A Brief Summary of the Australian Universal Health Coverage System: Must Increased Access Equate to Decreased Quality and Efficiency?

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I. INTRODUCTION

A common misperception and argument against universal health coverage is that countries that adhere to this system are forced to trade efficiency and freedom of care for overall access to care.1 However, a 2010 study performed by the Commonwealth Fund compared the health care systems of seven nations - Australia, Canada, Germany, the Netherlands, New Zealand, the United Kingdom, and the United States.2 The United States’ health care system, which does not provide universal health coverage, consistently ranks last or next-to-last in the five determinative measures in the assessment of a well performing health care system.3 Those areas include quality, access, efficiency, equity, and a healthy life.4 In contrast, the study referred to the performance of countries like Australia and the U.K., both of which have incorporated universal coverage, as demonstrating “superior performance” overall.5

The World Health Organization (WHO) is a strong proponent of

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3. Id.

4. Id.

5. Id. at v, vii.
universal health coverage. Its 2010 Health System Financing Report emphasized the importance of promotion and protection of health as a staple for human welfare and social development. It further declared that all people should have access to health care without risking their own financial ruin in the process. But access is not the only important factor of universal health coverage. To be effective, access must be timely and equitable; and health services must be properly promoted with a balanced focus on rehabilitation and prevention. The system must also have a successful means for monitoring and evaluating its own effectiveness.

This paper will offer a brief introduction to the structure and financing of Australia’s health care system. The paper will then address the misperception that access and quality must be inversely related through an evaluation and comparison of the results of the Commonwealth study as it relates to the United States and Australia. Lastly, this paper will evaluate the current state of the United States health care system and offer some reconciliation to the apparent discrepancy between perception and the reality and offer some recommendations for change in the United States.

II. AUSTRALIA HEALTH CARE

Regardless of age or economic status, the Australian national public health care system provides universal health coverage for all of its citizens, permanent residents, and to visitors from countries with whom Australia has signed a reciprocal health care agreement. Formulated in 1984, this

7. Id. at 7.
8. Id. at 8.
9. Id. at 7.
10. Id.
11. Id.
12. The Commonwealth Fund, The Australian Health Care System 8 (Jane Hall
comprehensive health care system, Medicare, offers free or subsidized medical care, some optometry services, and a laundry list of prescription drugs to all individuals.14

There are three main branches of the Medicare system.15 First, the Australian Health Care Agreements (AHCAs) is the system through which federal money is disbursed amongst the states and territories to the various public hospitals.16 The second branch is the Pharmaceutical Benefits Scheme (PBS), which subsidizes the cost of prescription drugs.17 The last branch, the Medicare Benefits Scheme (MBS), covers seventy-five percent of the scheduled fee for care by general practitioners and specialists within the public hospitals, along with 100% of the scheduled fee of care outside of the hospital.18 Care outside of hospitals can be covered completely when the practitioner agrees to accept the government scheduled fee and in effect leave nothing for the patient to pay.19

This national, local, state, and territory governments jointly fund the public health care system.20 Medicare is funded primarily by general goods and services tax and also by a tax levy on personal income of most taxpayers.21 The levy, which is generally at 1.5%, can be reduced for individuals making less than a certain threshold level, or waived for the very poor.22 Australians whose income is higher than a certain threshold
who do not obtain private health insurance for themselves or their dependants are subject to the additional Medicare Surcharge Levy which equals one percent of the sum of taxable income, reportable fringe benefits, and any amount on which family trust distribution has been paid.23

The Australian government covers approximately two-thirds of total health expenditures -forty-three percent of which comes from the Australian government and twenty-six percent from the local state and territory governments.24 The Government is responsible primarily for universal medical services, the funding of public hospitals, pharmaceuticals, health research, and training of health professionals.25 Patients on Medicare are treated for free at public hospitals where they are appointed a doctor or specialist for each episode of care.26

Administration of the health care system takes place on the state and territory level and provides more specific care with the provision of a number of other direct health related services, such as the acute and psychiatric hospitals and community and public health services.27 The local government also works to shape the culture by providing school health, dental care, maternal and child health services, occupational health, and disease control services.28 In addition, they also provide home care, preventative care, and immunization coverage.29 Outside of prevention and health maintenance measures, patients in need of a higher level of care in a given year are eligible to obtain safety net coverage, which aids in the

(JULY 19, 2011), available at http://www.ato.gov.au/individuals/content.aspx?doc=/content/00250854.htm. In 2010-11, the levy was reduced for individuals with a taxable income of $22,163 or less, and waived for individuals with a taxable income of $18,839 or less. Id.
23. Id.
24. SYSTEM, supra note 12, at 9.
25. ABOUT AUSTRALIA, supra note 13.
26. Id.
27. Id.
28. Id.
29. Id.
payment of out of pocket fees not covered by Medicare; or if that is insufficient, the Extended Medicare Safety Net, which subsidizes eighty percent of non-hospital out-of-pocket costs once the annual limit is reached.30

Approximately half of all Australians have private health insurance, which the government incentivizes with a thirty percent rebate on the cost of the premium.31 And one-third of the hospital beds in Australia are held in private hospitals.32 In addition to access to private hospitals, private health insurance also covers enhanced “private patient” care in public hospitals, which provides patients with improved treatment such as shortened waiting times, the ability to choose one’s own physician, increased access to private hospitals for elective and other ancillary medical services such as dental, eye care and chiropractic treatment.33

Australia is a successful example of a universal coverage system, especially in light of The Commonwealth Fund’s findings of its “superior performance” and highest rankings with regard to long, healthy, and productive lives.34

III. A COMPARISON OF THE UNITED STATES HEALTH CARE SYSTEM TO THE AUSTRALIAN HEALTH CARE SYSTEM

The overall ranking report by The Commonwealth Fund demonstrates that there does not need to be a tradeoff between quality and efficiency in the conversion to universal health coverage, as many countries have successfully implemented this type of system without compromising those

30. SYSTEM, supra note 12.
31. ABOUT AUSTRALIA, supra note 13, at 2.
32. Id.
33. STIEBER, supra note 15, at 5.
34. DAVIS ET AL., supra note 2, at vii.
measures.35 The Commonwealth Report dispels this frequent misperception through examples in the Netherlands and Germany - both universal health coverage countries - that have timely access to specialists with little cost to the individual.36 Overall, Australia scored higher with regard to affordability and access, while the United States had shorter waiting times for elective surgery.37 An objective, statistical analysis of cost and coverage metrics is more indicative as to the general value and merit of each of the systems.

In 2009, Australia spent 8.7% of its gross domestic product (GDP) on its universal health coverage system, equating to approximately $3,357 (USD) per capita.38 The United States spent nearly double that, sixteen percent of its GDP on health care, equating to $7,290 (USD) per capita.39 While Australia provides universal health coverage, the United States spends more than twice per capita than Australia and still manages to leave over forty-seven million people without health insurance.40 Even more alarming, in spite of the money spent and people overlooked, the United States still ranked last overall in measures of access, patient safety, coordination of care, efficiency, and equity; whereas Australia trailed closely behind first-place Netherlands.41

From an accessibility perspective, the report demonstrates that many Americans with legitimate health problems are forced to forego needed care because of the cost.42 Interestingly, while there are longer waiting times for

35. Id. at v.
36. Id. at vi.
38. Id.; DAVIS ET AL., supra note 2.
40. Mascarenhas, supra note 37.
41. DAVIS ET AL., supra note 2.
42. Id. at vi.
elective procedures, Australia ranked second for overall efficiency. The United States ranked last for efficiency partly because of its health expenditures, administrative costs, low performing information technology systems, hospital readmission rates, and performance of unnecessary medical procedures. The United States and Australia were also on opposing sides of the spectrum with regard to “long, healthy and productive lives,” with the United States ranking last overall and Australia ranking first.

IV. REEVALUATION OF HEALTH CARE IN THE UNITED STATES

The astounding disparities found between the United States and the other industrial nations by The Commonwealth Fund point to a profound need for expanded coverage and increased quality and efficiency in the United States. It also demonstrates that increased spending does not necessarily lead to better access or outcomes for a nation’s people, as the United States stands out among other nations as unable to provide value in return for the health care dollars spent, and its overall quality and efficiency stands strides behind other industrial nations.

Recent health care legislation in the United States attempts to address some of these concerns. For increased efficiency and quality, President Barack Obama signed the American Recovery and Reinvestment Act (ARRA) in 2009, which allocated $19 billion for expanded use of information technology. The Patient Protection and Affordable Care Act of 2010 (PPACA) will help extend public government health care coverage

43. Mascarenhas, supra note 37; Davis et al., supra note 2 at vi.
44. Id.
45. Id. at vii.
46. Id. at v.
47. Id.
48. Id. at vi.
49. Id.
to thirty-two million people by 2014.50 This extension will contribute to the overall stability of the health care system in the United States, while at the same time promote enhanced quality and efficiency throughout the country by realigning provider incentives, encouraging efficient care, and promoting prevention and overall health throughout the community.51

Both forms of legislation take proactive strides toward better access and quality of care, but these are only the first steps toward universal health coverage and the nation must be vigilant supporters and monitors in order for it to be successful.52

The need for vigilant supporters may present a challenge, however, as Republicans are unanimous in their opposition to the health care reform legislation.53 In fear of socialized medicine, and even totalitarianism, Republicans have vowed to repeal this legislation once they regain power in the White House.54 The country remains sharply divided in its opinion of the merits of the legislation, and many fear the burden that increased regulation and taxes will have on small businesses nationwide.55 Others fear that the imposition of universal health coverage will delay care for weeks, months, and in some cases, years.56 Others fear a lack of resources, availability of elective procedures, and hospital beds.57 While it is true that access to healthcare for the insured may be faster, this is not the case for those who have lost their jobs or other for others who cannot afford to

50.  Id. at 17.
51.  Id. at vi.
52.  Id. at 18.
54.  Id.
56.  Martin, supra note 1.
57.  See Id.
purchase their own insurance.\textsuperscript{58} What society needs to come to terms with is the apparent discrepancy between these limited situations and the reality of the finding of The Commonwealth Fund wherein the United States underperforms various countries who have implemented universal health coverage in the areas of access, patient safety, coordination, efficiency, and equity.\textsuperscript{59}

The WHO provides three steps in the path to universal coverage.\textsuperscript{60} First, countries must raise sufficient funds.\textsuperscript{61} Some suggestions for raising sufficient funds are through the taxation of various financial transactions to include a “sin tax” and other excise taxes such as upon airline tickets.\textsuperscript{62}

Second, countries must reduce reliance on direct payments to finance services.\textsuperscript{63} The overreliance on payment for care is a barrier to universal health coverage because it forces those without adequate financial backing to forgo care or risk severe financial hardship.\textsuperscript{64} The requirement for upfront payment, co-payments, co-insurance, and deductibles needs to be subsidized or eliminated for universal health coverage to succeed.\textsuperscript{65}

An inefficient and inequitable health care system is the third major barrier to universal health coverage.\textsuperscript{66} Approximately $1.2 to $2.2 trillion is being attributed to waste in the United States and account for more than half of all health care spending.\textsuperscript{67} Waste can be decreased through the practice of defensive medicine, more efficient claims processing, and

\begin{itemize}
\item \textsuperscript{58} Id.
\item \textsuperscript{59} Davis et al., supra note 2.
\item \textsuperscript{60} World Health Report, supra note 6, at 9.
\item \textsuperscript{61} Id.
\item \textsuperscript{63} World Health Report, supra note 6, at 9.
\item \textsuperscript{64} Id.
\item \textsuperscript{65} Id.
\item \textsuperscript{66} Id.
\item \textsuperscript{67} PriceWaterhouseCoopers’ Health Research Institute, The Price of Excess: Identifying Waste in Healthcare Spending 1 (2010).
\end{itemize}
focused care on preventative conditions such as obesity.68

The key to eliminate waste and inefficiency in the United States is a widespread culture shift.69 Then, once the culture shift takes place, politics, money, and system-wide incentives will shift toward collaboration in order to solve these issues and work toward this shared value.70

V. CONCLUSION

The findings of the Commonwealth Report demonstrate that the incorporation of universal health coverage will not inevitably lead to a tradeoff of access for quality and efficiency.71 The Australian national public health care system, Medicare, offers universal coverage.72 Despite spending less than half per capita as the United States,73 Australia still outperforms them in the categories of quality care, access, efficiency, equity, and long, healthy, productive lives.74 The ongoing implementation of the PPACA and other forms of health reform legislation in the United States aims to improve performance in each of those areas.75 Yet the nation still remains deeply divided on the topic,76 and many want to avoid the issues of government run systems, such as delays in care and shortages of doctors.77 The Commonwealth Fund Report concludes its report with the suggestion that “when a country fails to meet the needs of the most vulnerable, it also fails to meet the needs of the average citizen.”78 The citizens of the United States must realize the immense importance of equity

68. Id.
69. See Id.
70. Id.
71. DAVIS ET AL., supra note 2.
72. SYSTEM supra note 12.
73. DAVIS ET AL., supra note 2.
74. Id.
75. Id. at vi.
76. Reassure, supra note 55.
77. Martin, supra note 1.
78. DAVIS ET AL., supra note 2, at 18.
and support the implementation of a system that works for everyone.\textsuperscript{79} The first steps have been taken in that direction, the nation now needs to stand united as vigilant supporters and monitors in order for universal health coverage to emerge and succeed in this country.\textsuperscript{80}

\textsuperscript{79} Id.

\textsuperscript{80} See id.