

Life, Death and Dollars: does Medicare need major surgery?

UTS Public Lecture
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Why is surgery being considered?

- 8 of 10 Australians generally dissatisfied with the health system
- Costs to the economy 4% GDP in 1970 to 9.7% now
- 68% of the \$78.4b spent by government
- Success of National Competition Policy

- Predicted to rise to 15% GDP by mid-century
- Private spending through health insurance and out-of-pocket payments increasing faster than other household budget items

Don't just sit there ...

- *One area in which there is much opinion but often poor analysis and evidence is health care reform. Reform and research seldom march arm in arm. The challenge for researchers is to slow the rush of politicians enthusiasms. (Maynard)*

Radical surgery or conservative treatment?

- Overall our system does reasonably well
- Health systems are victims of their own success
- Ill considered reform is bad for your health

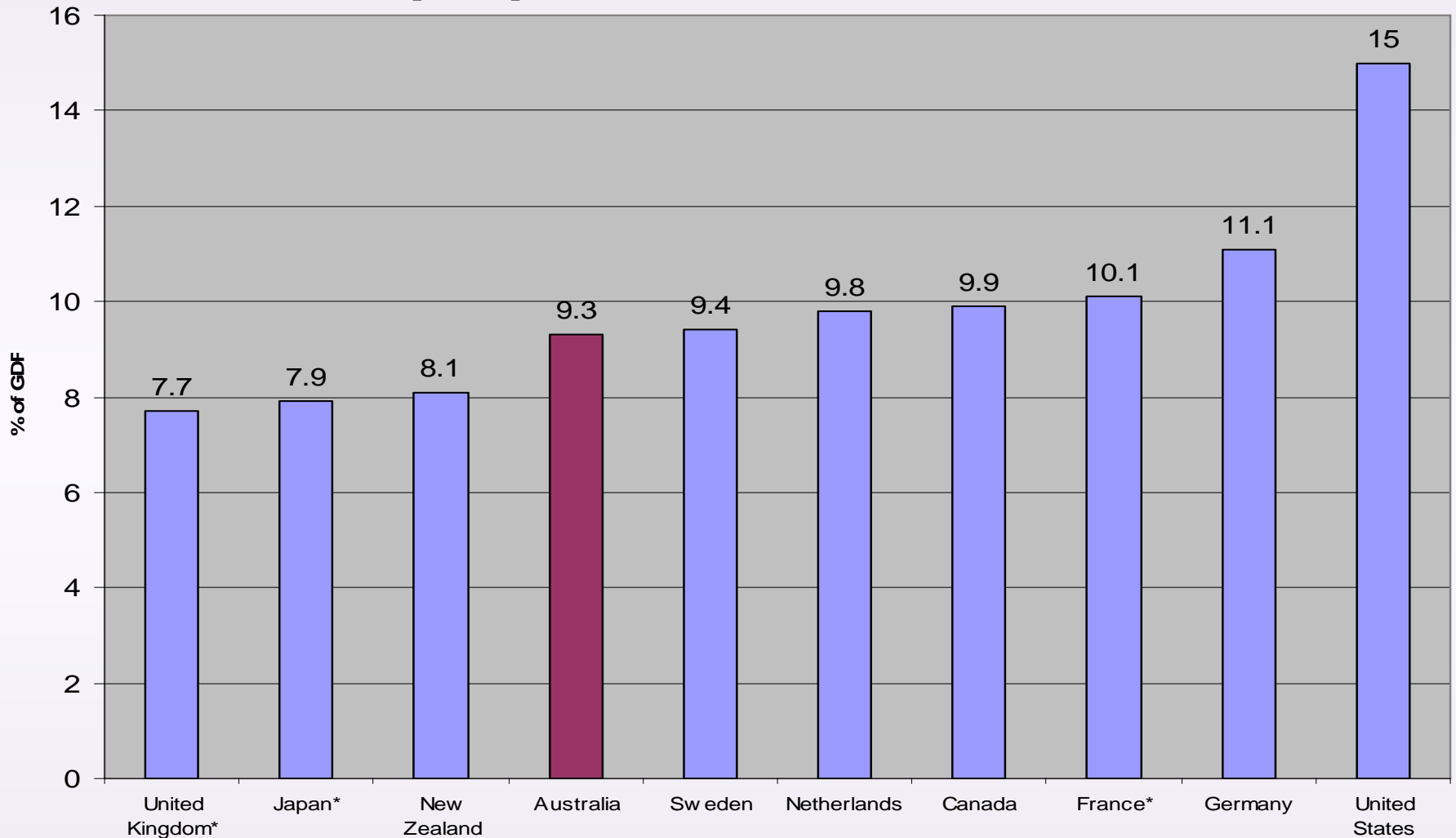
The building blocks of the system

- Free treatment in public hospitals
- Subsidised or no charge medical services (MBS)
- Subsidised pharmaceuticals (PBS)
- Duplicate & supplementary private health insurance
 - Private treatment in hospital
 - ancillaries

What the system delivers

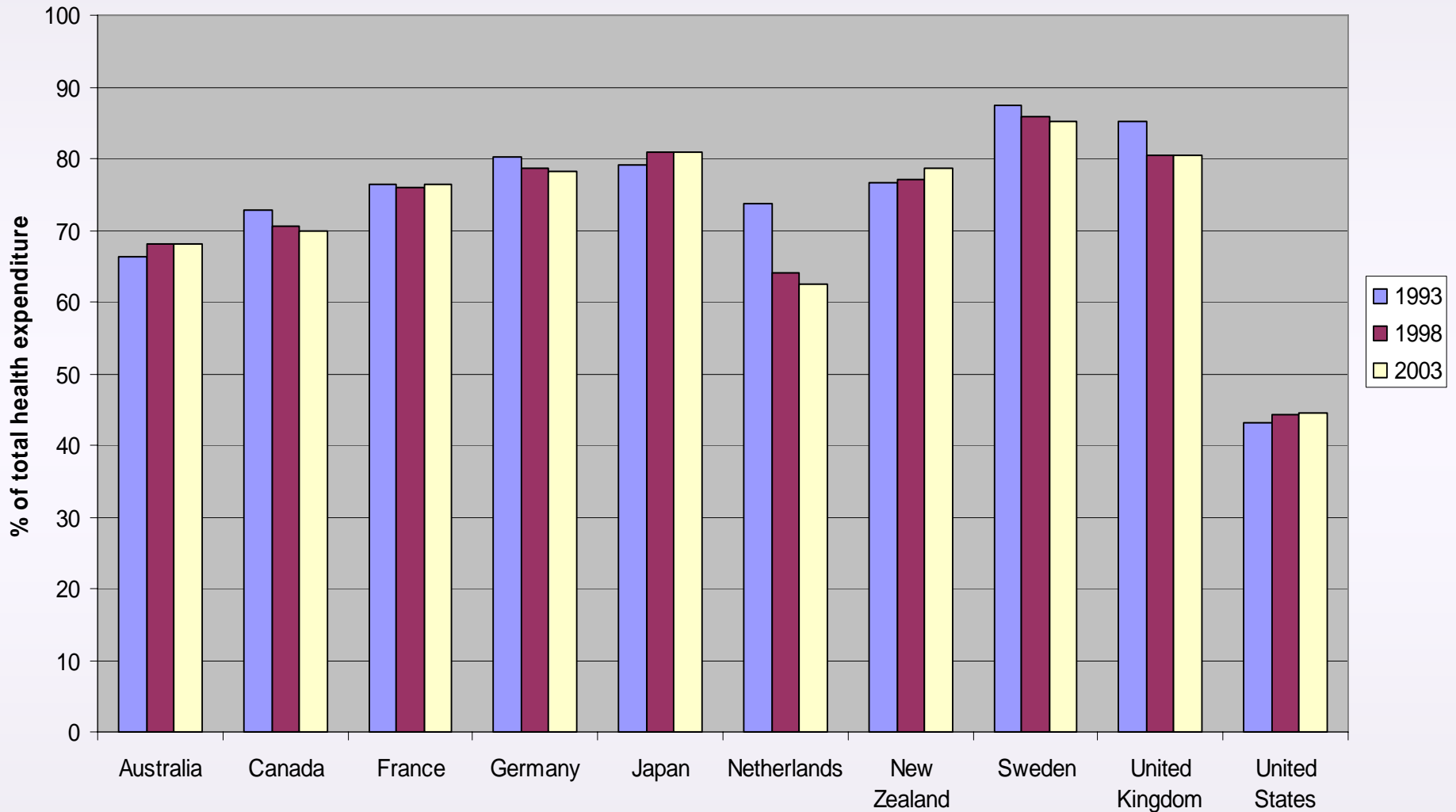
- Healthy long life
- Reasonable cost
- Similar level of government funding
- Average levels of satisfaction
- Universal coverage
- Pro-poor utilisation
- High out-of-pocket expenses

Total health services expenditure as a proportion of GDP 2003



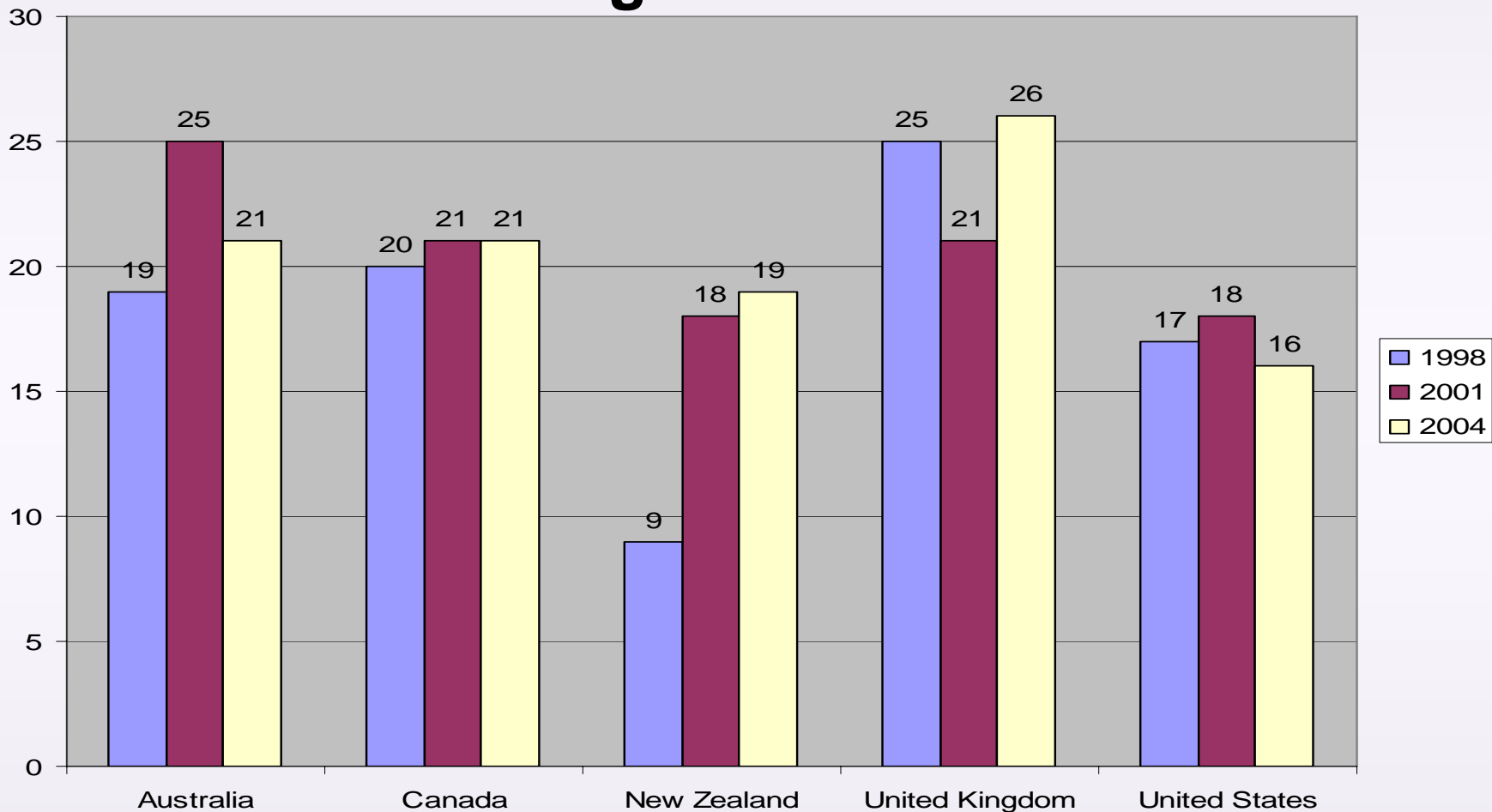
* Data for 2002 or estimated (Source: OECD health data 2005)

Government expenditure share of total health expenditure – international comparisons



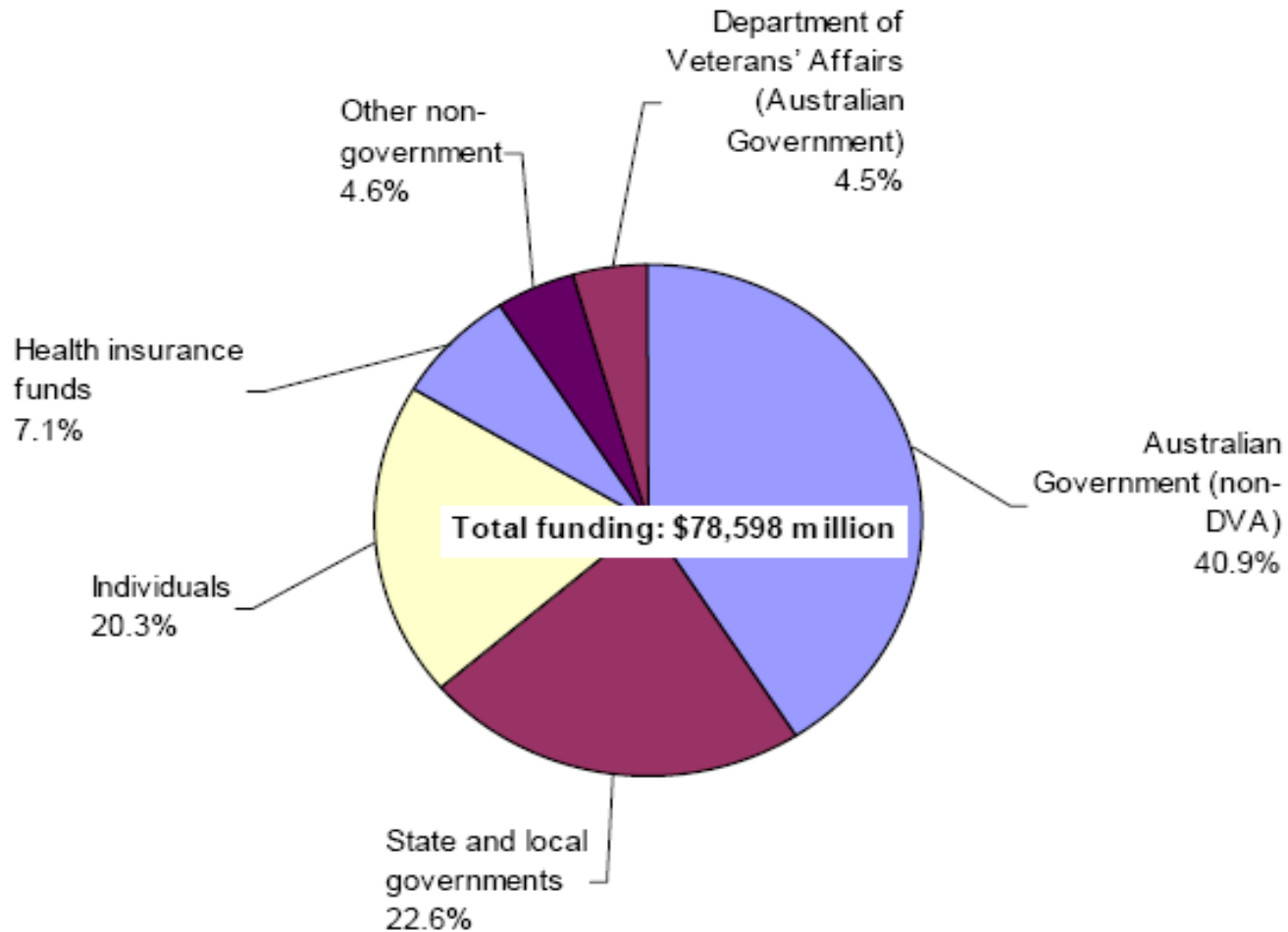
Source: AIHW Health Expenditure Australia 2003/04; OECD 2005

5 Country Survey: general satisfaction with health system % saying only minor changes needed



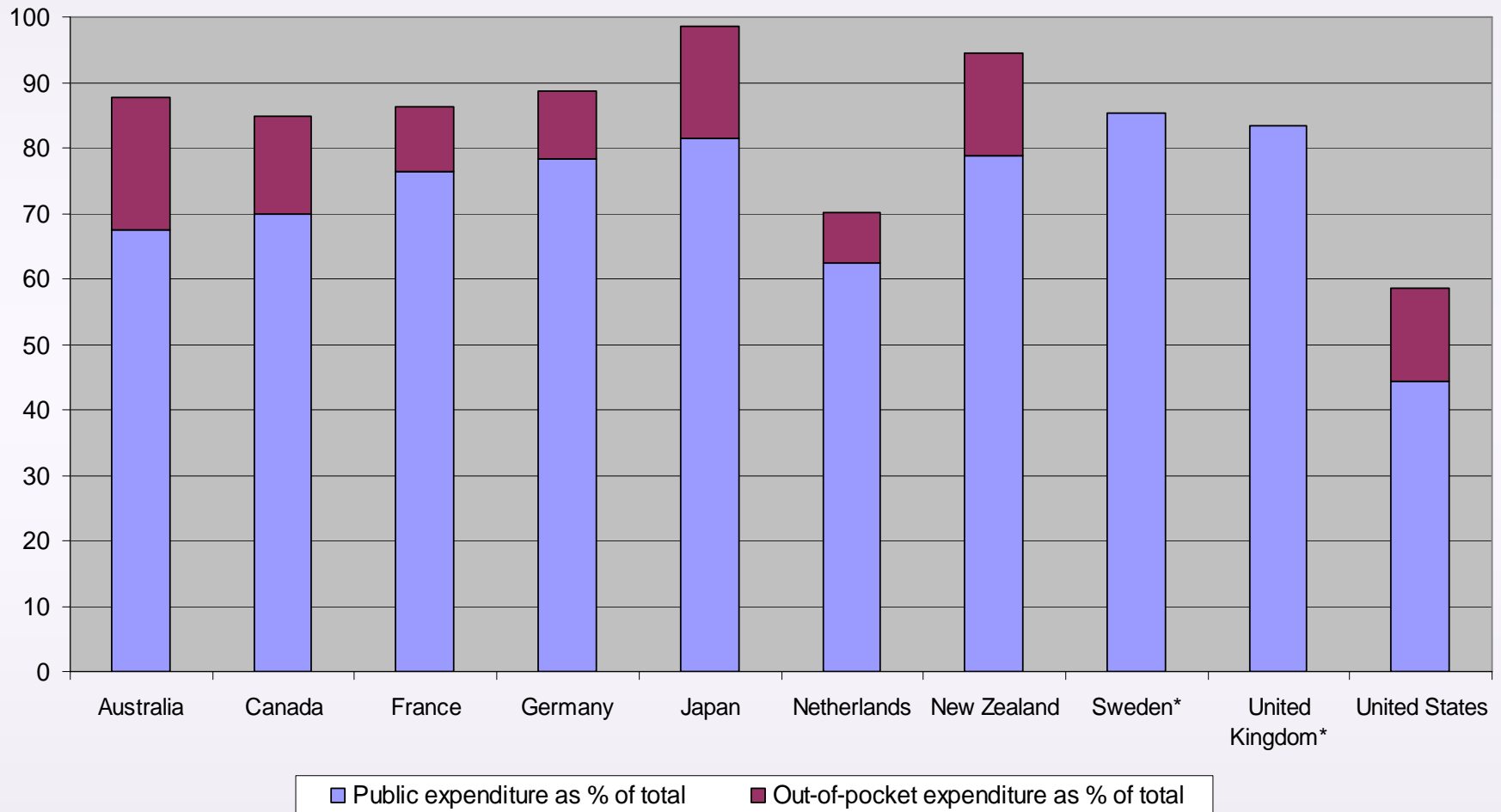
Source: Commonwealth Fund International Health Policy Survey 2004

Source of funding



Source: AIHW Health Expenditure Australia 2003/04

Public and out-of-pocket expenditure as a % of total



* Data for out-of-pocket expenditure not available

Source: OECD health data 2005 & AIHW Health Expenditure 2003/04

Health systems – victims of success

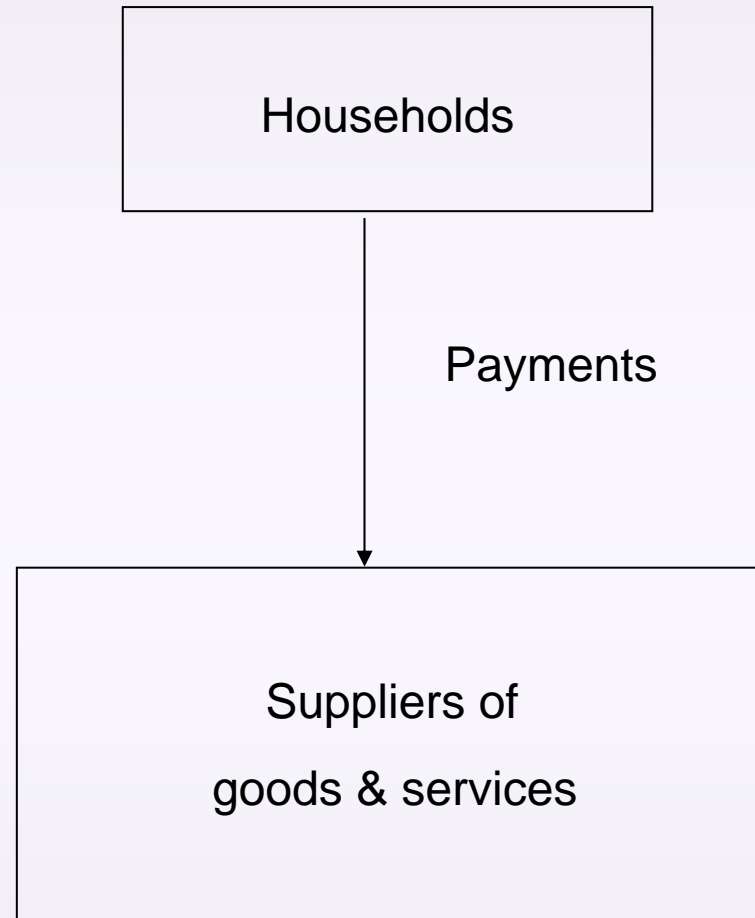
- Advances in technology
 - *Not for the good that it will do
But that nothing may be left undone
On the margin of the impossible (TS Eliot)*
- Developments in funding
 - *Universal and affordable access to high quality medical, hospital and pharmaceutical services (Dept Health & Ageing)*

Value for money – the key issue

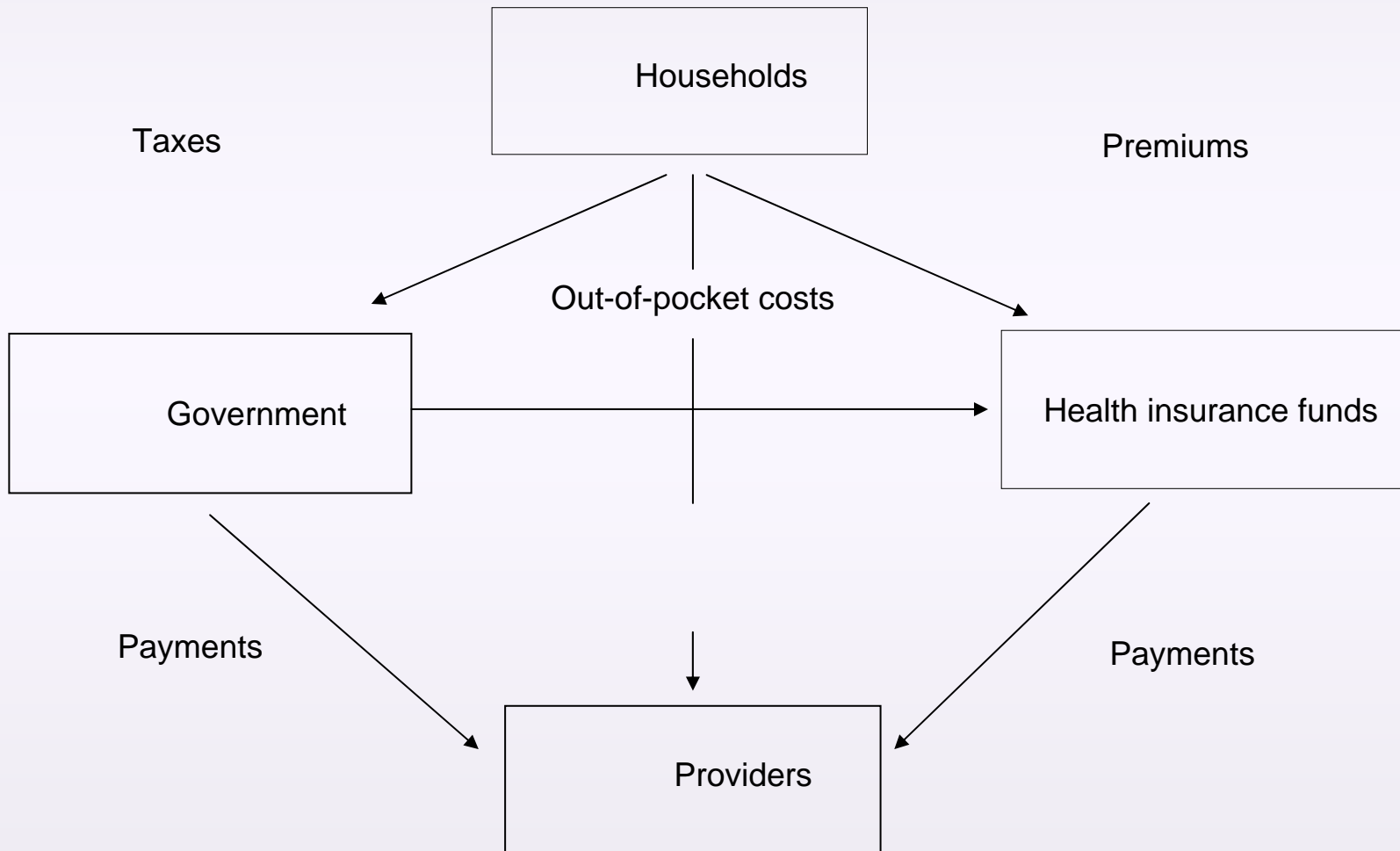
- *Advances in medical technology can induce increased spending – the critical issue is whether increased spending brings benefits that exceed the additional costs (Productivity Commission)*
- *Policy-makers worldwide are on a quest to control national spending for health care and to enhance the value of whatever is being spent on health care (Reinhardt)*

Judging the value of health care

- Buying health care but valuing health
- Consumers' lack of information means reliance on professional advice
- Uncertainty leads to insurance
- Altruism requires cross-subsidies



Simplified flow of health funding in the domestic health sector



Understanding complex systems

- Providers respond to incentives
- Medical practice variations
- Change incentives or constraints and behaviour changes

Medicare Safety Net

- At the outset the policy was estimated to:
 - Costs \$440 million over 4 years
 - Cover 450,000 families and individuals
- Seven months after implementation, these figures were revised to:
 - Costs \$1 billion over four years
 - Cover 650,000 families and individuals

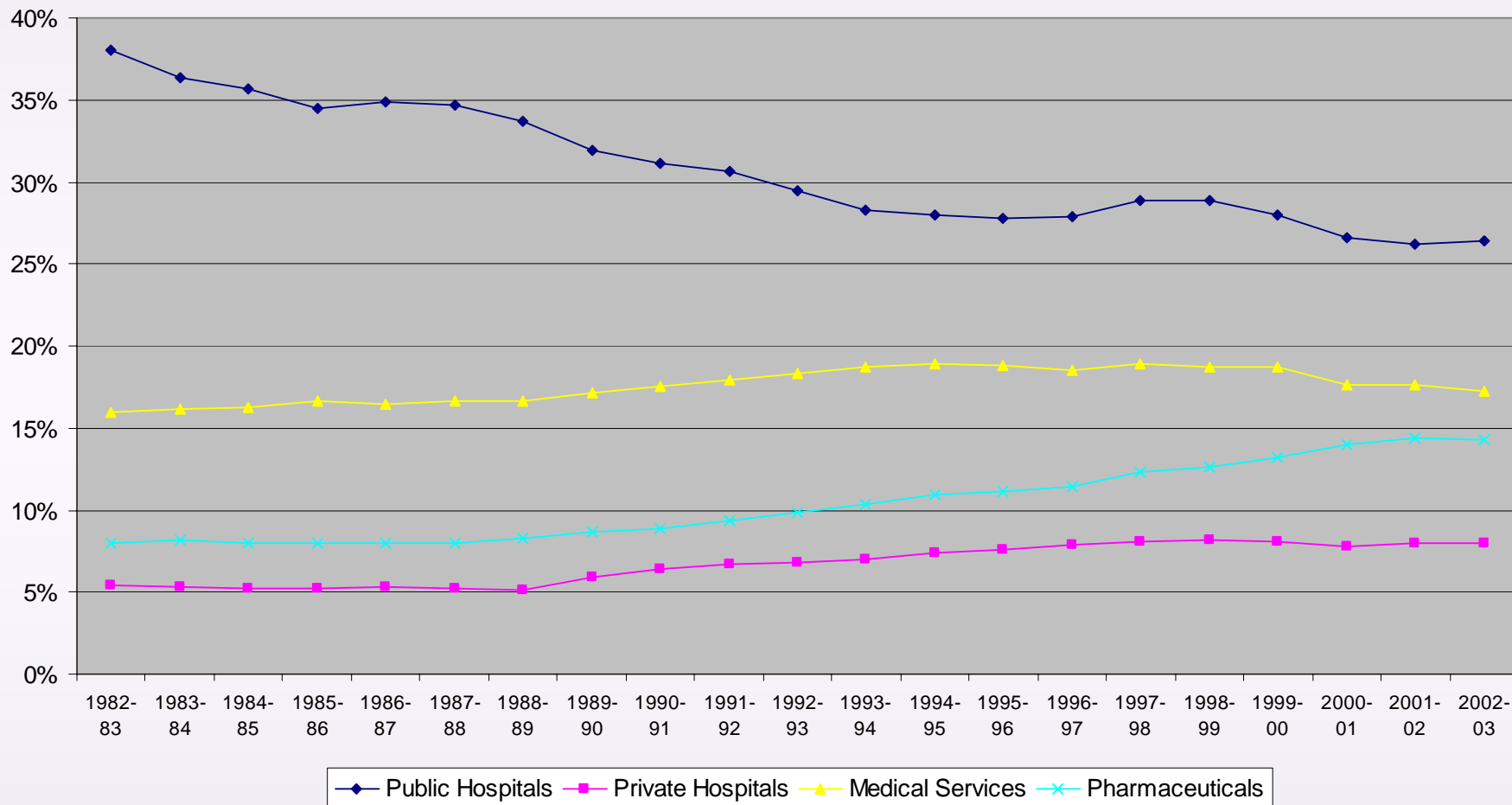
Ill considered reform is bad for your health

- Rand study on co-payments (Manning et al, 1987)
- Nursing levels and adverse events (Aitken et al 2002)
- Competition and quality in the NHS (Propper et al, 2004)

So where does that get us?

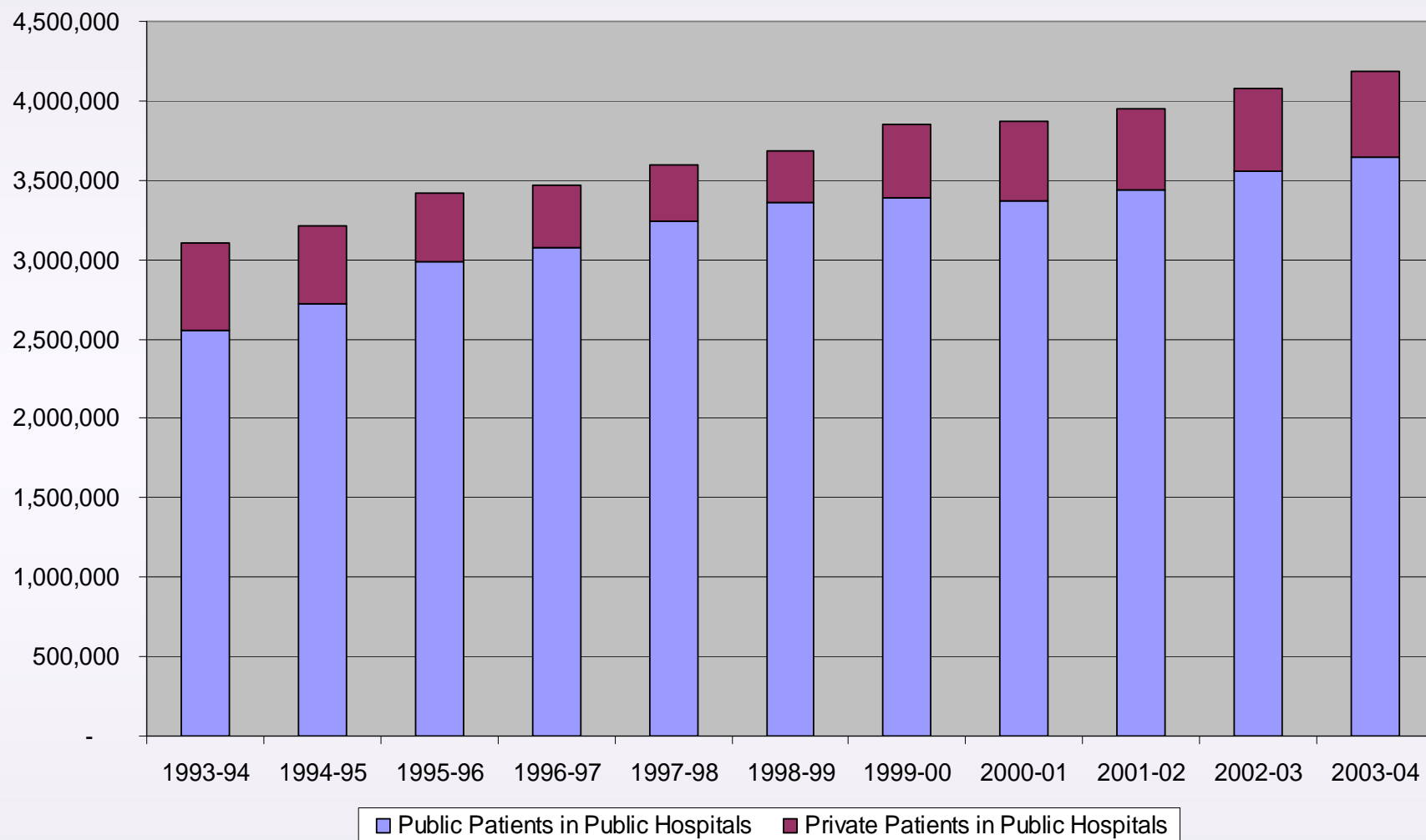
- For every complex problem there is always a simple solution
- And it's always wrong

Australia % share of total health expenditure by selected areas 1982-2003



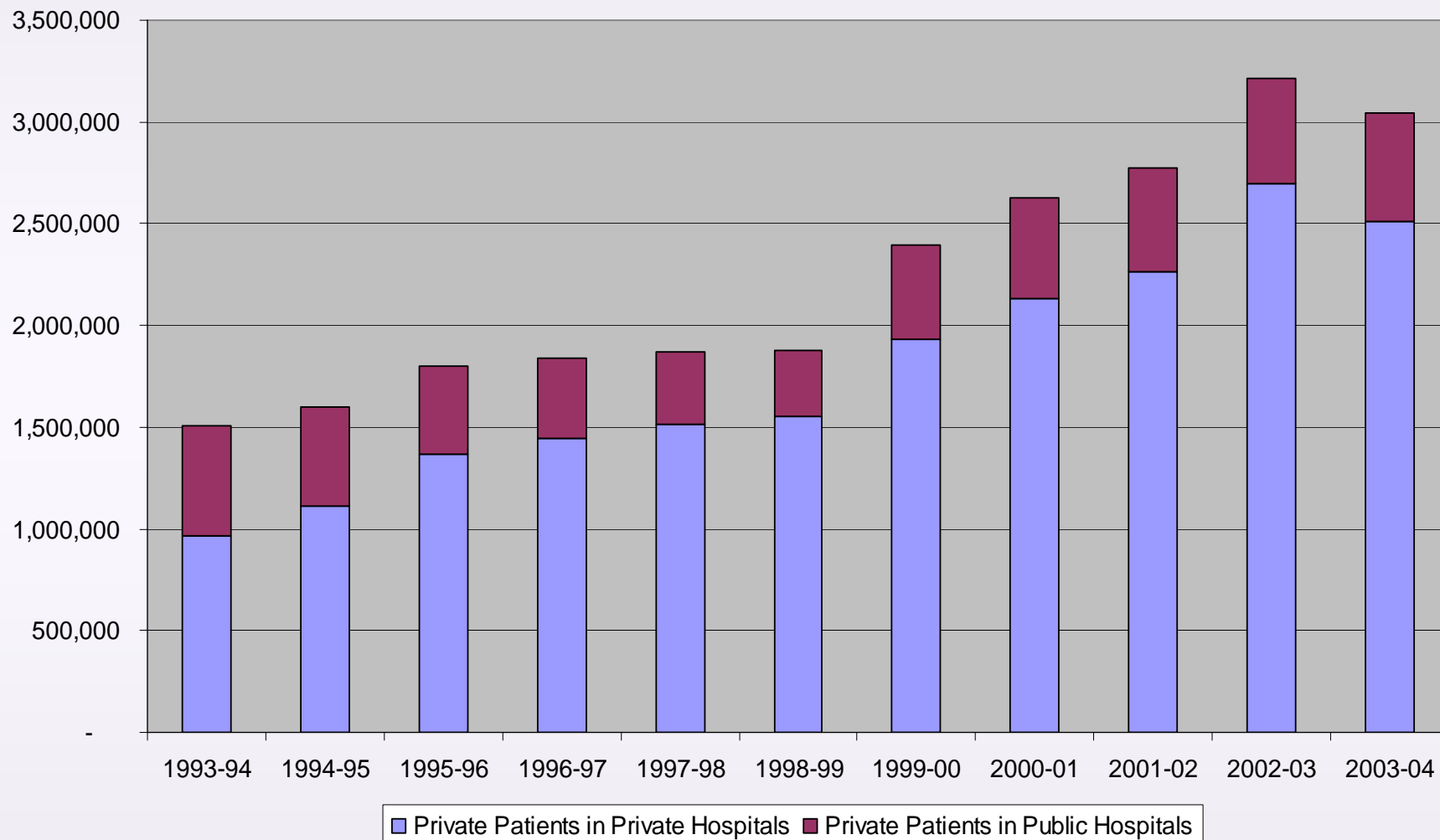
Source: AIHW Health Expenditure Australia

Growth in public hospitals



Source: AIHW Health Expenditure Australia

Private patients in public & private hospitals



Source: AIHW Health Expenditure Australia

Public hospitals

- Changing technology leading to shorter lengths of stay, more out-of-hospital treatment
- Budgets set by state & territory governments
- Increasing workload – quantity and complexity
- Lack of potential for change

In & out of hospital care

- Separate funding programs
- Historically appropriate
- Problems of lack of flexibility and poor co-ordination
- Budget holding

Australian evidence

- Co-ordinated care trials – large demonstration projects
- Notional budgets, pooling public funds
- Control groups used to evaluate
- Equivocal on outcomes and costs
- Several trials would not be financially viable

UK evidence

- Initial trial scheme for GP budget holding achieved spending limits but self selected
- Part of wider NHS reforms
- GP budget holding considered a success and now extended across England and to 75% of health care budget
- Major increase in health care budget

Lessons for reformers

- Complex systems need complex solutions
- Health care can be a financial black hole

Advantages of budget holding

- More co-ordinated care
- Flexibility to move funds
- Budget constraint

But

- Efficiency gains not easy
- Who should hold the budget?
- For what population?
- Under what incentives?
- What structure for resource allocation?

So what about insurers as budget holders?

- Managed competition
- Insurers compete on price and quality
- Insurers must offer comprehensive cover
- Consumers free to choose insurer and switch insurers

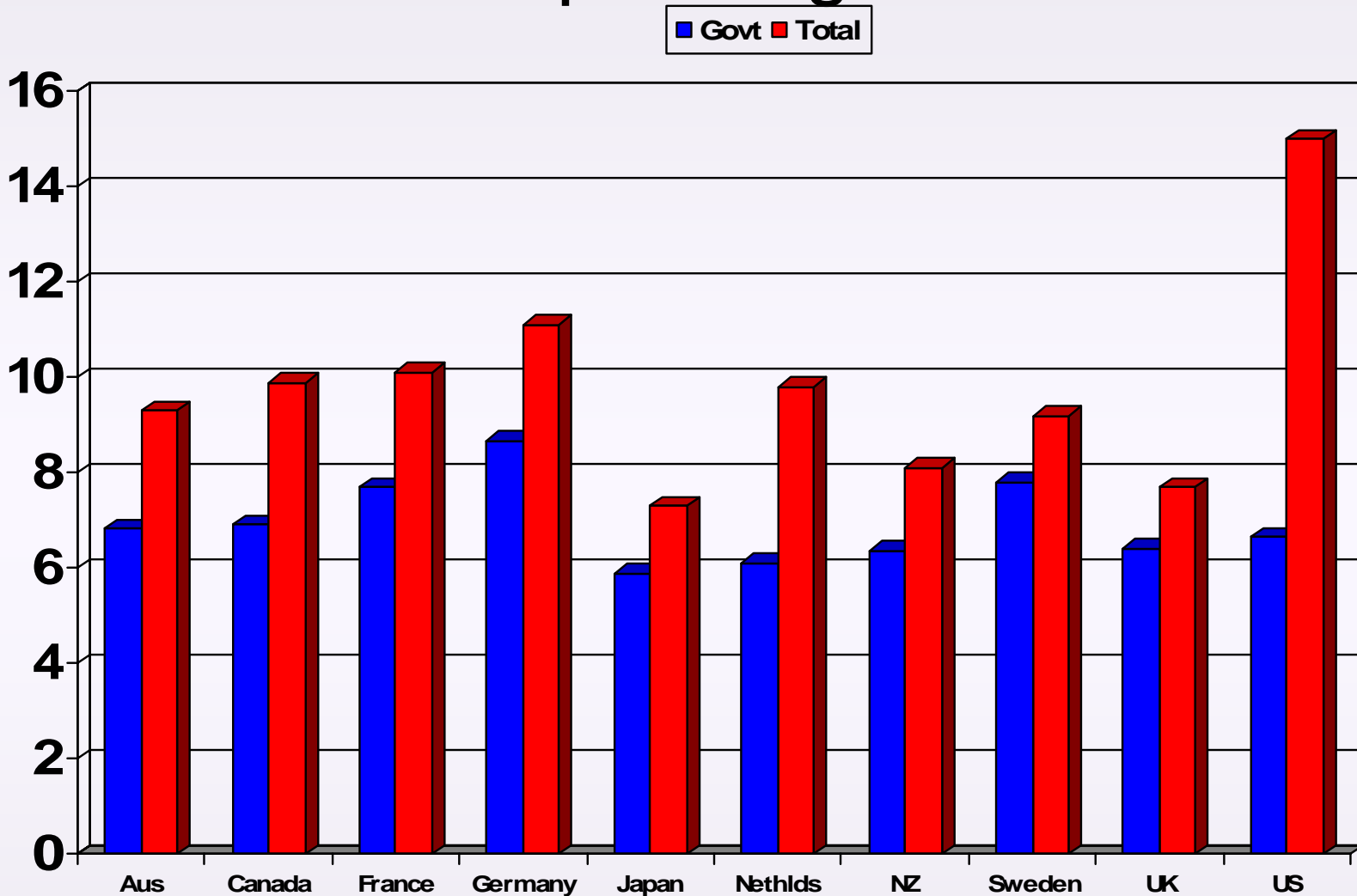
Everyone is better off ... (in theory)

- Consumers have choice which will meet their preferences
- Providers are wooed by insurance companies
- Governments spend less
- Insurers make a profit
- Health outcomes improve
- Health care sector is more efficient
- Social welfare increases

US evidence on competitive insurance

- High spending, high growth, high prices.
- Problems of uninsured
- Higher administration and compliance costs
- Major government involvement.

Government spending as %GDP



US evidence on managed care

- Move to managed care in 1980s
- Managed care plans had lower growth in spending during 1990s (Glied 2000; Reinhardt 2000)
- High users are less likely to select managed care
- After controlling for selection, costs & use are lower to no different;
- Insurers faced excess capacity in doctors and hospitals (Miller & Luft 1997)
- Cost reductions appear to be once-only (Heffler, Smith 2002)

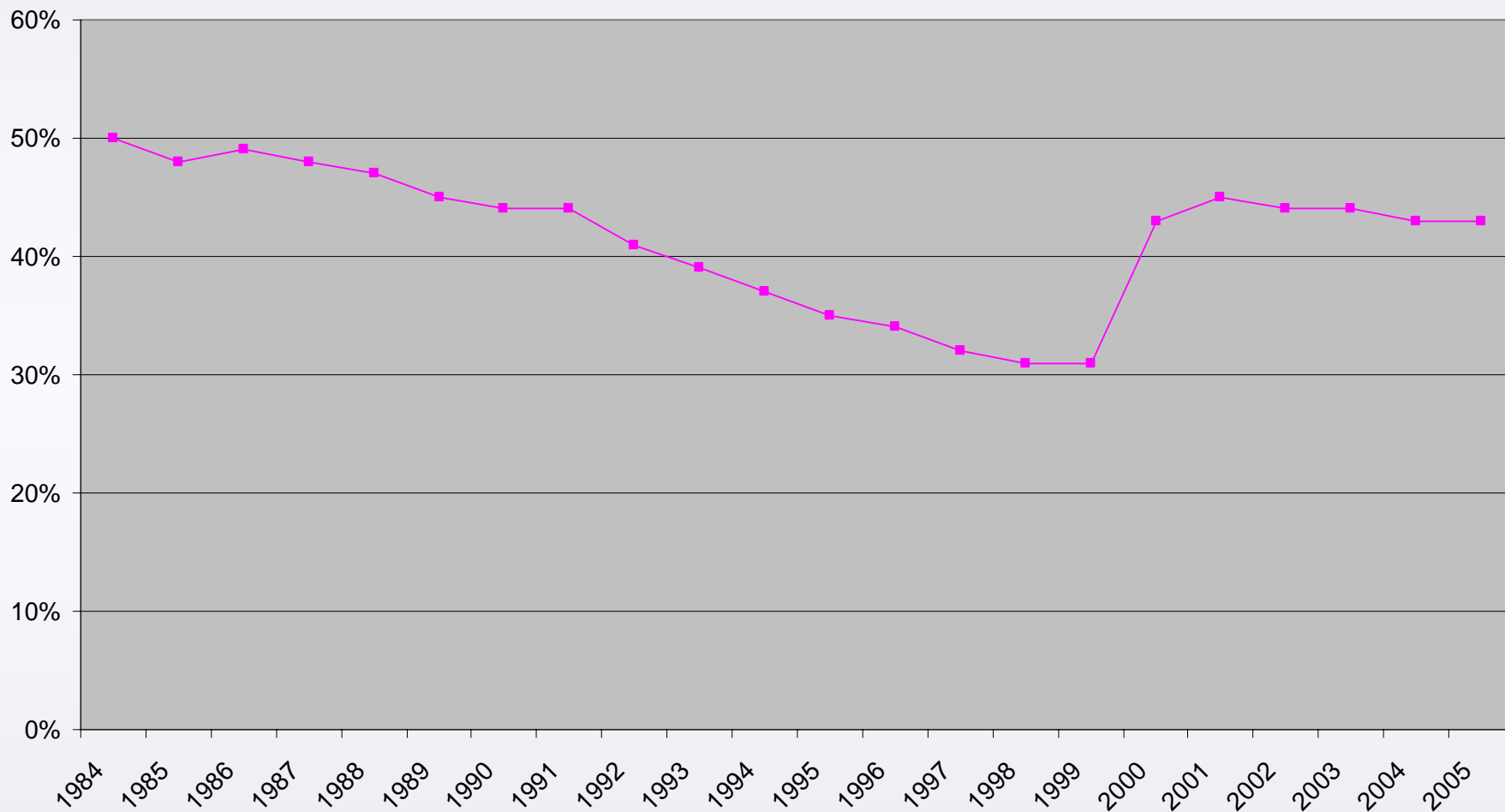
Consumer choice

- Satisfaction results mixed
- Cost, service coverage, choice of doctors and quality are important
- Information hard to understand
- Choosing difficult and frustrating
- Reluctance to switch

Australian health insurance

- Duplicates public services - private hospitals & choice of doctor
- Australian private insurance in public hospitals

% of Australian population with private hospital insurance 1984 – 2005

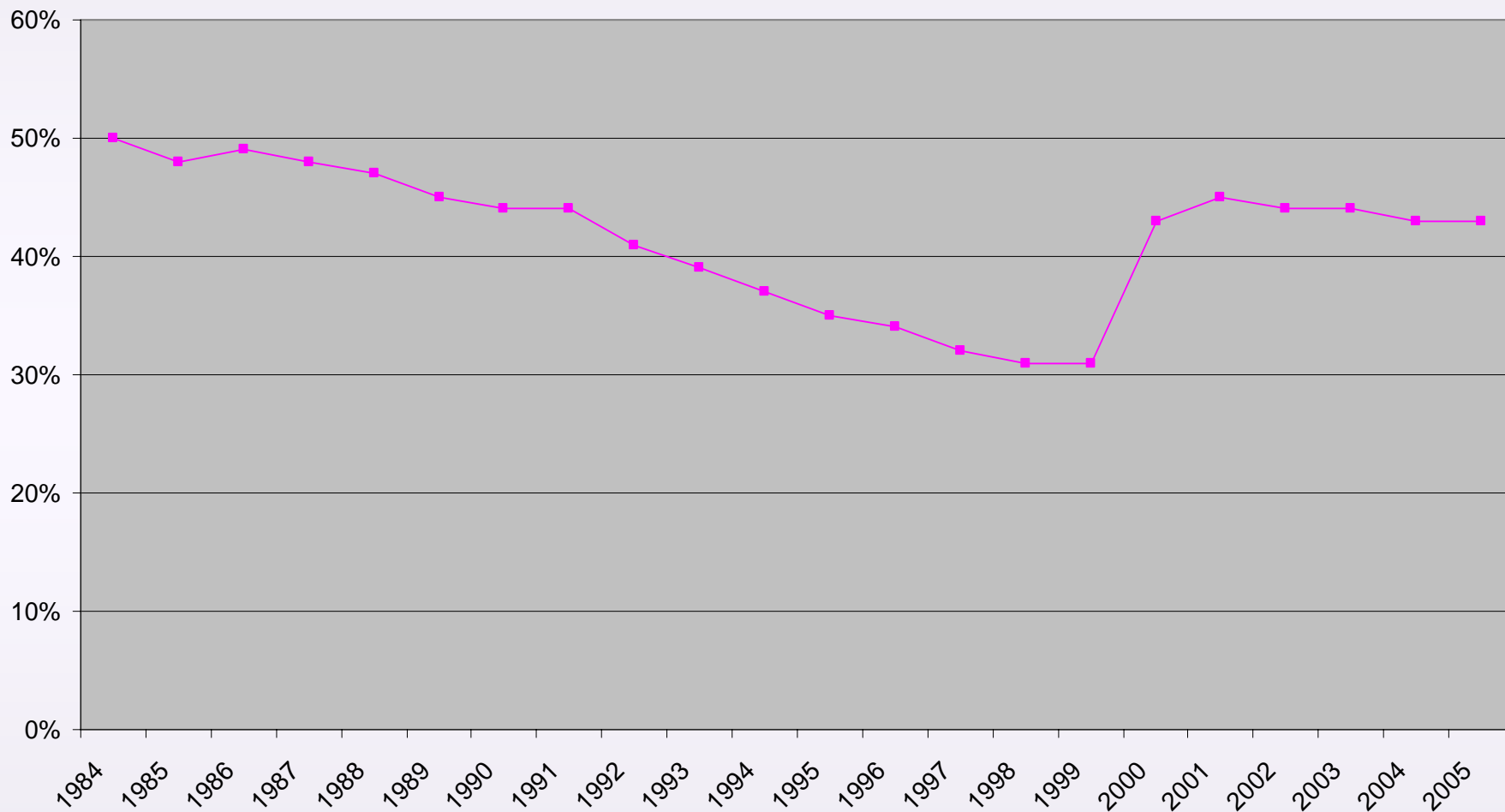


Source: PHIAC

Private health insurance policy - carrots and sticks

July 1997	Rebates for low income tax surcharge for high income
January 1999	30% rebate - no means test. Tax surcharge remains Insurance cheaper for the rich
July 2000	Lifetime healthcover

% of Australian population with private hospital insurance 1984 – 2005



Source: PHIAC

Changes to private health insurance

- Age profile changed
 - 65+ from 14% to 10%
- 33% increase in benefits per person covered
- Premiums continued to increase around 7% pa

Due to ...

- 29% increase in benefits per episode
- No gap policies increase - 81% of services provided
- Private hospitals no more efficient than public (Duckett & Jackson 2000)
- Private patients stay longer (Savage & Wright 2003)
- Private patients have more procedures (Robertson & Richardson 2000)
- 74% increase in benefits paid per hospital day

Duplicate insurance

- Government approves premium increases and pays for 30% of them
- Must offer more than the free public alternative
- Affordability means restricting choice
- US style managed care restrictions unpopular

Private health insurance

- Is the policy effort warranted?
- Is 30% subsidy warranted?

Developing the health workforce

- Productivity Commission
 - More flexibility
 - Open medical benefits to other professional groups

General practice in Australia 2000-01

- 9 600 businesses, 13 305 practices
- 70% solo practitioner, 6% >6 practitioners
- \$10 335m turnover
- 43.8% Medicare services
- 5 visits per person per year

Source: AIHW 2004

Reasons for GP encounter

Table 6.10: GP consultations: 20 most frequent patient reasons for encounter, 2002–03

Patient reason for encounter	Per cent of total RFEs	Rate per 100 encounters	Patient reason for encounter	Per cent of total RFEs	Rate per 100 encounters
Check-up	9.0	13.6	Headache	1.4	2.1
Prescription	7.1	10.8	Abdominal pain	1.3	1.9
Cough	4.5	6.7	Depression	1.3	1.9
Test results	3.6	5.4	Hypertension	1.2	1.8
Immunisation/vaccination	3.1	4.7	Nasal congestion/sneezing	1.2	1.7
Throat complaint	2.5	3.8	Ear pain	1.1	1.7
Back complaint	2.3	3.5	Diarrhoea	1.0	1.6
Rash	1.9	2.8	Weakness/tiredness	1.0	1.5
Fever	1.5	2.2	Administrative procedure	1.0	1.4
Upper respiratory tract infection	1.4	2.2	Knee complaint	0.9	1.3

Note: RFE—reason for encounter. Based on 152,341 RFEs at 100,987 encounters.

Source: AIHW: Britt et al. 2003.

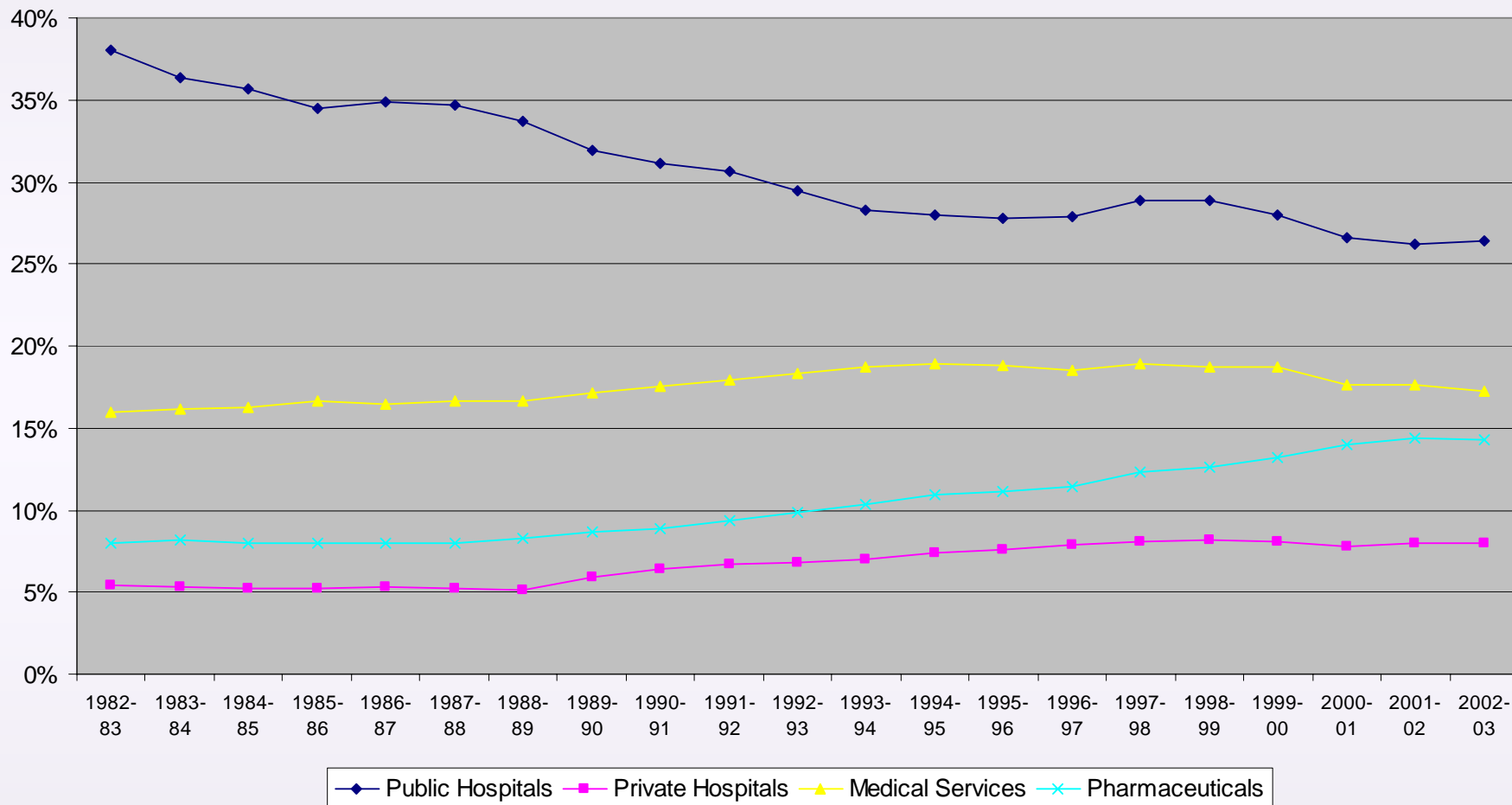
Competition in optometry

- Non-medically trained optometrists allowed to claim MBS items
- Price fell – bulkbilling 75% to 90%
- Services doubled

New approach to primary care

- Structure for efficiency
 - Size and skill mix
- Multidisciplinary teams
- Alternatives to fee for service

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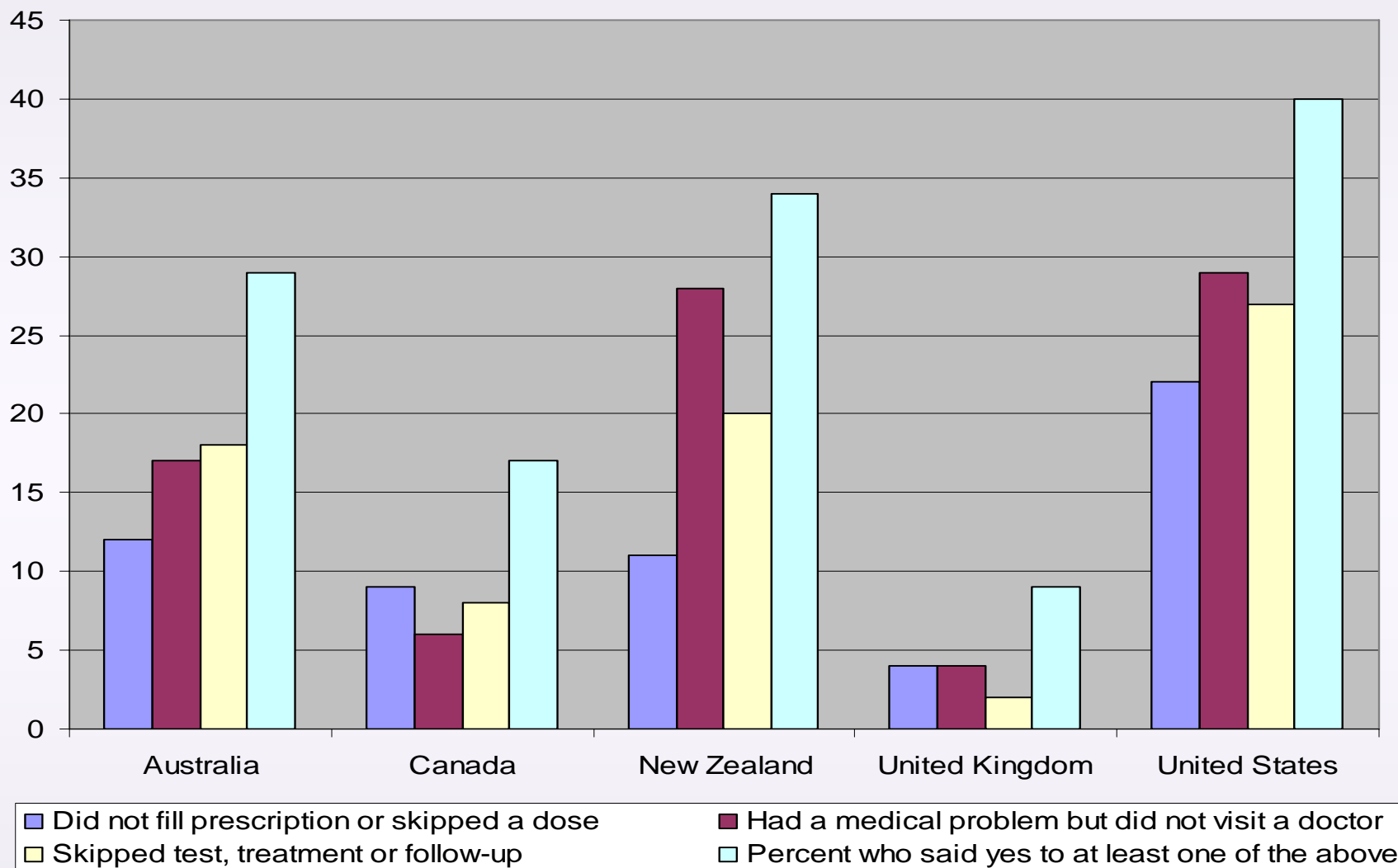


Source: AIHW Health Expenditure Australia

Out-of-pockets

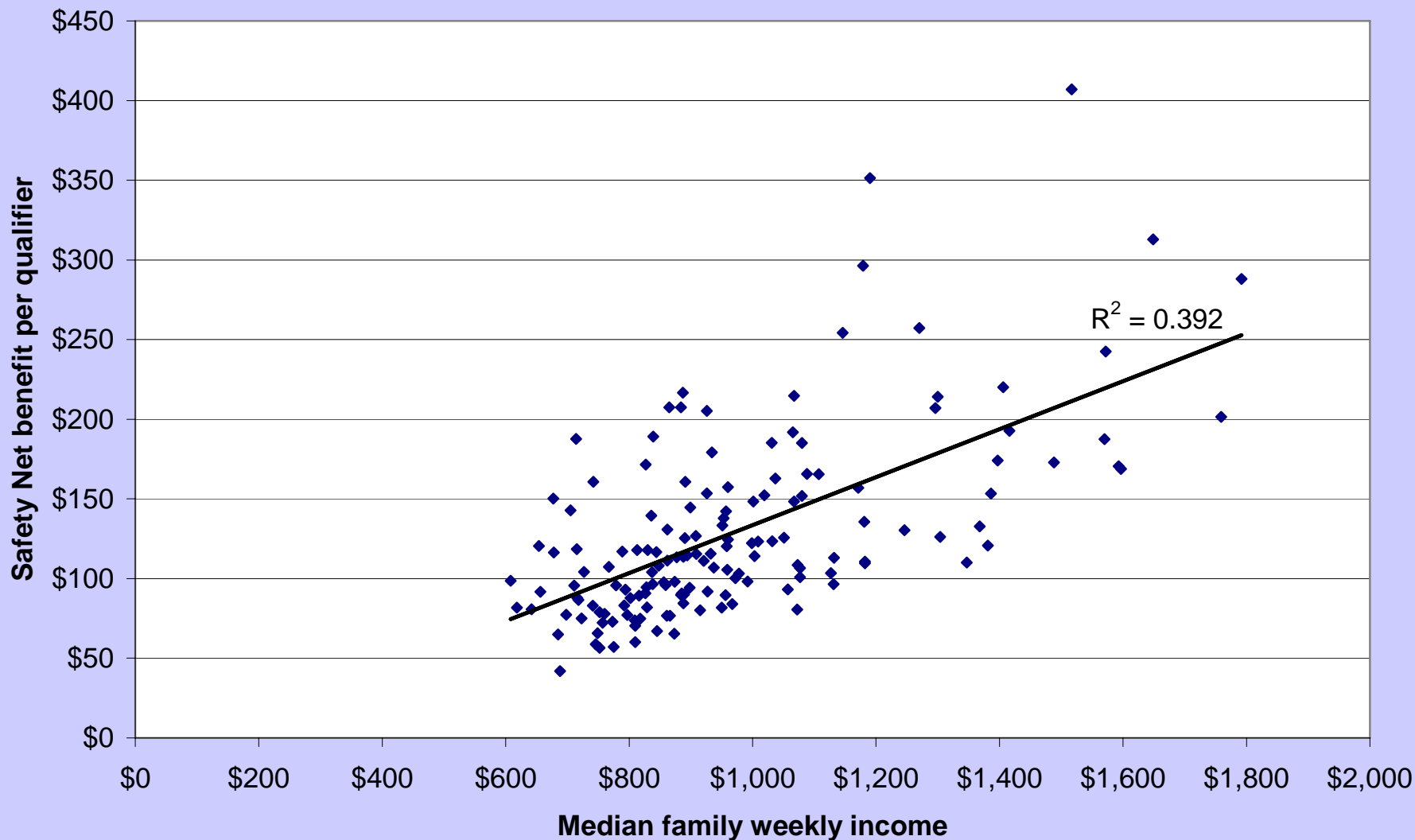
- Non PBS pharmaceuticals 26%
- Dental services 21%
- Aids and appliances 14%
- Other professional services 13%
- Medical services 10%

5 Country Survey: cost-related Issues



Source: Commonwealth Fund International Health policy Survey 2004

Safety Net benefits and median family income by federal electorate



Lessons for reformers

- Incentives work but not always as predicted
- Simple solutions do not fit complex systems
- Health is a financial black hole
- All health care expenditure is provider income

But lots we don't know

- Understanding behaviours
- No one is an average doctor or an average patient
- Use data
- Generate data under experimental conditions