Education and debate

Healthcare lessons from Australia: what can Michael Howard learn from John Howard?

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Australia is held up as a model of how to increase use of private health care in the United Kingdom, but the effects of its reforms are not all beneficial

The Australian prime minister, John Howard, has engineered a major expansion in private healthcare insurance and been re-elected. The electorally popular Medicare provides universal coverage for free public hospital treatment, out of hospital medical services, and pharmaceuticals. Private insurance is limited to private treatment in hospital and some ancillary services, including dental care.¹ Yet the two decade trend of falling insurance cover has been reversed, and over three years the proportion of the population insured grew from 30% to 45%.² What can the leader of the British opposition, Michael Howard, and other European conservatives learn from an Australian colleague who has deliberately sought to enhance the role of the private sector?

Australian health service

John Howard and the Liberal party have been opposed to Medicare since its introduction in the early 1980s. In 1996, when the Liberal party was returned to government, it promised to maintain Medicare while strengthening private insurance. In fact, government policy has supported private health insurance. It introduced a 30% subsidy of the cost of premiums, which has been associated with a growth in use of private hospitals, private dental care, and other ancillary services while public hospitals and general practice, essential components of Medicare, faced growing difficulties with increased waiting time for hospital care and growing gaps between the cost to patients of primary care and Medicare reimbursements.^{3 4}

The Australian private health insurance industry is heavily regulated; only approved insurance funds can offer health insurance, insurers (generally) are obliged to take all comers, premiums are community rated (that is, individuals pay the same rate regardless of their individual risk), and premium increases require government approval. Some debate has arisen about the extent of adverse selection (sicker people staying insured while the healthier ones drop out) and cream skimming (insurers picking good risks). Although insurance coverage was undoubtedly falling before 1996, the average age of contributors was increasing and the insured population tended to be wealthier and therefore healthier. Even under community rating,

insurance packages were designed to discriminate—for example, by not offering hip replacements or covering childbirth.

Reforms

The first element of the Howard reform in 1997 was an income related subsidy, together with penalties for higher income earners without insurance.⁵ The maximum rebate on the premium was \$100 (£40, US\$78, €58) for a single person (for hospital only cover) and \$450 for a family (for both hospital and ancillary services cover), phasing out at taxable income thresholds of \$35 000 for a single person and \$70 000 for a couple plus \$3000 for each child. At the other end of the income scale, people without private health insurance had to pay an income tax surcharge. Single people earning more than \$50 000 and couples earning over \$100 000 (plus \$1500 for each dependent child after the first) were subjected to a tax surcharge of 1% of their income. The reform had little effect on the downward trend of insurance purchase.^{5 6} This is not surprising as it targeted the extreme ends of the income distribution. Most high income earners already had insurance and insurance remained relatively expensive for the lowest income groups.

In 1999, means testing was removed and anyone purchasing insurance was offered a 30% rebate

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Should Michael Howard (left) be singing from John Howard's songsheet?

through a reduced purchase price or as a tax rebate.^{5 6} The tax surcharge was retained. At this time, the fall in insurance coverage seemed to have been stopped. The change meant that for many high income earners, the cost of insurance was less than the Medicare surcharge so they were better off buying insurance.

This was quickly followed by the third element of the Howard reforms, lifetime health cover, introduced in mid-2000. People who purchase health insurance pay a premium related to their age at the time. People joining up to the age of 30 years pay the base rate for the rest of their lifetime; older people pay the base rate plus a 2% premium for each year past 30. The age premium breached strict community rating but is asserted to be lifetime community rating; individuals are not discriminated by risk but by the age at which they first purchase insurance.^{5 6} The rationale behind this policy was that insurance funds suffered adverse selection on age; younger, healthier people relied on the public system while the older, higher service users held on to their private insurance.

A strong government advertising campaign accompanied the policy change. The advocacy associated with this policy was so effective that insurance fund switchboards were jammed, and the deadline for purchasing insurance had to be extended. This element of the Howard reforms drove coverage up to 45%, although the most recent data show it has fallen to 42%.²

However, many of the insurance packages require high lump sum initial payments whenever care is consumed. This means that insured individuals face high personal costs and a clear incentive to be admitted as public patients rather than claim on their private insurance. Even without the high front-end payments, many policyholders faced unknown and potentially high copayments. Subsequent changes have encouraged no gap and known gap policies to overcome this.⁷

The rising level of copayments was tackled by another initiative, the Medicare safety net, introduced in March 2004.⁸ This bypasses private insurance to provide 80% reimbursement of all fees charged on out of hospital medical services once a threshold of \$700 a family (\$300 for lower income families) is reached. It is, in effect, an open ended insurance arrangement, paid for by government, to cover what doctors charge without any constraint on payments, such as limiting them to agreed or scheduled fees. In the recent election campaign, further commitments were made to raise the private insurance rebate to 35% for the 65-75 age group and 40% for the over 75s.

Effect of reforms

The Howard policy is a nice social experiment that merits careful evaluation. Clearly, it has increased the purchase of health insurance, an apparent success for the government. The health insurance funds have gained members, revenue, and reserves but not profit—the new members have not reduced their payouts. Overall, the privately insured have continued to use hospitals at the same level as before the big increase in coverage, so the new members are apparently not a low use group. However, the benefits paid per hospital day have increased, putting pressure on insurance premiums, and premiums have increased 7% each year over the past three years.²

Admissions to private hospitals have increased. Admissions to public hospitals have also increased, although the balance of public and private patients has shifted, with a higher proportion of admissions to public hospital being public patients.³ This does not necessarily represent a reduction in public hospital waiting lists, as private hospital admissions were increasing before the changes to health insurance, and a recent inquiry found that only 39% of people admitted to public hospitals with private insurance actually declared it and were treated as private patients.⁹

Thus, the private insurance subsidies do not seem to have reduced pressure on Australian public hospitals as forecast by the government. This has led commentators to ask whether the funds injected into private insurance would be spent more effectively if invested directly in the public hospital system.⁴ The cost of the 30% subsidy is now \$2.6bn annually, most of which goes to the 30% of the population who already hold private insurance—that is, affluent and elderly people. The further increase in rebate levels for elderly people seems destined to be another gain for the already insured, at a cost to the government.

The government's share of healthcare expenditure increased at first (from 47.3% in 1994-95 to 48.5% in 2001-02) but fell back to 46% in 2002-03.³ The distribution of the government share has also altered, with higher contributions to private hospitals, private dental services, and other ancillary services such as physiotherapy. The private contribution has also increased because of out of pocket spending, particularly on copayments. Copayments for medical services have been particularly unpopular—private patients pay their taxes, their Medicare levy, their insurance premiums, and then face out of pocket costs as well. Government encouragement of no gap insurance policies that ensure the patient faces no copayment seems to be overcoming this problem. Over 80% of in-hospital medical services had no copayment in June 2003, up from around 50% in June 2000.⁷

For out of hospital services, payouts under the safety net have reached double their predicted level. However, the highest level of payments is to people living in higher income areas.¹⁰ Although this is partly due to wealthier people being more likely to use specialist services, as was expected, it seems that specialists' fees are rising because of the loss of constraint from patient copayments.¹¹ These and other new health policies mean that the future costs of health care, and the government's share of them, will rise.

The government's success in resuscitating private health insurance in Australia is expensive. Every time that insurance premiums rise, tax subsidies increase. The policy has not led to a fall in insurance premiums, as predicted by the health minister at the time. The increases require government approval and are therefore highly visible, making private insurance a high profile part of national politics. With nearly half the population now having some insurance coverage, the public is sensitive about any reduction in the subsidy because it represents a loss of a benefit. Although it was the introduction of lifetime health cover (cheap) rather than the (expensive) subsidy that seems to have increased coverage,⁶ it is not clear that high insurance coverage would be maintained if the subsidy was reduced.

To prosper, the industry must either control patient demand or control the fees and the activity rates of providers. Patient demand can be controlled either by copayments or by restricting the benefit package. However, such a reversal of policy would be politically damaging as private insurance has been sold to the electorate as providing freedom of choice of provider, with no restrictions or waiting for care.

Greater control of providers would require insurers to scrutinise their activity rates and appropriateness of care. It would also require greater control of the fees charged by doctors and hospitals. In the past 12 months, the funds' payments to hospitals increased by 9% but their payments to doctors increased by 33%.⁷ This is associated with the move to policies with no copayments, but anecdote suggests that doctors are using the opportunity to increase their fees. To better manage such trends selective contracting and restrictions on the freedom of providers to charge freely and determine use independently are unavoidable. Critics of such a move refer to such policies as US-style managed care, which seems to be as unpopular with the Australian electorate as it is in the United States.

The ideological focus of these reforms makes them attractive to those who prefer private institutions to fund health care. They show, however, that such policies create increased fiscal burdens for government, increase inequality in funding care, and have no observable effects on efficiency. Worldwide, the private health insurance industry shows an inability to control costs and micro-manage its labour force. British and continental European conservatives should beware of the simple solutions used by their Antipodean colleagues. However, with John Howard being re-elected for a record fourth term in October 2004, they may also recognise that creating cost inflation and greater inequity in health care pays politically.

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Competing interests: The Centre for Health Economics Research and Evaluation provides health economics advice and undertakes commissioned research projects for the Australian Department of Health and Ageing from time to time. AM is

Summary points

The Australian government has engineered a major expansion of private health insurance alongside a universal, publicly funded health system

Various incentives and penalties have driven coverage up from 30% to 45% of the population

The strategy of subsidising insurance premiums has been expensive and primarily benefited the wealthy

Inflation of premiums has been high, which has increased the cost of public subsidies

Pressure on public hospitals has not decreased

chair of the NHS Hospitals Trust and has received research funding from the Department of Health to investigate consultant productivity.

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One hundred years ago

Sick nursing in France

If it is always good to see ourselves as others see us, our nursing institutions and those who are interested in their welfare will derive much encouragement from the account given by Dr. MARC BLATIN in a recent book on medical nursing and nurses. He gives first a history of nursing in France, and an account of existing provisions for the nursing of the sick in hospital and private practice; he then describes the English nursing system, and makes a series of suggestions for the betterment of nursing as an occupation in France, adding a plea for its organization along the lines which have proved so successful in this country.

Dr. Blatin ascribes the superiority of the English system to the popularity of nursing among the middle and upper classes, to the thoroughness of the training which is enforced, to the discipline

which governs nursing institutions and the nursing departments of hospitals, and to the exclusion of men from the immediate government and direction of nursing affairs. He lays special stress upon the thoroughness with which English nurses are taught their profession.

The English have applied to the instruction of their nurses the great principle which they apply throughout in the matter of education to their engineers, men of business, soldiers, and sailors: "C'est en forgeant qu'on devient forgeron." Nurses have no need of elaborate theories. On the other hand, they ought to be acquainted with a mass of practical details which they cannot learn from books. The old principle is therefore applicable and applied to them with the greatest advantage. (*BMJ* 1905;i:79)