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Opinion Piece by Dr Henry Cutler

"The case for competition in Australian healthcare"

Tax reform is the talk of the town, but when it comes to funding our healthcare system, Health Minister Sussan Ley assures us there will be no additional taxes.

Ley says it is a matter of spending our healthcare dollars more efficiently. And no wonder. Expenditure on health care continues to grow and will be over $150 billion this year. Governments will provide around $100bn. We spend around 9.7 per cent of GDP on healthcare, while governments spent around 25 per cent of their tax revenue. Greater efficiency will reduce some of the budget pressure faced by the government.

Therein lies the rub: our healthcare system is less than perfect when it comes to promoting efficiency.

In April this year, the Productivity Commission released a report outlining several areas of inefficiency. The use of health technology assessment, for example, is inconsistent across governments and providers. Our fee for service funding arrangements encourage over- servicing and cost-shifting with no account for quality.

There is also limited use of evidence-based guidelines, leading to large variations in clinical practice. The CareTrack study found that Australians get care consistent with evidence or consensus-based guidelines in only 57 per cent of encounters. Compliance ranged from 13 per cent to 90 per cent across conditions.

Additional areas of inefficiency included fragmented funding and policy responsibilities for preventative healthcare, workforce restrictions, and limited access to health and healthcare data, among others.

In recognition, the government has started several reviews to promote better value for money, such as the Primary Health Care Advisory Group, Medicare Benefits Schedule Review, and a private health insurance review.

But a greater force is arguably available to government that could increase efficiency. This is where competition in healthcare may help.

Healthcare is complex. The value of services is somewhat uncertain, and the demand is irregular and unpredictable, only occurring in the event of illness or disability. Large uncertainty in a world where providers have more information means one of the preconditions for an effective competitive market is muted.

And while efficiency is important in healthcare, society also aims for broader objectives.

The notion of a ‘fair go’ embodies our approach to delivering equitable access to services, which are primarily funded by governments but delivered through a combination of public, private and not-for-profit organisations.

In a departure from the competitive norm, many healthcare providers price-discriminate services to help meet equity objectives, such as bulk billing in GP practices. The political backlash received by the government in its attempt to introduce GP co-payments is testament to how strongly we feel about a ‘fair go’ in healthcare.

What does the evidence tell us?

While competition in healthcare is synonymous with the US health system, in the past 20 years, countries with universal coverage such as the UK and some parts of Europe have introduced greater competition in an attempt to improve quality and efficiency.

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Reforms within the English National Health Service that occurred between 2003 and 2008 were squarely aimed at increasing competition and choice within public hospital services and could offer us some insight into a framework for greater competition in Australia.

First, prices for elective surgery were centrally set, and hospitals received funding based on the number and type of patients treated, similar to activity-based funding in Australia. Information on hospital quality, waiting times and other attributes of care became available to the public.

Private hospitals were encouraged to enter the market to compete for NHS funded elective care patients through nationally agreed contracts.

Probably the most significant change was the introduction of hospital choice. Starting in 2006, patients undergoing elective surgery were provided information on the quality, timeliness and distance to care and offered the choice of up to five hospitals by their GP, including one private hospital.

By 2008, patients could choose any public or private hospital in the NHS. Prior to these reforms, public patients could not select which hospital they went to.

These reforms were introduced alongside other changes, including substantial growth in the NHS budget, greater autonomy to managers of high-performing hospitals, introduction of financial incentives, and stronger performance management targets.

Several evaluations of these reforms suggest competition has improved outcomes and efficiency, increased access to hospital services for people with lower socioeconomic status, and reduced hospital waiting times.

But the market must be carefully designed and regulated.

While it is problematic to transfer results from the UK to the Australian setting, competition in hospital markets with fixed prices could potentially improve clinical quality, efficiency and access under the right conditions.

Australian governments should, therefore, explore the use of greater choice across public hospitals and within hospitals, such as choice over who provides care. This should be done in the context of a carefully designed framework that can harness the good and mitigate the bad.

But any attempt to introduce greater competition must be done with full recognition of the social objectives these sectors are trying to achieve, and the potential costs associated with reform and ongoing market transactions. Particular attention must be paid to areas where competition may not be effective due to a smaller number of providers, such as rural and remote areas.

Regulated input markets, such as labour and capital, should also be reviewed as they may also limit positive outcomes from competition.

Any discussion around competition should also consider opening up some of the constraints within the health care workforce while ensuring safety is maintained, such as recognition of overseas qualifications and the ability for multiple types of health care professionals to offer services, given they are qualified.

The question is not whether competition should be introduced into health and human services, but what level of competition is appropriate, and what needs to change within our regulatory and institutional environment, and our contractual and funding landscape to facilitate that level of competition.

ENDS

Dr Cutler's opinion piece was first published in Business Spectator on 10 November 2015.