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Money and markets in Australia's healthcare system

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Since the 1980s, changes in government policy, including legislation to enable third-party insurance contracting, increased levels of state support for private health insurance, and public–private partnerships,¹ have encouraged corporate investment into the hospitals, medical centres, pathology laboratories and diagnostic facilities of the Australian healthcare system. Driven by the ‘new public management’ (NPM) reform agenda (English 2005, p. 93), and in conformity with the contradictory and crisis-driven nature of neoliberalism (Peck, Theodore & Brenner 2012, p. 25), the government’s explicit agenda of privatisation and marketisation has profoundly altered the way the system is financed and organised. The sector, once dominated by public and not-for-profit, charity or religious institutions, with their own distinct

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1 Public–private partnerships refer to the involvement of private consortia with government to provide infrastructure and related services to the public. The origin of these in Australia, in their current form, can be traced to the election of conservative state governments in New South Wales (1989) and Victoria (1992) (English 2005, p. 92).

but complementary functions, has lost its universal character and been transformed into a highly protected market system. This new system has been very much a creation of government, intent on building private healthcare and health insurance markets, and its presence raises questions about the financial sustainability of a system which is largely uncapped, and about the extent to which healthcare, driven by market rather than medical considerations, can continue to deliver the high quality, accessible healthcare services once envisaged under the concept of Medibank.

This chapter begins with a brief overview of the Australian healthcare system and relevant policies. This leads on to an exploration of the history of private and public health insurance schemes, followed by the history of private and public healthcare services. These narratives reveal the extent to which the system has become corporatised and privatised, demonstrating the connections between government policy, the entry of corporate investment, the growth of for-profit organisations, and the changing balance between the private and public sectors. The chapter concludes by examining some of the implications of these changes for the healthcare budget, for the effective planning and delivery of services and for access to essential healthcare services for all Australians.

The Australian healthcare system

The Australian healthcare system is composed of both public and private facilities, and public and private sector workforces, and funded through a complex mix of Commonwealth and state government, corporate, religious, philanthropic and individual sources. Citizens have access to free medical care in public hospitals, and under the national, compulsory health insurance scheme, Medicare, are provided with free or subsidised access to doctors and various medical and health facilities – even though many of these are in the private sector and charge on a fee-for-service basis. The Pharmaceutical Benefits Scheme is also universal and government-funded, providing patients with pharmaceuticals from privately owned pharmacies at a significantly reduced cost where these are recommended by a doctor and on the list of essential medicines.

The Commonwealth government supplies the funds for both Medicare and the Pharmaceutical Benefits Scheme, thus providing the bulk of funds for medical services occurring outside hospitals. State and territory governments join with the Commonwealth to fund public hospitals and community care for aged and disabled persons, while the states and territories are the main providers for ambulance, public dental services (most dental services are provided in the private sector and are not subsidised), public health activities and community health services. Government-owned and operated community health centres are mostly found in locations that are not attractive to the private sector. They do not charge patients for services or access to facilities.

The healthcare system has long been dominated by its large public hospital sector, where most of the research and training is conducted and the specialities of medicine are found (Productivity Commission 2009). These public hospitals provide both in-patient and out-patient services at no charge to Australian citizens. However, the healthcare system also includes an array of small and large private hospitals and facilities (both religious not-for-profits, and corporate for-profits) that patients can access through private health insurance or personal payment. The non-government, religious and charitable sector provides a substantial level of residential aged care, but also a number of hospitals. These services are mostly financed by government.

The funding of healthcare in Australia

In the latter half of the 19th century, healthcare services in Australia developed from their colonial, military roots into a heterogeneous system funded from private, government, military and religious sources. During the first 60 years of the 20th century, several attempts were made by Commonwealth governments to introduce funding reform into this fragmented array of services. The first was in 1928 by Earle Page, a surgeon and Treasurer in the Country–Nationalist Coalition government led by Stanley Bruce (1923–28). Page's national insurance scheme for maternity, old age, sickness and invalidity, based on compulsory contributions from individuals and their employers, was thwarted by the friendly societies (voluntary health insurance associations), employers and doctors' groups. A second proposal came in 1938 from Treasurer

Richard Casey of the newly formed United Australia Party in the conservative government led by Joe Lyons (1932–39). This plan involved a public insurance scheme funded out of the wage system, and was also opposed by the medical profession, employers and even the Australian Labor Party, with the latter insisting on public provision and arguing contributions should not come from wages (Collyer 2012, p. 119).

In 1944, the Labor government created the *Pharmaceutical Benefits Act*, which aimed to provide essential medicines free of charge. Doctors, fearful of ‘civil conscription’ and the imposition of a ‘socialist’ health system styled on the British National Health Service, opposed this Act. The matter ended in the High Court and led to a referendum in 1946 to extend the Commonwealth’s powers to legislate on health-care services. These powers remained limited, for the constitutional amendment prohibited the government from requiring medical professionals ‘to work in a nationalised health or dental service’ (de Voe & Short 2003, p. 348). Given the continuing opposition of doctors (organised at this time by an Australian branch of the British Medical Association), and the newly formed conservative Liberal Party, the consequence for the next few years was the operation of a very limited – and patchy – national health program, with various subsidies offered to *some* hospitals in *some* states for the treatment of *some* public patients.

Further reform to the system occurred in 1953 under a Liberal–Country Party government, when Earle Page, this time as Minister for Health, proposed an alternative, voluntary, government-sponsored health insurance program in consultation with the medical profession. The ‘Earle Page scheme’, as it came to be known, offered public insurance administered by private, non-profit funds. These benefits were subsidised by the Commonwealth government and met part of the cost of medical expenses. Tax deductions were also provided by the Menzies Coalition government to assist with the cost of health insurance premiums (Stebbing & Spies-Butcher 2010, p. 591). Nevertheless, healthcare services during the 1950s and 1960s remained inaccessible to many individuals, for the scheme required patients to purchase private insurance before they could access government benefits. Indeed, the high cost of services led to an accumulation of bad debts which then drove up doctors’ fees, and resulted in 17 percent of Australians without medical coverage. In 1968, the Committee of Inquiry into Health Insurance, established by the Gorton Coalition government (1968–71), confirmed

criticisms of the scheme's failure to cover the entire population, the often large gap between fees charged and insurers' refunds, and the program's complexity and cost (Palmer & Short 2010, p. 61). The committee also pointed out that many of the insurance companies were not only delivering substandard benefits, but appropriating an unreasonably high proportion of the contributions (de Voe & Short 2003, p. 349).

Ideas for alternative healthcare schemes were fiercely debated during these years. In large part, this level of public discussion was made possible by the expansion of the middle class, itself stimulated by growth in the university sector where the new professions (such as social work) and new disciplines (such as health economics, public health and sociology) were beginning to make an impact in the Australian setting (Collyer 2012, pp. 124–25). In opposition in 1969, the Australian Labor Party sought to win over the public by promising to mend the inefficiencies of Australia's existing 78 private medical insurance funds and 109 private hospital insurance funds, with a proposal for a population-wide, compulsory health insurance program funded from a health tax. The scheme, eventually called Medibank, drew heavily on the work of economists Dick Scotton and John Deeble and was put forward as a more equitable and efficient alternative, with patients' costs proportional to incomes and multiple health funds replaced by one government-administered fund (Palmer & Short 2010, p. 62).

Medibank: the national health insurance scheme

After Labor was elected at the 1972 federal election, the Whitlam government set about implementing this health insurance program. Again, efforts to construct a national, publicly funded program were strongly opposed: this time by the Australian Medical Association (AMA),² private health funds and the opposition political parties. The legislation to introduce Medibank was twice rejected by the Senate but finally passed after a dissolution of both houses of parliament, a federal election in which health was again a major issue, and a joint sitting of both houses

2 Branches of the British Medical Association were formed in Australia in the 19th century, and these branches eventually merged to establish the AMA in 1962.

to resolve the continuing deadlock over this and other legislation (Scotton & Macdonald 1993).

Medibank commenced from mid-1975, beginning with the establishment of the Health Insurance Commission (HIC) on 1 July to administer this public medical insurance scheme. Unlike its proposed precursors, the scheme was initially funded entirely from Commonwealth revenue. Doctors were able to bill patients, or the HIC, and accept 85 percent of the scheduled fee as full payment. Later that year free medical care in public hospitals was made available under Medibank, with patients still able to choose to be treated privately, because private health insurance was also available to fund private patient costs in either public or private hospitals (Palmer & Short 2010, p. 63). Under Medibank, all Australians were for the first time provided with full access to hospital care, subsidised for their essential medicines, and able to access services (without cost, or with the assistance of a generous subsidy), when visiting a general practitioner (GP) or having diagnostic tests.

Immediately upon election in 1975, the Fraser Liberal–National Party government commenced the dismantling of Medibank, allowing individuals to opt out of the health tax by paying for private health insurance, and imposing a levy of two point five percent of taxable income for those covered only by the HIC. This was essentially a return to the voluntary Earle Page scheme of the 1950s, for changes in 1981 directed Commonwealth subsidies only to those who paid to join private health insurance funds (with contributions eligible for tax rebates), and it thus eliminated free hospital treatment (Gray 1996, p. 592). These were strong incentives to take out private health insurance coverage. It was a policy designed to reverse the decline in fund membership which had occurred since the introduction of Medibank (Palmer & Short 2010, p. 63).

The Hawke Labor government (1983–91) re-introduced a tax-funded public health insurance scheme on 1 February 1984. Like its predecessor Medibank, it was administered by the HIC but renamed Medicare Australia. In addition to general taxation revenue, the scheme was funded from a one percent levy on taxable income, with lower and upper limits.³ Fees for each specified service were set out in the Medicare Benefits Schedule (MBS), and insurance companies were not allowed to offer ‘gap’ insurance to meet the difference between the

scheduled fee and the actual fee charged by the doctor or hospital (Palmer & Short 2010, pp. 63–64). On this occasion, opposition to the introduction of Medicare from the medical profession was relatively muted. Nonetheless Medicare, like Medibank before it, led to a decline in the proportion of the population covered by private hospital insurance, from above 55 percent in the early 1980s, to 48 percent in 1985 and 30 percent in 1998 (Harley et al. 2011). This decline was not constructed as a 'policy problem' until after the Liberal–National Coalition government took office in 1996. Over the next 11 years, the Coalition continued to 'pay lip service' to Medicare while focusing its efforts on building a financially viable private health insurance sector.

The Coalition government re-built the private health insurance sector by introducing a series of measures to encourage the uptake of private health insurance, including both 'carrots and sticks' (Hall, de Abreu Lourenco & Viney 1999). The 'carrot' of the Private Health Insurance Incentives Scheme (PHIIS) subsidised the cost of premiums for those with low incomes, while the 'stick' was the Medicare Levy Surcharge: a one percent tax on high-income earners who did not purchase cover. The combination of government measures, but especially Lifetime Health Cover (Butler 2002), and the 'fear factor' about being uninsured (Deeble, in Gray 2004, p. 38), arrested and reversed the decline in insurance membership rates. These lifted from a low of 32 percent for hospital insurance and 33 percent ancillary coverage in March 2000, to 46 percent (hospital) and 41 percent (ancillary) in September 2000, and 45 percent (hospital) and 51 percent (ancillary) by June 2009 (Harley et al. 2011, p. 308). In 1999, the PHIIS was extended to a universal 30 percent private health insurance rebate (increased to 35 percent for individuals aged 65–69 years and 40 percent for those 70 years and older in 2005) (PHIAC 2009, p. 12; Kay 2007, p. 587).

Both the Liberal Coalition and Labor parties have shifted positions on the role of Medicare and private health insurance. In the run-up to the 1996 election, Liberal leader John Howard announced his new-found support for Medicare, a strategic move which assisted the Liberal Coalition to win government:

3 The Medicare levy has subsequently been increased to 1.5 percent and the upper limit (of \$700) removed.

Medicare gives people a sense of security ... when Medicare was first introduced I was critical of it ... But over the years people have grown to support it ... And there's no law in politics that says that you can't over a period of time change your view about an issue (Howard 1996, p. 9).

It was a new policy narrative, offering support for the public insurance scheme but constructing the low rate of private health insurance membership as a 'policy problem' requiring an immediate solution (Elliot 2006, p. 133). Changes also occurred on the other side of politics. While in opposition, Labor had opposed the Coalition's private health insurance incentive schemes. However, in the lead-up to the 2007 federal election it committed to retaining the rebate (Biggs 2009, p. 4). Following their election, the Rudd and Gillard Labor governments adopted the language of 'balance' previously employed by the Coalition (Elliot 2006), calling for the rebate to be means-tested and proportionately reduced, and the Medicare Levy Surcharge increased for those on high incomes. A 2009 budget announcement proposed the scheme would be 're-balanced' so that the highest income earners (around one in 10 adults) would 'receive less "carrot" and more "stick" to be insured' (Roxon & Swan 2009). Under this proposal, the private health insurance rebate would no longer be available to the highest income tier, and reduced (by 20 and 10 percent respectively) for the two tiers below; conversely, the Medicare Levy Surcharge would be increased from one percent to 1.5 and 1.25 percent respectively for the top two tiers.⁴ Legislation to this effect was fiercely opposed by the Coalition opposition and defeated in the Senate in 2009; however, the re-introduced Fairer Private Health Insurance Incentives Bill 2011 (and related bills) were passed in 2012. While this change removed or reduced the transfer of public financial support for the highest income earners to purchase private insurance, and reduced annual government expenditure by some

4 As a consequence of this legislation, citizens are eligible for a tax rebate depending on their level of income, whether they have dependents, and whether they are single. The threshold for payment varies each year, changing with the growth in Average Weekly Ordinary Time Earnings. Information about the three tiers of rebate can be found at Department of Human Services (n. d).

\$746.3 million in 2012–13, the rebate scheme preserves substantial public funding of the private health insurance sector.

The private health insurance sector

The private health insurance sector is diverse, including small restricted membership organisations (generally associated with a particular employer or union), the large and influential Blue Cross funds (until recently HCF, HBA, HBF, Mutual Hospital and MBF), friendly societies, regional hospital funds and, since the 1980s, commercial for-profit funds and the national government fund, Medibank Private (the largest insurer). While legislation to privatise Medibank Private was passed in the final term of the Howard Coalition government, the sale was not implemented. The Rudd Labor government transformed this into a 'for-profit' entity with capacity to submit surpluses to Treasury (Shamsullah 2011, p. 27). In contrast, most of the Blue Cross funds were established and run by healthcare providers (doctors, hospitals and associated charities) with little contributor representation on their boards. They have thus traditionally been seen as working in the interests of providers, contributing to the cost control problems associated with voluntary insurance (Shamsullah 2011, p. 26).

The 1990s and 2000s have seen significant consolidation of the private health insurance sector, with 56 health benefits organisations (or insurers) operating in 1989, 44 in 2001 and 34 in 2011 (Industry Commission 1997, p. 97; PHIAC 2001, 2011). However, this consolidation or concentration has not meant a diminishing commercialisation of the sector. The overall *number* of for-profit organisations in the private health insurance sector has varied since they were allowed to operate in Australia after the introduction of Medicare (Shamsullah 2011, p. 27). Indeed, the number of for-profit insurers fluctuated between two and four during the 1990s (Industry Commission 1997), grew to six by 30 June 2001 (PHIAC 2001), increased to seven (of a total of 38 funds) by 2008, nine (of 37) in 2009 and 10 in 2010, dropping back to seven (of 34) in the next year with a number of mergers (PHIAC 2007, 2008, 2009, 2010, 2011). Nevertheless, there has been a significant growth in the *amount of business* conducted by this commercial segment of the insurance sector, for 'the bulk of the health insurance business is now

conducted by funds classed as “for-profit” (Shamsullah 2011, p. 29). These organisations include Medibank Private, the state-owned corporation with the largest market share (PHIAC 2011), followed closely by BUPA (British United Provident Association), which provides health insurance and healthcare service facilities in almost every country in the world (BUPA 2012). This new concentration of private enterprise in the health insurance sector is evident. At 30 June 2011, the seven for-profit insurers had 69 percent of market share, up from 42 percent in 2009 (PHIAC 2009, 2011), and from less than 13 percent in 1997 (Industry Commission 1997).

A protected industry

Private health insurance is an arena where we can see the direct coupling of government policy to strategic, corporate investment. This can be seen at the level of individual organisations as well as the industry as a whole. Medibank Private, the for-profit with the largest market share, for example, was created in 1976 and rapidly developed into the largest fund by 1982. As a new fund, it attracted a younger, lower-risk membership, but was advantaged from the start by its connection with the government fund, Medicare. Administered by the same government authority, the HIC, and able to share its shop front offices with Medicare, the private company’s infrastructure costs were significantly reduced (Shamsullah 2011, p. 27). Complaints from its competitors led to the Howard government’s attempt to privatise the organisation, and when this was unsuccessful, its eventual corporatisation. Medibank Private’s initial market advantage has continued to assist its prosperity, perhaps because it is still regarded by many members of the public as a public entity. With regard to the private health insurance industry as a whole, Shamsullah (2011, p. 23) argues it has ‘never been distinguished by profit-driven firms competing whole-heartedly in a dynamic, free market’. Indeed it has a unique position among industry sectors in Australia, protected from market competition and market downturns through government subsidies and a suite of legislation. The subsidy itself is large. Through the Private Health Insurance Tax Rebate, several billion dollars are shifted to the private health sector each year. In 2011–12, the subsidising of private health insurance amounted to \$4.7

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billion (AIHW 2013a, p. 38). The figures for 1999–2010 are presented in Table 8.1.

Table 8.1: Private health insurance subsidy, Australian Government 1999–2010

Year	Health insurance premium rebates (\$ million)
1999–00	1,576
2000–1	2,031
2001–2	2,118
2002–3	2,250
2003–4	2,387
2004–5	2,645
2005–6	2,883
2006–7	3,073
2007–8	3,587
2008–9	3,643
2009–10	4,262

Source: Australian Institute of Health and Welfare (AIHW) 2011, p. 27. Table 3.5: Funding of health expenditure by the Australian Government, current prices, by type of expenditure.

Government legislation also protects this industry from market competition. Aiming to ensure insurance products were accessible to all (regardless of health status), the fair treatment of contributors and the sound management of the funds; ‘competition between funds on price and product innovation and differentiation has been deliberately stifled’ (Shamsullah 2011, p. 27). Government action has meant the industry’s policies must comply with a comprehensive body of rules,⁵ and its activities are intensively scrutinised by the Private Health Insurance Administration Council (Shamsullah 2011, p. 27). Restrictions include the inability to exclude high risk members, the provision of standard

5 The rules pertaining to the private health insurance industry can be found at Department of Health (2011).

statements of all policies, and price control. There is, consequently, little differentiation between the funds.

One of the implications of state support for the private health insurance sector is that it translates into support – and profit – for private providers of healthcare services. This is clearly seen in the increases in net profits for the largest health service providers that immediately followed the Howard government’s promotion of private health insurance. These increases ranged from 34 percent for Healthscope to 142 percent for Ramsay in 2000–1, and were attributed in their annual reports to ‘improving market conditions associated with increases in private health insurance coverage’ (Hopkins 2001, pp. 232–33). Indeed, the private healthcare services sector, which includes the large for-profit companies Ramsay Health Care and Healthscope, as well as the private but not-for-profit Catholic Hospitals, benefit significantly from the state promotion and subsidisation of private health insurance. Over a 12-month period, the private hospital sector alone expanded its bed capacity by two percent to 28,351 and increased its income by nine percent to \$10.7 billion (2010–11 figures, ABS 2012). Although the relationship between the private health insurance sector and the private provision of healthcare services is a complex one, these figures are indicative of the importance of private health insurance to the sustainability of the private healthcare sector. This is particularly important given that 37 percent of the funding for private hospitals is derived from the state, including 21 percent from the private health insurance rebate.⁶ We turn now to consider healthcare services provision.

The provision of healthcare services

During the 1980s and 1990s, the healthcare services landscape in Australia began to radically alter as corporate players realised the potential

6 Private hospitals in Australia are funded from a variety of sources. In 2009–10, the breakdown of its sources of funding was: health insurance funds (45 percent), individuals (12 percent), other (six percent), and government (37 percent). This latter figure is a combination of Department of Veteran Affairs (nine percent), Australian government (three percent), rebates of health insurance premiums (21 percent), and state/territory governments (four percent) (AIHW 2012a, p. 4).

for expansion of private healthcare and began to systematically enter the market. This pattern, of significant government funding for healthcare services followed by a heightening of corporate and investor interest, is not unique to Australia. It also occurred, for instance, in the United States, where the establishment of the public health insurance schemes in 1965, Medicare and Medicaid, supported and encouraged the growth of private hospitals (Collyer & White 2001, p. 4). Over the subsequent decade, the for-profit hospital sector in that country grew by 55 percent compared with only 28 percent for the non-profit sector (Sax 1990). Publicly funded insurance schemes guarantee *government* income for the medical profession, and given this would otherwise represent the greatest expense to a hospital, provides a significant incentive for investors to enter the healthcare sector.

The rise of the corporate hospital

In Australia, the entry of corporate capital into the healthcare services sector would eventually – and profoundly – alter the provision of services as diverse as pathology laboratories and general practice. It was hospitals, however, that were the first to show the effects of marketisation. The Australian hospital system has unique characteristics and a unique history. Unlike the European model with its basis in religious and private hospitals, the earliest hospitals in this country were military facilities, catering for convicts and military personnel (Daniel 1990, p. 71). The first non-military hospitals were state-owned facilities, created in 1848, seven years after the end of convict transportation and the formal handing over of the military hospitals to government for the use of civilians (Hicks 1981, p. 6). This event also followed the first *Hospitals Act 1847*, where although government took the major responsibility for the cost, hospitals were provided with the autonomy to receive donations and own land (Hicks 1981, p. 6). In contrast to England and Europe, religious and philanthropic hospitals only started to appear in Australia in the middle of the 19th century, as did the private hospitals (Daniel 1990, p. 71; Hicks 1981, pp. 6–7). Moreover, all hospital types were given some government funding, particularly the religious ones (Hicks 1981, p. 6; Sax 1984, p. 25), and historically this has remained the case, with all Australian hospitals relying heavily on government subsidies (Gray 1996, p. 589).

Until the mid-1970s, however, state funding was uncertain and irregular, varying enormously across jurisdictions, and subject to radical change with shifts in government, preventing hospital boards from effectively planning for expansion or renewal. While the Australian Labor Party has always supported the principle of public hospitals, private hospitals (with minimal subsidy) have been the preference of the conservative parties (Gray 1996, p. 590). Thus the renewed support for public hospitals introduced by the Australian Labor Party in the 1940s, ended in the 1950s (Gray 1996, p. 591). Only with the introduction of Medibank, which provided a regular and secure funding basis for hospitals for the first time (Collyer 2012, pp. 128–29; Whitlam 1968), were the large, publicly owned and publicly run institutions able to strengthen and become dominant features of the healthcare system.

From the mid-1980s, however, investors began purchasing the numerous, owner-operated, small private hospitals offering a limited range of services and interspersed throughout the sector. Some investors built new facilities, often luxurious, with an eye to attracting offshore clientele, and sometimes co-located with a large public hospital (Bloom 2000; Brown & Barnett 2004). There were also purchases of some larger, publicly owned institutions, and investors entered into commercial contracts with governments to manage and/or build these ‘public’ hospitals (Collyer 1997; Collyer & White 2001; Collyer, Wettenhall & McMaster 2003; Collyer, McMaster & Wettenhall 2001).

The result was a rapid concentration of hospital ownership in Australia, with a few large corporations purchasing, building, or otherwise owning ‘chains’ of sizeable hospitals (White & Collyer 1998, p. 492). This new hospital landscape emerged with an overall growth in the number of private hospitals from the early 1990s (from 430 in 1991–92 to 593 in 2010–11), and a ‘modest contraction’ in the number of public hospitals (758 in 1991–92, 752 in 2010–11) (an issue discussed in detail below). Table 8.2 shows the change in the relative number of private and public hospitals between 1991–92 and 2010–11, indicating the rapid growth of the private, free-standing, day hospital facilities over the same period.

A similar pattern of change in the hospital sector can be seen in the figures for hospital ‘separations’ (that is, episodes of care). Between 1995–96 and 2004–05 these increased for all hospitals by 35.7 percent. In the public sector the increase was 19.5 percent (acute hospitals),

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Table 8.2: Hospital sector growth 1991–2011. For sources and notes, see appendix at the end of the chapter

Sector and type of hospital	1991–2	1996–7	2001–2	2006–7	2010–11
Public hospitals (acute and psychiatric)	758	729	746	758	752
Private hospitals (acute and psychiatric)	319	319	301	289	279
Private free-standing day hospital facilities	111*	153	246	268	314
Total private hospitals	430	472	547	557	593

but it was a much larger 73.8 percent in the private sector (including free-standing day facilities) (AIHW 2006, p. x). We can best examine these changes over time in terms of 'bed' numbers, a ready measure of 'throughput'. Table 8.3 indicates a remarkable growth in the number of private hospital beds available in the Australian healthcare system between 1991 and 2011. Bed numbers in the public sector have not increased to the same extent over the same period.

The 'modest contraction' or lack of growth in the public hospital sector needs further explanation, as it is of significance to the story of corporate growth and consolidation. Hospitals 'lost' to the public sector over the period were primarily psychiatric hospitals. Two were the result of administrative changes (with three hospitals in Tasmania becoming one 'reporting unit' in 2009–10), and others closed or sold in the process of de-institutionalisation. The number of acute hospitals in the public sector has remained fairly stable, in part due to the growth and preference for day surgery (where medically appropriate). Yet these hospital statistics do not reveal the number of 'public hospitals' now owned and/or managed by the private sector, where 'public' patients are admitted under contract to government. Such hospitals are classified as 'public' within the ABS and AIHW collections, and its patients identified only as public or private.⁷ In other words, there is no separate

⁷ A public hospital is defined as one that is operated by, or on behalf of, the government of the state or territory in which it is established. This includes hospitals which are owned by private or charitable groups but are authorised or

Table 8.3: Available hospital ‘beds/chairs’ 1991–2011

Sector and type of hospital	1991–92	1996–97	2001–2	2006–7	2010–11
Public hospital (acute and psychiatric) beds	57,053	56,836	51,461	55,904	57,772
Private free-standing day hospital beds	–	1,163	1,851	2,251	2,957
Other private hospital beds	–	22,966	25,556	24,427	25,394
Total private hospital beds	19,923	24,129	27,407	26,678	28,351

Source: Compiled from ABS (1995) for 1991–92 data and AIHW (2002, 2003, 2012b, 2013b) with AIHW Australian Hospital Statistics reports for other years also consulted.

category for these privately owned/managed ‘public’ hospitals, nor a category for ‘publicly admitted patients’ who represent a profit-making unit for the corporations concerned. Hence what appears to be a ‘modest contraction’ of the public hospital sector in fact obscures another area of growth in corporate activity – at the cost of state-owned facilities and state-provided care. Moreover, the financial costs of these activities to the state are not available for public scrutiny, as they are only documented in the commercial-in-confidence contracts these corporations have with state governments, and details are not provided even under freedom of information requests. This is a problem of privatisation and has been evident also in the United Kingdom, the United States (White & Collyer 1998, p. 503) and Canada (Whiteside 2013).

Integration and concentration in health services

These dramatic changes to the Australian hospital sector eventually began to have ramifications for other health services as the hospital corporations began to diversify through ‘vertical integration’: the purchasing of radiology and pathology testing laboratories, general practices (White & Collyer 1998; White 2000) and even pharmaceutical

contracted by the government to deliver public hospital services’ (Productivity Commission 2009).

and research facilities (Collyer 2004). Since 2000 there has been an increasing consolidation of the medical market and a concentration of ownership, with ongoing corporatisation, consolidation and integration of pathology companies and diagnostic imaging, and both vertical and horizontal integration of companies and services. For instance, between January 2000 and June 2001, the corporate share of the private radiology market jumped from less than 10 percent to an estimated 46 percent, dominated by Medical Imaging Australasia (20 percent share), Sonic Health Care (12 percent), Mayne (10 percent) and I-Med (eight percent) (Quinlivan 2001); and by 2010 the top four public corporations' share of the private radiology market was above 60 percent (Jones 2010). In pathology, four companies had a 79 percent share of the private market by 2005 (Sonic 36 percent; Mayne 30 percent; Healthscope nine percent; Primary Health Care four percent). In 2009, following Primary Health Care's acquisition of Mayne's pathology interests, the remaining three accounted for 86 percent share, with the non-profit, St John of God, having an additional five percent share (NEHTA 2009).

Companies in both radiology and pathology benefit from the sizeable flow of Medicare funding (Quinlivan 2001). Diagnostic imaging services for example, which include ultrasound, magnetic resonance imaging (MRI) and computed tomography (CT scans), constitute six percent of all medical claims to Medicare, and expenditure on these services represents \$2.15 billion or 14 percent of the Medicare budget (Medical Benefits Reviews Task Group 2012, p. 4). These technologies are distributed across both sectors (for example, 76 MRI machines are in private and 49 in public settings (see Medical Benefits Reviews Task Group 2012, p. 4), and public funding, via Medicare, is provided for both capital and recurrent costs on a fee-for-service basis for both public and private patients.

The arena of general practice demonstrates the complexity of privatisation in healthcare provision. When Medibank was devised in the early 1970s, no attempt was made to alter the fee-for-service nature of this sector. Most GPs operate their own, or work within a private practice, and the introduction of the Medibank system only altered their method of payment, not their status as private sector, self-employed workers. This status nevertheless shifted with the corporatisation of general practice. This began in the 1980s and 1990s with the luxuriously decorated high-traffic 'super clinics' established by the doctor and en-

trepreneur, Geoffrey Edelsten, quickly followed by various competitors including Viscount Holdings (Collyer & White 2001, p. 11). The rate of corporatisation has since settled into a more sustainable pattern, with three main companies involved in their ownership (down from seven in 2007). Two are listed on the Australian Securities Exchange (ASX), and are among the top 100 companies: Sonic Healthcare and Primary Health Care. Sonic leads in terms of market capitalisation (\$5.3 billion), followed by Primary (\$1.8 billion) (ASX 2012). A third large company, the Healthscope Group, though de-listed from the ASX in 2010 with its acquisition by transnationals (The Carlyle Group and TPG, both with headquarters in North America), also owns medical centres in Australia, alongside its pathology and hospital businesses.

In this industry sub-sector, medical centres represent a business opportunity. Medicare benefits paid by the federal government for general practice (across the industry sector) totalled \$4.2 billion for the year ending June 2012 (Healthscope 2013, p. 47). There are approximately 9,380 medical centres and over 27,000 GPs in Australia, and 12 percent of the latter work for either Independent Practitioner Network Ltd (IPN) (Sonic's general practice company since 2008), Primary or Healthscope. The Healthscope Group owns and operates 46 medical centres in Australia (Healthscope 2013, p. 54). Primary Health Care, which acquired Mayne Nickless' health assets in 2008, operates 58 large-scale medical centres (Primary Health Care 2013) and IPN manages over 190 multi-disciplinary medical centres around Australia (IPN 2011; Sonic Healthcare 2011).

During the early 2000s, corporate medical centres appeared to be unprofitable ventures, with their commercial value primarily in the generation of referrals to pathology and diagnostic services owned by the same vertically integrated companies (Jones 2007). It was also thought that many GPs, while valuing the management and support services provided in corporate practice, were averse to restrictions to their clinical autonomy that might be entailed in making for-profit corporatisation profitable (Anderson et al. 2005). In this second decade of the millennium, the sub-industry has consolidated, with medical centres a staple of the larger, for-profit, healthcare sector.

The ownership of private hospitals, and the provision of hospital services, are other significant businesses in the corporate healthcare sector. In Australia there are currently 1,345 hospitals (including free-

standing day hospital facilities), with public hospitals constituting, at most, 56 percent of these.⁸ This has been reduced from its 1991 level of 65 percent, when there were 1,188 hospitals, and public hospitals were the dominant form. Within the corporate hospital sector, there are two leading hospital operators: Ramsay Health Care and the Healthscope Group. Both are large companies, with Ramsay Health Care listed on the ASX (with \$4.8 billion in market capitalisation and revenues of \$2.1 billion for the whole group), and the Healthscope Group, the second largest hospital operator, with revenues of \$2.1 billion (Healthscope 2013, p. 14). Ramsay's Australian hospital portfolio includes a total of 66 hospitals and day facilities (Ramsay 2012a), including many 'public' hospitals – such as the Mildura Base Hospital in Victoria, the Joondalup Health Campus in Perth, and the Peel Health Campus in Western Australia – that it has built or operates as public–private partnerships with state governments. Healthscope has a portfolio of 44 private hospitals across Australia, and its hospital division generates its largest proportion of revenues. Six of its hospitals are co-located with large public teaching hospitals, three are operated on behalf of the Adelaide Community Healthcare Alliance, and a further 11 are leased (Healthscope 2013, p. 52).

The corporate hospital market in Australia is thriving. Although there has not been a growth in the *number* of for-profit companies owning and/or managing hospitals since the 1980s, these companies have nevertheless grown in size and extended their operations into all areas of healthcare, including laboratories and rehabilitation services. And while some companies are independent, owning only one hospital, others are 'group' or 'chain' operations. In 1986 there were 14 for-profit groups, owning an average of six hospitals each. By 2002, the 11 for-profit groups owned an average of 12 hospitals, with 104 between them (O'Loughlin 2002, p. 106). By 2013, over 120 of the 593 private hospitals are for-profit hospitals, including those owned by Ramsay (52 hospitals), Healthscope (44), Health Care (12) and Independent Private Hospitals (seven), as well as numerous independent hospital operators. The 'group' sector continues to grow. Indeed, the Manag-

8 The phrase 'at most,' is used at this point to remind readers that the ABS and AIHW 'public' category for hospitals does not take into account the number of hospitals owned or managed by the private sector.

ing Director of Ramsay, Christopher Rex, suggested in a February 2012 ASX Announcement that 'given the emerging theme of public/private partnerships, the role of the private sector could grow even further' (Ramsay 2012b).

The politics of health service reform

Support for public, universal, compulsory health insurance has long been a feature of Australian Labor governments. Likewise, Labor has historically shown a greater preference for supporting the *public* hospital system and providing *public* healthcare services. Nevertheless, the reshaping of the healthcare services landscape through marketisation and corporatisation has been the product of the action of all major parties – albeit unequally – at both Commonwealth and state government levels. The Coalition's new-found support for Medicare from 1996 (alongside a strengthened advocacy for private health insurance), was only marginally pre-dated by another significant shift, this time legislative, introduced in 1993 by the Keating Labor Commonwealth government (1991–96). Charged with the responsibility for managing a highly complex private-public system that has never been able to effectively cap medical fees, the government's response to continually rising costs was to amend the *Health Insurance Act 1973* and the *National Health Act 1953*, to allow third parties to sign contracts with individual doctors or hospitals so that health services could be supplied for fixed fees.

This legislation enabled health insurance companies (or other bodies such as unions or employer groups) to offer direct contracts with hospitals (which could then sign up appropriate specialists) for services supplied to their members. It also allowed the insurance funds to offer 'gap' coverage to members, and limit this to members treated in the hospitals nominated by the funds. The legislation provided greater power to the insurance companies to negotiate with practitioners and hospitals, altering their previously passive role in price setting, shifting the risk to the hospitals themselves by changing the means by which the funds pay the hospitals from a bed day to per-episode basis, and in turn, encouraging investors to purchase several hospitals to improve their bargaining strength (O'Loughlin 2002, p. 113). The private hospitals and new hospital 'chains' also responded by strategically seeking

opportunities for vertical integration, increasing the possibility of corporate control over the referral process. Such changes occurred relatively quickly, even though the contract system itself has not been, and remains, unpopular with doctors. The resistance to contracts is largely the result of its strong parallels with the American health system, where Health Maintenance Organisations combine insurance with the provision of services, and hence control access to services as well as determining the nature of services provided. Concern about the imposition of an American-style health system in Australia, with its restrictions on the autonomy of doctors, led to a sustained level of public outrage led by the AMA and the Doctors Reform Society (Collyer & White 2001, pp. 11–12). Under the Howard government, concessions were made to the professions to allow non-contractual agreements with funds, and to the providers, enabling hospitals to obtain the same benefits where no contracts were entered into (Shamsullah 2011, p. 29). Despite this reform, professional resistance continues and few contracts have been finalised.

The legislation also increased the capacity of state governments to introduce market principles into the healthcare services sector. State governments have traditionally played a key role in encouraging investment and managing hospitals and other services within their jurisdiction. Thus the flood of corporate investment into the sector during the 1980s and 1990s was welcomed and actively encouraged by various state governments (Collyer & White 2001). For example, the Liberal Greiner (1988–92) and Fahey (1992–95) governments in New South Wales (NSW) sold most of the state psychiatric hospitals and closed hundreds of public hospital beds. They promoted the construction of new private hospitals, and put out tenders for 24 hospital co-location opportunities on public hospital campuses (Bloom 2000, p. 236). Likewise the Liberal Kennett government in Victoria (in power 1992–99), was responsible for the closure of many public hospitals and the use of market mechanisms to 'reform' public services: including the introduction of a casemix system of funding hospitals and widespread competitive tendering (Collyer & White 2001, p. 5).

While the privatisation of healthcare services slowed with the subsequent election of Labor state governments in NSW (Carr/Iemma/Rees/Keneally, 1995–2011) and Victoria (Bracks/Brumby, 1999–2010), it did not stop. A particular focus has been hospitals built – and oper-

ated – through public–private partnerships, of which there were 12 in Australia by December 2006 (four each in NSW and Victoria, two in Western Australia and one each in Queensland and Tasmania) (English 2006). Data about the extent of hospital public–private partnerships in Australia is severely limited, but they continue to be created in most states of Australia, particularly, but not exclusively, where Liberal or Coalition governments are in power. The Bracks Labor government established Partnerships Victoria, which oversaw public–private partnerships for the construction of several hospitals including the Casey Community Hospital (opened 2004), Royal Women’s Hospital (opened 2008), the new Royal Children’s Hospital Project (2011) and the New Bendigo Hospital (Partnerships Victoria 2012). The election of a conservative Liberal Coalition government in Western Australia in 2008 (led by Colin Barnett) led to the renewal of a privatisation agenda and the significant contracting out of labour and services at a series of public hospitals, including the Albany, the Midland, the Royal Perth and the Fiona Stanley hospitals. In Queensland in 2012, under the Newman Coalition government, Exemplar Health won the tender to design, finance, construct and maintain (for 25 years) the Sunshine Coast University Hospital under a public–private partnership, and Ramsay Health Care given the right to build, operate and own a private hospital on the same site (Queensland Health 2012). In South Australia, under the Rann Labor government, a public–private partnership with a 35-year contract was used to build and finance the new Royal Adelaide Hospital (South Australia Health 2011); and the NSW Liberal government, despite the failure of its previous for-profit, public–private partnership (the Port Macquarie Base Hospital, see Collyer 1997), announced plans in 2013 for a public–private partnership for the new Frenchs Forest public hospital.

Some implications for the healthcare system

Over the past 100 years, the public–private balance of the Australian healthcare system has altered as successive governments, with distinct philosophical and ideological perspectives, have pursued diverse policy and financing strategies. In recent decades however, an entirely new system began to emerge with the adoption – by both major parties – of the NPM agenda and amidst the rhetoric and free-market ideologies

of neoliberalism. Key principles of this reform program have included minimising the role of government in the provision of services, and funding institutions based on outcomes rather than inputs. Reforms have focused on 'the sale of public assets; the adoption of market models and competitive management and information reporting systems for a wide range of public sector organisations' (English 2005, p. 94). In the Australian case, these have been combined with an increasing preference for using social tax expenditures as a policy mechanism (such as the private health insurance rebate). These operate as fiscal welfare to the wealthier segments of society but at the same time allow governments to promote markets and support private firms (Stebbing & Spies-Butcher 2010, pp. 591–93; see also Meagher & Wilson and Stebbing, in this volume). Various policies of Australian governments, based on this agenda, have enabled the growth of *corporate* healthcare, bringing a qualitatively different approach to the financing of services and a reshaping of the system's structure and form. The new system is unlike its predecessor because the clear distinctions between the public and private sectors, which had developed by the middle of the 20th century, and the once dominant position of the public sector, have now given way to a more even spread of healthcare services across the public, for-profit and not-for-profit sectors, with increasing activity in the for-profit sector. Differences between the tasks performed by the public and private sectors are less apparent than they once were. In the past, private hospitals rarely offered a full range of services, but tended to specialise in a small number of surgical procedures, particularly elective surgeries (Productivity Commission 2009, p. 56). Moreover, few provided emergency department services, undertook research or clinical training for health and medical staff and students, or assumed the community functions of their public counterparts (Brown & Barnett 2004, p. 428). In contrast, the public hospitals had a full range of specialist units (such as domiciliary care, obstetrics and maternity, alcohol, drug and coronary care units) as well as undertaking the clinical research and training activities essential for sustaining the hospital sector, determining best practice, and setting its quality and standards.

Although the large metropolitan public hospitals continue to offer the full range of services, new funding mechanisms (such as casemix) have provided the financial incentive for the private sector to improve its services (O'Loughlin 2002, p. 113). Government has also encouraged

the broadening of the operations of the private hospitals and broken down distinctions between the two sectors – particularly with regard to research and training activities – with programs such as the Expanded Specialist Training Program (Productivity Commission 2009, pp. 59–60). In addition, the private hospital sector has actively responded to pressures for diversification, with some now including emergency departments. Although this particular development is mostly restricted to the densely populated metropolitan areas, it is the result of several pressures, including the rising expectations of insured patients who prefer not to attend a public hospital in an emergency. It has been adopted by a small number of private hospitals as a means to source new patients for the hospital independently of the specialists; as a strategy to attract new specialists by offering them a more diverse casemix and complexity; and as a way of financing a medical staff presence 24 hours per day (Productivity Commission 2009, pp. 60–61). The distinction between the two sectors has been further blurred with the advent of the privatised public hospitals and the use of government contracts with the not-for-profit sector to operate public hospitals with a full range of facilities. The full extent of this latter development however, is obscured by the inclusion of these hospitals within the category of ‘public’ hospitals within all official statistical collections, including those of the Australian Bureau of Statistics and Australian Institute of Health and Welfare.

Another feature distinguishing the current healthcare system from previous iterations is its rapidly diminishing universality. The growth in private health insurance membership over the past decade has attracted larger numbers of patients into the private sector, leaving individuals without private insurance, and without the means to pay for private healthcare, in the public system (Moorin & Holman 2006, pp. 248–49). With elective surgery increasingly being moved into the private hospitals (Griffith 2006, p. 42), and the higher remuneration of surgeons operating in private hospitals (Duckett 2005, p. 88), a two-tier system has developed, whereby the least wealthy – and those most in medical need of services – are denied access to timely surgery. While the increase in private hospital usage is often seen as a positive outcome for the healthcare budget, and phrased in terms of ‘taking the load off the public sector’; this is a controversial change. The total amount contributed to the health bill by the private health insurance sector

has continued to fall (Kay 2007, p. 587), the relative levels of funding to the public sector have dropped and the amount contributed by individual patients has risen. Yet at the same time, the government's subsidy of the industry has increased (Griffith 2006, p. 22). Hence the subsidy is rapidly becoming a 'significant and rising fiscal burden for the Commonwealth Government' (Peter Dawkins in Griffith 2006, p. 39). Clearly, the movement of patients into the private sector has not reduced the healthcare costs to either government or the individual patient, nor assisted the public hospitals. The planning of these 'reforms' was based not on evidence but on assumptions about the greater efficiency of the private sector, for there is little evidence of any savings to the healthcare budget from the private health insurance subsidies (Duckett & Jackson 2000; McAuley 2005; Richardson & Segal 2004), or from public-private partnership schemes in the healthcare sector (Acerete, Stafford & Stapleton 2012; English 2005). Such schemes are ostensibly introduced to reduce public expenditures:

[y]et greater profit making for private partners and contractors does not necessarily translate into lower costs for taxpayers, especially when hospital infrastructure is privately financed. P3s [public-private partnerships] are often used by government to avoid upfront capital expenses and as a way of shifting costs and risks away from the public sector – however higher interest rates, hidden fees, inadequate or misleading risk transfer, and higher private partner overhead costs all add up, producing more expensive infrastructure and services over the long run (Whiteside 2013).

The increasing government support of the private healthcare sector also removes resources from the public system. In a small market such as Australia, where almost all surgeons operate in both the public and the private sectors, increases in the level of private sector work (particularly where it is for private patients and elective surgery) diminishes the profession's capacity to attend to those in the public sector (Duckett 2005, p. 88). And it is the public sector which cares for a much larger proportion of patients with relatively low socioeconomic status and more complex medical needs (Productivity Commission 2009, p. 29, 55). Moreover, instead of reducing public waiting lists, growth in the use of the private sector may have the opposite effect because the higher

remuneration of private hospitals provides surgeons with a 'perverse incentive to maintain high waiting times in the public sector to encourage prospective patients to seek private care' (Duckett 2005, p. 88; also Pratt 2005).

The new healthcare system is fundamentally different in yet another way. Although the two sectors may be becoming more alike with regard to their functions, their historically divergent operational motives, incentives and responsibilities have been brought into tension. Under the NPM agenda, and triggered by the signing of the 1995 National Competition Policy (NCP) – which bound state and federal governments to the 'competitive norms and rules' of the private sector (English 2005, p. 95) – corporate medical facilities and the expansion of for-profit insurance firms were ushered into the Australian marketplace. Under the NCP, a 'competitive neutrality between the private and public sectors became enshrined in law' (English 2005, p. 95). In other words, governments are compelled to ignore the diverse operational motives of the two sectors.

This largely explains the lack of parliamentary debate about the extent to which health funding is ending up in the private sector. Where previous Commonwealth and state health budgets were primarily spent on the provision of public services and the building of its infrastructure, an increasing proportion of those budgets is now channelled into corporate profits and other private surpluses. In 1990, for instance, private hospitals received five percent of their total recurrent funds from the Commonwealth. By 1999, it was providing 23 percent of their funds (O'Loughlin 2002, p. 11). By 2009–10, this has risen to 33 percent (AIHW 2012a, p. 4). With rising numbers of patients treated within the for-profit hospital sector, and growth in the number of public hospitals now under for-profit, private ownership and/or management, government expenditures are rising. Indeed, corporations such as Ramsay Health Care expect health expenditure, as a proportion of GDP, to increase to 14.5 percent by 2050 (Rex 2013).

Despite this change to healthcare financing, corporate healthcare has not been constituted as a policy 'problem' in need of a 'solution'. Yet the contrasting operational agendas of the two sectors lies at the heart of this issue. Privately owned/managed hospitals have an incentive to increase 'throughput' as they operate under a fee-for-service funding model, and for-profit hospitals have a duty to maximise returns

to shareholders/owners. In the not-for-profit sector, the revenue-generation motive is less obvious, but there is nevertheless an aim to avoid losses (Productivity Commission 2009, p. 47).⁹ In the public sector, a 'core function may be to assemble infrastructure, workforce and knowledge around the care of patients to improve their health' (Productivity Commission 2009, p. 82), and the cost efficiency of its services is only one of many concerns. Introducing marketisation into the healthcare sector does not simply mean bringing in more private firms, but also increasing the overall demand for services. This occurs because private health insurance incentives raise expectations about the increased capacity of the private system, and thus in themselves increase demand for services (Pratt 2005). It is also because there are greater incentives in the private sector to clinically or surgically intervene and provide services to patients. And there is evidence of 'over-servicing' in the private sector. For example, patients admitted to private hospitals are significantly more likely to receive intensive treatments, requiring more specialists to be transferred out of the public sector (Richardson & Segal 2004, p. 40).

The new healthcare system then, is no longer government-driven but market-shaped. Planning decisions are increasingly informed by market considerations rather than medical need. Private facilities are placed geographically to maximise revenue for corporate investors, even where this will compete with local public services and duplicate resources, leaving other regions undersupplied. This situation is currently occurring across Australia, because even while private hospital beds are increasingly available in capital cities, they are being reduced in regional areas where profitability is lower (Productivity Commission 2009, p. 65). Governments are unable to control the planning of appropriate hospital facilities, because the legal framework within which

9 It should also be noted that organisations in the not-for-profit sector may have their own agendas. While often considered to offer an alternative to the profit-motive of the corporate hospitals, the institutional mission of the not-for-profits can also shape the services they provide. For instance, the code of ethics of Catholic Health Australia, Australia's largest not-for-profit group (Productivity Commission 2009), precludes direct provision or referrals for abortion, some fertility treatments, vasectomy and other forms of sterilisation and birth control, including for women who have been raped (Catholic Health Australia 2001).

claims are heard is based on the needs and property rights of entrepreneurs, not the user rights of patients or the service responsibilities of government (Duckett 1989). Given that all medical services and hospitals in Australia rely heavily on public funding, this situation wastes scarce resources and produces no net gain in services for the community (White & Collyer 1998, p. 502). Equally, marketisation means standards of accountability and transparency are weakened, with less information provided about where the health budget is spent. This is particularly apparent when funding is subject to the 'commercial confidentiality' clauses of the public-private contracts, but also where important government data collections have been discontinued (including class-based disease categories and mortality rates) or simply not updated, obscuring the role and impact of radical changes in the healthcare system.

Conclusion

This chapter has provided a description and analysis of how the Australian healthcare system has developed since European settlement, and its radical transformation over the past three decades. The focus has been two areas within the healthcare system: the national insurance scheme of Medicare and its private health insurance counterpart, and the private and public hospital sectors. These areas are closely linked in the private sector, given that the health funds are a major source of a private hospital's revenue, and hospital services constitute most of a fund's expenditures. Our analysis has concentrated on the private sector, particularly the role of the large, for-profit corporations rather than the small independent private entities, religious institutions and not-for-profit insurance schemes. This is because there has been relatively little discussion or analysis of *corporate* healthcare in the Australian setting, even though it has been the most significant development since the introduction of Medibank.

Corporate healthcare has, as we have seen, brought a new complexity to an already complex healthcare system. Prior to their entry, the mixed system contained private, primarily not-for-profit religious providers of healthcare services and not-for-profit insurance services. With the growth in corporate healthcare and for-profit insurance com-

panies, new administrative and regulatory processes have become essential. For instance, in the hospital sector, the introduction of public–private partnerships and contracts to care for public patients has forced governments to create new regulatory and monitoring mechanisms to ensure comparable quality across all services, and new programs and policies to ensure sufficient medical and specialist training positions. Corporate, for-profit healthcare has also transformed the landscape of the services sector, creating new scarcities within the public system, new demands on the healthcare budget, new obstacles to the efficient planning of services, and new constraints on the provision of information and the maintenance of previously high standards of transparency and accountability. In this new healthcare system, market actors and market principles have a much larger role than ever before.

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Appendix

Sources and notes to Table 8.2.

- Compiled from ABS (1995) and AIHW (1999) for 1991–92 data and AIHW (2002, 2003 [updated version of table 2.1], 2012b, 2013b) with AIHW Australian Hospital Statistics reports for other years also consulted. It should be noted that each hospital is a reporting unit rather than necessarily one separate building, and there has been some variance in administrative definitions over the period above.
* Figures for these facilities in 1991–92 are not available, hence 1993–94 figures are supplied as an indicator of growth in this sub-sector.

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