Chapter 3

OPTIONS FOR UNIVERSALITY OF COVER

RECOMMENDATIONS

6. **Australia should continue to ensure that all citizens are covered for the cost of basic health care.**

7. **An independent standing committee be established to advise the Australian Ministers for Health about: (i) the range of affordable health services to be included in the Medicare scheme; (ii) the level of co-payments to be paid by users of each health service.**

8. **Australia should continue to have a mixed public and private health care financing system supporting a mixed public and private health care delivery system.**

BACKGROUND

A national health insurance scheme with the broad objective of universal coverage has existed in Australia since 1953.

Prior to 1975, universal coverage was not fully achieved although the uninsured numbers (excluding uninsured Queenslanders) were only around three to four per cent of the population. The scheme was principally provided by a heavily subsidised, highly regulated voluntary private health insurance industry.

From July 1975, universality was achieved through the Medibank program, which was removed in the late 1970s, and re-achieved through the Medicare program, which commenced in February 1984. Australians would not now accept an option of dropping universality of coverage for a range of basic health services. Within the universality of cover requirement, there are three issues to be considered:

1. **The Definition of Medicare Health Services:** Is the present range and level of eligible Medicare services correct? Should the range of eligible services be extended to those provided by the private sector not already covered by Medicare? What should be the process to determine which new health services are included, including services involving new medical technologies, as well as health services currently not included?

2. **The Delivery of Medicare Health Services:** How should Medicare's health services be delivered? Is the mix of Commonwealth, State and private sector services appropriate? What options are there for changing the mix?

3. **The Affordability of Medicare Health Services:** How should Australia keep the cost of Medicare's basic health services affordable? Are current methods the best? Should Australia be using methods of cost curtailment currently being developed in other OECD countries, such as funder/provider splits in the public health system (which has now been introduced in Western Australia), forms of managed competition and forms of managed care in the private health system? What overall goals and targets for affordability should be set?

MEDICARE HEALTH SERVICES

The current definition of Medicare health services includes:

- ambulatory medical services, which are delivered free of charge to patients if the doctor bulk bills, or delivered with some level of patient payment;
- ambulatory optometrical services (because of overlap with ophthalmological services). These are delivered free of charge to patients because optometrists have agreed to always bulk bill;
- hospital outpatient services. These are delivered free of charge to patients;
- acute and chronic public hospital Medicare patient inpatient care. These are delivered free of charge to patients who waive choice of doctor, and include pharmaceuticals required while in hospital and usually for a limited period post hospitalisation.

Medicare does not include:

- ambulatory dental and paramedical services;
- "private hospital" inpatient and outpatient care;
- pharmaceuticals prescribed as a result of ambulatory care - but a separate government program heavily subsidises these pharmaceuticals.

Medicare also pays for a component of the cost of:

- public hospital "private" inpatient care;
- long term care of non acute patients in public hospitals;
- medical services provided in private hospitals.

There are three other Commonwealth programs providing health services:

- Pharmaceutical Benefits Program. Since 1953 this program has heavily subsidised pharmaceuticals prescribed by registered medical practitioners to ambulatory patients - but not to in-hospital patients in public hospitals. It also often heavily subsidises pharmaceuticals prescribed to patients in private hospitals, private nursing homes and hostels;

- Aged Care Program - particularly in respect of "care" benefits provided to patients in private nursing homes and government subsidised hostels;

- Veterans Affairs Health Programs. The Department of Veterans Affairs owns its own hospitals which provide services to war veterans and to other patients. The Commonwealth has embarked on a long term program to transfer these hospitals into State public hospital systems.

There seems to be a perception among Australians that these three programs are part of Medicare.

The Aged Care Program provides health care services or benefits, personal care services and benefits, and benefits for accommodation for the frail aged. It would not

be easy to separate the health care services and benefits from the other services and benefits of this program.

As mentioned above, the long term objective of the Commonwealth seems to be to include the health care services provided to war veterans within the Medicare program, albeit with special conditions and privileges for these patients.

The pharmaceutical benefit scheme, however, is funded as a separate program and administered by the Health Insurance Commission - the same body that administers the Medicare ambulatory medical benefits program. There seems no reason why this program should not be a component of Medicare, while still continuing the special arrangements with the pharmaceutical manufacturing industry (for example Factor f[2]).

In recent years, increasing Pharmaceutical Benefit Scheme co-payments may have been used as a proxy for endeavouring to curb the growth of ambulatory medical services, costs (see Table 3). However, the change in mix of services and the increases in dispersing costs have generally kept the copayment in the range of 40 to 70 per cent of the "cost" for "general benefits" and 20 to 30 per cent of "concessional benefits". This is another reason why the Pharmaceutical Benefit Scheme should be included as part of Medicare, to enable a more direct approach to curb the demand for medical services.

CHANGING THE DEFINITION OF MEDICARE HEALTH SERVICES

The definition of Medicare health services is likely to change as a response to:

- pressures by payers (including government) to reduce costs and increase productivity and improve outcomes;
- pressures from the community for coverage of services at the margin of basic health services;
- pressures from providers for their unincluded services to be included;
- "me-too" pressures generated from studies of other countries' health financing systems;
- pressures from the community and the health professions for coverage of new services developed out of emerging health care technologies.

[2] Factor f is an export enhancement scheme for pharmaceutical manufacturers.

TABLE 3: PHARMACEUTICAL BENEFIT SCHEME CO-PAYMENTS FROM 1960 TO 1993

Date of Change	Amount General	Percentage of average cost of a "general benefit"	Amount Concessional	Percentage of average cost of a "concessional benefit"
March 1960	$0.50	22%		
November 1971	$1.00	40%		
September 1975	$1.50	51%		
March 1976	$2.00	59%		
July 1978	$2.50	60%		
September 1979	$2.75	60%		
December 1981	$3.20	62%		
January 1983	$4.00	69%	$2.00	34%
July 1985	$5.00	73%	$2.00	32%
July 1986	$5.00	64%	$2.00	29%
November 1986	Max $10.00	54%	$2.50	27%
July 1988	Max $11.00	51%	$2.50	27%
July 1989	Max $11.00	53%	$2.50	25%
July 1990	Max $11.00	49%	$2.50	23%
November 1990	Max $15.00	55%	$2.50	21%
August 1991 *	Max $15.70	57% **	$2.50	21% **
October 1991 *	Max $15.70	52% **	$2.60	22% **
August 1992 *	Max $15.90	45% **	$2.60	20% **

* Maximum patient contribution applies to PBS items where a household's cumulative threshold is below $312.30 for the calendar year. Subsequently, all general prescriptions attract a maximum patient contribution of $2.60, until a further threshold of $52.00 is reached. Thereafter, they are entitled to PBS medications free of charge for the remainder of the calendar year.

Pensioners and Concessional patients pay a maximum of $2.60 per items for the first 52 prescriptions. Thereafter, they are entitled to PBS medications free of charge for the duration of the calendar year.

** Preliminary estimates.

The ideal definition needs to be flexible enough to adapt to sustained long term pressures in any direction, but robust enough to avoid succumbing to pressures which are likely to last for only a short time (eg. recession induced budgetary restraints).

In view of past and future developments in technology, issues of budgetary restraint and affordability, it is inevitable that changes to Medicare health services will occur. The provision of funds to finance increases or improvements in Medicare health services will become increasingly difficult for the Australian community to afford.

What is needed in Australia is a definite process by which governments, taxpayers and health care providers continually consider what is included, and what is excluded, in the core of eligible services wholly or heavily financed by the taxpayer. As evidenced by the abandonment of the Commonwealth's proposal in the 1993 budget to eliminate eye testing from core services, government will not be able to easily vary basic health

services or their "out-of-pocket' costs for reasons of financial restraint, without an appropriate majority in both Houses of Parliament.

For this reason alone, a standing committee, representative of all stakeholders (Commonwealth, States, medical and other health professionals, and consumers), is needed to evaluate the future mix of affordable health services to be included in the Medicare scheme, and the level of "out-of-pocket" costs, if any, that should be associated with each health service. The advantage of this approach would be to remove from the political arena the decision to include or exclude particular Medicare services, and the decisions on the levels of benefits to be payable.

PAYING FOR BASIC HEALTH SERVICES IN AUSTRALIA

Ambulatory Care

With the exception of ambulatory medical services not bulk billed[3], and the pharmaceuticals prescribed as a result of an ambulatory medical service, basic health services are provided "free" at the point of service. Government fully pays for ambulatory medical services that are bulk billed, and pays for a component of the cost of the pharmaceuticals prescribed as a result of ambulatory medical services.

Hospital Care

Government fully pays the cost of hospitalisation of a Medicare patient in a public hospital. Government partly pays for "private" public hospital inpatient care, and also long term care provided in public hospitals.

Patients finance the cost of services not met by government, mostly via private heath insurance arrangements for high cost services, and usually out of their own incomes or savings, for lower cost services.

EQUITY OF ACCESS

Equity of access to Medicare is a primary and important goal. However, unless there are surplus capacities in all components of the "basic" health system (and in all geographic areas), and all basic health services are affordable at the point of service for all persons, then equity of access cannot be fully achieved. Because major components of government expenditure on health are limited, equity of access cannot mean immediate basic health service availability to all citizens, regardless of socio-economic and geographic status. Therefore, equity of access, in practice, has to mean something less than the ideal. Equity has to be compromised by decisions made by health administrators and clinicians which relate to the resources available because of budgetary allocations, the efficiency by which the demanded services can be provided, and the effectiveness of the likely outcomes. Waiting times for some basic health services have to be the inevitable result, and occasionally people have to miss out entirely on some services.

[3] Some 63 per cent of all medical services are bulk-billed. (72 per cent of general practitioner services are bulk billed.)

Waiting times are a difficult issue to deal with when resources are finite because:

- They can vary enormously from procedure to procedure (or illness to illness) and from one geographical area to another. Reducing the variation in the length of waiting times across geographical areas is difficult, because it often requires moving resources, which in itself is often an expensive exercise. Reducing the variation in the length of waiting times across procedures (or illnesses) is also not easy if the cause of the variation is the lack of trained specialist personnel or the lack of specific facilities, since both tend to have long lead times to correct.

- They are open to manipulation. Such manipulation may just be benign (i.e., because a patient or the patient's GP is a close friend of the required specialist). Other manipulation may result from one patient being more convenient to treat than another, or more "profitable" to treat than another. Often, persons with higher economic means are able to reduce their waiting times at the expense of persons with lower economic means.

- There are often compilation errors. For example, individual patients may be on several waiting lists for the same procedure, and once the procedure is obtained the patient might not be immediately eliminated from all the waiting times they were on.

EQUITY IN FINANCING

How a universal health scheme can be financed equitably does not have an easy answer. The concept of all citizens paying for basic health care according to their means, although laudable, is not regarded as entirely appropriate for other basic necessities such as water, power, basic food, housing, clothing and education.

While the provision of water was traditionally financed through water rates based on the rateable value of a property, the trend now is to user pays. This is justified on the grounds that water is a scarce resource and a user pays system ensures it is less likely to be wasted. On the other hand, electricity, which is also a "basic" commodity, has always been provided on a user pays basis, although some subsidisation occurs between classes of users.

The user pays system is also used for other basic commodities, such as food, shelter and clothing. User pays is employed with sometimes significant government subsidies for private school education but not the alternate, often equally effective, public school education. User pays is employed with significant government subsidies to university eduction. Overseas students, however, have to fully meet their own education costs in Australia.

Health is different, because the demand for the higher cost services invariably occurs at the time when a person is not able to pay. In any event, treatment of major illnesses and medical events is so expensive, that nearly all those suffering major medical events would not be able to pay for the services as and when they were used. A third party intermediary is, therefore, required to pay for these services. Government or government owned or sponsored "insurance" businesses (often called social insurers) often act as the third party intermediary financing health services provided to a country's citizens. Government or government owned insurers are mostly financed by

taxation revenue, social security and "health" levies, or taxes or surcharges on employees and employers incomes, or through direct payroll taxes.

BASIC HEALTH FINANCING AND DELIVERY MODELS

In ten OECD countries (Australia, Canada, France, Germany, Italy, New Zealand, Spain, Switzerland, United Kingdom and USA) basic health care is provided and financed by three different models. Elements of two or more models are found in each country to some degree. The three models are:

- The National Health Service Model - the entire population is given free access to publicly controlled basic medical care which is mainly funded out of general tax revenue;
- The Social Insurance Model - basic health care is mainly financed by payroll or similar taxes shared between employer and employees. Usually there is a mixture of public and private providers of the health care provided under this model;
- The Private Insurance Model - health care is mainly financed by voluntary private health insurance contributions. Most health care is provided by private providers.

Each of the models has general advantages and disadvantages.

The National Health Service Model has an efficient and "equitable" financing system, but may result in a fairly restricted health care delivery system, leading to inequities of access. Both in the United Kingdom and New Zealand, attempts are being made through funder/provider splits to make the delivery of health care more competitive (and hopefully more efficient) under this model. The problem with principally tax financed schemes is that they add to the tax burden of a country, and potentially reduce the community's incentive to become more productive.

The social insurance model has a less efficient financing system, which may have specific implications on business growth in the longer term, if it is financed principally by payroll taxes. Often there are competing social insurers when there is a predominantly private health care delivery system.

In reality, each country has its own combination of health financing and delivery models which often develop from its historical culture. Each country's model has its own peculiar advantages and disadvantages. All OECD countries seem to have similar problems with their health financing and delivery systems. The common problems are cost or lack of resources, or both, with the major reasons being:

- the rapid developments in medical technology;
- the globalisation of medicine due primarily to the information revolution;
- additional demands caused by changing population demographics and changing social structures.

These elements of change appear to be pushing the costs of health up rapidly in nearly all OECD countries, and only when GDP growth is strong in a country does it appear that health care costs are relatively under control.

CONTROLLING HEALTH COSTS

Methods that can be used by governments to control health costs include:

- More tightly defining basic health care. This shifts services from basic health care to non basic health care, and may cause such services to be unable to be accessed by some groups of the population;
- Introducing "prices" at the point of service for services that were otherwise provided free of charge. Even small co-payments or coinsurances often have a significant impact on the utilisation of previously "free" services;
- Rationing some components of basic health care delivery. This often results from top down global budgetary approaches to controlling health costs, often referred to as "capping" expenditure. It usually reduces the growth in costs but also usually reduces access equity. This could be brought about, for example, by reducing hospital bed numbers or restricting the number of medical practitioners;
- Suppressing health care prices or price increases, or suppressing increases in subsidies to cause consumer payments to increase in lieu;
- Introducing regulations to restrict health care work practices, for example, by regulating referral practices;
- Delaying the introduction or widespread use of new expensive health care technologies, especially when their efficacy is unproven;
- Improving efficiency in the health care delivery and administrative systems by, for example, changing incentive arrangements within the system.

The first five methods often cause health cost growth to slow initially, but usually eventually cause a shift in who pays for health care. Sometimes in facilitating such a shift, some health care prices will actually increase significantly. Sometimes such a shift will cause health care prices to fall initially before again rising at a similar rate. Use of the last two methods can cause a reduction in the growth of health care expenditure which may be permanent.

Private sector financed health costs can also be controlled by:

- Reducing health care prices through directly influencing referral mechanisms by preferred provider, and similar channelling arrangements;
- Increasing consumer co-payments, co-insurance, limits, deductibles, etc.;
- Changing the incentive structures of the payment systems by risk sharing arrangements;

- Direct vertical integration with providers;
- Changing the incentive structures of the payment system to influence the efficiency by which health care is delivered.

The first two mechanisms tend to have the effect of shifting costs on to patients. The last three can also have a permanent effect on health costs. In the past, quite different approaches were used by different forms of health financing organisations. Gradually each form of organisation (indemnity insurer, Health Maintenance Organisation, Preferred Provider Organisation, etc.) is using controls successfully to effect cost savings. Australian health insurers have tended to use control forms that have excluded risk sharing arrangements, but some are now beginning to look at how they might also change incentives by applying risk sharing as well.

CONTROLLING HEALTH COSTS IN AUSTRALIA

In comparison with the US, Australia has enjoyed reasonable success in controlling its health price inflation. For the ten years from 1980 to 1990, Australia's real health price inflation (above general inflation) averaged 0.1 per cent a year. In the US, it averaged 2.2 per cent over the same period, in Canada 1.9 per cent and in the UK 1.2 per cent. (OECD data). Real health expenditure growth per capita averaged 2.2 per cent a year in Australia over the same period against 2.1 per cent in the US, 2.3 per cent in Canada and 1.9 per cent in the UK[4].

Because Australia's real GDP growth per capita more than kept pace with its real health expenditure growth per capita over most of the 1980s, there was little change in the share of health expenditure of GDP over the decade (i.e., 7.4 per cent in 1979/80 to 7.8 per cent in 1989/90). The recession in 1982/83 caused most of the jump and the recession in 1990/92 escalated the proportion to 8.6 per cent in 1991/92, and a little higher in 1992/93.

The public sector has usually been regarded as being much better at controlling health price inflation than the private sector, but often its controls meant costs have been shifted to the private sector. For example, the Commonwealth has done this by keeping Medicare schedule fees increases to a minimum. Consequently, Medicare schedule fees for most items have now become around two thirds or less of the AMA published recommended fee level, and private patients, particularly those of specialists, now have very significant patient "gap" payments to make. Prices charged for private inpatient treatment in public hospitals have also been artificially held in check by Commonwealth regulations on the maximum benefit that may be provided by registered health insurers.

In reality, the Commonwealth has been regulating much higher rises in public hospital charges (benefits) than private hospitals have been obtaining from private health insurers. The average benefit for overnight bed day for public and private hospitals in Australia in the fourth quarter of 1988 and 1992 are shown below. The benefits for private hospitals include the average benefits for theatre fees, etc., per bed day.

[4] Figures supplied by Australian Institute of Health & Welfare

Also shown is the average Medicare schedule fee charged for an in-hospital service and the average dental fee charged for which fund benefits were paid. All these services rose faster in the four years from 1988 to 1992 than either the Consumer Price Index or Average Weekly Earnings. Part of the increase in average fees or benefits for private hospital bed days and medical schedule fees are, however, due to changes in the mix of service.

TABLE 4: SELECTED HEALTH PRICE INFLATION INDICATORS[5]

	4th Quarter		
	1988	1992	Average rise p.a.
Av Public Hospital bed day benefits	$139.95	$197.86	9.0%
Av Private Hospital bed day benefits	$298.27	$376.60	6.0%
Av Medicare Schedule fee per service (in-hospital benefits)	$64.42	$77.61	4.8%
Av Cost of Dental Service (insured)	$43.39	$54.37	5.8%
Consumer Price Index	92.0	107.9	4.1%
Average Weekly Earnings	$430.1	$504.1	4.0%

Although the Commonwealth's prescription of Public Hospital bed day benefits had the highest rate of growth, the benefits increased from a much lower base, and in effect reflect the States' wishes to increase their charges to private patients.

PUBLIC, PRIVATE OR MIXED HEALTH FINANCING SYSTEM?

Should Australians have a solely public sector financed third party payment system for Medicare health services, or a wholly private system or a mixed system? Clearly a solely private sector financing system is not an option, with Medicare far too popular for any such consideration. The question is, should the Medicare program be built on to become the sole health financing system for all eligible Medicare health services, or should there be some combination of Medicare and voluntary private health insurance?

The trend, since the commencement of Medicare, is for a slowly growing proportion of total health expenditure in Australia to be met by the private sector sources, so governments appear to have been indicating a preference towards a more mixed financing system than initially indicated when Medicare was introduced. This trend to more private financing of health care has happened despite the reduction in the percentage of population covered for health insurance over the ensuing nine years. (See Chapter 5).

Even in OECD countries with statutory health insurance or social insurance schemes, there is still a private health insurance market, even if health insurers are restricted to supplementary or "top up" cover. The number of insureds as a percentage of the population in 1990 for the ten OECD countries is shown in Table 5. Australia's percentage insured includes persons covered by employer funded self-insurance

[5] Figures taken from Dept of Health Registered Benefit Organisation statistics and from Statistics provided by the Private Health Insurance Administration Council

programs and persons covered only for ancillary benefits, such as physiotherapy and dental services.

TABLE 5: PERCENTAGE OF POPULATION COVERED BY PRIVATE HEALTH INSURANCE IN 1990

Country	%
Australia	52
Canada	49
France	21
Germany	18
Italy	7
New Zealand	48
Spain	16
Switzerland	6
United Kingdom	13
U.S.A.	65

Although there has been a decline in the numbers covered by private health insurance in Australia, the ABS still reported 47.8 per cent[6] of the total population at June 1992 had health insurance coverage of some form, although hospital cover had fallen to only 41 per cent. This indicates that even in a recessionary period, and after eight years of Medicare, private health insurance in some form is currently desired by almost half of the population of Australia who contribute more than $4.3 billion through their health insurance contributions to health costs in Australia.

The conclusion, therefore, is that the Australian public, along with the Commonwealth and State Governments, clearly prefers a mixed public and private health care financing and delivery system.

[6] See Table 18 in the appendix. The difference between the 41 per cent hospital cover of private health insurance contributors and 47.8 per cent was made up of three per cent of people covered under self-insurance schemes and the balance with insurance which did not cover hospital treatment.