 20 AN-DRGs in both sectors (ranked by number of separations) represent the primary classes of admitted patient care in Australia - they account for 33.5 per cent of total separations in public hospitals and 42.2 per cent of total separations in private hospitals.

In total 30 AN-DRGs make up the top 20 AN-DRG lists of the public and private sectors: ten AN-DRGs form the common ground of admitted patient care, appearing on both top 20 lists of most frequent AN-DRGs, and representing nearly 25 per cent of total separations in the public sector and 28 per cent of total separations in the private sector. They comprise medical procedures for chronic and acute conditions (kidney disease, medical back problems and chemotherapy), obstetric and gynaecological procedures, surgery for skin and eye conditions, and diagnostic investigations.

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\(^{15}\) Source data for the following analysis of mix of services is from Department of Health and Aged Care, National Hospital (Casemix) Morbidity Database (unpublished).
The ranking or frequency of these ten AN-DRGs within the top 20 lists is different across the sectors. This is evident in the difference between the top three AN-DRGs for each sector: renal dialysis, chemotherapy and vaginal delivery in the public sector (with respective ranks of seven, four and eight in private hospitals) and other gastroscopy, other colonoscopy and lens procedures in the private sector (with respective ranks of four, five and thirteen in public hospitals).

In addition these ten AN-DRGs account for different proportions of the total costs of admitted patient care in both sectors, and representing 9.2 per cent of total costs in public hospitals and 14.5 per cent of total costs in private hospitals. Thus each one per cent of separations in the 10 AN-DRGs consumed 0.37 per cent of total costs in the public sector and 0.52 per cent of total costs in the private sector (or approximately 40 per cent more in the private sector) even though the average length of stay tended to be higher in the public sector.

Twenty AN-DRGs make up the remaining places on the top 20 lists of both sectors. They show the difference in the nature of admitted patient care between public and private hospitals.

The ten AN-DRGs specific to the public sector top 20 list represent conditions which often require emergency admission: bronchitis and asthma, chronic obstructive airways disease, heart failure and chest pain (the same AN-DRGs have a rank of 50 or more in the private sector).

The ten AN-DRGs specific to the private sector top 20 list relate principally to elective surgery procedures: dental extractions, knee, ENT, hernia and anal surgery (the same AN-DRGs have a rank between 20 and 50 in the public sector).

The types of services provided in private hospitals have become more varied over time, resulting in more patient referrals. There are indications that private hospitals are beginning to provide higher-cost treatments in an increasing range of specialised units, resulting in a concurrent increase in the complexity of the casemix. Almost every health care service except transplants and very specialised treatment (for example, burns units) is available in the private sector and the numbers of accident and emergency units and special care wards are increasing. The number of private hospital special care units (including intensive care, coronary care, neonatal intensive care units and high dependency units) increased from 93 in 1991–92 to 136 in 1997–98; the number of private hospital accident and emergency units increased from ten in 1991–92 to 36 in 1997–98 and there was a corresponding increase in accident and emergency beds from 28 to 282 (ABS, 1993, p8; ABS, 1999b, p16).

**Equity of access**

Under Medicare, public hospital patients are treated free of charge which ensures that public hospital care is available irrespective of ability to pay. National Centre for Social and Economic Modelling findings show that public expenditure to provide needs-based access to free public hospital care theoretically redistributes substantial benefits to low-income earners, with persons in the lowest income quintile receiving five times the expenditure received by persons in the top quintile (Schofield, 1998, p10).
However, greater use of public hospital services by low-income earners also reflects that those individuals are more likely to be ill, less likely to have taken preventative health measures, more likely to have inadequately controlled chronic diseases, and less likely to have private health insurance than higher-income earners. This suggests that public hospital care is allocated on the basis of need, not socioeconomic status, and that the need for such care is likely to be higher among those with low incomes.

**Location**

Access to public health services, particularly public hospitals, is limited in some rural and remote areas of Australia. Public hospitals are, however, relatively well dispersed compared to private hospitals. For example, in 1995–96, the numbers of private hospital beds per 100,000 population in large rural centres and small rural centres were 241 and 76 respectively. For public hospitals, the figures were 494 and 364 (AIHW, 1998c, p78). Only consumers in metropolitan and large rural centres and those willing and able to travel considerable distances have the potential to choose between competing private hospitals.

In many rural locations there are no private hospitals. Government support for the private sector to establish in such locations (for example, through co-location with public facilities) has the potential to create local area private sector monopolies. To be consistent with the Trade Practices Act principles, private hospitals cannot exclude specialists from their facilities for anti-competitive reasons, for example as a result of pressure from a particular specialist college or group of regional specialists. In addition, market share agreements between private hospitals would also be considered to be anti-competitive (for example, where each hospital agrees to treat only patients residing within their own regions).

The geographic maldistribution of private hospitals is closely linked to the availability of specialist medical practitioners. A lack of specialists to provide inpatient care in rural locations has been a long-term problem for both the public and private sectors (Baume, 1994, p76). Specialists need access to a minimum population base to maintain adequate skill levels. Only recently have specialist colleges and governments explored strategies, for example, the rotation of specialist trainees through rural and remote posts (AMWAC and AIHW, 1999, p30), to ensure patients outside metropolitan locations have reasonable access to specialists’ services. GPs provide primary specialist services to reduce the impact of the low availability of specialists in these locations (AIHW, 1996). State and Territory Governments have also developed various arrangements to allow GPs to provide both non-specialist and specialist services in those rural hospitals (AMWAC and AIHW, 1999, p60).

**Waiting times**

Waiting times in both public and private hospitals is, to an extent, influenced by specialist supply. Waiting times for patients’ initial clinical appointments with specialists in short supply can be up to two months (Baume, 1994, p41). Waiting times and admissions for elective surgery in the public sector reflect both a discretionary method of cost control over public sector expenditure and the level of occupancy. Recent moves to fund hospitals according to throughput (for example, through casemix funding) have, to some extent, moved the incentive structures in the
public system towards maximising throughput. This has the potential to reduce elective surgery waiting times for public patients.

Waiting time for elective surgery in public hospitals is one measure of efficient access to services. Waiting list priority in public hospitals is determined by the urgency category of the patient. Category 1 patients are those for whom admission within 30 days is desirable, category 2 patients are those for whom admission within 90 days is desirable and all other patients are classed as category 3, for whom admission within 12 months is desirable.

Department of Health and Aged Care unpublished data shows that the percentage of patients waiting longer than the desirable time has decreased consistently. In 1996–97, 89.8 per cent of category 1 patients were admitted within 30 days. Category 2 patients were admitted within 90 days in at least 82 per cent of cases in all States and Territories except Tasmania and the Australian Capital Territory. In those States with systems implemented to measure Category 3 waiting lists, at least 87 per cent of these patients were admitted within 12 months.

Private hospitals do not operate with 100 per cent occupancy rates and so waiting times are not used to measure efficiencies in these facilities. In addition, private hospitals less frequently seek to reduce throughput to contain costs. Private health insurers, on the other hand, are starting to impose some cost-containment measures on private hospitals through the use of case payments, which attempt to reduce ALOS, and volume discounting, by which they can attempt to cap total bed days.

It should be noted, however, that medical practitioners independently exert significant influence on length of stay and throughput in hospitals.

**Quality of care**

Effective competition between private and public sector acute hospitals would be expected to result in better quality of care as both sectors seek new clients.

It is difficult, however, to define and measure the quality of health services. The public sector has been more proactive than the private sector in investing in the development of quality indicators. Currently, the National Health Ministers’ Benchmarking Working Group (NHMBWG) is developing national indicators of quality for the acute hospital sector in the area of effectiveness.

The Commonwealth will provide the States and Territories with about $660 million, through the 1998–2003 AHCAs, to support quality improvement activities. The Commonwealth has committed $40 million to improving the quality and safety of hospital care. The four-year Acute Care Reform Program will focus on health information technology, performance information, implementation of clinical practice guidelines, stronger accreditation processes, improved consumer participation and the promotion of efficiencies in hospitals.

At present, the only quality indicator being implemented by the NHMBWG is the level of accreditation by the Australian Council on Healthcare Standards (ACHS). In 1998, 42 per cent of public hospitals were accredited,
covering 69 per cent of all hospital beds, while 73 per cent of private hospitals and 87 per cent of private hospital beds were accredited (AIHW, 1999, p12). The constant improvement and adaptation of the hospital accreditation process over the past 10 years prevents comparison with previous findings.

Work is under way to develop patient satisfaction, safety and complaints indicators and accreditation. Patient satisfaction indicators emphasise the relationship between the consumer and the service and are commonly measured through satisfaction surveys and complaints mechanisms (Productivity Commission, 1999). Patient safety identifies ‘adverse events’ and develops ways to prevent them. An ‘adverse event’ can be defined as ‘any situation in which an inappropriate decision was made when, at the time, an appropriate alternative could have been chosen’ (Productivity Commission, 1999, pp258–259). Incident monitoring measures unplanned readmissions to hospital, unplanned readmissions to the operating room and hospital-acquired infection rates.

However, existing quality indicators cannot be validly compared between the public and private sectors or between individual private hospitals because these indicators do not reflect the different quality criteria which need to be measured to reliably assess outcomes for differing casemix profiles. For example, a hospital that provides a high proportion of gastrointestinal surgery may have a higher reinfection rate than one which specialises in procedures less prone to infection.

Other factors that affect quality of care across public and private hospitals include the generally better timeliness of access to emergency care in public hospitals and the enhanced access to medical specialists in major public teaching hospitals.16

**Barriers to entry**

According to market theory, if there are barriers that limit the likelihood of new businesses entering a market, then existing market operators will be less subject to pressures of contestability and thus will have less incentive to pursue efficiency.

Barriers to market entry fall primarily into two categories: institutional barriers and structural barriers. Institutional barriers result from current market and provider arrangements and include, for example, private hospitals’ need for substantial financial backing. Structural barriers, such as legislation and planning regulations, are applied by governments or other bodies to ensure services and service providers meet adequate standards. They may be applied with the intention of restricting entry to the market.

16 The quality of care provided in hospitals is also dependent on the quality of services provided by specialist practitioners in that setting. Across all specialties, specialist colleges play the principal role in selecting, training, and assessing practitioners to be recognised by that college. Requirements for continuing medical education for specialists vary across colleges and are usually not obligatory for ongoing recognition as a specialist. Where training and assessment are undertaken by one body, the skill level of all recognised college members is likely to be comparable. A drawback of that arrangement, until recently, is that trainees have had no mechanism by which to appeal an unfavourable assessment.
Hospitals

A range of factors affect the feasibility of the entry of new players to the private hospital market. For example, the purchase of assets (such as land and infrastructure) has been the subject of increased competition among most major domestic hospital groups, including not-for-profit groups, for-profit groups and private health insurers. Private hospitals need to be established in locations that will attract specialist practitioners. These are usually inner-metropolitan locations, where land is expensive and rarely available. Often such properties are acquired through acquisitions and amalgamations of existing private hospitals. The increasing cost of purchasing these assets and falling hospital profitability reduces short-term returns for the purchasers, creating less incentive for new private investors.

The private hospital sector has also been affected by an uncertain policy environment relating to:

- the future of private health insurance in a period of rapid decline in the levels of that insurance;
- government policy towards private hospitals where some States are considering abolishing private hospital planning regulations; and
- future Commonwealth Government and State Government support for private hospitals and their views on the potential role of the private sector in delivering publicly funded services.

In 1991–92, the ratio of total revenue to recurrent expenditure for the private hospital sector was 1.12:1, while in 1997–98, this ratio was 1.09:1 (derived from ABS, 1999b, pp. 10-11). The overall profit margin of the private hospitals industry in 1997–98 was 8.4 per cent of revenue, marginally lower than the 1996–97 profit margin of 8.9 per cent, although the gross margin per bed day increased slightly from $45.50 in 1991–92 to $48.70 in 1997–98 unadjusted for inflation (derived from ABS, 1999b, pp. 10-11).

Competition among providers for institutional funding

Governments, private health insurers and individuals are the major sources of funding for hospital services.

While some patients self-insure for non-emergency acute hospital treatment, this source of funding is comparatively small and will not be addressed in this section.

Competition between hospitals for public funding

In recent years, contestability has been used increasingly as a benchmark to ensure the public sector delivers efficient and effective services. Private hospitals are now expanding their role as service providers to public patients. In 1997–98, 43,563 eligible public patients received care in private hospitals compared to just over 4,000 four years earlier (AIHW, 1999, table 5.5).

In States such as Victoria that have actively contracted out the delivery of hospital services for public patients, public hospitals cannot assume that their geographical location or prior service delivery responsibilities will automatically entitle them to continued State Government funding. This policy is aimed at promoting efficiencies
and competition between public sector services and between public and private sector services in areas that were previously protected from competition. This trend is consistent with the Commonwealth Government’s tendering of veterans’ acute hospital services to both public and private hospitals. Currently, about 385 of the 446 private hospitals and day procedure centres have contracted to provide hospital services to veterans.

Where the public sector is able to define and monitor outcomes, it may not matter which sector delivers the service. However, contracting arrangements are still being refined and it is probably too early to determine whether it is indeed possible to define and monitor outcomes appropriately. If not, there is a risk that quality could be compromised by the private sector as it pursues efficiency and, ultimately, profit. However, this must be evaluated against possible inefficiencies in public hospital services.

**Competition between hospitals for private health insurance funds**

Private hospitals receive 74 per cent of all private health insurance hospital benefits paid out (PHIAC, 1998, p97) and are reliant on these for their continued viability. There is considerable competition between private health insurers and private hospitals to minimise their respective costs and maximise revenue.

Over the past few years, hospital purchaser provider agreements (HPPAs) have been introduced between hospitals and private health insurers and 90 per cent of private hospitals and day surgeries have entered into at least one such contract. These agreements potentially offer patients some certainty about the insurance benefits they will receive and the out-of-pocket expenses they will face for hospital care, but do not provide certainty about additional out-of-pocket payments for medical specialist services.

There has been a significant shift of private patients from public to private hospitals. In an effort to reduce the overall benefits private insurers are required to pay as a result of this increased utilisation of private hospitals, some (for example, AXA Australia Health Insurance) have introduced competitive tendering with private hospitals based on price, willingness to enter long-term (three-year) contracts, a shared vision and contractual obligation of partnership, efficiency, location, specialties offered, evaluation and monitoring. Unsuccessful tenderers are then paid in a number of ways, including by second tier default benefit level arrangements, discussed below.

Private hospitals have raised concerns about HPPA arrangements, arguing that:

- with lapsed contracts, private health insurers are now paying for 1999 services at 1998 prices;
- insurers have been unwilling to adjust payment rates to account for increases in salaries and other costs, resulting in decreased profits for private hospitals;
- insurers have attempted to transfer risk to private hospitals in other ways (for example, by combining allocations for different items into one cost item) but with no mechanism to compensate for future price increases;
- insurers have bundled additional services such as allied health services into the fixed price they offer without appropriately compensating for the full cost of these services;
• insurers are applying step-down payments and case payments in an attempt to reduce ALOS as well as applying volume discounts on services in an attempt to cap total bed days; and
• insurers have transferred revenue collection risk by requiring hospitals to recover front-end deductible payments from patients.

Private hospitals have also argued that they have little scope to achieve greater efficiencies because 60 per cent of their costs are tied to employee wages and 10 per cent to drugs and consumables, both of which they claim are relatively fixed costs. However, significant differences in ALOS and the prices charged for the same procedures across private hospitals suggest there is some scope to achieve further efficiencies.

In the absence of an HPPA, private health insurers are required by legislation to pay either the second tier default benefit level, based on 85 per cent of the average benefit paid under HPPAs, or a lower standard default rate determined and legislated by the Commonwealth. The benefits public hospitals receive from insurers for their private patients are set at the lower default rate. The higher level second tier default benefit level (which is still lower than the average HPPA payment) is now available to hospitals which do not have an HPPA but which are accredited, provide simplified billing, and have met other quality assurance criteria. Currently, only about six private hospitals are on a second tier default benefit level, possibly indicating unwillingness on the part of insurers to pay above the default rate for non-contracted hospitals.

The relationship between private hospitals and private health insurers is complex since both parties seek to maximise profits in their contractual negotiations. Provisions in the Trade Practices Act prevent hospitals that operate as independent businesses from collaborating with competitors to increase their bargaining power. As a result, large private health insurers with significant market power have the stronger position in negotiations with individual hospitals and smaller hospital chains. Conversely, as noted by the Victorian Health Services Policy Review (Phillip Fox and Casemix Consulting, 1999, p65), smaller private health insurers are in the weaker position in negotiations with the larger hospital chains.

Overall, private hospitals and private health insurers remain interdependent, but private hospitals also have the infrastructure to provide services for the public sector (as has occurred in Victoria). Private health insurers, on the other hand, rely on maintaining a viable private hospital industry as private hospital care is their most important product.

Factors affecting competition between public and private hospitals

Both private and public funding arrangements prevent there being a level playing field between public and private hospitals.

In 1997–98 only 9.4 per cent of all public hospital separations were for eligible private patients (AIHW, 1999, table 5.5). The shift of private patients from public to private hospitals has reduced the strength of public hospitals in negotiations with private health insurance funds. While the AHCAs permit public hospitals to contract at any amount for private patient treatment, there have been no contracts with private health insurers to date. Instead,
there has been a tacit agreement to contract at the lower default rate set in legislation, even though from the Commonwealth’s perspective, public hospitals are able to obtain full cost recovery for private patient services and potentially retain any private patient fee income.

State Governments could increase the bed day rate for private patients in public hospitals to at least the second tier default benefit level to ensure public hospitals are not disadvantaged in terms of private patients. However, if private health insurers were not willing to pay increased rates for these patients, then the patients would have to bear additional charges. That would not be a palatable political position for State Governments and it could jeopardise the remaining private patient services provided in public hospitals.

Public hospitals have an interest in maintaining private patient services to help attract medical specialists, who are then also available to treat public patients. The emergence of co-located private for-profit hospitals with public hospitals is another potential mechanism to attract specialists to work in public hospitals. It is not clear, however, whether this trend will influence State Government policy on prices charged to private patients in the public hospitals.

Public funding arrangements also affect competition between private and public hospitals. Private hospitals can access PBS subsidies for pharmaceuticals for their private inpatients, but the Commonwealth has precluded public hospitals from accessing the PBS since these pharmaceutical costs were already funded under the previous Medicare Agreements. As the Victorian Health Services Policy Review observed, ‘(e)ffectively a private hospital is able to deliver a course of treatment to a patient without charge when the same course of treatment may leave a $15,000 dent in a public hospital drug budget’ (Phillip Fox and Casemix Consulting, 1999, p56).

The Commonwealth has now proposed new arrangements to provide PBS subsidies for pharmaceuticals provided by public hospitals to all non-admitted patients, to admitted patients upon their discharge and for chemotherapy drugs provided to public and private day-only admitted patients. The significant remaining restriction under the AHCAs will relate to pharmaceuticals, other than day-only chemotherapy drugs, provided to admitted patients in public hospitals. This was omitted from the pharmaceutical reform package because:

- the intention of the package was to extend PBS subsidy to whole classes of public hospital patients and to avoid inequitable treatment of public and private patients in the same hospital; and
- opening access to the PBS to private admitted patients as a distinct group raises logistical difficulties in auditing the admission status of patients.

**Competition between specialists**

Specialist practitioners compete for both private and public funding.

**Private funding**

The funding arrangements for medical specialist charges are integral to the total funding of private hospital care and, therefore, to consumers’ decisions to purchase private health insurance and to use private hospital services.
Most specialists provide services on a fee-for-service basis at rates well above the MBS schedule fee. Private health insurers and government play a very limited role in defining the types of services and almost no role in limiting the number of services provided by specialists. Medical practitioners have the option to enter medical purchaser-provider agreements (MPPAs) with insurers or provider agreements with private hospitals, but these agreements are relatively rare, with specialists expressing concern that they could reduce clinical autonomy; alleging, for example, that hospitals could impose inappropriate clinical restrictions on patient care in the interests of profitability or that private health insurers could control what treatment should be made available to individual patients.

A very small number of insurers have successfully negotiated agreements with practitioners to pay fixed fees, for certain procedures, that are above the MBS schedule fee but below the Australian Medical Association (AMA) recommended fee. Such arrangements could soon enable private health insurers to guarantee, in advance, the total cost of private acute care treatment. For example, providers accepting patients under AXA Australia Health Insurance’s ‘Mediplus Eziclaim’ charge a pre-agreed price, leaving the patient with no out-of-pocket expenses. Practitioners using this system have not reported loss of clinical autonomy. Although these agreements are entered into on an episode-by-episode arrangement, AXA Australia Health Insurance reports that most participating doctors offer the arrangements to all eligible patients. While there is the potential to reduce the levels of fee-for-service payments through contracting and agreements, private health insurers still have little control over the total number of services provided and can end up paying a higher percentage of the cost of those services.

For public funding

In the past, specialists often occupied salaried positions in the public sector, primarily in major teaching hospitals. Specialists now provide most services to public sector patients under fee-for-service or sessional arrangements negotiated regularly with each State and Territory Government. Since most training of specialists is provided by specialists in major public teaching hospitals, those hospitals able to offer training facilities have been able to attract specialists to undertake both training and related patient care.

Public hospitals have always maintained a workforce of salaried medical practitioners to carry out a substantial proportion of medical services. Private hospitals are also introducing similar salaried positions in response to their changed services, which are increasingly likely to require access to 24-hour medical practitioner care, but the number of privately employed salaried medical officers is still quite low.

Typically, negotiations for specialists to work in public hospitals are undertaken on a State-by-State basis with the major medical industrial body, the Australian Medical Association (AMA). The structure of these negotiations is now beginning to change. Negotiations in Victoria and the Australian Capital Territory, for example, now take place with individual practitioners. The Australian Competition and Consumer Commission has ruled that, after 30 June 1999 in South Australia, individually negotiated contracts or terms and conditions determined unilaterally by South Australian Health Commission must replace collective negotiations with the AMA, because agreements with professional associations can set a floor price for specific services across different regions and have been assessed as anti-competitive.
Similar principles are likely to apply in all other States and Territories except in New South Wales which has specific State legislation requiring the AMA to act on behalf of visiting medical officers.

Legally, specialists do not directly receive public funding through MBS for the provision of services to private patients, because the funding is reimbursed to the patient rather than paid directly to the specialist. There is little doubt, however, that specialists’ extra charges for these services, often well over the schedule fee, contribute to patient disenchantment with the value of private health insurance and private health care in general.

**Competition between funders**

Competition in the funding of health services is affected by the relationship between Medicare and private health insurance as sources of acute care funding and by competition between different private health insurers to fund private acute care services.

**Key institutional funding players**

The key players in health care funding in Australia are the Medicare system of universal public health insurance, the Department of Veterans’ Affairs who provide separate funding for Veterans’ health services and the private health insurance industry.

Medicare is funded through compulsory tax contributions. It provides free hospital and medical services for public patients in public hospitals and subsidised medical treatment for private patients in all hospitals. Medicare also pays 85 per cent of the schedule fee for all out-of-hospital services. While consumers are usually bulk-billed for GP services, they often still face large out-of-pocket payments for medical specialists’ services.

Private health insurance is funded through the payment of premiums by members. It primarily pays for enhanced access to acute care and enhanced accommodation services. The introduction of Medicare in 1984 reduced the role of private health insurance. Private health insurance premiums are additional to compulsory Medicare levy and taxation obligations. Individuals cannot elect to opt out of Medicare or increase their Medicare subsidy to purchase a higher level of service.

The 1997 Industry Commission review into private health insurance (Industry Commission, 1997) described the Commonwealth’s objectives in relation to private health insurance as:

- relieving pressure on public funding;
- encouraging private funding; and
- providing a choice between public and private service provision.

The private health insurance industry is diverse and has a large number of players, although the six largest cover almost 80 per cent of the insured population (see table 7). There are 44 registered health insurance organisations. Of these, 29 are ‘open’ private health insurance funds, covering 92.5 per cent of people insured and 15 are restricted membership organisations. Only AXA Australia Health Insurance, SGIO Health and Grand United Corporate operate on a for-profit basis and are liable for income tax on their reserves.
### Table 7: Hospital and ancillary private health insurance coverage and market share as at 30 June 1998

<table>
<thead>
<tr>
<th></th>
<th>Number of persons covered</th>
<th>National market share (per cent)</th>
<th>Cumulative market share (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medibank Private</td>
<td>1,971,025</td>
<td>26.9</td>
<td>26.9</td>
</tr>
<tr>
<td>Medical Benefits Fund of Australia</td>
<td>1,284,728</td>
<td>17.6</td>
<td>44.5</td>
</tr>
<tr>
<td>Hospital Benefits Fund of WA</td>
<td>787,866</td>
<td>10.8</td>
<td>55.3</td>
</tr>
<tr>
<td>AXA Australia Health Insurance</td>
<td>749,367</td>
<td>10.2</td>
<td>65.5</td>
</tr>
<tr>
<td>Hospital Contribution Fund of Australia</td>
<td>620,780</td>
<td>8.5</td>
<td>74.0</td>
</tr>
<tr>
<td>NIB Health Funds</td>
<td>340,843</td>
<td>4.7</td>
<td>78.7</td>
</tr>
<tr>
<td>Other open organisations</td>
<td>1,012,025</td>
<td>13.8</td>
<td>92.5</td>
</tr>
<tr>
<td>Restricted membership organisations</td>
<td>551,302</td>
<td>7.5</td>
<td>100.0</td>
</tr>
<tr>
<td>National total</td>
<td>7,317,936</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>


The removal of the traditional requirement for private health insurers to have a separate fund registered for each State in which they operate has seen a decline in their numbers in the past 10 years. Some of the larger insurers have increased their national market share by expanding into new States. The traditional State based operations of funds along with regional ‘brand loyalty’ has effectively created seven sub-markets for private health insurance (the Australian Capital Territory is part of the New South Wales market), each dominated by two or three insurers (Industry Commission, 1997, p100). As the Industry Commission report observed, ‘despite the large number of insurers operating in Australia, there is a high degree of seller concentration at the state level’ (Industry Commission, 1997, p101).

### Relationship between private health insurance and Medicare

Private health insurance both complements and supplements Medicare.

It plays a complementary role by funding services and amenities that are not funded through Medicare (for example, dental care, physiotherapy and ancillary services) and, in certain circumstances, the fees charged by medical practitioners that are in excess of what is reimbursed through Medicare.

Private health insurance supplements Medicare by allowing individuals to choose and fund a different level of service (that is, a choice of doctor, different standards of hospital accommodation and flexibility in the timing of treatment).

There are only limited areas of the health system in which consumers choose between private insurance and Medicare as a source of funding, the main one being the funding of acute hospital services for elective surgery.
**Price**

Compulsory individual contributions to Medicare provide only a portion of total Government outlays for publicly funded hospital care. Individuals cannot choose private health insurance instead of Medicare. Their insurance premiums will be additional to, not instead of, their compulsory Medicare contributions. For example, a family with private health insurance covering private hospital treatment will be charged about $2,000 in premiums on top of their Medicare contributions\(^\text{17}\).

Private health insurance has not been an attractive option for acute hospital funding, especially for younger and healthier people who consider public sector care to be acceptable and believe they are at low risk of requiring medical services (Quints and Marks, 1997, piv). Increasingly, too, consumers consider that private health insurance is too expensive for the additional benefits that it provides (Quints and Marks, 1997, pvii) and are concerned about the significant out-of-pocket expenses.

**Satisfaction and choice**

Private health insurance offers hospital patients their choice of doctor and hospital (and therefore choice of accommodation standards) and, in some cases, more timely care than the public system might provide. These benefits are most pertinent in relation to elective surgery, which may involve a considerable waiting period for public patients, although public satisfaction with waiting times in public hospitals is improving in some States, most notably Victoria and South Australia (Quints and Marks, 1997, pp28–30). Major emergency procedures are still predominantly provided in public hospitals where, in most cases, emergency treatment is not differentiated on the basis of public or private patient status.

The extent to which choice of doctor is a benefit for privately insured patients varies depending on the level of information available to the patient. Many consumers do not have the knowledge to exercise this choice properly and, in most cases, rely on the referral advice of their general practitioner. In addition, it is possible that a patient receiving some forms of specialist care would be treated by the same doctor regardless of insurance status if they live in a region with a shortage of practitioners.

**Efficiency and cost-effectiveness**

The public health funding arrangements and the private health insurance funders have limited influence over consumers’ initial choice to seek medical care and the number and type of services provided.

Wasem (1995) noted that health care costs and quality are significantly influenced by the health care system’s inherent incentive structures for health care service providers.

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\(^{17}\) This amount excludes the Federal Government’s 30 per cent Rebate on private health premiums. Once this is taken into account, the amount to be paid reduces to around $1,400.
Traditional fee-for-service arrangements provide few mechanisms for funders of health care services to specify health care priorities or to cap the benefits payable annually for such services. Priority has now been given to developing such mechanisms, but this process is still in its early stages.

The public sector is now placing more conditions on provision of funding, to a certain extent acting as a purchaser (see also discussion in chapter 5), for example:

- service agreements between the Commonwealth Government and particular professional groups have enabled the Commonwealth, as a funder, to negotiate a limited or capped budget, making the professional group responsible for ensuring the budget is not exceeded; and
- public sector funding decisions under MBS and PBS are based on information on the effectiveness and value of competing services, which is provided by the Pharmaceutical Benefits Advisory Committee and the Medical Services Advisory Committee.

Traditionally, private health insurers have not sought to influence incentive structures for those delivering services (primarily doctors). Free choice and non-interference have been seen as guarantees of quality. Until recently, limited demand-side cost containment measures such as copayments and deductibles were the only mechanisms private health insurers used to pressure suppliers of services through consumers.

Private health insurers in Europe also have primarily relied on government intervention, through regulation of the health care system to limit expenditure, because their market power in many countries is too small to influence service delivery. They also believe that private sector service delivery is influenced downstream by the regulation and restriction of service delivery in the public sector (Wasem, 1995).

This holds true, in part, in Australia, where private health insurers have not been as successful as governments, which have used their roles as monopsony purchasers and funders across large areas of the health system to introduce explicit funding criteria. More recently, however, private health insurers have used contract arrangements with hospitals which are seeing them gradually determining:

- how much they are prepared to pay per service;
- what services they are prepared to pay for; and
- differential levels of payment for different standards or quality of care.

Nevertheless, the profitability of the industry has fallen because of the decline in fund membership and the increase in the total benefits paid due to the worsening risk profile of members (see the discussion of adverse selection in chapter 2). The average operating profit for all funds in the 1997–98 financial year was 1.6 per cent (PHIAC, 1998, p53). It is important to note, however that because most private health insurers are run by not-for-profit organisations, any profit that they make will enhance their future viability and is likely to impact on the price of premiums in the future.

Traditionally private health insurers have operated as indemnity funders for acute hospital services, providing retrospective funding without discriminating between different types of services. They are now moving to introduce more conditions into their funding arrangements by defining criteria to determine which types of
services will be purchased and how much will be paid. For example, private health insurers are linking higher levels of benefits to the use of quality-based decision-making frameworks, such as clinical pathways and evidence-based medicine in particular hospitals. They are also paying higher benefits for services that include appropriate health prevention strategies. Some private health insurers are also establishing links with specialist colleges who provide guidance on the efficacy of new expensive treatments and whether they should be purchased. This form of funding systematises the provision of services but maintains considerable clinical discretion for doctors.

Private health insurers have not, to date, started to purchase or manage the provision of care for individual patients. To do so would require their involvement in confirming diagnoses and guiding treatment according to defined protocols. Such arrangements would still require latitude for clinicians to deviate from the standard protocols for particular patients, although they would have to justify their clinical judgments.

It is this involvement in the area of individual clinical decision-making that the medical profession is most concerned about. It has argued that the quality of health care services could be compromised if private health insurers determine the types of treatment for which benefits will be paid. There is, however, potential to adopt protocols, developed by the profession itself, to decide under what circumstances benefits will be paid, with scope for consideration of outlier cases. While Medicare continues to be a viable and attractive option for consumers, it would be a risky commercial decision for private insurers to reduce the quality of private health services purely in the interests of short-term profit. Insurers are primarily interested in negotiating better care for their members at the current price or at a lower price if there is wastage and inefficiency in the service provision industry. However, information asymmetry may prevent consumers from readily identifying services as being of lower quality.

The private health insurance reforms outlined in this chapter have the potential to improve the efficiency of privately funded services and to reduce the price of premiums, making the ‘private health insurance plus Medicare’ product more competitive against Medicare alone. Although price is a major factor in determining whether consumers buy private health insurance, the additional choice and coverage that the product provides over and above Medicare is also important. Ultimately, consumers have to accept a trade-off between choice and price. Any changes to the existing private health insurance product need to be seen by consumers as enhancements. For example, the benefits of changed or substituted service delivery arrangements, such as early discharge services, need to be promoted over traditional inpatient hospital services, otherwise consumers may believe the value of their private health insurance cover has decreased and subsequently drop that private cover.18

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18 The current boundaries of funding responsibility quarantine funding to certain parts of the health system. This creates disincentives for sensible substitution to meet the patient’s needs and better allocative efficiency if the substitution crosses lines of funding responsibility. The substitution of traditional in-hospital care for community care arrangements could be difficult if private health insurers are expected to pay for community services which have traditionally been funded under Medicare or by State Governments.
The following discussion on early discharge trials examines some of the issues surrounding the early discharge arrangements.

### Early discharge trials

A range of early discharge trials are being conducted to test alternative models of in-hospital care. The ultimate aim of early discharge arrangements is to make private health insurance more attractive to consumers by allowing it to cover clinically appropriate alternatives to in-hospital treatment.

The current trials include the St Francis Xavier Cabrini Domiciliary Palliative Care program in Victoria, the South Australian Psychiatric Patient Trial and the Victorian Rehabilitation Patient Trial. Each trial involves an agreement between the participating private health insurers and hospitals to substitute outreach services for in-hospital care for an agreed daily benefit.

They will assess whether early discharge programs for private patients represent safe, sound clinical practice that is accepted by all levels of the profession and demonstrate cost efficiencies. The trials aim to extend the range of services available to private patients and have the longer-term objective of extending the definition of hospital treatment and the scope of private health care.

Early discharge offers several advantages including enhancing consumer satisfaction, as many consumers prefer alternatives to in-hospital care, reducing costs and expanding the range of services that private hospitals and private health insurers can offer.

Assessment and evaluation of the trials involves determining whether early discharge programs for private patients:

- are safe in terms of patient selection and represent sound clinical practice;
- are accepted by all levels of the profession and assist clinicians to improve their practices;
- are beneficial to patients by reducing admissions and increasing patient satisfaction;
- can demonstrate cost efficiencies for both private health insurers and fund members; and
- are a true substitution rather than an additional service.

Ultimately, the attractiveness of private health insurance as a source of funding for health services depends on the cost of insurance premiums. To maintain private health insurance premiums at an acceptable price, insurers will have to introduce strategies to contribute to the management of aggregate health expenditure. These would affect both supply and demand and could include:

- products that share the cost with members, thereby reducing moral hazard (for example, coverage which includes front-end-deductible consumer contributions);
- encouraging changes in consumer behaviour, including providing positive incentives for risk reduction (for example, non-smoker discounts), reducing premiums for consumers willing to use cost-effective providers.
and treatments and educating consumers to take more responsibility for their own health (Laing et al, 1988, p22);

- information programs to help members make informed decisions about treatment options, quality and cost;
- utilisation reviews;
- discounts for second opinions;
- offering more products which promote alternative and appropriate out-of-hospital care (for example, hospice care and hospital in the home);
- offering products with benefit ceilings and/or exclusions for certain types of expensive procedures;
- applying price discounts in contracts after a defined threshold volume throughput is reached;
- reduction or elimination of excesses in return for agreeing to more cost-effective treatments; and
- supporting the assessment of the efficiency and cost-benefit of development in medical technology (for example, funding research in these areas) (Industry Commission, 1997, p228 and p376; Laing et al, 1988, p21).

In terms of additional costs to the health system, the Industry Commission report (1997) notes that administration costs for the private health insurance industry are lower than for many other parts of the insurance sector. However there is a wide variation across private health insurers in the average cost of management expenses per member.

Overall administration costs are much higher for private health insurance than Medicare, at around 4 per cent for Medicare\(^\text{19}\) compared with 12 per cent for private health insurance (PHIAC, 1998, p53). This is largely due to the economies of scale achieved under the public system. Any increase in private health insurance coverage that is not accompanied by significant increases in administrative efficiency could result in a greater proportion of the health funding being spent on the administration rather than health service delivery.

**Competition and Risk**

As discussed in chapter 2, circumstances of moral hazard have the potential to lead both providers and consumers to instigate more services than are necessary. At the same time, adverse selection reduces the degree to which risks are spread, and increases the cost of insurance.

It is commonly argued that funding by the public or private sectors will determine the balance between individual and collective responsibility within the health care system, with public sector funding being the best way to collectively share the financial risk of the community’s health care costs. There are, however, redistributive mechanisms that allow private health insurers to share risks collectively; for example, community rating and reinsurance arrangements.

\(^{19}\) Estimated from Department of Health and Aged Care 1999, Budget Related Papers No 11 (Department of Health and Aged Care, 1999e) taking into account portfolio expenditure on HIC administration and total MBS and PBS outlays.
The community rating requirement obliges private health insurers to charge the same premium for all people who purchase equivalent levels of coverage, regardless of their medical history, claims made or length of fund membership. This regulation prevents insurers from excluding ‘bad risks’, who could otherwise suffer compromised access to services, and distributes the risk more evenly between public and private insurance.

The reinsurance system transfers funds from insurers with a low proportion of claims relating to aged and chronically ill members to insurers with a high proportion of such claims, to minimise the competitive disadvantages for insurers with high proportions of aged and chronically ill members.

These schemes distort the beneficial effects of competition by reducing the need for insurers to incorporate effective risk-management strategies into their financial planning, although it has also been argued that the community rating obligation operates as a method of risk management in terms of the community’s total health care costs. Private health insurance is a more effective and equitable method of sharing the risk of health costs across the community than allowing individuals to pay for their health care costs (sometimes known as self-insurance) because it redistributes the risk across a larger group of insured people.

Under current health financing arrangements, Medicare and private health insurers do not bear the same level of risk. Private health insurers seek to improve the risk profile of their membership by trying to attract low risk members from Medicare or other insurers, primarily by offering cheaper exclusionary or ancillary products to younger, healthier people. While the risks between public and private sector funders are not equal because privately insured members can still elect to be public patients and draw on public funding, the current cost of insurance premiums takes advantage of this difference. If this option were not available, the price of private premiums would be even higher.

Finally, private and public funders do not equally share the financial risks for longer-term or whole-of-community health care costs. Private insurers have not traditionally taken on responsibility for ‘public goods’ such as immunisation and other preventive health and health screening programs. There is also less incentive for these insurers to consider themselves responsible for the longer-term health care costs of any particular individual because privately insured members can elect to opt in or out of insurance at will. However, some insurers are introducing initiatives aimed at promoting good health (for example, health checkups and subsidised preventive health programs) with the aim of reducing the future health risks of longer-term members.

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20 The introduction of Lifetime Healthcover may change this although individuals will still be able to move between private health funds.
Competition between private health insurance funds

According to market theory, providers who compete successfully for additional customers will increase their revenues and potentially their profits. The private health insurance market, however, differs in that:

- community rating forces insurers to offer equivalent cover to everyone regardless of their insurance risk; and
- it is difficult to calculate the actuarial risk of each additional new member, and most research indicates that predictive models can only explain between 20 per cent and 50 per cent of the variation in health care consumption.\(^{21}\)

New high-risk members could potentially destabilise the operating position of an insurer so there is an ongoing dilemma for insurers in terms of the extent to which they should actively recruit new members.\(^{22}\) Developing products to attract new low-risk members are one way to counter this problem.

There is little competition between restricted membership private health insurance funds, because they only offer cover for a defined constituency, usually based around an employment or professional group. This also limits their ability to compete with other private health insurers for members. Therefore, to improve their financial position they must develop products that will encourage existing members to upgrade their membership coverage.

There is, however, some competition between restricted membership and open private health insurance funds operating in the same jurisdictions, with aggressive marketing and discount premiums for high-volume membership offered by larger open private health insurance funds. These strategies are used to attract existing or eligible members of restricted membership private health insurance funds as well as members of other open private health insurance funds and those who do not have private health insurance.

**Barriers to fair competition**

Competition between insurers is restricted by a number of barriers to new entrants to the private health insurance market. The Industry Commission noted that these include:

- the different income tax treatment of for-profit and not-for-profit insurers, which may force new for-profit insurers to price their products higher, or subsidise them to compete with the premiums of not-for-profit insurers (although the value of these taxation exemptions for not-for-profit insurers is small) (Industry Commission, 1997);
- low average profitability;

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\(^{21}\) The extent of variability predicted depends on the modelling techniques used and such factors as the population being examined and extent of service utilisation covered by the model.

\(^{22}\) Although reinsurance arrangements allow private health insurers to share some of the costs of high-risk members, a large number of additional high-risk members joining a fund could result in claims that cost more than the premiums which have been paid to cover their costs.
• regulations which preclude innovative product reform; and
• uncertainty surrounding the future direction of Government policy (Industry Commission, 1997).

The other concern over competitive neutrality between private health insurers has been the former relationship between Medibank Private and the Health Insurance Commission (HIC). The financial separation of the two from 1 May 1998 and their physical separation from 1 July 1998 has ensured that Medibank Private does not enjoy a competitive advantage because of its previous commercial relationship with HIC, which included co-location of retail offices.

**Price and efficiency**

Competitive pricing between private health insurers is dependent on a combination of factors including private health insurers’ ability to:

- negotiate cheaper forms of cover – usually through agreements with service providers and through exclusionary products;
- subsidise reduced prices from any operating surplus – although in the current environment most private health insurers do not have sufficient surplus to draw from; and/or
- operate more efficiently – although the management expenses of private health insurers are not the main driver of premium prices.

Some private health insurers are competing on the basis of reduced premium costs by offering discounts for employees of large corporate employers in return for administrative savings that arise from the handling of bulk memberships. Apart from these arrangements, however, there is little competition between private health insurers on the basis of the price of their products. This is because the level of benefit for the most expensive components of private hospital treatment (high-technology and theatre band fees) is fairly standard across the industry. The extension of private insurance coverage to out-of-hospital care, such as nursing services, and the use of adjacent ‘step down’ or minimum care facilities and hospital-in-the home arrangements has the potential to increase allocative efficiency and lower premiums. More importantly in terms of the price of premiums, private health insurance offers unlimited access to health care and consequently private health insurers are unable to control the number of services for which they are obliged to pay.

Most private health insurers have very little scope to reduce their premiums because they are required to maintain a minimum level of reserves and mutual private health insurance funds are unable to draw on other sources of capital to fund price reductions.

In addition to the amount of benefits paid out, the price of premiums is also affected by the efficiency of the private health insurers’ operations (for example, transaction and administrative costs). Data for the financial year ending 30 June 1998 shows the average cost of management expenses per member across all private health insurers was $162.21, but with wide variation between private health insurers, ranging from under $100 to over $250 per member (PHIAC, 1998, pp50–53). The Industry Commission report noted that non-profit status and insurer’s size do not correlate with administrative efficiency (PHIAC cited in Industry Commission, 1997, p52).
Closed private health insurance funds had significantly lower average management expenses than open private health insurance funds because they had reduced need for multiple shopfronts and could develop joint administration arrangements with employers. The level of management fees is correlated with:

- the product mix offered by private health insurers – those private health insurers who pay out a greater share of benefits as ancillaries also spend more on management expenses;
- membership size – the Industry Commission report found that economies of scale were achieved by larger private health insurers which can spread fixed costs over a larger membership base; and
- the length of time a particular private health insurer has been operating – expenses are higher for new insurers, reflecting increased establishment costs (Industry Commission, 1997, p117).

Current reinsurance arrangements reduce the incentive for private health insurers to compete on the basis of efficiency because insurers who are able to negotiate lower-priced care for the aged and chronically ill or who are able to achieve administrative efficiencies are compelled to share part of the gain with other insurers.

**Mix of services – competing through product diversity**

Market theory predicts that competition between private health insurers should result in lower-priced products with more attractive features. However, current regulation prescribes mandatory cover of certain types of medical expenses (for example, minimal hospital cover) and restricts cover for others (for example, uninsurable medical gaps for medical services provided in the community). To a certain extent, this regulation and the community rating principles preclude competition and innovation in the industry.

However, the Industry Commission report noted that private health insurers appear to engage in product competition and innovation within the constraints imposed by the regulatory environment. Much of the early product innovation and commercially oriented contracting arrangements were initiated by a large for-profit private health insurer in an attempt to increase market share and profits.

Since the release of the Industry Commission’s report, and partially in response to the declining membership base, there has been an increase in competition between insurers. This is evident in the development of more innovative products which package basic hospital cover with a limited range of additional ancillary products which have been selected to appeal to a particular group in the community, for example, a particular age-group. Other examples of product diversification include:

- exclusionary tables which aim to attract younger and healthier members who may perceive themselves as having a very low risk of requiring one of the restricted procedures;
- growth in front-end-deductible tables which introduce an excess payment in return for lower premiums and sometimes reduce the excess depending on the length of membership.\(^{23}\)

\(^{23}\) Since 1989, there has been a rapid growth in the popularity of front-end-deductible products, with 35 per cent of members covered by front-end-deductible policies at June 1998 (PHIAC, 1999, p24). Under these policies, the consumer is taking
• new ancillary products to encourage people to look after their own health;
• simplified billing arrangements; and
• products which guarantee no-out-of-pocket expenses.

Private health insurers will soon be allowed to offer bonuses to members on the basis of length of membership, which will increase competition for long-term members. The increasing complexity of the different products, however, reduces the competition between insurers to a certain extent because it makes it difficult for consumers to compare products.

The future of the market

The regulation of the private health insurance industry in terms of reinsurance and product type dampens the incentive for private health insurers to compete on the basis of efficiency and quality. Regulatory changes, in particular removing some of the prescriptive requirements relating to provision and removing some of the perverse incentives that result from the reinsurance arrangements, could be expected to facilitate increased competition and, in turn, increased efficiency across the industry. In the absence of regulatory reform, a large number of relatively small, less efficient mutual private health insurers will continue to be supported. There are currently a large number of small private health insurers which could be consolidated to increase their bargaining power. The large number of mutual private health insurers in the market makes the possibility of industry consolidation through hostile takeovers remote. However, even without this impediment, consolidation of smaller private health insurers would have limited effect on the efficiency of the whole industry because almost 80 per cent of members belong to the six largest private health insurers.

The introduction of more for-profit insurers could result in better control of outgoings as a result of the more experienced financial and business expertise that a for-profit organisation may bring. Access to equity markets that are available to for-profit insurers would also allow financial expansion of the market and allow private health insurers to invest in new products and systems.

Government intervention in the private health insurance market

The degree of government intervention required to counter the market failures in the health care system depends partly on the role of private health insurance. If private health insurance has a ‘topping up’ role (supplementary), less government intervention is required than if it is an alternative to Medicare. If it were an alternative, regulation would be required to ensure members had access to appropriate and high quality services at least equivalent to that which Medicare offers.

responsible for more of the cost of their health care in return for lower premiums. The additional cost to the consumer is capped, known in advance and can be planned for.
The Commonwealth Government has been highly interventionist in the operation of the private health insurance sector. This intervention, mostly in the form of regulation includes:

- price regulation, which covers the price of premiums and of certain benefits paid;
- product regulation, including defining those products which are able to be offered and cover which must be offered;
- access provisions, such as community rating; and
- regulation of the fund’s business operations, such as defined minimum levels of financial reserves, the establishment of an industry-funded complaints mechanism, registration requirements, reinsurance arrangements and controls applying to contracting between private health insurers and hospitals.

Recently, Government involvement in the industry has extended to subsidising premiums in an attempt to encourage more people to take out private health insurance.

Currently, the effect of some of these forms of regulation is minimal.

Some government regulation affects the relationship between private health insurers and health service providers. For example, prescribed default benefits to be paid by private health insurers to public and private hospitals are set by Government. The low level of this default rate impacts on patients who may be required to meet extra out-of-pocket payments as a result of the low insurance cover. It also provides a low level of reimbursement in respect of private patient services provided in public hospitals.

Other regulation affects the operational aspects of insurers, impeding free competition. For example, there is some question about whether regulating premiums inappropriately curtails private health insurers’ abilities to make their own financial decisions in response to their particular commercial circumstances. Some of the regulation governing private health insurance reflects the Government’s lack of confidence in the industry’s ability to operate effectively. Premium price scrutiny has been introduced because price increases over the past few years, attributable to a range of factors, have eroded the public’s confidence in the industry. Other regulations, such as reinsurance and reserve arrangements, protect existing private health insurers and may remove incentives to operate as efficiently and effectively as possible. This support for inefficient operators may be preventing industry restructuring.

In other competitive industries, government restricts interference to the minimum required to ensure appropriate access to safe and effective services is maintained. Minimal regulation of private health insurers to protect the safety and effectiveness of privately funded health care could be achieved through a limited number of regulations to ensure that:

- all consumers, regardless of gender, age and existing health status, have access to health services of appropriate quality through affordable private health insurance cover;

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For a discussion on drivers of premium increases, see *Private health insurance, Report no 57*, Industry Commission, 1997.
• a minimum reserve level equivalent to the value of unexpired premiums and liability for unpresented claims is maintained; and
• there is no waiting period for consumers transferring from a collapsed fund.

Regulation also limits the health services that can be covered by private health insurers, and therefore the nature of the relationship between private insurance and Medicare. For example, out-of-hospital medical services and pharmaceutical copayments are partially funded under Medicare but are unable to be fully covered by private health insurance. This ensures that price signals are in place to limit consumer demand, but precludes private health insurers from insuring a full episode of care. The involvement of private health insurers in coordinated care trials provides an opportunity to pool private health insurance funds and public funds (Medicare and State Government funding) to cover a full episode of care. Access to pooled funding to purchase a full range of health services for members would allow private health insurers to create a product with minimal out-of-pocket expenses, which would be more attractive for consumers (see also discussion on coordinated care trials in chapter 5).

In summary, much of the regulation of private health insurance has been introduced to protect the balance of responsibilities between private insurance and public funding and equalise the risks between the two. However, it also affects the way the private health insurance market operates internally, restricting normal business operations and the benefits that accrue from competition. At the same time, there is a lack of regulation to ensure the quality of services funded by private health insurers is appropriate. In the future, it might be more appropriate to see a reduction in the range of regulations covering the detailed business operations of private health insurance funds alongside an expansion of regulation protecting the quality of services purchased and health outcomes achieved for services funded under private health insurance cover.

**Competition from the consumer’s perspective**

From the consumer’s perspective, the choice of acute hospital care is essentially a choice between:
• private care, which uses private health insurance funding to pay for private patient services which are increasingly delivered through private hospitals; or
• public care, which uses public sector funding to pay for services which are generally delivered in public hospitals.

Even with consumer preferences showing that, of those who had an opinion on the matter, most would prefer to go to a private hospital over a public hospital (Quints and Marks, 1997), there is still a reluctance to purchase private health insurance. The proportion of the population covered by private health insurance was 30.9 per cent at September, 1999 (PHIAC, 1999b).

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Though consumers also have the option of funding private services individually, most competition between public and private funding of acute hospital services is in terms of institutional funding, ie private health insurance versus Medicare.
Currently, private health insurance covers a particular demographic mix of consumers and is therefore not accessed equitably across the whole population. The most significant determinants are income and age. In 1995–96, approximately 63 per cent of those in the highest gross income quintile were estimated to hold private health insurance cover, compared to 20 per cent in the lowest income quintile (Schofield et al, 1997, p13). The 1998 PHIAC data indicated that people aged 20 to 30 years have the lowest rate of private health insurance (less than 20 per cent of their age cohort are covered by private health insurance) while the 50 to 65-year-old age group have the highest incidence (with more than 40 per cent of their age cohort covered by insurance). There were also above average rates of insurance cover for all age groups 65 years and older (PHIAC, 1998).

Other factors associated with lower rates of private health insurance include:

- lack of risk aversion;
- smoking or higher than average alcohol consumption;
- coming from a non-English speaking background, with the exception of Asian immigrants; and
- living in non-metropolitan regions (Industry Commission, 1997).

The lower rate of private health insurance in non-metropolitan regions may be due, in part, to the concentration of private hospitals in metropolitan regions or the lower income levels in non-metropolitan regions and occurs despite the fact that non-metropolitan residents have more hospital episodes per person than their metropolitan counterparts.

The system of private health insurance operating alongside a public insurance system offers consumers more choice about additional levels of service and access they may be prepared to purchase. Under the Australian Health Care Agreements private patient access is carefully defined to ensure that appropriate access to hospital services for public patients is not prejudiced. This requires careful balancing both by public hospitals in providing public and private acute care services and by Government which wants to make private acute hospital care attractive without suggesting that public acute hospital care is inadequate or second rate.

The consumer’s role in actually choosing what hospital to use is, however, limited. With the exception of some elective surgery and obstetrics, choice of hospital is usually determined by:

- what type of acute care is required – emergency and highly specialised services are generally provided in public hospitals;
- the hospital preferred by the specialist for procedural work; and
- the patient’s desire to obtain faster access to hospital care.

The increasing use of private hospital operators to deliver services to public patients under contract with State Governments will make it more difficult to discriminate between public and private acute hospital care. If the quality and standard of hospital accommodation services provided by private operators to public patients under contract and to private patients are similar, this will further increase the homogenous appearance of public and private hospital services.
Private acute care offers a limited range of benefits that must be assessed against the additional price charged. The cost of private health insurance premiums is a specific barrier to low-income earners and is identified as the major deterrent to private health insurance by the majority of uninsured people. This is exacerbated by the fact premiums have risen at rates greater than the consumer price index for a number of years. A further reason for the recent decline in private health insurance is dissatisfaction by consumers who unexpectedly incurred additional out-of-pocket expenses. The Industry Commission Report noted that consumers had a range of other concerns about the cost of private health insurance, including inefficient payment systems that could require an individual consumer to track dozens of bills (Industry Commission, 1997, p367).

The Commonwealth Government has recently taken steps to address some of the concerns of consumers and encourage higher rates of private health insurance membership, including:

- an additional Medicare surcharge for high-income earners who do not take out private health insurance;
- directly improving affordability through the Federal Government’s 30 per cent rebate on private health insurance premiums, premium discounts, loyalty bonuses and encouraging private health insurers to reduce gap payments;
- improving the risk profile of members through Lifetime Cover to encourage people to take out private health insurance earlier in life and retain continuous membership, and extending waiting periods for certain pre-existing conditions;
- improving the structure of the industry, particularly through changes to the reinsurance arrangements; and
- improving consumer choice and the attractiveness of the private product through simplified billing and trialing the substitution of out-of-hospital care for in-hospital care (see ‘Early discharge trials’ discussion above).

Some of these strategies, in particular Lifetime Cover and the additional Medicare surcharge for the uninsured, could be viewed as effectively limiting choice for consumers, but universal access to Medicare means consumers are still able to choose between public and private acute health care.

The industry has also taken steps to increase the attractiveness of private health insurance by expanding the range of private health insurance products, with a particular focus on less expensive insurance policies that include, for example, agreed front-end-deductible payments.

The increase in contracting with hospitals and the development of simplified billing arrangements are also expected to enhance the attractiveness of private health insurance for consumers. Most private hospitals and day surgeries have entered into at least one contract with private health insurance funds and most large private health insurers are paying out a large proportion of their benefits under contracting arrangements.26 Far fewer agreements

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26 For example, the majority of benefits paid by HCF, a major player in the New South Wales private health insurance market, in 1997-98 were covered by HPPAs, that is, more than 98 per cent of all private surgical admissions and 85 per cent of all private same day procedures (HCF, 1998).
have been reached with doctors, although, through mechanisms discussed earlier, some private health insurers have negotiated fixed-fee arrangements with practitioners.

All of these arrangements attempt to enhance the private health insurance product and address some of the concerns of consumers by providing:

- some certainty about the out-of-pocket costs that will be incurred and, where possible, eliminating out-of-pocket costs altogether; and
- simplifying reimbursement, subsidy and payment arrangements between funders and service providers.

Despite these reforms, there remains a need for fundamental change in the way services are managed and integrated for individual consumers. One way the product could be enhanced to incorporate evolving best practice in health care would be to introduce better integration of health care across a range of services and settings.

There may be potential, in the future, for private health insurers to facilitate integrated care for their members, particularly across private sector health services, however regulatory restrictions have limited the opportunities for private health insurers to initiate coordinated care activities, given their current inability to pay for non-hospital services.

Coordinated care trials (see chapter 5) may provide a suitable forum in which private health insurers could offer cover for appropriate non-hospital services, while reducing their exposure to high hospital costs. For those with private health insurance, the advantages of better coordinated care could include better access to community support services, greater flexibility in the care of patients resulting in reductions in avoidable hospitalisations and better health outcomes.
Summary

Due to the different mix of services they offer, in many circumstances there is relatively little competition between the public and private sectors. Where the sectors do overlap in their acute hospital service provision, it is not yet possible to assess whether there is any significant difference between the quality of medical services and health outcomes achieved by either sector.

Where there is potential competition for private patients, hospitals compete for the services of specialist practitioners who generally dictate the location of private patient treatment, leaving patients with little choice in that selection.

There is, however, potential competition between public and private hospitals for private patients, with an increasing number of private patients using private hospitals rather than public hospitals. The increase in State Government contracting with private operators to provide public hospital services also introduces an element of competition and contestability into the provision of public patient services, but risks blurring the distinction between public and private acute hospital care. There is also competition between public and private hospitals for medical specialists and this has resulted in the development of conveniently co-located private hospitals partly in an attempt to attract medical specialists to work in public hospitals.

Overall, there has been an increasing focus on improving the efficiency of acute hospital services across both public and private hospitals, with some level of success as throughput has increased and length of stay has decreased. Both sectors are more efficient at providing the range and number of services that they currently provide. However, there is still scope for further improvements in efficiency, particularly in private hospitals, as demonstrated by the variation in charges across hospitals for the same procedures.

Some of the contracting arrangements introduced to increase competition between acute hospital providers have the potential to further increase the efficiency of the acute care hospital sector while maintaining checks and balances on private sector operations.

Arrangements to contract with private hospitals to provide public services are too new to assess their impact on efficiency and quality. Given that the quality and outcomes of some hospital services are difficult to define and monitor, there may be some risk inherent in outsourcing these activities. However, this would have to be weighed up against the possibility of lower quality and less efficiency if the services continued to be delivered by the public sector without definition, monitoring or scrutiny.

Arrangements for private health insurers to contract with private hospitals for the delivery of private patient services are also in their infancy. They have the potential to increase the efficiency of the private hospital sector, which could in turn result in private acute hospital care becoming a more attractive and viable alternative to public...
acute hospital care. However, they could also jeopardise the long term viability of private hospital care if they are abused by either of the negotiating parties. The price differential between public and private insurance will determine whether consumers are ultimately prepared to purchase the private hospital product. There have been some recent moves to reduce this price differential; for example, the Federal Government’s 30 per cent rebate on private health insurance and the introduction of front-end deductible policies by private insurers. However, both price and value for money must improve as a result of contracting before significantly more consumers will be prepared to purchase the private hospital product.
Case study 1: The provision of public hospital services

Introduction

The nature of public hospital service delivery in Australia is changing as public hospitals come under increasing pressure to account for their actions and results. These pressures have arisen from:

- the State Governments’ increasing emphasis on accountability as they evolve from funders to purchasers;
- budgetary constraints, which require greater efficiency; and
- the push for less State Government involvement and the private provision of public services where possible (largely in response to national competition policy, but also as part of experiments to split the funder and provider roles and the desire to shift liability for capital expenditure to the private sector).

Budgetary pressures are not new; public hospital managers have long argued their budgets are inadequate to meet the community’s inexhaustible demand for services. More recently State Governments have claimed that public hospitals are under pressure due to the decline in private health insurance coverage resulting in more public patients and reduced hospital income as the number of private patients in public hospitals declines.

National competition policy and public hospitals

National competition policy aims to ensure resources are allocated in the most efficient way.

A key tenet of the policy is competitive neutrality, which requires that Government-owned service providers that face actual or potential competition from the private sector do not receive a net competitive advantage (Samuel, 1999, p6). Competitive neutrality does not, however, override policy objectives and recognises that such an advantage or the regulation of competition may by justified in the public interest. It requires these decisions to be conscious and transparent (Samuel, 1999, p7). National competition policy does not require measures such as privatisation, purchaser-provider splits or competitive tendering (Samuel, 1999, p9).

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27 The term ‘public hospital services’ refers to services provided to public patients regardless of whether they are actually provided in traditional public hospital settings. Under the 1998-2003 AHCAs the Commonwealth and the States have agreed that public hospital services may be provided in any appropriate environment, provided that patients continue to receive care free of charge, on the basis of clinical need and within a clinically appropriate time.
The President of the National Competition Council, Graeme Samuel, said that, under national competition policy, in the long term, public hospital services:

will ultimately be provided by accountable organisations through explicit contracts with government departments, irrespective of whether these agents are public, private charitable organisations or private-for-profit organisations (Samuel, 1999, p14).

The major competitive advantage which public hospitals currently enjoy in their provision of hospital services for private patients is their differential tax treatment. While tax treatment varies between jurisdictions, the major differences relate to public hospital exemptions from wholesale sales tax, land sales tax, stamp duties, financial institutions duty, debits tax, payroll tax and company income tax. Whilst there has been a good deal of discussion regarding the advantage which public and not-for-profit hospitals receive due to their fringe benefits tax exemptions, the former Victorian Government has concluded that this is not a competitive advantage under the parameters of National Competition Policy (Victorian Government, 1998, p77).

Public sector organisations may also face competitive disadvantages due to accountability requirements or restrictions on managerial flexibility imposed by their Government ownership. The Victorian Health Services Policy Review discussion paper identified the following competitive disadvantages of public hospitals:

- previous Medicare Agreements forced public hospitals to limit private patient charges to an amount agreed between the Commonwealth and State Health Ministers;
- public hospitals have generally not contracted with private health insurers for higher rates of health insurance subsidies for private patients under Hospital Purchaser Provider Agreements. In addition, the second tier default benefit level mechanism is not open to public hospitals and the structure of default benefits does not treat public and private hospitals equally;
- public hospitals are precluded from keeping private patient fee income under the Victorian WEIS public hospital funding formula and similar arrangements may apply in other States;
- unlike private hospitals, public hospitals cannot access the PBS for private admitted patients; and
- public hospitals are unable to obtain a patient episode initiation fee for pathology services from the Health Insurance Commission (Phillip Fox and Casemix Consulting, 1999, pp65–66).

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28 Because public hospitals do not have Hospital Purchaser Provider Agreements with private health insurance funds, private health insurers reimburse the treatment of private patients in public hospitals at a standard default rate which is outlined in legislation.

29 See Chapter 3, Competition among providers for institutional funding for explanation of second tier default.
Emerging trends in the provision of public hospital services

There are expected to be three changes in the provision of public hospital services:

- public providers of public hospital services will continue to become more accountable and efficient;
- public providers of public hospital services will increasingly outsource specific, defined services to private sector providers; and
- private providers will be increasingly contracted to operate public hospitals and will provide a full range of public hospital services.

The change of government in Victoria could, however, lead to a reversal of the trend in that State to contract out the operation of public hospitals. Other jurisdictions are also likely to be closely examining the outcomes of projects already underway.

Increased efficiency and accountability of public hospitals

If average length of stay is a true measure of efficiency, then public hospitals have become more efficient during the 1990s. Table 8 shows the changing nature of public acute hospitals activity in Australia.

<table>
<thead>
<tr>
<th>Table 8: Public acute hospital activity 1993–94 and 1997–98</th>
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<td>1993–94</td>
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<tr>
<td>Separations ('000s)</td>
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<tr>
<td>Same day separations ('000s)</td>
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<td>Same day separations as a percentage of total</td>
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<td>Separations per 1,000 population</td>
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<td>Average length of stay (days)</td>
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<td>Average length of stay, excluding same day separations (days)</td>
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Source: AIHW, 1999, Table 4.1.

Between 1991-92 and 1995–96, government real per capita recurrent public hospital expenditure increased by 4.5 per cent (Productivity Commission 1998, p310). Separations per 1,000 population increased by 8.4 per cent between 1993-94 and 1997-98 (AIHW, 1999, Table 4.1). The increase in the proportion of same day separations has provided large cost savings for public hospitals although some of these services are new services rather than
substitutes for traditional inpatient services. Other innovations in the public and private sector to reduce costs include:

- step-down facilities (where patients are transferred from an acute care ward to a facility where their progress is monitored less intensively); and
- ‘hospital in the home’ programs (where acute care is provided in a non-hospital setting).

Victoria estimated that its progress in defining services and specifying standards for private sector contracting will change service arrangements for the State’s public hospitals and have flow-on effects to public hospital operating arrangements in about two years. In Victoria, current private sector definitions and standards represent best practice (Urlich, 1999, pers comm).

Measuring changes in accountability is more difficult. While it is possible to consider accountability in terms of the effectiveness and efficiency of the health care system, socio-economic and environmental factors, such as education and housing standards, also affect outcomes.

The most important recent development in increasing hospital accountability may be the move towards using output-based DRG information systems for funding or management information. These provide uniform and therefore more comparable reports of activity from hospitals within each jurisdiction.

The increasing focus on evidence-based medicine and attempts to better identify and prevent adverse effects are other important moves towards increasing accountability. Three major studies on incident monitoring and reporting are currently underway:

- Quality Assurance Royal North Shore, covering Royal North Shore, Hornsby, Ryde and Seventh Day Adventist hospitals in Sydney;
- Limited Adverse Events Screening, covering 13 hospitals in Victoria, Queensland and New South Wales; and
- the Australian Incident Monitoring Study, which covers all hospitals in South Australia and the Northern Territory and one metropolitan network and four rural consortia in Victoria, and may be extended to Western Australia and the Australian Capital Territory (Productivity Commission, 1999, p260).

Benchmarking of hospital activity is also occurring at both the national and local levels. Benchmarking at the national level focuses on broad outcome and output measurement based on comparative data, while benchmarking at the local level focuses on the processes that lead to the outcomes (NHMBWG, 1998, p59). Benchmarking activities are being undertaken by many organisations, including the Australian Catholic Healthcare Association, the Australian Council on Healthcare Standards, the Cardiothoracic Unit at the Royal Perth Hospital, the Wentworth Area Health Service in New South Wales and Women’s Hospitals Australia and the Australian Association of Paediatric Teaching Centres (NHMBWG, 1998, pp96–99).

30 These figures have also been influenced by changes to the classification of dialysis and chemotherapy patients due to financial incentives which favour admitted patient activity over non-admitted patient activity in some States.
Public hospitals are now required to be directly accountable to their patients through public patient charters, which inform public patients of the services they can expect to receive and where they can get further information or make a complaint. In addition, the Victorian Department of Human Services is tendering to develop a model for the ongoing monitoring of patient satisfaction to provide reliable and comparable information on patient perceptions of their hospital care (Productivity Commission, 1999, p258).

**Outsourcing individual public hospital services**

Individual hospital managers may use private organisations to provide business and clinical services for their hospitals, such as payroll management and pathology and diagnostic imaging services. Contracts for such services must specify and define the type and quality of services being purchased.

A 1997 United States survey (Sunseri, 1997, pp54–58) found that more than half the respondent hospitals had outsourced six business functions (pest control, waste management, biomedical engineering, laundry/linen, clinical equipment maintenance and collections). The services all received mean ratings greater than three on a four-point scale of satisfaction. More than two-thirds of the hospitals built quality improvement specifications and assumption-of-risk requirements into contracts with private service providers.

The survey found outsourcing of clinical functions was less common, with four clinical functions (dialysis, speech/speech pathology, durable medical equipment and anaesthesiology) outsourced by more than 40 per cent of participating hospitals. All outsourced clinical functions received mean ratings greater than three on the four-point scale of satisfaction. More than 80 per cent of contracts for clinical services included quality improvement requirements and almost 70 per cent required service providers to assume some risk.

Details on outsourcing in Australia are not readily available, but it appears hospitals are making outsourcing decisions for financial reasons on a case-by-case basis: hospitals may continue to provide their own services where a potential contractor cannot deliver the service more cheaply, even if the contractor satisfies the hospital’s other requirements.

The 1996–97 annual report of the Western Australian Health Department (WA Department of Health, 1997) made limited reference to the scope for outsourcing components of public hospital services. Contracts worth around $50 million (4.2 per cent of the Department’s gross expenditure) had been awarded as at 30 June 1997, with an expected saving to Government of $6.6 million. A further $40 million (3.4 per cent of the Department’s gross expenditure) of non-core services were retained after market testing showed it was not commercially viable to award contracts.

There is also an increasing trend for private hospitals to purchase services from the public sector. This is particularly common for co-located hospitals.
Private sector operators of public hospitals

It has been argued that private sector operators may be able to build hospitals and operate hospitals more efficiently than the public sector and there are instances across Australia where governments have, with varying success, contracted private operators to do so. This type of contracting requires governments to identify potential projects and to then decide on transferring risk for capital expenditure and transferring risk for recurrent costs.

It is important to note that the private not-for-profit provision of public hospital services has a long history in Australia. Religious organisations have been providing public hospital services since last century, when the Sisters of Charity arrived in the colony of New South Wales, and established St Vincent’s Hospital in Potts Point in 1857. The role of religious organisations in providing hospital services continued, and between 1880 and 1901, 14 Catholic institutions providing health care and staffed by religious sisters responded to requests to come to Australia.

It is estimated that 40 per cent of Australia’s public hospitals will require rebuilding or replacement in the next 15 years, at a cost of $22.5 billion.

Proponents of private sector provision of public hospital services argue that private sector operators have more ready access to capital for the construction of infrastructure. It is likely, however, that governments would be able to access capital at a lower price, although they may choose not to (for example, the former Victorian Government limited government borrowing in an attempt to regain its AAA credit rating).

Some public hospitals have contracted private sector operators to provide management services, indicating some State Governments believe private providers can build infrastructure and deliver services more efficiently than the public sector (although Modbury Hospital in South Australia provides an example where it appears that the contracted private sector manager was unable to operate at the agreed price) (Healthcover, 1999). The issue remains contentious due to the difficulty of measuring efficiency. Healthscope has made an abnormal provision in its accounts for future losses on the Modbury Hospital, which it expects will continue to operate at a loss until the contract expires in 2010 (Healthcover, 1999, p9).

There are several models for engaging private operators of public hospitals that vary depending on who builds and/or owns the infrastructure, who operates the services and how risk is transferred for capital and recurrent costs:

- **Build, Own, Operate:** The private sector operator constructs and owns the infrastructure and operates the hospital. For example, LaTrobe Regional Hospital, Victoria;
- **Build, Own, Operate, Transfer:** The private sector operator constructs the infrastructure, retains ownership for a specified period of time, and operates the hospital. After the specified period of time, ownership of the infrastructure is transferred to the State. For example, Hawkesbury Hospital, New South Wales;
- **Build, Own, Lease-back:** The private sector operator constructs and retains ownership of the infrastructure. The Government leases the infrastructure from the private sector owner and operates the hospital. For example, Mt Gambier Hospital, South Australia;
• Government-owned, Privately Operated: The infrastructure is owned by the Government, but the hospital is operated by the private sector organisation. For example, Mersey Hospital, Tasmania; and

• Build, Own, Separately Operated: One private sector organisation constructs and retains ownership of the infrastructure and a second private sector organisation operates the hospital. There are currently no hospitals operating according to the BOSO model in Australia.

There does not appear to be substantial transparency in governments’ tendering decisions. The former Victorian Government accepted tenders which were equal to or lower than the projected cost for a public sector operator if the bid is satisfactory in all other areas (Urlich, 1999, pers comm), but it is not clear how it chose a preferred tenderer from those that met the requirements, but were not equal in all respects.

Owners and operators may receive either separate payments for capital and recurrent costs or a combined income stream for both; this will be partly determined by which model for engaging the private sector is chosen. There is an increased risk operators will charge higher prices under the one payment stream model to ensure their capital costs are covered even if throughput is lower than expected. The Government may be able to minimise the risk of making higher than necessary payments by using a sliding scale based on throughput, similar to the step-down contracts being trialed between some private health insurers and private hospitals, whereby a fixed rate is paid for a specified number of separations and a proportionate rate is paid for the separations in excess of the threshold. The one payment stream model requires governments to find a joint tenderer, with both the builder and the operator of the hospital prepared to share financial risks.

Contracting independent organisations to provide public hospital services requires Governments to define clearly what they want to purchase. In the past this has been done on the basis of inputs, but it is anticipated there will be a move towards ‘service agreements’ which describe services and expected outcomes, but allow for flexibility in actual service delivery. Such contracts should specify that providers follow treatment protocols and best practice, rather than defining how input costs should be managed. Service agreements depend upon more co-operative and collaborative relationships between governments and service providers (Goddard et al, 1997, p21).

Any analysis of the potential savings from contracting must also consider the full range of costs involved, including:

• bargaining costs (that is, the costs of negotiating the contract and any subsequent amendments to it) and the cost of disputes (Vining and Globerman, 1999, p81);

• ‘opportunism’ costs (that is, the cost of one party acting in bad faith in an attempt to maximise outcomes for itself) (Vining and Globerman, 1999, p81);

• transaction and monitoring costs to ensure the terms of the contract are met (increased transaction costs in contracting situations may reflect an inadequate amount of resources being committed to transparency and accountability under traditional non-contracted hospital funding arrangements) (Vining and Globerman, 1999, p81); and
• contestability costs (it could be argued that Governments must retain the capacity to provide comparable services or to engage alternative providers if they are to ensure they get maximum value from contracts with private operators).

Governments and the private sector will be better able to complete cost-benefit analyses with greater accuracy as experience with contracting grows. Already in Victoria private providers’ tenders have been increasingly approaching the forecast public sector costs (Urlich, 1999, pers comm), putting an end to the large savings that were initially available. More accurate cost and risk assessments are likely to lead to more marginal savings through contracts with the private sector.

Many of the contracts which govern the private sector operations of public hospitals run for periods of between 15 and 25 years. This provides private sector operators time to earn a sufficient return on their investment, but the difficulty in accurately forecasting future conditions poses a significant risk to both operators and governments.

**General issues surrounding private sector involvement**

The decision to involve the private sector in the delivery of public hospital services raises several issues for governments.

**Risk**

States may decide upon a private sector owner to transfer risk in relation to infrastructure, maintenance, upgrade and the costs of technological change and obsolescence.

• Contract negotiations should allocate risks in a way that maximises the benefits of competitive tendering and contracting. For example, an operator faced with risks it is not best placed to manage may charge a high-risk premium, while an operator that does not accept the risks it is best placed to manage may lack incentive to improve performance (Productivity Commission, 1998, p75).

• Public hospital managers face the risk that suppliers of outsourced services may be unable to deliver as agreed and that alternative suppliers may be unavailable. In addition, the hospital may no longer be equipped to deliver the service in-house.

While Governments may try to transfer risks arising from technological change and population change through contracting with private sector operators to run public hospitals, it has been argued a State may be found liable for a private sector owner or operator’s actions as an ‘agent’ of the State. In this case, the State has a duty of care to patients to ensure the contractor is qualified, meets its obligations and exercises reasonable care (Storr, 1998).

The type of contract will be a key factor in the ability to transfer financial risk. Contracts based on throughput do not effectively transfer the risk of increased demand to the operator, although a cap on total funding can reduce the risk to the Government. Contracts with capped funding however, can end up transferring the risk to patients unless there is adequate definition of services in the contract and monitoring of the contract. Contracts based on outcomes, such as the delivery of specific services to a defined population, more successfully transfer risk: the
operator accepts the risk that demographics or clinical procedures may differ from forecasts, although the Government retains the risk that it has not accurately defined its requirements.

Teaching, training and research

It is unclear whether private sector operators are principally concerned with cost issues and would therefore be less concerned with undertaking research and teaching. The evidence on the issue is mixed. For example, there is anecdotal evidence that staff who have moved from public hospitals to the new LaTrobe Hospital have been offered a significant increase in the level of staff training.

A 1996 KPMG report undertaken on behalf of the Commonwealth Government and State Governments, found that:

- much teaching and training in public hospitals occurs in a patient care context and thus constitutes ‘multiple products’, which cannot and should not be disaggregated into lower level components for costing purposes;
- it may be inappropriate for hospitals to separately identify teaching and training grants at cost centre level;
- teaching and training activities in public hospitals may be associated with ‘slow-down’ and possibly higher consumption of diagnostics and consumables (although measurement of this is difficult and current views are based on perception only); and
- there is a widely held view that teaching and training activities in public hospitals are associated with improved or higher patient care (although there is little conclusive evidence to support this in Australia) (KPMG 1996).

The former Victorian Government was considering tenders from the private sector to operate the Austin Hospital. The Austin is one of Australia’s largest teaching hospitals, incorporating university and other teaching institutions, research institutes and 563 hospital-based researchers (Victorian Government, 1998). It would have been the first time the operation of such a large teaching hospital had been offered to the private sector. Although the Government had aimed to develop outcome indicators for teaching, training and carefully specified outcomes and costing would need to have been included in the contract to ensure that teaching and training standards were protected. The newly elected Victorian Government does not intend to proceed with this tendering process.

The issue of funding levels and the quality of teaching, training and research is of particular concern to the Commonwealth, which recognises the strategic importance of maintaining standards in this area. According to the Wills Report, the Commonwealth Government and the higher education sector together provide 47.5 per cent of funding for medical and public health research (Wills, 1998, p150). Given the significance of the Commonwealth’s contribution, it is appropriate that the Commonwealth continues to monitor the impact of private sector provision of public hospital services on teaching, training and research.
Quality

It has been argued that hospital managers may be unable to effectively control the quality of outsourced services and that private sector operators will not be as easily influenced by or feel as accountable to governments. These arguments may point to private sector providers focusing on cost and profit at the expense of quality. This problem should be avoidable by the inclusion of clear quality requirements within the terms of contracts, but consensus on quality standards and measures has so far proved elusive, despite such multilateral processes as the National Health Ministers’ Benchmarking Working Group.

Transfer of knowledge and skills

The shift of services provision to the private sector may risk the loss of some skills from the public sector. Governments need to decide whether there is intrinsic value in maintaining a skills base within the public sector and, if so, at what point contracting should stop. The public sector skills base gives governments contestability, benchmarking and bargaining capacity.

Co-location

The predominant co-location model involves a separate private hospital on the same campus as a public hospital. Other models include a private hospital occupying a ward of a public hospital, and a private hospital adjacent to a public hospital.

The issues which apply to outsourced services generally also apply to the sharing of services by co-located hospitals. The AHMAC Working Party on Co-location and Privatisation of Hospital Services has identified additional issues specific to co-location:

- management of shared risk in relation to shared sites;
- methods for allocating public hospital patients to private hospitals for treatment; and
- control of emergency department and other medical work volumes (in public hospitals given the opportunities to direct privately insured patients to co-located private hospitals) (AHMAC, 1999).

The advantages of co-location for a private hospital are:

- lower operating costs due to shared facilities such as pathology, radiology, laundry, catering and parking;
- an increased customer base through patients admitted via the public hospital accident and emergency ward;
- greater access to doctors;
- greater access to research and development, new equipment and new techniques; and
- greater opportunities to provide private services in rural locations, which may be unable to support a separately sited private hospital, but may sustain a co-located private hospital.
The advantages of co-location for a public hospital are:

- decreased operating costs by sharing facilities;
- greater access to doctors; and
- better utilisation of equipment.

The disadvantages of co-location for both public and private hospitals are:

- loss of total management control due to contractual obligations to the co-located hospital; and
- increased dependency on the operator of the co-located hospital to jointly manage risks.

In addition, there may be unforeseen problems. For example, there has been a case of a private hospital withdrawing from an agreement to provide equipment sterilisation services for its co-located public hospital because it did not agree with the provision of particular types of treatment provided at the public hospital (AHMAC, 1999). The potential for situations such as this to disrupt services must be considered when co-located hospitals share facilities.

It is unclear whether co-located private hospitals that have been established recently are delivering the financial gains private hospitals had expected. Anecdotal evidence suggests that they are not, however this may not be uniform for all co-locations; for example, the New South Wales Health Department believes that North Shore Private Hospital has gained market share and benefited from its association with Royal North Shore Hospital and that the value of this association could have been reflected in a higher lease payment than was originally negotiated (AHMAC, 1999).

There might be some pressure on private health insurance premiums as some private patients move from public hospitals to co-located private hospitals where fees and charges for private patients are higher.

In addition, co-location potentially provides some opportunities for cost-shifting of medical services (such as emergency department and non-admitted patient services which would otherwise have been provided to public patients). The AHCAs (Department of Health and Aged Care, 1999d) do not prevent this type of shift in the site of service delivery under agreed Measure and Share provisions. However, such shifts in service provision need to be overt and measurable and evaluated to ensure that the provision of services for public patients is maintained.

**Summary**

The Commonwealth Government and the State and Territory Governments face several challenges in relation to the future provision of public hospital services. Each of these challenges hinges on the quantification and costing of the components of public hospital services and mechanisms for achieving an appropriate balance between efficiency and quality in the delivery of those services.
Case study 2: Department of Veterans’ Affairs

Background

In the past, veterans were entitled to treatment in Repatriation Hospitals (RH) that were owned and operated by the Commonwealth Government through the Repatriation Commission. In 1988, following the recommendations of the Brand report (Brand, 1985) and a review of the health program by the Department of Veterans’ Affairs, the Commonwealth Government decided to divest itself of all RHs. This was predicated on Arrangements with State governments to:

- provide veterans with access to a greater range of hospital and specialist services;
- improve the access of veterans and war widows to hospital services closer to where they lived; and
- enable the retention of the RHs as viable institutions.

The Repatriation Commission achieved these objectives through a combination of integration of Repatriation Hospitals into State systems, sale of RHs and greater use of private hospital services. As each of the RHs were integrated into the State or sold, the Repatriation Private Patient Scheme (RPPS) was introduced into that State. Under the RPPS, the Repatriation Commission has identified three tiers of preference for hospital admissions.

The First Tier is public hospitals, former RHs and selected Veteran Partnering private hospitals. This means that eligible veterans and war widow(er)s can receive treatment at Departmental cost, as a private patient, in a shared ward, with the doctor of their choice. Admission to a Tier 1 hospital does not require prior financial authorisation from the Department.

The Second Tier is contracted private hospitals. If treatment cannot be provided within a reasonable time in a Tier 1 hospital, there is a system of Tier 2 hospitals available to provide care. Admission of an entitled person to a Tier 2 hospital requires prior financial authorisation from the Department.

The Third Tier of hospital care is non-contracted private hospitals. As with the Second Tier, prior financial authorisation is necessary from the Department before a veteran is admitted. Approval to attend a Tier 3 hospital would only be given when the service was not available at a Tier 1 or Tier 2 hospital.

In an emergency, a Repatriation patient can be admitted to the nearest hospital, public or private, without reference to the Department.

The Repatriation Commission now purchases rather than provides all hospital services to veterans. Hospital services are provided to veterans as private patients:

- in public hospitals under a combination of block payments and fee-for-service payments; and
- in private hospitals on a fee-for-service basis under Hospital Service Agreements with private operators in all States.
Of course, as members of the general public, all veterans are also entitled to admission as public patients in State public hospitals.

These new arrangements have led to changes in usage and expenditure patterns. Figure 3 shows that since the introduction of the reforms, Commonwealth expenditure on institutional health services for veterans in public hospitals has declined, while there has been a marked increase in the expenditure by the Department of Veterans’ Affairs on services in private hospitals.

The Repatriation Private Patient Scheme Review (RPPS) (Department of Veterans’ Affairs, 1998, p2) and the Australian National Audit Office (ANAO) noted a trend towards the use of private hospitals other than former RHs. The Department of Veterans’ Affairs expenditure on these private hospitals rose from 16.7 per cent of its total hospital expenditure in 1992–93 to 32.4 per cent in 1996–97.

Figure 3: Recurrent expenditure on acute care services by the Department of Veterans’ Affairs, 1989-90 to 1995-96 ($million)

Factors affecting competition

A competitive market should lead to improvements in choice, satisfaction and access for clients and efficiencies that will benefit the Commonwealth through lower costs.

Although the existing tiers of preference for hospital admissions result in admission of veterans as private patients to public hospitals in the majority of cases, there are several strategies that are being introduced to improve private hospitals’ ability to compete to provide services to veterans:

- the removal of the requirement for prior financial authorisation (this has occurred in some rural and remote areas usually where private hospitals are the sole available service and so, competition has not been enhanced);
• if a veteran is given approval to attend a Tier 2 private hospital then they may elect to attend a Tier 3 hospital and pay the difference in rates, thus enhancing client choice and satisfaction; and
• new ‘veteran partnering’ (VP) arrangements with private hospitals in Victoria through a competitive tendering process which provide private hospitals with Tier 1 status, ie enabling direct competition with public hospitals.  This arrangement is also being progressed in South Australia and Tasmania and will be evaluated before it is progressed in other States.

Assessment of the reforms

The changes to the provision of services for veterans were introduced to assist the Department of Veterans’ Affairs achieve its dual objectives of quality and cost-effectiveness.

Efficiency

A range of factors makes it difficult to compare the cost-effectiveness of the various funding and service delivery arrangements for hospital care for veterans:

• a lack of information about the total cost to the Commonwealth of treating veterans in public hospitals prevents the Department properly assessing whether private sector suppliers can supply services at a lower cost than the public sector (ANAO, 1998);
• there has been a problem in the past with public hospitals providing timely data (ANAO 1998). The third ANAO report (ANAO 1998) recommended the introduction of a more comprehensive penalty regime and additional incentives to encourage the provision of the data;
• the use of different classification systems hinders comparison. It is intended that a casemix classification be adopted to allow comparison of efficiency across hospitals to measure hospital input (goods and services) and output (diagnosis and treatment of illness). The Casemix Hospital Utilisation Monitoring System (CHUMS) has, since February 1998, collected information from private hospitals for a data warehouse. A new system is being developed for the collection of public hospital data; and
• it is difficult to fully compare the cost-effectiveness of block payment arrangements with fee-for-service arrangements. New arrangements with State Governments will see more fee-for-service payments and the provision of casemix data.

A standard Hospital Services Deed is now used throughout Australia for all contracted private hospitals, which sets out agreed fees and has led to greater consistency in contract negotiation (ANAO, 1997).

The adoption of the casemix classification system to benchmark public hospital services, in the second phase of the arrangements with the States, will put the Department of Veterans’ Affairs in a better position to measure the respective inputs and outputs of public and private providers.

31 Except for White Card holders where eligibility is uncertain or for respite care recipients.
Exposure to risks

The Commonwealth must carefully consider the respective risks involved in both fee-for-service funding and block payments.

Under block funding, the Commonwealth risks making an overpayment or receiving fewer services from States unless sufficient data is available to reconcile what has been paid.

The Department has not, as yet, adopted a capitation-based or population-based funding model. Under this third model, the States or private hospital operators would fully bear the financial risks, but the Commonwealth would need to be very specific in defining and monitoring appropriate care to ensure quality of service.

Effect on quality

The RPPS review (Department of Veterans’ Affairs, 1998) concluded that the scheme had, overall, successfully provided veterans and widow(er)s with access to timely, quality health care.

Ultimately patient satisfaction provides the best indicator of quality of service. The third ANAO audit report (ANAO, 1998) found that the State committees responsible for monitoring clinical standards had received minimal complaints. For instance, in 1997–98, the Victorian monitoring committee reported 38 complaints, 11 of which related to standards of care and five to discharge planning. In the same year, the Queensland monitoring committee noted an increase in complaints from 17 to 36, owing mainly to improvements in information collection. Fourteen complaints came from private hospitals, 10 from the former RH Greenslopes, seven from public hospitals and five from non-hospital care.

Accreditation also plays a major role in measuring providers’ ability to provide high quality care. DVA prefers to contract with private providers who have been either accredited or certified with an appropriate body, such as the Evaluation and Quality Improvement Program (EQUIP) of the Australian Council of Health Care Standards (ACHS). The Care Evaluation Program of ACHS is responsible for developing clinical indicators of care.

In the Department’s arrangements for public hospitals services, accreditation / certification is encouraged but not mandated. It is the Victorian Government’s policy that by the year 2000 all providers of acute services must have third party accreditation under EQUIP or certification under ISO 9000, providing a baseline indicator of quality of care.

The RPPS review remarked that the level of quality control exercised by the Department in privatised former RHs through its close relationship with Ramsay Health Care, the operator of the privatised RH hospitals in Queensland and Western Australia, was not always possible with State authorities. It was recommended that consideration be given to developing a similar relationship with private operators in those States that had opted for integration.

Simpler billing procedures are being encouraged, through electronic transmission of data.
Equity of access

All private operators are required to provide access to treatment which:

- is timely and in accordance with medical need;
- gives preference to veterans provided care of other patients is not impaired; and
- is at least equal to that provided to other patients.

Under the 1998–2003 Australian Health Care Agreements (AHCAs), public hospitals have some latitude in the provision of access to entitled veterans provided that public patients receive care in line with the AHCA Principles. Public hospitals have the scope to provide entitled veterans with access to hospital services on a par with private hospitals, so long as access by public patients continues to be provided on the basis of clinical need and within a clinically appropriate period, as required by AHCA Principle 2.

Summary

A proper comparative study of the effectiveness and efficiency of the public and private sectors as providers of hospital services to veterans is not possible. Better comparisons will be able to be made once the Department’s new arrangements with State Governments are in place and casemix data is provided by both sectors.

In terms of widening access for veterans beyond RHs and in encouraging competition for the provision of quality hospital services at a competitive price, the Department’s shift from being a provider to being a purchaser only of hospital services has been a success.

Policy changes which give preferred status to some private hospitals under the Veteran Partnering arrangements equivalent to that of first tier hospitals may assist in facilitating comparison of private hospital and public hospital service provision. In addition, further reforms such as the use of consistent purchasing methodologies for the public and private sectors with direct purchasing to individual State public hospitals would put the Commonwealth in a better position to compare services across both the public and private sectors.
4. The role of the sectors in other areas of health care

Introduction

In most areas of health care, responsibilities for providing and funding services are primarily the responsibility of either the public or the private sector, with relatively little overlap. Often, however, the public sector is responsible for funding while the private sector is primarily responsible for service delivery, for example, general practice (GP) and pharmaceutical services. Some other health services are predominantly both funded and provided by the private sector, for example, dentistry and physiotherapy.

This chapter presents three case studies to explore three areas of health care that represent quite different health care provision and funding mechanisms. This highlights issues that arise when different combinations of private and public funding and delivery arrangements operate and the effects on service provision when specific action is taken to change the mix of public and private responsibilities.

The areas of health care delivery to be considered are:

- the provision of community-based GP services, which illustrates the effect of public funding and private sector delivery;
- funding and delivery reforms to the Commonwealth Hearing Services Program, which illustrate the effect of corporatising an area of traditional public sector service delivery and exposing it to competition from private sector services; and
- changes in the public and private sectors’ roles in delivering pathology services.

Overall, these studies suggest that, with the appropriate funding mechanisms in place, there is scope for efficient and cost-effective delivery of health care in either sector.
Case study 3: Community-based general practice

In Australia, general practitioners (GPs) are largely publicly funded but work predominantly in the private sector. This case study considers the scope for, and evidence of, competition between GPs. Many factors, including information asymmetry, maldistribution of the workforce, and continuing inefficiencies in general practice limit effective competition.

Key workforce issues

In Australia, GPs (both recognised and other general practitioners\(^{32}\)) serve as gatekeepers for the remainder of the medical and hospital service system. Individuals must be referred by a GP before they can receive treatment from specialist medical practitioners or elective surgery from hospitals.

In 1996–97, 18,078 recognised GPs and 6,447 other general practitioners earned the majority of their income through GP consultations to Australians which are reimbursed under MBS. The full-time equivalent total of this workforce was 16,200, comprising 14,619 recognised GPs and 1,581 other general practitioners. From 1984–85 to 1996–97, the number of full-time equivalent GPs per 100,000 population increased from 65.8 to 87.5 (AMWAC and AIHW, 1998, p27). Only about 400 of these practitioners practise in the public sector.

The Government, as funder of general practice services, allows these practitioners to directly bill for these services, or they can be paid for by the consumer, who is then reimbursed under the MBS.

Competition in general practice

The consumer’s perspective

Information asymmetry between medical practitioners and patients means consumers are likely to accept treatments recommended by a medical practitioner. However, it is often difficult for consumers to readily compare the outcomes of services provided by medical practitioners and determine whether the services provided are ‘value for money’.

\(^{32}\) The 1998 review of the Commonwealth General Practice Strategy defined a recognised GP as ‘a doctor who has completed the Fellowship of the Royal Australian College of General Practitioners (RACGP) or has an equivalent qualification and who provides primary, continuing, comprehensive whole-person care to individuals, families and the community’. The classification distinguishes GPs from ‘other general practitioners’, who are not recognised by the RACGP. Other general practitioners continue to provide general practice-type care, under similar, though not identical, funding and service provision arrangements.
Consumers would be better able to select a practitioner suited to their needs if medical practitioners were to compete openly by, for example, advertising surgery hours, services available and fees charged. In some States and Territories regulation or legislation imposes advertising restrictions and is subject to review as part of the legislative review process of the National Competition Policy. However, in some cases the medical profession restricts such activities by its members. This is now being scrutinised by the Australian Competition and Consumer Commission, while recognising scope for competition may be validly restricted if it would place the consumer at risk, has expressed concerns that advertising restrictions unnecessarily limit the information available to potential consumers.

**Availability and affordability**

It is generally assumed that, with increasing levels of competition, providers of services will reduce their prices and devote additional resources to making their products more easily accessible and of a higher quality.

In 1996–97, 79.4 per cent of services provided by vocationally registered GPs were direct-billed, that is, provided at no price to the patient. This compares to 52.5 per cent of GP services that were bulk-billed in 1984 (AIHW, 1996, p28). The number of GP services which are bulk-billed has now plateaued.

Services provided by GPs are unreferred; that is, they can be obtained on demand. Access to these services, therefore, is dependent on the availability and affordability of the service providers. Service providers are totally free to choose the geographical location of their practices. However, there is currently heavy skewing of the availability of services towards high socioeconomic, urban locations; for example, inner-metropolitan suburbs. In 1996-97, the number of primary care practitioners per 100,000 population in different Australian regions ranged from 96.7 in capital cities to 36.0 in other remote areas. Table 9 shows the increase in numbers of full-time equivalent GPs across geographic regions from 1984–85 to 1996–97 (AMWAC and AIHW, 1999, p27).

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33 Australian regions classified into seven groups according to the Rural, Remote and Metropolitan Areas Classification.
Table 9: Full-time equivalent (FTE) GPs per 100,000 population by geographic area, 1984–85 to 1996–97

<table>
<thead>
<tr>
<th>Region</th>
<th>1984–85</th>
<th>1996–97</th>
<th>Increase in number of FTE GPs per 100,000</th>
<th>Increase (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital city</td>
<td>69.8</td>
<td>96.7</td>
<td>26.9</td>
<td>38.6</td>
</tr>
<tr>
<td>Other metropolitan</td>
<td>72.5</td>
<td>90.5</td>
<td>18.0</td>
<td>24.9</td>
</tr>
<tr>
<td>Large rural centres</td>
<td>65.5</td>
<td>83.3</td>
<td>17.9</td>
<td>27.3</td>
</tr>
<tr>
<td>Small rural centres</td>
<td>66.4</td>
<td>76.6</td>
<td>10.2</td>
<td>15.3</td>
</tr>
<tr>
<td>Other rural</td>
<td>51.9</td>
<td>59.4</td>
<td>7.5</td>
<td>14.4</td>
</tr>
<tr>
<td>Remote centres</td>
<td>41.9</td>
<td>53.2</td>
<td>11.2</td>
<td>26.8</td>
</tr>
<tr>
<td>Other remote</td>
<td>29.0</td>
<td>36.0</td>
<td>6.9</td>
<td>23.9</td>
</tr>
<tr>
<td>Total</td>
<td>65.8</td>
<td>87.5</td>
<td>21.7</td>
<td>33.0</td>
</tr>
</tbody>
</table>

Source: AMWAC and AIHW, 1999, p27.

There is a high level of competition between GPs in metropolitan locations in terms of price, which has resulted in high levels of bulk-billing, and extended operating hours. This is less frequently the case in other geographical locations. GPs face high levels of competition in metropolitan locations and this has resulted in these GPs charging the Medicare rebate which has become a de facto floor price for GP services in these areas.

For consumers in rural Australia, access to medical services is often limited to one GP, who may not practise in that location full-time. Although all levels of government continue to offer various incentives for GPs to work in these locations, supply does not match demand in all areas. The General Practice Strategy Review (GPSR) noted that, ‘[d]espite the Rural Incentives Program, there are serious deficiencies in health service provision in rural and remote communities’ (General Practice Strategy Review Group, 1998, p132). The lack of price competition in these areas means that services provided are more likely to be charged at levels above the schedule fee and the Medicare rebate. The average copayment for GPs’ services is 12.2 per cent of the schedule fee in rural areas and 19.5 per cent of the schedule fee in remote areas, compared to 7.3 per cent in capital cities (AMWAC and AIHW, 1999, p37).

Traditionally, GPs were expected to be on-call 24 hours a day as part of their normal working arrangements. Outside normal hours and after-hours care in metropolitan areas is often provided by deputising services. On-call obligations may still apply to those practising solo or in small practices in rural and remote locations because it is not financially viable for a deputising services to operate in areas where they are only providing on-call services on behalf of a small number of practitioners. The GPSR recommended that more effective methods of providing after-hours care, to be developed (General Practice Strategy Review Group, 1998, p135).
Quality issues

In a perfect market, quality of service is a factor on which different providers compete for consumers’ business. It is widely recognised that it is difficult to define quality with respect to general practice. For example, consumers may measure quality of care according to ‘interpersonal skills and personal qualities of the GP, provision of information by the GP, the length of consultation and technical competence...’ whereas GPs view the quality of their services primarily on the basis of whether the problem is solved (General Practice Strategy Review Group, 1998, p186).

The GPSR noted that consumers should be able to have confidence that the practice of their choice offers a core range of services and meets agreed quality measures, but concluded that this was not yet the case (General Practice Strategy Review Group, 1998, p108). It concluded that GPs have traditionally worked ‘in a health system that does little to support high-quality care or to encourage them to enhance quality over time’ (General Practice Strategy Review Group, 1998, p184). The Review recommends that research be undertaken to develop a comprehensive set of indicators to measure quality in general practice (General Practice Strategy Review Group, 1998, p189).

The funder’s perspective

The relationship between GPs, consumers of their services and the Commonwealth Government (as principal funder) is complex. Legally, GPs are not funded by the Government for provision of care, but charge a price for that service to the consumer who then obtains financial reimbursement from the Government under MBS.

The Government, as primary funder of GP services, has considerable incentives for ensuring a cost-effective, efficient product is made available to consumers, but, overall, competition between general practitioners has not been sufficient to encourage practitioners to improve the quality and cost-effectiveness of services themselves. The GPSR also concluded that current funding arrangements allow inefficient practices to continue and may actually be a disincentive to quality care (General Practice Strategy Review Group, 1998, p184). Where GPs have addressed accessibility and availability and where they have adopted public health initiatives (for example, immunisation), it has usually been as a result of financial incentives or disincentives offered by the Commonwealth Government.

Government incentives have also been the main triggers encouraging GPs to maintain, improve or update their skills (General Practice Strategy Review Group, 1998, p5). The Commonwealth Government’s 1991 requirement that those entitled to formal recognition as GPs first obtain fellowship of the Royal Australian College of General Practitioners, caused considerable dissatisfaction for some key professional bodies. The Commonwealth’s extensions of this requirement, that the annual number of available training places be capped, and finally, that only those with such recognition be entitled to provide Medicare rebatable services, were of greater significance to new medical graduates and overseas trained doctors to whom these restrictions primarily apply.
Efficiencies of general practice

Quantitative information on efficiency of general practice is limited, but the recent GPSR concluded that the sector is not particularly efficient (General Practice Strategy Review Group, 1998, p114). It also noted that economies of scale can improve efficiencies, with the Australian Bureau of Statistics reporting that practices comprising one to two doctors achieved lower profit margins (23.9 per cent) than those with six or more practitioners (34.1 per cent) (General Practice Strategy Review Group, 1998, p114). However in 1997, 60 per cent of practices had one to two practitioners, while only 14 per cent had six or more (General Practice Strategy Review Group, 1998, p110). Amalgamations of general practices also have the potential to create more flexible work arrangements for individual practitioners.

Other reforms, such as those adopted by physicians (including primary care and specialist practitioners) in the United States also illustrate ways of increasing the efficiencies of practices for example:

- restructuring into multi-specialty groups in which physicians are employees or employee-owners;
- employing physician-practice-management companies; and
- restructuring around physician-hospital organisations which provide integrated services.

Inefficiencies in general practice organisations are of concern, given the large turnover of this sector. In 1994–95, the general practice sector had a gross income of $2,817 million and operating profit before tax of $778 million, and, on average, gross fees from medical services for both full-time and part-time doctors amounted to $124,900 per doctor, or 3.5 times the yearly income of an Australian on average weekly earnings for that period (ABS, 1999a; ABS, 1999c).

The Commonwealth Government has introduced various arrangements to encourage practices to operate more efficiently to maximise the cost-effectiveness of health expenditure; for example, by improving the quality and range of services available to patients and acquiring the infrastructure to support quality care (General Practice Strategy Review Group, 1998, p118).

Barriers to entry to the market

Governments restrict entry to the medical services market to ensure providers meet competency and knowledge requirements. The Commonwealth Government has also limited the growth rate of the full-time-equivalent GP workforce by:

- restricting access to Medicare rebates to recognised GPs;
- capping at 400 a year the number of practitioners able to enter the RACGP training program to obtain that recognition; and
- restricting access of overseas-trained doctors to register to practise.

The Australian Competition and Consumer Commission (ACCC) is considering the anti-competitive nature of restrictions on overseas doctors against the public benefit that may be served by limiting total Government health outlays through restrictions on supply.
The ACCC has also investigated unconfirmed claims that GPs have engaged in price-fixing by collectively refusing to bulk-bill patients in areas with large numbers of practitioners, which would breach the Trades Practices Act.

**Quality of care**

While the Commonwealth Government reimburses patients who obtain GP services, it has relatively few ways to ensure that practitioners are competent and aware of new treatments on an ongoing basis (General Practice Strategy Review Group, 1998, p196) and provide safe, high-quality care (General Practice Strategy Review Group, 1998, p185). Recognition of a medical practitioner as a service provider whose services can be reimbursed under Medicare has been a relatively routine, administrative procedure undertaken by the Health Insurance Commission. MBS reimbursement for GP services does not take account of the specific care and treatment that make up the service, nor is it dependent on the service being of satisfactory quality or outcome.

The Commonwealth Government has offered blended payment arrangements to GPs to improve their services through the Better Practice Program and now the Practice Incentives Program. These schemes supplement the existing fee-for-service payment for practices meeting certain quality standards such as offering flexible consultation times, providing access to 24-hour care, and making away-from-surgery visits. Payments are non-volume dependent and now target additional specific activities identified by the profession, such as electronic prescribing or hosting undergraduate student placements.

The Government, through the Professional Services Review processes, also investigates practitioners who provide excessive numbers of services. The GPSR recognises, however, that ‘there are few brakes on doctors who choose to engage in high-throughput medicine’ and that these processes identify relatively few cases (General Practice Strategy Review Group, 1998, p185). The number of services provided by full-time equivalent practitioners in 1996–97 averaged 6,500 (AIHW, 1996, p16). However, about 1,700 GPs averaged 400 or fewer consultations per year, while about 300 averaged 15,000 or more (General Practice Strategy Review Group, 1998, p257).

In consultation with the Australian Medical Association, the Government has identified an upper limit on the number of services a practitioner may provide in a given period. Practitioners who provide 80 or more services per day on more than 20 days in a year, will be deemed to have engaged in inappropriate practice unless they are able to demonstrate that exceptional circumstances applied. However, this upper cap will not make a significant difference to overall MBS outlays, given that, in 1996, the average number of services provided by GPs was closer to 25 per day.

The Government also provides funding to encourage and assist GPs to make better use of computer facilities and information technology. This promotes faster payments and services for both GP and the consumer and more efficient service provision for the Commonwealth as funder. The GPSR noted that use of information technology in general practice is presently very low, with privacy and confidentiality concerns, lack of technical knowledge and lack of hardware and software acting as barriers to the adoption of new technology (General Practice Strategy Review Group, 1998, p223).
The provider’s perspective

The services provided

Many GPs now prefer to practise in urban locations and under arrangements that allow a better balance of professional and personal responsibilities (General Practice Strategy Review Group, 1998, p123; AIHW, 1996, p45). To some extent, over the past 30 years, GPs, particularly those in metropolitan locations, have experienced reductions in the complexity of services they provide (General Practice Strategy Review Group, 1998, pp86–87). While GPs practising in rural and remote locations are still called on to provide an extensive range of services (General Practice Strategy Review Group, 1998, p86), it is now more common for patients in urban locations to obtain such services from specialist practitioners after an initial GP consultation. The GP workforce is also now largely excluded from providing services in hospitals. However, some GPs are expanding the range of services they offer to niche specialisations, for example alternative therapies, sports and exercise medicine (AMWAC and AIHW, 1999, p45).

In certain circumstances, GPs compete with specialists. Patients seeking obstetric care and minor surgery can sometimes receive these services from a GP or seek a referral to an appropriate specialist. Although arrangements by which GPs refer patients to specialists have the potential to be anti-competitive, under most circumstances specialists take into account the views of the patient as to which specialist they wish to be referred to before finalising the referral. For example, if a patient requests that a particular anaesthetist provides anaesthetic services to that patient it is expected that most surgeons would accommodate such requests even if the anaesthetist is not normally one that the surgeon works with; provided of course that the anaesthetist has the credentials to perform the services at the particular hospital.

More competition?

It is possible that competition in many parts of Australia could be increased by removing restrictions on training places, however this may lead to an unacceptable increase in overall expenditure on GP services.

Alternatively, further Government intervention could be introduced, for example, the regulation of practice locations through planning mechanisms. This could be accompanied by competitive bidding for Medicare provider numbers in metropolitan areas, with a lower price charged in rural and remote areas to encourage GPs to work in these areas. Competition to gain access to the market would not in itself guarantee that GPs would provide good quality, cost-effective services, unless the annual renewal of the licence to practise was dependent on defined quality standards being met.

However, given the unconditional open-ended reimbursement for primary care combined with the existence of a floor price and an increasing total number of services, the possible impact of increased competition amongst GPs on government funding needs to be carefully assessed before extensive development of competitive models for entry to the primary health care market is undertaken.
Case study 4: Commonwealth Hearing Services Program

The Commonwealth Hearing Services Program aims to reduce the consequences of hearing loss for eligible clients and the incidence of hearing loss in the broader community. The Program enables, (mostly) elderly clients and children to access hearing assessments and appropriate treatments to improve hearing; for example, the fitting of hearing aids. The 1997 reforms to the Program have resulted in wider private sector involvement in the provision of publicly funded services. This has affected:

- the scope and outcomes of services provided under the program;
- the efficiency, effectiveness and cost of the program; and
- demand for and access to the program.

History

There have been three major changes in the Hearing Services Program in the past 10 years. In 1991–92, Australian Hearing Services (AHS), which provided all services to eligible clients, became a statutory authority. Until around 1993, the Government provided services to about 65 per cent of people wearing hearing aids.

Pre-voucher system

The eligibility criteria for the program widened to cover an additional 380,000 part-pensioners in April 1993 and a further 40,000 people of pension age with income below the age pension cut-off limit in June 1994. Under these widened criteria the Government assumed responsibility for over 75 per cent of people requiring hearing services in Australia. During this period, the program was delivered entirely through Australian Hearing Services, which subcontracted to the private sector when its capacity was exceeded. Under these subcontracting arrangements AHS determined who would provide services to individual clients.

Voucher system

On 1 November 1997, the current system was introduced whereby eligible clients are issued with a voucher which they can redeem for services provided by either AHS or any one of the 125 accredited private providers. Under the voucher system, AHS and private providers compete to provide publicly funded services to eligible consumers. Currently all people under 21, pensioners, veterans, Comcare clients, members of the defence forces and some Commonwealth employees are eligible. It is estimated that there will be approximately 190,000 full-pensioners, 75,000 part-pensioners, 85,000 veterans and 40,000 children participating in the program in 1999-00. About 20,000 of these clients will be nursing home residents.

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34 Unless otherwise referenced, data included in this case study is derived from unpublished departmental information.
Expenditure

Each of these changes has been accompanied by a significant increase in aggregate program expenditure largely in response to increased demand. Figure 4 shows the changes in program expenditure since 1988–89, highlighting the impact of each policy change.

**Figure 4: Hearing Services Program outlays, 1988-89 to 1998-99**

Source: Department of Health and Aged Care, unpublished data.

Impact on supply

Competition between private providers and between the private sector and AHS has increased since the introduction of the voucher system and, in the process, the traditional ‘gate-keeping’ or ‘queuing’ capacity of AHS has been removed.

Previously, AHS controlled the total program outlays using a ‘queuing’ system for client appointments and controls on the number of referrals made to the (relatively more expensive) privately contracted service providers at any particular time. The Government no longer has such global control over services that are provided under the program. At the same time, opening the market to competing private sector providers who are paid on a fee-for-service basis has encouraged increased throughput. This is due to increases in both supplier-induced demand, as providers seek new market share through promotion of their services, and consumer-induced demand, as a result of satisfaction with a more consumer-focused industry.

Overall, demand has increased as providers compete for more market share. It was initially estimated that the new voucher system would result in 83,000 eligible clients (excluding maintenance clients) receiving hearing services
each year, but the actual number of clients applying for a voucher has been about 140,000 per year, with approximately 110,000 actually presenting for hearing services within the year.35

There are a number of possible reasons for this increase in demand:

- the new competitive arrangements provide incentives for the AHS and private providers to seek out new clients and it is likely that increased publicity and advertising is stimulating demand from eligible clients who have not previously applied for assistance;
- fitting rates have fallen under the voucher program, with a higher than estimated number of clients receiving only an assessment. This suggests that the voucher system may be attracting less chronic patients who are only requiring an initial assessment;
- improvements in technology that have made hearing aids smaller and more cosmetically attractive may have motivated those clients who were previously deterred by the appearance of hearing aids;
- demographic changes, especially in relation to people over 65, are estimated to account for two per cent growth in program costs per year;
- the large cohort of part-pensioners who became eligible for the program in the 1993–94 Federal Budget may be returning to the program to renew their original hearing devices because hearing aids are deemed to have an effective lifetime of approximately four years; and
- there are currently no criteria by which eligible persons are refused a voucher, i.e. it is a demand-driven program, although there is provision in the legislation for the Commonwealth to introduce some form of rationing or prioritising for those receiving a service.

Impact on efficiency

In 1996, a review of the program was conducted to determine how the services should be delivered in the future and what longer-term strategies would ensure the viability of the hearing services market. The review found that AHS provided lower-cost services than privately contracted providers, primarily because of the lower price of the devices that AHS fit, but also due to:

- economies of scale in AHS’s operations;
- AHS’s purchasing power; and
- differences in the services provided by AHS and private providers, including more monaural fittings (fittings in one ear only) as opposed to binaural fittings (fittings in both ears).

35 It is difficult to measure the likely demand for the Hearing Services Program. There are currently a total of 350,000 clients in the program compared with figures from the ABS 1998 Aged and Disability Survey which show that 650,000 over 60 year olds have a hearing disability. Given these figures, there may be a large group of potentially eligible clients who have not yet applied for assistance under the Program. In relation to future demand, it is also important to note that: self-reported hearing loss is under-reported but there is growing community acceptance of hearing aids; and anticipated advances in new device technology are likely to increase the acceptance of hearing aid use among eligible clients.
With the introduction of the voucher system in 1997, some of these advantages were foregone in favour of a more competitive market across both the public and private sectors which was predicted to lead to increased quality and efficiency in service delivery. Substantial savings were negotiated with private providers in terms of the price paid for each individual service, which they agreed to reduce when the voucher system was introduced in the expectation that their throughput would increase as a result of increased competition and potential new market share. However, reductions in the cost of individual services which could be expected to flow from increased competition between providers was limited to the reduction achieved in the upfront negotiations with the private sector. This is because the Government offered a fixed contracted price to apply to all private sector operators rather than competitively tendering for services; that is, providers do not compete with each other on the basis of price.

Under the voucher system:

- AHS on average receives more per client and private operators on average receive less per client than they did prior to the voucher system; and
- the price difference between AHS and private operators has reduced significantly since vouchers were introduced.

Increases in hearing device prices and service fees represent another funding pressure for the Program. The Commonwealth granted some increases in late 1998 to ensure that service providers and manufacturers continued to provide services for voucher holders. Under the old arrangements, where AHS was funded to provide all services, program funding over the years was increased periodically to ensure that AHS’s operations remained financially viable. Under the voucher system, private sector operators are able to pressure the Commonwealth, as purchaser, to increase prices paid for voucher services in return for maintaining client choice and not disrupting private sector service delivery. This is balanced to a certain extent by the Commonwealth’s ability as a monopsony purchaser to negotiate lower prices with the industry. At the same time, because the voucher system provides funds on the basis of throughput, the Commonwealth bears a significant financial risk in this regard.

**Impact on demand—cost containment mechanisms**

*Queuing and waiting times*

Prior to the introduction of the voucher system, demand for the program was contained through queuing and streaming by AHS. The 1996 review found that ‘the use of queues to both ensure full capacity and to deter frivolous demand is a standard procedure for allocating free services’ (Centre for International Economics, 1996, pxi).

The review also attempted to ascertain whether waiting time was a significant concern for consumers. Survey results seemed to suggest that queuing did not unduly worry consumers although consumer organisations and representatives stressed the problem of long waiting times. The 1995 Roy Morgan client survey for the program found that the average number of days from initial client contract to assessment was 42 for AHS clients and 12 for privately contracted services. Since the introduction of the voucher system, averaging waiting time between the
issue of a voucher and assessment is approximately 35 days across all services, although this also includes any delay in clients contacting their preferred provider for an appointment after receiving their voucher. The difference between waiting times for AHS compared with private providers since the introduction of the voucher system is unknown. Although the voucher system ended previous queuing arrangements and decreased average waiting times, it is not clear whether the benefits of queuing in deterring unnecessary follow-up services outweighed the problems for clients who were denied timely access to services. As the Review concluded:

it is a value judgement as to which is better: lower costs and under use; or higher costs and over use.

[However], as a rule, queues are not an efficient screening mechanism as they screen out those with a high opportunity cost of time (Centre for International Economics, 1996, p103).

**Copayments**

Cost sharing measures such as consumer copayments are a common way to provide price signals and thus minimise the incentive for over-consumption. Under the Program, patients are charged a copayment of $30 towards the cost of batteries and maintenance of hearing aids. This copayment existed before the introduction of the voucher system and has not increased substantially since it was introduced. It could be argued that this copayment is too low to significantly affect demand. Recently the Government has introduced an additional charge of $30 for replacement of hearing aids which are lost or damaged beyond repair and a requirement for clients to complete a statutory declaration. This may reduce the number of return visits by clients.

**Impact on service delivery**

**Quality and mix of services**

Historically, the diagnosis and treatment of hearing impairment has remained the responsibility of the service provider which, in many cases is further devolved to the individual professional practitioner. Before the introduction of the voucher system, there was some degree of uniformity in the level and type of services provided for particular conditions because AHS was the sole provider of services. During this period, given AHS’s capped budget and mandate to provide services to as many eligible people as possible, AHS’s practice was to provide monaural hearing aids to the majority of clients. Under the voucher system, decisions on treatment of clients are still very much driven by individual clinicians within AHS. For example:

- AHS continues to provide a lower level of binaural fittings than private sector services for both new clients and return clients; and
- AHS provides a higher level of binaural fittings at subsequent consultations (i.e. fitting the second hearing aid), particularly for return clients, than does the private sector.

There are no agreed protocols or guidelines on the use of monaural or binaural fittings to indicate whether this reflects over-servicing by private sector operators or under-servicing by the AHS. Indeed, the 1996 review noted a significant difference between the percentage of new clients with binaural aids and the percentage of return clients.
with binaural aids, suggesting that at least some of the return clients had received a second hearing aid at a follow-up visit (Centre for International Economics, 1996, p51).

While some would argue that binaural fittings provide better outcomes for the client, the improvement may be very small for some clients, particularly the very elderly. AHS appears to take a conservative approach and fit a single aid whenever there is doubt as to the clinical effectiveness of a second aid. The review pointed out that ultimately this strategy can be more expensive as it increases the amount of time required to service the client in follow-up visits but that this has to be weighed up against the possibility of an unnecessary binaural fitting.

Audits by the Office of Hearing Services have revealed that some private providers and some AHS outlets are not providing the full and comprehensive service for which they are being paid under the Clinical Standards Attachment in the private service provider contract and the contract with AHS.

The benefits of competition for the purchaser accrue when services are well defined in contractual arrangements, therefore avoiding information asymmetry and supplier-induced demand. There is therefore some question as to the appropriateness of the Commonwealth assuming a purchaser role when the choice of services continues to be made by those delivering the service.

**Top-up provisions**

Top-up provisions were introduced at the same time as the voucher system. The 1996 review recommended the introduction of top-ups to ensure that the range of assistance was similar for public and privately funded clients. These arrangements increase the level of choice for clients, allowing them to purchase devices of a quality that is beyond that necessary to achieve a satisfactory hearing outcome. The review also suggested that, without top-ups, the industry would become polarised into those service providers offering a basic (low-cost) service and those who offered a top-of-the-range (high-cost) service. There would be insufficient volume in the middle range to justify an individual operator providing different levels of service. Private sector providers supported the introduction of top-up arrangements as part of accepting lower service fees under the new voucher system.

On average, one per cent of the clients of individual AHS practitioners choose top-up services compared to 11 per cent of the clients of individual private provider practitioners. This difference could be due in part to the Bernafon device issued by AHS under the free program which is a high quality free-to-client device of equivalent standard to some of the top-up devices on the market. However, there is also a risk and some anecdotal evidence that some private providers may be pressuring clients to purchase more expensive devices through these top-up arrangements, despite this being explicitly prohibited in the service agreement. Although this is being monitored, there will continue to be some risk of over-servicing as a result of information asymmetry between clients and service providers. This risk has to be weighed up against the additional choice that is now available to clients of the program.
Client satisfaction

Market share

Private providers of hearing services vary from large companies, which in some cases are owned and operated by the manufacturers of specific devices, to small independent practices. Larger private providers benefit from some economies of scale, including implicit volume discounts from their parent company. Small practices have lower overheads but also low volumes, which preclude them from bulk purchasing discounts. The market share of the largest private firms is small compared to AHS’s share of the market.

Even before the introduction of the voucher system, the 1996 review noted the large number of small private operators, which suggests that there was a demand among private clients for a range of different types of operators. The review also noted the ease of entry into the private market and explicit competition between private operators in relation to privately funded services. This competition was seen as keeping private service prices in Australia at about $3,000 per privately funded service, which is below the OECD average.

Before the introduction of the voucher system, AHS streamed clients to private contractors on the basis of monthly quotas that took into account a set annual allocation for contract services. In general, clients who were identified as complex cases would be serviced by AHS and clients who had already been supplied with a hearing aid by a private provider in the previous four years, would be streamed to a private contractor. Under the voucher system, clients themselves can choose which provider they wish to go to. This reform has resulted in a reduction in the market share of AHS in comparison to private providers.

Health outcomes—satisfaction surveys

There is no objectively measured data on the health outcomes of the Hearing Services Program. Instead, client satisfaction surveys provide a self-reported measure of the effectiveness of the services received. Subjective client satisfaction surveys are accepted internationally as the most effective outcome measure. Two key indicators are used as a measure of the outcome of the services:

- satisfaction with the device that was fitted and with the level of service provided; and
- hours of use of device, on the assumption that the more a hearing aid is used, the more satisfied the client and the better the health outcome.

Roy Morgan client outcome surveys and AHS surveys conducted before the introduction of the voucher system indicate very high levels of satisfaction for both AHS and privately contracted services. No such data is available to compare the levels of satisfaction between the AHS and private providers after the introduction of the voucher system, but the Hearing Services Program General Satisfaction Survey conducted in August 1998 shows continued high satisfaction rates across all service providers.

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36 Under these ownership arrangements, private services can be a retail outlet for their owner’s products.
Similarly, data reveal consistent use of devices for an average of five and more hours per day, suggesting the introduction of the voucher system has not altered consumers’ satisfaction with the services provided or client-reported utilisation rates.

**Access—location of services**

AHS operates out of 349 sites while 125 private providers operate out of 1,373 sites around Australia. Both sectors operate some visiting sites in less populated areas. The number of AHS sites increased markedly just prior to the introduction of the voucher system. The regional distribution of AHS and private services is fairly uniform, with more access to services along the Eastern seaboard and around capital cities and far less access to services in rural and remote locations. Although AHS receives specific funding to operate visiting services in remote areas as part of its community service obligation funding, clients with complex hearing problems and other special needs can choose to apply for a voucher and receive services from a private provider. Consequently, private practitioners also now provide visiting clinics to rural areas and also some remote areas.

**Access—socioeconomic and population demographics**

It appears that the only significant change in average client characteristics since the introduction of the voucher system is the increasing number of services provided to clients with less chronic conditions. Although data is limited, it also appears that changes in the service provider arrangements have not affected equity of access for any particular client group.

**Degree of competition in the market**

Despite the introduction of the voucher system, the hearing services market is still not a fully competitive market.

AHS has a contract with Bernafon, which requires it to purchase a set number of hearing aids in return for a comparatively lower price than the price paid by private providers for these devices. In 1996 AHS paid $180 for one type of Bernafon aid which sold on the private retail market at that time for around $400 (Centre for International Economics, 1996, p.xii).

This arrangement significantly reduces the overall costs of AHS-delivered services. In recognition of the lower cost of devices for AHS under the contract with Bernafon, and to ensure a ‘level playing field’ between AHS and private providers, the average price paid for AHS vouchers is lower than that for private providers.

There is currently no competition between providers for the right to provide services under the Program. Tendering by both AHS and private providers on a competitively neutral basis would encourage increased efficiency and consumer responsiveness and could potentially reduce the overall cost of the program. Under price tendering arrangements, there is potential for the Commonwealth to use the existing Bernafon contracted prices as benchmarks for the assessment of future bids. The 1996 review suggested that the Government could maximise cost-effective service delivery by setting price or quality and using competitive bidding to maximise quality and/or minimise cost. However the contract period and volume would have to be long enough and large enough...
for the winning tenderers to make sufficient savings to pass on as lower prices but not too long or large to prevent future competition.

At the same time, AHS does not provide services to consumers who are not eligible for Commonwealth assistance. This also limits competition among providers of private patient services.

**Government intervention in the market**

The Government uses regulation and explicit funding of community service obligations to safeguard quality and access to services under the program.

**Regulation**

Before the introduction of vouchers, AHS specified a range of standards and guidelines in their contracts with private operators. They also conducted audits of these operators. It is assumed that AHS developed these guidelines based on their own practice standards. The range of strategies to regulate and define appropriate and quality service delivery has expanded since the introduction of the voucher system. The expanded range of strategies includes:

- regular audits to ensure contract provisions are being met;
- monitoring of provider claims for payments to check for irregularities and so safeguard against inappropriate supply of services;
- an overall quality assurance plan and accreditation requirements;
- defined technical standards to guarantee the quality of the devices fitted;
- criteria to determine which clinical conditions justify the use of more expensive aids to prevent unnecessary use of expensive devices;
- audits of providers who fit a relatively high number of hearing aids to people with mild degrees of hearing impairment; and
- restrictions on false and misleading advertising.

AHS is treated no differently to other providers in respect of these standards and obligations, which are independently monitored by the Office of Hearing Services.

**Community service obligations**

At the time that it introduced the voucher system, the Commonwealth Government made a commitment to continue to provide services to certain high-need groups in the community through AHS. AHS receives specific community service obligation funding to provide services to people under 21, clients with complex rehabilitation needs, eligible Aboriginal and Torres Strait Islander peoples, eligible people in remote areas and for research and noise-related activities. This funding is based on input costs which are calculated by AHS and there is no competitive tendering between AHS and private operators to provide these services.
The pool of services provided under these arrangements are not well defined or measured so it is difficult to determine whether AHS has fulfilled these obligations. It is also difficult to determine how many eligible clients there are in these categories. Community service obligations could be explicitly set out in contracts in the future if the outcomes can be defined and measured and the number of eligible clients can be better predicted. However, as reported in the Senate Committee’s report on the Australian Hearing Services Reform Bill 1998,

the Government has indicated that it will not make any changes to the existing provision of community service obligations by AHS unless it can be clearly demonstrated that such a change would lead to further improvements in the level and quality of hearing rehabilitation outcomes for children (Senate Community Affairs Legislation Committee, 1998, p.4).

Summary

The introduction of a voucher system for the Hearing Services Program has enabled clients to choose to receive publicly funded services from a range of contracted hearing services providers including the public provider AHS. The increase in private sector market share since vouchers were introduced shows that a significant proportion of new and return clients is supportive of this increased choice of service provider. Although waiting times have reduced and overall client satisfaction has been retained, it is not clear whether there has been a change in clinical outcomes.

The Commonwealth has significantly reduced the difference in prices paid to private operators and AHS for similar services under the voucher contracts. However, there is still a tendency for private operators to deliver higher-cost services than AHS by virtue of a greater number of binaural fittings and top-up rates. The Commonwealth no longer has the ability to change the mix of service delivery between AHS and private providers, a mechanism that was available to Government and used to control the total number of services prior to the introduction of the voucher system.

The larger pool of competing operators engaging in more aggressive promotion of the Program has resulted in increased demand that has significantly increased aggregate expenditure. AHS’s previous queuing and streaming practices may have deterred both unwarranted and legitimate demand to a certain extent. Under the voucher system there is currently no rationing of vouchers. Rationing of health services is a difficult political issue, but it would be possible to introduce rationing criteria; for example, on the basis of severity of hearing loss, date of application and/or age of applicant. Alternatively funding caps could be agreed with the industry to contain the overall cost of the program or individual price-volume contracts could be negotiated with competing providers. This would minimise supplier-induced demand (which may occur under fee-for-service funding arrangements). However, any such arrangements would depend on having a better understanding of the demand for services and the outcomes being purchased.

The current arrangements limit the level of competition across the industry and therefore do not realise the full potential for increased efficiency and quality. To maximise the benefits of competition in the hearing services industry:
the Commonwealth, as purchaser of services for eligible clients under the Hearing Services Program, could tender for operators who can provide the best services at the best prices; and

- AHS could compete to provide privately funded services.

Under the top-up arrangements, the voucher system provides one of the first examples of a government health care subsidy that can be cashed-out and combined with personal funds to purchase a higher level of service. This increases choice for clients of the public program and may provide a model for a mixture of public and private funding for other parts of the health system.
Case study 5: Pathology services

Introduction

There are a range of issues surrounding the public and private sectors in the delivery of pathology services in the Australian health system.

Increased accessibility of pathology testing

Originally, pathology services were largely hospital-based, but they have extended into the community over the past 25 to 30 years, as a result of:

- developments in the methods and applications of laboratory testing;
- expansion of the role pathology plays in patient care;
- the intrinsic nature of pathology, which tests samples rather than patients, and so is not as subject to location criteria as other services;
- shifts from acute and tertiary health care settings to primary care settings; and
- the economies of scale which have come with testing developments and the commercial imperative to maximise their use.

Billion dollar plus industry

The Commonwealth funds pathology services through a number of mechanisms including:

- the Australian Health Care Agreements for public inpatient and outpatient services;
- the MBS for private inpatient and community-based services provided by both the public and private sectors;
- Health Program Grants paid mainly to five providers, four of which are public providers of private patient services; and
- the Veterans’ Affairs and Defence portfolios.

Data on the national expenditure on pathology is not available, but MBS expenditure now amounts to $1 billion a year and Health Program Grants amount to $51 million a year.

Changes in market structure

The public and private sectors have gone through significant restructuring over the past 10 years and there has been a shift between the two sectors.

In the public sector, there has been corporatisation and amalgamation of hospital-based pathology laboratories into larger business entities. Some States, particularly Victoria, have privatised their public hospital pathology
services, blurring the traditional distinctions between provision, patient status and funding. In the private sector, mergers and takeovers through both vertical and horizontal integration have seen the emergence of companies that operate across a number of States, but, to date, there is no truly national provider. There is also a strong not-for-profit charitable sector, which is beginning to examine the possibility of establishing a national presence.

These changes have resulted in the privatisation of the market and greater concentration of the MBS market among a handful of private operators, a number of which are owned by investors, some with interests in other parts of the health industry. For example, in 1997–98, the top five private companies accounted for 45 per cent of all MBS payments while in 1994–95, their share was 35 per cent. While the number of public and private pathology operators has declined, there remains a large number providing MBS services albeit some providing small numbers of services and in some providing specialised services.

While nationally private provision dominates, there are substantial differences in the structure of the pathology market across the States and Territories. In South Australia, a public pathology provider funded via a Health Program Grant provides a significant share of private patient work; to a lesser extent, this also applies to Western Australia. In Queensland, by contrast, private work by public laboratories is low. In Victoria, the public sector was once a significant player, but this has been much reduced through the privatisation of pathology services during the 1990s. Overall, the proportion of MBS activity performed by public providers has been decreasing steadily and is now about eight per cent, compared to 12 to 13 per cent 10 years ago. Privatisation of the market is not as marked in those States where Health Program Grants to public providers apply.

**Patient charges: price competition**

At the same time, direct billing and the rate of observance of schedule fees have steadily increased in pathology under the MBS. Today, over 80 per cent of all pathology services funded under the MBS are direct-billed and almost 91 per cent are either direct-billed or patient-billed at or below the schedule fee.

**Types of services provided**

Historically, the public and private sectors have fulfilled different roles, with the public sector providing most of the reference type and specialised testing services as well as a training and research. Today, many of the large laboratories, public and private, perform the full range of tests while some laboratories specialise in certain tests. There is movement of specimens across the two sectors depending on the testing involved. There are concerns that the privatisation of public hospital services and pressures on hospital budgets will have an adverse impact on the public sector’s capacity to continue to provide reference type testing and training and research.

**Remuneration issues**

Pathology under the MBS arrangements has been characterised by persistent high rates of growth in service use and expenditure. To address the growth, successive restructuring packages have been developed with the pathologists within the broad framework of the MBS arrangements. They have been aimed at reducing the rate of
growth in expenditure rather than cutting base spending, and have focused on the supply side with strategies aimed at reducing unit prices and reducing the cost structure of the industry.

Reductions in unit prices have sought to harness economies of scale and other productivity dividends flowing from technological and other developments. They have been achieved through a series of changes in the way pathology providers are remunerated. For example: schedule fees for individual tests have been reduced; tests have been grouped under an item to cap the benefit; benefits for groups of services which can be performed either together or sequentially have been reduced; benefits for certain episodes of testing have been capped; and overhead costs have been separated from individual pathology test costs during an episode of testing to ensure these costs are only paid once. Generally, these changes in remuneration have applied to all providers regardless of ownership.

An ongoing issue between public and private providers of medical services is the different cost structures and risks they face in their private patient work. Pathology has traditionally recognised these factors through differential MBS fees for the two sectors. Historically, specialised private pathology rates were 25 per cent higher than the rates of other providers (including hospitals). Since 1992, this has been replaced by the patient episode initiation (PEI) fee, which only applies to services delivered by private pathology providers. The PEI operates on the basis that the Commonwealth already contributes to these overhead type costs via the AHCAs, with any private patient work done by a public provider being at a marginal, not average cost.

This has been a contentious issue. Some argue that PEIs have provided an incentive for some States to privatise or cost-shift services to the MBS and that they impede the ability of the public sector to compete for private patient and community sector work.

**Other level playing field issues**

The suppliers of pathology services under the MBS are regulated under a framework that has evolved over many years. For pathology services to be eligible for Medicare benefits, they must be performed by or on behalf of an Approved Pathology Practitioner in an Accredited Pathology Laboratory owned by an Approved Pathology Authority. Standards for pathology laboratories are developed by the National Pathology Accreditation Advisory Council (NPAAC) and laboratories are inspected regularly to ensure compliance. There are also administrative rules about the availability and ease with which tests can be requested.

The same rules and standards apply regardless of whether the pathology operator is privately owned or publicly owned. A review of the pathology Health Program Grants is currently examining concerns that Health Program Grant-funded providers are not subject to the same rules and level of scrutiny by the Health Insurance Commission as MBS funded providers. This is being examined as part of a review of the pathology health program grants.

In addition, a comprehensive review of the regulatory framework for pathology under the MBS will examine all relevant regulation and legislation affecting the pathology industry.
Increasing market access—product competition

Pathology providers seek to maximise their market access. In Australia, a key means of increasing access to pathology services has been through the collection of specimens. This is a form of product competition. Since 1992, private sector pathology specimen collection centres have required a licence for collection and in order to attract Medicare benefits. The scheme was introduced as a supply control measure in response to concerns about the proliferation of centres under an open market and the pressure they placed on pathology costs and Government expenditure.

Some argue the licensing scheme favours the private sector and provides another incentive to privatise. Others argue that it is not in line with the Government’s regulatory reform and the further development and implementation of national competition policy. Structural reform of the scheme to address competition and public policy concerns and interests has been identified as a key element of the second Pathology Agreement. The new arrangements will be based on the accreditation of centres, shifting the focus from the regulation of the number of facilities to the quality of practice. Some supply measures will remain and there will be transitional arrangements to allow for sectoral adjustment.

Shift in approach to managing pathology

There have been successive restructuring packages to reduce the underlying high rates of growth in service use and expenditure in the pathology sector. These have been developed cooperatively with peak organisations of the pathology industry and profession. Early restructuring packages focused on specific sets of interventions and had only short-term success. The approach has evolved into a joint outlays management approach through three-year Pathology Agreements between pathologists and the Government under which the benefits for selected items are adjusted up and potentially down to ensure an expenditure target is met. As well as managing expenditure within agreed budgets and parameters, the agreements have provided an environment for structural reform and other innovations.

Summary

The three case studies in this chapter have described particular health care settings in which Government has taken action to change funding and/or service delivery arrangements. GPs have maintained their historical preference to practice solo despite some encouragement by the Commonwealth to reform existing practice arrangements. There is as yet no mechanism to ensure that services are adequately available to those in unpopular locations. Where practitioners choose to remain in areas that are oversupplied, they are now more likely to provide high throughput, services that may not represent good quality, cost-effective medical care.

The current general practice funding and delivery arrangements provide evidence that private sector involvement cannot itself be expected to generate competition that also supports good health, equity and efficiency when the
funding environment is open-ended. The Government’s regulatory role in this area of health care is still to be clearly identified and applied.

The direction of change for the other two case studies is quite different. The provision of hearing services in Australia has changed from being largely funded and delivered by the public sector to a situation where Government funding is also available for privately delivered services.

In this case, access to Government funding for privately delivered care has been a recent development and assessments of the impact on health outcomes resulting from different and sometimes higher-cost services provided by private sector providers have yet to be made. Compared to GPs, private sector hearing service providers operate more competitively and are more geographically dispersed. In addition, the voucher system for hearing aids has given consumers the option of accessing a greater range of service providers and receiving services more quickly.

As with high-throughput general practice care in 24-hour clinics, the increased availability and reduced waiting time through the voucher system may prompt consumers to demand services for conditions for which previously they would not have sought professional help. In the case of hearing services, the assessment has still to be made whether this represents cost effective care and results in better health outcomes.

It is likely that with continuing open-ended Government funding for hearing services, many of the concerns about the cost-effectiveness of publicly funded and privately delivered health care in other parts of the system could continue to apply.

Pathology services, on the other hand, were largely public sector-based but more recently became a substantial private sector service as public hospital pathology services were privatised and private sector pathologists amalgamated to form large businesses. The dominance of private provision dependent on public funding in the pathology industry may have been one of the reasons that the Government has successfully negotiated revised payment mechanisms in order to encourage efficiencies and lower costs.
5. Resource Allocation

In the interests of improving the objectives of the health system, governments are taking action to improve allocative and technical efficiency and attempting to restrain aggregate health expenditure across both the public and private health sectors. This is true in all countries, as no country is prepared to allocate unlimited resources to health services.

Competition in service delivery and increased private sector involvement in a market-based health system is supposed to increase allocative and technical efficiency. However, although competitive funding arrangements may influence the unit price of individual services, they do not in themselves influence the way resources are allocated or the total quantity of services consumed. Information asymmetry, moral hazard and opportunities for supplier-induced demand in the health market may result in sub-optimal efficiency.

Resource allocation must also take into account the ability of individuals and population groups to benefit. Effective resource allocation aims to both maximise allocative efficiency across different health services for the general population and to allocate resources proportionately to those who can most benefit from them.

Therefore it is both the nature of resource allocation and who is responsible for resource allocation that determines the equity, allocative and technical efficiency and the cost-effectiveness of a health system.

Different approaches to resource allocation have different potential effects. The various approaches can be described along a continuum from traditional indemnity funding to pooled funding through a fund-holder. This chapter describes this resource allocation continuum and discusses the role of the fund-holder responsible for allocating pooled resources.

How resources are allocated

Until recently, health funders took on a relatively passive role, retrospectively reimbursing service providers who made decisions in relation to the quality, quantity, scope or price of the services provided, sometimes on the basis of clinical protocols. These indemnity funding arrangements involved a direct relationship between funders and service providers.
More recently, funders increasingly manage aggregate outlays by applying conditions to their indemnity funding arrangements. Macro-economic controls are now used by funders to exercise some control on overall expenditure, for example:

- defining the scope, quality and price of individual services;
- agreeing in advance on the total funding available for a group of services; and
- defining the circumstances under which funding will be provided.

However, under these arrangements, it is still service providers who make decisions on individuals’ access to services and funding is provided retrospectively in response to these decisions. Although indemnity funders traditionally quarantine funding to discrete areas of the health system, they have limited influence on the appropriateness of particular services for individual patients (that is, allocative efficiency). In the Australian health system, funding comes from a variety of sources and is earmarked to pay for a specific and limited range of health services. As described earlier, this leads to a range of cost-shifting behaviours by funders which impact on allocative efficiency and ultimately the cost-effectiveness of the health system.

Resource allocation for the provision of public hospital services in most jurisdictions takes the form of fund-holding arrangements where a capped amount of funding is provided to area health services and/or specific institutions for the provision of universally accessible public patient services in a particular region. Under these arrangements, funding is generally based on an average price that the funder is prepared to pay for each type of service, information on previous throughput and estimates of future demand. The fund-holder therefore seeks to improve the overall efficiency of service provision to ensure that services can be delivered within the allocated budget.

Competitive tendering of service provision has already realised improvements in technical efficiency. For example, as illustrated by case studies 1 and 2, State governments and the Department of Veterans’ Affairs have negotiated on the range, price and quality of services to be provided under contracted hospital services; this has the potential to improve technical efficiency in the delivery of public hospital services and health services for veterans.

Moving further along this funding arrangement continuum, the funder can exercise more control on the total level of expenditure and allocative efficiency either by defining and controlling the provision of individual services or by introducing a third-party fund-holder into the funding arrangement. Both of these arrangements introduce a

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37 Conditional indemnity funding arrangements have the potential to improve allocative efficiency in the health system by limiting funding to those which can be identified as being cost-effective prior to service provision. It is important to note, however, that in defining which services will be funded, the funder must also be prepared to define what will not be funded. Defining those health services which will not be available is a sensitive task because many people consider all health services to be a public good which should be available to all at any cost. Recent debate over whether the public sector should subsidise abortion, in-vitro fertilisation treatment and cosmetic surgery illustrate this conflict.
level of prospective control on the provision of individual services (that is, purchasing specific services on behalf of consumers) and encourage the use of micro-economic strategies to increase the efficiency of resource use.

Where the funder delegates a budget to a separate fund-holder, the financial risks associated with the funding can be shared by the funder and fund-holder or be fully borne by the fund-holder. The degree of financial risk the fund-holder agrees to bear will depend on their perceived ability to improve both allocative and technical efficiency. This arrangement can introduce a clear split between the funder and the provider, reducing the opportunity for supplier-induced demand but increasing the potential tension between fund-holders and providers over clinical decision-making. Alternatively, the fund-holder role can be given to a provider, such as a general practitioner, which might reduce concerns about the clinical autonomy of the provider but nevertheless retain the potential for over-supply of services, depending on the financial risk borne by the provider.

One of the other benefits of a fund-holding arrangement is that it provides the opportunity to pool funding from a range of previously disjoint funders. This pooled funding can then be used to purchase the most appropriate services for the individual consumer, alleviating some of the problems that exist under traditional funding arrangements where funders have an incentive to try and shift the costs of an individual patient onto other funders.

The key attributes of fund-holding are:

- a contractual responsibility on the part of a fund-holder to deliver a defined range of services;
- the funder makes fixed payments, which are calculated prospectively and are independent of the level of services used, to the fund-holder; and
- the fund-holder bears a level of financial risk which is then shared with service providers who, through risk-sharing arrangements, are often rewarded for appropriate use of resources or penalised for overuse.

Theoretically, the effects of fund-holding are expected to include:

- countering supplier-induced demand by separating the decisions about which services will be ‘purchased’ from those providing services or, where the fund-holding role is located with a service provider, providing incentives to counteract supplier-induced demand;
- the potential to significantly reduce cost-shifting behaviour through the pooling of funding across different health services and health programs;

38 The difficulty of predicting health care needs makes it difficult to determine the level of funding sufficient to cover the financial risk of any individual or group of individuals under a fund-holding arrangement. The US Government has recognised that the current funding paid to a health management organisation per Medicare beneficiary does not adequately represent the true costs of individuals’ health care; in some cases payments are too high and in others payments are insufficient. As a result, the Government is changing the risk adjustment payment method. The new payment formula will include some risk adjustment for health and age factors as well as differential adjustments based on a blend of local and national rates so that rates in lower-cost, predominantly rural, areas will increase. However, there is ongoing international debate about the most appropriate way to calculate risk-rated payments to cover the health care costs of consumers.
• increased allocative efficiency by removing the barriers to integrated care arrangements and facilitating appropriate substitution arrangements;
• improved technical efficiency by introducing competition between those delivering services;
• overcoming the problems of information asymmetry between consumer and provider by introducing an advocate for individual consumers;\(^{39}\)
• improvements in efficiency arising because the fund-holder is involved in decisions about what services should be provided in individual cases and by whom; and
• a possible reduction in the range of choices available to consumers and service providers and a risk of some sub-optimal decisions being imposed by fund-holders.

Many types of funding arrangements already exist across both the public and private sectors in Australia. Table 10 summarises some of the key funding arrangements in the Australian health system.

<table>
<thead>
<tr>
<th>Table 10: Funding arrangements in the Australian health system</th>
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<td><strong>Public sector initiatives</strong></td>
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<tr>
<td><strong>Indemnity arrangements</strong></td>
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<tr>
<td><strong>Indemnity arrangements with some restrictions, definitions or conditions imposed by the funder</strong></td>
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<tr>
<td><strong>Funding/fund-holder arrangements</strong></td>
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<tr>
<td>Commonwealth Government hospital funding arrangements with the States define broadly the scope of services to be provided and limit the total amount the Commonwealth, as funder, is prepared to pay for these services.</td>
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\(^{39}\) Although this role is integral to fund-holding, it is also possible to introduce a consumer advocate into the health system to assist in service advice and referral without the consumer advocate also having responsibility for purchasing services on behalf of the consumer.
Table 10: Funding arrangements in the Australian health system cont.

| Fund-holding arrangements are part of the Coordinated Care Trials (discussed later in this chapter) under which a care coordinator is responsible for purchasing appropriate care for each enrolled person. Unlike many fund-holding arrangements overseas, in the first round of trials, the level of funding was not strictly capped and additional funding was made available from existing mainstream programs when required. Future trials may provide the opportunity to test more strictly applied caps on capitation-based budgets for a defined population. |

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As table 10 shows, private health insurers have not introduced the fund-holding role in their funding arrangements to date. The proposed new prospective private health insurance reinsurance arrangements will strengthen incentives for private health insurers to pursue efficiency gains because individual insurers will no longer have to share efficiency gains with other insurers. Prospective risk adjustment will put private health insurers in a neutral starting position in respect of each new member regardless of their age or sex and this will provide an incentive to manage the cost of members within the limits of the premiums that they have set. If a private health insurer is able to achieve cost efficiencies as a result of better claims management, contractual terms or preventive programs, then the gains can be retained by the insurer. This contrasts with the existing reinsurance arrangements, where retrospective risk is shared between insurers creating minimal incentive on the part of individual insurers to manage that risk.

In addition, as a result of their current transactions, private health insurers collect a huge amount of detailed comparative information, including data on doctors’ practice patterns and charging patterns in hospitals, that is not readily available to or understood by patients. There is potential for this information to be used to assess cost and quality of care options on behalf of individual members and to encourage competing service providers to provide appropriately integrated and cost-effective services for their members.

However, private health insurers will have to assess the benefits of any efficiencies gained by placing restrictions or limitations on what private health insurance covers against the effect that these restrictions would have on consumers, who may believe that this devalues the private health insurance product too much relative to Medicare and drop their private health insurance cover.

Funders are able to employ a range of demand and supply mechanisms to attempt to control health care costs. Many of these are reasonably accepted by consumers and have already been introduced as conditions imposed under indemnity arrangements (Smith, 1997, pp1495–1496). These include queuing to slow the rate of resource use, copayments to discourage unnecessary consumption, and pre-admission certification and gatekeeping through GPs as a way of managing access to more expensive secondary care. There are, however, a number of additional tools which are more likely to be used by fund-holders including:
• financial incentives to encourage consumers to minimise unnecessary service requests and consumption of services;
• supply tools such as influencing who delivers health services, for example, by promoting more telemedicine and greater use of allied health professionals; and
• financial incentives, which can be used to influence referral behaviour and encourage cost-effective use of resources by providers of health services, for example, bonuses and penalties, and withholding of payments if care does not meet pre-set standards (Robinson and Steiner, 1998).

Who should allocate resources?

Both public sector and private sector funders have traditionally played a very conservative role in the allocation of resources. In addition, because different parts of the health care system are funded by different players, there are few opportunities for funders to reallocate resources across different areas of the health system to achieve an appropriate outcome for a particular individual. Currently, decisions about what services should be provided are made by service providers and are significantly influenced by the funding boundaries that have been created within the health care system.

The introduction of fund-holders who are able to pool resources across funding boundaries and are involved in decisions about appropriate care for individual consumers is one way to enhance the allocation of resources. Most concerns about the introduction of fund-holding relate to the capacity and willingness of fund-holders to make appropriate decisions about access to services.

Appropriate use is generally defined as economical use, that is, providing appropriate and preferably low-cost early interventions to prevent later high-cost interventions. To provide sufficient incentive for a fund-holder to manage health care costs in such a way as to maximise the outcomes, the fund-holder must bear the financial risk of an individual’s future health costs.40

In the same way that service providers have financial incentives to deliver the maximum number of services, fund-holders stand to gain financially from not purchasing services. This tension may be partly resolved by ensuring that fund-holders’ use substantial evidence from valid studies to define which services will be funded and that they develop appropriate funding criteria which are flexible enough to take into account the needs and circumstances of individual patients. Much of the debate around fund-holding is about who is in the best position to define what is appropriate.

The Australian coordinated care trials for example, use a care coordinator (in many cases a GP) who is responsible for assessing the needs of individual patients and purchasing appropriate services on their behalf. Similarly, the UK fund-holding model uses GPs as fund-holders who define the appropriate use of services for individual

40 Competitive fund-holding arrangements in which consumers can change the fund-holder who represents them at any time reduce some of this incentive.
patients within an overall funding framework. Although these models alleviate concerns about retaining the clinical autonomy of medical practitioners, the large number of fund-holders involved is likely to result in significant variation in the level and types of services provided.

In the United States, different types of fund-holders are also distinguished by the extent to which the fund-holder and the service provider functions are integrated and by the extent to which fund-holders deal exclusively or non-exclusively with a defined group of service providers.\(^{41}\)

Generally, however, under most managed care models in the United States, the fund-holder determines a detailed set of criteria against which all individual treatments are assessed. This model is criticised for attempting to apply uniform criteria to all patients. Ultimately, the greater the number of independent decision makers in a health system, the less likely there will be consensus on what is appropriate care. Deriving clinical-guidelines of appropriate care from evidence-based medicine in collaboration with the medical profession may alleviate some of these concerns.

The key issue in fund-holder models is finding the right balance between mandating uniform treatment methodologies, which could lead to overall increases in efficiency, and allowing sufficient variation to accommodate individual circumstances, which could achieve optimal health outcomes for individual patients. Ultimately, in the absence of objective definitions of appropriate health care, fund-holder models which use GPs or other health professionals to determine appropriate service delivery are more likely to be acceptable to the profession and to consumers.

**The private sector as a fund-holder**

The role of the fund-holder could be undertaken by the public or private sector. In both the United Kingdom and the United States, the role of the fund-holder lies in the private sector, that is, with GPs in the United Kingdom and health maintenance organisations in the United States\(^{42}\). However, in the United Kingdom there appears to be acceptance of GPs undertaking this role whereas in the United States there is some degree of discomfort about a private sector organisation as a fund-holder. This has partly arisen from the very restrictive purchasing behaviour

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\(^{41}\) There are a range of US managed care models: health maintenance organisations require members to use a network of affiliated service providers and work through GPs who coordinates all of their care, including specialist referrals. Point of service plans require members to work through GPs and have a list of network health providers, but members have the option of paying more to receive care from providers outside the network. Preferred provider organisations do not require care to be referred or coordinated by a GP and, although members can use providers from outside of the network, there are financial incentives to use network providers.

\(^{42}\) In the United States, the public sector funder (Medicare) allows publicly funded individuals to purchase their health services through private purchasing agents (health maintenance organisations). As of 1 March 1999, about 6.7 million people, or 17 per cent of Medicare’s 39 million beneficiaries, were enrolled in 300 managed care plans (United States General Accounting Office, 1999).
of some managed care organisations in the United States, which has led consumers to believe they will not necessarily act in their best interests. It is also because, in the United Kingdom, GPs operate in a highly government-regulated environment which controls and defines the nature of their services and consumers’ entitlements to these services.

Other factors that influence whether private sector fund-holders are publicly accepted include:

- whether fund-holders allow providers sufficient autonomy to make decisions based on an individual consumer’s particular circumstances; and
- whether fund-holders are operating on a for-profit basis, creating a fear that maximising profit could override a concern for the quality and outcomes of services purchased.

**Role of Government**

If fund-holding is to improve the quality and efficiency of the health care system, an appropriate balance between price and quality needs to be achieved. To date, this has proved difficult, particularly in models that use competing private sector fund-holders, such as managed care in the United States. In this case, it has been necessary to provide an increased range of regulation to protect the quality of and access to the health system through measures such as the Consumer Protection Standards Act (Textmed, 1999) and an array of additional State and Federal government regulations. These regulations cover issues such as defining timelines for treatment, requiring timely payment for straightforward claims, defining and certifying levels of internal review, defining emergency coverage that is realistic, defining specialty primary care situations, requiring clear plan information disclosure, regulating against unfair dismissals of practitioners and defining transition coverage.

The United Kingdom Government, in its funding capacity, also defines a range of rules which are incorporated into contracts with fund-holders to protect the standard of care and access to care by patients.

Some protective mechanisms are already in place in Australia, for example State health ombudsmen or complaints commissioners investigate complaints by patients. A more widespread fund-holding model would still require a mechanism such as the Trade Practices Act, to ensure that neither providers nor fund-holders behaved anti-competitively, and appropriate consumer advocacy forums.

**Competition between fund-holders for enrollees**

Funding arrangements using fund-holders can operate in a variety of ways.

Under one model, consumers are allocated to a particular fund-holder, usually on the basis of their geographic location. In this case the role of fund-holder may be undertaken by a government agency or an independent agency selected by the funder to purchase on behalf of a group of individuals (for example, GPs operate as fund-holders in the United Kingdom, while a government fund-holding body contracts with service providers to deliver services in New Zealand).
Alternatively, potential fund-holders could compete for enrollees. Under this model, sometimes called managed competition (Scotton, 1999, pp214–231), there is ongoing competition between fund-holders for the right to manage and coordinate health services on behalf of an individual. A number of countries have competing fund-holder arrangements; for example, private health insurers in the Netherlands and managed care organisations in the United States.

Where fund-holders do not compete, and where the government at least partially funds that care, the management of the risk between government and the single fund-holder becomes a high priority. Where there are multiple competing fund-holders, the level of risk is spread much wider, with any one fund-holder’s failure representing a smaller problem for the funder.

Where fund-holders are guaranteed a geographic-based constituency, they can benefit from monopsony purchasing powers for the constituency.

A lack of competition reduces choice for consumers and the fund-holder is likely to be more remote and less responsive to individual consumers. Conversely, competition between fund-holders is likely to produce increased consumer-focus and a higher emphasis on the quality of services. However, these incentives only come into play if consumers have sufficient information about competing fund-holders to make informed choices and are responsible for those choices.

Competition between fund-holders creates the potential for cost-shifting of high-risk consumers and high-cost services and ‘cream-skimming’ of lower-risk consumers. The United States Government, as funder, is trying to overcome the problem of cream-skimming by increasing payments to plans that care for the sickest beneficiaries, creating market incentives for plans to enrol people who are likely to be higher risk to the purchasing agent (HCFA, 1999).

The greater the number of fund-holders operating in a market, the greater is the proportion of the health budget spent on transaction and administration costs and the more money is spent on advertising and promotion. These additional costs of competitive fund-holding may outweigh any financial benefits achieved through improvements in technical efficiency.

**Assessment of the impact of fund-holding in the US**

The experience of other health systems is useful in assessing the merits of introducing fund-holding. The US model provides the most comprehensive and oldest example of fund-holding arrangements. In a comprehensive and systematic analysis of over 70 studies, Robinson and Steiner (1998) identified the following strengths and weaknesses of the US fund-holding model over the traditional indemnity funding through fee-for-service payments to service providers:

- US fund-holding is associated with less use of hospital care through lower admissions, more frequent visits to doctors (except for mental health visits where managed care patients receive less treatment), and fewer expensive procedures or ones for which less costly alternatives exist;
there does not appear to be any significant difference in total hospital charges per stay between US fund-holding and fee-for-service patients;

US fund-holding led to improved rates of preventive screening and health promotion activity;

US fund-holding afforded significantly less access to treatment, but in all other respects there was no difference in the quality of care received under US fund-holding and fee-for-service funding. Treatment for particular diagnoses varied (for example, under US fund-holding, cancer care was better, mental health care was worse and chronic disease management was mostly equivalent);

consumer satisfaction levels were lower for managed care patients and there was particular concern about clinicians’ technical proficiency and communication skills under US fund-holding; and

in terms of equity, treatment of children was better under US fund-holding although ante-natal care for women with low-incomes was worse. Childbirth outcomes did not differ.

The authors concluded that the more discretionary the treatment is perceived to be, the more scope there is for fund-holding to make a difference (Robinson and Steiner, 1998, p180). Sometimes this difference is positive, for example, chronic disease management under fund-holding arrangements achieves savings by substituting less expensive care options without compromising health outcomes and consumer satisfaction. In other circumstances, this level of discretion results in worse health outcomes, such as the poor access to mental health services under many fund-holding arrangements.

Some of the main benefits of fund-holding in the US appear to have come from restrictions on unnecessary utilisation of services rather than from significant reductions in prices paid per service. This could be a way to reduce the variation in practice patterns that exists under many indemnity funding models. However, market intervention in the delivery of health services through fund-holders has been both credited for eliminating unnecessary care and blamed for forcing providers to skimp on the quality and quantity of care.

Analysis of fund-holding in the UK (Department of Health and Aged Care 1999f, p69) reveals similar results: the level of savings possible is debateable, varying across different parts of the health system, and the quality of care has been maintained by comparison with traditional fee-for-service arrangements.

In summary, while there may not be overwhelming evidence that a fund-holding model appropriately reduces total health expenditure, there are other documented benefits. These include, in particular, improved health outcomes as a result of early intervention, increased preventive health strategies and more integrated and appropriately coordinated care.

In addition, a recent study in the US (Baker, 1999, pp432–437) suggests there is potential for fund-holding on behalf of some consumers to have a flow-on effect to service provision under more traditional funding arrangements. The study found that, within local areas, the rate of fee-for-service expenditures paid by Medicare decreased as the market share of managed care organisations increased. The author concluded that individual doctors were appropriately reducing the number and intensity of services both for their HMO-enrolled patients and their fee-for-service patients.
Fund-holding in Australia

The most advanced example of fund-holding in the Australian health system is the Commonwealth’s coordinated care trials (see box below). The trials establish a role for a fund-holder who is able to ‘purchase’ a comprehensive range of health services for consumers enrolled in the trials. The early phases of the trials pooled funding from a range of sources, primarily publicly funded health programs, with services purchased from both public and private sector providers. The trials aim to improve health outcomes for people with chronic and complex illness, using existing levels of resources, through the improvement of coordination and through the pooling of resources (financial integration). Evaluation of these trials will provide information about the impact of this kind of fund-holding on health outcomes, efficiency, equity and access to services, quality of services and consumer satisfaction.

Coordinated care trials

A series of coordinated care trials is exploring innovative approaches to improving health and community service delivery across Australia. These trials involve cooperation between the Commonwealth, States, Territories, local health service providers and the public. There are thirteen trials, nine mainstream trials and four trials in predominantly Aboriginal communities - operating in all States and Territories.

The mainstream trials primarily cover publicly funded services for voluntarily enrolled individuals in a geographic area or population subgroup. Some 10,000 people are receiving coordinated care in the trials; a further 6,000 people comprise control groups, receiving care in the usual way, to facilitate comparisons in the evaluation of the trials. The fund-holders are not in competition with each other for clients.

All trials are designed to test whether multi-disciplinary care planning and explicit service coordination can improve the health and well-being of people with chronic health conditions or complex care needs while using only existing levels of resources.

The pooling of Commonwealth, State and Territory health program funding is also being trialed, as a means of providing funding flexibility to support coordinated service delivery. The amount of money placed in each pool is based on estimates of what would otherwise have been spent on services for the clients participating in the trials.

The funds in each trial are variously held by State health departments, existing statutory authorities, and GP divisions. In some instances, wholly owned companies with boards representing the various stakeholders have been established.

Fund-holding is pursued as a support to service flexibility. This reflects the trials’ emphasis on improving quality of care rather than achieving cost reductions. The primary constraint on the costs of some services remains the use of government monopsony powers through standard fee schedules, associated rebates and management controls on service costs.

No new restrictions are imposed on people’s access to and use of services, within or outside the trial. This means there can be no suggestion of coercion or the imposition of stringent supply side controls like those associated with United States-style managed care. However, the cost of services received outside of the auspices of the trial by trial clients is debited against the trial pool. The emphasis in the trials is to manage demand by supplying an effective service so that people do not feel the need to go elsewhere.
Coordinated care trials cont.

Each trial is monitored by groups representing both the Commonwealth and the State or Territory in which the trial is being conducted and the trials are also being independently evaluated at both the national and local level, with final reports scheduled for June 2000.

The Aboriginal trials differ from the mainstream trials in a number of ways. Firstly, there is an emphasis on providing coordinated health care for whole communities, as well as for individuals with chronic health care needs. Secondly, contributions to the funds pool in respect of the MBS and the PBS are calculated a capitation basis, rather than according to individuals’ historical levels of usage, and are provided in respect of all members of the community rather than selected individuals. Thirdly, the Aboriginal trials give particular emphasis to empowering their communities. Aboriginal organisations are involved in the management of each of the trials. Finally, there are no control groups in these trials.

Private health insurers could also introduce fund-holding as a way of lowering cost, increasing consumer satisfaction and improving the quality of the private health product for their members.

The private health insurers MBF and HCF are already participating in the existing coordinated care trials. Key issues arising from their participation so far include:

- the need to address regulatory impediments to private health insurers drawing on hospital table funds for non-hospital services; and
- the need to consider changes in reinsurance arrangements which currently reduce incentives for private health insurers to minimise hospitalisations amongst those members aged 65 and over.

To date, a lack of sufficient privately insured members in the trial populations has provided a logistical impediment to the participation of other private health insurers. There are several now actively pursuing the possibility of trials which specifically target the insured. This is being done in similar fashion to the establishment of the current trials.

Expressions of interest in developing new trials under the extended Coordinated Care Program will be sought from private sector providers of services, with the onus on those providers to negotiate cover by private health insurers where appropriate. It is expected that allowing providers to take the initiative will more likely generate workable proposals, which are more acceptable to those concerned about private health insurers encroaching on the autonomy of providers. These arrangements would still provide insurers with more control over their outlays than currently exists.

In most of the coordinated care trials, the key transfer of resources, to the extent that it occurs, is from hospital services to primary and community care. The major outlays of private health insurers are on hospital charges, and it is here that the new trials incorporating the private sector may or may not achieve a transfer of resources through coordinated provision of primary and community based care.
However, given that health services for privately insured consumers are funded from both public and private funding, there would have to be some mechanism to pool funds from a range of different sources to allow the fund-holder maximum scope to substitute appropriate services.

The fund-holder model is still being tested, both internationally and in Australia. The Australian coordinated care trials are building on lessons from overseas fund-holding models and providing an opportunity to test some of the assumptions about the impact of funding-holding in the Australian context. In some senses however this Australian approach has been unique because the objective of these trials is to increase the quality of health care by improving the allocation of services within existing resources rather than to reduce expenditure per se, which has been the primary motive behind the introduction of fund-holding in most other health systems.

Ultimately however, the success of any new health system model depends on a number of things. Firstly, it depends on the skills that are available to build and operate it. In terms of the skills required for fund-holding in a health system:

- there are currently no internationally agreed methodologies for calculating actuarially fair capitation payments, either for individuals or groups of people, which would provide an appropriate level of funding for their health needs and would minimise adverse selection;
- related to this, there would need to be an agreed minimum health care entitlement to form the basis of calculating an appropriate level of health funding for individuals and some agreement about who should provide that funding (that is, defining any public funding entitlement); and
- there is little fund-holding and service coordination expertise in Australia at the present time and this would have to be developed before a more widespread fund-holding role were introduced into the Australian health system. In addition, if competitive fund-holding were introduced, there would need to be a large number of purchasers with no barriers to market entry to ensure the high degree of competition upon which the benefits of competitive purchasing are premised.

Secondly, it depends on having the right environment to introduce the model:

- the unique size and population distribution of Australia provide a challenge to fund-holding. Scotton (1999, p221) has concluded that a minimum client base of 500,000 to 1,000,000 would be required to secure economies of scale and spread risk. While this might be achievable in some metropolitan areas, it is a potential problem for rural and remote areas. Fund-holding on behalf of Australia’s more geographically dispersed residents would need to be carefully developed; and
- the successful introduction of fund-holding in Australia would also depend on the support of a diverse range of existing funders who would be required to pool their current funding to achieve maximum allocative efficiency and reduce cost-shifting.

Thirdly, it depends on the ability to define a model which achieves the best balance between the competing objectives of the health system. The development of any fund-holding model would need to take into account whether:
the potential increase in transaction costs as a result of an increase in the number of players involved in the operation of the health system would be greater than any efficiency gains realised;

• a fund-holder's ability to negotiate on price would be as effective as government monopsony power under the current system;

• the quality of health care would be compromised due to the profit motive of a fund-holder, particularly a fund-holder in the private sector;

• it is possible to ensure that fund-holders do not inappropriately interfere with the clinical autonomy of providers but have some ability to encourage appropriate service provision; and

• consumers would accept the reduction in choice that may result from fund-holders contracting with some providers and not others, in return for potentially more consumer-focused health care and a reduction in information asymmetry.

And finally, it depends on weighing up the impact of the model for different groups in the community:

• there is still some debate about the efficacy of fund-holding and care coordination to improve allocative efficiency for particular groups in the community, such as those with chronic conditions and complex health care needs, compared with the benefits of introducing these arrangements for the general population; and

• there is also still some question about whether it is possible to improve allocative efficiency by introducing care coordination but maintaining existing funding arrangements i.e. not introducing any fund-holding. This is something which may be tested in the second round of coordinated care trials.

The coordinated care trials are a unique opportunity to explore many of these issues while retaining the existing health system in place in case care coordination and/or fund-holding fail to improve the objectives of the health system.
Conclusion

Various important conclusions can be drawn by comparing public and private health care funding and service delivery within the framework of achieving the four broad objectives of the health care system: good health, low cost, equity and satisfaction. These conclusions have been found to be consistent across health care systems in countries outside Australia and are also supported by the findings of this report. They suggest that the objectives of a health system are best met when there is a partnership between public and private sectors, as is the case with Medicare in Australia which is based on public and private sector contributions to both funding and service delivery. The nature of the optimal public/private sector mix is still being explored both in Australia and internationally.

Funding of health care

Equity is most soundly guaranteed when the public sector provides all funding. Government funding systems, including Medicare, are based on progressive tax and risk pooling arrangements that spread the funding burden across the total population.

However, there are limits to the total amount of public sector funding that is available to fund health care. Private contributions, either through private health insurance and/or through individual copayments, are required to provide access to services additional to those which can be afforded from public funding. Alternatively, public funding could be restricted, with private funding mandatory for certain groups of consumers such as those with higher incomes. Given the unpredictable nature of an individual’s health, private health insurance would need to be available to ensure that those who were not eligible for public funding could still access essential health services.

However, equity declines as the private sector’s responsibility for funding increases, with those on low incomes often excluded from a privately funded insurance system and services funded by the private sector. In addition, without community rating, private health insurers, applying risk selection strategies, may not offer their product to consumers with existing health problems, who are most likely to need health care.

Concerns that private sector funding jeopardises equity in a health care system can be addressed if both public and private sector funding are integral to the health care system. Under such arrangements public funding would be used to provide essential emergency care and a comprehensive array of supplementary services. The funding role of the private sector could then become that of providing greater choice in respect of a full range of health services or more choice in respect of elective or non-essential care only. However this mix of public and private funding responsibilities could allow private funders to design their products to transfer high-cost services and high-risk patients to the publicly funded system.

In Australia, the private sector already plays a substantial role in funding health care. Many of the associated equity and access concerns have been effectively addressed through Government strategies. These include
universal accessibility to a comprehensive, publicly funded health care system and the requirement that all private health insurers apply community rating principles to ensure equity of access to private funding.

International comparisons have provided strong evidence that it is more efficient to fund essential medical care through the public sector revenue collection system than through individual payments to a range of private sector funders such as private health insurers. The public sector funding arrangements in Australia efficiently redistribute the funding collected through the tax and Medicare systems across the population.

Funders may also influence the efficiencies of service providers. For example, while timeliness of public hospital care has previously been an issue, State Governments, as funders, have been able to influence hospital performance so that the waiting period for most public hospital services is now within medically appropriate times. The public sector, as funder, has had a significant impact on the containment of growth in health care outlays, which, at 8.4 per cent of GDP, is mid-range in relation to other OECD countries (OECD Health Data 1997). This has been achieved through monopsonistic purchasing powers, such as the Commonwealth Government’s influence over the price of pharmaceuticals.

The public sector has also taken primary responsibility for funding areas of the health system that require longer term investment before improved health outcomes can be identified. The private sector accepts less responsibility for investing in the future capacity of the health care system through education, training and research and for funding population health or preventive health strategies. That said, funding from the private sector does increase total available health care funding, reduces demand for publicly funded health care and offers consumers and providers greater choice of services.

Ultimately, most health systems rely on a combination of private and public funding. In Australia, scope for competition between funders is quite limited. Private health insurers operate as an additional option to Medicare, not as an alternative, and are prevented by legislation from competing with the public system for the funding of many services. There are also other legislative barriers to competition within the private health insurance market, but the larger private health insurers are starting to compete more aggressively for increased market share.

**Delivery of health care**

The private sector plays a significant role in delivering health care to Australians. Almost 70 per cent of all funding is used to deliver services in the private sector. The mix of private-public sector funding and delivery is complex with some types of care, such as medical specialist services, funded and delivered through the full continuum of public-private permutations.

It is yet to be proven whether private or public sector delivery of health services has any impact on the achievement of the health system objectives. While it is commonly argued that the private sector brings greater efficiencies to health care delivery, this is yet to be supported by hard evidence.

Appropriate incentives can improve efficiencies in either sector. Competition between and within the public and private sectors might increase efficiencies. This is one of the approaches being introduced across various areas of
health service delivery (for example, hospital services and hearing services), although it is too early yet to assess the outcome.

It appears possible to use specific funding mechanisms to minimise inter-sectoral variation between services. These mechanisms include output-focused contracts that define the level and type of service to be provided and explicit funding of community service obligations to be met by either the public or private sector when delivering health services.

Balancing low cost and equity is also important. Public sector service delivery can offer particular benefits in this regard. For example, the public sector to date has accepted responsibility for providing care in less populated areas which do not present a profitable proposition to potential private sector providers. Withdrawing such services would reduce equitable access to care. Private delivery of such care would be possible if contracting and incentives were appropriately designed. Regulation or incentive schemes may also be required to ensure that residents in all locations have reasonable access to doctors’ services.

Similar regulatory mechanisms can also be used to ensure services provided in both sectors are of appropriate quality. Although the public sector has played the major role in the development of quality measures, different measures are used across both sectors and the definition of quality of health outcomes is still its infancy. Therefore, it is not yet possible to assess whether or not there are significant differences in the quality of health services and health outcomes across the sectors.

In general, it appears that the private sector’s potential for contributing to health system objectives is greatest when it provides services that have identifiable, measurable goals that are regularly monitored and evaluated. The private sector is less likely to achieve the appropriate balance between gains in efficiency, equity and quality of care if it is required to deliver health care services that are difficult to define and have complex goals. Conversely, some private sector providers bring greater flexibility to their work arrangements, allowing them to incorporate new innovations and upgrade facilities more rapidly than public sector providers.

The UK Government has introduced a mixed public/private sector approach to service delivery through its Private Finance Initiative and Public Private Partnerships. As stated by the Right Hon Alan Milburn, Chief Secretary to the UK Treasury in the Blair Government:

In some areas, the private sector is best able to provide the services. In others, the public sector is in the best position. And in many cases the best way forward is through new partnerships between the public and the private sectors. Where each brings something to the table….the key test is what works. We recognise that what the public want is better quality, more responsive public services. Quite rightly, they want their services to be both dependable and modern. Their concern - like the Government's - is about outcomes not ownership (UK Treasury, 1999).

Consumer choice of, and satisfaction with, health care delivery is expected to increase when there is competition between a range of service providers. Currently, there is little competition either within or between the sectors and the consumer’s role in choosing between providers is questionable in many areas of the health system. The limited
availability of specialists, particularly in rural and remote locations, and GP-specialist referral arrangements also limit consumer choice. The scope to increase consumer choice through privately delivered health care and competition is relatively limited under Australia’s current health care arrangements.

The primary area in which competition between public and private sectors has existed for some time has been in the provision of acute hospital services. Even here, the level of competition is quite limited. Taxing and funding entitlements and/or restrictions have affected the competitive neutrality of this market and potentially the scope for fair competition. Some private hospitals have responded to this competition by changing their product; for example, by developing niche markets to reduce their level of direct competition with the public sector. At the same time, although private hospitals are providing more complex care, the range, complexity and severity of cases covered in public and private facilities remains different and the private sector can still restrict the range of complex or costly services it offers.

**Resource allocation**

Decisions about service delivery in both sectors are largely the responsibility of individual providers, principally medical practitioners. In these circumstances, the relationship between funders’ or consumers’ priorities and the type of care actually delivered can be tenuous. In addition, the boundaries between differing funding areas also result in less than optimal resource allocation as they encourage perverse behaviours, such as cost-shifting, preclude substitution and prejudice the appropriateness of health care.

Improved resource allocation, on the other hand, has the potential to meld financing and delivery systems to better address health care objectives and achieve a more optimal mix of services for individual clients across both public and private service systems.

‘It is the quality and availability of health care services which is important not the identity of the provider and/or the purchaser of that service’ (Samuel, 1999). However, it should also be noted that improved technical and allocative efficiency usually results in reduced choice for consumers and less clinical autonomy for service providers.

Conversely, traditional indemnity funding across separate components of the health care system does not encourage decisions to be made about the appropriateness of one type of service over another, or whether a service should be provided at all, for an individual patient. These same issues apply regardless of whether the indemnity funding comes from the private or public sector.

One potential way to improve allocative efficiency and appropriateness of services is to have a fund-holder who is able to pool funding across programs, substitute more appropriate services and help coordinate and integrate services for the individual. These fund-holders could sit in either the public or private sectors and competition for fund-holding responsibility on behalf of a constituency or competition between fund-holders for clients could improve their performance.
If responsibility for resource allocation remains with service providers, there may be limited improvements in efficiency. However, transferring funding responsibility to fund-holders needs to be done carefully if service providers are to retain the appropriate level of clinical autonomy and quality of services. This concern applies equally to fund-holding by either the public or private sector. In addition, the introduction of any fund-holding arrangement would require further development in a number of areas including:

- the costs and benefits of introducing such a model in the Australian health care context;
- the definition of a minimum package of health care services of specified quality to which all individuals would be entitled;
- a methodology for calculating capitated payments; and
- fund-holding and service coordination expertise in Australia.

Finally, there is room for improvement in our current health system in relation to all of the objectives of the health system but in particular in terms of efficiency and the coordination of consumer-focussed services.

In relation to the funding of services in the future, evidence suggests that it is more efficient and equitable for basic health care to be primarily funded by the public sector, however there will continue to be a legitimate demand for additional services which can be privately funded.

In relation to the provision of services, the sector of service delivery is less important than the nature of the funding arrangements, which can be improved by more active purchasing of services rather than passive indemnity arrangements. This will require more expertise in specifying and measuring the services to be delivered and the outcomes to be achieved. There is an opportunity to learn more from the growing number of public and private funders who are defining, monitoring and evaluating services under contracting arrangements.

Pooled fund-holding arrangements may offer an opportunity to increase allocative efficiency, but before going down this route, it would be necessary to ensure that the benefits derived would not undermine the benefits inherent in the current health system, that they would not be outweighed by the cost of any transition and that they would not undermine the other objectives of the health system.
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