

PUBLIC-PRIVATE PARTNERSHIPS

AUSTRALIA

A Mixed System With A Public Base

Healthcare Systems Perpetual Stresses

Perpetual Stresses			
Structural Option	Feasibility	Sustainability	Satisfaction
Private Health Insurance	<ul style="list-style-type: none"> • Universal Coverage Not Possible • Unconstrained Grow and Costs 	Excluded Grow as Unconstrained System Becomes Increasingly Expensive	Disadvantaged Generally Excluded
Mixed System with Private Base	Balance Achievable in Carefully Designed System	Private Health Insurance May Become Too Expensive	Complicated Structure
Mixed System with Public Base	Balance Achievable in Carefully Designed System	Funding Problems Result in Public Sector Constraints	Dissatisfaction with Constraints, Waiting Lists and Out-of-Pocket Spending
Public Health Insurance	Unpopular Constraints	Political Funding Problems/Constraints	Dissatisfaction with Constraints

Historical Context – Pre 1975

Overview

- Hospital Services
 - Large Public Hospital Sector
 - Mainly Religious and Charitable
 - Charges Raised
 - Small Private Sector
 - Medical Services
 - Good Coverage
 - Earned Relatively Good Incomes
 - Financed by Social Insurance – some 70 voluntary health insurers
-

Historical Context – Pre 1975

Closer Look

- Queensland had a “free at point of service” Public Hospital System.
 - Inpatient and Outpatient.
 - All other states charged for all hospital treatment.
 - Social Insurers were extensively subsidised by Commonwealth Government.
-

Health Insurance – Pre 1975

Subsidies from Commonwealth

■ Premiums

- Tax Deductible
- Fully or Partially met for unemployed, low income families, etc.

■ Benefits

- About half of medical benefits paid.
 - About 10% of hospital benefits paid.
 - All of the costs of chronically ill and other high users.
-

1975 Medibank Scheme

- ❑ Funding of Ambulatory Medical Services – Commonwealth paid 85% of Commonwealth Schedule.
 - ❑ Public Hospitals – free of charge for “public” patients once States signed agreement with Commonwealth.
 - ❑ Health Insurers provided benefits for “private” patients of public and private hospitals.
-

1975 Health Insurers

- No Tax Deductibility.
 - No cover for Ambulatory Medical
 - Allowed to cover Dental, ambulatory therapies etc.
 - Supposed to “wither on the vine”.
 - Considerable rationalisation
-

1976 Medibank Mark 2

- New Government reverses some aspects of Medibank
 - Health Insurance Levy. Opt out of levy if covered by private health insurance.
 - Wasn't high enough and politically couldn't be raised.
 - Many cheated and taxation system unable to identify most of the cheats.
 - Health insurers covered ambulatory medical for insureds.
-

Medicare 1984



□ Reversion to Medibank-Type Scheme

- Subsidies to insurers withdrawn in 1986
- Extra costs added in 1986.
- Membership of insurers declined significantly over following years

□ Morale of medical profession declines.

- Commonwealth fee schedule not kept up with CPI inflation (let alone AWE).
 - Insurers “top up” insured hospital services but not ambulatory services.
-

Current Arrangements

- Over 50% of population has some form of private health insurance.
 - Around 70% of elective surgery is done in private sector
 - Mostly covered by health insurance.
 - Around 70% of hospitalisations are in Public hospitals.
 - Aged and Chronically ill.
-

Current Private Health Insurance Arrangements

□ Community Rated (by product)

- Hospital cover is has age at entry loading of 2% for each age above age 30 (maximum 70%). Loading payable for 10 years.
 - 30% tax rebate.
 - 1% tax levy on incomes if not covered by PHI. (but \$50,000 threshold singles, \$100,000 couples, slightly higher for families with children.)
-

Current Private Health Insurance Administration

- Culture shift from social insurance to PHI.
 - Strong RBC based solvency/capital adequacy arrangements.
 - Administered by independent health insurance regulator that reports to Minister of Health.
 - Appointed Actuary arrangements
 - Risk management focus.
-

Current Public Medical

□ Ambulatory Medical Treatment

- The most common GP consultation item (<20 minutes) pays \$32.10 (US\$26).
 - About 70% of ambulatory services are bulk-billed. (Patient has no point of service "cost")
 - The balance are usually charged at much higher rates than the Commonwealth Medical Benefit.
 - AMA Recommended Fee for simple GP Cons is \$55.
-

Current Public Drugs

□ Pharmaceutical Benefit Schedule

- Maximum co-pay is \$30.70. (\$4.90 for concessional card holders)
 - Safety Net is \$1,059 then charge reduces to \$4.90. (\$274.40 for concessional then no co-pay)
 - If drug costs less than \$30.70 then no Pharmaceutical benefit.
-

Current Public Hospital

- Free of charge for all Australian Residents.
 - But waiting lists for all except emergency treatment.
 - Even ambulances sometimes have to “hospital shop”.
 - No choice of doctor.
 - Medical services can be provided by trainees.
-

Aged Care

- Hostels and Nursing Homes
 - Funded by Commonwealth
 - Significant per diem co-pays.
 - Either “up front” or “back end” capital charges to patients.
-

Funding Health

Commonwealth	Patients
■ Ambulatory medical	Varies
■ 30% PHI premiums	70%
■ Ambulatory Pharmaceutical	\$30.70
■ Nursing Home and Hostel	Varies
■ Hospital Medical (private p'nts)	Varies depends on insurance

Funding Health

- State Government Patients
 - Public Hospital (inc. Medical) Nil
 - Some Commonwealth Funding
 - Non Institutional Aged Care Varies
 - Local Government
 - Non Institutional Aged Care Varies
 - Non Insured Patients
 - Ambulatory dental optical, therapies etc
-

Funding Health

- Private Health Insurance
 - Hospital
 - Medical in Hospital
 - Non-PBS Pharmaceuticals
 - Ambulatory dental, optical, etc
 - Note public hospitals do not charge private patients (residents) cost +
 - Charges are about 1/3rd of Private Hospitals (due to Commonwealth controls)
- | | Patients |
|-----------------------------------|-----------|
| ■ Hospital | often nil |
| ■ Medical in Hospital | often nil |
| ■ Non-PBS Pharmaceuticals | \$30.70 |
| ■ Ambulatory dental, optical, etc | varies |
-

What Does Public Private Partnership Achieve in Aust?

- Usually medical specialists have economically viable private practices.
 - Public know health is not a “free good”
 - Insureds don’t “wait” (for long).
 - Insureds have “choice of doctor”.
 - Insureds have “choice of quality”.
 - Strong private hospital sector.
 - Also relatively efficient
-

What Does Public Private Partnership Not Achieve In Aust?

- GP Satisfaction
 - Enough Doctors
 - Importing from poorer countries
 - Enough Nurses
 - Importing from poorer countries
 - Health Cost Control
 - Viable, Vibrant Public Hospitals.
 - Political Harmony
-

What Could Be Improved?

- Funding splits should be removed.
 - Commonwealth (or States) should fund all health not covered by PHI.
 - If Commonwealth then States would cede about 40% of their budget.
 - If States then fiscal imbalance would worsen.
 - PHI should fund all health costs for insureds.
 - But this would make PHI very expensive.
-

History & Culture

- A country's health scheme is a product of its history and culture.
 - Public won't usually accept a big bang approach to change.
 - Improve by increments.
 - Have a very long term vision – 50 years!
 - Private sector should be funded by PHI.
 - Needs strong regulation based on solvency, risk and accountability to maintain confidence in the private sector.
-