# 10. Embracing Private Finance and Private Provision: The Australian System


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CHAPTER 10

# Embracing Private Finance and Private Provision: The Australian System

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Litigation has commenced in Canada challenging the aspects of the legislation that instantiates the *Canada Health Act* on the basis that a public monopoly in delivering medically necessary services has resulted in Canadians experiencing long wait times for health care, contrary to their *Charter* rights.[1] If the *Cambie* challenge is successful, in whole or in part, federal, provincial, and territorial governments will need to rethink Canadian medicare. In considering health care reforms, they will likely examine how other similar national jurisdictions manage blended public and private health systems. One such country they will likely examine is Australia, given the similarities between the two countries (discussed below). The Australian health system is characterized by a complex division of responsibilities and roles shared between the federal (the Commonwealth of Australia) and state governments,[2] as well as a complicated interplay between public and private sectors (both in terms of funding and delivery). This chapter is divided into two

1 See Colleen Flood & Bryan Thomas, "A Successful Charter Challenge to Medicare? Policy Options for Canadian Provincial Governments" (2018) Health Economics, Pol'y & L 1 at 2 [Flood & Thomas]; Colleen Fuller, "Cambie Corp. Goes to Court: The Legal Assault on Universal Health Care" (2015) Canadian Centre for Policy Alternatives at 11–13, online: *Canada Centre for Policy Alternatives* <www.policyalternatives.ca/publications/reports/cambie-corp-goes-court>.

2 We will use the term "state" to refer to both state and territory governments.

parts. In the first part, we analyze constitutional and political factors that have contributed to the federal government financially supporting (directly and indirectly) both public and private health systems. A constitutional provision, prohibiting the "civil conscription" of health professionals, places some limits on the federal government's ability to control health professionals' practice, particularly the extent to which they can work in a duplicative private tier. Politically, one of the major political groupings in Australian politics—a coalition between the Liberal and National Parties (centre-right and right-leaning parties) (the Coalition)—opposed the introduction of a universal public health system and its continuation until the 1990s. The Coalition has now conceded that it cannot survive politically if it continues its opposition to the public financing system known as Medicare, but, despite this, it has maintained an ideological commitment to encouraging a parallel private health sector subsidized directly and indirectly by the federal government. In the second part of this chapter we highlight some of the key challenges experienced by Australia in supporting a two-tier health care system. This includes ongoing issues about the long-term sustainability of both systems due to the direct financial costs of funding both systems, the dispersion of health professionals between systems, and the impact on wait times.

## Canada and Australia

Canadian policy-makers may look to the Australian health system because of the many similarities between the two nations, and we begin with a brief analysis of the similarities and differences between the two. Both are geographically large with fairly small, densely concentrated populations. Canada has 9.985 million square kilometres of territory, while Australia has 7.692 million square kilometres. Canada's population is larger, at an estimated 37.5 million,[3] versus Australia's 25.5 million.[4] Both have similar population distributions, with most Canadians living reasonably close to the border with the United States and most Australians close to the coastline.

3 See Statistics Canada, *Canada at a glance: Population* (Ottawa: Statistics Canada, 2019) online: <https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1710000501>.

4 See Australian Bureau of Statistics, "Population Clock" (Canberra: ABS, 2019), online: <https://www.abs.gov.au/ausstats/abs@.nsf/0/1647509ef7e25faaca2568a900154b63?OpenDocument>.

Both are former British colonies, current members of the Commonwealth of Nations, members of the Organisation for Economic Co-operation and Development, and are considered highly developed countries. Their legal systems are similar, based on the English common-law system (with variation in the Canadian province of Quebec). Both are federations, with the primary responsibility for health-system management resting with the provinces in Canada and significant responsibilities at the state level in Australia. Both have similar per capita spending and spend similar amounts of GDP on health care.[5] Finally Australia's Medicare system was adapted from Canada's.[6]

## Australia's Constitutional and Legal Framework

It was only in 1973 that Australia reluctantly opened the doors to the creation of a universal, publicly funded health system, and not until 1984 that it was established.[7] In 1901, at the formation of the Commonwealth of Australia, health care was not assigned as a federal responsibility in the Constitution, with the Commonwealth's only direct health-related powers being in respect of quarantine.[8] In 1944, a left-leaning Labor government passed legislation setting up the Pharmaceutical Benefits Scheme to subsidize the costs of selected medications (antibiotics) for Australians.[9] The government of the state of Victoria challenged the legislation, arguing the commonwealth legislation was ultra vires.[10] The High Court of Australia (equivalent to the Supreme Court of Canada) overturned the legislation, finding that the Commonwealth had no powers under the Constitution to pass it.[11] Subsequently, the Commonwealth government convened a constitutional referendum to obtain broader powers in the Constitution in respect of health and welfare. It was

5 In 2018, the percentage of GDP on health care (total) was 9.3 per cent in Australia, 10.7 per cent in Canada; the per capita spend was AUD$7,170 and C$6,448. Organisation for Economic Cooperation and Development, OECD HealthData <https://stats.oecd.org/Index.aspx?DataSetCode=SHA>.

6 RB Scotton & CR Macdonald, *The Making of Medibank* (Sydney: School of Health Services Management, University of New South Wales, 1993).

7 *Health Insurance Act 1973* (Cth).

8 *Commonwealth of Australia Constitution Act 1900* (Cth), s 51 (ix) [*Constitution Act*].

9 *Pharmaceutical Benefits Act 1944* (Cth).

10 *Attorney-General (Vic) ex rel Dale v Commonwealth* (1945), 71 CLR 237 at 239.

11 *Ibid* at 266.

successful and the Constitution was duly amended, permitting the Commonwealth to provide hospital benefits and medical and dental services.[12] While the referendum was clear evidence of wide public support for publicly funded health services and pharmaceuticals, the prospect of so-called socialized medicine, as was the characterization of Britain's National Health Service, concerned many members of the medical profession who foresaw losing lucrative private practices.[13] A "civil conscription" sub-provision was added to the section amending the Constitution to protect the interests of medical doctors.[14]

Section 51 of the Australian Constitution states:

> The Parliament shall, subject to this Constitution, have power to make laws for the peace, order, and good government of the Commonwealth with respect to:
>
> (xxiiiA) the provision of maternity allowances, widows' pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services (*but not so as to authorize any form of civil conscription*), benefits to students and family allowances.[15]

There have been three cases before the High Court to determine what the civil conscription sub-clause means.[16] In *General Practitioners*

12 *Constitution Act, supra* note 8 at s 51(xxiiiA); *Constitution Alteration (Social Services) 1946*.

13 The Australian Medical Association and many members of the medical profession have shared this opposition, as they see their interests as being "best served by a free enterprise, private practice, fee-for-service model" (George Palmer & Stephanie Short, *Health Care and Public Policy: An Australian Analysis*, 5th ed (South Yarra: Palgrave Macmillan, 2014) at 74); Adrian Kay, "Tense Layering and Synthetic Policy Paradigms: The Politics of Health Insurance in Australia" (2007) 42:4 Australian J Political Science 579 at 585.

14 T Faunce, "*Selim v Lele* and the civil (industrial) conscription prohibition: constitutional protection against federal legislation controlling or privatising Australian Public hospitals" (2008) 16 J Law Med 36 at 40.

15 *Constitution Act, supra* note 8 [emphasis added].

16 See *Federal Council of the British Medical Association in Australia v Commonwealth* (1949) 9 CLR 201; *General Practitioners Society v Commonwealth* (1980) 145 CLR 532; *Wong v Commonwealth; Selim v Professional Services Review Committee* (2009) 236 CLR 573. See also Fiona McDonald "Regulation of Health Professionals" in Ben

*Society v Commonwealth*,[17] the High Court interpreted the constraints on the Commonwealth's power in respect of doctors to be that the Commonwealth cannot exert any legal or practical compulsion on doctors to provide a service.[18] In short, the Commonwealth cannot stop doctors working in public hospitals or public health systems from also working privately (i.e., it cannot limit dual practice, restricted or prohibited in Canada), and it cannot require doctors to work in the public system.[19] The government has also interpreted the civil-conscription provision to mean that it cannot impose any limitations on the amount charged to patients by doctors working in private practice.[20] This latter interpretation has not been challenged before the High Court. The implications of this for the Australian health system amount to a constitutional guarantee that a private market for health services can exist in parallel to a public health system, largely unrestricted.

Although Commonwealth legislation re-establishing the pharmaceutical benefits scheme, providing universal subsidies for approved pharmaceuticals, was passed in 1947,[21] shortly after the reform to the Constitution, the Labor government lost power, before it could establish universal public health care. The Coalition was then in power in Australia, from 1949 to 1972. The Coalition was opposed to universal health care and believed that the role for government was as a safety net provider for the very poor; everyone else should pay directly for health care. Thus, there was a strong commitment

White, Fiona McDonald & Lindy Willmott, eds, *Health Law in Australia*, 3rd ed (Sydney: Thomson, 2018) 647 at 651–653; Faunce, *supra* note 14.

17 *General Practitioners Society v Commonwealth* (1980), 145 CLR 532.

18 *Ibid* at 571.

19 *Wong v Commonwealth; Selim v Professional Services Review Committee* (2009) 236 CLR 573.

20 See, e.g., Australian Commonwealth, Department of Health and Aging, *Submission to the Senate Standing Committee for Community Affairs for the Inquiry into the Health Insurance Amendment (Extended Medicare Safety Net) Bill 2009* (Canberra: Senate Standing Committee, 2009) at 7, online: *Parliament of Australia* <https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/2008-10/health_insur_extend_medicare_safety_net_09/submissions/sublist>.

21 *Pharmaceutical Benefits Act 1947 (Cth).*

by the Coalition to both private financing and provision, even if a public system could be more efficient.[22]

In 1972, a Labor government was elected and sought to create a universal public health system (then called Medibank) based on Canadian medicare, with adaptions for the Australian context.[23] The Labor government could not get the universal public health insurance legislation through a hostile Senate on two occasions. The Labor government then had the Governor-General dissolve both houses of Parliament and call an election.[24] Although Labor was re-elected, with a majority in the lower house, the legislation was again defeated in the Senate; thus, a joint sitting of both houses was required to pass the legislation.[25]

Within months of the universal Medibank scheme being implemented, the Coalition blocked budget legislation in the Senate, a constitutional crisis ensued, and the Governor-General dismissed the Labor government and replaced it with the Coalition. The Coalition won the subsequent election and, despite its pre-election promises, systematically dismantled the public, universal system.[26] In 1983, a Labor government was elected and passed legislation to recreate a universal public health system, renamed as Medicare. In opposition, the Coalition continued to campaign on the basis of repealing Medicare. It was not until 1996 that the Coalition accepted that it could not be re-elected if it continued to oppose universal public health care.[27] It recognized pragmatically that, if it wanted to govern

22 Ian McAuley, "Private Health Insurance and Public Policy" (Paper delivered at the 2016 Health Insurance Summit in Sydney, 28 July 2016) at 7 [unpublished], online: <https://cpd.org.au/wp-content/uploads/2016/07/PHI-conference-July-2016.pdf> at 3 [emphasis in the original].

23 Scotton & Macdonald, *supra* note 6.

24 See Stephen Duckett & Sharon Willcox, *The Australian Health Care System*, 5th ed (South Melbourne: Oxford University Press, 2015) 361–364; Anne-Marie Boxall & James A Gillespie, *Making Medicare: The Politics of Universal Health Care in Australia* (Sydney: NewSouth Publishing, University of New South Wales Press, 2013) 36–51.

25 World Bank, 2014, *supra* note 7.

26 Boxall & Gillespie, *supra* note 24, 78–89.

27 The then-Health Minister Wooldridge had studied health policy under the previous Liberal government and had identified the strong public support for Medicare as one reason the Liberals lost elections against Labor in the ensuing period: see Palmer & Short, *supra* note 13. See also Fran Collyer, Kirsten Harley & Stephanie Short, "Money and Markets in Australia's Healthcare System" in Gabrielle Meagher & Susan Goodwin, eds, *Markets,*

again, it must undertake not to repeal Medicare, although it remained ideologically opposed to it.[28] Both the political environment and constitutional constraints have and continue to shape the design of the Australian health systems, and have made a two-tier health care system inevitable. We describe this system in the next section.

## The Australian Health System

In Australia, public hospitals are majority funded by the states and partially funded by the Commonwealth under its constitutional power to provide conditional funding to the states.[29] It uses this power, rather than funding public hospitals through its section 51(xxiiiA) ("hospital benefits") power, as the payment was originally structured as support for the states' public hospital systems. The states' grants power (s. 96) has the benefit of the Commonwealth being able to impose conditions on the transfer of funding and thus have a greater control over health policy. Commonwealth funding to the states for public hospitals services is provided pursuant to the National Healthcare Agreement, which is renegotiated regularly.[30] The National Healthcare Agreement funds a base level of activity and payments for additional activity each year, with the Commonwealth funding 45 per cent of the costs of activity.[31]

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*Rights and Power in Australian Social Policy* (Sydney: Sydney University Press, 2015) 257 at 263–64. The current Coalition government has stated that Medicare "is a core Government service" (Jane Norman, "Election 2016: Malcolm Turnbull Says 'Every Element' of Medicare Will Stay in Government Hands," *ABC News* (18 June 2016), online: <www.abc.net.au/news/2016-06-18/medicare-will-never-be-privatised,-turnbull-says/7523242>.

28 *Ibid*.

29 *Constitution Act*, *supra* note 8 at s 96.

30 Most recently through the Council of Australian Governments: Austl, Commonwealth, Council of Australian Governments, *National Healthcare Agreement 2012* (Canberra: COAG, 2012), online: *Council on Federal Financial Relations* <http://www.federalfinancialrelations.gov.au/content/national_health_reform.aspx>.

31 With the payment for activity varying by type of patient, with payment per patient being standard across the country; the "national efficient price." See Stephen Duckett, "Expanding the breadth of Medicare: learning from Australia" (2018) 13 (Special issue 3/4) J Health Economics Pol'y & L 344–368. The Labor policy was for the cost of growth to be funded initially at 45 per cent by the Commonwealth but phased up to equal funding. The Coalition reversed the phasing-up as a savings measure.

Payments from the states to public hospitals are also generally based on activity, with the activity payment taking the costs of staffing and materials, such as pharmaceuticals, into account.[32] Doctors are permitted constitutionally (as discussed above) and by their terms and conditions of employment to work both in the public and private systems (dual practice) and if they are working in a public hospital their employment contract reflects this. Some doctors may be permitted to offer services to private patients in public hospitals in some circumstances.[33] Primary medical care is overwhelmingly remunerated on a fee-for-service basis and provided by general practitioners (GPs) in small practices, privately incorporated companies or partnerships.

Medicare provides a rebate against the costs of medical services (other than in-hospital medical services provided to public patients and patients covered by compensation schemes, such as transport accident schemes),[34] including approved diagnostic tests (pathology/radiology) and services provided by some other health providers (e.g., nurse practitioners, midwives, etc).[35] The rebate can be claimed for private patients receiving care in public hospitals.[36] The provision of services by public hospitals to private patients provides an additional income stream for public hospitals.[37] Most

32 Salaries are negotiated through collective bargaining between the health professional union(s) and the states/territories as the employer. Industrial action, such as strikes, is permitted under certain circumstances. If no agreement is reached, Fair Work Australia (an independent government agency) may make a determination.

33 A professional medical service may be provided under a private-practice agreement entered into between a public hospital and a specialist physician (*Health Insurance Act*, *supra* note 7 at s 19).

34 All patients presenting at a "public hospital" can elect to be treated as a public patient without any direct financial payment. Medical costs, including diagnostic tests, provided to public patients are covered in the public hospital-funding arrangements.

35 *Health Insurance Act*, *supra* note 7 at s 4.

36 *Ibid* at s 19. Section 19 of the *Health Insurance Act 1973* states that a Medicare benefit may be paid if the professional service is provided under a private-practice agreement entered into between a public hospital and a specialist.

37 In Queensland, e.g., it is stated that this generates AUD$500 million annually in gross revenue across Queensland. Austl, Queensland, *Private Practice in the Queensland Public Health Sector Framework* (Brisbane: QLD Health, 2015) at 6, online: <https://www.health.qld.gov.au/__data/assets/pdf_file/0024/395700/qh-pol-403.pdf>.

GPs and some specialists bulk-bill the government for patient services, and the Medicare rebate is paid direct to the practice at no additional cost to the patient. Others bill the patient whatever that practice determines the cost of the appointment should be, and then the rebate (which is less than the cost) is paid directly to the patient. In the March quarter of 2018, 84 per cent of all GP visits were bulk-billed, meaning that these patients were not extra-billed by doctors in those practices.[38]

Historically, the Commonwealth has not tested the "civil conscription" limitation in section 51 (xxiiiA) of the Constitution and has acted as if it were prohibited by the Constitution from controlling pricing. Doctors providing services privately may, therefore, extra-bill patients any amount above the amount reimbursed by Medicare. If a GP visit was not bulk-billed, patients had an average out-of-pocket cost of AUD$68 per item.[39] Thus, individual doctors in private practice have full autonomy in determining their own fees, although consumer/contract law also applies.[40] Medicare reimbursement rates have been indexed against the Department of Finance's wage-cost index and the consumer-price index. However, as a cost-containment measure, the government stopped indexation from 2013, although is gradually reintroducing it from 2018.[41]

38 Australian Government Department of Health, "Quarterly Medicare Statistics" (4 September 2019), online: <http://health.gov.au/internet/main/publishing.nsf/Content/Quarterly-Medicare-Statistics>, Table 1.1b.

39 *Ibid*.

40 *Competition and Consumer Act 2010* (Cth). This *Act* is based on a premise that competition in markets is desirable. Doctors who mislead patients over fees may be subject to sanctions under this *Act*. Fees are also subject to self-regulation. See the Australian Medical Association, Australian Medical Association Code of Ethics (2004) online: <https://ama.com.au/sites/default/files/documents/AMA%20Code%20of%20Ethics%202004.%20Editorially%20Revised%202006.%20Revised%202016_0.pdf> at 2.7. It addresses fee setting and states: "Set a fair and reasonable fee having regard to the time, skill and experience involved in the performance of your services, the relevant practice costs and the particular circumstances of the case and the patient." A doctor who charged excessively could face disciplinary proceedings by the Medical Board of Australia, although it appears that these matters tend to be resolved before a disciplinary hearing; I Freckelton, "The ethics and regulation of overcharging: issues in the commerciality of the health practitioner-patient relationship" (2014) 21:3 J Law Med. 497.

41 Austl, Commonwealth, *Budget overview*, (Canberra: Commonwealth of Australia, 2017) online: <https://www.budget.gov.au/2017-18/content/glossies/overview/html/overview-07.htm>.

The Australian Medical Association has stated in any event that the indexing did not keep pace with real cost increases.[42] In summary, Australia's Medicare arrangements remain, as famously characterized more than fifty years ago, as "private practice, publicly supported."[43]

The introduction of Medicare and free public hospital care did not undermine the continued importance of private finance in the Australian system but it did result in a rapid decrease in the number of Australians holding private health insurance (PHI) for public hospital care. Initially insurance for private hospital care remained stable.[44] The Coalition was re-elected in 1996 and wanted to maintain a vigorous private health system because of the ideological position as discussed. Accordingly, from 1996, it progressively instituted a regulatory framework to encourage Australians to purchase PHI covering care in private hospitals.[45] It is important to note that, unlike in Canada or the United States, PHI is not provided through employers as part of an employment package; individuals must choose whether or not to purchase the product.[46] The Coalition argued that such a regulatory framework was necessary for the sustainability of the public health system as a robust privately financed

42 Australian Medical Association, *Guide for Patients on how the health care system funds medical care*, (Canberra, AMA, 2015) online: <https://ama.com.au/article/guide-patients-how-health-care-system-funds-medical-care#First>.

43 Theodore Fox, "The Antipodes: Private Practice Publicly Supported" (1963) 281:7286 The Lancet 875–879.

44 Fiona McDonald & Stephen Duckett, "Regulation, Private Health Insurance, and the Australian Health System" (2017) 11:1 McGill JL & Health S31 at S43.

45 *Ibid* at S31; Stephen Duckett & Terri Jackson, "The new health insurance rebate: An inefficient way of assisting public hospitals" (2000) Medical J Austl, 172 (9), 439–444; Stephen Duckett, "Coercing, Subsidising and Encouraging: Two Decades of Support for Private Health Insurance" in Damien Cahill & Phillip Toner, eds, *Wrong Way: How Privatisation and Economic Reform Backfired* (Melbourne: La Trobe University Press in conjunction with Black Inc., 2018), 40–58 at 47.

46 Initially, access to hospital care for poorer people was provided through state government public hospitals; access to general practitioners was supported through friendly society and other "lodge" type arrangements, with these eventually supplanted by voluntary medical-insurance arrangements, often sponsored by medical societies; see Boxall & Gillespie, *supra* note 24. In these circumstances there was no real policy vacuum for employer-sponsored arrangements. Early-twentieth-century industrial relations frameworks focussed on ensuring that all (male) employees had a decent wage to support their family, with health care costs not being separately provided for.

sector would (it was claimed) take pressure off the public system by moving patients into the private system, enable consumer choice of providers, help the private sector, and restore "balance" between the public and private sectors.[47] Since 1953, the Commonwealth has used its constitutional power over insurance[48] to intervene in the PHI market in Australia to require PHI to be community-risk rated rather than individually risk rated. That is to say, private insurers are prohibited by law from fixing a premium price based on an individual' age, gender, or health status.[49]

The first step in the regulatory framework supporting the privately financed sector was for the Commonwealth to subsidize PHI premiums for approved products (i.e., those that offered private hospital cover). From 1 July 2019, the premium subsidy was 25.059 per cent for those under sixty-five years of age, 29.236 per cent for those aged sixty-five to sixty-nine, and 33.413 per cent for those aged seventy and older, on the lowest income tier.[50] The subsidy rate is adjusted annually in an attempt to moderate the rate of growth of government outlays on PHI.[51] The subsidy is also means-tested. For example, for a single person, the subsidy is reduced by about 10 per cent if one earns over AUD$90,000, 20 per cent if one earns over AUD$105,000, and completely eliminated if one earns more than AUD$140,000.[52] The average wage in Australia is approximately AUD$85,000.[53] The premium subsidy, which was more modest when initially introduced, resulted in minimal increased uptake of PHI.[54]

In response, the Commonwealth in 1997 introduced a 1–1.5 per cent taxation penalty (Medicare levy surcharge) on those who do not have PHI after age thirty-one or who cease holding PHI after age

47 McDonald & Duckett, *supra* note 44 at S44–45.

48 *Constitution Act*, *supra* note 8 at s 51(xiv).

49 *Private Health Insurance Act 2007* (Cth), s 55–1.

50 Australian Commonwealth, Australian Taxation Office, "Income Thresholds and Rates for the Private Health Insurance Rebate" (29 June 2017), online: <https://www.ato.gov.au/individuals/medicare-levy/private-health-insurance-rebate/income-thresholds-and-rates-for-the-private-health-insurance-rebate/>.

51 *Private Health Insurance Act*, *supra* note 49 at ss 22–15(5A) to (5E), 22–30 to 22–45; *Tax Laws Amendment Act (Medicare Levy Surcharge Thresholds) Act (No 2) 2008* (Cth), Schedule 1, ss 2, 7.

52 *Ibid* ss 22–15(2) to (4), 22–35; *supra* note 50.

53 See Austl, Commonwealth, Australian Bureau of Statistics, "Full-time average total earnings" (November 2017), <http://www.abs.gov.au/ausstats/abs@.nsf/mf/6302.0>.

54 McDonald & Duckett, *supra* note 44 at S43.

thirty-one.[55] There is a limited exception in that the Medicare levy surcharge does not apply to singles with incomes under AUD$90,000 or to families with incomes under AUD$180,000.[56] However, this too only resulted in minimal increased uptake of those holding approved PHI policies.[57]

Finally, the Commonwealth introduced a scheme called "lifetime health cover loading";[58] if a person does not hold PHI after age thirty-one, or ceases holding it at any point, and then purchases PHI, the insurance companies are required to increase that person's premiums for a ten-year period at a rate of 2 per cent extra on the premium for each year after age thirty that they take out PHI. This policy measure substantially increased the number of persons holding PHI, from 33.5 per cent in 1996,[59] when the lifetime arrangements came into effect, to its 2015/2016 level of approximately 46 per cent.[60] However, while there were increases in the number of Australians who held PHI after 1996, changes introduced in 1995 allowed the development of policies which did not cover all types of care, and fewer people post-1996 thus had a comprehensive PHI policy. More held policies that did not cover certain services, for example, obstetrics, or where there was a policy excess—that is, the policy holder has to pay the first thousand dollars, or where coverage was capped at a specified dollar value, and beyond that the individual had to pay any additional costs.[61] So while 46 per cent of Australians in 2015/2016 held some form of approved PHI (that covers private hospital treatment),[62] the fact that approximately

55 *Medicare Levy Act 1986* (Cth), ss 6, 8B–8G.

56 Austl, Commonwealth, Australian Tax Office, *M2 Medicare Levy Surcharge (MLS)* (Canberra: ATO, 2018), online: <https://www.ato.gov.au/Individuals/Tax-Return/2018/Tax-return/Medicare-levy-questions-M1-M2/M2-Medicare-levy-surcharge-(MLS)-2018/?=redirected>.

57 McDonald & Duckett, *supra* note 44.

58 *Private Health Insurance Act*, *supra* note 49 at s 31–1.

59 Austl, Commonwealth, Bills Digest 76, *Private Health Insurance Incentives Bill 1996*, (Canberra: Commonwealth of Australia, 1996/1997), online: <https://www.aph.gov.au/Parliamentary_Business/Bills_Legislation/bd/BD9697/97bd076>.

60 Austl, Commonwealth, Australian Institute of Health and Welfare, *Private Health Insurance Expenditure* (Canberra: AIHW 2015–2016), online: <https://www.aihw.gov.au/getmedia/08320d6a-4ceb-4c75-a16b-aa1a4c9f6d15/aihw-20592-private-health-insurance-expenditure.pdf.aspx> [Private Health Insurance Expenditure].

61 McDonald & Duckett, *supra* note 44 at S43; *Private Health Insurance Act*, *supra* note 49.

62 Private Health Insurance Expenditure, *supra* note 60.

32 per cent of those who held approved PHI had non-comprehensive policies[63] implies the purchase thereof was for cost-containment and tax-avoidance reasons, rather than wanting the product.[64] There is increasing dissatisfaction among the Australian population toward the significant annual premium increases being imposed by insurers and "junk" policies that are either non-usable or not usable without significant copayments.[65]

## Consequences of Health-System Design

The Commonwealth government is constrained constitutionally to allow a two-tier system,[66] and politically one dominant political grouping, the Coalition (since 1947 it has been in government for, over different periods, approximately fify years), is, as discussed earlier, ideologically predisposed not only to permit but to actively support and subsidize a strong "private" system,[67] no matter if there are more significant efficiencies to be obtained from a different design. In the next section, we turn to examine some of the consequences of the public/private system design in Australia.

### *Sustainability*

The subsidies paid by the Commonwealth for PHI are estimated to cost over AUD$6 billion per annum. Further support for private health provision is provided outside the PHI regulatory framework through Medicare rebates for private hospital care at over

63 McDonald & Duckett, *supra* note 44.

64 *Ibid* at S51.

65 Austl, Commonwealth, *Private Health Insurance Consultation* (Canberra: Health, 2015–2016), online: <http://www.health.gov.au/internet/main/publishing.nsf/Content/PHIconsultations2015-16>.

66 Phrased as not allowing "civil conscription" in the *Commonwealth of Australia Constitution Act 1900* (Cth), s 51(xxiiiA).

67 About 70 per cent of all health care funding in Australia is from government; the focus in the public debate has been on how much of that funding should be through public entities ("public provision") compared to through privately incorporated bodies, including privately incorporated medical practices ("private provision"). Despite the very large public subsidy, private providers have extensive autonomy about ownership structures—including listing of the Australian Stock Exchange—and billing arrangements. It is this level of autonomy, rather than their funding, which allows the continued use of the designation "private" for these services.

AUD$3 billion per annum. This comes to a total of approximately AUD$10 billion annually, paid for from the public purse.[68] The federal government subsidy for PHI is expected to grow 7 per cent in real terms over the period from 2015/2016 to 2018/2019.[69] Growth in Commonwealth government spending in health is 3.2 per cent overall, and its spending on public hospitals is expected to grow at 6.7 per cent from 2015/2016 to 2018/2019.[70] The rate of the growth in the PHI subsidy raises concerns about whether this is sustainable in the long term.[71] It also raises concerns about whether the large subsidy for PHI is the most efficient use of taxpayer and private funds, as overheads are higher in the private system.[72]

### *Cream skimming*

A further issue is transfers of high-cost and high-risk patients between private and public hospitals. A recent study found that the incidence of Australian private hospitals transferring patients to public hospitals increased with disease severity and treatment complexity.[73] The authors suggest that this is evidence of a phenomenon referred to as "cream skimming," where there is an incentive for private providers to transfer more expensive patients to the public system.[74] It found that these patients are more likely to stay longer and cost more, even when health conditions and personal characteristics (i.e., higher acuity patients who need the greater post-operative support that can be provided in public hospitals) are controlled for.[75] As Cheng et al note, "the practice of cream skimming by private hospitals

68 Duckett, *supra* note 45 at 49–50.

69 See Stephen Duckett, "Aged and Confused: Why the Private Health Insurance Industry is Ripe for Reform" *The Conversation* (10 November 2015), online: *The Conversation* <http://theconversation.com/aged-and-confused-why-the-private-health-insurance-industry-is-ripe-for-reform-50384>; Austl, Commonwealth, *Budget 2015–2016: Budget Strategy and Outlook*, Budget Paper No 1 (Canberra: Commonwealth of Australia, 2015) at 5–13, 5–23, online: <https://budget.gov.au/2019-20/content/bp1/index.htm>.

70 *Ibid.*

71 McDonald & Duckett, *supra* note 44 at S56–58.

72 *Ibid* at S57.

73 TC Cheng, JP Haisken-DeNew & J Yong, "Cream skimming and hospital transfers in a mixed public-private system" (2015) 132 Social Science and Medicine 156 at 160.

74 *Ibid* at 162–163.

75 *Ibid* at 162.

implies that public hospitals will be saddled with difficult and high-cost patients, who are adding strain on an increasingly limited budget."[76] The research also found that the same phenomenon held in reverse, that is, public hospitals were more likely to transfer cheaper (healthier) patients to private hospitals.[77] This was also suggested to be an example of cream skimming but, in this instance, on the part of dual-practice physicians.[78] Given that private-sector work is more lucrative,[79] doctors who work in dual practice are postulated to have an incentive to treat healthier (cheaper) patients in the private system, and hence to transfer those patients from the public system to the private one.[80] This dual practice has significant implications for the sustainability of the Australian public health system.

### *Workforce implications*

McAuley argues that the assumption underlying the PHI regulatory framework—that higher rates of private hospital usage would relieve public hospitals—was flawed, as it considered only demand-side factors.[81] Supply-side factors suggest that human resources, especially specialist doctors, will go where the money is.[82] Research indicates that when medical practitioners allocate more hours of work to the private sector, the number of hours they are available to work in the public sector decreases.[83] As of 2013, remuneration was greater in the private sector in Australia.[84] Canada's system may be less able to compensate for any shift should private practice be made more

76 *Ibid* at 163.

77 *Ibid* at 160.

78 *Ibid*.

79 TC Cheng, G Kalb & A Scott, *"Public, Private or Both? Analysing Factors Influencing the Labour Supply of Medical Specialists"* (Melbourne Institute Working Paper No 40/13, 2013), online: <https://melbourneinstitute.unimelb.edu.au/downloads/working-paper-series/wp2013n40.pdf> at 1.

80 Cheng et al, *supra* note 73 at 157.

81 Ian McAuley, "Private Health Insurance and Public Policy" (Paper delivered at the 2016 Health Insurance Summit in Sydney, 28 July 2016) at 7 [unpublished], online: <https://cpd.org.au/wp-content/uploads/2016/07/PHI-conference-July-2016.pdf>.

82 See Cheng et al, *supra* note 79 at 1; McAuley, *ibid*.

83 E Mossialos et al, *International Profiles of Health Care Systems* (Commonwealth Fund, 2017) at 7.

84 Cheng, *supra* note 79 at 9.

available in that country as it has 2.5 practicing physicians per 1,000 population, in comparison with Australia's 3.5.[85]

### *Wait times*

The data in respect of wait times in Australia and Canada are somewhat unclear but show some significant differences. Table 10.1 presents data from Commonwealth Fund comparisons. First and second rows of the table relate to out-of-hospital care. In Australia, PHI does not cover out-of-hospital care by primary-care doctors or specialists (who are all considered private providers in the Australian health system) if those services are covered by Medicare. Some patients will pay a copayment. On the face of it, third row of the table indicates that wait times for elective surgery are less in Australia than in Canada. The Australian data may be average waits for public hospital care—where there are waits—and private hospital care where there are no waits.

**Table 10.1. Wait times, 2016**

| | Australia | Canada |
|---|---|---|
| Same-day/next-day appointments | 67% | 43% |
| Two months or more to see a specialist | 13% | 30% |
| Four months or more for elective surgery[86] | 8% | 18% |

Source: Commonwealth Fund, *International Profiles of Health Care Systems* (Commonwealth Fund 2017) < https://international.commonwealthfund.org/stats/?cat=access_to_care>.

A closer look at the data shows a different picture. About 748,000 Australians on a waiting list were admitted to public hospitals for elective surgery in 2016/2017.[87] Recent data suggests that, in 2016/2017, the median waiting time for elective surgery in Australia was thirty-eight days.[88] The amount of time within which 90 per cent of patients were admitted for elective surgery was 258 days.[89] The national proportion of patients who waited more than 365 days to

85 Mossialos et al, *supra* note 83 at 7.

86 The Australian wait time is for public hospital care only; there are essentially no waiting periods for private hospital care in Australia.

87 Austl, Commonwealth, Australian Institute of Health and Welfare, *Elective surgery waiting times 2016–2017 Australian hospital statistics* (Canberra: AIHW, 2017) at vii.

88 *Ibid* at 28.

89 *Ibid*.

be admitted for elective surgery was 1.7 per cent.[90] Table 10.2 presents OECD data by procedure type in the public health systems in Australia and Canada, and indicates that patients wait longer for key elective-surgery categories in Australia.

**Table 10.2. Wait times from specialist assessment to treatment, days, 2016**

| Surgery type | Australia | Canada |
|---|---|---|
| Cataract surgery | 85 | 67 |
| Coronary bypass | 13 | 6 |
| Prostatectomy | 41 | 39 |
| Hip replacement (total and partial, including the revision of hip replacement) | 110 | 98 |
| Knee replacement | 195 | 116 |

Source: OECD, "Health Care Utilisation: Waiting Times" (20 June 2019), online: <https://stats.oecd.org/Index.aspx?QueryId=49344>

While data on waiting lists for elective surgery is kept and reported on nationally in Australia, the hidden wait list is the time it takes to get a specialist appointment and/or appointments for diagnostic procedures through the public system. There is no consistent data on the extent of these hidden waiting lists: some states do not publish anything (e.g., New South Wales) and, for others, the use of different metrics make comparisons difficult.[91] However, media reports suggest that hidden wait times may be significant. In South Australia, one patient was reported waiting sixteen years for an appointment.[92]Australian Capital Territory media reported that the wait time for an initial appointment with a specialist for those at the ninetieth percentile (i.e., those who wait the longest) varied significantly between specialties, with a wait of 1,398 days (3.8 years)

90 *Ibid.*

91 Stephen Duckett, "Getting an initial specialists' appointment is the hidden waitlist," *The Conversation* (7 January 2018), online: *The Conversation* <https://theconversation.com/getting-an-initial-specialists-appointment-is-the-hidden-waitlist-99507>.

92 ABC news, "Some patients waiting more than 16 years for hospital treatment in SA" *ABC News* (1 July 2018) online: <http://www.abc.net.au/news/2018-07-01/patients-waiting-more-than-16-years-for-hospital-treatment-in-sa/9929146>.

to see a urologist and 213 days to see a gynecologist.[93] In Victoria, 2015 data indicated that the median wait in one regional hospital for an ear, nose, and throat specialist was 469 days, and seven days for a gynecologist, although there was significant variation between hospitals.[94] At least one state suggests that they may collect and make public such data in the future.[95]

By comparison, waiting times in the private sector for elective surgery are so small as to be negligible. The absence of lengthy waiting times is a key selling point for private health insurers, who promote "on demand" surgeries as a major benefit of their policies. There is some evidence that the differential between waiting times influences relative levels of demand for public and private hospitals; a 2011 paper by the Melbourne Institute suggested that the two key simultaneous determinants of choice between being treated in a public or private hospital were public health-system waiting times and PHI costs.[96] The implication of the Australian experience is that an extensive private system is not associated with shorter average waits; rather, the reverse is true.

### *Private health insurance*

While PHI may reduce wait times for individuals who hold PHI, McAuley argues that PHI re-assigns queues for services on the basis of ability to purchase a PHI policy, rather than on the basis of clinical need.[97] There is no evidence that the increase in the privately insured population has led to a significant reduction in public-sector waiting times. A Melbourne Institute report states that the empirical data suggests the "impact of private health insurance on alleviating the

93 D White, "Hidden data reveals that patients can wait five years to see a specialist," *Canberra Times* (30 April 2018), online: <https://www.canberratimes.com.au/politics/act/hidden-data-shows-patients-can-wait-five-years-to-see-a-specialist-20180424-p4zbeh.html>.

94 J Medew, "Secret data on hospital waiting times shows public health system is in 'crisis'," *The Sydney Morning Herald* (17 August 2015), online: <https://www.smh.com.au/healthcare/secret-data-on-hospital-waiting-times-shows-public-health-system-is-in-crisis-20150817-gjorwq.html>.

95 White, *supra* note 93.

96 T Cheng & F Vahid, *Demand for hospital care and private health insurance in a mixed public-private system: Empirical evidence using a simultaneous equation modelling approach* (Melbourne: Melbourne Institute of Applied Economic and Social Research, University of Melbourne, 2011) at 2.

97 McAuley, *supra* note 81.

burden on the public hospital system is not expected to be large."[98] Indeed, research from 2005 indicated that a higher proportion of private admissions to hospital is associated with *higher* public hospital waiting times, not lower.[99] The PHI regulatory framework commenced on 1998; however, in 2009, the Commonwealth government entered into an agreement to provide the states with additional funding to manage elective-surgery wait times in the public system.[100] This implies that wait times continued to be a problem—even nearly ten years after the PHI framework of regulation, subsidies, and penalties was introduced.

Other research indicates there was, at best, minimal shifts in private and public shares of hospital admissions.[101] Duckett has suggested that this is not surprising for five reasons.[102] First, few private hospitals provide emergency care, so this type of care cannot be diverted from the public system. Second, some elective surgeries are only performed in public hospitals due to a requirement for extensive post-surgery support than is available in a private hospital. Third, some private patients may have procedures in a private hospital that are not clinically necessary, for which they would not have been admitted into a public hospital. Fourth, some people who purchase PHI are healthy and would, therefore, not affect demand on the public hospital system. Fifth, if a person is taking out PHI for tax-avoidance reasons, they may not hold a product they can use without significant extra costs to them, and would continue to use the free public system.[103]

98 Cheng & Vahid, *supra* note 96 at 25.

99 Stephen J Duckett, "Private Care and Public Waiting" (2005) 29:1 Aust Health Rev 87 at 92.

100 Austl, Commonwealth, Council of Australian Governments, *National Partnership Agreement on the Elective Surgery Waiting List Reduction Plan*, (Canberra: COAG, 2009) online: <http://www.federalfinancialrelations.gov.au/content/npa/health/national-partnership/past/elective-surgery-waiting-lists-NP.pdf> [Waiting List Reduction Plan].

101 See R Moorin and C Holam, "Does federal health care policy influence switching between the public and private sectors in Australia?" (2006) 79:2/3 Health Pol'y 284; Kate Brameld, D'Arcy Holman & Rachael Moorin, "Possession of Health Insurance in Australia: How Does it Affect Hospital Use and Outcomes?" (2006) 11:2 J Health Serv Res Policy 94 at 97; Rachael Elizabeth Moorin, Cashel D'Arcy & James Holman, "Modelling Changes in the Determinants of PHI Utilisation in Western Australia across Five Health Care Policy Eras between 1981 and 2001" (2007) 81:2 Health Pol'y 183 at 188; Ian McAuley, "Private Health Insurance: Still Muddling Through" (2005) 12:2 Agenda 159 at 167–68; Duckett, *supra* note 99 at 92.

102 Duckett, *supra* note 45 40–58.

103 See also McDonald & Duckett, *supra* note 44 at S52; McAuley, *supra* note 81.

### *Wait time initiatives*

The initial rhetoric about public subsidies for PHI posited a causal relationship between increased numbers of persons holding PHI and shorter wait times. However, as noted, the reality is the reverse.[104] There are many factors which influence waiting times, and there have been a plethora of initiatives to reduce waiting.

The National Partnership Agreement on the Elective Surgery Waiting List Reduction Plan[105] was entered into by the Commonwealth and the states and territories in 2009 and expired in 2011. The Commonwealth committed funding to reduce the numbers of persons waiting longer than clinically indicated times by improving efficiency and capacity within the public system, with AUD$150 million for an immediate reduction in public waiting lists, AUD$150 million for systems and infrastructure improvement, and a further AUD$300 million for reducing the numbers of "long wait" patients to comply with the National Elective Surgery Urgency Categorisation Guideline[106] and to improve overall efficiency.[107] National Elective Surgery Targets (NEST) were established in 2013.[108] The states agreed to report quarterly data to the Commonwealth about their achievements against NEST, and that that data be made public on the MyHospitals website[109] and on state health department websites. Reports suggest that results from this cash injection were mixed:

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104 Duckett, *supra* note 45.

105 Waiting List Reduction Plan, *supra* note 100.

106 Australian Health Ministers' Advisory Council, *National Elective Surgery Urgency Categorisation Guideline* (2015), online: <http://www.coaghealthcouncil.gov.au/Portals/0/National%20Elective%20Surgery%20Categorisation%20-%20Guideline%20-%20April%202015.pdf>.

107 *Ibid* at 3. Essentially, there are target maximum waiting times for different categories of patients, e.g., urgent patients (category 1) should be seen in thirty days, semi-urgent in ninety days. Patients waiting longer than these periods are "long waits."

108 Austl, Commonwealth, *National Partnership Agreement on Improving Public Hospital Services* (2013) online: <http://www.federalfinancialrelations.gov.au/content/npa/health/_archive/national-workforce-reform/national_partnership.pdf> [Improving Public Hospital Services].

109 See "My Hospitals" (2018), online: *Australian Institute of Health and Welfare* <https://www.myhospitals.gov.au/>. The data continues to be publicly reported despite the agreement having expired in 2015.

> While the total volume of elective surgery under the plan exceeded expectations (41,584 operations were completed against a target of 25,278), the number of "long wait" patients actually increased over the period 2007–2008 to 2009–2010. This means that while some patients were seen within clinically recommended times, the number of people who waited for significant periods of time continued to increase.[110]

This agreement was followed by the National Partnership Agreement on Improving Public Hospital Services (NPA IPHS), which promised the states up to AUD$650 million to meet NEST, up to AUD$150 million in elective surgery capital, up to AUD$500 million to achieve a four-hour National Emergency Access Target (established in the NPA IPHS) in public hospital emergency departments, up to AUD$250 million in emergency-department capital, up to AUD$1.6 billion for new subacute beds, and up to AUD$200 million in a flexible funding pool for capital and recurrent projects across elective surgery, emergency departments, and subacute care.[111] At the state level, Queensland Health reported that NPA IPHS led to it implementing "a range of clinical and process improvements in relation to elective surgery services in response to NPA IPHS. These actions resulted in a significant reduction in the number of people waiting longer than clinically recommended for elective surgery in Queensland."[112] Some states also provided further supplementary funding to reduce elective-surgery wait times; for example, in 2017, New South Wales promised an additional AUD$3 million for some health districts.[113]

110 R de Boer, *Reducing elective surgery waiting times—is more money the answer?* (2011), online: *Parliament of Australia* <https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/FlagPost/2011/November/Reducing_elective_surgery_waiting_times_-_is_more_money_the_answer>.

111 Improving Public Hospital Services, *supra* note 108 at 3.

112 Austl, Queensland, Queensland Department of Health, *Wait Times Strategy Statewide Consultation Handbook* (Brisbane: Qld Health, 2015) at 4, online: <https://www.health.qld.gov.au/__data/assets/pdf_file/0025/443914/wait-times-strategy-consultation.pdf>.

113 New South Wales Government, Media Release, "Shorter wait times for elective surgery: Local health districts will receive $3 million to help reduce the wait times for common elective surgery" (12 September 2017), online: <https://www.nsw.gov.au/news-and-events/news/shorter-wait-times-for-elective-surgery/>.

As mentioned earlier, doctors in public hospitals in Australia are paid by the hospital, normally, on a salary basis, not on the fee-for-service model as is usual in Canada. This provides policy-makers and administrators with greater authority to require units within the hospitals and health professionals, including doctors, to achieve efficiencies in service provision through measures such as those described above, and through changes to funding models. In 2011, activity-based funding for public hospital services was introduced to pay the states and territories a "national efficient price" for public hospital services so as to encourage efficiencies.[114]

All of the agreements discussed in this section accept that there is capacity for improvement in efficiency across the system and a desire to use mechanisms and invest funding to achieve them. Australia's public health system is more efficient than Canada's.[115] This significant injection of cash into both the direct provision of services to reduce waiting lists and in efficiencies within the system, as well as public reporting, has likely been a significant factor in the current status of wait times for elective surgery in Australia.

## Conclusion

The Australian health system is characterized by a complex division of responsibilities and roles shared between the Commonwealth of Australia and state governments, as well as a complicated interplay between public and private sectors. A constitutional provision, prohibiting civil conscription, places some limits on the Commonwealth government's ability to limit the creation and maintenance of a private sector. The Commonwealth's current interpretation of the Constitution is that it is unable to control prices charged by doctors in private practice; an interpretation which has not yet been examined by the High Court of Australia. Although Australia's Medicare

114 Austl, Commonwealth, Council of Australian Governments, *National Health Reform Agreement* (Canberra: COAG, 2011), online: <http://www.federalfinancialrelations.gov.au/content/npa/health/_archive/national-agreement.pdf>. Activity-based funding was first introduced in 1993 in Victoria; see S Duckett, "Hospital payment arrangements to encourage efficiency: The case of Victoria, Australia." (1995) 34 Health Pol'y 113–134.

115 Y Varabyova & J Schreyögg, "International comparisons of the technical efficiency of the hospital sector: panel data analysis of OECD countries using parametric and non-parametric approaches" (2013) 112(1/2) Health Pol'y 70.

system was based on Canada's, there are significant differences due to Australia's constitutional framework and political ideologies, which, in effect, guarantees the existence of a two-tier system, regardless of policy merit.

Politically, the Coalition opposed the introduction of a universal public health system until the late 1980s. The Coalition then conceded that it could not politically continue to oppose Medicare, but, despite this, it has maintained an ideological commitment to not just allow but also to encourage and subsidize a parallel private health sector. This active role in promoting a private health sector is different from many other countries that permit a public/private health system but that do not actively promote PHI and the private system to the same extent as seen in Australia.[116] Ireland is an exception to this as it offers subsidies for PHI, also for the expressed purpose of allowing people to access the private system to avoid waiting times. It also imposes penalties on those who do not take up PHI.[117] Some other countries offer subsidies to employers to assist them to provide PHI to their employees, but employers have never played a significant role in providing PHI to employees in Australia. This is a significant difference in tradition between Australia and Canada, as Canada's norm is that employers provide PHI (albeit focused on pharmaceuticals and dental care). Given 66 per cent of Canadians currently hold PHI through their employer, any expectation emerging from the *Cambie* litigation that employers should provide PHI that also covers medically necessary services could have significant implications for productivity and employment rates.[118]

The consequences of Australia's approach to its public/private system provide a number of lessons for Canada. Australia's significant subsidy of PHI raises questions about sustainability in terms of the direct and indirect costs of the subsidy. Similar questions are also raised about the sustainability of the public health system, due to the phenomenon of dual practice and cream skimming, with expensive patients shifted to the public system and less expensive ones to the private.

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116 McDonald & Duckett, *supra* note 44.

117 S Thomas, "A Comparative Evaluation of Two-Tier Care and the Relationship to Wait Times" (7 February 2018), online: *Centre for Health Law, Policy and Ethics* <http://ottawahealthlaw.ca/twotiercomparative>.

118 Flood & Thomas, *supra* note 1 at 445.

A key argument in the *Cambie* case is that wait times for elective surgery would be better in Canada if it had parallel public and private systems. A superficial look suggests that Australia's system performs substantially better than Canada's with respect to wait times. However, a detailed look at public hospital wait times for particular procedures indicates that wait times in the public system in Australia may be longer than in Canada for some procedures. In other words, Australians may on, aggregate, wait less time for elective surgery but those who rely on the public system wait longer than Canadians. It is important to note that there is also a lack of public information about wait times to get on the public elective-surgical waiting list, or in respect of the public management of non-emergency medical care unconnected to surgery in Australia.

It would seem unlikely than any better performance in terms of wait time management is solely linked to Australia's approach of actively supporting a parallel private health system through using regulatory measures to encourage Australians to purchase PHI. While one of the premises behind the PHI regulatory framework was that higher numbers of people with PHI would reduce waiting times, as this chapter discusses, it is unclear what, if any, positive impact this has had on waiting lists or public hospital utilization more generally. It is, however, clear that Australia did not only rely on the private health system to manage elective-surgery wait times in the public system. The Commonwealth government also provided significant funding targeted at enabling the states to achieve efficiencies within elective-surgery management and the management of the public hospital system more generally, as well as to directly reduce waiting lists by undertaking more surgeries. It accompanied this with accountability mechanisms that set clear targets for elective surgery, and subsequently, emergency-department throughput, required reporting to the Commonwealth of data in relation to certain indicators on a quarterly basis, and placed this data on publicly accessible websites, enabling public scrutiny.

Australia's higher number of doctors per capita may make it easier for it to adjust to the time-sharing of many specialists between the private and public sectors, or the loss of doctors to the private system, in contrast with Canada, which has a significantly lower number of doctors per capita, which could also account for some of the wait time differentials.