FINDING THE BALANCE BETWEEN PUBLIC AND PRIVATE HEALTH

THE EXAMPLE OF AUSTRALIA

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This note provides an overview of the principal elements of Australia's public health system, and recent reforms to ensure its ongoing viability in view of spiralling costs in health care, and to maintain a level of burden sharing between the private and public systems.

I – Australia's public health system

The public health system comprises two principal components – Medicare and the Pharmaceutical Benefits Health Scheme (PBS). These relate to the cost of health care services (in hospital and out of hospital treatment, including visits to doctors and specialists) and the cost of drugs and medicines.

As part of its public health strategy, the Australian Government closely regulates the private health insurance industry to ensure its equitable and accessible operation and to maintain the viability of the private sector so that it continues to carry its share of the burden of meeting health care needs.

It is important to note that the Australian Government has no explicit power over health in the *Australian Constitution (1901)*. Theoretically, therefore, health is intended to be a State and Territory responsibility (Australia has six States and two Territories). State and Territory governments therefore maintain the majority responsibility for the day to day funding and operation of hospitals, although, these costs are in part covered by financial grants from the Australian Government.

However, the Australian Government enjoys greater resources than the States and Territories through its capacity to levy income tax. Due to the superior financial power of the Australian Government has, over time and principally through the creation of the Medicare and PBS schemes, become a significant force in the development of health policy and practice nationwide.

A - Medicare

Australia's public health system called Medicare has been in existence in one form or another since 1974. It is a universal health care system which provides Australian citizens and residents easy access to high-quality health care.

The Medicare system is financed by the Australian Government from general revenue from taxation, but also through the imposition of a Medicare levy of 1.5% percent, imposed on tax payers: The Medicare Levy raises about $AUD7 billion (€4.2 billion) a year. However, the total annual cost of Medicare is around $AUD18 billion (€10.7 billion) a year.

Medicare provides access to:

- free treatment as a public patient in a public hospital, and
- free or subsidised treatment by medical practitioners including general practitioners and specialists.

Note that some procedures such as cosmetic surgery, and other services such as dentistry, podiatry and physiotherapy are generally excluded from the Medicare system, meaning a patient must either pay for them directly; or have insurance which covers it.

Every Australian has a Medicare card with a Medicare number. This enables the card holder to see a doctor, go to hospital, have a test, pay for it, and then seek reimbursement from the Australian Government on the basis of receipts for services.

However, it is important to note that the card holder/patient is generally not reimbursed for the entire cost of the service. The Government maintains a Medicare Benefits Schedule which sets out the rates of reimbursement from the Australian Government. While doctors are free to charge whatever they want, the existence of the Schedule, in addition to the expectation from most Australians that health services will be free, or almost free, helps to keep charges reasonably low.

For example, the Schedule reimbursement for a visit to the doctor is currently around $AUD35 (€20), whereas the actual cost charged by the doctor may be in the order of $AUD45 (€26) or more. While the existence of this 'gap' keeps downward pressure on medical costs (if the gap is too great people will find another doctor), it also operates as a disincentive to wasteful usage of health resources. In other words, people think twice about whether they really need to go see a doctor or visit the hospital for a minor ailment if they have to pay $10 or more out of their own funds.

Recent policies have sought to do two things:

- make this reimbursement or repayment process more automatic,
- increase incentives for doctors to charge only the Medicare Schedule rate.

In relation to the first, increasingly people are able to use their Medicare card like a credit card at doctors' surgeries and hospitals – to use it to pay for services, and to 'top up' the payment through their own funds, rather than to be obliged to pay the full amount and seek reimbursement later which can be a somewhat tiresome and paper-based process.

In relation to the second, the Government provides financial incentives to doctors (general practitioners), particularly in regional areas, to increase 'bulk billing' – a practice whereby doctors charge their patients the Schedule rate automatically, meaning no payment is required from the patient at the time of service. Some specialists also adopt this practice informally, charging patients with lesser financial means the Medicare Schedule rate.

B – Pharmaceutical Benefits Scheme

The Pharmaceutical Benefits Scheme has existed for over 60 years and provides subsidised access to medicines.

Under this system, medicines which are listed on the Pharmaceutical Benefits Scheme (PBS) cost the purchaser no more than $AUD31.30 (€18) (often less), when the actual cost of the medicine can be much more. Those with a concession card (the aged, pensioners, veterans, people on low incomes etc) only pay $AUD5. Again, the co-contribution is considered to be an appropriate measure against waste.

Obviously, therefore, drug companies have strong interest in getting their drugs listed on the register and there is a significant amount of lobbying undertaken by pharmaceutical companies to get their drugs on the register.

Around 80% of prescriptions dispensed in Australia are subsidised under the PBS, and around 170 million prescriptions are covered by the PBS each year. This equates to about eight prescriptions per person in Australia for the year.

The cost of the PBS is currently around $AUD7 billion (€4.2 billion) per year.

C – Regulation of the private health insurance system

The Australian Government's regulation of the private health insurance system is also an important part of its public health policy.

1. The advantages of the private health insurance system

First, it is important to understand that the motivation to have private health insurance in Australia is strong. Unlike the United States, where health insurance is generally considered a benefit of employment and is funded by the employer, the decision to have, or not have, private health insurance, is one pertaining to each individual or family.

While the public health system is generally of a high standard, particularly for general surgery, emergency surgery and obstetrics, over time the standard for specialist care appears to be growing higher in private hospitals. As a public patient, the patient cannot choose his or her doctor, will generally be accommodated in a ward room (a room of four beds), and may be subject to a waiting period for non-essential treatment. Furthermore, some services are excluded from the Medicare

system, such as dentistry, podiatry and physiotherapy - meaning either the patient must pay for this service, or have private health insurance to cover the cost of it.

As a private patient, the patient is able to choose his or her treating doctor, will generally have a single room, and can, to some extent, choose the timing of procedures. Private patients in a private hospital generally can generally expect a higher standard of care and a higher degree of attention, although this is not always the case. Private insurance can be bought to cover almost anything and everything, including treatments generally considered to be 'ancillary' and thus not covered by the public system.

Everyone uses the public system one way or the other and having private health insurance does not prohibit any person from accessing the public system. Most people have some private health insurance to cover the cost of hospital stays, as this can be the most expensive, particularly in a private hospital. Some also have private health insurance to 'cover the gap' that is, to cover the difference between the amount paid by the Government through the Medicare system and the actual rate charged by the doctor or specialist.

2. The Australian Government's role in price setting

The Australian Government has two levers in relation to price setting in the private market:

- Its regulation of price increases in private health insurance; and
- Its ownership of Medibank Private, a private health insurance fund which is a government owned enterprise.

Regulation of price increases

All private health insurance funds are required to notify the Department of Health and Ageing of any proposed change to premiums. Health funds seeking to increase the cost of their premiums have to provide reasons for the premium change when they submit notice of the change.

While there is no formal approval by the Minister of Health and Aging of changes to premiums, the Minister does have the power to disallow changes to rules (including premiums) where they would be contrary to the public interest.

As a result, an informal approval process has arisen, and the Minister announces each year in the first week of March, the permitted increase in health insurance premiums. This ranges between 5 – 7% a year, and is generally the object of much public disapproval and complaint. Nevertheless, without this process increases in premiums would inevitably be higher.

Ownership of Medibank Private

There are almost 40 different private health insurance funds operating in Australia, but Medibank Private, created by the then Coalition Government in 1975, is the largest fund with around 29% of the market and 1.3 million members.

While Medibank Private is now run almost exclusively as a private enterprise, various plans to sell Medibank Private by the centre-right when in government have stalled due to public opinion and opposition from the Labor Party. This is due to the perception that Medibank Private acts as "the conscience of the industry" – more focussed on the long term benefit of its members, and the Australian public, as opposed to short term profit. Its profit record would, however, suggest otherwise.

These three measures: Medicare, the Pharmaceutical Benefits Scheme and the regulation of private health insurance, have generally kept the public and private health care systems in some degree of harmony between the mid 70s and mid 90s. However, a significant collapse in the level of private health insurance take up in the late 1990s made the Australian Government look at measures to reverse the trend and preserve the balance between private and public expenditure on health.

II – Recent reforms to the health care system

In 1999, the then centre right Australian Government (made up of the Liberal Party and National Party Coalition) introduced a series of reforms to ensure Australia would be able to meet the increasing long term costs of health care and to balance the demands on, and the costs met by, the private and public sectors.

This followed a significant decrease in the number of Australians holding private health insurance. In 30 June 1984 just over 60 per cent of all Australians were covered for private hospital insurance. By 30 June 1998, this figure had fallen to 30.6 per cent and showed signs of decreasing further.

The Coalition Government's reforms to increase take up in private health insurance consisted of:

- The introduction of a 30% health care rebate;
- The introduction of the "lifetime health cover" policy to encourage people to take up insurance early and keep it through life.

A – The 30% health care rebate

In 1999 the Australian Government introduced a 30% Rebate for private health insurance.

The 30% Rebate gives all people with private health insurance a 30% discount on their private insurance premiums. In practice, each year a person with private health insurance will receive an invoice from their health insurance fund, indicating the total value of the premium, then the 30% discount provided by the Government. The policy holder pays the 30% reduced rate.

So if, for example, the cost of private health insurance for a single person is $AUD900 a year, the person receives a bill for $AUD900 but is informed, that as a result of the Government's Rebate, the person need only pay $AUD600. The remaining $AUD300 will be paid by the Australian Government directly to the insurance provider.

This Rebate has been the subject of much political debate. It was strongly criticised by the Labor Party when in opposition, as a waste of public funds which could otherwise be directly provided to Australian hospitals (via payments to the States and Territories). However, now in government, the Labor Party does not seem likely to abolish the system as the political response to doing so would be too negative.

While it has not, as yet, made any commitment of this nature, the Labor Party may move to impose a means test on the recipients of the Rebate to deny it to high income earners, or to limit it to hospital cover only, rather than to ancillary cover including physiotherapy etc.

The Rebate costs the Australian Government around $AUD3 billion (€1.8 billion) a year.

B – Lifetime health cover

In the late 1990s it became obvious that the number of Australians with private health insurance was declining significantly and that the balance between the public and private systems which had existed since the 1970s was at risk. A policy known as "Lifetime Health Cover" was introduced in 2001 to strike a better balance in the public and private systems by encouraging people to take out hospital insurance earlier in life, and to maintain it. It provided this encouragement through both a system of financial carrots and financial sticks.

Under the Lifetime Health Cover policy, health funds are able to charge different premiums based on the age of each member when they first take out private health insurance for hospital stays.

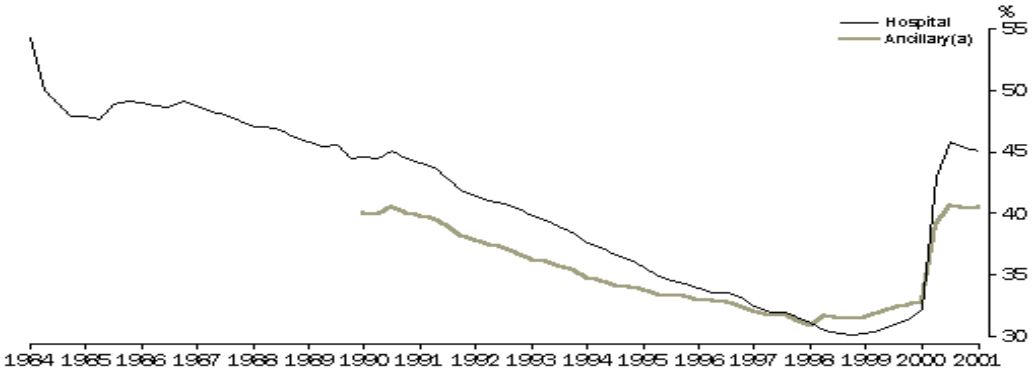
In other words, the earlier you take out health insurance, and the longer you keep it for, the lower your premiums will be. People who take out cover early in life will be charged lower premiums throughout their life, relative to people who take out cover later.

The potential financial penalties can be quite significant: people who delay taking out hospital cover beyond the age of 30 pay a 2 per cent loading on top of their premium for every year they are aged over 30 when they first take out hospital cover. For example, a person who delays joining until the age of 40 will pay 20 per cent more (10 years multiplied by 2%) than someone who joined at the age of 30. The maximum loading a person can be required to pay is 70 per cent, payable by people who first take out hospital cover at age 65 or older.

Unsurprisingly, the introduction of this initiative caused a huge increase in the number of people above 30 taking out private health insurance, particularly at the 'low end' of the market, that is in cheap and simple hospital only private health insurance. However, due to the cheapness of the products on the market (and their associated exclusion clauses), many people with private health care insurance for hospital stay continued to use the public health care system.

As a result of these initiatives, private health insurance take up rose from its low of 30.6% in 1998 to up to 45.7% in September 2000. It later stabilised at a level of around 42–43% from 2003.

Australian Population With Private Health Insurance



C – The Medicare levy surcharge

If a person is eligible for Medicare, but earns an annual income in excess of $AUD50,000 (€30.000) for singles and in excess of $AUD 100,000 (€60.000) for couples/families (with family income being adjusted by $1,500 per annum for each child after the first), that person is required to pay the Medicare Levy Surcharge if he or she does not have an appropriate level of private health insurance.

The Medicare Levy Surcharge is 1% of income and is administered as a tax. This means that high income earners without private health insurance pay 1% more tax than they would if they had private health insurance. This is *in addition to* the 1.5% Medicare Levy payable by all taxpayers

The aim of the Medicare Levy Surcharge is to encourage high-income earners to take out private hospital cover and, where possible, to use the private system to reduce the demand on the public system.

Conclusion

This note indicates a range of measures pursued by the centre right Government in Australia over the last ten years to ensure all Australians have ready access to high quality health care in both the public and private systems, and that the challenge of meeting the ever increasing costs of health care are equitably shared between the public and private sectors.

The measures have been largely successful in meeting their goals. Australia has a reasonably high take up of private health insurance. This has relieved some of the pressure on the public system. But it has also increased pressure on the private system. A new class of private health insurance policy holders, many of whom did not have private insurance before the 2000 reforms, have become "heavy users" of

the system, keeping the costs of private health high, and thus the costs of premiums on the increase. It is hoped this will settle in time. If the cost of private health insurance can be stabilised, the rate of take up of private health insurance would be even greater.

Health policy has been the subject of considerable political debate and discord between the centre-right and centre-left political parties, the latter preferring to put money directly into public hospitals, and the former preferring to build a financially sustainable health sector by striking a balance between public and private sectors.

While the policies have been successful in meeting their goals, it is the threat of spiralling costs which, ultimately, may undo many of the benefits of the policies. The costs of health care are expanding exponentially, with the cost of Medicare rising from an annual cost of around $AUD12 billion (€7.2 billion) in 2003–04 to more than $AUD18 billion (€10.7 billion) today.