



Lessons from Abroad

A Series on Health Care Reform



Health Care Lessons from **Australia**

by Nadeem Esmail

Foreword by **Janice MacKinnon**, former Saskatchewan NDP Finance Minister

Contents

Foreword *by Janice MacKinnon* / iii

Executive summary / v

Introduction / 1

Health system performance—Canada compared to Australia / 3

Australia's health policy framework / 14

Lessons for Canada / 24

References / 31

About the author & Acknowledgments / 37

Publishing information / 38

Supporting the Fraser Institute / 39

Purpose, funding, & independence / 40

About the Fraser Institute / 41

Editorial Advisory Board / 42

Janice MacKinnon is a professor in the School of Public Health at the University of Saskatchewan. She holds a Ph.D. in history from Queen's University and is a Fellow of the Royal Society of Canada. Between 1991 and 2001, Dr. MacKinnon was a cabinet minister in the NDP Government of Saskatchewan and held such posts as the Minister of Finance and the Minister of Social Services. During her tenure as Finance Minister, Saskatchewan became the first government in Canada to balance its budget in the 1990s and established a foundation for other governments, including the Conservatives in Alberta and the Liberals federally to build on.



Foreword

In the 2005 judgment of *Chaoulli v. Quebec*,¹ the Justices of the Supreme Court made some perceptive comments about Canada's health care system. That case decided that the government of Quebec could not prevent its citizens from buying private insurance for services covered by Medicare at the same time as there were long wait times in the public system, which were causing a deterioration in the health of some patients. The majority judgment stated that "delays in the public system are widespread and have serious, sometimes grave, consequences" (*Chaoulli*: para. 112). The majority of the Justices also noted: "governments [in Canada] have promised on numerous occasions to find a solution to the problem of waiting lists. Given the tendency to focus the debate on a sociopolitical philosophy, it seems that governments have lost sight of the urgency of taking concrete action" (*Chaoulli*: para. 96). Furthermore, the jurists greeted various defenses of Medicare with skepticism, writing that "many western democracies that do not impose a monopoly on the delivery of health care have successfully delivered to their citizens medical services that are superior to and more affordable than the services that are presently available in Canada" (*Chaoulli*: para. 140). The Court's observations pinpointed three major issues with Canada's health care system: its shortcomings, the role of ideology in impeding its reform, and, perhaps most crucially, the importance of looking beyond North America for solutions.

1 [2005] S.C.R. 791, 2005 SCC 35 [*Chaoulli*].

Waiting lists aside, another problem with Medicare is that it is expensive. In fact, the costs of Canada's health care system are rising at a faster rate than the revenue of any government, meaning it is being funded by money squeezed out of other services, such as education, social programs for the poor, and the environment. This is unfortunate, as education, income levels, and other factors like the environment are related to the overall health of the population. It is thus not surprising that studies comparing our health care system with those of other comparable countries have yielded three troubling conclusions: ours is expensive, it features relatively long waiting lists, and the overall health of the population is mediocre.²

The need for change is widely recognized. Various studies have argued forcefully that health care reform is essential. Yet change is difficult to achieve in a country in which the debate is too often marked by ideology. Public-sector unions and other staunch defenders of the status quo strongly oppose changes like the private delivery of publicly funded health care services. These groups warn that such innovations will lead to the privatization of Medicare, which, in turn, will usher in an American-style, two-tiered health care system. These arguments are myopic and predictable. When the choice is between the Canadian publicly funded model and an American system that has historically left millions without coverage, the decision is, of course, an easy one: the Canadian status quo is more desirable. However, the authors of the *Chaoulli* judgment were correct: the debate needs to be moved beyond the stark choices in North America to consider other countries of the Organisation for Economic and Co-operative Development (OECD) whose systems are less expensive and feature shorter waiting lists and better outcomes.

Looking at other OECD countries for solutions to Canada's health care challenges will not necessarily lead to a consensus about the changes required. For instance, I myself do not agree with all of the recommendations contained in the studies that follow. I do, however, strongly support the need to look beyond North America for solutions and to have an open and vigorous debate about what changes are needed to improve the affordability and effectiveness of Canada's health care system.

Janice MacKinnon

2 See, for example, Conference Board of Canada, 2004; OECD, 2012b; Simpson, 2012.

Executive summary

This paper is the first in a series that examines the way health services are funded and delivered in other nations. The nations profiled all aim to achieve the noble goal of Canada's health care system: access to high quality care regardless of ability to pay. How they organize to achieve that goal differs markedly from the Canadian approach. So do their performances and results.

The first nation to be studied in this series is Australia. The Australian health care system provides some of the best outcomes when compared with other developed nations that have universal approaches to health care insurance. A careful examination of the Australian health care system will provide insights and information that will be useful in the Canadian debate over the future of Medicare.

Health system performance—Canada compared to Australia

Health care expenditures in Canada are considerably higher than in Australia or the average nation providing universal access. In 2009, Canada's health expenditures (age-adjusted, as older people require more care) were 26% higher than in Australia and the average universal-access nation. In fact, in 2009 Canada's health expenditures, as an age-adjusted share of GDP, were the highest among universal-access developed nations.

Unfortunately, the performance of Canada's health care system does not reflect this level of expenditure. With respect to access to health care services, the Canadian health care system outperforms the Australian health care system in one of nine measures examined: ratio of MRIs to population. On the other hand, the Australian health care system outperforms the Canadian in the remaining eight measures: ratios of physicians to population, nurses to population, hospital beds to population, CT scanners to population; and wait times for emergency care, primary care, specialist care, and elective surgery.

Looking at factors such as the ability of the health care system to provide healthy longevity, low levels of mortality from disease, and effective treatment for both chronic and terminal illnesses, it seems the Australian health care system broadly performs at a level similar, if not superior, to that

in Canada. Specifically, the Canadian health care system outperforms the Australia's in four of 13 measures examined: two of three measures of primary care performance, and three of six measures of patient safety. Conversely, the Australian health care system outperforms the Canada's in eight measures: infant mortality, mortality amenable to health care, two of three measures of in-hospital mortality, one of three measures of primary care performance, and three of six measures of patient safety.

Australia's health policy framework

Australia's federal organization of health care is notably different from that in Canada. In Australia, the federal government is responsible for funding ambulatory or outpatient care through Medicare Australia, while state governments (supported by federal transfers) regulate health care providers and fund hospital care for the population. Australia's health care system is, like Canada's, funded primarily through general taxation.

Australia's health care system relies on cost sharing to encourage informed decision-making from those in need of health care. The federal government in Australia sets the benefit rates that will be paid for medical services, and commits itself to paying 100% of the scheduled fee for general practitioner services, 85% of the scheduled fee for other out-of-hospital services including specialist consultations, and 75% of the scheduled fee for in-hospital medical services for private patients in public or private hospitals.

Australia's approach to cost sharing, however, is different from that pursued in most developed nations and encompasses greater pricing freedom for medical practitioners than is commonly found in universal-access health care systems. Importantly, physicians are not bound by the fee schedule and are free to charge prices they set for their services. In instances where general practitioners are willing to accept 100% of the scheduled fee and specialists are willing to accept 85% of the scheduled fee as full payment for services, they earn the ability to "bulk bill" government for their services directly. Otherwise, patients are to be charged the cost of the service and must apply to Medicare for reimbursement of either 100% or 85% of the schedule fee as appropriate. Annual limits apply to both "gap" payments (the difference between the scheduled fee and Medicare reimbursement) and to total out-of-pocket payments.

Primary Care

General practitioners in Australia are mostly self-employed and run their practices as small businesses. In Australia, the most common type (some 2/3) is the solo practice but only about one third of GPs work in such practices as most are employed in private group or multiprovider practices.

Health system performance—Canada compared to Australia

Indicator*	Canada	Australia
Total health expenditures (age-adjusted, % of GDP)	12.5	9.9
Physicians (age-adjusted, per 1,000 pop.)	2.6	3.4
Nurses (age-adjusted, per 1,000 pop.)	10.3	11.6
MRI machines (age-adjusted, per million pop.)	8.8	6.7
CT scanners (age-adjusted, per million pop.)	15.2	43.8
Hospital beds (age-adjusted, per 1,000 pop).		
<i>Total</i>	3.6	4.4
<i>Curative care beds</i>	2.0	4.0
Waited less than 30 minutes in emergency room before being treated (% of patients, 2010)	20%	33%
Same- or next-day appointment with doctor or nurse when sick or needing care (% of patients, 2010)	45%	65%
Waited less than one month for specialist appointment (% of patients, 2010)	41%	54%
Waited less than one month for elective surgery (% of patients, 2010)	35%	53%
Waited for four hours or more in emergency room before being treated (% of patients, 2010)	31%	16%
Waited six days or more for access to doctor or nurse when sick or needing care (% of patients, 2010)	33%	14%
Waited two months or more for specialist appointment (% of patients, 2010)	41%	28%
Waited four months or more for elective surgery (% of patients, 2010)	25%	18%
Infant mortality rate (per 1,000 live births)	5.1	4.3
Mortality amenable to health care (per 100,000 pop, 2007)	74	68
In-hospital case-fatality rates within 30 days, AMI**	3.8	3.2
In-hospital case-fatality rates within 30 days, hemorrhagic stroke**	20.6	17.2
In-hospital case-fatality rates within 30 days, ischemic stroke	6.3	5.7
Uncontrolled diabetes hospital admission rate (per 100,000 pop.)**	15.2	7.5
COPD hospital admission rate (per 100,000 pop.)**	183.3	311.7
Asthma hospital admission rate (per 100,000 pop.)**	15.7	66.6
Obstetric trauma, vaginal delivery w/ instrument (per 100 patients)	13.7	7.4
Obstetric trauma, vaginal delivery w/out instrument (per 100 patients)	2.7	2.0
Foreign body left in during procedure (per 100,000 hospital discharges)	9.7	9.8
Accidental puncture or laceration (per 100,000 hospital discharges)	525	352
Postoperative pulmonary embolism or deep vein thrombosis (per 100,000 hospital discharges)	566	1,020
Postoperative sepsis (per 100,000 hospital discharges)	769	1,455

Notes: * 2009 or nearest year, unless otherwise noted. ** The difference for this indicator is statistically significant (95% confidence interval). Note that confidence intervals apply to in-hospital case-fatality rates and hospital admission rates.

Sources: OECD, 2011; Commonwealth Fund, 2010; Gay et al., 2011; calculations by author.

GPs in Australia have a formal gate-keeping role, referring patients to specialists. This is enforced through financial incentives where reimbursements are paid only for referred consultations. Patients have free choice in choosing a physician for out-of-hospital care.

For the most part, primary care providers in Australia are paid on a fee-for-service basis, with fees set by the federal government. Primary care practices may also receive payment under the Practice Incentives Program, which offers financial incentives for improving quality and accountability.

The federal government in Australia also funds Divisions of General Practice that are intended to improve quality of care, in part by encouraging practitioners to update their knowledge and skills, and increasing cooperation. Medicare locals are another federally funded initiative that encourage GPs and other providers to coordinate primary care delivery, deal with service gaps, and improve access to after-hours care, among other goals. Incentive programs also exist to encourage the employment of nurses in primary care and the establishment of multidisciplinary teams.

Specialized, hospital, and surgical care

The delivery of hospital care in Australia is undertaken by both public and private hospitals. While the sector remains dominated by public providers, recent reforms have led to an increased role for the private sector in public hospital care through contracts to treat public patients and through public-private partnerships for the construction and operation of public hospitals. In 2001/02, 70% of the stock of hospital beds was in public hospitals with the other 30% found in private hospitals.

Large public hospitals in Australia provide advanced treatments including intensive care, major surgery, and organ transplants. Private hospitals traditionally provide less complex non-emergency care for private patients, though their clinical capacity has been expanded in recent years following the advent of more accessible technology and new procedures such as minimally invasive surgery. Private hospitals are primarily focused on providing an alternative to elective surgery in public hospitals, which are often subject to long waiting lists.

Public hospitals in Australia offer free-of-charge accommodation, medical, nursing, and other care to patients under the universal-access insurance scheme; this includes outpatient treatment. However, while patients can choose their public hospital they cannot choose their care provider as doctors and specialists for care in public hospitals will be nominated by the hospital.

Patients may also elect to be treated as a private patient at a public or private hospital, in which case the public subsidy is 75% of the schedule fee for medical services with no subsidy for hospital accommodation. Private insurance may be used to cover the unsubsidized portion of the medical fee

and the costs of hospital accommodation. Private patients, in addition to avoiding queuing, are able to choose their treating doctor and/or specialist.

Hospital funding in Australia is to a large extent done on a case-mix or diagnosis-related-group (DRG) basis, where hospitals are funded according to the type and mix of cases treated. A portion of hospital funding in Australia is based on global budgets. State governments also purchase hospital services from the private sector using detailed purchase-of-service contracts.

With respect to outpatient care, specialists in Australia are, like GPs, primarily independent practitioners paid on a fee-for-service basis where fees are set by the federal government but are not binding.

Doctors providing in-hospital care may fall under one of two principal categories. Some hospitals employ salaried physicians or medical officers who work full time in the hospital. Visiting medical officers may be engaged as independent contractors to the hospital and be paid either a fee-for-service per procedure or on a sessional basis for a certain amount of time per period. Visiting medical officers may be permitted to see private patients in the public hospital, as may salaried medical officers, under conditions previously agreed to. Conditions usually include fees payable to the hospital. Compensation for specialists in public hospitals is determined at the state level, unlike fee-for-service payments for ambulatory care, which are federal.

Privately funded options and alternatives

Australia's health care system relies to a large extent on a private, parallel health care sector. One of Australia's policy goals is to ensure the public system is complemented by a fair and affordable private sector that expands choice for Australians. Not surprisingly, the private sector in Australia plays a large role in both financing and delivery of health care, and especially elective surgery.

Importantly, the role of private insurance in funding physician services is limited to hospital care, and private insurers are not permitted to cover any gap payments for outpatient GP or specialist care. Private insurers are, however, permitted to cover ancillary services such as dental care, optical care, physiotherapy, and prescribed medicines not covered by the public scheme. In addition, they are permitted to negotiate contracts with providers (including hospitals and doctors) and develop preferred-provider networks.

The federal government of Australia relies on a series of policies designed to encourage citizens to purchase private insurance:

- ◆ 1% income-tax surcharge for high income earners (AUS\$80,000 individual or AUS\$160,000 family) who do not have private insurance (enacted 1997);
- ◆ 30% rebate on private health-insurance premiums (enacted 1999); increased to 35% for those aged 65 to 69 and to 40% for those 70 and over in 2005; income-based reductions in rebate introduced in 2012;

- ♦ lifetime community rating that imposes higher premiums on those who join a private health fund after age 30; the increase is 2% for each year of age after 30 until the individual has joined (enacted 2000).

Australia's private health care sector shares medical resources with the public, universal sector. Physicians in Australia are permitted to serve both public and private hospital patients (a policy known as dual practice). Hospitals in Australia are also permitted to serve patients on a public or private basis.

Lessons for Canada

The combination of superior access to health care and potentially superior health outcomes for substantially lower cost suggests there is much Canadians can learn from the Australian health care system. Importantly, emulating the Australian health care system would not require a marked departure from the current tax-funded, provincially managed, federally supported health care system in Canada. An Australian approach to health care in Canada would primarily require important changes to financial flows within provincial tax-funded systems, a greater reliance on competition and private ownership, and public support for private insurance cover.

The Australian health care system departs from the Canadian model in the following important ways:

- ♦ cost sharing for outpatient medical services;
- ♦ some private provision of hospital and surgical services;
- ♦ activity-based funding for hospital care;
- ♦ broad private, parallel health care sector with taxpayer support and dual practice.

Of these core policy differences, three can be implemented by Canada's provinces without violating the letter of the Canada Health Act (CHA): private hospital services and surgical facilities; activity-based funding; and public support for private insurance coverage with dual practice. Of course, some Australian policies would violate the letter of the CHA while others might be interpreted to do so by the federal government. This said, interference or compliance with the CHA neither validates nor invalidates policy reforms. It is critical to recognize that many of the health policies pursued throughout the developed world would violate the CHA and past federal interpretations

of the CHA. Yet these reforms have been shown to provide superior access to, and outcomes from, the health care process. Thus, the recommendations below set aside discussion of the CHA and focus only on the policy changes that would need to take place if Canada were to more closely emulate the Australian approach to health care.

Recommendation 1 *Activity-based funding models—possibly with competitive benchmarking employed to set fees—and private provision of hospital and surgical services.*

Recommendation 2 *Private health care and health care insurance for medically necessary care; financial incentives for the purchase of insurance (perhaps with government paying some portion of costs for privately funded care); dual practice for physicians to maximize the volume of services provided to patients in both public and private settings.*

Recommendation 3 *Cost-sharing regimes for universally accessible health care with reasonable annual limits and automated exemptions for low-income populations.*

Introduction

Every government of a developed nation provides some manner of health insurance for its populace. In some cases, comprehensive health care coverage is provided by a government-run insurance scheme on a universal basis; in others, it is provided by government only for specifically identified population groups while the bulk of the population obtains coverage through a private insurance system. In between these two extremes fall various types of mixed insurance systems, including those where comprehensive private insurance is mandatory and those where government provides both a tax-funded universal insurance product and tax-funded supports for private insurance premiums. Some systems even allow consumers to choose between comprehensive private and universal health insurance.

Each of these approaches to health insurance is built around a set of policies that determines how health services will be financed, who will be permitted to provide those health services, how physicians and hospitals will be paid, what responsibilities patients will have for payment of services, and whether or not patients can opt to finance all of their care privately. Ultimately, the types of policies that governments choose will affect the quantity and quality of care that is provided to their populations. Health policy choices must therefore be assessed on the basis of value for money—in other words, how good is the health system at making sick and injured people better, at making health services available, and at what economic cost?¹ One way of assessing health policy choices is to examine the choices of other developed nations and the performance that has resulted from those choices.

This publication is the first in a series that examines the way health services are funded and delivered in other nations. The nations to be studied all aim to achieve the noble goal of Canada's health care system: access to

1 This is a contested statement in the Canadian health policy debate. Some in the Canadian debate see outcomes as secondary to the justice of the structures and processes by which they are achieved. Still others consider “Canadian values” to be the primary determinant of health policy choices. This analysis seeks, however, to determine what health policies may be the most beneficial for those in need of care and those who are funding that care within a universal framework.

high-quality care regardless of the patient's ability to pay. How they go about achieving that goal, however, differs markedly from the Canadian approach. And, as suggested above, so do their performances in achieving that goal.

The first nation to be studied in this series is Australia. The Australian health care system has previously been identified as a system that provides some of the best outcomes on an aggregate basis when compared with other developed nations that maintain universal approaches to health care insurance (Esmail and Walker, 2008). A careful examination of the Australian health care system may provide useful insights and information to help inform the Canadian debate over the future of Medicare.

The next section examines the performances of the Canadian and Australian health care systems across a broad range of measures. A detailed examination of Australian health care policy is undertaken in the third section. A section considering what lessons can be taken from the Australian experience for Canadians interested in improving the state of Medicare follows.

Health system performance—Canada compared to Australia

The comparisons below look at the health care systems of both Canada and Australia as well as the average performance of health care systems in other developed nations² that also maintain universal approaches to health care insurance. Health care expenditures in Canada are considerably higher than in Australia or the average nation providing universal access (chart 1).³ In 2009, Canada's health expenditures (age-adjusted,⁴ as older people require more care) were 26% higher than in Australia and the average universal-access nation. In fact, in 2009 Canada's health expenditures, as an age-adjusted share of GDP, were the highest among universal-access developed nations.⁵

Access

Unfortunately, access to health care services in Canada does not reflect this level of expenditure.⁶ The Australian health care system seems to offer a better balance between cost and access to health care than does Canada's.

2 Defined here as member nations of the Organisation for Economic Co-operation and Development (OECD) in 2009.

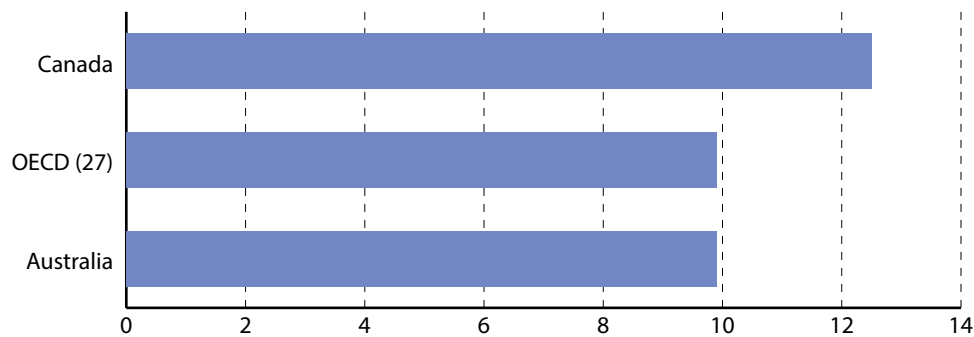
3 Unless otherwise noted, all data in this section are from OECD, 2011.

4 The age-adjustment methodology used here is from Esmail and Walker, 2008. Age-adjustment is based on the percent of population over age 65 in a given country relative to the average of OECD nations that maintain universal access. A complete description of the methodology is available in Esmail and Walker, 2008, pages 17–22, with a mathematical example shown in Box 2, page 21.

5 Note that Turkey was not included in age-adjusted averages due to a low proportion of population over age 65 that was not conducive to meaningful adjustment.

6 It should be noted of course that we cannot directly measure access, but rather are measuring here the quantity of medical goods and services available to individuals in these countries and the wait times for receiving medical care, to provide insight into the availability of medical services for individuals in these countries.

Chart 1: Total health expenditures, age-adjusted share (%) of GDP, 2009 or nearest year



Note: The number of universal-access member nations of the OECD in 2009 for whom data was available to create the average is shown in parentheses.

Sources: OECD, 2011; calculations by author.

Supply of physicians and nurses

With respect to physicians, Canada performs relatively poorly compared to both the universal-access average and Australia (chart 2). In 2009, Canada had 2.6 physicians per 1,000 population (age-adjusted). That compares to an OECD average of 3.3 and Australia's 3.4 per 1,000 population. Canada's ratio of nurses to population is more positive (chart 3). Both Canada (10.3) and Australia (11.6) have more nurses per 1,000 population (age-adjusted) than the average universal access nation (9.6).

MRI machines and CT scanners

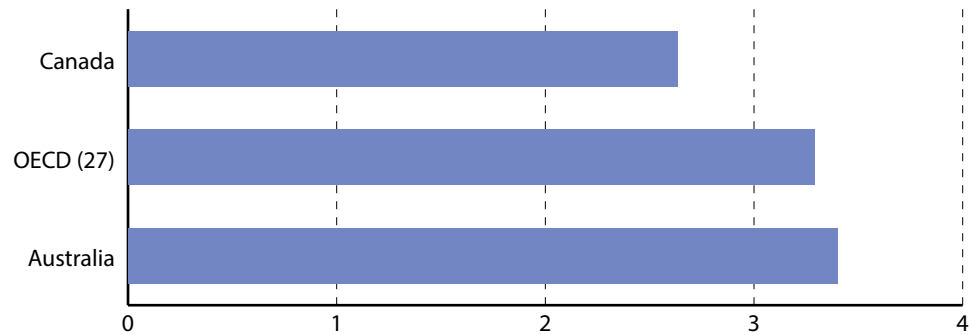
Canada (8.8) compares well with Australia (6.7) for MRI machines per million population (age-adjusted), but relatively poorly with the OECD average of 12.9 (chart 4). With respect to CT scanners per million population (age-adjusted), Canada (15.2) performs relatively poorly in comparison with both the OECD average (23.9) and Australia (43.8) (chart 5). It should be noted that CT scanners and MRI scanners can to some extent act as a substitute for one another, suggesting that Australia's performance in stocks of medical technologies is superior to Canada's in aggregate.

Hospital beds

The supply of hospital beds in both the Canadian and Australian health care systems is below the universal-access average in total (chart 6). In 2009, Canada had 3.6 hospital beds for every 1,000 population (age-adjusted), of which 2.0 were curative care beds.⁷ This is fewer than were available in

⁷ Curative care beds are beds specifically for accommodating patients for the purposes of providing non-mental-illness health care (excluding palliative care), including childbirth, treatment for health conditions, recovery from health conditions or surgery, and for diagnostic or therapeutic procedures.

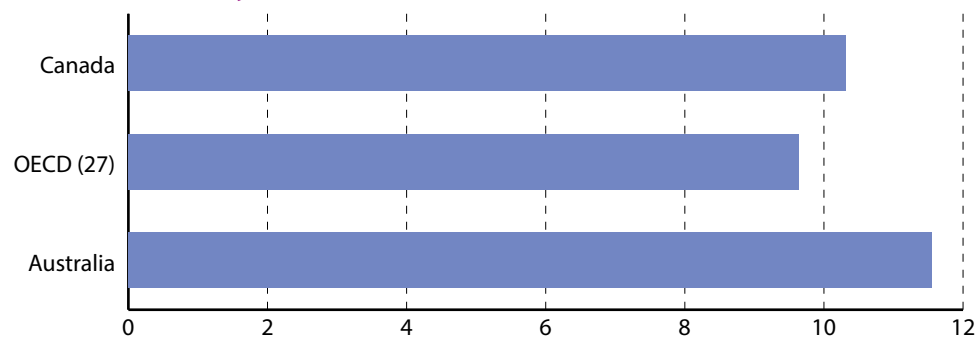
Chart 2: Physicians per 1,000 population, age-adjusted, 2009 or nearest year



Note: The number of universal-access member nations of the OECD in 2009 for whom data was available to create the average is shown in parentheses.

Sources: OECD, 2011; calculations by author.

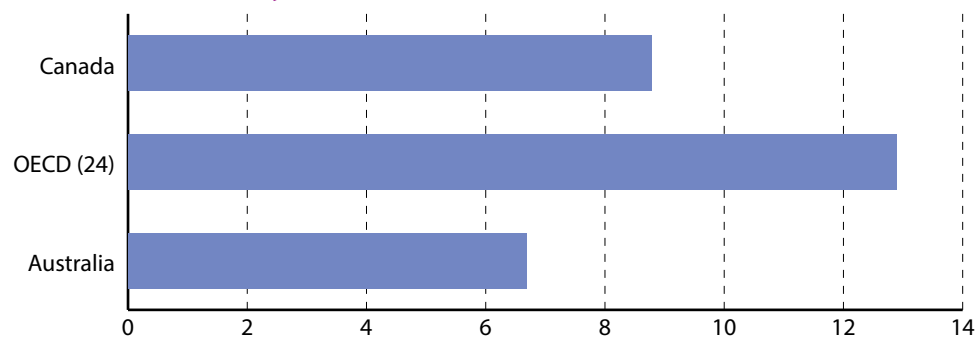
Chart 3: Nurses per 1,000 population, age-adjusted, 2009 or nearest year



Note: The number of universal-access member nations of the OECD in 2009 for whom data was available to create the average is shown in parentheses.

Sources: OECD, 2011; calculations by author.

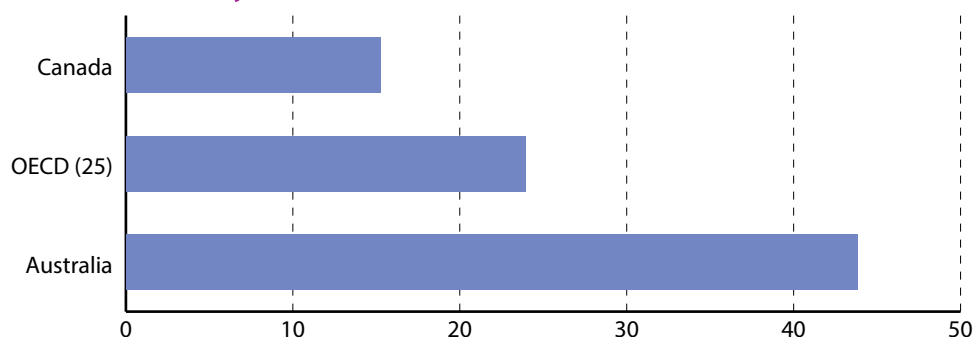
Chart 4: MRI machines per million population, age-adjusted, 2009 or nearest year



Note: The number of universal-access member nations of the OECD in 2009 for whom data was available to create the average is shown in parentheses.

Sources: OECD, 2011; calculations by author.

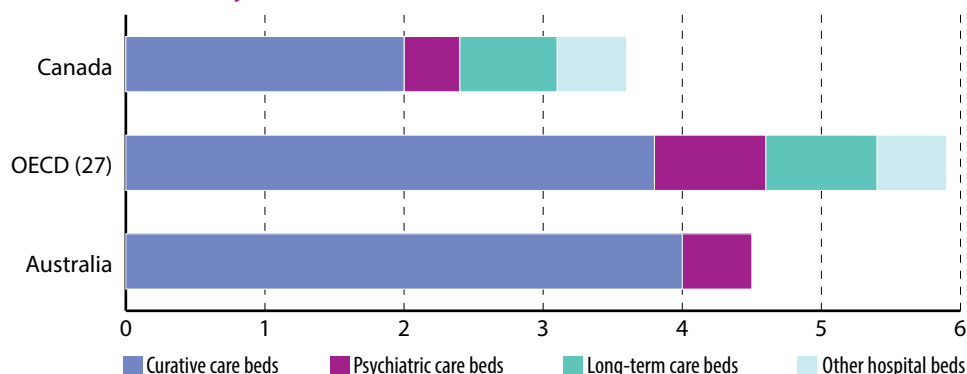
Chart 5: CT scanners per million population, age-adjusted, 2009 or nearest year



Note: The number of universal-access member nations of the OECD in 2009 for whom data was available to create the average is shown in parentheses.

Sources: OECD, 2011; calculations by author.

Chart 6: Hospital beds per 1,000 population, age-adjusted, 2009 or nearest year



Note: The number of universal-access member nations of the OECD in 2009 for whom data was available to create the average is shown in parentheses.

Sources: OECD, 2011; calculations by author.

Australia where 4.0 curative care beds of a total of 4.4 hospital beds were present per 1,000 population. The average nation offering universal-access health care maintained 5.6 total beds per 1,000 population (age-adjusted), of which 3.8 were curative care beds. Interestingly, Siciliani and Hurst (2003) find that ratios of acute care beds⁸ to population are negatively related to waiting times. This suggests that the Australian health care system may be better able to deliver health care in a timely fashion than Canada's. Wait times data from the Commonwealth Fund confirm this to be the case.

8 The OECD's definitions of "acute care" (OECD, 2013) and "curative care" (OECD, 2011) are similar, with the notable exception that the term "non-mental illness" appears in the definition given in OECD, 2011. However, the term "curative care" is used above following OECD, 2011 while term "acute care" is used here following Siciliani and Hurst, 2003.

Wait times

According to *The Commonwealth Fund 2010 International Health Policy Survey* (2010), Canadians were less likely than Australians to experience a reasonably short waiting time for access to emergency care, primary care, and specialist care. In all cases these differences were sizable: 20% of Canadians reported waiting less than 30 minutes in the emergency room compared to 33% of Australians. Further, only 45% of Canadians reported a same- or next-day appointment for primary care when ill compared to 65% of Australians. Canadians (41% and 35%, respectively) were also much less likely to report relatively short wait times to see specialists and receive elective surgery than were Australians (54% and 53%) (chart 7).

Looking at long waits, again according to the Commonwealth Fund's survey (2010), Canadians' access to health care was poorer than that experienced by Australians (chart 8): 31% of Canadians reported waiting four hours or more in emergency compared to 16% of Australians. The proportion of respondents reporting a wait of six days or more for primary care in Canada was 33%, compared to 14% in Australia, and 41% of Canadians reported waiting two months or more for a specialist appointment compared to 28% of Australians. Finally, one quarter of Canadian respondents reported waiting four months or more for elective surgery compared to 18% of Australians.

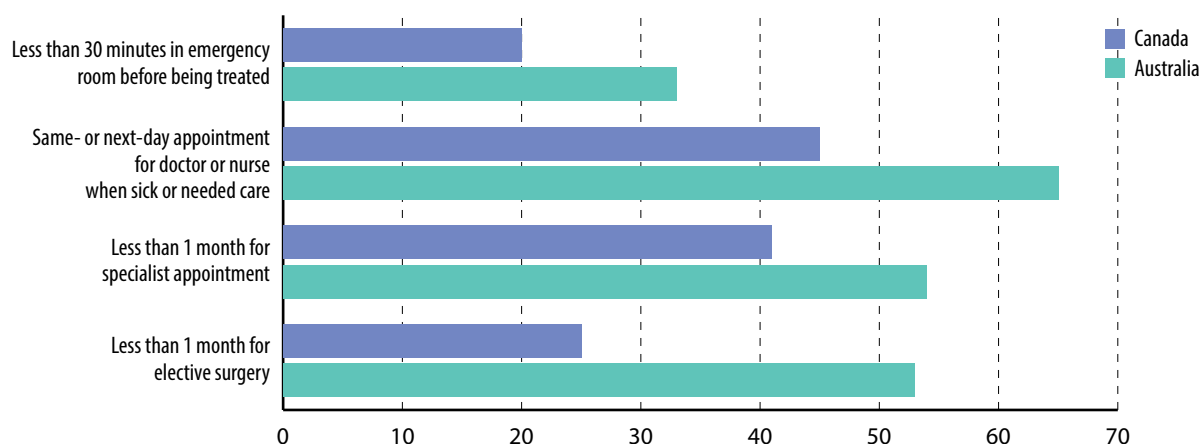
Summary

Overall, it seems that the Australian health care system is able to provide more timely access to health care services and a more abundant supply of physicians, nurses, and medical technologies for markedly lower expenditure as an age-adjusted share of GDP.

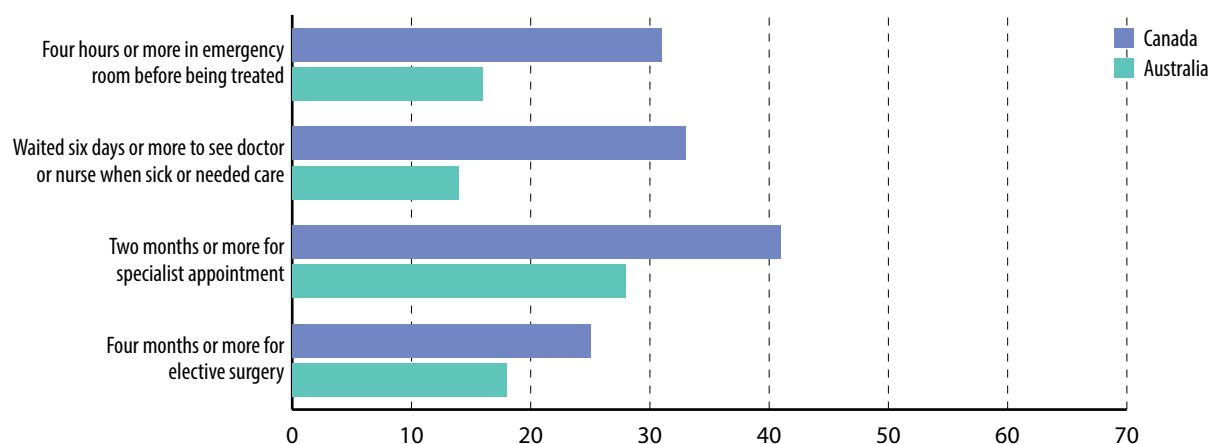
Outcomes

Looking at factors such as the ability of the health care system to provide healthy longevity,⁹ low levels of mortality from disease, and effective treatment for both chronic and terminal illnesses,¹⁰ it seems the Australian health care system broadly performs at a level similar, if not superior, to that in Canada.

-
- 9 Life expectancy, one of the more common measures of longevity, is not included in the measures below principally because factors outside of the health care system can be significant drivers of overall longevity. This exclusion does not affect the analysis however: Australia's life expectancy is 81.6 years compared to Canada's 80.7 (OECD, 2011).
 - 10 It is important to recognize that data on the quality of health care may capture more than only the effects of the health care system. Though a high-performing health care system may provide an essential component, health outcomes are ultimately determined by several processes of which the health care system is only one (Busse, 2002). With this in

Chart 7: Wait times, percentage seen or treated in relatively short time frame

Source: Commonwealth Fund, 2010.

Chart 8: Wait times, percentage seen or treated in relatively long time frame

Source: Commonwealth Fund, 2010.

Infant mortality

One of the most basic measures of mortality commonly used to compare health status is infant mortality rates. Although infant mortality rates can be affected by immigration from poor countries, unhealthy outlier populations, and other population characteristics (Seeman, 2003), they can also serve as indicators of a well-functioning health care system, in particular, of the health care system's capacity to prevent death at the youngest ages and the

mind, the indicators used for comparison here were selected for their ability to measure as directly as possible the performance of the health care system and for their ability to be affected as little as possible by factors external to the application of health care.

effectiveness of health care interventions during pregnancy and childbirth. For example, Or (2001) found that OECD countries with higher physician-to-population ratios (used as a proxy measure for health care resources) had lower infant mortality rates.

Australia's performance in preventing death at the youngest ages appears to be superior to Canada's (chart 9). In 2009, Australians experienced an infant mortality rate of 4.3 per 1,000 live births. The average universal-access nation experienced a rate of 4.0; Canada's rate that year was 5.1. It is important to recognize that this was not an outlier year—Canada has long lagged in comparisons of infant mortality rates as well as perinatal mortality rates (28 weeks gestation to first week of life) (Esmail and Walker, 2008).

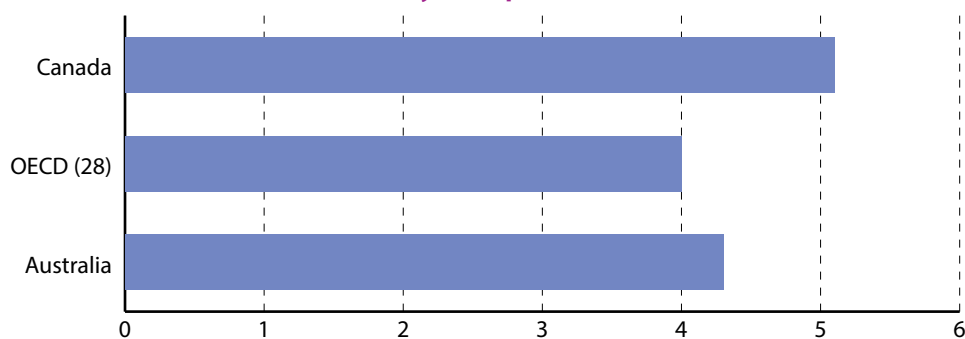
Preventable deaths

Another way of looking at mortality is to examine deaths that were likely preventable with the application of appropriate health care, or deaths that should not occur if effective health care is applied in a timely fashion. Gay et al. (2011) provide estimates of mortality amenable to health care that can be used to examine how the Canadian and Australian health care systems perform in savings lives that should, in the presence of timely and effective health care, not be lost.¹¹ This calculation relies on counting the number of deaths for specific conditions and diseases in specific age ranges for which there is evidence that timely, effective health care can prevent mortality. In this comparison (chart 10), both Canada (74 per 100,000 population) and Australia (68 per 100,000 population) outperform the average universal-access health care system. However, the Australian rate of mortality amenable to health care is roughly 8% lower than Canada's.

Rapidity of medical intervention

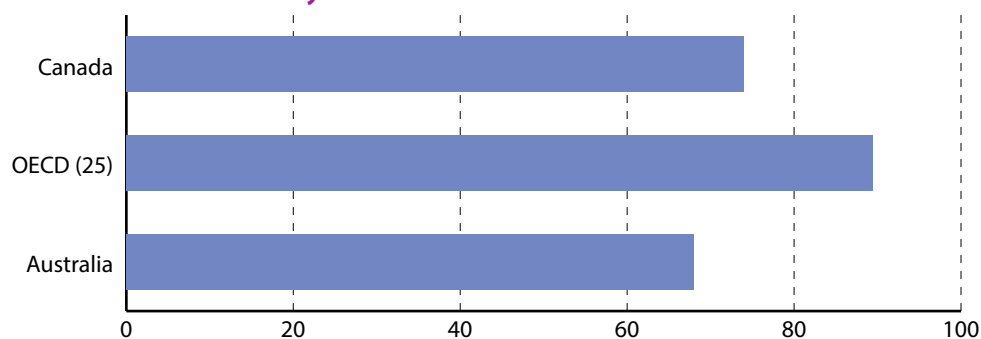
It is also possible to look at indicators that can provide insight into the ability of a health care system to provide effective medical interventions quickly. Chart 11 reports in-hospital case fatality rates within 30 days after admission for acute myocardial infarction (AMI or heart attack), and ischemic (obstruction) and haemorrhagic (rupture) stroke. For AMI, both Canada and Australia perform better than the universal-access average, with Australia having a lower rate of mortality than Canada. Canada lags the average for both measures of mortality from stroke, with Australia's performance being better than Canada's in haemorrhagic but not ischemic stroke.

¹¹ Gay et al. (2011) provide calculations of mortality amenable to health care using two widely used lists of causes amenable to health care: the list published by Tobias and Yeh, and the list published by Nolte and McKee. For consistency with comparisons published by Esmail and Walker, 2008, this series uses calculations based on Nolte and McKee's list of causes.

Chart 9: Infant mortality rate, per 1,000 live births, 2009 or nearest year

Note: The number of universal-access member nations of the OECD in 2009 for whom data was available to create the average is shown in parentheses.

Source: OECD, 2011.

Chart 10: Mortality amenable to health care, per 100,000 population, 2007 or latest year available

Note: The number of universal-access member nations of the OECD in 2009 for whom data was available to create the average is shown in parentheses.

Source: Gay et al., 2011.

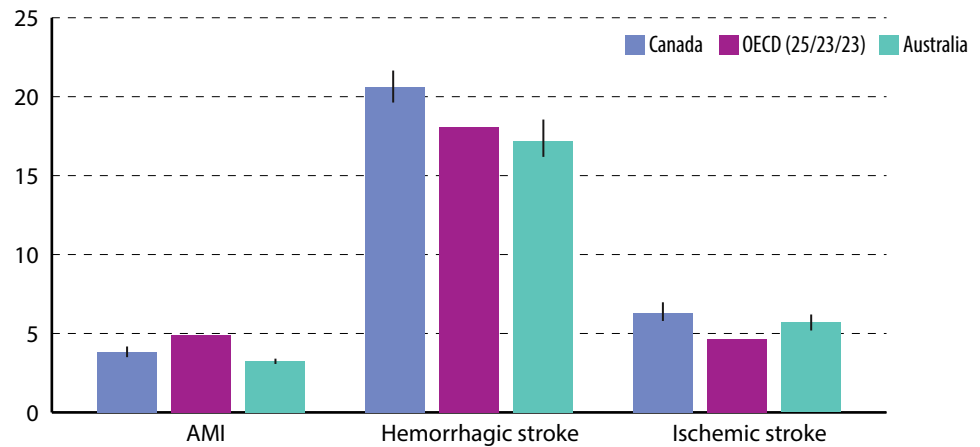
Chronic illness

Insight into the quality of primary care services in a health care system and, in particular, the ability of the primary care sector to manage (including coordination and care continuity) chronic illness successfully can be gleaned from measures such as hospital admission rates for chronic obstructive pulmonary disease (COPD), uncontrolled diabetes, and asthma. The rates shown in chart 12 suggest that Canada's primary care sector may be performing better than Australia's. Both Canada and Australia outperform the universal-access average in uncontrolled diabetes with Australia outperforming Canada. On the other hand, for both COPD and asthma, Canada outperforms the average of universal-access nations while Australia lags the average in both measures.

Patient safety

The final set of measures examined here in the comparison of health system performance relate to patient safety when undergoing treatment in the health

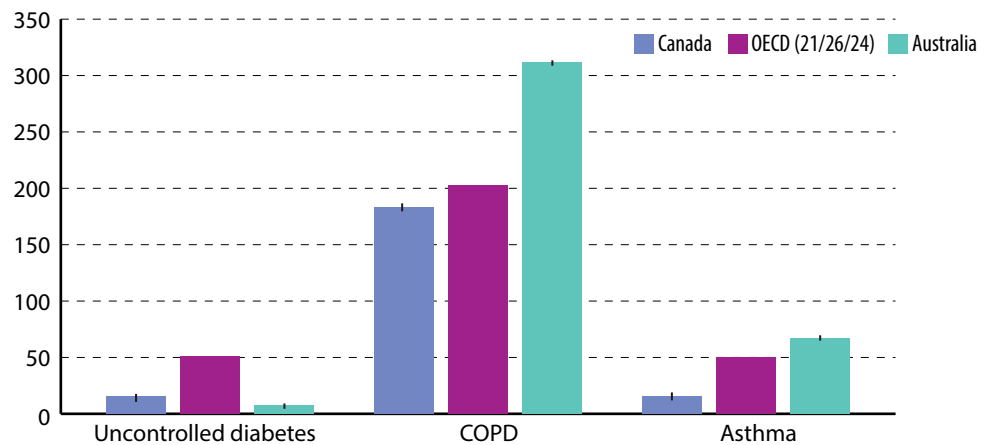
Chart 11: In-hospital case-fatality rates (age-, sex-standardized) within 30 days after admission for select conditions, 2009 or nearest year



Note: The number of universal-access member nations of the OECD in 2009 for whom data was available to create the average is shown in parentheses.

Source: OECD, 2011.

Chart 12: Hospital admission rates per 100,000 population aged 15 and over (age-, sex-adjusted) for select conditions, 2009 or nearest year

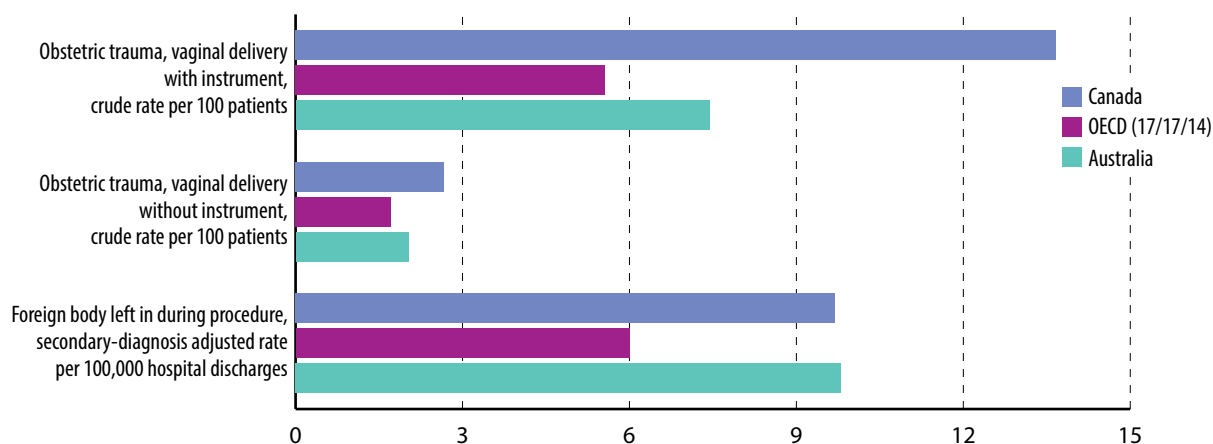


Notes: The number of universal-access member nations of the OECD in 2009 for whom data was available to create the average is shown in parentheses.

Sources: OECD, 2011; calculations by author.

care system. As shown in charts 13 and 14, Australia outperforms Canada but not the average in obstetric trauma with and without instrument, and accidental puncture or laceration. On the other hand, Canada outperforms Australia but not the average in foreign body left during procedure, and both Australia and the average in postoperative pulmonary embolism or deep-vein thrombosis and postoperative sepsis.

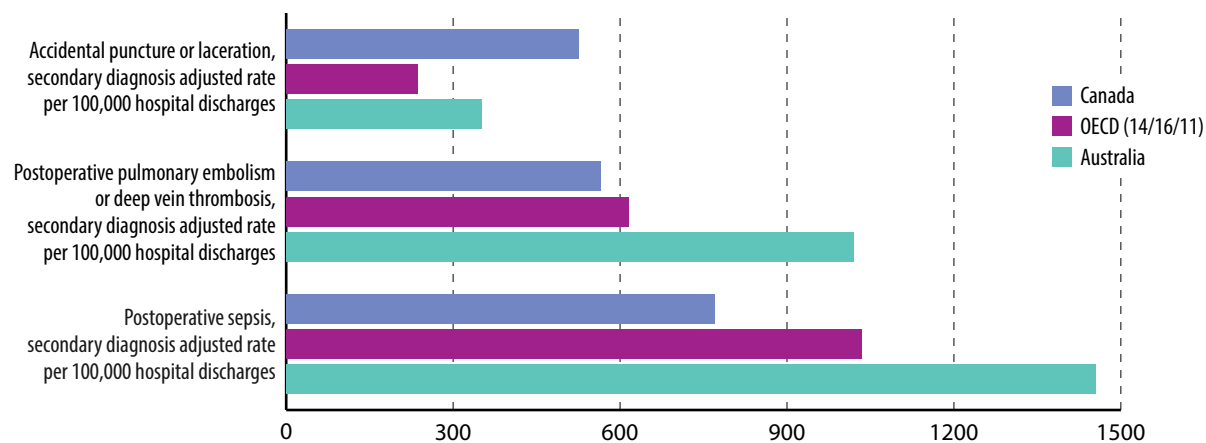
Chart 13: Patient safety (obstetric trauma, foreign body), Canada, OECD, and Australia, 2009 or nearest year



Note: The number of universal-access member nations of the OECD in 2009 for whom data was available to create the average is shown in parentheses.

Source: OECD, 2011.

Chart 14: Patient safety (accidental puncture/laceration, embolism/thrombosis, sepsis), Canada, OECD, and Australia, 2009 or nearest year



Note: The number of universal-access member nations of the OECD in 2009 for whom data was available to create the average is shown in parentheses.

Source: OECD, 2011.

Summary

The Canadian health care system outperforms the Australian health care system in:

- ◆ ratio of MRI machines to population,
- ◆ two of three measures of primary care performance, and
- ◆ three of six measures of patient safety.

Conversely, the Australian health care system outperforms the Canadian health care system in:

- ◆ ratio of physicians to population,
- ◆ ratio of nurses to population,
- ◆ ratio of CT scanners to population (and possibly access to MRI and CT combined),
- ◆ ratio of hospital beds to population
- ◆ wait times,
- ◆ infant mortality,
- ◆ mortality amenable to health care,
- ◆ two of three measures of in-hospital mortality,
- ◆ one of three measures of primary care performance, and
- ◆ three of six measures of patient safety.

Importantly, Australia's superior performance across measures of access and outcomes from the health care process comes at markedly reduced cost compared to Canada. The superior value for money provided by the Australian health care model suggests it is well worth examining if lessons are to be learned for effective, positive reform of the Canadian health care system.

Australia's health policy framework

General overview

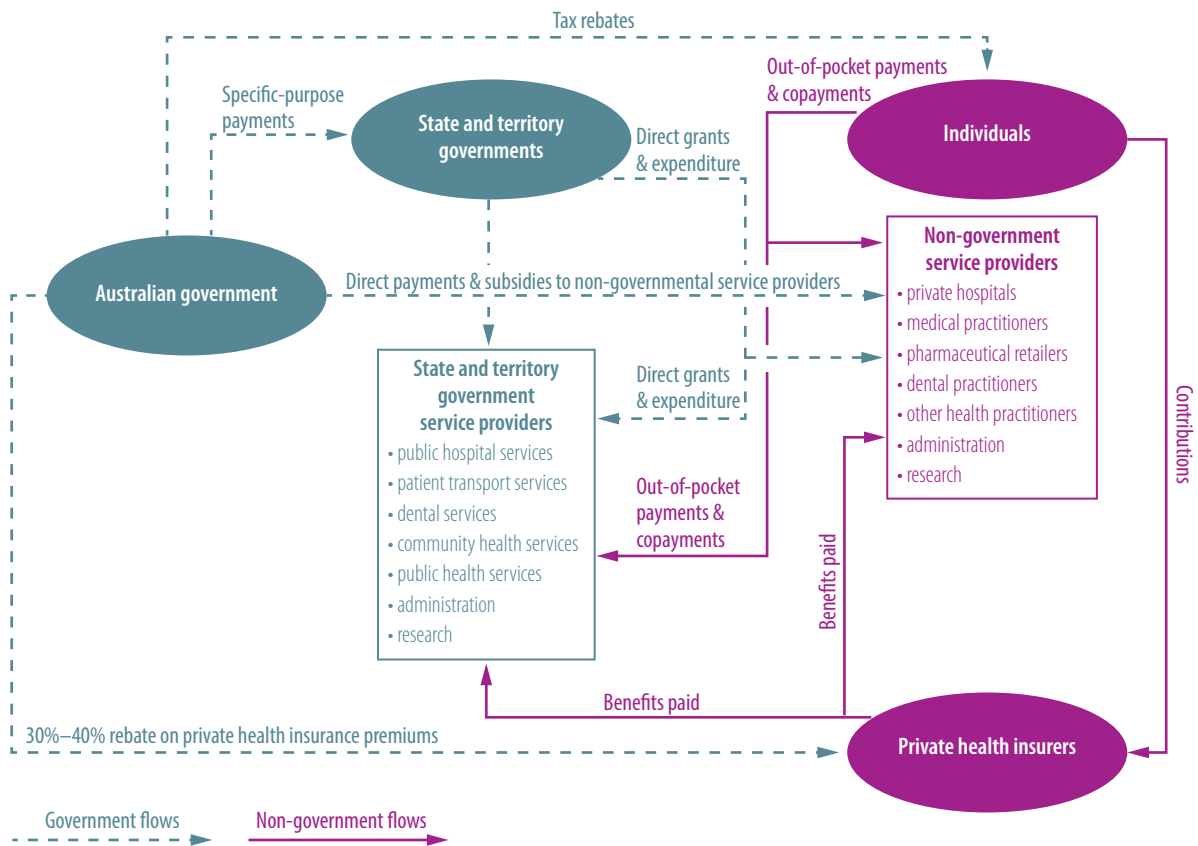
Australia's federal organization of health care is notably different from that in Canada (figure 1).¹¹ In Australia, the federal government is responsible for funding ambulatory or outpatient care through Medicare Australia, while state governments regulate health care providers and fund hospital care for the population. State expenditures on health care are, as in Canada, supported by federal transfers, both general and those specific to health.

Australia's universal-access health care system, as it exists today, was created in 1984 under the Health Legislation Amendment Act of 1983. This legislation followed several pieces of legislation through the 1940s and 1950s implementing federal subsidies for pharmaceuticals and medical services. Acute-care hospital services, however, have remained the responsibility of state governments, who are tasked with the responsibility of ensuring free-of-charge hospital care for all public patients. Interestingly, the federal role in health care in Australia required a constitutional amendment in the 1940s that allowed the federal government to make laws affecting health and provide health insurance to the population.

In an important departure from Canada's approach to health care, Australia's health care system relies to a large extent on a private, parallel health care sector. One of Australia's policy goals is to ensure the public system is complemented by a fair and affordable private sector that expands choice for Australians. The importance of the private sector to Australia's overarching policy goals is reflected in a series of policies intended to encourage uptake of private health insurance among the population.

Australia's health care system is, like others through the developed world, in a constant state of reform and reorganization as federal and state governments seek to improve equity, quality, safety, and access while managing

11 The description of the Australian health care system in this section is based on information found in: European Observatory on Health Systems and Policies, 2006; Harper, 2003; Healy et al., 2006; Healy, 2012; Paris et al., 2010.

Figure 1: The structure of the Australian health care system and its flow of funds

Source: Based on Australian Institute of Health and Welfare material, Australian Institute of Health and Welfare, 2012: fig. 1.1.

costs. Since 1984, other than significant changes to private health insurance policy, Australia has not seen a major reform of core health policies. However, incremental changes, which are substantial once considered cumulatively, have been taking place in recent years. Important recent reforms in Australia have included reviews and restructurings of state departments of health, pay for performance in primary care, a greater focus on altering funding incentives in primary care (discussed in more detail below), privatization of public facilities, increasing reliance on private providers (for example through outsourcing non-core services), and promoting private-sector competition in areas that previously operated as public-sector monopolies (for example, hearing services).¹²

¹² Many Australian health departments also experimented with purchaser-provider splits. However, these have largely reverted to more traditional public sector funding due to an inability to adequately specify contracts and difficulties in purchaser-provider relationships (Healy et al., 2006).

Fiscal and financing arrangements

Australia's health care system is, like Canada's, funded primarily through general taxation. However, as noted above and discussed further below, the mix of public and private in Australian health care is markedly different from that in Canada. Of total health expenditures in Australia, 68% is from government sources, 7% from private health insurance, 20% from individuals (a minority of which is user charges for physician care and pharmaceutical benefits), and 5% from other sources, including private workers' compensation insurance and third-party car insurance (Healy et al., 2006).¹³

Funding for health care comes primarily from general tax revenues. In addition to a broad mix of taxes, Australia's federal government collects a 1.5% Medicare levy from those above a certain income threshold and imposes an additional 1% surcharge for high-income earners who choose to not purchase private insurance cover for hospital treatment. States, in addition to levying taxes on property and payrolls, receive two types of funding from the federal government: general support and health-specific funding. General support comes in part through a 100% sharing of federal goods and services tax (GST)¹⁴ revenue. Health-specific funding comes in part through the Australian Health Care Agreements, which are negotiated every five years and provide a block grant to the states for public hospitals. The Australian Health Care Agreements include some requirements for state governments including the requirement of no cost sharing for public hospital treatment and (in the current agreement) publishing information on hospital performance including wait times. It is estimated that in 2002/03, the federal government provided 49.2% of funding for public hospitals with states providing 42.9% of funding and the balance of 7.9% made up by non-government sources (Healy et al., 2006).

Australia's universal-access health care system, comprising the federally funded Medical Benefits Scheme and Pharmaceutical Benefits Scheme, and shared funding of the Hospital Benefits Scheme offers broad coverage for permanent residents (including New Zealand citizens and, with some limitations, coverage for visitors from countries with a reciprocal health care agreement with Australia). Coverage includes out-of-hospital consultations with physician of choice (GP and specialist), eye tests performed by optometrists, some surgical procedures performed by approved dentists,

13 Canada's total health expenditures break down as approximately 70% public and 30% private. Public expenditures cover 91% of all spending on hospitals and 99% of all spending on physicians, while covering less than half (46%) of prescribed drug expenditures. On the other hand, nearly half (46%) of private expenditures on health care in Canada are for drugs (both prescribed and non-prescribed) and dental care (CIHI, 2012).

14 Australia's federal Goods and Services Tax (GST) rate is 10%.

specified dental and allied health services for those who are chronically ill, prescription drugs, and hospital care. Coverage is not provided for cosmetic surgery, private dental services, allied health services (generally speaking, health professions other than dentistry, nursing, medicine, and pharmacy), or complementary medicine, though some of these services may be covered by private health insurance.

Australia's health care system relies on cost sharing to encourage informed decision making from demanders of health care. However, Australia's approach to cost sharing is different from that pursued in most health care systems and encompasses greater pricing freedom for medical practitioners than is commonly found in universal-access health care systems. The federal government in Australia sets the benefit rates that will be paid for medical services and commits itself to paying 100% of the scheduled fee for general practitioner services, 85% of the scheduled fee for other out-of-hospital services including specialist consultations, and 75% of the scheduled fee for in-hospital medical services for private patients in public or private hospitals.¹⁵ An annual limit for "gap" payments applies, above which 100% of the scheduled fee will be reimbursed for the remainder of the year. There is also an annual limit for total out-of-pocket costs, beyond which 80% of out-of-pocket costs are covered by Medicare. Cost sharing for pharmaceutical benefits includes a co-payment of AUS\$35.40 for each prescription (plus any upcharge if the medicine is only partially covered) while pensioners and holders of other entitlement cards pay a concessional rate of AUS\$5.80 (Healy, 2012; Healy et al., 2006). Annual limits apply to both, after which general consumers pay the concessional rate and concessional rate payers face no further co-payments. Figure 1 provides an overview of financial flows in Australia's health care system.

Importantly, physicians are not bound by the fee schedule and are free to charge prices they set for their services. In instances where general practitioners are willing to accept 100% of the scheduled fee and specialists are willing to accept 85% of the scheduled fee as full payment for services, they earn the ability to "bulk bill" government for their services directly.¹⁶ Otherwise, patients are to be charged the cost of the service and must apply to Medicare for reimbursement of either 100% or 85% of the scheduled fee as appropriate. In 2005, some 74.9% of GP services were bulk billed, while bulk billing is much less common for specialist care (Healy et al., 2006).

15 The Department of Veterans' Affairs subsidizes GP and specialist services at a higher rate than Medicare for eligible war veterans and war widows.

16 Additional payment is provided if practitioners bulk bill concession-card holders (low-income, older people), children under 16 years of age, and residents of rural and remote areas.

Delivery of primary care

General practitioners in Australia, like those in Canada, are mostly self-employed and run their practices as small businesses. In Australia, the most common type (some 2/3) is the solo practice but only about one third of GPs work in such practices as most are employed in private group or multiprovider practices. There has also been a general trend towards corporatization of primary care practices with companies taking on administration under contract to physicians, with an estimated 7.8% of practitioners working in such practices in 2002 (Healy et al., 2006). In some cases, this has also involved co-locating GPs with pathologists and other specialists in group practices.¹⁷ Market-based cooperatives and collective offices (where GPs co-locate but retain their own practice) are also being introduced in Australia.

Nurses in Australia also provide some primary health care in general practitioner clinics as well as through public community health centres, home nursing services, public mother-and-baby health clinics, and other venues. Nurse consultations are not covered by Medicare except for limited treatment by nurses working in general practice. However, the federal government does provide subsidies to GPs who employ nurses.

GPs in Australia have a formal gate-keeping role, referring patients to specialists, hospital out-patient clinics, and other health services if they qualify for coverage by public insurance (for example, allied health services for the chronically ill). This is enforced through financial incentives for providers where the scheduled fee is only reimbursed for referred consultations while referrals are required if hospital outpatient departments wish to bulk bill. However, patients do have free choice of physician for out-of-hospital care. This means Australians are able to choose their GP and are able to discuss to which out-of-hospital provider of specialist care their referral will be sent.

A small number of general practitioners in Australia are salaried employees of various levels of government. For the most part, primary care providers in Australia are paid on a fee-for-service basis, with fees set by the federal government.¹⁸ As noted above, physicians are not limited to being compensated only the scheduled benefit and are free to set their own prices, but gain the privilege of billing government directly if they are willing to accept 100% of the scheduled fee as full payment for care. In addition to the fee-for-service component, primary care practices may also receive payment

17 According to Healy (2012), multidisciplinary teams are the norm in community health centers but not in private general practices.

18 Physician fees in Australia are defined in the Medicare Benefits Schedule, and are set unilaterally by the commonwealth government. Paris et al. (2010) define this structure as a fee set unilaterally at the central level where providers can always exceed fees paid and statutory copayments.

under the Practice Incentives Program, which offers financial incentives for improving quality and accountability including, for example, adopting information management systems, employing practice nurses, providing after-hours service, training medical students, and participating in incentive programs such as screening and immunization.¹⁹ In addition, practice nurses are allocated an increasing number of items in the benefits schedule, while GPs can claim for specified services provided by practice nurses under GP direction.

The federal government also funds Divisions of General Practice that are intended to improve quality of care in part by encouraging updating of knowledge and skills, and increasing cooperation. Divisions are required to identify the needs of the local population and agree on appropriate outcomes for funding. Divisions offer a network for professional support, connect practitioners with other health professionals and consumers, provide continuing medical education, fund or administer projects promoting health, and coordinate shared-care agreements. Approximately 94% of GPs belong to a local Division (Healy et al., 2006). Medicare locals, of which 61 were formed as of 2012, are another federally funded initiative including GPs and other providers that are intended to coordinate primary care delivery, deal with service gaps, and improve access to after-hours care, among other goals (Healy, 2012).

Like Canada, Australia is experiencing a shortage of physicians, in spite of the fact that Australia has 29% more physicians (GPs and specialists) per 1,000 population (age-adjusted) than Canada (OECD, 2011; calculations by author). Also like Canada, Australia is facing difficulties with physician services in rural and outlying areas and for aboriginal populations. Initiatives to deal with this problem in Australia have included an increase in taxpayer-subsidized training for physicians, financial incentives for providers, and rural training initiatives. Non-governmental responses have included privately funded physician training (where students are trained in the same schools but do not receive taxpayer-funded subsidies) and the opening of a new private medical school.

Delivery of specialized, hospital, and surgical care

The delivery of hospital care in Australia is undertaken by both public and private hospitals. While the sector remains dominated by public providers, recent reforms have led to an increased role for the private sector in public hospital care, including through contracts to treat public patients, and

¹⁹ In 2002/03, nearly 80% of GP services were provided in a practice that participated in the Practice Incentives Program (Healy et al., 2006).

through public-private partnerships for the construction and operation of public hospitals. In 2001/02, 70% of the stock of hospital beds was in public hospitals with the other 30% found in private hospitals (Healy et al., 2006).²⁰

Large public hospitals in Australia provide advanced treatments including intensive care, major surgery, and organ transplants. Further, large tertiary-care hospitals and those associated with university medical schools have a teaching function. For the most part, Australian hospitals can be classified as acute-care facilities, and most new hospitals are general hospitals while most specialist hospitals have merged with general hospitals. Notable exceptions to the predominance of general hospitals are psychiatric hospitals, cancer care hospitals, and children's hospitals.

Private hospitals traditionally provide less complex non-emergency care for private patients, though their clinical capacity has been expanded in recent years following the advent of more accessible technology and new procedures such as minimally invasive surgery. They are primarily focused on providing an alternative to elective surgery in public hospitals, which are often subject to long waiting lists. While the stock of public hospital beds in Australia declined over the 1990s, the stock of private beds increased slightly. More than two thirds of private hospital beds in Australia are owned by large for-profit chains and the Catholic Church (Healy et al., 2006).

Public hospitals in Australia offer cost-sharing free accommodation, medical, nursing, and other care to patients under the universal-access insurance scheme; this includes outpatient treatment. However, while patients can choose their public hospital they cannot choose their care provider. Doctors and specialists for public hospital care will be nominated by the hospital. Choice of hospital in Australia is supported through governmental reporting initiatives that report on clinical outcomes, the use of appropriate processes, patient satisfaction, and patient experiences (Paris et al., 2010).

Patients may also elect to be treated as a private patient at a public or private hospital, in which case the public subsidy is 75% of the schedule fee for medical services, with no subsidy for hospital accommodation. Private insurance (discussed below) may be used to cover the unsubsidized portion of the medical fee and the costs of hospital accommodation. Private patients, in addition to avoiding queues, are able to choose their treating doctor or specialist.

With respect to ambulatory care, specialists in Australia are, like GPs, primarily independent practitioners paid on a fee-for-service basis where fees are set by the federal government but are not binding. Most work in private group practices. Ambulatory care may be provided in private consulting rooms,

20 Paris et al., (2010) report, from their 2008/2009 health system characteristics survey, that 69.6% of acute-care beds were in publicly owned hospitals, 14.4% in not-for-profit, privately owned hospitals, and 16.0% in for-profit, privately owned hospitals.

or in outpatient departments of public or private hospitals. Senior specialists may also maintain academic appointments in addition to their private practice.

Doctors providing in-hospital care may fall under one of two principal categories. Some hospitals maintain as employees salaried physicians or medical officers who work full time in the hospital. Visiting medical officers may be engaged as independent contractors to the hospital and be paid either a fee for service per procedure or paid on a sessional basis for a certain amount of time per period. Visiting medical officers may be permitted to see private patients in the public hospital, as may salaried medical officers, under conditions previously agreed to. These usually include fees payable to the hospital. Compensation for specialists in public hospitals is determined at the state level, unlike ambulatory care fee-for-services payments, which are federal.

Hospital funding in Australia is to a large extent done on a case-mix or diagnosis-related group (DRG) basis, where hospitals are funded according to the type and mix of cases treated. While much of hospital care is funded in this activity-based manner (hospitals are paid on the basis of activity), more than half of hospital funding in Australia is based on global budgets and/or on a population-basis (an annual budget for the provision of hospital care). State governments also purchase hospital services from the private sector using detailed purchase-of-service contracts (Healy et al., 2006; Paris et al., 2010).

Privately funded options and alternatives

Private health insurance in Australia plays a large role in both financing and delivery of health care, most specifically elective surgery. More than 50% of surgical activity for common surgical procedures²¹ in 2000/01 was privately funded, with services provided mainly in privately-owned hospitals (Hurst and Siciliani, 2003b). More recent data show that private hospitals treat 40% of admitted hospital patients, representing 30% of all days of hospitalization (Paris et al., 2010).

The federal government provides a number of financial supports for health care delivered on a private basis in public or private hospitals, and for purchase of private insurance coverage. One of Australia's policy goals is to ensure the public system is complemented by a fair and affordable private sector that expands choice for Australians. Support for private health insurance and the private sector is intended to reduce the burden of health care on the public purse.

Patients choosing to be treated as private patients in public or private hospitals receive a subsidy from Medicare equal to 75% of the scheduled

21 This included cataract surgery, PTCA, coronary bypass, cholecystectomy, inguinal and femoral hernia, prostatectomy, vaginal hysterectomy, knee arthroscopy, hip replacement, knee replacement, and varicose veins (Hurst and Siciliani, 2003b).

benefit for medical services delivered during their hospital stay. Private insurance can be used to top up the unfunded portion of medical services and to pay for hospital accommodation costs. Importantly, the role of private insurance in funding physician services is limited to hospital care,²² and private insurers are not permitted to cover any gap payments for ambulatory GP or specialist care. Private insurers are, however, permitted to cover ancillary services such as dental care, optical care, physiotherapy, and prescribed medicines not covered by the public scheme. In addition, private insurers are permitted to individually negotiate contracts with providers (including hospitals and doctors) and develop preferred provider networks.

In 2004, there were 41 registered health-benefits organizations in Australia. The market is dominated by six funds that have a combined share of 76% of the marketplace by premium income (Healy et al., 2006). The two largest private insurance funds are Medibank Private (a government business enterprise) and Medical Benefits Fund of Australia. The private insurance industry is regulated by the (federal) Private Health Insurance Administration Council, and private insurers must be registered with government and are subject to a number of strict regulations.

Private health insurers must charge community-rated premiums but are permitted to index premiums by age.²³ Individuals in Australia not only have a choice of private insurer but have regulated portability in the private insurance sector. Private health funds are not permitted to impose benefit limitation periods on those who transfer from another fund (this does not apply to newly insured individuals). Thus, individuals, if dissatisfied with their current insurer, are able to change insurers without coverage penalties.

The federal government of Australia relies on a series of policies designed to encourage citizens to purchase private insurance. These policies were implemented in response to a decline in private insurance coverage, which led to increasing premiums as only those who were older or more likely to need care remained in the insurance pool.²⁴ Combined, these poli-

22 Since 2007, private insurers have been permitted to cover out-of-hospital services that prevent or substitute for in-hospital care. Little development of these services has taken place (Healy, 2012).

23 The ability to index by age was introduced following reforms in 1999, noted below.

24 Importantly, community rating, intended to subsidize care of the sick (and older) with premiums from the healthy (and younger), may have played an important role in decreasing the rate of uptake of private health insurance in Australia. The young and healthy opted out of private health insurance, instead choosing to use the public system or to self-insure (pay for private services directly without the assistance of insurance), leaving a deteriorating health (and older age) profile of the privately insured (Harper, 2003). Healy et al. (2006) note that allowing age-related indexation of community-rated premiums is regarded to be the crucial change that led to higher uptake of private health insurance. They further argue that the other forms of inducement may be unnecessary or at least unnecessarily costly.

cies saw the proportion of Australians who were privately insured rise from approximately 30% in 1998 to over 45% in 2000, though there was a slight decline to 43% by 2004 (Harper, 2003; Healy et al., 2006). The following key policies encourage the use of private insurance:

- ◆ 1% income-tax surcharge for high income earners (AUS\$80,000 individual or AUS\$160,000 family) who do not have private insurance (enacted 1997);
- ◆ 30% rebate on private health-insurance premiums (enacted 1999); increased to 35% for those aged 65 to 69 and to 40% for those 70 and over in 2005; income-based reductions in rebate introduced in 2012;
- ◆ lifetime community rating that imposes higher premiums on those who join a private health fund after age 30; the increase is 2% for each year of age after 30 until the individual has joined (enacted 2000).

Australia's private health-care sector shares medical resources with the public, universal sector. Physicians in Australia are permitted to serve both public and private hospital patients (a policy known as dual practice). Hospitals in Australia are also permitted to serve patients on a public or private basis.

Lessons for Canada

The combination of superior access to health care and potentially superior health outcomes for substantially lower cost suggests there is much Canadians can learn from the Australian health care system. Importantly, emulating the Australian health care system would not require a marked departure from the current tax-funded, provincially managed, federally supported health care system in Canada. An Australian approach to health care in Canada would primarily require important changes to financial flows within provincial tax-funded systems, a greater reliance on competition and private ownership, and public support for private insurance cover.

The Australian health care system departs from the Canadian model in the following important ways:²⁵

- ◆ cost sharing for outpatient medical services;
- ◆ some private provision of hospital and surgical services;
- ◆ activity-based funding for hospital care;²⁶
- ◆ broad private, parallel health care sector with support from taxpayers and dual practice.

Of these core policy differences, three can be implemented by Canada's provinces without violating the letter of the Canada Health Act (CHA): private acute-care services and surgical facilities; activity-based funding; and public support for private insurance coverage with dual practice. As noted by

25 In addition to these differences in core health policy are differences in the prevalence of group and multiprovider practices and supplementary funding approaches (in addition to fee-for-service funding) for primary care. As these policies are slowly being adopted in Canada, though the details vary considerably both within Canada and between Canada and Australia, I shall discuss them in detail in another publication.

26 Payment based on services provided, as opposed to budgetary models that pre-fund patient care in bulk.

Clemens and Esmail (2012), however, a federal interpretation of the term “reasonable access” in section 12 of the CHA could be used to disallow a broad range of policies at the sole discretion of the federal government including, in particular, private acute-care providers and dual practice for providers. Given that these reforms are emulating a more successful approach to universal-access health care, however, and thus cannot be reasonably opposed in a factual manner, this restrictive feature of the Act is not considered here.²⁷

The first policy difference, cost sharing, does clearly violate the CHA and would result in required reductions in federal transfers for health and social services under sections 19 and 20 of the CHA.²⁸ Support from public funds for privately funded health care (namely sharing costs between the public and private sectors), but not support for purchase of private health insurance, violates the CHA in a similar manner. These policy choices either require a federal change to the CHA, which may be undertaken unilaterally by the federal government (Clemens and Esmail, 2012; Boychuk, 2008), or require a province to accept dollar-for-dollar reductions in federal cash transfers to implement this policy. Setting aside concerns about the politics of doing so, this latter option may not necessarily be against the province’s financial interest, depending on the savings that may accrue from such a policy decision (Esmail, 2006).

This said, interference or compliance with the CHA neither validates nor invalidates these policies. It is critical to recognize that many of the health policy constructs pursued throughout the developed world would violate the CHA and past federal interpretations of the CHA. Yet these constructs have been shown to provide superior access to, and outcomes from, the health care (see, for example, Esmail and Walker, 2008). The Canada Health Act has clearly not produced superior access and outcomes for Canadians. Thus, the discussion of reforms below sets aside compliance with the CHA and focuses only on the policy changes that would need to take place if Canada were to emulate more closely the Australian approach to health care.

27 Of course, the argument against these policies by a federal government could be purely ideological in nature, as so many discussions of allowable health policy have been in the past. As it is difficult to predict the outcome of such ideological opposition, and in the interests of objectivity, such an argument is not entertained here.

28 Clemens and Esmail (2012) also note that the CHA, partly through limitation on cost sharing, effectively discourages the inclusion of pharmaceuticals under the taxpayer-funded universal health insurance scheme. Clemens and Esmail argue that “free” physician and hospital care required by the CHA encourages patients to forego pharmaceutical care unless the province sets deductibles or co-payments to zero and bears the full cost. This either harms the health of patients and decreases cost-effectiveness, or forces provincial policy decisions regarding pharmaceutical coverage. Clemens and Esmail further note that this distortion under the CHA relates to many areas of health care in addition to pharmaceuticals, including home care and long-term care.

Private provision of services and activity-based funding

Principal policy differences two and three are very much intertwined and relate strongly to the efficiency of hospital and surgical care. Importantly, the economic literature generally finds that private businesses (both for- and not-for-profit) operate more efficiently and at higher quality with a greater focus on consumers than their public counterparts. Reviews of the literature focused on hospital care are generally supportive of the conclusion for businesses in general (Esmail and Walker, 2008). Indeed, a recent survey of the literature on hospitals and surgical clinics finds that competition, and delivery via a blend of public and private (both for- and not-for-profit) providers will likely have a positive impact on some measures of health care, little impact on others, and is unlikely to have a negative impact. The survey concludes that “a carefully crafted policy that encourages competition among non-profit, for-profit, and public providers can result in a health care system that is fiscally sustainable, ensures access to quality health care, and results in better health outcomes” (Ruseski, 2009: 42). Further, reviews of hospital funding mechanisms have generally found that activity-based funding is markedly superior to budget-based funding in terms of efficiency and output (Esmail, 2007). Neither result is surprising when one considers the incentives associated with the various approaches to ownership and financing.

Janos Kornai (1992) identified budget constraints as one of the major and unchangeable differences between private-sector businesses and government. Government budget constraints are “soft”, since it is effectively impossible for government to be de-capitalized. Private-sector businesses, on the other hand, face “hard” budget constraints: if they incur sustained losses, or even a few large losses, the decline of capital can push them into bankruptcy. Kornai argued that this central difference between the two types of entities can result in extraordinary differences in operations. Private-sector businesses must provide consumers with the goods and services they demand in a timely manner and at affordable prices that are consistent with their quality. Government business enterprises (GBEs) do not face the same constraints. They can consistently lose money by offering goods and services whose prices do not reflect their quality or timeliness. Put more simply, private businesses face the risk of going under if they fail to provide good value, and thus will usually behave differently from their public sector counterparts, who do not. Further, Megginson and Netter (2001) found that GBEs tend to develop with less capital and thus are more labour-intensive than their private-sector counterparts. That GBEs do not incorporate an optimal amount of capital has negative implications for both labour and total factor productivity.

With respect to funding, global budgets or block grants (the dominant form of hospital funding in Canada) disconnect funding from the provision of services. As a result, incentives to provide a superior quality of care to patients are weak, as are incentives to function efficiently, especially in the presence

of “soft” budget constraints (Gerdtham et al., 1999). Conversely, administrators working under global budgets have an incentive to discharge patients quickly, avoid admitting costly patients, and shift patients to other outside institutions as a means of controlling expenditures (Leonard et al., 2003). Activity-based funding, on the other hand, creates incentives for hospitals to treat more patients and to provide the types of services that patients desire while still maintaining an incentive for cost-efficiency by paying prospectively the average cost of treatment and not retrospectively for all services actually delivered. Studies have shown that activity-based funding can lead to a greater volume of services being delivered using existing health care infrastructure, reductions in waiting time, reductions in excessive hospital stays, improved quality of care, more rapid diffusion of medical technologies and best practice methods, and the elimination of waste (OECD-DFEACC, 2006; Bibbee and Padrini, 2006; Biørn et al., 2003; Siciliani and Hurst, 2003).

Studies have also shown a positive benefit to including private providers within an activity-based funding model, particularly if a competitive bidding process is employed to determine compensation rates. For example, the OECD-DFEACC notes the “presence of for-profit hospitals can be associated with 2.4 percent lower hospital payments in a geographic area”, that “[p]rice competition between selectively contracted hospitals can lead to price reductions of 7 percent or more”, and that “[b]enchmarking of payment levels against most efficient hospitals can lead to a 6 percent reduction in costs at less efficient hospitals” (2006: 25). An OECD economic survey of the United Kingdom has also noted that “[i]nvolving a broader mix of providers can stimulate productivity as public and private providers learn from each other’s innovations” (OECD, 2004: 5).

It is valuable to reiterate the benefits created by combining activity-based funding and competition with private provision of services. Vitally, when it comes to efficiency, ownership (though an important factor) may be less important than the extent of competition. Both public and private providers are likely to be less efficient in the absence of competition, while both are likely to operate more efficiently when it is present. The key advantage of introducing more private provision in health care is that it would provide greater competition, putting pressure on all providers (whether public or private) to operate more efficiently.²⁹

The distribution of hospital care in Australia, where care is generally divided between public acute-care hospitals and smaller private hospitals focusing on less complex surgeries, does not negate these conclusions. Indeed, allowing specialization and the creation of smaller hospitals focused on less complex cases may in fact provide additional benefits. Allowing acute-care

29 Further, as noted above, there may be differences between public and private providers in their responsiveness to competition and to financial incentives.

hospitals (public or private) to focus on more medically difficult cases while leaving medically easier cases to specialty clinics may be a superior outcome to having all patients (no matter their level of medical complexity) treated in full-service facilities (Ruseski, 2009). Competition between the two for patients can also be beneficial. A central challenge for governments however is to ensure that the care provided to more complex patients is remunerated appropriately so that full-service hospitals do not need to rely on financial cross-subsidization from care provided to less complex patients, and that remuneration for less complex patients appropriately reflects the lower cost of caring for them (particularly in specialized clinics focused on routinized, less risky procedures with commensurate lower capital costs).³⁰ Clearly there are significant benefits that can accrue from shifting from global budgets to activity-based funding and including private providers under the universal access health insurance scheme.

Recommendation 1 *Activity-based funding models—possibly with competitive benchmarking employed to set fees—and private provision of hospital and surgical services.*

Many in the Canadian debate about health care have argued that allowing a private, parallel health care sector is tantamount to abandoning the ideal of universality or that it will put Canada on a slippery slope to abandoning universality. Yet the Australian health care system not only allows but encourages such private activity and manages to provide superior universal access to health care at less cost. What may come as a surprise to many Canadians is that part of Australia's superior health care performance is the result of a private, parallel health care sector.

A private, parallel health care sector plays several important roles. First, it provides individuals an option to return to normal life more rapidly than might be possible through the universal system. This has private benefits for those who opt not to wait, including reduced financial losses from being unable to work while waiting and fewer limitations on personal activities. This also has potential benefits for worker productivity, bringing increased work effort and productivity for those who opt not to wait for care. Second, when patients exit the universal system and use the private, parallel health

30 It is important to reiterate that specialized clinics are not merely taking advantage of less complex cases, but rather are employing more efficient, less risky, less complex, more standardized approaches to care in a focused setting. This has a positive impact on both efficiency and the patient experience. To the extent specialized clinics are contributing to advances in standardization and decreasing complexity, they further contribute to quality and efficiency. On the other hand, specialized clinics should not be able to impose costs of readmissions, complications, or error on acute-care hospitals or other providers.

care sector, they free resources in the universal system for patients who have opted not to seek private care. Third, a private, parallel health care sector provides a safety valve for the public system in the event of reduced capacity or a sudden increase in demand. Fourth, a private, parallel health care sector creates incentives for better service in the public system through competition.

These benefits are not only theoretical but have been borne out in practice. For example, Siciliani and Hurst (2005) found, in a review of policies to tackle waiting times in twelve developed nations, preliminary evidence supporting the conclusion that wait times may be reduced by an increase in private health insurance coverage. A closer look at the Australian experience confirms that providing public support for private insurance and privately funded health care has helped to keep the cost of the public hospital system down over time (in particular, publicly funded hospital care) and has allowed a substantial portion of health care delivered to Australians to be funded outside the public purse, providing substantial net savings to taxpayers (Harper, 2005).

Australia also allows physicians to work in both the public and private health care sectors rather than requiring them to opt out of the universal system (as some Canadian provinces do). This has the benefit of making more efficient use of highly skilled medical resources. Importantly, under dual practice, any spare time that may be available to physicians because of limitations upon practice under the universal scheme or restricted access to operating theatres can be employed to treat patients in private settings, thus increasing the total volume of services provided. Even in the absence of such “free time”, physicians may be encouraged to take less time as leisure and work additional hours in return for supplementary private compensation.

Dual practice for physicians is not an unusual practice in the developed world. Dual practice for physicians can be found in Denmark, England, Ireland, New Zealand, Norway, Spain, Sweden, Australia, Finland, and Italy. In Australia, Denmark, England, and Ireland, specialists working in public hospitals can also visit or treat private patients within the same institution. This said, restrictions may be imposed either in terms of earnings (England), authorizations (Finland), restrictions on the use of public hospitals (Spain, Sweden, Netherlands), or by other regulations (Hurst and Siciliani, 2003a). Allowing dual practice in an effort to employ valuable medical resources more efficiently is not uncommon, and various regulations that work to avoid possible negative consequences are available to be studied and adopted as well.

Recommendation 2 *Private health care and health care insurance for medically necessary care; financial incentives for the purchase of insurance (perhaps with government paying some portion of costs for privately funded care); dual practice for physicians to maximize the volume of services provided to patients in both public and private settings.*

The absence of cost sharing for medical services in Canada has resulted in excessive demand and wasted resources.³¹ By encouraging patients to make a more informed decision about when and where they can make best use of the health care system, cost sharing both increases cost efficiency of health care (ultimately reducing total spending) and improves access to practitioners for those in need of care, as demand for services is reduced through a nominal out-of-pocket charge. This is borne out in the economic literature showing the value of cost sharing in an insurance scheme (Ramsay, 1998; Newhouse et al., 1993). Further, policies permitting cost sharing have also been shown not to have an adverse impact on health outcomes as long as specific populations are exempt (Newhouse et al., 1993; Esmail and Walker, 2008).

On this latter point, work on the effects of cost sharing in Nordic countries (Denmark, Finland, Iceland, Norway, and Sweden) emphasizes the need for appropriate and effective exemptions for low-income individuals in order to ensure that these individuals have access to the health care system in times of need (Øvretveit, 2001). Also, the process by which these exemptions are granted should be proactively administered and automated as much as possible in order to ensure that all who qualify for an exemption are receiving one, since a lack of knowledge of exemptions, social stigmas, and the need to complete special forms (increasing the cost of getting subsidies) can result in many individuals not receiving appropriate assistance or protection (Warburton, 2005; Øvretveit, 2001).

Recommendation 3 *Cost-sharing regimes for universally accessible health care with reasonable annual limits and automated exemptions for low-income populations.*

31 There are some in the Canadian debate who disagree with this view, often citing studies by Forget et al. (2002) and Roos et al. (2004). However, neither of these studies demonstrates that low-income users and high demanders of health care are not wasteful. Nor do they demonstrate that use of health care among those of higher income or among those who are low demanders is not wasteful. They show clearly that the majority of health spending is driven by a small portion of the population and that use of health care increases with income (while sensitivity to cost sharing falls as income rises). But this is true in the health care systems of all developed nations—it is not unique to the Canadian experience.

Thus, to the extent that we can rely on international experience, we can rely on studies of the implementation of cost sharing in other nations (including the RAND Health Insurance Experiment) to inform thinking on cost sharing in Canada. Such studies typically show not insignificant reductions in total expenditures from low levels of cost sharing. Further, even if we accept that there is no excess demand for health care services on the part of patients, cost sharing can act as a brake on excess supply of services by practitioners, a point made by both Newhouse (1993) and Tussing (1983).

References

Altenstetter, Christa, and James Warner Björkman, eds. (1997). *Health Policy Reform, National Variations, and Globalization*. MacMillan Press.

Australian Institute of Health and Welfare (2012). *Health Expenditure Australia 2010–11*. Health and Welfare Expenditure Series No. 47. Cat. No. HWE 56. AIHW.

Bibbee, Alexandra, and Falvio Padrini (2006). Balancing Health Care Quality and Cost Containment: The Case of Norway. Economics Department Working Papers, No. 481. OECD.

Biørn, Erik, Terje P. Hagen, Tor Iversen, and Jon Magnussen (2003). The Effect of Activity-Based Financing on Hospital Efficiency: A Panel Data Analysis of DEA Efficiency Scores 1992-2000. *Health Care Management Science* 6, 4: 271–283.

Boyчук, Gerard W. (2008). *The Regulation of Private Health Funding and Insurance in Alberta under the Canada Health Act: A Comparative Cross-Provincial Perspective*. SPS Research Papers, Health Series, 1, 1. University of Calgary School of Policy Studies.

Busse, Reinhard (2002). *The British and the German Health Care Systems*. Anglo-German Foundation.

Butler, Eamonn, ed. (1992). *Privatization in the Nineties*. Adam Smith Institute.

Clemens, Jason, and Nadeem Esmail (2012). *First, Do No Harm: How the Canada Health Act Obstructs Reform and Innovation*. Macdonald-Laurier Institute.

Commonwealth Fund (2010). *The Commonwealth Fund 2010 International Health Policy Survey in Eleven Countries*. <www.commonwealthfund.org> as of March 31, 2012.

Conference Board of Canada (2004). *Understanding Health Care Cost Drivers and Escalators*. Conference Board of Canada.

Docteur, Elizabeth, and Howard Oxley (2003). *Health-Care Systems: Lessons from the Reform Experience*. OECD Health Working Papers, No. 9. OECD.

Drösler, Saskia, Patrick Romano, and Lihan Wei (2009). *Health Care Quality Indicators Project: Patient Safety Indicators Report 2009*. OECD Health Working Papers, No. 47. OECD.

Duggan, Mark G. (2000). *Hospital Ownership and Public Medical Spending*. NBER Working Paper Series, 7789. National Bureau of Economic Research.

Esmail, Nadeem (2006). Federal Transfers and the Opportunity for Health Reform. *Fraser Forum* (July/August): 16–18.

Esmail, Nadeem (2007). More Efficient and Higher Quality Hospital Care through Better Incentives. *Fraser Forum* (June): 22–25.

Esmail, Nadeem (2011). Canada's Physician Supply. *Fraser Forum* (March/April): 12–18.

Esmail, Nadeem, and Michael Walker (2008). *How Good Is Canadian Health Care?* Fraser Institute.

European Observatory on Health Systems and Policies (2006). *HiT Summary: Australia*. <www.euro.who.int/observatory>.

Gay, Juan G., Valérie Paris, Marion Devaux, and Michael de Looper (2011). *Mortality Amenable to Health Care in 31 OECD Countries: Estimates and Methodological Issues*. OECD Health Working Papers, No. 55. OECD.

Gerdtham, U-G., C. Rehnberg, and M. Tambour (1999). The Impact of Internal Markets on Health Care Efficiency: Evidence from Health Care Reforms in Sweden. *Applied Economics* 31: 935–945.

Ghent, Alice (2010). What? No Waiting Lists? *Bulletin of the World Health Organization* 88, 4: 249–250.

Håkansson, Stefan (2000). Productivity Changes after Introduction of Prospective Hospital Payments in Sweden. *CASEMIX Quarterly* 2, 2: 47–57.

- Harper, Ian R. (2003). Health Sense: When Spending Money Saves Money. *Policy* 19, 3: 19–24.
- Healy, Judith (2012). The Australian Health Care System, 2012. In Thomson, Sarah, Robin Osborn, David Squires, and Miraya Jun, eds, *International Profiles of Health Care Systems, 2012* (Commonwealth Fund): 11–18.
- Healy, Judith, Evelyn Sharman, and Buddhima Lokuge (2006). *Australia: Health System Review*. Health Systems in Transition 8, 5. European Observatory on Health Systems and Policies.
- Hurst, Jeremy (2010). *Effective Ways to Realise Policy Reforms in Health Systems*. OECD Health Working Papers, No. 51. OECD.
- Hurst, Jeremy, and Luigi Siciliani (2003a). *Tackling Excessive Waiting Times for Elective Surgery: A Comparison of Policies in Twelve OECD Countries*. OECD Health Working Papers, No. 6. OECD.
- Hurst, Jeremy, and Luigi Siciliani (2003b). *Tackling Excessive Waiting Times for Elective Surgery: A Comparison of Policies in Twelve OECD Countries. Annexes 1, 2, 3*. OECD Health Working Papers, No. 6. OECD.
- Kneebone, Ronald (2012). *How You Pay Determines What You Get: Alternative Financing Options as a Determinant of Publicly Funded Health Care in Canada*. SPP Research Papers, 5, 21. The School of Public Policy, University of Calgary. <<http://www.policyschool.ucalgary.ca/sites/default/files/research/r-kneebone-althealthpayfinal.pdf>>, as of February 14, 2013.
- Kornai, Janos (1992). *The Socialist System: The Political Economy of Communism*. Princeton University Press.
- Leonard, Kevin J., Marion S. Rauner, Michaela-Maria Schaffhauser-Linzatti, and Richard Yap (2003). The Effect of Funding Policy on Day of Week Admissions and Discharges in Hospitals: the Cases of Austria and Canada. *Health Policy* 63: 239–257.
- Lichtenberg, Frank R. (2001). Are the Benefits of Newer Drugs Worth Their Cost? Evidence from the 1996 MEPS. *Health Affairs* 20, 5: 241–251.
- Matthews, Robert B., G. Keith Jenkins, and Joey Robertson (2012). Health Care Reform: Why Not Best Practices? *American Journal of Health Sciences* 3, 1: 97–114.

Magnussen, Jon, Karsten Vrangbæk, Richard B. Saltman (eds.) (2009). *Nordic Health Care Systems: Recent Reforms and Current Policy Challenges*. Open University Press.

Meggison, William L., and Jeffery M. Netter (2001). From State to Market: A Survey of Empirical Studies on Privatization. *Journal of Economic Literature* 39, 2: 321–389.

Newhouse, Joseph P., and the Insurance Experiment Group (1993). *Free for All? Lessons from the RAND Health Insurance Experiment*. Harvard University Press.

Organisation for Economic Co-operation and Development [OECD] (2004). *OECD Economic Survey of the United Kingdom 2004: Activity-Based Funding, Incentives and Waiting Times in Health Care*. OECD.

Organisation for Economic Co-operation and Development [OECD] (2005). *The OECD Health Project: Health Technology and Decision Making*. OECD.

Organisation for Economic Co-operation and Development [OECD] (2010). *Health Care Systems: Getting More Value for Money*. OECD Economics Department Policy Notes, No. 2. OECD.

Organisation for Economic Co-operation and Development [OECD] (2011). *Health at a Glance 2011: OECD Indicators*. OECD.

Organisation for Economic Co-operation and Development [OECD] (2012a). *OECD Economic Surveys: Canada 2012*. OECD.

Organization for Economic Co-operation and Development [OECD] (2012b). *Health Data, 2012*. Electronic database. OECD.

Organisation for Economic Co-operation and Development [OECD] (2013). *OECD. Stat Extracts*. <stats.oecd.org>, as of January 2, 2013.

OECD Directorate for Financial and Enterprise Affairs Competition Committee [OECD-DFEACC] (2006). *Competition in the Provision of Hospital Services*. OECD.

Or, Zeynep (2001). *Exploring the Effects of Health Care on Mortality across OECD Countries*. Labour Market and Social Policy – Occasional Papers, No. 48.

- Øvretveit, John. 2001. *The Changing Public-Private Mix in Nordic Healthcare – An Analysis*. Nordic School of Public Health.
- Palacios, Milagros, and Nadeem Esmail (2012). *The Unfunded Liability of Canada's Health Care System*. Fraser Institute.
- Paris, Valérie, Marion Devaux, and Lihan Wei (2010). *Health Systems Institutional Characteristics: A Survey of 29 OECD Countries*. OECD Health Working Papers, No. 50. OECD.
- Park, M., T. Braun, G. Carrin, and D. Evans (2007). *Provider Payments and Cost-Containment. Lessons from OECD Countries*. Technical Briefs for Policy-Makers, No. 2. World Health Organization.
- Ramsay, Cynthia (1998). *Medical Savings Accounts: Universal, Accessible, Portable, Comprehensive Health Care for Canadians*. Fraser Institute.
- Rydén, Lars, Graham Stokoe, Gunter Breithardt, Fred Lindemans, Adriaan Potgieter, on behalf of Task Force 2 of the Cardiovascular Round Table of the European Society of Cardiology (2004). Patient Access to Medical Technology across Europe. *European Heart Journal* 25: 611–616.
- Seeman, Neil (2003). Canada's Missing News—Part II: Lower Infant Mortality Rankings. *Fraser Forum* (March): 20–21.
- Siciliani, Luigi, and Jeremy Hurst (2003). *Explaining Waiting Times Variations for Elective Surgery across OECD Countries*. OECD Health Working Papers, No. 7. OECD.
- Siciliani, Luigi, and Jeremy Hurst (2005). Tackling Excessive Waiting Times for Elective Surgery: A Comparative Analysis of Policies in 12 OECD Countries. *Health Policy* 72, 2: 201–215.
- Jeffrey Simpson (2012), *Chronic Condition: Why Canada's Health Care System Needs to Be Dragged into the 21st Century*. Alan Lane (Penguin Group).
- Svensson, H., and L. Garelius (1994). *Har Ekonomiska Incitament Påverkat Läkarnas Beslutsfattande? Utvärdering av Stockholmsmodellen*. Spri-rapport 392.
- Technological Change in Health Care [TECH] Research Network (2001). Technological Change around the World: Evidence from Heart Attack Care. *Health Affairs* 20, 3: 25–42.

Veldhuis, Niels, and Jason Clemens (2003). Clarifying the Federal Government's Contribution to Health Care. *Fraser Forum* (February): 3–5.

Warburton, Rebecca N. (2005). Takeup of Income-Tested Health-Care Premium Subsidies: Evidence and Remedies for British Columbia. *Canadian Tax Journal* 53, 1: 1–28.

Wilcox, Sharon, Mary Seddon, Stephen Dunn, Rhiannon Tudor Edwards, Jim Pearse, and Jack V. Tu (2007). Measuring and Reducing Waiting Times: A Cross-National Comparison of Strategies. *Health Affairs* 26, 4: 1078–1087.

About the author

Nadeem Esmail

Nadeem Esmail is the Director of Health Policy Studies at the Fraser Institute. He first joined the Fraser Institute in 2001, served as Director of Health System Performance Studies from 2006 to 2009, and was a Senior Fellow with the Fraser Institute from 2009 to 2013. Mr Esmail has spearheaded critical Fraser Institute research including the annual *Waiting Your Turn* survey of surgical wait times across Canada and *How Good Is Canadian Health Care?*, an international comparison of health care systems. In addition, he has been the author or co-author of more than 30 comprehensive studies and more than 150 articles on a wide range of topics including the cost of public health care insurance, international comparisons of health care systems, hospital performance, medical technology, and physician shortages. A frequent commentator on radio and TV, Mr. Esmail's articles have appeared in newspapers across North America. He completed his B.A. (Honours) in Economics at the University of Calgary and received an M.A. in Economics from the University of British Columbia.

Acknowledgments

The author would like to acknowledge Marc Law and Herb Emery, who reviewed this paper. Any remaining errors and omissions are the sole responsibility of the author. The views expressed in this study do not necessarily represent the views of the trustees, supporters, or other staff of the Fraser Institute.

Publishing information

Distribution

These publications are available from <<http://www.fraserinstitute.org>> in Portable Document Format (PDF) and can be read with Adobe Acrobat® 7 or Adobe Reader®, versions 7 or later. Adobe Reader® XI, the most recent version, is available free of charge from Adobe Systems Inc. at <<http://get.adobe.com/reader/>>. Readers who have trouble viewing or printing our PDF files using applications from other manufacturers (e.g., Apple's Preview) should use Reader® or Acrobat®.

Ordering publications

For information about ordering the printed publications of the Fraser Institute, please contact the publications coordinator:

- e-mail: sales@fraserinstitute.org
- telephone: 604.688.0221 ext. 580 or, toll free, 1.800.665.3558 ext. 580
- fax: 604.688.8539.

Media

For media enquiries, please contact our Communications Department:

- 604.714.4582
- e-mail: communications@fraserinstitute.org.

Copyright

Copyright © 2013 by the Fraser Institute. All rights reserved. No part of this publication may be reproduced in any manner whatsoever without written permission except in the case of brief passages quoted in critical articles and reviews.

Date of issue

February 2013

Citation

Esmail, Nadeem (2013). *Health Care Lessons from Australia*. Lessons from Abroad: A Series on Health Care Reform. Fraser Institute. <<http://www.fraserinstitute.org>>.

Cover design

Bill Ray

Cover images

- ©RBerteig (Ayres Rock)
- ©Marmion, Bigstock (group of doctors)
- ©zurijeta, Bigstock (African American man)

Supporting the Fraser Institute

To learn how to support the Fraser Institute, please contact

- Development Department, Fraser Institute
Fourth Floor, 1770 Burrard Street
Vancouver, British Columbia, V6J 3G7 Canada
- telephone, toll-free: 1.800.665.3558 ext. 586
- e-mail: development@fraserinstitute.org

Lifetime patrons

For their long-standing and valuable support contributing to the success of the Fraser Institute, the following people have been recognized and inducted as Lifetime Patrons of the Fraser Institute.

Sonja Bata	Serge Darkazanli	Fred Mannix
Charles Barlow	John Dobson	Jack Pirie
Ev Berg	Raymond Heung	Con Riley
Art Grunder	Bill Korol	Catherine Windels
Jim Chaplin	Bill Mackness	

Purpose, funding, & independence

The Fraser Institute provides a useful public service. We report objective information about the economic and social effects of current public policies, and we offer evidence-based research and education about policy options that can improve the quality of life.

The Institute is a non-profit organization. Our activities are funded by charitable donations, unrestricted grants, ticket sales, and sponsorships from events, the licensing of products for public distribution, and the sale of publications.

All research is subject to rigorous review by external experts, and is conducted and published separately from the Institute's Board of Trustees and its donors.

The opinions expressed by the authors are those of the individuals themselves, and do not necessarily reflect those of the Institute, its Board of Trustees, its donors and supporters, or its staff. This publication in no way implies that the Fraser Institute, its trustees, or staff are in favour of, or oppose the passage of, any bill; or that they support or oppose any particular political party or candidate.

As a healthy part of public discussion among fellow citizens who desire to improve the lives of people through better public policy, the Institute welcomes evidence-focused scrutiny of the research we publish, including verification of data sources, replication of analytical methods, and intelligent debate about the practical effects of policy recommendations.

About the Fraser Institute

Our vision is a free and prosperous world where individuals benefit from greater choice, competitive markets, and personal responsibility. Our mission is to measure, study, and communicate the impact of competitive markets and government interventions on the welfare of individuals.

Founded in 1974, we are an independent Canadian research and educational organization with locations throughout North America and international partners in over 85 countries. Our work is financed by tax-deductible contributions from thousands of individuals, organizations, and foundations. In order to protect its independence, the Institute does not accept grants from government or contracts for research.

Nous envisageons un monde libre et prospère, où chaque personne bénéficie d'un plus grand choix, de marchés concurrentiels et de responsabilités individuelles. Notre mission consiste à mesurer, à étudier et à communiquer l'effet des marchés concurrentiels et des interventions gouvernementales sur le bien-être des individus.

Peer review—validating the accuracy of our research

The Fraser Institute maintains a rigorous peer review process for its research. New research, major research projects, and substantively modified research conducted by the Fraser Institute are reviewed by experts with a recognized expertise in the topic area being addressed. Whenever possible, external review is a blind process. Updates to previously reviewed research or new editions of previously reviewed research are not reviewed unless the update includes substantive or material changes in the methodology.

The review process is overseen by the directors of the Institute's research departments who are responsible for ensuring all research published by the Institute passes through the appropriate peer review. If a dispute about the recommendations of the reviewers should arise during the Institute's peer review process, the Institute has an Editorial Advisory Board, a panel of scholars from Canada, the United States, and Europe to whom it can turn for help in resolving the dispute.

Editorial Advisory Board

Members

Prof. Terry L. Anderson	Prof. Herbert G. Grubel
Prof. Robert Barro	Prof. James Gwartney
Prof. Michael Bliss	Prof. Ronald W. Jones
Prof. Jean-Pierre Centi	Dr. Jerry Jordan
Prof. John Chant	Prof. Ross McKittrick
Prof. Bev Dahlby	Prof. Michael Parkin
Prof. Erwin Diewert	Prof. Friedrich Schneider
Prof. Stephen Easton	Prof. Lawrence B. Smith
Prof. J.C. Herbert Emery	Dr. Vito Tanzi
Prof. Jack L. Granatstein	

Past members

Prof. Armen Alchian*	Prof. F.G. Pennance*
Prof. James M. Buchanan* [†]	Prof. George Stigler* [†]
Prof. Friedrich A. Hayek* [†]	Sir Alan Walters*
Prof. H.G. Johnson*	Prof. Edwin G. West*

* deceased; [†] Nobel Laureate