Towards a Health Productivity Reform Agenda for Australia

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Executive summary

- Health is forecast to be one of the biggest sectors of the Australian economy over the next few decades, but the debate over health policy ignores any concept of "productivity".
- Productivity can be generally defined as the quantity of goods or services produced per unit of input, and are an important indicator of the extent to which scarce resources are being efficiently applied in the production process.
- There are numerous difficulties in accurately estimating productivity trends in the health care sector; however the available evidence suggests that the productivity performance of health care providers generally lags that of other industries.
- Within this there is some indirect evidence that government owned and managed providers of health care services, such as public hospitals, are not performing as efficiency as their private sector peers.
- A number of institutional and policy obstacles constrain the capacity of health care operators to improve upon their productivity performance.
    - The disconnection between financing and use of publicly provided health care services obscures the delivery of productivity gains.
    - The growth in health bureaucracies effectively displaces additional outputs in favour of extra labour inputs, and generates internal red tape stymieing efficient services delivery.
    - Private health sector operates are burdened by overregulation, impeding their capacity to deliver additional productivity improvements.
    - The misplaced belief that health care is 'special,' in the sense of being immune to the application of market forces, diverts attention away from pursuing productivity gains.
- The key means by which to secure an improved productivity performance in health is through reducing restraints upon competition, encouraging providers to generate more output with fewer inputs and benefiting health care consumers in the process.
- A range of interrelated reform principles are cited as the way to improve productivity within the health care system, including: improving the responsiveness of providers to consumer demands; encouraging greater differentiation in health care provision; reducing regulatory impediments to health care services provision; alleviating health sector workforce rigidities; and greater public transparency of operations to consumers and taxpayers.
- Implementation of the productivity reform principles outlined in this paper should deliver gains to health sector productivity well in excess of previous Productivity Commission estimates of a five per cent gain from hospitals reform alone.

Introduction

The strangest feature of the current economic policy debate is that arguably the most important topic within it - productivity - is floating past health care, one of the largest sectors in the country, in silence or with barely a whimper.

After all, read any newspaper or watch a news or current affairs bulletin on television and its hard not to trip over some discussion about the fortunes of mining, on the other hand, or the woes of manufacturing or retailing on the other framed against the broader discussion about productivity.

The questions frequently being asked include: how did Australia manage to suffer a productivity slump over the past few years? How can we all work harder and smarter to produce a productivity recovery setting us up for the next phase of prosperity?

And, of course, a highly charged and partisan debate is being waged right now about the effect of different government policies on national productivity.

What contributions did WorkChoices under Howard,or the re-regulated industrial relations system under Rudd and Gillard, make to Australian productivity? Did the fiscal stimulus make a positive contribution to our productivity capacity in the long term? What productivity effects will the proposed carbon tax have?

But where does health fit into this general picture? Nowhere, if the deafening silence about the role of productivity in the health sector is any guide.

This is not to say that health is unimportant to many Australians. It clearly is of great importance.

It is true that most Australians recognise that the health care sector is large.

It is estimated that total expenditure on health was $112.8 billion in 2008-09,[1] equating on average to $5,190 spent on health goods and services for each Australian resident. Also, close to 550,000 people are estimated to be directly employed within health occupations.[2]

The projection is that health care spending will increase to between 12 per cent and 15 per cent of gross domestic product (GDP) over the next thirty years, which would represent a significant shift in real resources to be absorbed for health care purposes.[3]

It is also true that most Australians understand that health care is complex.

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[1] Business Council of Australia, 2011, 'Selected Facts and Statistics on Australia's Healthcare Sector', http://www.bca.com.au/UserFiles/Selected_Facts_and_Statistics_on_Australia's_Healthcare_Sector_FINAL_16.2.2011(4).pdf, p. 6.

[2] http://www.aihw.gov.au/health-workforce/.

[3] Ibid.

The Australian health care sector comprises an array of heterogeneous services with a mixture of private and public sector providers, with three levels of Australian government and the private sector all have significant roles in raising funds, allocating resources, regulating and delivering health care services.

In fact, this marble cake mix of provision and activity by different players sets the scene for the blame and cost shifting between providers that frustrate a clear majority of Australians, particularly those on daily basis who seek good outcomes from the system.

But perhaps the reason for the lack of focus on the productivity performance of the providers who deliver health care treatments and services to the Australian population is a combination of two things.

The simplest, but perhaps least convincing, explanation is that a national fire-side chat about productivity and health is being sidelined for now simply because productivity flashpoints in other sectors of the economy appear more pressing, and are thus preoccupying academic, media and policy circles.

For example, if the conventional wisdom holds that mining is the saving grace for an Australian economy wracked by post-GFC stagnation then copious amounts of ink will be spilt focussing on how to boost productivity there.

Arguably the more convincing explanation is that there is a widespread preference not to talk about productivity, and how to enhance it, in health care services.

The treatment that patients receive from their health care providers is paramount to the overall quality of life, whether it is the fairly routine procedure of fixing a broken ankle, leg or shoulder to the often technically difficult, and always emotionally fraught, campaign to cure a patient of their cancer.

Whatever it is, the quality of life is an important outcome to be derived from engaging with the health care system and, for many, good outcomes can often not be reduced to dollars and cents.

For some precepts about the dignity of the human being undergoing medical and other treatments, regardless of their complexity, renders unethical any discussion about the need for staff, managers, businesses and government agencies involved in providing health care to become more productive.

In this context, productivity in health is seen as a dirty word.

Other tend to defend the status quo in the Australian health care sector on the basis that because providing health care, and ensuring quality patient outcomes, is invariably a labour-intensive exercise then productivity cannot be enhanced in any meaningful way.

And when a GP works countless hours treating a revolving door of patients in a fifteen to twenty minute block, or when a surgeon performs a complex medical procedure such as tumour removal or

an organ transplant through a twelve or even fifteen hour shift, they might be forgiven for not thinking of their obligations to improve productivity at every turn.

Whatever the reason for the lack of consideration of productivity performance in health care, and what can be done to improve it, is a serious oversight which requires serious remedy.

There is simply too much money and resources invested in Australian health care not to be talking about productivity.

The purpose of this paper is to throw open a discussion about the productivity performance of the Australian health care sector, as it stands, and what can be done to improve its productivity performance to deliver economy in the use of financial and real resources whilst continuing to improve the quality of health care for the community.

The next section will specify the case for a health productivity reform agenda, based on an assessment upon the extent to which the sector can secure additional productivity gain within the context of the current policy environment.

This will be followed by an examination of the structural roadblocks to change which impede the ability of health care providers to maximise their productivity potential.

A suite of key reform principles will also be outlined which would be expected to invoke powerful effects by way of unleashing productivity gains in health.The selection of these principles will be informed by the view that greater competition amongst providers for the delivery of health care services poses as a key imperative to enhance productivity within the sector.

Just like for any other market in the Australian economy, incentives to encourage greater competition will be expected to substantially enhance total factor productivity within the health care sector, with significant flow on benefits in terms of maintaining a world-class health system that Australians deserve and expect.

The case for a productivity reform agenda in health care

What is productivity?

In general terms, production by all sectors of the economy involves the process of transforming tangible and intangible resources (inputs) to produce goods and services (outputs).

The inputs absorbed by health care operators include the health workforce (staff and their skills), buildings, land, technology, medical supplies, food, bed linen, office supplies, utilities and other materials that are used to produce its outputs.[4]

[4] Owen Gabbitas and Christopher Jeffs, 2007, 'Assessing productivity in the delivery of health services in Australia: Some experimental estimates', Paper presented to the Productivity Commission Productivity Perspectives 2007 Conference, p. 1.

The outputs of the health care sector are numerous and vary substantially in character encompassing consultative and procedural services delivered in a range of community and institutional settings.These include general practitioner consultations, acute care treatment (such as hip replacements, cataract operations, organ transplants and oncology treatments), immunisations, staff training and scientific research.[5]

Derived from this understanding of the production process, productivity can be defined as the quantity of goods and services produced per unit of input. This incorporates the (technical) efficiency with which inputs are transformed into outputs. An increase in efficiency implies either more output is produced with the same amount of inputs, or that fewer inputs are required to produce the same level of output, given existing technology.[6]

The concept of technical efficiency is complemented by that of allocative efficiency, which occurs when the input mix is that which minimises cost, given input prices or, alternatively, when the output mix is that which maximises revenue, given output prices. Overall efficiency is dictated by the attainment of both technical and allocative efficiencies.[7]

While much of the empirical and statistical evidence of the productivity performance of Australian health presented here will focus mainly upon technical efficiency, other studies will be referred to which provide a broader view while the policy recommendations contained in this paper pertain to broader conceptions of productivity change over time.

The challenges of measuring health sector productivity

While the estimation of productivity is never a straightforward task, there are certain issues which ensure that quantifying productivity by the health care sector is fraught with significant difficulties.

At the outset the measurement of productivity in services such as health is considerably more difficult than for sectors that produce tangible products. As discussed by American economist Tyler Cowen:

'The doctor doesn't face the same market test as the apple does. We know right away how good the apple tastes, and if it's bad, we'll stop buying that brand or stop buying from that store. On the other hand, very often we don't know for a long time, if ever, what the doctor did for us. In other words, the market is testing whether or not the doctor can give us hope and the feeling of having been taken care of, not whether the doctor really makes us healthier. Feeling more or less hopeful is a pretty inaccurate test. Hope is even supposed to be a bit irrational.'[8]

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[5] Ibid.

[6] Mark Rogers, 1998, 'The Definition and Measurement of Productivity', University of Melbourne, Melbourne Institute of Applied Economic and Social Research, Working Paper No. 9/98, p. 5.

[7] Bruce Hollingsworth, 2008, 'The Measurement of Efficiency and Productivity of Health Care Delivery', *Health Economics* 17: 1107-1128.

[8] Tyler Cowen, 2011, *The Great Stagnation: How America Ate All the Low-Hanging Fruit of Modern History, Got Sick, and Will (Eventually) Feel Better*, Dutton, New York, p. 30.

Changes in output quality by health care providers can have an important effect on health outcomes experienced by patients, and should thus quality considerations should be incorporated into any analysis of productivity change within the sector.

Even so, quality measurement in health care is notoriously difficult.

Factors outside the control of health care providers, such as chronic illnesses in patients or the provision of safe, nutritious foods and clean environments, may affect the quality of care outcomes whilst the sheer impossibilities of accurately envisioning counterfactual states of the world can render it difficult, and indeed in some circumstances almost impossible, to measure changes in quality specifically attributable to health care interventions.

It should also be noted that various providers of health care services provide a multiplicity of outputs that add to the complexity of measuring health sector productivity.Health economist James Burgess, for example, has referred to 'the fundamental nature of health care services as multi-product goods, even to the extreme conception of the treatment of each patient as a unique individual product.'[9]

Like in other sectors of the economy, the character and mix of inputs, processes and outputs, and the outcomes from the health care goods and services provided, varies substantially over time with the introduction of new or improved products, technological innovation affecting the delivery of products and changes in ways of working as well as with broader influences such as relative prices and income levels.[10]

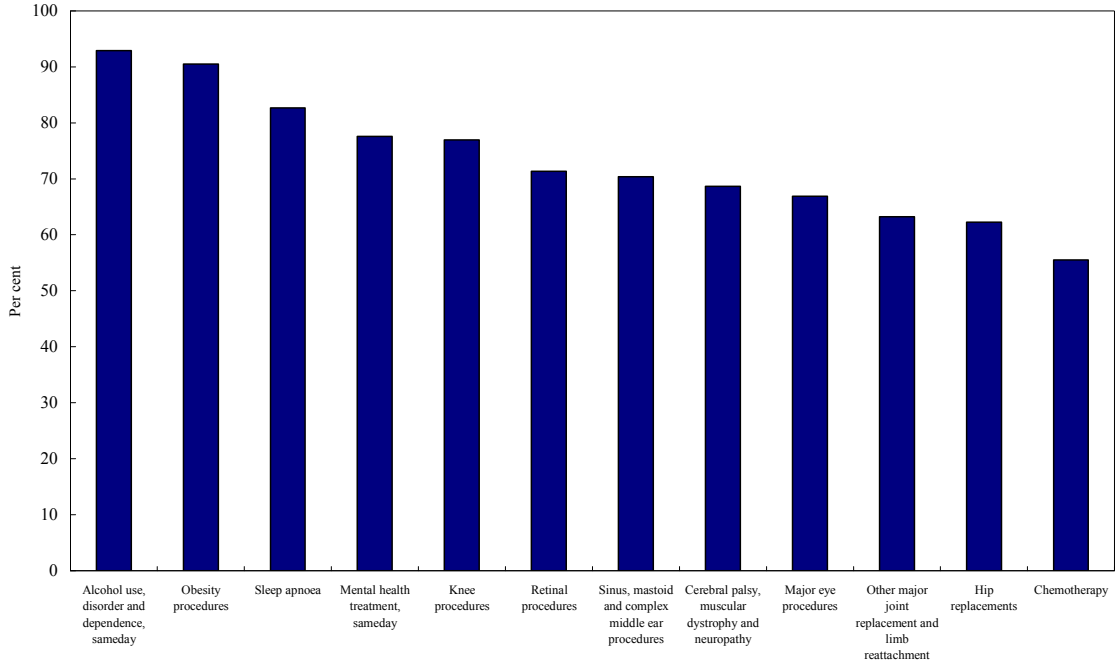
Differences in institutional and operating environments can affect the ability to make reasonable comparisons of the productivity performance of health care providers.

If inputs and outputs are priced appropriately to reflect their value then profitability would represent the most appropriate measure of the contribution that health sector activities make. However health care in most advanced societies are predominantly organised on the basis of providing services on a non-marketable basis.

Even where Australian private hospitals are increasingly providing a mix of treatments similar to those found in public hospitals (Figure 1), it is widely held that public hospitals are less able to influence the level and mix of patients due to their role of providing services outside of the market process and at no direct cost to the consumer.

[9] James F Burgess Jr, 2006, 'Productivity analysis in health care', in Andrew M Jones, ed., *The Elgar Companion to Health Economics*, Edward Elgar, Cheltenham, p. 335.
[10] Gabbitas and Jeffs, op. cit, p. 2.

Figure 1: Private hospital share of separations for selected treatments, 2006-07



Based on AR-DRG version 5.1.

Source: Julie Novak, Chris Berg and Tim Wilson, 2010, *The Impact and Cost of Health Sector Regulation*, Australian Centre for Health Research.

Recent estimates of Australian health sector productivity

The numerous difficulties surrounding the estimation of productivity should not be taken to imply that the health care sector ought to be exempt from any rigorous assessment and scrutiny of its productivity performance, to the extent that it is amenable to (even indirect) measurement.

As explained recently by a business representative organisation, '[t]he scale of the sector and the significance of health care as a growing proportion of public and individual budgets is such that efficiency, value for money and outcomes are important.'[11]

A number of studies in recent years have attempted to estimate the extent to which productivity of the Australian health sector could be improved relative to those in other countries (Table 1).

Whilst there are variations in estimation techniques used, not to mention international variations in regulatory and health status environments, most of the available studies indicate that the Australian health sector could reduce existing inefficiency gaps by reducing input without compromising on the level of outputs provided.

[11] Business Council of Australia, 2011, *Using Microeconomic Reform to Deliver Patient-Centred Health Care: Engaging and Empowering Citizens is the Key to Better Health Outcomes*, http://www.bca.com.au/UserFiles/Using_Microeconomic_Reform_to_Deliver_Patient-Centred_Health_Care_FINAL_16.2.2011(2).pdf, p. 11.

Table 1: Estimates of implied inefficiency in Australian health care sector

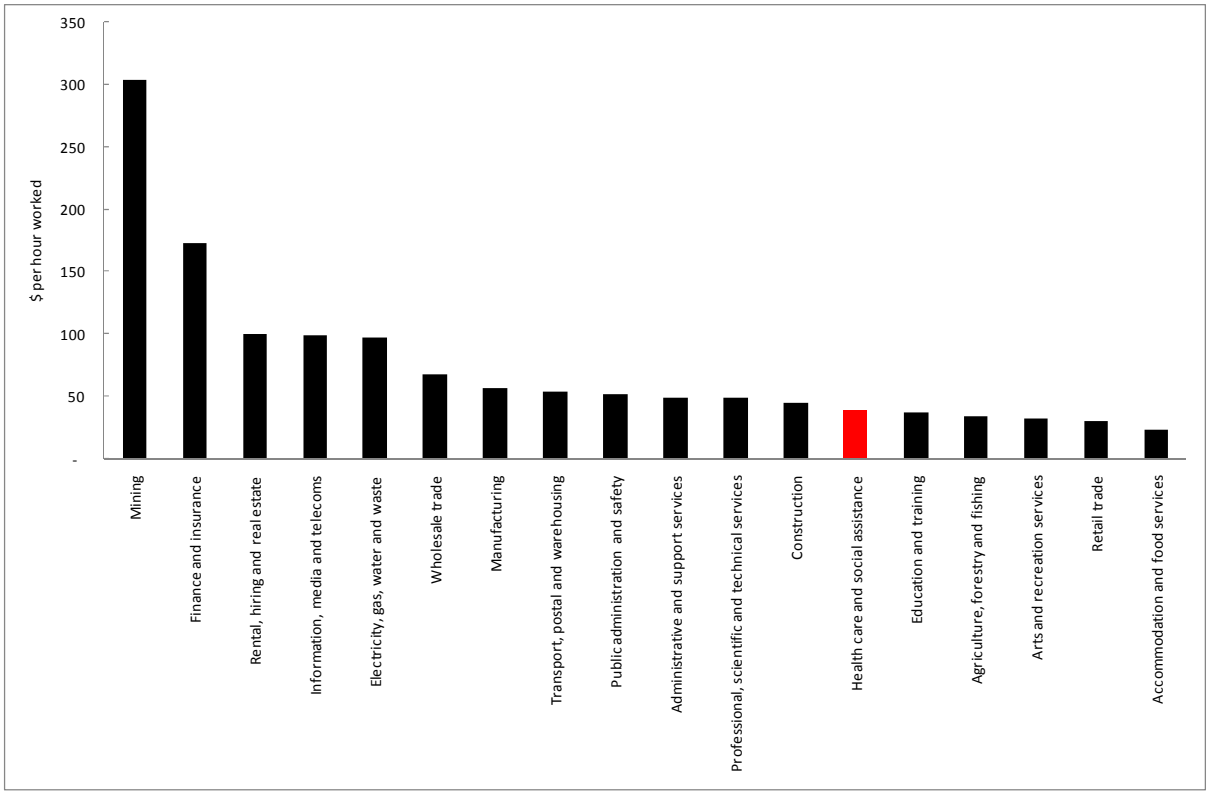
Study	Estimation method	Technical efficiency score for Australia	Implied inefficiency
WHO (2000)	Global rankings based on composite index	Overall index of 0.88	14
Evans et al (2001)	Regression estimation	Less than 0.94	6
Gravelle et al (2003)	SFA	Around 0.91	10
Greene (2003)	SFA	0.99	1
Afonso & Aubyn (2005)	FDH and SFA	0.92	9
Kumbhakar (2004)	SFA	0.94	6
Vasanthakumar (2005)	DEA	0.75	33

The estimation methods refer to data envelopment analysis (DEA), stochastic frontier analysis (SEA) and free disposal hull (FDH). The inferred inefficiency score is expressed as a share of the technical efficiency score, indicating the potential for improvement.

Source: Owen Gabbitas and Christopher Jeffs, 2007, 'Assessing productivity in the delivery of health services in Australia: Some experimental estimates', Paper presented to the Productivity Commission Productivity Perspectives Conference.

It is possible to derive measurements of labour productivity generated by the 'health care and social assistance' sectors-incorporating hospitals, medical and other health care services, residential care, child care and other social assistance -using data provided by the Australian Bureau of Statistics (Figure 2).

Figure 2: Labour productivity by sector, 2009-10



Aggregate hours worked for each sector derived by grossing up estimates of average hours worked in the survey week for the middle month of each quarter in 2009-10. Output is gross value added (chain volume measure).

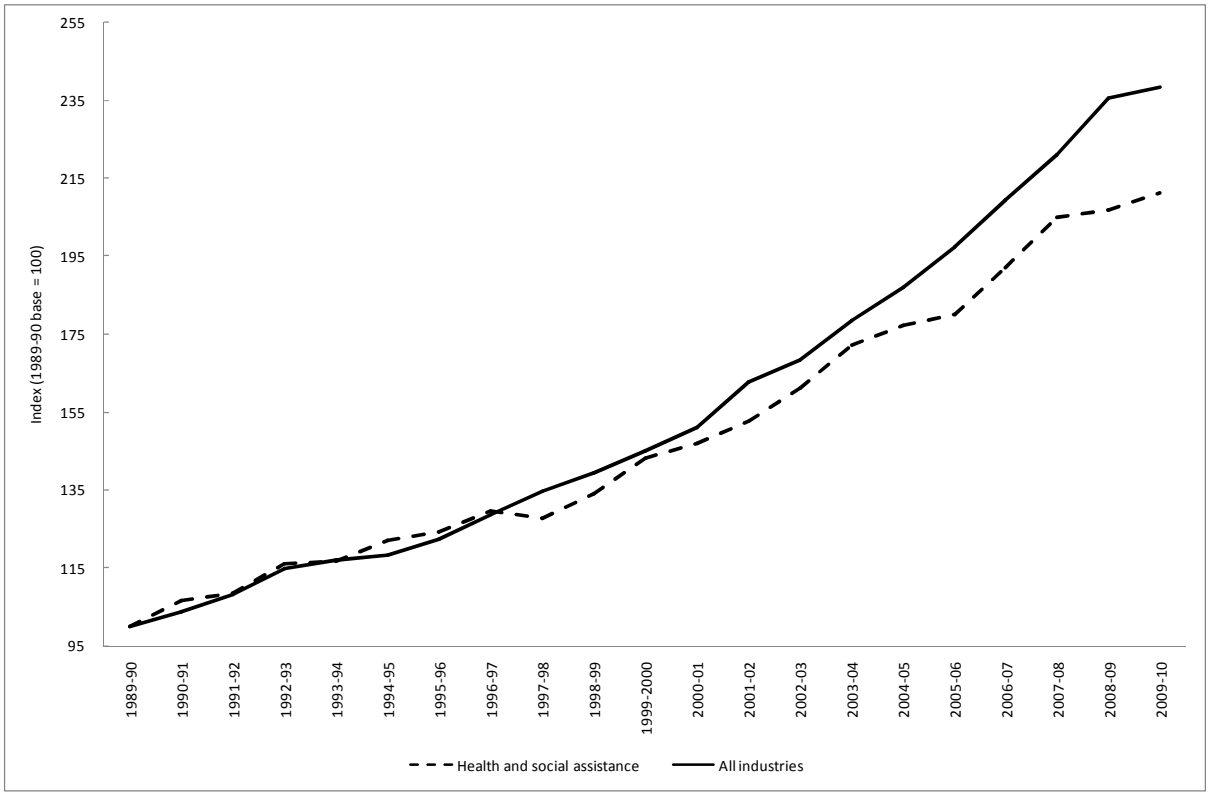
Source: Australian Bureau of Statistics, Australian System of National Accounts, 2009-10, cat. no. 5204.0; Australian Bureau of Statistics, Labour Force, Australia, Detailed, Quarterly, cat. no. 6291.0.55.001; IPA calculations.

Labour productivity in the health care and social assistance sectors are among the lowest in the Australian economy, at $39 per hour in 2009-10. The amount of output generated per hour worked in this sector was some 40 per cent below the average for all sectors.

Given annual variations in the data, it is appropriate to gauge the extent to which sectors of the economy are utilising resources efficiently over a longer period of time.

Figure 3 provides a time series for labour productivity in the health care and social assistance sectors, compared with the average for all industries. It illustrates that the implied 'productivity gap' between the health care and social assistance sectors and the all-industry average has tended to increase over the last decade.

Figure 3: Labour productivity by selected sectors, 1989-90 to 2009-10



Aggregate hours worked for each sector derived by grossing up estimates of average hours worked in the survey week for the middle month of each quarter in 2009-10. Output is gross value added.

Source: Australian Bureau of Statistics, various years, Australian System of National Accounts, 2009-10, cat. no. 5204.0; Australian Bureau of Statistics, various years, Labour Force, Australia, Detailed, Quarterly, cat. no. 6291.0.55.001; IPA calculations.

While the compounded growth in gross value added in the health care and social services sector over the period from 1989-90 to 2009-10 was a full percentage point ahead of the average for all industries, the growth in hours worked in health and social services was double that for all Australian industries.

Some studies have emerged in recent years also investigating the productivity performance of different segments of the Australian health care sector.

Last year the Productivity Commission released a study on the comparative performance of Australian public and private hospitals.Taking an output-orientated approach to technical efficiency (i.e., how well a hospital maximises output from its given resources) the Commission found that hospitals have the potential to increase their output by about ten per cent based on the current level of input utilisation.[12]

Table 2 summarises the findings, providing a measurement score of the volume of output that a type of hospital is producing relative to the maximum volumes they could potentially produce from its current inputs. In this context, say, a measurement score of 90 implies that a hospital is producing at 90 per cent of its full output potential.

The estimates suggest that modest variations exist in the relative technical efficiency of hospitals by their form of ownership, with public hospitals on average being less efficient (in terms of securing output gains from given resources) than their private hospital peers.

Table 2: Technical efficiency scores by type of hospital ownership

	Public	**Private**			**Public contract**	**All hospitals**
		Not-for-profit	*For-profit*	*All*		
Mean	89.1	85.6	94.8	92.6	92.4	90.0
Median	90.6	90.1	95.4	94.8	93.0	91.8
5th percentile	75.6	62.0	89.9	82.9	85.5	76.6
95th percentile	97.0	96.8	97.7	97.6	97.2	97.2

Source: Productivity Commission, 2010, *Public and Private Hospitals: Multivariate Analysis*, Supplement to Research Report.

Another important finding from the study was that hospitals which have higher than expected mortality rates are estimated to be relatively less productive for their given input level, and more resource intensive for their given output level.[13]

The productivity performance of Australian hospitals can also be gauged using surrogate indicatorsforlabour or capital productivity (Table 3). The measures used here imply that hospitals with high levels of total staff, and bed, productivity are more likely to be technically efficient in their use of labour, and capital, respectively.

[12]Productivity Commission, 2010, *Public and Private Hospitals: Multivariate Analysis*, Supplement to Research Report, Canberra, p. 77.
[13] Ibid.

Table 3: Labour and capital productivity in public and private hospitals

	Labour productivity *(casemix-adjusted separations per FTE staff member)*			**Capital productivity** *(casemix-adjusted separations per bed)*		
	1996-97	2004-05	2009-10	1996-97	2004-05	2009-10
Public hospitals						
NSW	19	19	21	62	72	84
Vic	21	20	20	77	98	106
Qld	21	22	20	59	76	85
WA	23	18	20	65	77	90
SA	21	22	20	65	76	85
Tas	18	19	17	60	71	79
ACT	19	21	21	70	102	98
NT	17	23	20	67	100	99
Australia	20	20	20	65	79	90
Private hospitals						
NSW	43	55	62	69	93	125
Vic	39	47	50	70	89	116
Qld	38	52	55	68	90	115
WA	27	43	np	53	79	np
SA	np	56	63	57	84	124
Tas, ACT and NT	np	np	np	np	np	np
Australia	39	50	53	67	86	114

Source: Australian Bureau of Statistics, various years, Private Hospitals, Australia, cat. no. 4390.0; Australian Institute of Health and Welfare, various years,*Australian Hospital Statistics*; Owen Gabbitas and Christopher Jeffs, 2007, 'Assessing productivity in the delivery of health services in Australia: Some experimental estimates', Paper presented to the Productivity Commission Productivity Perspectives Conference; IPA calculations.

The trends suggest that labour productivity has been relatively flat in public hospitals, whereas levels of productivity of staff in private hospitals have increased from 1996-97 albeit at a declining growth rate. While capital productivity levels in public and private hospitals were similar from 1996-97 to 2004-05, the growth in capital productivity since has been stronger amongst private hospitals.

Another indirect indicator of hospital productivity commonly used is the 'relative stay index' (RSI) defined as the actual number of acute care patient days divided by the expected number of acute care patient days, adjusted for casemix. A RSI greater than one indicates that an average patient's length of stay is greater than would be expected given the casemix for the category of interest (for example, hospital sector or jurisdiction).[14]

As shown in Table 4, there were relatively longer periods of stay on average for public hospital patients admitted in surgical and other diagnostic related groups (DRGs). By contrast private hospital patients undertaking various medical procedures stayed, on average, in hospital for longer.

[14] Australian Institute of Health and Welfare (AIHW), 2011, *Australian Hospital Statistics 2009-10*, Health Services Series No. 40, p. 22.

Table 4: Directly standardised relative stay index for public and private hospitals, by AR-DRG, 2009-10

	Medical		Surgical		Other	
	Public	Private	Public	Private	Public	Private
NSW	1.03	1.24	1.10	0.93	1.16	0.93
Vic	0.90	1.16	0.99	0.97	0.99	0.95
Qld	0.91	1.20	1.05	0.97	1.05	1.02
WA	0.97	1.20	1.08	1.02	1.01	1.06
SA	0.99	1.11	1.08	0.95	1.08	0.98
Tas	1.08	np	1.04	np	1.03	np
ACT	0.98	np	0.96	np	1.00	np
NT	1.11	np	1.49	np	1.42	np
Total	0.96	1.18	1.05	0.96	1.06	0.97

Source: Australian Institute of Health and Welfare, 2011, *Australian Hospital Statistics 2009-10*, Health Services Series No. 40.

There exists a dearth of evidence regarding the productivity performance of other segments within the Australian health care sector, such as general practices, pharmaceutical manufacturers and distributors, and private health insurers. Further research will be necessary to fill the existing gaps in knowledge with respect to these areas.

Nevertheless the available productivity measures, as indirect as they might be, give rise to concerns that resources utilised by the Australian health sector are not being used as efficiently as possible, implying scope for improvement in eliminating wasteful practices and delivering more output without compromising care outcomes.

What are the obstacles to a health productivity reform agenda?

The financing and use of health care is too disconnected from each other, obscuring the means to best secure productivity gains

One of the greatest structural problems facing Australia's health care sector is the disconnect in charging for and paying for services which exists between the consumers of health care (someone who makes use of health services) and providers of health care (including doctors, specialists and their government overseers), giving rise to the inefficient application of scarce resources.

This problem is particularly relevant when it comes to the governmental provision of health care, but can also be prevalent if the government subsidises private sector health services. As noted by Marlow and Orzechowski, this is because fiscal processes divorce payment of service from their use which in turn influences the public choices that citizens make:

'Most government-supplied goods are greatly subsidised or have zero prices for users. This means that uses of goods are separated from payment, which take the form of taxes. Taxes are virtually inescapable levies ... and, indeed, they must be since few citizens would offer sufficient donations in the face of zero or greatly subsidized prices. Given greatly subsidized prices at the point of use, payments must come from a source that is virtually inescapable. ...

The supply of government goods is politically determined through the apparatus of representative government. And so, on one side of the coin, we have use determined largely by politics, and on the other side, payment for such services mostly separated from the former via taxes levied on "intermediate bases" (income, retail sales, and so forth).'[15]

A range of adverse consequences flow from any disconnection between the financing and use of goods and services. Once these two elements are split, encouraging consumption as a 'universal right,'prices no longer exist to guide the consumer since the payment of taxes are essentially disconnected from actual uses of goods. The linkage between costs and benefits provided through the price mechanism is abolished and, in practice, tax earmarking seldom operates in such a way to reconnect financing and use.[16]

Closely related to this is the notion that voters would have little incentive to signal the same demands for spending that would arise in a private market where use and payment are connected. As Milton Friedman once wrote, '[l]egislation cannot repeal the non-legislated law of demand and supply. The lower the price, the greater the quantity demanded; at a zero price, the quantity demanded becomes infinite. Some method of rationing must be substituted for price and that invariably means administrative rationing.'[17]

The separation of financing and use in the provision of goods and services also increases the extent to which consumers become ignorant to the costs of outputs on offer, as the incentive to search for the most cost-effective treatment option is greatly diminished when outputs are heavily subsidised or free. As recently explained by the British economist Mark Pennington:

'both the finance and delivery of care are controlled by the state, with the price system almost entirely eliminated from the patient-supplier relationship. As a consequence, consumers have no scope to compare the costs and benefit of rival models of supply – and indeed are left in a state of almost total ignorance with respect to the costs of the treatments they receive. In the absence of any price signals acting as spontaneous constraints on consumer demand, the only source of cost and quality control is derived from professional providers who ration care according to government-determined criteria of patient 'need.''[18]

Meanwhile, non-users of the affected good or service effectively have a portion of their incomes transferred to users through the taxation system and are left poorer in the process.[19]

In the Australian context the Medicare system-the taxpayer-financed health insurance system providing subsidised treatments by general practitioners and medical specialists, and free treatments in public hospitals -delivers outcomes that strikingly resemble the problems described above.

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[15] Michael L Marlow and William P Orzechowski, 1997, 'The Separation of Spending from Taxation: Implications for Collective Choices', *Constitutional Political Economy* 8 (2): 151-163, p. 153.
[16] Ibid.
[17] Milton Friedman, 2001, 'How to cure health care', *The Public Interest* 142 (Winter): 3-30, p. 8.
[18] Mark Pennington, 2011, *Robust Political Economy: Classical Liberalism and the Future of Public Policy*, Edward Elgar, Cheltenham, p. 171.
[19] Marlow and Orzechowski, op. cit.

Medicare distorts the market for health care services by driving a wedge between the price that the buyer pays and the return that the seller receives. This creates an excessive level of demand for medical services through a relative price effect, since health care services covered by the Medicare Benefits Schedule are cheaper than would otherwise be the case, and an income effect as the consequently greater disposable incomes of patients' leads to expenditure on additional services.[20]

As part of the Medicare package introduced in 1984, the Hawke government imposed a 'Medicare Levy' initially at a rate of one per cent of taxable personal incomes in an attempt to reduce the extent to which financing and use of health care services would be divorced.

Despite the then Health Minister, Dr Neal Blewett, suggesting that 'Medicare will be substantially self-funding through the 1 per cent levy'[21] the amount of commonwealth (and state) government expenditure on health care has consistently exceeded Levy revenues on an annual basis by a factor of many multiples.

A general assessment of the situation is that 'the effect of the Australian government's universal health plan, Medicare, is to generate more demand for medical services that are valued less than their costs of production. The result is larger government outlays, and so more taxes, and a distorted, wasteful allocation of resources in medical markets.'[22]

The increasing demand for public hospital services under the Medicare system has effectively led to a shifting of fiscal cost burdens from the commonwealth government to the states and territories, which own and manage public hospitals in Australia.In response to this the states have sought to ration hospital outputs by reducing the number of available beds by almost half during the Medicare era-the number of acute public hospital beds per 1,000 population have fallen from 4.8 beds in 1983 to about 2.5 beds today.[23]

Despite record levels of government expenditure the states' bed rationalisation has contributed to a severe degree of dysfunction faced by many public hospitals, such as extensive waiting lists for elective treatments, that compromises an ability to provide quality care in a timely fashion (Box 1).

[20] John Logan, David G Green and Alan Woodfield, 1989, *Healthy Competition*, Centre for Independent Studies, St. Leonards, p. 37-38.
[21] The Hon Dr Neal Blewett, 1983, Proceedings of the House of Representatives, 6 September.
[22] Ibid, p. 40-41.
[23] AIHW, op. cit; Jeremy Sammut, 2009, 'Why Public Hospitals are Overcrowded: Ten Points for Policymakers', Centre for Independent Studies, Policy Monograph No. 99.

Box 1: The adverse effects of public hospital service rationalisation on output provision

The existence of waiting lists for elective surgery and significant delays in emergency department treatments provides *prima facie* evidence of restrictions placed on the provision of outputs within the public hospital system, with direct consequences for achievement of productivity improvements.

According to benchmarking analysis by the Australian Medical Association (AMA), 64 per cent of emergency department patients classified as 'urgent' were seen within the recommended 30 minutes. This is below the 80 per cent target of emergency department presentations seen within clinically recommended triage times as recommended by the Australasian College for Emergency Medicine.

Further outlining the extent of the 'access block' problem caused by bed rationalisation, it is estimated that one in three emergency patients requiring admission in a hospital waits longer than eight hours before being admitted to a bed. There is also anecdotal evidence of ambulances transporting ill patients queuing outside hospitals, or driving from hospital to hospital, in order to find suitable room within hospitals to treat patients.

As for waiting times for elective surgery, 78 per cent of 'Category 2' elective surgery patients were seen within the recommended time of 90 days in 2008-09. This was well short of the target of 95 per cent by 2014 as established by the Council of Australian Governments (COAG).

The median waiting time for all elective surgery undertaken by public hospitals was 34 days in 2007-08. There has been an uninterrupted increase in the length of the median waiting times over the last seven years.

Even so, these waiting periods tend to be understated because of lengthy waiting times between the general practitioner and medical specialist consultations that constitute the 'gateway' for placement on the public hospital elective surgery wait list. As revealed by a 2009 investigation by the Victorian Auditor General, there is also the risk that data could be manipulated by hospitals or government departments to either secure additional funding or to alleviate political sensitivities associated with long patient waiting periods.

These trends are persisting even though additional government funding has been dedicated, including through intergovernmental arrangements, to tackling the symptoms of restrictions on public hospital services. As noted by the latest AMA report card on public hospitals, $150 million in funding by the commonwealth to 'blitz'elective surgery waiting lists 'did not result in significant numbers of additional elective surgery procedures above the numbers that would normally have been expected to be performed.'

Source: Australian Medical Association, 2010, *Public Hospital Report Card 2010*; Jeremy Sammut, 2011, *How! Not How Much: Medicare Spending and Health Resource Allocation in Australia*, Centre for Independent Studies; Victorian Auditor-General, 2009, *Access to Public Hospitals: Measuring Performance*.

What has been less appreciated is that quantity restrictionshave effectively increased the power of providers -public hospital physicians and managers, and state bureaucrats- over consumers - public hospital patients, especially those lacking private health insurance - when it comes to the provision of public hospital services.

This is because public hospital staff and bureaucrats find themselves in a position acting as allocators of scarce resources and, as discussed above, they have achieved this by creating 'an unlimited right of access to a waiting list from which - with a few exceptions - ... [patients]... will not be excluded.'[24]

More generally the risk is that the separation of financing and use of health care services, wherever it may be found, ensures that providers, and their interests, rather than that of consumers become the central focus of the health care system. As discussed by Donald Berwick in a paper published in the *Health Affairs* journal in 2009:

'a profession ... [is] ... a work group that reserves to itself the authority to judge the quality of its own work. ... society cedes this authority to a profession because of three beliefs: (1) altruism - that professionals will work in the best interests of those they serve, rather than their own interests; (2) expertise - that professionals are in command of a special body of technical knowledge not readily accessible to nonprofessionals, and (3) self-regulation - that professionals will police each other.

[This] ... definition of a profession contradicts the usual assumption of consumer-oriented production, in which the consumer, not the producer, has the "authority," exercised by marketplace choices, to judge quality. ... excellence is in the eye of the professional. In the more normal world of products and services, excellence is in the eye of the customer.'[25]

Berwick has described how the provider orientation within health care provision leads to '[p]atients keep having to repeat their name because the system has no memory. We dress them in silly-looking gowns. We give them the food we make instead of the food they want. We don't let them look into their medical record unless they have permission. Health care keeps telling patients the rules instead of asking patients about their individual needs. What is said is, "This is how we do things here," not "How would you like things done?"'[26]

These structural factors have led to a situation in which the processes of engaging with consumers have been found to be lacking within the existing structure of Australian health care.

According to Dr Judy Gregory from the Australian Institute of Health Policy Studies at Monash University, 'consumer engagement in Australian health policy is poorly understood, inconsistently practised, and under theorised.'[27]Similar sentiments were expressed by the Australian Nursing Federation, in a submission to a 2005 House of Representative Standing Committee Inquiry into Health Funding:

'Health consumers lament the lack of clear, informative and useful information available to them about the health system and health services that will assist them to make informed decisions. They have been at the forefront of a push to get better information systems and reporting happening in the health system. It is time

[24] Helen Evans, 2008, 'NHS as State Failure: Lessons from the Reality of Nationalised Healthcare', *Economic Affairs* 28 (4): 5-9, p. 6.
[25] Donald M Berwick, 2009, 'What 'Patient-Centered' Should Mean: Confessions of An Extremist', *Health Affairs* 28 (4): 555-565.
[26] Pauline W Chen, 2009, 'Letting the patient call the shots', The New York Times, 4 June, http://www.nytimes.com/2009/06/04/health/04chen.html.
[27] Judy Gregory, 2008, *Engaging consumers in discussion about Australian health policy: Emerging key themes*, Australian Institute of Health Policy Studies, Monash University.

that they ceased to be treated as mushrooms and high risk litigants and are actively engaged in developing a transparent system providing them with freely given information and more say about the health system they want.'[28]

In some respects the discounting of the needs of consumers within health care services underpinned by government subsidisation has more severe consequences than people not knowing what they pay for and how to navigate a complex health system. Nurse Nola Fraser, the prominent whistleblower on mismanagement in Campbelltown and Camden hospitals in Sydney's south-west once stated that:

'[i]f you are an advocate for the patients, you are seen as rocking the boat rather than doing your job. They make an example of you, and bully and harass you, and before you know it you are forced out of the system.'[29]

The complexity of the system, and the convoluted and obscure ways it is financed, has facilitated the development of a health care sector in which, unlike many other service delivery markets, the interests of consumers are of secondary importance.[30] This compromises the capacity of the sector to more actively search for productivity gains in response to patient needs, with the responsiveness, accuracy, cost and method of service delivery all suffering as a consequence.

The health care sector is rife with bureaucracy, further displacing output in favour of additional inputs and loading health care personnel with unnecessary tasks

Consistent with the significant growth in health expenditure, and in regulations and their complexity, by governments, it would be expected that the numbers of employees working in the public health sector has commensurately increased.However, it is difficult to obtain consistent sources of data to verify the true extent of growth of the aggregate public sector health workforce.

The ABS data series on public sector labour indicates that the number of people working in the 'health and community services' (the latter being later reclassified as 'social assistance') sector rose from 317,500 people in 2000-01 to 413,300 in 2009-10.[31] This represents an increase of almost 96,000 people over the period, or an average of about three per cent each year.

Since the ABS has not reported further data on the number of health and social assistance employees engaged by level of government, additional information has been obtained from commonwealth and state government documents from a variety of sources (including public sector commission and health department annual reports).

Inconsistencies in the availability, and frequent changes to the coverage, of published data diminish the extent to which interjurisdictional comparisons can be made over time.At the commonwealth

[28]Australian Nursing Federation, 2005, Submission to the House of Representative Standing Committee Inquiry into Health Funding, p. 15.
[29] Mike Steketee, 2007, 'Situation is no accident', The Australian, 6 October.
[30] National Health and Hospitals Reform Commission, 2009, *A Healthier Future for All Australians*, Final Report of the Commission, Canberra, p. 51.
[31] Australian Bureau of Statistics (ABS), Employment and Earnings, Public Sector, Australia, cat. no. 6248.0.55.002; ABS, Wage and Salary Earners, Public Sector, Australia, cat. no. 6248.0.55.001.

level the total numbers of staff employed by the Department of Health and Ageing (DoHA) have risen substantially, by 46 per cent to 5,232 people, from 2000-01 to 2009-10.

The increase in DoHA staffing is significant given the lack of responsibility of the commonwealth in delivering health services, and is suggestive of an increase in the commonwealth's policy and administrative influence over the states and the private sector with respect to the organisation, management and provision of health care.

In New South Wales the total numbers of (full-time equivalent) staff employed within the state's public health system has risen from 78,265 to 95,895, representing an increase in staffing numbers of about 23 per cent from 2000-01 to 2009-10. In Queensland the increase has been somewhat higher, as FTE staff numbers in health rose from 41,356 to 64,158 over the same period.

This data, as fragmented as it may be, implies that there has been a significant increase in health labourers employed by governments across Australia. It is possible to supplement this with additional information on employment within various components of the health care sector.

The Australian Institute of Health and Welfare (AIHW) presents information on public hospital staffing on an annual basis (Table 5). From 1996-97 to 2009-10 the total full-time equivalent number of people employed within public hospitals grew from about 174,700 people to 251,400, representing an average annual increase in employment by 2.8 per cent each year.

Table 5: Full time equivalent staff employed in public acute and psychiatric hospitals

	1996-97	**2004-05**	**2009-10**
Salaried medical officers, nurses and other personal care staff	96,989	115,386	144,514
Diagnostic and allied health professionals	22,360	30,502	35,456
Administrative and clerical staff	24,418	32,895	38,158
Domestic and other staff	30,927	31,769	31,269
Total	174,695	211,645	251,416

Source: Australian Institute of Health and Welfare, various years,*Australian Hospital Statistics*.

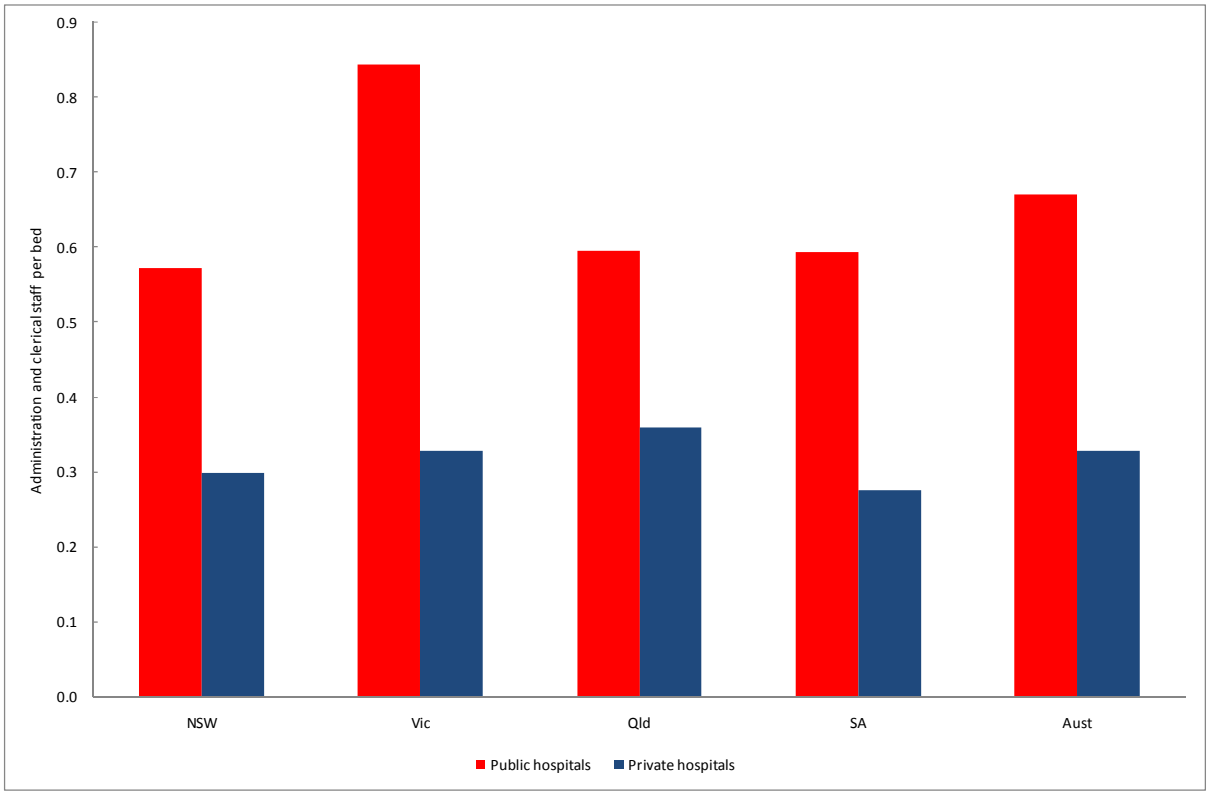
There is some statistical and other information to suggest that funding has been increasingly directed away from the provision of frontline services within the Australian public health system.

Based on the information presented in Table 5, the numbers of public hospital administrative and clerical staff as a share of total staff has increased from 14 per cent in 1996-97 to 15.2 per cent in 2009-10.

If the share of administrative and clerical staff within Australian public hospitals were returned to an average of 14 per cent then 2,960 positions could have been freed up last financial year to provide additional acute and psychiatric care services to Australians requiring care.

The latest available data also suggests that, generally speaking, public hospitals employed twice as many administrative and clerical staff than did private hospitals in 2009-10 (Figure 4).

Figure 4: Administrative labour intensity of public and private hospitals, 2009-10



Includes acute care and psychiatric hospitals. Data for administrative and clerical staff not separately identified for Western Australia, Tasmania, ACT and NT.

Source: Australian Bureau of Statistics, Private Hospitals, Australia, 2009-10, cat. no. 4390.0; Australian Institute of Health and Welfare, 2011, Australian Hospital Statistics 2009-10, Health Services Series No. 40.

Anecdotal evidence tendered by health policy experts also indicate that a large share of the available funding pool was consumed by the health care bureaucracy at the expense of frontline service provision.

Former head of the NSW and Victorian Departments of Premier and Cabinet, Ken Baxter, estimated that between 20 and 50 per cent of states' public health system staff were primarily occupied in administrative and similar roles. In the case of New South Wales there were more clerks than nurses employed.[32]

In the case of Queensland, information on health district staffing provided by Queensland Health shows an increase in the proportion of managerial and clerical personnel in that state during the

[32] Siobhain Ryan, 2008, ''More clerks than nurses': ex-chief', The Australian, 19 March.

previous decade.[33] Analysis by the AMA Queensland revealed in 2008-09 there were 13,645 managerial and clerical staff in the state's Department of Health but only 6,715 doctors.[34]

These findings were shared by the former head of the Bundaberg Hospital Commission of Inquiry, Anthony Morris QC, who stated in 2005 that 'only 20% of the Department's employees (totalling some 64,000) are doctors or nurses; for every clinician who actually deals with patients, there are four other employees who have to justify their existence within Queensland Health.'[35]

The detrimental effect of bureaucratisation upon the otherwise ceaseless search for productivity improvements within the health sector is aggravated by what is known as the 'Gammon effect.'

In the late 1970s Dr Max Gammon authored a study in the British National Health Service, in which he explicated a 'bureaucratic displacement proposition'that suggests that productive tasks are increasingly crowded out by unproductive tasks as the administrative apparatus of health care expands.[36]

Consistent with the Gammon proposition, the psychiatrist and former representative for junior doctors within the AMA, Tanveer Ahmed, wrote in 2009 that:

'[i]ncreasing centralisation of medical decision-making is another hazard of a monopolistic system, with its consequent reduction of the role of doctors to clerks executing commands. While the government, as the sole supplier of health care within public hospitals, has the right to demand value for money, I often see my superiors spending their precious time in combat with committees instead of applying their clinical skills.

Furthermore, treating doctors, in effect, as clerks after they have undergone many years of arduous training destroys their morale.'[37]

Similar trends within the NSW public hospitals environment had also been chronicled by Wolfgang Kasper:

'The social mechanisms behind Gammon's Law have been the major reason for the explosive growth of hospital costs in Australia. We have witnessed an enormous increase in the number of highly paid officials who pretend to manage and plan hospitals. The administration offers sinecures for well-connected and unionised health professionals, who typically prefer the administrative desk or the staff seminar to hard work in the ward. Attending staff meetings and seminars, going on business trips, writing vacuous survey reports, whether useful or not, and working on computer screens have become more desirable than doing night duty with patients, looking after frail old patients and sick children, making beds, and taking responsibility for the right dosage of medication.

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[33] Julie Novak, 2009, *A growing risk: The impacts and consequences of rising state government employment*, Institute of Public Affairs, Occasional Paper, October.

[34] Australian Medical Association (AMA) Queensland, 'AMA Queensland launches war on waste', http://www.amaq.com.au/index.php?action=view&view=62894&pid=1446.

[35] Cited in Novak, op. cit, p. 17.

[36] Milton Friedman and Rose Friedman, 1980, *Free to Choose: A Personal Statement*, Harcourt Brace Jovanovich, New York; Australian Doctors Fund, '"Gammon's Law of Bureaucratic Displacement" A note from Dr Max Gammon with some quotes from Milton Friedman', http://www.adf.com.au/archive.php?doc_id=113.

[37] Tanveer Ahmed, 2009, 'Unshackle our Leninist hospitals', The Australian, 18 February.

The cost of a proliferating bureaucracy does not stop there: administrators keep inventing paperwork that occupies more and more of the time of the frontline doctors and nurses and displaces productive activity.'[38]

The manifestation of a 'provider-first' mentality crowding out productive, if not life-saving, activities have been all too frequently documented in official inquiries into the performance of aspects of the Australian health system in recent years.

For instance, the 2008 Garling Report into NSW public hospital acute care painted a picture of bureaucratised public hospital systems that are insufficiently flexible to meet the service demands of the population, thus hampering the productivity potential of state public hospitals to the detriment of the consuming public.Similar sentiments were expressed in the 2005 Forster Report into Queensland's health systems.

As will be discussed below, numerous stakeholders have also pointed to the effect of onerous government regulatory conditions hampering the responsiveness of non-public providers of health care to changing market conditions.

The employment of administrative staff at a sufficient minimum level is important to maintain effective systems of service delivery. However the functional value of these bureaucrats within the health care sector greatly diminishes in its value when their growth and activities complicate, delay or undermine the pursuit of the fundamental objective - i.e., the provision of efficient health care services - which translate intothe foregone allocation of resources more efficiently deployed in services provision.

The private health care sector is overregulated, impeding the pursuit of productivity gains by suppliers

Numerous private sector organisations are actively involved in the provision of health care services to Australians on a daily basis, and play an important role in reducing the total exposure of the taxpayer to growth in health care costs.

It is estimated that private sector health providers, including private acute and psychiatric hospitals, general practitioners, medical specialists and allied health care providers, generated about $52 billion in income in 2009-10. These providers also contribute to the employment of thousands of staff directly or indirectly involved in the provision of medical treatments and care.[39]

In addition, Australia has a significant pharmaceutical industry with a turnover of some $17 billion and which employs 34,000 people either directly in manufacturing or indirectly. The domestic pharmaceutical industry comprises a complex chain of biomedical research, biotechnology firms,

[38] Wolfgang Kasper, 2010, 'Radical Surgery: The Only Cure for Public Hospitals', in Jeremy Sammut, ed., *No Quick Fix: Three Essays on the Future of the Australian Health System*, Centre for Independent Studies, St. Leonards.

[39] ABS, Health Care Services, Australia, 2009-10, cat.no. 8570.0; ABS, Private Hospitals, Australia, 2009-10, cat. no. 4390.0.

originator and generic medicines companies and service related segments including wholesaling, distribution and retail.[40]

The capacity of these entities to competitively strive to provide the best available care methodologies at least cost to the patient is circumvented to some degree by the existence of a pervasive array of regulations covering almost every aspect of health care and provider operations, from safety and quality standards for providers to the maintenance of financial prudence by health insurers.

A proxy indicator that is commonly used to quantify the level of regulation burden is the number of pages of current primary legislation imposed by each relevant jurisdiction. Based on information derived from commonwealth, state and territory legislation websites, it is estimated that the health care sector is subject to over 300 Acts which in turn contain over 22,600 pages of requirements (Table 6).

Table 6: Number of Acts and pages administered by Australian Health Ministers

	C'wealth	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Acts	59	37	27	36	41	30	32	23	20	305
Pages	5,025	1,623	3,732	5,023	2,735	1,023	1,310	1,552	630	22,653
Pages per Act	85	44	138	140	67	34	41	67	32	74

Source: Julie Novak, Chris Berg and Tim Wilson, 2010, *The Impact and Cost of Health Sector Regulation*, Australian Centre for Health Research, p. 65.

While governments publicly maintain that the motivation for the imposition of health care regulation is to ensure the provision of safe, affordable services to the general public, the underpinning reason for the imposition of often detailed rules and commands upon private sector health care providers is grounded upon a belief that an unregulated health care system is inherently incapable of meeting the service delivery expectations of the public without at least some form of governmental involvement.

As noted by Productivity Commission head Gary Banks, the imposition of regulations rarely translates into intended outcomes as a consequence of the following problems:

- Problems with the regulations themselves, including unclear or questionable objectives, overly complex or excessively prescriptive requirements, redundant regulation and 'regulatory creep'
- Poor enforcement and administration, including excessive reporting requirements, overzealous regulation, regulatory bias or capture and inexperience or lack of expertise of regulators
- Unnecessary duplication and inconsistency, including duplicated requirements across regulators, regulatory inconsistencies within or across jurisdictions and variations in regulatory definitions and reporting requirements.[41]

[40] Julie Novak, Chris Berg and Tim Wilson, 2010, *The Impact and Cost of Health Sector Regulation*, Australian Centre for Health Research, p. 30.

[41] Regulation Task Force, 2006, *Rethinking Regulation: Report of the Taskforce on Reducing Regulatory Burdens on Business*, Report to the Prime Minister and the Treasurer, Canberra, p. iii.

Further, governments are prone to additional invoke regulation because they have become increasingly risk adverse -and, in the health sector, risk can often mean death. As a consequence the health system is characterised by a regulatory environment in which government efforts to eliminate risk have grown completely out of proportion to the potential damage a less-regulated environment could cause.[42]

A range of financial and economic costs are imposed upon health sector businesses resulting from the increase in, often prescriptive, regulation.

General practitioners (GPs) have reported that regulation and red tape undermine their productivity by raising costs associated with filling paperwork.Excessively complicated regulations such as the Medicare Benefits Schedule (MBS) consume the productive time of GPs.

The MBS outlines the payment arrangements for Medicare benefits within the health system, and GPs are expected to familiarise themselves with this document on a regular basis.The MBS is 862 pages long, contains over 4,400 different items and fees and is updated several times each year. Indeed, 'the MBS is now so unwieldy that the Department of Health and Ageing has ceased producing a hard copy.'[43]

New items added onto the MBS come with detailed restrictions, including limitations on how often those services may be provided to patients, and how those services are to be delivered. It has been argued that these requirements are often 'unnecessarily prescriptive' and 'disturb existing systems and processes that operate effectively.'[44] Consequently, it is of little surprise that general practitioners have called for the MBS 'to be simplified and updated to reflect modern medical practice.'[45]

Other areas of paperwork regulatory compliance burden cited by GPs as significant problems include their role in administering Centrelink and Department of Veterans' Affairs programs, requirements under the Practice Incentive Program, workforce programs and subsidised taxi services arranged for patients.[46]

The frustration of GPs with the scale of an ever-increasing regulatory workload is illustrated in the following passage written by the Vice-President of AMA Victoria:

''Just one small form,' we are told. 'It won't take up much time,' we are told. Well, there is a final straw. When dozens of agencies are all adding to the regulation, the red tape, the bureaucracy, the load on GPs becomes too much.

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[42] Chris Berg, 2008, *The Growth of Australia's Regulatory State: Ideology, Accountability and the Mega-Regulators*, Institute of Public Affairs, Melbourne.
[43] Novak, Berg and Wilson, op. cit, p. 24.
[44] Rosanna Capolingua, 2009, Submission to Productivity Commission Annual Review of Regulatory Burdens on Business - Social and Economic Infrastructure Services, Australian Medical Association, p. 2-3.
[45] AMA, 2010, op. cit.
[46] Dr Andrew Pesce, 2010, 'GP red tape blues', Australian Medicine, July, p. 3.

I get seriously annoyed by official forms which are poorly constructed. Two examples that come immediately to mind are the Department of Human Services' housing relocation form on medical grounds, and the Victorian Taxi Directorate's application form for a taxi subsidy card. The latter is a beauty - two forms totalling 25 pages.

I love that I have to explain my diagnoses and treatment plan to the Victorian Taxi Directorate. I'm sure that fine organisation has dozens of medical advisers working through the forms from GPs and second-guessing our diagnoses. Or perhaps the onerous administrative burden for GPs and patients is just a form of rationing, designed to deny benefits to those who need them?

There are Centrelink forms - just hope you are using the latest version. New onerous death certificate forms - cleverly designed in a trifold paper that is impossible to fax. The Royal District Nursing Service and aged care facilities won't accept a medication chart printed using our practice software. It goes on and on.'[47]

According to the AMA '[s]ome estimates indicate that family doctors must spend up to nine hours a week complying with red tape obligations. For every hour that a family doctor is tied up doing Government paperwork, about four patients cannot get to see that doctor.'[48]

The Productivity Commission estimated that about five per cent of general practitioner income is absorbed by these costs: 'under the Commission's base case, in 2001-02 the estimated incremental administrative and compliance costs resulting from Commonwealth policies and programs amounted to about $228 million (about 5 per cent of GPs' estimated total income from public and private sources). This is equivalent to about $13,100 per GP per year (for GPs who work at least one day per week).'[49]

With the average GP business earning $519,400 per year as of June 2010, the cost of administrative and regulatory compliance could now well exceed $25,970 per GP per year.

Despite their significant contribution to health outcomes, pharmaceuticals are heavily regulated, from their point of innovation to point of sale, in ways that induce significant delay costs. While there are numerous regulations affecting the industry, the principal regulations that affect pharmaceutical production, distribution and retail include the processes of securing:

- clinical trial data required throughout any medicines innovation process to ensure marketing approval
- marketing approval by the federal Therapeutic Goods Administration (TGA), who assess safety and efficacy for any pharmaceutical to be listed on the Australian Register of Therapeutic Goods (ARTG) as a requirement for sale in Australia
- licenses to manufacture pharmaceuticals in a TGA approved manufacturing facility
- listing on the commonwealth government's Pharmaceutical Benefits Scheme (PBS) that subsidises specific medicines, with the effect of ultimately deciding which medicines are likely to be prescribed by Australian doctors.[50]

[47]Dr Harry Hemley, 2009, 'A call to arms against war on red tape', Medical Observer, 13 March.
[48] AMA, 2010, 'Medicare needs 'real action' to 'move forward' to better serve patient needs', Media release, 19 July.
[49]Productivity Commission, 2003, *General Practice Administrative and Compliance Costs*, Research Report, Canberra, p. xvi.
[50]Novak, Berg and Wilson, op. cit, p. 31-32.

It has been estimated that the industry faces annual costs of at least $89 million to receive regulatory approval for sale of pharmaceuticals via ARTG listing, with a portion of the cost generated because of the need to seek regulatory approval already commenced or resolved overseas.[51]

The other cost of listing on the ARTG is the cost incurred by companies from time and sales lost while applications are assessed. These costs are also borne by patients who may require medical support. Table 7 outlines the maximum allowable timelines for assessment of category 1 and 2 applications, and mean evaluation times taken by the TGA.

Table 7: Timelines for consideration and approval of applications

Activity	**Timeframe (working days)**	
	Category 1	**Category 2**
Advice to proceed or reject application	40	20
Evaluation of application	225a	175a
Mean evaluation		
New chemical entities	150	
New generic	100	
New indications	160	
Product information changes	90	
Additional trade names	45	
Other category 1 applications	130	

Maximum allowable timeframe for consideration.

Source: Department of Health and Ageing, 'Australian regulatory guidelines for prescription medicines', http://www.tga.gov.au/pmeds/argpm.pdf (accessed 2 December 2009).

The TGA does occasionally exceed the maximum allowable period for assessment, but in these situations the cost to the sponsor is partially offset through a reduction of application fees by 25 per cent.

Government regulations and associated guidelines require private hospitals to construct and maintain specialised, and often high-cost, facilities.

General state government hospital legislation, and accompanying regulations, proscribes a range of standards concerning the quality of physical capital and facilities to be provided. Some of these standards tend to be highly prescriptive (Box 2), which may increase the cost of capital expenditure than would otherwise be the case. Local government planning regulations, and regulatory attitudes to development, can also have implications for capital investment costs within the private health care sector.

[51] Ibid, p. 36.

Box 2: Case study -South Australian private hospital facility standards

The South Australian *Health Care Regulations 2008* outlines the following and other standards of construction:

- Access: all corridors for bed, trolley or barouche traffic must have at least 1,800mm in width clear of handrails and other permanent intrusions; doorways to water closets, bathrooms and shower cubicles intended for access of wheelchairs must have a clear opening of at least 900mm, and if corridors are 1,800mm in width the doorway opening to wards must be at least 1,200mm in width.
- Room sizes: every room to be occupied by one patient must have a floor area of at least 9.3 square metres; every room with more than one patient must have at least 8.4 square metres of floor space for each patient, or at least 7.5 square metres for children aged up to 14 years or 3.9 square metres for each child in a cot.
- Ablution facilities: on each floor a hospital must have a bathroom, containing an island or peninsula plunge bath, with minimum floor dimensions of 3,000mm x 2,400mm or, in the case of a bathroom with a pedestal pan and hand basin, 3,000mm x 3,000mm.
- Maternity facilities: a private maternity hospital must have delivery room with minimum floor dimensions of 4,800mm x 3,900 mm and a minimum ceiling height of 2,70mm, and must be designed so that no person can enter the room from any other part of the hospital except through one door or point of entrance.
- Surgical facilities: a private surgical hospital must have an operating room with minimum floor dimensions of 6,000mm x 5,400mm and a minimum ceiling height of 2,700mm, both soiled and clean utility rooms, and separate change room facilities for staff.

Source: South Australian government legislation website.

Finally it is possible that the growth of prescriptive health regulations can have adverse effects for the realisation of dynamic competition and innovation within the system.

Under the *Private Health Insurance Act 2007* the commonwealth Minister for Health and Ageing has the power to approve applications for changes in private health insurance premiums. The Minister is obliged to approve all premium increases, unless it is deemed contrary to an (undefined) 'public interest' criterion. If the Minister does not allow an increase the reasons for this have to be publicly disclosed.

An application by a health fund to change its premium must be lodged at least sixty days prior to the proposed change taking effect. The Private Health Insurance Administration Council (PHIAC) provides the Minister with advice on prospective premium rises.[52]

According to the AHIA, the application process is 'arduous, labour intensive and has no certainty for individual funds in forecasting future premium income.'[53] A 2008 study by Carrington, Coelli and Rao suggests that insurers must submit detailed financial information and cost/benefit projections, all certified by an accredited actuary, to justify any premium increases sought.[54]

[52]Amanda Biggs, 'Private health insurance premium increases – an overview', Department of the Parliamentary Library Background Note, http://www.aph.gov.au/Library/pubs/BN/sp/HealthInsurancePremiums.htm.
[53]Australian Health Insurance Association (AHIA), 2005, Submission to Regulation Taskforce, November.
[54]Roger Carrington, Tim Coelli and D. S. Prasada Rao, 2008, 'Regulation of Private Health Insurance Premiums: Can Performance Assessment Play a Greater Role?',University of QueenslandSchool of Economics Centre for Efficiency and Productivity Analysis, Working Paper 04/2008.

Similarly, the Institute of Actuaries of Australia stated that 'registered insurers will need to clearly identify their case in applying … for a premium increase. This is a significant area of sovereign risk for health insurers.'[55]

A number of issues impinging on the overall burden of premium approval regulation include:

- the length of the process required to prepare an application and achieve the rate increase
- uncertainty about the rate application approval until the last moment
- the risk that rejection of a rate application will have an adverse impact on the prudential circumstances of a fund
- no advance knowledge of the date of approval which affects the production and distribution of brochures, publications and letters
- duplication of material and potential waste of resources resulting from this lack of certainty.[56]

Consultations with industry suggests that elements of the regulatory process are inherently flawed, creating unreasonably excessive burdens upon industry. Other concerns have been raised about the impact of the existing premium regulation on price competition and insurers' financial viability. The regulation effectively weakens incentives for insurers to minimise their costs, undertake efficient investments or act in an innovative or competitive manner.[57]

According to the Industry Commission, price regulations also 'act as a deterrent to entry by new players used to operating in a market in which they don't have to seek government approval for the prices of their services. In this sense, price controls may deter those market oriented firms most likely to introduce innovative products and to be active in pushing for cost minimisation – thus keeping average premium higher than necessary.'[58]

Winding back price regulation of private health insurance would give funds a greater incentive than at present to compete between each other, improving the efficiency of insurers and moving the market closer to optimal premium levels for the betterment of insured customers.

By complicating the delivery of health care services through the imposition of excessive regulation, and the financial and economic burdens associated with it, governments at all levels are undermining the ability of the private sector to deliver their health care services more productively. Excessive regulation does this by consuming time, increasing costs, reducing quality and stifling choice and competition.

The misplacedbelief that health care is'special,' and thus exemptsit from economic conditions and circumstances, diverts attention away from potential productivity gains

[55]Gayle Ginnane, 2007, 'The new private health insurance environment', Presentation to the Institute of Actuaries of Australia.
[56]AHIA, op cit.
[57]Access Economics, 2005, *Regulation of Private Health Insurance Pricing*, Report for Challenger Financial Services Group.
[58]Industry Commission, 1997, *Private Health Insurance*, Inquiry Report No. 57, AGPS, Canberra, p. 327.

As indicated above, Australians expect a great deal from their health care system and they spend a lot to receive it. Total expenditure on health was equivalent to nine per cent of GDP in 2008-09, with expectations that commonwealth expenditure alone will increase to between twelve and 15 per cent of GDP over the next thirty years.

To some extent the widespread prediction of an unabated relative increase in financial resources allocated to health care accords with issues recently expressed by Nobel Prize winning economist Robert Fogel:

'Why is it that although the average age of onset of disabilities has been delayed by ten years, and that these disabilities have become milder than they used to be, the share of GDP spent on health is rising? ... The main factor is that the long-term income elasticity of the demand for healthcare is 1.6 - for every 1 percent increase in a family's income, the family wants to increase its expenditures on healthcare by 1.6 percent. This is not a new trend.'[59]

While Fogel argues (albeit within the context of the debate over US health care) that there is no need to suppress the demand for health care in circumstances where care is required, such a message is not inconsistent with the central issue canvassed in this paper that productivity performance concerns within the health care sector be addressed as a matter of priority.

Perhaps the greatest impediment to the realisation of additional productivity gains is the deeply ingrained perception within the health community and the public policy culture that health care is not, or is far less, amenable to market forces that health consumers are accustomed to in almost every other aspect of their lives.

It follows from this proposition that reforms to ensure that health care participants are conditioned in their conduct more by the inherent logic of markets, rather than government fiat, will deliver adverse care consequences let alone not bring about the productivity enhancements initially hoped for.

However, to appreciate that productivity improvements are feasible within the health care system requires a prior acknowledgement that health care is like any other market or, more appropriately, is just as unique as every other market in existence.

In 1989 economist Michael James stated that 'health care, like any other commodity, can be produced efficiently and equitably only when producers are subjected to competitive pressures and consumers can work out their preferences in light of fully costed alternatives. This isn't to say that health care is no more important than any other good or service; the point rather is that it's too important to be subjected to the inefficiencies and distortions that typically flow from government's attempts to supply goods that the market is better equipped to handle.'[60]

Meanwhile, a former Secretary of the Victorian Department of Health and Community Services explained that:

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[59] Robert Fogel, 2009, 'Forecasting the Cost of U.S. Healthcare', The American, 3 September.
[60] John Logan, David G Green and Alan Woodfield, op. cit, p. ix-x.

'[h]ealth-care markets are imperfect, but what market is not? Health care contributes to long and healthy lives. So too does proper food, clothing, and exercise, which are usually treated as personal consumption choices. So why pretend that in health care there is always a life at stake and invoke the full regulatory, organisational and financial might of the state as, at present, we do?'[61]

The former president of the Australian National Competition Council, Graeme Samuel, similarly stated in 2000 that:

'it must be recognised that health care is an industry and that the benefits that competition is generally expected to bring - those of encouraging efficiency, reducing prices, responding to consumer demands and favouring innovation - are crucial here as elsewhere.

Resources spent on health care are necessarily diverted from other uses - uses that are similarly vital to achieving the basic responsibilities of government, such as education, infrastructure development or housing. Therefore, technical or allocative inefficiency in the provision of health services mean either a reduction in the quantity of services that can be provided for a given cost, or a reduction in the funds available to provide other public services. By contrast, the "efficiency dividend" from introducing competition increases the quantity of services able to be provided, whether within the healthcare area or in terms of freeing funds for other uses.'[62]

In 2009 the British writer and retired prison doctor Anthony Daniels, under the pseudonym 'Theodore Dalrymple,' wrote that:

'[p]eople sometimes argue in favor of a universal human right to health care by saying that health care is different from all other human goods or products. It is supposedly an important precondition of life itself. This is wrong. There are several other, much more important preconditions of human existence, such as food, shelter and clothing.'[63]

Even with in an policy environment typified by government subsidisation and regulation that stultifies the free operation of markets in health care, providers who operate on basis of profit-and-loss or are obliged to compete against other entities for custom do demonstrate generally superior performance than those who do not observe or adhere to such practices.

The data regarding the performance of private versus public hospitals shown above reveals that the Australian private hospital sector - which operates either on a for-profit or not-for-profit basis - delivers higher levels of relative productivity.

More generally from an outcomes perspective, as the Productivity Commission highlighted in a recent major study on the relative performance of Australian hospitals, private hospitals deliver

[61] John Paterson, 1995, 'Health and Welfare: The Third Last Frontier of Microeconomic Reform', *Agenda* 2 (1): 35-47.

[62] Graeme Samuel, 2000, 'Introducing competition in the public delivery of health care services', Presentation to the World Bank, Washington DC.

[63] Theodore Dalrymple, 2009, 'Is There a 'Right' to Health Care', The Wall Street Journal, 28 July.

more effective care than do their public sector peers,[64] while other studies show relatively lower rates of birth complications in private hospitals.[65]

Australian health care operators will also need to actively seek internal productivity gains into the future, in light of the emergent globalisation of medical services:

'[i]ncreasingly, waiting for doctors has become the prevailing form of rationing in the West: mild in the US, moderate in Australia and severe in Canada and the UK. This, in turn, has created millions of frustrated customers who have begun to look elsewhere. The Internet and cheap airfares have greatly increased consumers' opportunities and choices by creating new consumer-driven markets. Cosmetic surgery, retail walk-in clinics, boutique medicine, Internet pharmacies and international medical tourism are only some examples. These areas, where the states and other third-party agencies are absent, are bristling with innovation and entrepreneurship.'[66]

For many who accept, as a matter of principle, that markets can at least play a contributory role within a system that provides for the health care of patients, there often remains a certain sense of fatalism that, regardless of the conduct of health care sector participants or the direction of policy, productivity in health care will remain endemically low.

In the 1960s, economists William Baumol and William Bowen explained that many services are afflicted by secular cost increases, compared with other sectors, because of the difficulties in increasing the productivity of labour in health activities that require the 'human touch' of frequent physical contact between service provider and customer.[67]

The Baumol 'cost disease'effect suggests it is as difficult to ask physicians and medical staff to more efficiently performtreatment and provide after-treatment care, a view often expressed by those working in the health care sector:

'[r]educing room turnover would help lead to increased revenue, but here, the definition of productivity is different for nurses and doctors. ... For the nurse, there is a significant amount of preparation time needed in relation to a patient, from cleaning a room to discharging after a procedure. For the doctor, patient work is complete when that patient has left the doctor's care. "To a doctor that might be 45 minutes" before the nurse is ready to bring in the next patient, and that's downtime that could be used elsewhere ...'[68]

However, such views on the capacity of the health care sector to achieve productivity gains have not gone unchallenged. In an analysis of costs in US teaching hospitals Cutler and others concluded that health care price indices can overstate true medical care inflation, implying that the driver of

[64]Productivity Commission, 2009, *Public and Private Hospitals*, Research Report, Canberra.
[65]Lex Hall, 2009, 'Baby toll lower in private hospitals', The Australian, 16 February.
[66] Fred Hansen, 2008, 'A revolution in healthcare: Medicine meets the marketplace', *IPA Review* 59 (4): 43-45, p. 43.
[67] William J Baumol and William G Bowen, 1966, *Performing arts: The economic dilemma*, Twentieth Century Fund, New York; William J Baumol, 1993, 'Health Care, Education and the Cost Disease: A Looming Crisis for Public Choice', *Public Choice* 77 (1): 17-28.
[68] Shawn Rhea and Jean DerGurahian, 2009, 'Eye of the beholder', *Modern Healthcare* 39 (17): 6-7, 16.

expenditure growth in the health system is increasing quantities and not prices.[69] Others have suggested that when long term care commitments are excluded there is insufficient evidence for the Baumol effect.[70]

Tim Worstall argues that the Baumol effect does not invalidate the desirability of utilising additional labour-saving technologies in health: '[t]echnology reduces the costs of providing services by reducing the amount of labor that must go into that provision, a welcome change at a time of rising labor costs.'[71]

A belated recognition by health care providers and policymakers alike that economic forces already do, and can, exert powerful effects upon the performance of the sector will provide a strong platform for raising awareness and acceptance of the reforms that must be instituted to sustainably improve the productivity performance of Australian health.

Principles for enhanced productivity in the Australian health care sector

A key to unlocking productivity gains is to promote competition within health care

The central thesis of this paper is that the Australian health care sector has the capacity to generate additional productivity gains than those already observed. In order to achieve this it will be necessary for health care sector operators to increase their levels of service provision whilst also reducing resource utilisation and factor intensity, given existing technologies, especially those operators who wastefully tie up resources in low-productivity activities.

There are a number of ways in which productivity can be enhanced over time, such as the introduction of new technologies and innovative practices. Less commonly received, as a means to achieve productivity improvements in the specific context of health care, are reforms to improve the degree of competition within the sector itself.

Generally speaking, competition provides a powerful incentive to individual providers to improve productivity performance that captures market share or ensures survival as a viable concern.

It provides incentives to embrace economic change to gain product or price advantage over competitors, and places pressure on operators to rationalise, retire less productive operations and to modernise. Finally, competition spurs incentives to create new markets that in deliver gains from specialisation, economies of scale or the diffusion of risks.[72]

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[69] D M Cutler, M McClellan, J P Newhouse and D Remler, 1998, 'Are medical prices declining? Evidence from heart attack treatments', Quarterly Journal of Economics 53 (4): 991-1024.

[70] Carsten Colombier, 2010, 'Drivers of Health Care Expenditure: Does Baumol's Cost Disease Loom Large?',https://editorialexpress.com/cgi-bin/conference/download.cgi?db_name=IIPF66&paper_id=382.

[71] Tim Worstall, 2009, 'Baumol's Solution to the Baumol Effect', The American, 10 September.

[72] Productivity Commission, 1999, *Microeconomic Reform and Australian Productivity: Exploring the Links*, Research Paper, AusInfo, Canberra, p. 157.

As noted above the beneficial aspects of competition can be felt in health care services as much as any other sector of the economy. If it remains accepted that the Baumol effect is highly prevalent within the health care sector, 'it is surely wrong that we rely on a system of healthcare funding and provision that eradicates the forces of competition which can deliver technological innovation and productivity improvements at the quickest possible rate.'[73]

Even in the most socialised of health care systems around the world, such as Canada and the United Kingdom, the instigation of policy reforms conducive to promoting competition have delivered significant productivity improvements with consequent benefits accrued by patients (Box 3).

[73] Sam Collins, 2011, 'Healthcare - Trimming the Fat or Fit for the Future?', in Philip Booth, ed., *Sharper Axes, Lower Taxes: Big Steps to a Smaller State*, Institute of Economic Affairs, London, p. 91.

Box 3: Improving productivity and care - Health care reforms in other countries

A number of countries with relatively greater degrees of state involvement have undertaken (often piecemeal) reforms to improve the productivity of health care services.

The effect of the national *Canada Health Act* in outlawingthe direct purchase of health services in that country is being eroded, in part, through the emergence of private clinics and hospitals (including the Cambie Surgery Center in Vancouver, British Columbia). The impetus to develop viable alternatives to socialised medicine in Canada received a significant boost in 2005, when the Supreme Court of Canada found that Quebec's ban on private health insurance violated the Quebec Charter of Human Rights and Freedoms.

It has been estimated that private clinics are opening up in Canada at a rate of one each week, with the prospect that, from a health system perspective, supply side competition from these alternative providers can contribute to the provision of additional outputs at lower costs.

This appears to be confirmed, for example, by a 2008 study which found that private MRI clinics were providing services with lower waiting lists compared to their public sector peers.

These developments have spurred public health providers into action, with the Quebec Premier Jean Charest allowing hospitals to subcontract hip, knee and cataract surgery to private clinics while a health region in Saskatchewan outsourced CT scans to cut waiting lists.

In the United Kingdom, the former Blair government established a policy in 2006 mandating that all patients be offered the choice of five (and by 2008, any) hospital in the National Health Service (NHS) for their treatment. Prices could also be charged, albeit within the confines of government guidelines, to promote competition between hospitals.

An assessment of the reforms showed that hospitals where patients had more choice not only provided higher clinical quality, but patients stayed in hospital for shorter periods compared with hospitals in less competitive regions. The competitive hospitals achieved these outcomes without increasing total operating costs.

The rationale for these and other health reform initiatives in other countries has been explained in the following terms: '[i]n other fields, competition among service providers has been shown to be the best way - indeed, perhaps the only way - to drive improvements in productivity. Thus, the introduction of competition in health care delivery is not an end in itself. It is the means of encouraging improvements in productivity that will lead to a much more efficient and cost-effective delivery system' (Kirby and Keon 2004: 3).

It follows that the principles underpinning these reforms can be usefully applied in the Australian context to achieve the objective of enhancing patient care through productivity improvements.

Source: Eduard Bercovici and Chaim M Bell, 2008, 'How Busy are Private MRI Centres in Canada?', *Healthcare Policy* 4 (2): 59-68; Michael J L Kirby and Wilbert Keon, 2004, 'Why Competition Is Essential in the Delivery of Publicly Funded Health Care Services', Policy Matters 5 (8): 3-31; Clifford Krauss, 2006, 'As Canada's Slow-Motion Public Health System Falters, Private Medical Care Is Surging', The New York Times, 26 February; Brendon Nafzinger, 2011, 'CT outsourcing stirs debate in Canada', DotMed News, 17 January; Carol Propper, 2010, 'Healthcare competition saves lives', Bristol University, *Research in Public Policy* (Winter): 19-20.

In the sections that follow a number of interrelated key principles will be highlighted to guide health policy reform in the direction of enhancing productivity, through the encouragement of competitive dynamics between and amongst the array of private and public health care providers in Australia.

Principle #1 Promote productivity by enhancing demand-side competition

An important way to promote productivity in any market is to ensure that providers of goods and services become more responsive to the needs of their customers, who invariably seek quality outputs to fulfil their needs at reasonable prices.

In order to placate these consumer demands, especially in the context of actual or potential rivalrous provision of outputs, providers must ensure that their input cost structures are efficient and that their services provide effective treatment and care outcomes.

Given the problems of excessive demands for scarce health services within the Australian context, including as a result of the disconnection between financing and usage of a range of health outputs that encourages rent extraction by providers, it is not surprising that significant attention has been directed toward potential reforms to ensure that all health care operators, especially those within the public sector, are more attuned to the true demands of patients.

Writing for the Australian Centre for Health Research health academic Just Stoelwinder proposed a model, based on health care financing reforms in the Netherlands, which would promote consumer choice and ensure more sustainable funding for the health system, as a whole, by providing stronger linkages between public and private finances. The model is composed of the following elements:

- current government sourced funds would be pooled to fund a 'basic Medicare insurance' (called 'Medicare Choice') covering current Medicare entitlements. Private premium contributions (with an income-related rebate) could be added over time to fund growth
- health insurance funds would compete for all residents with a regulated range of 'basic Medicare insurance' products, and could add additional private hospital and supplementary insurance and benefits
- the risk equalisation arrangement could be operated by the Private Health Insurance Administration Council, as it does now for private health insurance, and consumer information by the Private Health Insurance Ombudsman
- health insurance funds would purchase services from public and private providers, according to the insurance product purchased.[74]

Henry Ergas has outlined a model that would transform Medicare into a risk-adjusted voucher funding scheme for health services. The governmentally provided Medicare insurance scheme would remain as a default, with health insurers able to compete for those individuals who opt out of the default arrangements to instead receive their entitlement in the guise of the voucher.[75]

[74] Johannes Stoelwinder, 2008, *Medicare Choice? Insights from Netherlands health insurance reforms*, Paper prepared for Australian Centre for Health Research, South Melbourne.

[75] Henry Ergas, 2008, 'Sustainable Funding for Australia's Future Health Care', Presentation to the Menzies Centre for Health Policy and Australian Centre for Economic Research on Health.

The National Health and Hospitals Reform Commission, established by the Rudd government and chaired by Christine Bennett, recommended the development of a 'Medicare Select' managed competition model to simplify, or at least more effectively marshal, public sector health funding towards the health needs of Australian patients.

Under this extension to the Medicare system, patients could access their risk-related funding entitlement either by being automatically covered by a government health plan or by opting to join an alternative Medicare Select health and hospital plan operated by state governments, private health insurers or other non-government organisations.[76]

In addition, Jeremy Sammut has recently recommended that 'Medicare must be de-monopolised and replaced with a soundly constructed competitive insurance system that properly protects people against the risk and high cost of exception health events, along the lines proposed under the Medicare Select health insurance 'voucher' scheme.'[77]

The underlying basis for these proposals is that the distribution of governmental funding should be determined on the basis of 'following the patient' to the most efficient private or public health care provider, rather than on the basis of sectoral ownership, level of inputs absorbed by entities or the 'accident' of historical precedent. Providers vying for greater shares of public funding would be obliged, other things being equal, to deliver effective health treatment and care regimes at a reasonable cost.

As necessary as this potential demand-side reform may be, it is insufficient on its own to encourage the desired momentum to build productivity within the sector.

Complementing a reconceptualisation of Medicare as it stands are numerous proposals to encourage Australians to save more to meet their health care needs when they arise, thus discouraging the incentive to overconsume health services.

Earlier this year Tim Wilson, of the Institute of Public Affairs, suggested that Australia explore the feasibility of introducing a regime of'health savings accounts' (HSAs) similar to those adopted by Singapore and some other countries:

'[i]nstead of continuing to provide universal health financing through a top-down government-knows-all model the government should use the opportunity … to restructure our health system toward a bottom-up individual health account system.

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[76] Mary Foley, Christine Bennett and Just Stoelwinder, 2009, 'Making Medicare Select Real: A roadmap for reform to put people at the centre of health care', PricewaterhouseCoopers Australia. There has been some debate as to whether some existing health insurance providers, especially those of a smaller scale, could expand their range of covered services consistent with providing a comprehensive health plan under the Medicare Select scheme. See Henry Ergas, 2009, 'Strengthening the governance of Australia's healthcare system: Option C – how others do it and how we could do it', Presentation to the Menzies Centre for Health Policy.

[77] Jeremy Sammut, 2011, *How! Not How Much: Medicare Spending and Health Resource Allocation in Australia*, Centre for Independent Studies, Policy Monograph No. 114.

Put simply every Australian would have an individual health account that they contribute to on a periodic basis from their income, like superannuation. That savings account would then be used to pay for healthcare services as required throughout their lifetime.'[78]

One of the key benefits, according to Wilson, of a HSA would be that '[b]y engaging patients more directly with the management of their health they'll come to appreciate healthcare is expensive and discourage inefficient, costly behaviours like the current problems of people using hospitals for primary care.'[79]

Similar reform sentiments were expressed by Richard Harper, an emeritus director of cardiology in Southern Health, Victoria. Noting that rising health costs are partly due to the lack of influence of competition in directing health expenditures, Harper recommends a Singaporean-style HSA model that:

'encourage and reward prudent behaviour without compromising health. A positive health account is an asset to be protected. It is a financial inducement to a healthy lifestyle and preventative medicine. With such a system, unnecessary visits to the doctor, over-ordering of tests and over-servicing (common in our system) would all be reduced. Competition between public and private hospitals for both insured and non-insured patients would result in further efficiencies and a reduction in waiting lists.'[80]

The Australian Medical Association released a policy paper in 2009 endorsing the HSA model, albeit as a complementary source of health financing in addition to existing models of public and private insurance.[81]

Finally, a number of health economists and policy analysts have advocated a relatively greater reliance on co-payments and insurance deductibles as another means to ration excessive demands for health care products and services or, in the words of Irvine and Gratzer, 'bringing patients back into the decision-making process and involving them in the financial consequences of their health care decisions.'[82]

The 1996 National Commission of Audit recommended a regime of co-payments for pharmaceutical products, and other health goods and services, linked to income levels and service cost growth:

'[f]or the majority of the population at lower risk and able to self manage most of their health care requirements, there is a much stronger case for the use of prices to ration access to health care where the information asymmetry is not large and the measurement of the outcome of most treatment is possible. This already occurs with services such as physiotherapy, podiatry and non-prescription drugs …

[78] Tim Wilson, 2011, 'Private health accounts may solve looming health crisis', The Australian, 23 May.
[79] Ibid.
[80] Richard Harper, 2010, 'Universal healthcare in Australia may become unaffordable', The Age, 15 March.
[81] Australian Medical Association, 2009, 'Health Savings Accounts Policy Paper', http://ama.com.au/node/4610.
[82] Carl Irvine and David Gratzer, 2002, 'Medicare and User Fees: Unsafe at any Price?', Atlantic Institute for Market Studies, Health Care Reform Background Paper No. 9.

Eschewing the use of price signals to the consumer forces a reliance on administrative measures to control the supply of services, such as administrative restrictions on doctor numbers, new diagnostic technologies, or prescribing of certain pharmaceuticals. Inevitably this leads to distortions in service supply and demand (costs expressed in dollars or waiting times) as providers and consumers adjust to the administrative restrictions, which then requires more administrative action and so on."[83]

There is some evidence to suggest that previous policy decisions to increase patient co-payments for medicines subsidised under the PBS have been effective in reducing demand.[84] According to Medicines Australia the observed price elasticity for demand for medicines appears to be in the order of about 0.25-implying that a 10 per cent increase in the price of a medicine would lead to a reduction in volumes sold by 2.5 per cent.[85]

While the use of price mechanisms to condition demand have been criticised by some from a health accessibility perspective, it should be recognised that opportunities to allow health care providers to directly charge for their goods and services would be conducive to price competition between such providers that, depending on the conduct and contestability of the market, would not necessarily preclude reductions in real prices to final consumers.

Principle #2 Promote productivity by enhancing supply-side competition

The realisation of productivity gains in the Australian health care sector in the longer term will also be dependent on the availability of sufficient numbers of providers, who will strive to compete for greater shares of an expected burgeoning health care market.

To maintain their economic viability, including their very existence within the sector, these providers will need to compete against each other and, in so doing, arrange their operations efficiently in ongoing efforts to deliver quality treatments and care at reasonable cost to consumers.

There are already movements within the health care sector to ensure the responsiveness of available supply to consumer needs. For example, a number of state governments have instituted arrangements to outsource the treatment of elective public hospital patients, languishing on waiting lists for an inordinate period of time, to private hospitals with excess capacity.

The Queensland government introduced in 2007 a time-limited 'Surgery Connect' program, costed at $8.5 million, enabling public patients to receive elective surgery in the areas of orthopaedic, cardio-thoracic, vascular, urology, ophthalmology, gynaecology and general surgery in private hospitals, arranged through an external brokerage process.[86]

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[83] National Commission of Audit, 1996, *Report to the Commonwealth Government*, AGPS, Canberra.

[84] Anna Hynd, Elizabeth E Roughead, David B Preen, John Glover, Max Bulsara and James Semmens, 2009, 'Increased patient co-payments and changes in PBS-subsidised prescription medicines dispensed in Western Australia', *Australia and New Zealand Journal of Public Health* 33 (3): 246-252.

[85] Dr Brendan Shaw, 2010, 'Sustaining the PBS for the future', Speech to the Second Future of Medicare Conference.

[86] Hon Stephen Robertson, 2007, 'Surgery sooner for 'long wait' elective patients', Queensland Minister for Health, Media Release, 5 April.

In 2009 urologists in Sydney were paid to operate on 58 public patients in a private hospital,[87] while in a slight variation on the theme the South Australian government a year earlier announced an agreement with a private medical company to fly in surgical teams to perform 210 operations at the Queen Elizabeth public hospital.[88]

The potential to extend such arrangements across Australia have been abandoned in the process of negotiating a health care reform agreement with the states and territories, as the Gillard government reneged on a previous commitment, developed under former Prime Minister Kevin Rudd, to guarantee private hospital care for public elective surgery patients.[89]

While the movement to rely on private treatment and care options provides the potential to increase throughput by the hospital sector, while at the same time reducing taxpayers' exposure to the cost of health care services provided, there is the potential to move from currently selective, *ad hoc* political arrangements towards more open tender processes to outsource treatments to the most efficient provider amongst the tendering field.

More broadly, the extent to which barriers to entry apply can also have a pervasive impact on the contestability of health care industries, with regulatory restrictions being practically a key characteristic of such deterrents to entry.

According to a licensing legislation mapping study undertaken as part of the Australian Commission on Safety and Quality in Health Care (ACSQHC) accreditation review, hospitals are obliged to meet a wide range of substantive, largely input-based conditions relating to:

- location, type of patient or service, and the number of patients or beds. For example, the South Australian *Health Care Act 2008* stipulates conditions for the licensing of private hospitals including 'the location of the premises or proposed premises and their proximity to other facilities' and 'whether the prescribed limit of hospital beds for the state, or for the particular region in which the premises or proposed premises are or will be situated, has already been reached or exceeded.'
- the type or character of the licensee. In Western Australia the hospital licensee must be 'a person of good character and repute and a fit and proper person to conduct a private hospital' and must have 'sufficient material and financial resources available.'
- clinical practice and health care quality. In a number of jurisdictions separate regulations apply to specific services provided, including emergency and intensive care, surgical, obstetric, rehabilitation, and psychiatric services in additional to general services provided by a private hospital. Other regulations stipulate the quality of care that must be provided to patients on private hospital premises (see below for further discussion).
- premises, facilities and equipment. In New South Wales there are provisions relating to furniture, furnishings and bed linen, kitchens and serveries, and medical, surgical and nursing equipment. The South Australian legislation specifies room sizes that are to apply in the state's private hospital facilities (see below for further discussion).

[87] Louise Hall, 2009, 'Public patient sent to doctors' own hospital', The Sydney Morning Herald, 27 August.
[88] Jeremy Sammut, 2008, 'Agnostics need faith in private hospital sector', http://www.crikey.com.au/2008/10/31/agnostics-need-faith-in-private-hospital-sector/.
[89] Mark Metherell, 2011, 'Private hospitals excised from wait fix', The Sydney Morning Herald, 7 July.

- management and staffing. In Western Australia and some other states a general private hospital must be staffed by registered general nurses, registered psychiatric nurses and enrolled nurses only.
- registers and records: Most states require private hospitals to maintain records of admitted patients, including medical condition subject to treatment.[90]

Licensing provisions also typically include a range of miscellaneous requirements covering such issues as patient rights, fire safety and emergency evacuation, hospital administrative practices and policies, storage and handling of drugs and chemicals, waste management and disposal, food safety and infection control. They may also specify compliance with other legislation or regulations.[91]

There is merit in easing mandatory licensing and accreditation requirements which artificially raise the costs of entry for new private hospitals and day clinics with a view to increasing the array of alternative suppliers available to consumers of health care outputs.

Reforms in these areas should be actively investigated as part of a broader policy focus on deregulating the health care sector, to be discussed in further detail below.

Principle #3 Promote productivity by deregulating health care markets

For a variety of reasons, including 'to provide a safe and healthy environment; prevent avoidable disease and injury; provide accessible and affordable care in times of illness; ... [and] ... safe, effective and affordable medicines,'[92]health care is one of the most heavily regulated sectors of the Australian economy.

The sheer breadth of regulatory intervention spanning almost every aspect of health care sector operations raises certain difficulties in terms of identifying immediate priorities for reform.Nonetheless, in 2010 the IPA identified a number of industry-specific regulations, based on representations from key stakeholders as well as published submissions to official government inquiries that present major barriers against health care providers in reducing costs and responding to their customer bases (Table 8).

[90] ACSQHC, 2008, *Proposals on an Alternative Model for Safety and Quality Accreditation and Matters relating to Costs and Duplication of Accreditation Processes*, February; State and territory government health legislation and regulations; 'State and Territory Private Health Facility Licensing Legislation Mapping', Study for ACSQHC Accreditation Review.

[91]Productivity Commission, 1999, *Private Hospitals in Australia*, Research Paper, AusInfo, Canberra.

[92] Regulation Taskforce, 2006, *Rethinking Regulation: Report of the Taskforce on Reducing Regulatory Burdens on Business*, Report to the Prime Minister and Treasurer, Canberra, p. 22.

Table 8: Priority areas for industry-specific health regulation reform

Industry	Identified regulations
General practice medical services	• Medical Benefits Schedule • Practice Incentive Payments • Enhanced Primary Care • Compliance with government agencies
Pharmaceuticals manufacturing and retailing	• Listing on the Australian Register of Therapeutic Goods • Clinical trials • Therapeutic Goods Administration marketing approvals • Pharmaceutical Benefits Schedule listing and pricing requirements • Manufacturing quality standards and licensing
Private health insurance services	• Consumer information product disclosure • Premium approvals • Private health insurance rebate
Private hospital services	• Licensing provisions • Physical capital requirements • Safety and quality regulations

Source: Julie Novak, Chris Berg and Tim Wilson, 2010, *The Impact and Cost of Health Sector Regulation*, Australian Centre for Health Research, p. 15.

Apart from the secular increase in the quality of regulation increasing the complexity of the environment in which health providers operate, other issues raised in the IPA study included problems with the design, administration and enforcement of regulation which effectively increased the extent of unnecessary burdens placed upon health care operators.

Within this a factor raised in discussions with health sector representativesremains the extent to which government ministers maintain discretion over regulatory decisions, to the detriment of the overall quality of regulation. For example, ministerial discretion over the extent of allowable premium increases raises significant degrees of uncertainty for private health insurers (Box 4).

Box 4: Ministerial discretion over health insurance premiums

Under the *Private Health Insurance Act 2007* the commonwealth government Minister for Health and Ageing has the power to approve applications for changes in private health insurance premiums.

The Minister is obliged to approve all premium increases, unless it is deemed contrary to an (undefined) 'public interest' criterion. If the Minister does not allow an increase the reasons for this have to be publicly disclosed.

An application by a health fund to change its premium must be lodged at least sixty days prior to the proposed change taking effect. The Private Health Insurance Administration Council (PHIAC) provides the Minister with advice on prospective premium rises.

There have been some changes to this regulatory stipulation over time. In 1996, the federal government introduced the practice whereby premium increases required approval by the health minister, in consultation with the prime minister and treasurer. In 2003, the process was streamlined with insurers seeking a premium increase below CPI not obliged to submit as much information compared to at- or above-CPI applicants.

With the passage of the *Private Health Insurance Act 2007*, the time required for insurers to submit price increase applications was lengthened. The minister is also obliged to approve all premium increases unless this would be contrary to the 'public interest.' However, the concept of public interest is left undefined in the legislation.

As noted by Access Economics in an assessment of the pricing approval regulatory framework, the result of this regulatory discretion 'is a climate of poor accountability and transparency, which creates considerable uncertainty for existing funds and potential market entrants.' It also introduces 'a political overtone to decisions.'

There is also the potential for approved premium increases larger than inflation to attract consumer complaints to the Private Health Insurance Ombudsman (PHIO), even if these price movements were approved by the federal minister.

Source: Julie Novak, Chris Berg and Tim Wilson, 2010, *The Impact and Cost of Health Sector Regulation*, Australian Centre for Health Research.

Issues concerning political uncertainty in the enforcement of regulatory regimes have recently resurfaced in relation to the listing of pharmaceuticals on the PBS.

Earlier this year the Gillard government deferred seven recommendations by the Pharmaceutical Benefits Advisory Committee (PBAC), which applies clinical cost-effectiveness trials of drugs that are pending PBS approval, for the inclusion of certain products on the PBS saving some $120 million in budgetary costs. According to eleven major pharmaceutical companies, such as Pfizer,

GlaxoSmithKline and Astra Zeneca, such actions lack transparency and are increasing uncertainties about the introduction of new medicines in Australia.[93]

Given the abundance of evidence available in recent years concerning the significant burdens that regulations impose on health care businesses and other providers, the question of how best to pursue regulatory reform, as part of a general platform to raise productivity, in the health care sector must now surely transcend the need for additional investigations on the nature and extent of these burdens.

With a dedicated commonwealth Minister for Finance and Deregulation, and ministers with generally equivalent roles in the states and territories, it should now be an opportune time for these ministers to orchestrate momentum for their governments, including through COAG, to outline priorities for regulatory reform for the health care sector and timetables for the successful and effective delivery of deregulatory outcomes. This should include the repeal of legislation and regulatory edicts which are deemed no longer necessary to fulfil policy objectives.

While a 'just do it' approach on a wide scale advocated here is certainly long overdue, the path to a more productive health care system is practically littered with dashed ambitions, accompanied by mountainous numbers of reports, to secure additional productivity gains through the reduction in regulatory burdens.

A probable explanation for this reform inertia, aside from the obvious and pervasive effect of vested interests in capturing health policy processes, is a lack of information available to reform-minded politicians concerning the implications of reforms to enhance health sector productivity.

It is true that international comparisons could be made in terms of the productivity, and other aspects of, performance in health care, however the divergent institutional, policy, demographic, economic and social scenarios of countries causes some difficulties in directly translating overseas reform experiences to Australian conditions.[94] Within the Australian context, the attenuation of competitive federal impulses in health care, particularly since the advent of Medicare, havetended to compromise the capacity to observe the effects of meaningful policy experiments at a state level.

Policymakers have increasingly extolled the virtues of 'evidence based' policies as a guide to policy evaluation and implementation. As noted by Productivity Commission chair Gary Banks in 2009:

'[a]ll policy effectively is experimentation. But that does not mean flying blind - we still need a good rationale or a good theory. Rationales and theories themselves can be subjected to scrutiny and debate, and in a sense that constitutes a form of evidence that can give some assurance about the likely outcomes. Importantly though, all

[93] Sue Dunlevy, 2011, 'Warning PBS row will stall drugs', The Australian, 20 July.

[94] That said Mark Pennington in his book, *Robust Political Economy*, provides summary evidence to support his point that greater private sector involvement in the financing and delivery of health care services is associated with superior health care outcomes across a variety of measures.

policy experiments need to be monitored and evaluated and, over time, corrected or terminated if they turn out to be failures.'[95]

In this spirit it might be possible to test the productivity implications of health care deregulation through localised reform trial experiments, which could then lead to a wider scale implementation of deregulation if successful. Kling and Schulz recently advocated the creation of special zones in which regulatory barriers could be lifted from health care providers at least for a period of time:

'imagine if state governments experimented by setting up healthcare enterprise zones. These would be areas where entrepreneurs could set up healthcare delivery systems without any rules concerning what license would be required to engage in any particular activity. Perhaps medical services could be delivered by workers with fewer credentials but more rigorous on-the-job training.

Healthcare providers would be accountable for the quality of their work, not for the certificates hanging on their walls. Instead of forcing work rules on the healthcare system, consumers and the government should hold innovative healthcare organizations accountable for results. If their success rates and error rates compare favourably with traditional hospitals and medical practices, then these alternative models should be free to remain in operation and to continue the process of redesigning healthcare.'[96]

Whether through a 'top-down' scheduling of a progressive program of health care deregulation by all levels of government, or a 'bottom-up' process of deregulatory experimentation with prospects for subsequent wider implementation, the unshackling of health care businesses and other operators from prescriptive regulations, that do not achieve underlying policy objectives, will be instrumental in forging a sustained improvement in health sector productivity into the future.

Principle #4 Promote productivity by addressing health workforce rigidities

An aspect of Australian health care that has remained largely resistant to regulatory reform is the pursuit of greater flexibilities within the health labour force.

In one respect, existing inflexibilities in workplace arrangements have a major impact on the productivity and effectiveness of the available health workforce. To the extent that the competencies of certain workers in the health system are not being fully developed and recognised, these inflexibilities also make workforce recruitment, retention and re-entry more difficult.[97]

Through a mixture of factors such as onerous licensing, tightening international recognition standards, capping doctor training and cultural impediments blocking the service delivery aspirations of nurse practitioners, midwives and pharmacists, general practitioners have maintained an effective monopoly over the delivery of primary health care services which many other health care professionals are capable of providing.

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[95] Gary Banks, 2009, 'Evidence-based policy making: What is it? How do we get it', ANU Public Lecture Series, Presented by ANZSOG, Productivity Commission, Canberra.
[96] Arnold Kling and Nick Schulz, 2011, 'Solving the Long-Term Jobs Problem', The American, 27 July.
[97] Productivity Commission, 2005, *Australia's Health Workforce*, Research Report, Canberra.

According to an Australian review of research into the substitutability of nurses for doctors, 'nurses could assume up to 70 per cent of the work currently undertaken by doctors,'[98] with other health care professionals performing other key roles without compromising quality.

Services such as blood pressure tests, immunisation, blood tests, prescribing rights for minor injuries, health promotion and the routine management of chronic diseases such as asthma, diabetes and heart disease can all be performed by non-GP health care professionals (such as nurse practitioners) under the appropriate circumstances or even at home using blood pressure or sugar-level monitoring equipment.

Pharmacists share a similar view with regard to their ability to deliver health care services, such as the renewal of existing prescriptions and the performance of triage services with protocol-based GP involvement:

'On average an Australian goes into a community pharmacy 14 times per year, which means there is at least 14 opportunities each year to provide low cost access to advice or other health interventions.'[99]

The pressure posed by workforce limitations upon the most efficient use of available labour within the health care sector has also been noted in the context of care providers such as hospitals:

'[h]ealth is rife with restrictive work practices and denial of career prospects, particularly for nurses, whether it is in the community or hospitals. Many senior nurses are more skilled and experienced than most junior doctors and many registrars. Because of the opposition by obstetricians, less than 10 per cent of normal births in Australia are managed by midwives. In the Netherlands it is over 70 per cent and in the UK over half. Many more leave nursing for management or academia because of a lack of career prospects and financial reward. The medical colleges protect their own interests in the name of 'quality.''[100]

Restrictive licensing standards tend to weaken service competition, reduce the total number of potential service providers and increase costs, all of which militate against the interests of the consumer, the taxpayer and certain health care providers:

'[a]s part of health care reform, breaking down the legislative and professional barriers to enhance the professional role of nurses, nurse practitioners and other allied health workers is an important issue, and one that needs addressing. Making the patient 'the centre of care' needs more than rhetoric and access to professional health care by the community is a basic right, not something that is to be restricted due to territorial disputes, or a view that the patient belongs to any particular primary health carer.'[101]

Current workforce practices curtail potential productivity gains within the health sector as not all tasks are being undertaken by the most economically efficient workers. For example, by delegating

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[98] Dr Rhonda Jolly, 2007, *Practice nursing in Australia*, Department of Parliamentary Services, Parliamentary Library, Research Paper No. 10.

[99] Pharmacy Guild of Australia, 2005, Submission to Inquiry into Health Funding, Parliament of Australia, House of Representatives, Standing Committee on Health and Ageing, p. 4.

[100] John Menadue, 2004, 'Curing sick hospitals', *Griffith Review* 4, p. 5.

[101] Australian Primary Care Community Patnership, 2008, First round submission to the National Health and Hospitals Reform Commission, p. 1.

less complicated services to non-GP health professionals scarce GP time could be freed up to concentrate on complex diagnoses, treatments and care which can more efficiently performed by a professional with more extensive training and expertise.

The industrial relations environment of the health professions, including nursing in the public hospital system, has long been identified as one characterised by inflexibility in working arrangements and a 'militancy which has flowed over into nurses' relationships with hospital authorities and the medical profession. This is not always to the advantage of the patient.'[102]

With projections suggesting that Australia needs to recruit half a million new workers for the health care sector over the next decade, in response to population ageing and the consequent expectations of increasing demand for health services, the relaxation of work restrictions will also assist in abating skills shortages to some degree, as segments of the existing workforce focus on more complex functions and delegate lower level functions to less qualified staff.

In addition to this investment in human capital, through the effective training of the future workforce by health care operators, may be another avenue to improve labour productivity in the long term.

In particular there is scope for the Australian private hospital sector to play a greater role in training medical specialists and other clinicians, supplementing the roles already played by specialist colleges and public hospitals.

Indeed a greater training role, such as that played by Greenslopes Private Hospital in Brisbane in partnership with the University of Queensland, would complement the trend towards an increasing complexity of casemix within private hospitals whilst alleviating somewhat the fiscal burdens imposed on taxpayers associated with training medical graduates in public hospitals.[103]

While it is widely acknowledged in health care policy circles that additional skilled workers will be required to placate expected increases in demands for services, opportunities might also exist to apply labour-saving technologies that will yield productivity gains without compromising care outcomes.

For example, telemedicine is widely cited as a potential means to improve access to health care and advice in remote areas, or across different time zones, bypassing the need to recruit additional labour to fill specific labour shortage gaps and also contributing to breaking down unnecessary workforce demarcations.

Principle #5 Promote productivity by improving transparency of health sector performance

Western countries, such as Canada, Italy, Sweden, the United Kingdom and United States, have progressively sought to publish information on the performance of health care providers.According

[102] Dr Bruce D Shepard, 1988, 'Industrial Relations in the Hospital and Medical Services Industry, Part II', Speech presented to H R Nicholls Society, Newcastle.
[103]Sid Maher, 2010, 'Private hospitals to boost medical graduate training', The Australian, 16 March.

to Mason and Street, an important rationale for the publication of health performance data is to support patient choices, by shifting the emphasis from quality control in the health system by government-imposed targets to quality driven by patient demands.[104]

In the Australian context health policy consultant Terry Barnes provides support for the publication of health sector performance measures for hospitals on the following basis:

'[s]tandardised performance information helps patients to make better-informed choices about hospitals, including asking their doctors for advice on where they should be admitted, questioning a recommendation of one hospital over another, or deciding to go private over public. ...

appropriate performance reporting is a spur to continuous improvement and innovation by both public and private hospital operators. ... better performers will be rewarded with increased patronage, enhanced reputation and better contract leverage. Poorer performers will be on notice to do better and rectify shortcomings.'[105]

By providing consumers with the means to make a more informed choice regarding their selection of health care service provider, publicly available performance information would promote competition amongst providers to imitate, and eventually improve upon, existing best practices which would, in turn, drive productivity improvements over time.

More broadly, the publication of rigorous performance information would improve the quality of care provided. A recent review of the international literature found that there is 'strong and consistent evidence that public reporting stimulates quality improvement in hospitals' and 'the majority of studies show significant positive impact of public reporting on clinical outcomes.'[106]

A number of organisations currently publish information on aspects of performance of different segments of the Australian health care sector.

The Australian Institute of Health and Welfare (AIHW) publish an annual report on Australian public and private hospitals, including their financial performance, patient admissions and separations, and outcomes in emergency departments and under elective waiting lists. The AIHW publish separate reports concerning general practitioner services and on a variety of specialist medical services.

Complementing this is the annual Productivity Commission Review of Government Services, which includes information about unplanned or unexpected readmissions, the extent of adverse events and infection rates in public hospitals.

In December 2010 the commonwealth government launched its 'MyHospital' website providing selective information about the performance of individual hospitals around the country.

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[104] Anne Mason and Andrew Street, 2006, 'Publishing outcome data: is it an effective approach?',*Journal of Evaluation in Clinical Practice* 12 (1): 37-48.

[105]Terry Barnes, 2008, 'All patients have a right to know', The Age, 15 September.

[106] Jack Chen, 2010, *Public Reporting of Health System Performance: Review of Evidence of Impact on Patients, Providers and Healthcare Organisations*, The Sax Institute.

The performance data included on the website includes bed numbers, patient admissions and hospital accreditation, and the types of specialised services each hospital provides. The website also provides comparisons to national public hospital performance statistics on waiting times for elective surgery and emergency department care.

While MyHospital is an important step towards promoting accountability and transparency of health care services to the general public, it remains hampered by certain flaws in its design (presumably, in part, to maintain data confidentiality for individual hospitals).

The limitations of the website includes the lack of real-time data on performance, which would be of great benefit to non-emergency patients, and a lack of information comparing individual hospitals against each other locally, regionally or within a given state (given similar casemix). Crucially, there is also no information on infection rates or adverse events.[107]

Another innovation on the road to greater public transparency of Australian health care is the availability of performance comparisons by medical specialists and surgeons within hospitals. As noted by Barnes:

'[m]edical specialists and surgeons should themselves be subject to appropriate comparisons that can aid consumer decisions, at least in basic areas such as complication and readmission rates for specific procedures. ...If a surgeon has a higher than average admission rate, before choosing a doctor, why shouldn't a patient be told this by their insurer or some other reliable information source?'[108]

Such information is already available overseas, including in the US states of New Jersey, New York and Pennsylvania and the United Kingdom with regard to cardiac surgeon performance,[109] with individual health care providers in Australia already collecting the basis of similar information that is presently available to publicly patients in the UK and US.

Conclusion

For better or for worse, the health care system has been characterised by economists Arnold Kling and Nick Schulz as a key element of the 'new commanding heights' of the American economy, judging by its relative size within the economy and consumption of real resources over time.[110]This picture is no less true for Australia, given the position of health care as already one of the nation's largest industries.[111]

Hagist and Kotlikoff have shown that, since 1970, the growth rate of Australian health care expenditure in real terms has been in the order of 5.7 per cent on an annual basis with increases in

[107]Adam Cresswell, 2010, 'Hospitals website hits early strife', The Australian, 11 December.
[108] Terry Barnes, op. cit.
[109] Steve Clarke and Justin Oakley, 2005, 'Publicising performance data on individual surgeons: The ethical issues - Policy implications', http://www.assa.edu.au/programs/policy/paper.php?id=5.
[110] Arnold Kling and Nick Schulz, 2011, 'The New Commanding Heights', *National Affairs* (Summer): 3-19.
[111] According to the ABS national accounts, health care (and social assistance) ranks as the sixth largest sector in the Australian economy (based on gross industry value added in 2009-10).

benefits driving much of the observed spending growth thus far.[112]With demographic change projected to augment this expenditure growth momentum, it is likely that health care will emerge as the largest consumer of governmental resources over the next few decades.

Despite its size, the productivity performance of the health care sector tends to lag behind those of other sectors of the economy. Within this, the level of productivity by the dominant public sector providers appears to be below that of the private sector.

Indeed, the available data tends to suggest that, unless offset by efficiency enhancing reforms (such as those to be discussed below), the drawing of additional resources into health industries will have adverse consequences for national labour productivity growth as a whole.

The restraints against the achievement of additional productivity within the health care sector are largely due to institutional and policy constraints which both constrain the level of output provided, especially by public providers of health care, while relaxing implicit constraints on the employment of inputs (particularly administrative labour) not directly involved in service delivery.

In addition to this there appears to be the persistence of a cultural belief within the health care sector that it is somehow special, or at least fundamentally different to other markets, and thus impervious to the typical means of securing productivity improvements through greater sectoral competition.

The central view expressed in this paper is that, to the contrary, the health care system can generate additional productivity outcomes if reform measures were put in place to promote greater competition, additional patient choice and incentives to secure lower costs.

Specifically, the measures would relate to a series of mutually inclusive principles such as: improving the responsiveness of providers to consumer demands; encouraging greater differentiation in health care provision; reducing regulatory impediments to health care services provision; alleviating health sector workforce rigidities; and greater public transparency of operations to consumers and taxpayers.

While it is not within the scope of this paper to provide precise estimates about the extent of gains as a result of competition-promoting reform, it would not be implausible to tentatively assume a total productivity gain of at least five per cent in the long run. This figure is based on a 2006 Productivity Commission study estimating the outer envelope of productivity gains from reforms to health services delivery, with information to inform this estimate primarily drawn from the hospitals sector.[113]

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[112]Christian Hagist and Laurence J Kotlikoff, 2009, 'Who's going broke? Comparing growth in public healthcare expenditure in ten OECD countries', *Revista de Economia Pública* 188 (1): 55-72.

[113] Productivity Commission, 2006, *Potential Benefits of the National Reform Agenda*, Report to the Council of Australian Governments, Canberra. One health insurer recently estimated that it would not be implausible to tentatively assume a reduction in health care costs of at least 20 per cent in the long run from a wide ranging package of reforms. Rohan Mead, 2011, 'Healthcare Reform and Beyond', Presentation to Melbourne Institute Economic and Social Outlook Conference, July.

Such an outcome would, in itself, prove indispensible in the provision of more efficient and better quality health care for Australian consumers.