
Health Group Strategies Pty Limited

(INC. IN NSW)

ABN: 16003 974 507

PO BOX 1095
DEE WHY NSW 2099
AUSTRALIA
Phone: 61 2 9948 0011
Fax: 61 2 9907 6115
Email: iheta@ozemail.com.au
Website: <http://www.hgs.aust.com>

AND

INSTITUTE OF HEALTH ECONOMICS AND TECHNOLOGY ASSESSMENT

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The value proposition for private health insurance and the private health sector in Australia: a framework for public debate about choices

Paul Gross¹

1. Director, Institute of Health Economics and Technology Assessment, Australia, France and Greater China. Paper presented at the AHIA National Conference, Shangri-La Hotel, Sydney, on 13 July 2004. Early research on the basic concepts reviewed in PART 3 of this paper was supported by a short-term consultancy funded by MBF.

OVERVIEW OF THIS PAPER

This paper has three broad purposes. I first describe some of the limits of partisan analysis that render difficult needed reforms of Medicare, arguing that we need to take note of reforms elsewhere that are overdue in Australia (PART 1). Second, I review the evolution of PHI worldwide, listing six reasons for government support of its rapid growth in the 1990's (PART 2). Finally, I summarise three arguments underpinning the value proposition for the private health sector and government rebates for PHI (PART 3).

I should indicate at the onset that this paper is a work-in-progress. Our Institute is currently in the process of quantifying two¹ of the three measures of the value proposition, using a framework outlined in PART 3.

1. MEDICARE REFORM, THE PRIVATE HEALTH SECTOR AND THE LIMITS OF PARTISANSHIP

Traditionally in Australia, when the subject of health care reform is raised, we tend to pursue well-worn paths. The defenders of Medicare, forming a generally cohesive whole in academia and in the three political parties espousing democratic socialism, continue to argue that a single-payer health system is superior to any other alternative.² Some of this group also argue that government subsidies for a private health insurance (PHI) system should go to public hospitals, with private hospitals paid directly by government. A few seem to believe that the federal government should take over funding of all care for citizens over 70 years of age.

On the other side of the political spectrum, a much smaller group of advocates in the private health sector and in the Coalition government defend the PHI rebates. In the last year, aided by analyses from economists not formerly connected with the health sector, this group have contested many arguments of the first group without receiving any public rebuttal. The contest of ideas is rare in Australian health care policy analysis and should be applauded.

In my view, Medicare, whatever its value to Australian society at its onset, is now a tired concept that has not been refreshed once since conception (some would say in 1968 in the writings of Deeble and Scotton, others in 1985 when Medicare emerged after the short-lived experiments called Medibank Mark I and Mark 2). Sitting somewhere in the middle of the ideological chasm (easy to do because it is very wide in 2004), and with (fading) recall of most policy reforms of the last 41 years of my experience in many nations, I liken the above debate on Medicare to dismounting from a tiring horse.

1 For an earlier review of the value proposition for higher investment in research and development in the health sector, see: Paul F Gross. "The social and economic value of innovative medicines: international policy reforms relevant to China". China Health Economics Monograph No 4, Beijing, November 2000.

2 The ALP is now joined by the Democrats and the Greens, who may be even more enthused about a single-payer system than most thinking members of the ALP front bench.

The failure to refurbish Medicare is the fault of a succession of governments of both dominant ideologies, as the following table of examples suggests.

Alternatives to dismounting from a tiring horse called Medicare

Alternative	Example in health policy arena
1. Feed the horse from a larger trough	Recent proposals for pooled funding of all healthcare, with one level of government responsible. Proposal to fund all care of the over-70 age group from Canberra
2. Get the horse a new trainer	Recent proposals for a Federal/State Health Reform Commission , initially in one state
3. Appoint a committee to study the horse	Macklin Committee Report 1990. AHMAC committees in 2003
4. Conduct site visits to see how others ride tiring horses	Succession of federal health ministers visiting Canada, UK and US health systems.
5. Hire a consultant jockey to show how a tired horse should be ridden	NSW Health Minister in 2002 SA Health Minister in 2003 Tasmania Health Minister in 2004
6. Compare the performance of the tired horse with other horses that are fed differently	Many recent claims that private hospitals have a cost advantage over public hospitals because of their less intensive casemix
7. Redefine “tiring”	All proposals to infuse more tax funding into an unchanged Medicare
8. Argue that we cannot afford a back-up horse	Any claim that the PHI subsidy is an inefficient use of scarce resources
9. Enter the horse in a different race	My preference to see Medicare restructured to <ul style="list-style-type: none"> ▪ prevent and treat chronic diseases ▪ pay GPs as health coaches ▪ educate the punters about responsibility and what constitutes quality of care ▪ pay for performance in both the public and private hospital sectors ▪ recognise PHI as essential to our future access to new and existing core health services

In the spirit of fuelling the debate about some issues that go far beyond what is the best financing option for health care, I declare at the onset that the last alternative number 9 is my declared preference for reform of our mixed system of financing, for reasons that I will try to summarise in different parts of this paper.

One problem thwarting any meaningful health policy reform is the partisan nature of the debate on alternatives. Partisanship has its limits for reasons identified by David Brooks:

“Partisanship is the building block of polarization ...”

“Partisanship serves a filter ... A partisan filters out facts that are inconsistent with the [political] party’s approved worldview and exaggerates facts that confirm it”.

David Brooks, NYT 5 June 2004

A second problem is the major theme of this paper. We have a mixed system of health care financing that consists of Medicare levies, general tax revenue, private health insurance premiums, and -often forgotten- uninsurable payments by private households. We have a mixed system of public and private hospitals, and within the latter we have for-profit and not-for-profit hospitals. The PHI funds of Australia will pay out about \$8 billion, or about 11% of \$72 billion of national health expenditures this year. If there is to be continued support for the mixed system of health care financing in Australia, we need to have in place a value proposition for a larger private health sector and for the 30% PHI rebate that supports the private health sector and public hospitals.³

To support my case that additional government support for PHI rebates might be justified by a value proposition to be discussed in **PART 3**, I first review some reasons why governments of different ideologies are walking away from tax-based financing of health care while expanding the role of PHI.

2. TRENDS IN PRIVATE HEALTH INSURANCE WORLDWIDE

(2.1) Overview

Around the world, governments are ditching ideologies that promote only tax-based financing of health care and limit the role of the private sector. Why?

I first enunciate six reasons why governments will continue to cost-shift the financing of health care to households and PHI (Section 2.2), and then summarise the types of PHI growth that is occurring (Section 2.3).

³ A related question, outside the scope of this paper, is who should be selling this value proposition? One obvious answer is everyone at this conference.

(2.2) Six reasons why governments embrace the private health sector and PHI

Reason 1: Tax -financed health care has huge hidden costs that are ignored by its supporters but NOT by government Treasurers

In the past fifty or so years, governments faced with competing pressures on their national budgets have preferred two fiscal strategies. The table below summarises the economist's view⁴ of what happens to the economy under each of these responses.

RESPONSE	IMPACTS	EFFECTS ON ECONOMY
1. Raise taxes	Higher deadweight costs of higher taxes Fall in participation rates Economic growth slows, lower investment	For every \$1 of tax increase, output falls by \$0.20 Lower output/capita Lower output
2. Cut government expenditure	Public and private consumption do not change in total, with a shift to private care Welfare loss with lower private savings	Higher prices in the private sector Lower living standards

We can see in the top line that tax-raising has a hidden cost labelled the “deadweight loss” of taxes. It measures the changes in consumption, workforce participation and saving behaviour that when a tax is imposed. Recent analyses suggest that depending on how the tax is raised, for every \$1 raised by taxes the loss to the national economy is at least \$0.20.⁵

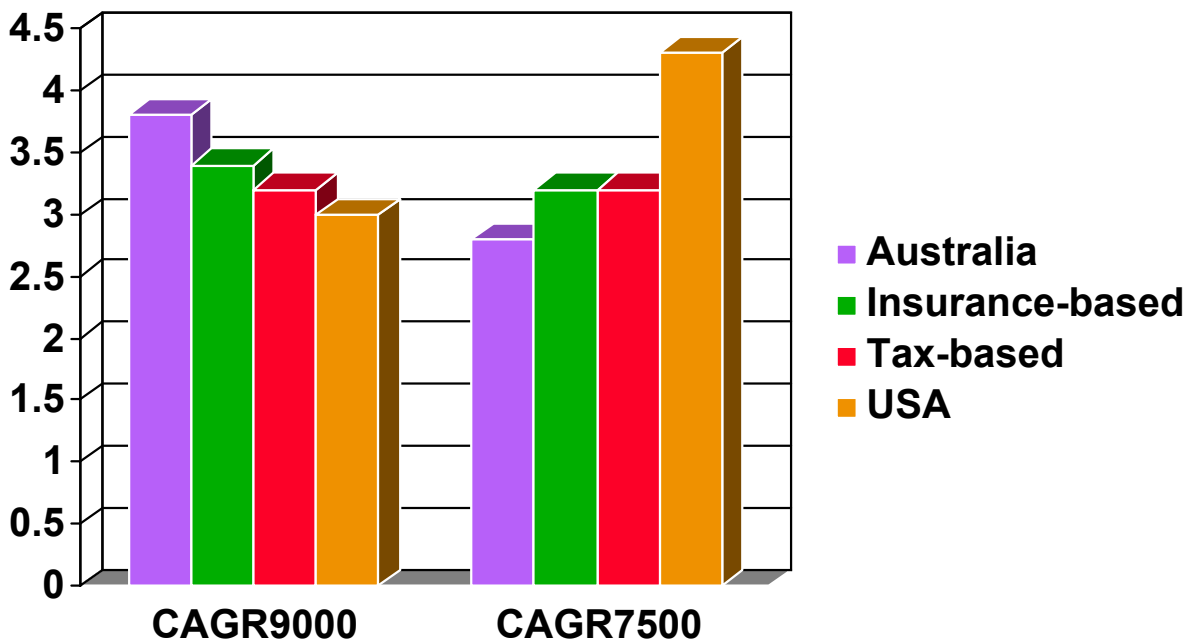
⁴ See the analysis in Access Economics. “Intergenerational modelling for Australian families.” Access Economics for ASFA, 22 April 2004.

⁵ Higher estimates are given in : M. Feldstein. “ *Tax avoidance and the deadweight loss of the income tax*”. National Bureau of Economic Research, NBER Working Paper N0 5055, March 1995; and CL Ballard, JB Shoven, J Whalley.” General equilibrium computations of the marginal welfare loss of taxes in the United States.” *American Economic Review* 1985; 75 (1): 128-138 and M Feldstein.” The welfare loss of excess health insurance.” *Journal of Political Economy* 1973; March-April: 251-280. Danzon assumed a welfare loss of 17% of claims revenue in her pivotal analysis-see: PM Danzon. “ Hidden overhead costs: is Canada’s system really less expensive?” *Health Affairs* Spring 1992, 21-43. The original research on deadweight loss was by Harberger in 1964, concluding that the deadweight loss of using a tax on labour income was about 2.5% of revenue raised- see: A Harberger.” Taxation, resource allocation, and welfare”. In: J Due (ed.). *The role of direct and indirect taxes in the federal revenue system.* Princeton University Press, 1964. Feldstein (1995) concluded that a more accurate figure was 12 times the Harberger estimate, or roughly twice the figure used by Danzon. Other references to the deadweight loss by Australasian economists include: E Diewert and D Lawrence. “New Zealand’s excess burden of tax”. *Agenda* 1995;2 (1): 27-34; and Access Economics. “Intergenerational modelling for Australian families.” Access Economics for ASFA, 22 April 2004 (at p. 23)

I have yet to see an analysis by Medicare supporters that mentions the deadweight loss,⁶ let alone use it in a comparative analysis of the costs of a single-payer system versus the costs of the current mixed system of health care financing.⁷

Reason 2: Government-run single payer systems are NOT the preferred strategy if cost control is a valid policy in 2004

Governments, even without the OECD Health Data 2004 released a few weeks ago, have quickly recognised that government-run health systems are very poor at cost control in health care over the long term. The chart below, drawn from OECD Health Data 2004, shows the cumulative annual growth rate (CAGR) in total healthcare expenditures per capita, adjusted for inflation, over the periods 1990-2000 and 1975-2000.



We can see that in long-term cost control in the health system over the period 1975-2000, tax-based health financing systems were no more effective than systems using PHI,⁸ and Australia’s mixed system was superior.

In the short-term (1990-2000), tax-based systems had a better track record in cost control (though inferior to the competitive US system) - but as we will see later, patient queues and patient copayments increased more rapidly as the tax-based nations cut

⁶ I note here that if the PHI rebate comes from the government tax base, it generates a deadweight loss, as does the tax revenue from the levy or general tax revenue that funds Medicare’s promises of universal access. I return to this situation in Section 3.3.

⁷ Danzon *op cit* was an early pioneer of comparative studies of health financing tools in her 1992 paper.

⁸ If we delete two outliers (Finland, Italy) in the tax-based nations and South Korea in the PHI nations, tax-based systems have higher CAGR’s than PHI nations.

government expenditure growth rates (not expenditure *levels*) and cost-shifted the economic burden to private households during these ten years. Queues at public hospitals emerged as a visible political problem as this cost-shifting occurred.

REASON 3: Neither equity of access to modern treatments nor better health outcomes are guaranteed by a publicly financed single payer system

Governments have also become aware that a tax-based, government controlled health system does NOT create equal access for all citizens, particularly the poor.

There are many examples of inequity of access in tax-based health systems. Canada's single payer model is the most conspicuous example.

- (1) Its *per capita* national healthcare expenditures are high, only exceeded by USA and Switzerland.
- (2) Waiting times at provincial public hospitals cause Canadian patients to jump border to US hospitals, and 20-30% of all patients on Canadian public hospital waiting lists die before getting care.⁹
- (3) Inequitable access of the poor to heart treatment¹⁰ is now measured.
- (4) Poor patient outcomes in cancer treatment¹¹ in Canada and other single payer systems are also evident.

The situation in Canada is such that one group of deprived citizens have reacted.

"Two Indian nations ... are planning to build private hospitals on tribal lands, where the Canadian government's laws do not apply."

Heartland Institute¹²

Despite these limitations, there are still voices arguing that the Canadian single-payer system is desirable in USA and Australia. EU nations are avoiding this path.

REASON 4: Three nations have recognised the value of private sector disease management companies in the care of the chronically ill

Even if we discount the above arguments about Canada (and UK, Italy and the Eastern European block nations), we then come up against another reality, viz, chronic diseases

⁹ JC Goodman and DM Herrick. "Twenty myths about single-payer health insurance". Dallas, National Center for Policy Analysis, 2002, page 73 of online version.

¹⁰ Reuters Health Information. "Inequities in access to cardiac care persist under universal health insurance". New York, *Reuters Health Information* 12 January 2004 (downloaded from www.medscape.com, reporting the paper by L Pilote et al. *Am Heart J* 2003; 146: 1030-1037, 938-940.

¹¹ GF Anderson and PS Hussey. "Multinational comparisons of health systems data. Commonwealth Fund. October. Cited in Goodman and Herrick, 2002. Figures 6-2 and 6-3 of online version.

¹² "Medical tourism comes of age". *Wall Street Journal* 22 June 2004 (downloaded 23 June 2004 from: <http://online.wsj.com>)

seem to be better controlled in nations where a competing private sector exists to bring forth innovations in patient care.

Three nations of vastly different ideologies have introduced legislation to bring private sector (and private health insurance) expertise to chronic disease management.

- (1) USA: US Medicare Modernization Act
- (2) UK: the NHS contracted a disease management pilot to a US private company;
- (3) Germany: disease management has been implemented in federal-state revenue-sharing for the health sector, with US companies helping.

The US Medicare Modernization Act, in an announcement on 21 April 2004,¹³ proposed 10 pilot projects, each with 15,000-30,000 enrollees. The target diseases include asthma, CHF, diabetes, and others. Its key assumption is that the successes in disease management achieved by PHI plans, the Medicare+Choice and Medicaid programs, can be extended to government-run Medicare populations reliant on controlled fee-for-service. The economic incentives in this proposal are exemplary. The contractor will not be paid if the coordination of care leads to savings of less than 5% in expenditures.

There is a clear message here that the government is prepared to back private sector innovation and risk management not yet observed in government-controlled programs.

REASON 5: PHI is better positioned than single payer systems to pay more for higher quality clinical care, efficiency and satisfied members

The recent literature on disease management (at least six journals) supports the belief that PHI can achieve change quicker than a government-run, single payer health system in influencing the quality of care of providers of care, the efficiency of health care, and the satisfaction of those who receive care.

PHI achieves these outcomes by applying

- (1) Evidence-based strategies
- (2) Pay for performance currencies for providers
- (3) Member incentives to seek quality care

Consider the following three issues in which prevailing wisdom is recorded in the second column, and the potential (in some cases, actual) role of PHI is presenting some countervailing views.

¹³ Associated Press. "Medicare to launch chronic-care programs by end of the year". *Wall Street Journal* 20 April 2004 (downloaded 22 April 2004 from: http://online.wsj.com/article_print/0..SB108249297888588250.00.html)

HEALTH CARE ISSUE	WHAT WE ARE TOLD	PHI ROLE IN THE DEBATE
1. Evidence-based medicine (EBM) guidelines are unused	EBM is an insult to doctors RCT has low external validity	Patients AND doctors need new information
2. Medical error rates are high and the quality of care remains unmeasured	It's a system problem Culture change first	Doctors need tools and incentives=pay-for-performance
3. Management of chronic conditions is poor	Government-run CC trials are the answer	Private sector doing it better elsewhere

Summarising the experiences of best-practice health insurers worldwide, five strategies are being used to expand the use of evidence-based medical and hospital practice:

Use of PHI resources ¹⁴	Specific action
1. Coverage decisions	Reviews of surgical, diagnostic and therapeutic interventions, medical devices based on E-B features
2. Disease management	Investment in secondary prevention benefits
3. Provider information	Information on best-practice outcomes and variations in use rates
4. Pay for performance contracts with hospital and medical providers	Financial incentives tied to adherence to clinical practice guidelines developed with medical experts
5. Consumer-directed care programs	Financial incentives to consumers to adhere to EB-treatment guidelines, better info on risks/benefits and price/quality tradeoffs

I conclude that, as practised by leading PHI companies, the new evidence-based medicine involves

**systematic review of the scientific data
PLUS
integration of this science with clinical experience (i.e., no cookbook medicine)
PLUS
active participation by patients in risk factor reduction using economic incentives
(the missing link in Australia)**

There is little evidence in Australia that similar government-run initiatives have had any impact on the use of E-B guidelines in medical and hospital practice, in reducing medical error rates, or in management of chronic conditions. In Australia, one has only to recall the inconclusive results of the government-run coordinated care trials, and the recent lament by the Baker Institute that it had experienced great difficulty in changing risky behaviour affecting heart disease.¹⁵

¹⁴ PH Keckley. "Evidence-based medicine in managed care: a survey of current and emerging strategies". *Medscape General Medicine* 2004; 6 (2), posted 1 April 2004 on www.medscape.com

¹⁵ Source: "Patients are not following CVD prevention advice." *Medical Observer* 28 May 2004,5. The sample size was 10,000 patients enrolled through GP's and involved evidence-based lifestyle advice, with a cardiovascular health check report sent directly to patients.

Furthermore, when PHI companies do pursue such initiatives, the impact on health outcomes, use of health care and patient satisfaction is measurable. Scott Weingarten's comprehensive review of disease management programs in 2002 showed how provider incentives, patient information and patient economic incentives achieved superior outcomes across many such measures, compared with programs that lacked these three sets of features:

Best practice disease management programs have odds ratios less than 1= superiority to programs without these interventions¹⁶

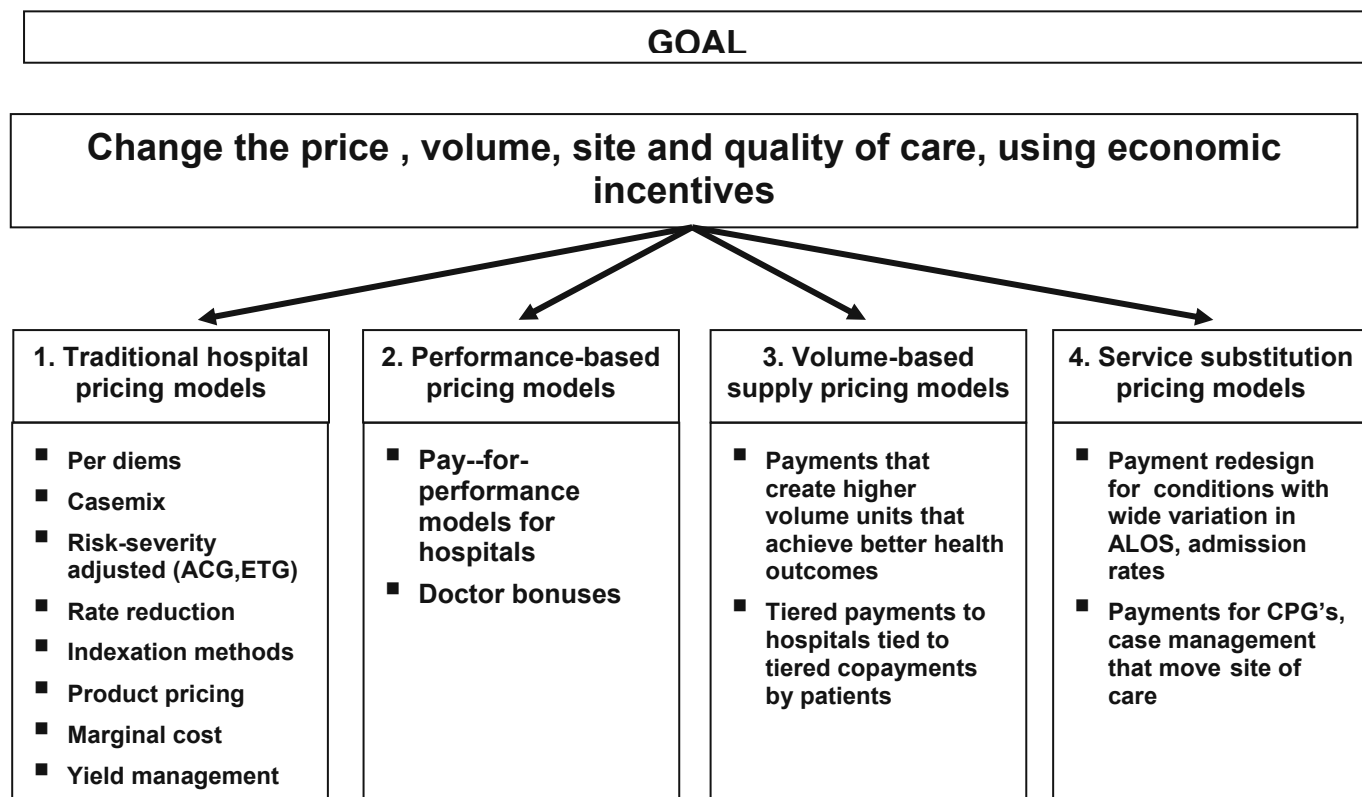
Condition	Programs with PROVIDER EDUCATION	Programs with PATIENT REMINDERS	Programs with PATIENT FINANCIAL INCENTIVES
Asthma	1.1 (0.04,2.1)	0.03 (-0.1,0.19)	
CAD	0.4 (0.18,0.62)	0.31 (-0.01,0.63)	
Chronic pain	0.87 (0.27,1.47)		
COPD	0.01 (-0.38,0.39)	0.29 (-0.3,0.86)	
Depression	0.27 (0.18,0.36)	0.34 (0.14,0.35)	0.26 (0.1,0.43)
Diabetes	0.22 (0.15,0.30)	0.31 (0.1,0.44)	
ESRD	-0.25 (-0.4,-0.06)		
Hyperlipidaemia	0.20 (0.07,0.33)	0.90 (-0.27,0.44)	0.25 (-0.04,0.48)
Hypertension	1.6 (0.3,2.9)		0.48 (0.44,0.53)
Rheumatoid arthritis/ osteoarthritis	0.1 (-0.11,0.30)	0.21 (-0.31,0.73)	
ALL CONDITIONS	0.24 (0.07,0.4)	0.27 (0.17,0.36)	0.4 (0.26,0.54)

The odds ratio of 0.27 for depression in the second column means that the use of new information to doctors and clinics caused a $(1-0.27=)$ 73% improvement in health outcomes compared to a program that had no such information. The figures in brackets are the 95% confidence limits that say in this example that there is a 95% probability that the improvement for depression lies between $(1-0.36=)$ 64% and $(1-0.18=)$ 82%.

One message of this table is that best practice disease management under PHI uses three sets of interventions to influence providers and patients in patients with depression and raised lipids. No similar results have been sighted in government-run health systems lacking the three inputs listed in the columns above.

Finally, from our Institute's ongoing work in three nations it is also evident that PHI is now paying to improve the quality of medical and hospital care through payment strategies that also attempt to change the price, volume and site of care:

¹⁶ S Weingarten. "Laying the foundation for evidence based medicine". Paper presented at Disease Management Congress, Chicago, 18-20 September 2002, published in *BMJ*; 325 (26 October).



Listed in the newer provider payment currencies (not just the pay-for-performance pricing models) are strategies that pay more for higher quality care, including care based on E-B guidelines that doctors and PHI companies develop together, and which are now shared with patients so they can recognise “quality” and buy access to care that exudes quality.¹⁷

By comparison, the Australian attack on medical errors and quality has relied on process changes that are slow and devoid of incentives, and driven by a single federal government committee with inappropriate resources. It is difficult to see how we can pursue these process change strategies in the wake of the quality assurance problems seen in Western Sydney public hospitals and other hospitals.

REASON 6: PHI can influence supply AND demand quicker than can single payer

The final reason why other national governments are willing to expand access to PHI is that, as some of the above examples illustrate, PHI has the potential to influence both supply and demand quicker than any government-run health system.

¹⁷ PF Gross.” New provider payment currencies in healthcare: what they mean to payers, providers and patients, and a business case for their use in Australian hospitals”. Presentation to eight health insurance funds in 2003-2004.

The vehicles that PHI companies are now using recognise (John Wennberg started the process in 2003) that there are three broad types of care that generate different proportions of total health expenditure, and that different types of economic incentive can influence specific sub-areas of such care, as summarised below:

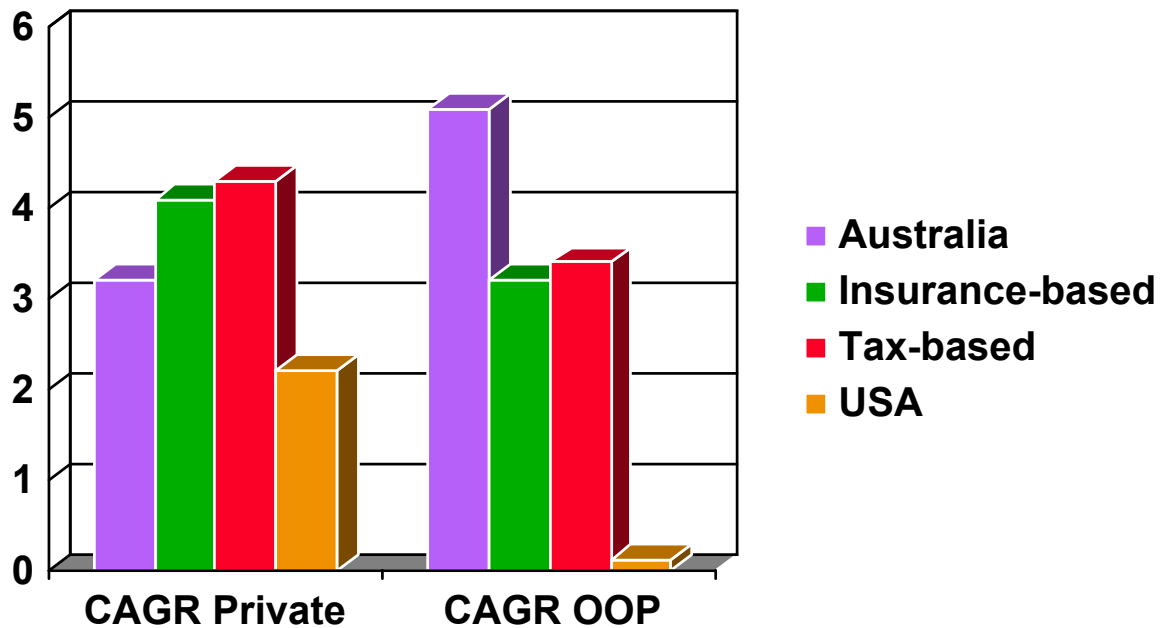
Type of care	Share of healthcare expenditures (percent)	Economic incentives are known to influence
1. Effective care	16	Risk factor reduction Management of chronic conditions
2. Supply-sensitive care	40-60	Demand for intensive care Demand for alternatives not yet covered by PHI
3. Preference-sensitive care	35-45	Demand for elective surgery Patient choices of surgical and non-surgical intervention

The last column suggests that PHI is able to influence many dimensions of supply and demand. I have seen no single payer government healthcare system pursue any of these actions that rely in large part on economic incentives not found in government controlled health systems.

(2.2) What have other national governments done when faced with these realities?

Faced with this range of evidence, governments across the globe have increased the role of PHI and Medical Savings Accounts, and expanded the private health system role in disease management.

As a result, between 1998 and 2000, tax-based systems had the highest cumulative annual growth rates in total private expenditures while Australia had the highest growth in out-of-pocket (OOP) payments, as shown below:



I draw two conclusions from the above chart:

- (1) Tax-based systems ran out of tax revenue, and went looking for new private insurance strategies.
- (2) Australia raised out-of-pocket payments fastest and this is one justification of the Howard government's creation of PHI subsidies to allow PHI to cushion the pain.

Government in many EU nations did not have to work hard to convince their taxpayers that extra funding beyond taxes was essential in the 1990's. The Stockholm Network eight-national survey in the first two months of 2004 led to the following observation by the study sponsors:¹⁸

"In the Czech Republic, Britain, Sweden and Italy, with their predominantly state-controlled, publicly financed systems, more people believe greater personal health spending will improve things than do not".

By the beginning of the 21st Century, PHI growth in EU nations was in two broad categories (complementary PHI and supplementary PHI), as follows:

¹⁸ Stockholm Network. *Impatient for change: European attitudes to health care reform*. London. The Stockholm Network, 2004, 204 pages (at page 17). The telephone survey of 1,000 persons in eight nations (Britain, Czech Republic, France, Germany, Italy, Netherlands, Spain and Sweden) took place in the period 26 January - 22 February 2004.

Type of PHI	Population coverage percent
PHI-all types	0.2% (Austria) -25% (Netherlands)
- Complementary to national programs/budgets	20-70%
- Supplementary to national programs/budgets	10%

By 2002, PHI funded about 12% of health care expenditures in fifteen EU nations (the EU-15 group).

A wide range of PHI reforms emerged in the 1990's in nations as different as China (the old home of the barefoot doctor) and the Eastern European nations, as illustrated below:

NATION	PROBLEM	PROPOSAL
USA	Elder care: 50%+ of US\$ 82 billion spent on LTC is funded by govt	Congressional bill to allow write off of 25% of cost of LTC insurance
CHINA	Urban healthcare: govt financing reduced	Urban Medical Insurance using MSA's+ FED's
UK	Lack of choice in tax-funded NHS	Proposal for opting out into PHI, with core services and GP control
HUNGARY	Inefficient public system	Private health sector lured by government subsidies
CZECH REPUBLIC	Inefficient public system	Proposals by the opposition to allow PHI based on MSA's and FED's

By 2004 the emergence of Medical Savings Accounts in nearly all urban areas of China paid for new forms of front-end deductible PHI for over 90 million employees. Four nations are now using MSA's tied to high front-end deductibles (South Africa, Singapore, USA and China).

In 2000 the French government decided to subsidise access of the poor to statutory health insurance with free PHI for low income. Coverage increased from 85% to 94% in 2002. I conclude that if commutarian governments, while wedded to social welfare, are willing to subsidise access of low income groups to PHI, and if PHI produces some of the benefits assumed in PART 3 of this paper, it is only a matter of time before other governments follow similar paths.

(2.3) Summary

Single-payer health systems cannot sustain the promises of governments and the growth of medical technology in an ageing society. Private sector roles have expanded, and private health insurance is being openly promoted in the EU, in Latin America (highest growth rate of insurance in the 1990's) and in the eastern European countries formerly under Communist control.

It is now worthwhile asking whether arguments exist to buttress the argument that a larger private share of total health expenditures and government subsidies for PHI

represents value for money rather than the waste of society's resources assumed by some Australian critics.

3. THE VALUE CASE FOR ADDED INVESTMENT IN HEALTH CARE AND A LARGER PRIVATE HEALTH SECTOR: A FRAMEWORK FOR ANALYSIS

We summarise here three sets of arguments for demonstrating:

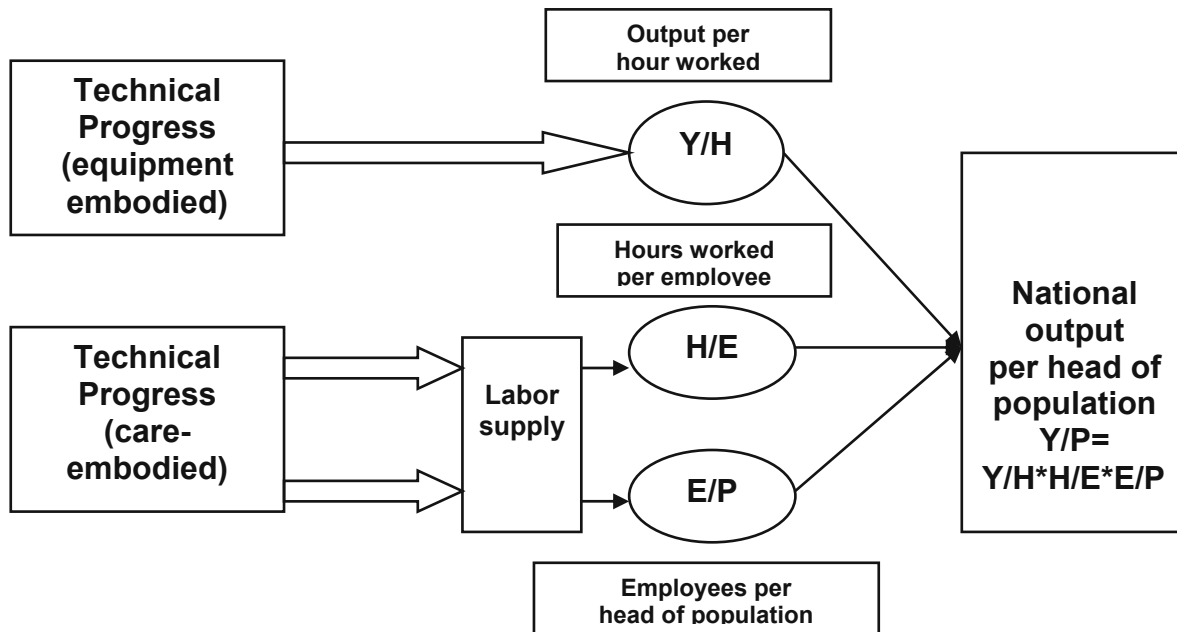
- (1) the value of “better health” and R&D of modern medicine and medical devices (Section 3.1);
- (2) the value case for a private health care system (Section 3.2); and
- (3) the value case for subsidising PHI by tax rebates (Section 3.3).

The empirical data needed to validate these arguments is a subject for a larger paper. Here, I restrict my discussion to the macro-arguments that seem defensible.

(3.1) Value case for higher investment in health care

In the 1990s, economists with prior experience in business economics and industrial economics produced new empirical studies confirming the value proposition that higher investment in health care – particularly interventions using innovative drugs - is associated with higher GDP growth, cost savings in the health sector and worker productivity gains.

The basic model used by Frank Lichtenberg (Columbia University) assumes two forms of technical and care-induced progress as measured by national output per head of population, as illustrated below:



I summarise here only one conclusion of the research by Lichtenberg,¹⁹ who studied the relationship of worker disability and access to modern drugs. He found that the rate of pharmaceutical-embodied technical progress with respect to activity limitations was about 18% per year. The implications of his findings were that governments should not kill innovation in health care by inadequate funding for health care, particularly if private sector R&D leads to innovative treatments that cause patients to have less disability.

A second study, released a few weeks ago, shows what happens when chronically ill persons (mainly aged persons - and therefore not covered by Lichtenberg's data on the workforce) do not have access to modern medicines. This study was financed by the US National Institute on Aging. It measured health status at the beginning and end of a period of 10 years in a population of Medicare program beneficiaries in the USA. About 10% of that population cut back their use of modern medicines because of the rising costs of drugs and/or the rising copayments collected from beneficiaries. The other 90% of survey respondents did not cut back their use of drugs.

The following chart summarises changes in four measures of chronic illness and "health" in the two groups.

¹⁹ F Lichtenberg. "The effect of changes in drug utilization on labor supply and per capita output". NBER Working Paper 9139, September 2002, 32 pages plus attachments.

Outcome	In the 10% who cut back drugs because of cost	Other 90% who did not cut back drugs
Experienced chest pain - %	11.9	8.2
Had not-fatal heart attack	7.8	5.3
Reported good health at beginning but poor health at end of three years - %	32.1	21.2
Respondents aged 72+ who had depression at beginning	16% worsening	

There is a distinct message here for an Australian government concerned about the future health of elderly PHI fund members, viz., let the PHI funds have access to HIC data on medical services use and PBS drug use so that the funds can provide optimal care for the chronically ill, including the provision of information and education noted in my earlier summary of the impact of disease management programs.

There is a parallel message for PHI funds: stratify your member risks to provide more support for members with chronic conditions, using modern predictive techniques plus hereto-inaccessible HIC data. It is NOT the HIC fault that this data gap pertains. We need to document the hidden costs of excessive privacy provisions that retard health improvements by limiting access to data that could help members choose risk factor reduction and disease management.

(3.2) Value case for a larger private health sector

My arguments for a stronger private health sector²⁰ rely on four assertions that are being validated in an ongoing study of the value proposition for private health insurance. My core argument is that any value proposition for the private health sector rests on its value to four groups:²¹

- (1) Individuals.
- (2) Governments.
- (3) The health sector.
- (4) The community at large.

The value proposition for **individuals** assumes five measures of the impact of the private health sector on:

- (1) Reductions in preventable stress, illness and incapacity.
- (2) Improved post-operative health and functional outcomes.
- (3) Increased earnings from reduced waiting times.
- (4) Reduced out-of-pocket expenses, doctors, medicines and home support.
- (5) Increased access to innovative treatments.

²⁰ The private health sector includes doctors, hospitals, allied health professionals, drug and device manufactures, and the PHI funds. It also includes private investors in public and private companies.

²¹ There are elements of double counting here, so the measures used have to be avoid double counting.

The value proposition for **government** assumes that the private health sector causes:

- (1) reduced income support expenditures while waiting for public hospital admission or therapy, and
- (2) reduced public hospital budget requirements.

The value proposition for the **health sector** as a whole assumes that a private health sector expands the total resources available for research, prevention and care, and it increases competition between providers in both the public and private sector.

Finally, the value proposition for the **whole community** assumes that a private health sector

- (1) improves productivity and by earlier return to productive work activity;
- (2) increases the total funding available for health care; and
- (3) increases all funding for R&D into drugs, medical devices and appliances.

I expect that the empirical evidence needed to evaluate all four sets of assertions will emerge from our ongoing project. Part of this “evidence” overlaps with evidence on the value *per se* of PHI and the current PHI rebate.

(3.3) The value proposition for PHI

The analytical framework being used to test this value proposition assumes that there are four basic costs of PHI, with one being a potential cost offset that is critical to the value proposition for PHI.

The table below summarises the sixteen costs and benefits that are being measured in our ongoing project:

Disaggregated costs and hidden benefits of private health insurance²²

Cost	Cost components	Hidden benefits
1. Premium collection	<ol style="list-style-type: none"> 1. Costs of commissions to pharmacists, brokers, group managers to enrol members 2. Fees to credit card companies when credit payment used 3. Member recruitment and re-enrolment costs (excl item 7 below) 	9. Reductions of deadweight loss of raising taxes in a single payer system
2. Claims administration and risk management costs	<ol style="list-style-type: none"> 3. Control of moral hazard <ul style="list-style-type: none"> - Pricing and copayments - Utilisation review - Case management of high-cost members - Provider information on best practice 4. Risk management activities <ul style="list-style-type: none"> - Actuarial services - Risk assessment, reinsurance 5. Investment performance monitoring 	<ol style="list-style-type: none"> 10. Reduction in deadweight loss of moral hazard in a single-payer system 11. Investment income from reserves to cover unexpected underwriting losses
3. Costs of contracting with providers and patients	<ol style="list-style-type: none"> 6. Network contracting and quality assurance 7. Consumer education and information 	<ol style="list-style-type: none"> 12. Reduction of inappropriate care using efficient provider payment currencies 13. Reduction in medical error rates using payments tied to performance 14. Value to member of information and education affecting self-care of chronic conditions
4. Costs of access to care	<ol style="list-style-type: none"> 8. Hidden indirect costs of queuing for public hospital and medical care in a single payer system <ul style="list-style-type: none"> - Excessive patient waiting time for hospital care - Excessive costs of many short visits to accommodate higher volume in single-payer system - Diminished QOL because of pain while waiting for beds - Loss of productivity with underused medical inputs - Loss of informal carer wages for elderly on waiting lists 	<ol style="list-style-type: none"> 15. Reduction in proportion of the informal costs in item 8 dependent on coverage and benefit design 16. Reduction in the federal and state government budget funding needed to underwrite an open-ended commitment to free public hospital beds and associated medical services (Harper, 2003)

Claims have been made that a single payer health system (ostensibly financed from a much larger Medicare levy or some combination of an increased Medicare levy and general tax revenue) is less wasteful than a system in which PHI has a major role in funding health care.

²² PF Gross. *The value proposition for private health insurance: implications of international trends*. Sydney, Institute of Health Economics and Technology Assessment, Health Economics Monograph No. 90, version 4 May 2004.

Using data on the management costs of health funds, our analytical framework above generates the following preliminary estimate of the costs of a single payer system versus a system with a larger role for PHI:

Overhead costs of PHI and single payer: percent of contribution income

Cost item	PHI	Single payer
1. Premium collection	2-3%	At least 20% (deadweight loss)
2. Claims administration and risk management	5-7%	1-2%
3. Contracting with providers and members	1-3%	1-2%
SUBTOTAL	8-13%	22%+
4. LESS any offsetting costs of improved access	Dependent on the percentage of population with PHI coverage who obtain quicker access	
5. PLUS a share of the deadweight loss of raising taxes to subsidise the 30% rebate	20% of 30%=6%	

The last two items are moot until we review new data collected on cost items 8, 15 and 16 in the framework table above. We will also need to adjust any measure of this offset in Item 4 above to reflect the fact that the taxes used to fund a single-payer system are also, in part, the taxes that pay the 30% PHI rebate, and so we must allocate some of that deadweight loss to item 5 above.

4. CONCLUSION: SEVEN MESSAGES THAT SHOULD BE HEARD IN THE NEXT ELECTION CAMPAIGN

The Australian health system, certainly that part of it called Medicare funding, is not yet in crisis but it is tired and in need of systematic reform. Medicare Plus is NOT a systematic reform - but it did recognise the plight of GP's and it took us some way towards new payment strategies for the chronically ill.

The choices we now need to make are about how to fund a health system that will see larger numbers of persons with chronic conditions and a larger frail aged population needing care that either we do not yet (1) support adequately from available funding sources or (2) have in place.

Based on the above analysis and on a study of health sector funding needs with more chronic illness, rising consumer demand and the more rapid diffusion of diagnostic, surgical and drug technology into medical practice,²³ it is reasonable to hope that government and the governed will, following the federal election, enter a protracted debate about the consequences of the following assertions:

- (1) Health care in Australia is now under-funded,²⁴ and we need new funding sources for health care not yet in place.
- (2) Worker productivity and the quality of life of the non-workforce are both reduced by chronic conditions, and we need to restructure the funding and management of workers compensation and health insurance in Australia.
- (3) Provider purchasing currencies must move beyond the preoccupation with casemix payments of hospitals and bulk-billing for GP's to embed new payments for higher quality.
- (4) Better health requires enhanced patient accountability, which in turn means new information and education as well as economic incentives for risk-reducing behaviour.
- (5) Tax-based financing has demonstrable limits and costs. The mix of alternative funding mechanisms is wide, and we need to discuss how and why health savings accounts, superannuation and health insurance require consistent tax incentives.
- (6) Social solidarity (or communitarianism) does NOT require universal access by everyone to every service - but it does justify priority attention to the needs of the poorest in government subsidies.
- (7) The PHI value proposition may be sufficiently compelling to justify an even higher PHI rebate. At least the possibility needs discussion and more data.

We are at another set of cross-roads, and while the consequences of taking the wrong road are worrying, perhaps we do not yet face the stark choice stated by that well-known health policy analyst, Woody Allen, who said:

"More than any other time in history, mankind faces the crossroads.

One path leads to despair and utter hopelessness, the other to total extinction.

I pray we have the wisdom to choose wisely."

²³ PF Gross. "New medical technologies to 2010: implications for healthcare funding, health insurers and technology companies". Paper to be presented at MIAA Annual Meeting, Sydney, 21 July 2004.

²⁴ I estimate the shortfall as \$6 billion in 2004, roughly 8% of estimated total national healthcare expenditures of \$72 billion.