

Slaves to economists?

A Canadian's view of the Australian health care system

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AN EXPERT IS DEFINED as someone from out of town — with slides. In health care, such experts also have a tendency to make cross-national comparisons on the basis of a short visit, a few conversations, and a desire to indicate “lessons learned”.¹ In that time-honoured tradition, on the basis of a visit to Melbourne to address the Victorian Healthcare Association, coupled with visits to several local hospitals, this Canadian identified several potential problems arising from Australia's approach to the public–private mix of hospital services.

As Keynes noted, “The ideas of economists and political philosophers, both when they are right and when they are wrong, are more powerful than is commonly understood. Indeed the world is ruled by little else. Practical men, who believe themselves to be quite exempt from any intellectual influence, are usually the slaves of some defunct economist.”² Over the past decades, many health care reformers have urged change — with varying degrees of success — based on a set of ideas that markets are always right, that competition is both necessary and sufficient for efficiency, and that private is superior to public. One consequence has been a push for a greater role for private delivery of health care services. This is currently hotly contested in Canada, with Australia providing either an exemplary example or a cautionary tale, depending upon ideological proclivities.

I was therefore interested in learning more from Australians as to areas of success or failure of the

public–private mix in Australia, and this paper highlights my observations.

The public–private mix

Although the appropriate mix of public and private is a key preoccupation of health policy in many countries, analysing this issue requires distinguishing how services are paid for (often termed “financing”) from how they are organised, managed, and provided (often termed “delivery”). The Organisation for Economic Co-operation and Development (OECD) has classified sources of funds as public (general taxation, earmarked taxation and social health insurance) and private (out-of-pocket payments and private insurance).^{3,4} Australia's experiment with private insurance as a major element in financing health care has attracted considerable attention,^{5–19} but this paper will instead concentrate on delivery: in particular, the public–private mix in hospital ownership.

In Canada, hospitals, for the most part, despite the confusing nomenclature of “public hospital”, are actually private, not-for-profit institutions with independent boards. (See Box for a classification of the five hospital types.) In consequence, although about 90% of the hospital sector in Canada is financed through public sources, government has had limited ability to direct their activities. Hospital employees are largely unionised, but are not government employees. In recent years, most Canadian provinces have sought to curb the power of hospitals by merging them into regional health authorities and insisting on greater “accountability” for funds spent. Accordingly, the lines between public and private have become less clear in practice. For-profit hospitals play a very minor role (a few were “grandfathered” and serve small niche markets), with almost no investor-owned hospitals.²⁰

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Hospital types²⁰⁻²²

Ownership Type 1: Public — managed by health system

This category of hospital is fully owned by the state, and is part of the health care hierarchy. With this ownership type, the hospital is an integral part of the public health service, and all strategic issues are controlled by rules set by the government. The individual hospital administrator has minimal control even over day-to-day decisions about the

factors related to the production and delivery of services (eg, staff mix, staff levels, services offered), which tend to be made centrally. This model was characteristic of the National Health Service in the UK before managerial reforms and, I was told, still describes public hospitals in some Australian states.

Ownership Type 2: Public — managerially independent

This category of hospital is also fully owned by the state (at the national, sub-national, and/or local levels), but has been given some degree of managerial independence. For example, the UK has been decentralising the National Health Service (NHS) and setting up "trusts" to manage

many health services, including hospitals, formerly managed from the centre. These trusts give managers more independence, and are employing more market-derived incentives to encourage efficiency, similar to the public hospitals I visited in Victoria.

Ownership Type 3: Private not-for-profit (NFP)

This category of hospital encompasses hospitals owned and operated by religious and other charitable organisations. The terminology used to refer to such hospitals can be confusing; for example, Canada commonly refers to these NFP organisations as "public hospitals," although they are neither publicly owned nor publicly managed, and are usually governed by an independent board of directors. In general, such organisations will not be bound by the same financial or administrative requirements that bind the public sector, although there is often considerable "red tape" involved in maintaining not-for-profit status. Indeed, current demands for "accountability" in some jurisdictions have been increasing public oversight to the extent that they can be

seen as moving closer to some variant of ownership type 2. Under most jurisdictions, they will be exempted from many taxes, and indeed may receive additional government grants, and contributions. They can also draw upon volunteers, and receive charitable contributions. They may also go bankrupt if they cannot raise sufficient revenues, although in practice this rarely occurs. NFP organisations are motivated by multiple objectives rather than just the financial bottom line and were the most common ownership structure in all of the jurisdictions we examined for a recent World Bank study,²¹ and describe almost all Canadian hospitals. One of the Melbourne hospitals I visited clearly fell into this category.

Ownership Type 4: Private for-profit, small business (FP/s)

These organisations do not comply with the legal requirements needed to attain not-for-profit status, but do not have shareholders. In many cases, they are provider-run (eg, physician offices, many physiotherapy clinics, most of the for-profit hospitals in Germany and Canada). Some of these organisations may have continuous service relationships with tax-funded and/or statutory health insurance payers (eg, the FP hospitals listed in German regional hospital plans); some would not. Like NFP organisations, FP/s businesses are less constrained by government "red tape" than is the case for public

ownership; they also risk bankruptcy. They differ from NFP organisations in that they are usually required to pay taxes, are usually subject to fewer "red tape" (accountability) requirements, are less likely to have to report fully on their activities, and have difficulty in accessing charitable and volunteer resources. They do not operate under the requirement of providing a return on investment to their shareholders. The few private hospitals in Canada tend to fall into this category; they are small, and provide niche services (eg, hernia repair) and are usually paid by the publicly-funded insurance plan.

Ownership Type 5: Private for-profit, investor owned (FP/c)

These organisations are incorporated and have shareholders who expect a return on their investment. These organisations are required to pay taxes, and have difficulty in attracting charitable donations or volunteer labour. However, they have the advantage of being able to access capital through issuing equity. Because they are corporations, their management can be seen as having a duty to maximise the return on investment and ensure that there are profits to be distributed to these investors. In

consequence, there can be conflict between the goal of providing high quality care, and the goal of running a successful business.

In general, this type of ownership of hospitals is rare. Australia appears to stand with the United States as one of the few jurisdictions which encourage private for-profit investor ownership. Indeed, the Netherlands prohibits it, while Canada and Germany discourage investor ownership.

In contrast, Australia has a mix of genuinely public hospitals, as well as private not-for-profit, and for-profit. The performance of the for-profits has evidently been controversial.²³⁻²⁷ During my visit it appeared that these hospitals concentrated on elective, and less expensive procedures. They seemed to avoid the less profitable — but still important — services. None appeared to be providing paediatric services; few appeared to have emergency departments — these services were left to the public hospitals.

We know that, in general, most people are healthy most of the time. Forget et al examined the distribution of expenditures for individually attributable physician and hospital services in the Canadian province of Manitoba.^{28,29} Health expenditures were heavily skewed, with the healthiest 50% of Manitobans using about 4% of resources, while the sickest 1% used 26%. In every age group, at least 80% of all people incurred costs less than the average for that age, while a small proportion incurred very high expenditures. These results paralleled those found in an analysis of the US National Medical Expenditure Studies.³⁰ This suggests that providers (and insurers) would only have to avoid a small proportion of the population to greatly reduce their expenditures; those likely to incur above-average costs were likely to be left to other, more altruistic providers. In theory, some of these problems can be alleviated — albeit not without transaction costs — by regulating providers (and insurers) and paying careful attention to how funding formulas are computed. In practice, this is often difficult.

In Australia, I found little evidence of such regulation of the private insurers. One hospital manager noted in dismay that insurers were allowed to sell products which would not cover cardiac care. Saltman and Busse cited a number of examples of “dysfunctional outcomes from unconstrained entrepreneurialism in the health sector” affecting cost, access, and quality.³¹ These included bankrupt insurance companies, efforts by sickness funds in the Netherlands to design service baskets which will “chase away undesirable (ie, more expensive) subscribers,”³¹ and even

incompetence and fraud. In short, there is a strong incentive to select potentially profitable market niches, leaving less profitable services (and patients) to others. When the private sector avoids the high users, the heaviest care, and costs, must be falling to the public system.

As befits any expert, I also had some conversations with “ordinary Australians” about their views of health care. One striking encounter confirmed that Dame Edna Everage had some real-life counterparts — it was reported to me that private care was better, in large part because one met a better class of people in the private hospitals. To a Canadian, this clarified the fragility of any system once the public stops believing in it.

Masters at cost-shifting

The easiest way to control costs is to shift them to someone else. This incentive to off-load costs is evident in both the Canadian and Australian systems, but Australia makes it easy. In one hospital, there was a door separating the public hospital from an outpatient clinic (which could bill the federal government), with another door leading to a for-profit subsidiary which could bill the private insurers. These activities may or may not improve care, but they certainly appeared to have increased administrative paper-pushing.

Competing for quality?

In Australia, the ethos of competition appeared triumphant. A striking presentation at the VHA conference by a member of the Australian Competition and Consumer Commission suggested that activities which many other countries encourage, such as promoting integration and coordination of services across providers, and consolidating some services into centres of excellence, were seen as inappropriate, and possibly illegal. The language of cartels abounded. One hospital informed me that they were not allowed to communicate with other hospitals about how much private insurers were willing to pay, which seemed less than fully competitive. (Don't economists believe in fully informed consumers?)

This made me question the balance between competition and cooperation in the Australian hospital system; particularly when we know that quality health care implies better clinical integration of services. The ethos of provision of services on the basis of need, with the goal of maximising health outcomes, often conflicts with the ethos of provision of services on the basis of willingness to pay, with the goal of maximising profits. Advocates of moving to a stewardship model suggest that successful adoption requires that all affected actors be committed to this approach.³² This in turn suggests that there may be some difficulties in implementing a stewardship model in the context of private for profit (investor owned) delivery, because the incentives for for-profit and not-for-profit providers often differ. As Saltman and Busse have noted, “Entrepreneurs inevitably seek to segment markets so as to exploit profitable niches, while publicly accountable regulators try to ensure that the entire market is served efficiently and affordably”.³¹ Efficiency is also defined differently: “In the private sector, the surrogate symbols for efficiency are, typically, increased profits as well as expanded market share and, in some industries, improved quality of product and service to customers. In the public sector, the surrogate symbols are improved volume and quality of service to clients, as well as generating a financial surplus and, in some sub-sectors, enhanced market share.”³¹

The strong belief in competition models appeared to have the potential to hinder quality assurance. Were hospitals able to jointly plan services without becoming guilty of cartel activities? Could hospitals control which physicians were allowed to work — either for reasons of cost control, or for quality assurance? How would patient information flow across competing providers? In short, could the essential need to cooperate and integrate services be made compatible with the desire for competition?

My impression was that in Victorian hospitals there was relatively little ability to control capacity, prices, or services offered. The system appeared to assume that Adam Smith’s invisible hand would

ensure that the services needed would be offered. Yet there was also little recognition that demand for services was not evenly distributed across the population. Experts may argue that waiting lists are not a major problem, but the public does not agree.³³⁻³⁵ Canada is currently in the midst of yet another crisis about waiting lists. Australia clarified for this Canadian observer that it is not enough for experts to argue that the fears are over-played; they must be addressed head on.

Why should Canadians (and Australians?) reject a greater reliance on FP/c (private for-profit investor owned) hospitals? (see Box)

Advocates of competition tend to assume that the underlying assumptions of economics always apply. Others, however, have noted the importance of “production characteristics” inherent in producing various goods and services.^{20,36} Three appear particularly relevant: contestability, measurability, and complexity.

In economic terms *contestable* goods are characterised by low barriers to entering and exiting markets. In contrast, non-contestable goods may have monopoly market power, geographic advantages, high sunk costs, and/or asset specificity (meaning that it is relatively difficult to transfer assets intended for use in a given transaction to other uses).³⁶ For example, the equipment and skills needed to perform open heart surgery could not easily be used for other purposes and therefore suggest asset specificity. In short, a contestable market is easy to enter, and to exit. In addition, contestability is hampered by the existence of organisations (or individuals) which consumers would wish to retain as care providers, even though they might be able to purchase similar services elsewhere for less money. Hospital services, for the most part, have high entry and exit barriers; expertise and trust are highly valued. In short, they are often not very contestable.

Measurability relates to “the precision with which inputs, processes, outputs, and outcomes of a good or service can be measured”.³⁶ Monitoring performance is easiest when measurability is high. For example, it is relatively simple to specify the performance desired for laboratory tests, or establish quality standards for pharmaceuticals. In con-

trast, it would be more difficult to specify the activities to be expected of a good general practitioner, and hence more difficult to monitor their performance to ensure quality. Many aspects of hospital care have low measurability and are therefore difficult to specify in sufficient detail to enable sophisticated contracting.

The third production factor is often termed *complexity*. Rather than referring to the complexity of the particular services performed, this term refers to the complexity of the system within which it is embedded, in particular, to whether the goods and services stand alone, or require coordination with other providers. Even laboratory tests, which are highly measurable, gain much of their value by being embedded within a system of care, in which providers order tests appropriately, and are aided in interpreting and acting upon their results. Similarly, even the most routine tasks within a hospital have requirements not common in normal business environments (eg, food services within a hospital must take account of dietary restrictions; cleaning staff must take account of hazardous materials, and so on).^{20,36} In economic terms, hospital services are complex.

My impressions of the Victorian and broader Australian health care system supported my concerns that health care does not have the production characteristics to enable an efficient market in the absence of regulation. In Australia there is still much debate as to whether expansion of the private sector (in particular for-profit, investor-owned hospitals) has had a positive or negative impact on the public hospital system.^{17,37-40} What is clear is that a strong for-profit private sector often relies on a lack of confidence in the public sector. I believe, from what I saw and what I heard, that the health system in Victoria, and probably throughout Australia, despite its excellence, is travelling a path likely to encourage further erosion of public confidence. This is a concern; as the Canadian example has demonstrated, confidence is clearly fragile, and difficult to restore. The signs are there — the competitive foundations designed to improve the Australian health care system may instead have the potential to further compromise the capability and capacity

of the public health care sector, increase total costs, and diminish equity. What is unclear is why so many appeared to think this was a good thing. It obviously calls for another visit!

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