Saving Australia's Health Care System: Nostrums or Cures?

Steven Schwartz

How to bring the market back into health care

Health care, and the difficulty of obtaining it, is rarely out of the news. Barely a day goes by without a story about lengthening surgical waiting lists, the shortage of publicly-funded dentists, or increasingly costly drugs. The public wants more (and better) health services, but it is reluctant to pay higher taxes, or insurance premiums, to get them.

This state of affairs is not unique to Australia; most countries in the industrialised world are struggling to meet the health needs of their people without increasing health expenditures. They are all doomed to fail. The members of the large baby-boom generation are now in their 50s. Twenty years from now, when they hit their 70s – the years when most health dollars are spent – our current system for financing health (and the systems of most other OECD countries) will collapse. There will be too many ailing boomers and too few people working to pay for their health costs. This fate can be prevented only by a drastic change to the way health care is financed. What type of change, and how such change may be accomplished, is the subject of this paper, which has four parts.

The first part is a description of the Australian health industry as it exists today. Next comes a review of how we got to where we are, followed by a look forward to where we are likely to wind up if nothing changes. The paper concludes with some recommendations about what can, and should, be done to save Australia's health care system.

Consider the Australian health industry today. Health is one of Australia's largest employers: 7 per cent of all jobs in Australia are in the health industry (Australian Institute of Health and Welfare 1998: 292). It is also one of Australia's biggest industries, accounting for 8·5 per cent of Australia's gross domestic product (Australian Institute of Health and Welfare 1998: 292). This is exactly the OECD average (omitting the US, which is a nation in a league of its own when it comes to health expenditures). The Australian health industry has grown in real terms every year since the introduction of Medicare in 1985 (see Figure 1). Recently, growth in the health industry has averaged between 4 and 5 per cent per year in constant dollars.

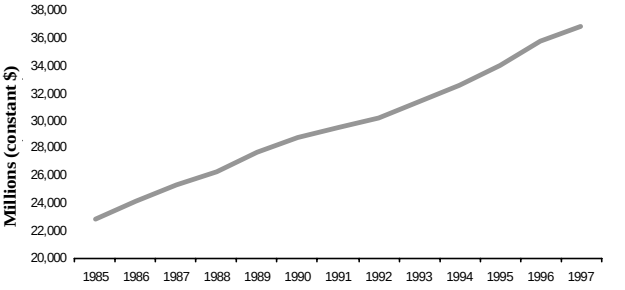

Figure 1. Increase in health expenditures in constant dollar since the introduction of Medicare. The data in this and all other graphs in this paper come from Australian Institute of Health and Welfare (1998)

The demand for health services is increasing faster than the supply. One result has already been noted: patients must wait longer for surgery in public hospitals. In a report tabled in the West Australian State Parliament in January 1999, the Perth Metropolitan Health Services Board revealed that *the majority* of seriously ill patients in Western Australian public hospitals were not operated on within accepted benchmark times. More than half the public hospital patients wait two months or longer for their operations; some poor souls wait a year or more. The situation is much the same across the nation (see Figure 2). Many of the patients waiting for surgery are unable to work. Thus, the price paid by Australia for long surgical waiting lists is not only poorer health but also lower national productivity.

Of course, to patients languishing on surgical waiting

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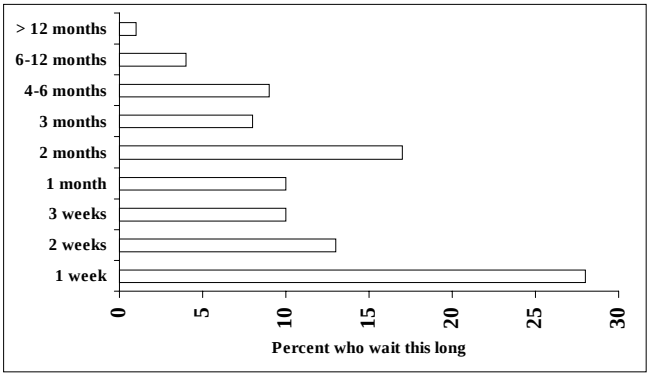

Figure 2. National waiting times for elective surgery.

lists, the most important consideration is getting well. Unfortunately, even this cannot be guaranteed. Many of those kept waiting for months are Category 1 patients whose surgeons deem it necessary for them to be operated on within 30 days (Hodge 1999: 1, 4-5). These patients are not merely inconvenienced; some are seriously harmed by the wait.

Demand is also growing for pharmaceuticals. Expenditures under the pharmaceutical benefits scheme have increased from $1.5 billion to $3 billion over the past six years (see Figure 3). To slow growth, the government has restricted patients' choice of drugs (Commonwealth Department of Health and Family Services 1997-98).

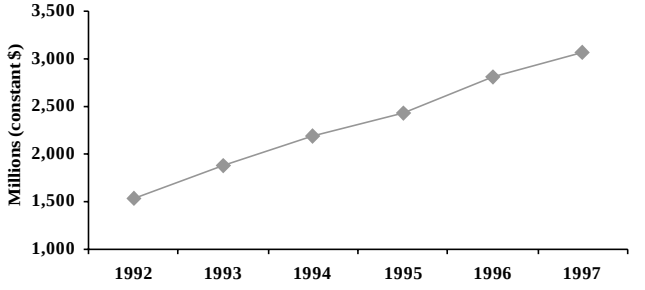

Figure 3. Expenditures of the Pharmaceutical Benefits Scheme

Each year, more people place themselves at the government's mercy. When Medicare was first introduced, about half the population had private health insurance. By 1997, this number had decreased to only 32 per cent (see Figure 4) and hit around 30 per cent at the end of 1998. The government, which dominates all aspects of the health industry, requires private health insurance companies to charge all policyholders the same 'community-rated' premium. In practice, this means that every policyholder – young or old, sick or healthy – is considered to have the same risk of making an insurance claim. In reality, of course, young and healthy policyholders subsidise the old and sick. Not unreasonably, the young resent this, so they drop their insurance. The result is 'adverse selection'; only the poor and the sick remain insured. As the healthy and young drop out, costs increase for those who remain covered. At the same time, fewer private patients mean more public ones.

To summarise, health is one of our largest and fastest growing industries. It is dominated by the government, which makes the rules. Private insurance is becoming a rarity, access to drugs is being curtailed and surgical waiting lists are long, sometimes dangerously long.

How did we get to this situation? Some of the causes are obvious. Health expenditures are rising because of inflation and population growth (more people mean more doctor visits, more hospitalisations, and more drugs). Social welfare programs, that aim to redress past inequities, require more resources as do most new treatments and health technologies. There are also some less obvious reasons for the rise in health costs: the ageing population and the absence of market forces.

The ageing population will be addressed first. The most important fact to know about health care costs is that they increase dramatically with age. From the teenage years through to the mid-40s most people's health care costs are low. They begin to increase about the age of 45 and they really pick up when people reach 75 and over. The health costs for the average 75-year-old are about three times those of the average 25-year-old (Australian Institute of Health and Welfare 1998: 195). Australia's population is getting older. As we age, our health costs increase. In 20 years, when the post-war baby boom generation reaches their 70s, Australia's health costs will blow out dramatically.

The second important factor fuelling the growth in health costs is the absence of market forces. For example, there is no relationship between the probability that a person will make a claim and the price of private health insurance. Likewise, there is little relationship between the amount people pay in Medicare or other taxes and the amount they claim in health costs. In other words, the normal price signals to consumers do not apply in health.

Market forces are blunted because most health costs are paid by third parties. In Australia, governments of one type or another pay approximately 70 per cent of all health costs (Australian Institute of Health and Welfare 1998: 195). Insurance covers another 13 per cent. Private out-of-pocket payments are small. The average GP visit costs the patient about $1.90, the average pathology service about $1.70 and an optometry consultation costs only about $0.50 (Commonwealth Department of Health and Family Services 1998). There is little motivation to

economise when someone else is paying the bill. Instead, we produce fertile ground for the breeding of moral hazard.

A lack of market signals robs consumers of power. Instead of its customers, the patients, the health industry is arranged for the convenience and protection of health care providers. The learned colleges severely restrict the number of Australian doctors who can undertake specialty training. Foreign-trained doctors are also restrained from practising in Australia. The usual justification for keeping foreign doctors out is that they are not as well trained as ours. This may apply to doctors trained in inferior universities in backward countries. However, entry into the private practice of some specialties has been denied to graduates of Harvard and Yale, medical schools whose graduates might be expected to be as good as those of our own universities.

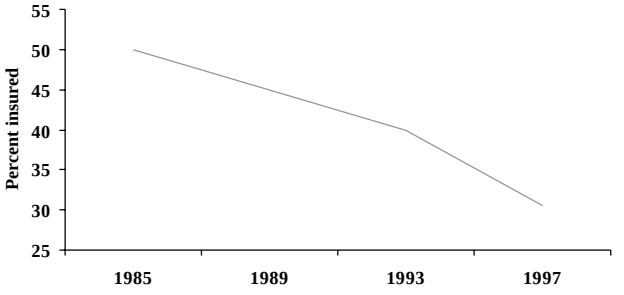

Figure 4. Proportion of population with private health insurance.

Restrictive retail practices also protect providers. For example, rules that require pharmacies to be owned by chemists or that require spectacles to be sold in shops owned by optometrists do nothing for consumers; they just protect these guilds by keeping prices high. Work practices, such as inviting referring GPs to 'assist' in surgery, also drive up costs.

We've now seen where we are, now let's look at where we are heading.

There is a population time bomb ticking away in Australia. As noted, the post-war baby boom generation will reach their 70s in 20 years and, at that point, health costs will explode. There will not be enough people working and paying taxes to cover the costs of all those old folks. If nothing is changed, either taxes will rise dramatically or services will collapse.

What is the Australian government doing to avoid this catastrophe? The answer is a patchwork of miscellaneous nostrums. For example, to try to keep people in private health insurance and out of the public hospital system, the government has been trying to make health insurance more attractive. The latest attempt is a 30 per cent subsidy. This may slow the exodus from health insurance, but it is unlikely to make health insurance attractive to young, healthy people. After all, they will still subsidise the old and the sick through community rating and they will still be required to pay the Medicare levy.

Restricting doctor numbers is another failed tactic. Cutting back doctor numbers is based on the idea that doctors 'generate their own demand'. By forcing people to undergo unnecessary tests, inflicting useless treatments, and prescribing unnecessary drugs, doctors increase their incomes at the expense of their hapless patients. If this is the case, then fewer doctors means fewer people around to rort the system. Unfortunately, it also means lower access to care because doctors can make a living in the city and do not feel the pressure to work in under-served country areas. The opposite approach of flooding the country with doctors and making them compete has never been seriously considered.

A favourite way to put a lid on costs is to inhibit the dissemination of drugs and technology. In Australia, we have taken this approach pretty far. There are now numerous drugs that are not available to Australians that are available overseas (Commonwealth Department of Health and Family Services 1997-98). We also have lower access to high technology instruments than patients in the US and many European countries.

Lengthening waiting lists is another common ploy. Provided that not too many people die during their wait, the question of waiting lists is only addressed near elections. As mentioned earlier, the cost to the economy of having people waiting and not working is rarely addressed.

Another technique used to reduce costs is policing 'over-servicing' to make sure that doctors are not 'ripping off' Medicare. Thus far, the cost of such policing has been much higher than the amount recovered (Health Insurance Commission 1996-97).

Other possibilities for saving money include the 'capping' or rationing of doctor visits, hospitals, and drugs. This is the approach taken by managed care companies in the US. Under managed care, people pay yearly premiums to health maintenance organisations that are contracted to look after all their health needs. These organisations make money by reducing costs and by denying services whenever they can get away with it (Herzlinger 1997).

The problem with a patchwork of miscellaneous fixes is that each one causes another problem. Subsidising private health insurance distorts price signals even more than they are being distorted at present. Restricting competition while inhibiting patient access and choice reduces the quality of health care as does increasing the time patients must wait for surgery. Rationing works, but

only for a short time. As the American health maintenance organisations are discovering, a political alliance of patients and doctors is forcing the government to legislate 'standards' of care (specifying the services that health maintenance organisations must provide, for example). As a result, these organisations are finding themselves unable to control their costs (Kaiser 1995: 7).

So, what should Australia do? Forget further restrictions on the health care system. These always fail. They do not save money, they are never efficient, and they do not result in high quality care. Instead, Australia should develop an open, informed, and competitive market in which patients have choices and are free to act responsibly. Such a market will be able to do what the government system would like to do, but cannot. It will make health care more efficient, more productive, and more effective.

Three steps to developing an efficient health market are needed.

Step 1. Admit that health is an industry. The public is used to considering health care as solely a cost to the nation, similar to the cost of cleaning up pollution. Yet, growth in the health industry has the same economic effects as growth in any other industry. It is not considered an economic crisis if wine producers increase their production and consumers increase their consumption. (Of course, it may produce a health crisis, but that is another story.) Why is health different? One common argument is that health is different because it is necessary for life. As my mother says, 'If you have your health, you have everything'. This argument does not hold. Food and clothing are also necessities of life, but there is no 'Foodcare' levy and there is no Food Insurance Commission to make sure that Coles does not try to sell you two bottles of milk when the government deems one bottle sufficient for average needs.

Step 2. Encourage fair competition. Eliminate the restrictions on practitioner numbers and the other anti-competitive practices that have grown up over the years. Anyone should be allowed to own a pharmacy provided that qualified pharmacists do the dispensing. Allow hospitals to determine how many people are required in surgery and eliminate unnecessary assistants.

Step 3. Reward economising. At present, there is no incentive to cut back on health care consumption. If I forego seeing the doctor for a sore throat, the country gains, but not me personally. We will never get control over health expenditures until we make it worthwhile to economise.

How do we do this? A good start is to transform Medicare from a 'first dollar' to a catastrophic insurance plan. Because of the politics involved, this will have to be done gradually. The process should begin by introducing an excess and gradually increasing its size until Medicare covers only catastrophic expenses. This means that individuals will be responsible for an excess each year; once that excess is expended the catastrophic insurance kicks in. At the same time, medical savings accounts should be introduced. This is a variant on the medical savings accounts first mooted in the US (American Academy of Actuaries 1995).

The idea is that everyone deposits in their medical savings account either a fixed proportion of yearly income (as in the superannuation guarantee levy) or – if we want to make the system more progressive – an amount proportional to taxable income. Either way, the rich will pay more of their own costs as well as the costs of others through higher taxes. Medical savings accounts could receive favourable tax treatment, similar to the treatment given to superannuation accounts. A debit card can be attached to these accounts and used to pay doctors, dentists, and other approved health providers.

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What will happen to people with low or no income? They will be offered guaranteed loans for the minimum yearly excess. In effect, the government provides their excess, but this is not a gift. These loans will be recoverable from later deposits if, and when, the person gets a job, or from the person's estate after death. Because many older people have assets but no income, death duties are an easy and equitable way for them to make a contribution – a true 'pay-as-you-go' policy (*Washington Monthly* 1997). To avoid bad publicity, it might be better to collect death duty after the surviving spouse dies ('double or nothing').

Under these proposals, consumers would be empowered. Because they get to keep any money not expended on health, they have an incentive to economise. Moreover, providers have to please patients rather than governments or insurance companies. A market-driven system makes providers compete for patients in the ways providers have always competed, by improving quality and

lowering costs.

What are the objections to these proposals? The first is that health is too vital to be left to the market. This is not a compelling argument. Food and clothing are also essential to life, and we leave their provision to the market.

A second objection is that people may be so motivated to save money they forego medical attention even when they need it. This would indeed be a bad outcome, but an unlikely one. There is a lot of economising that could be done before anyone's health is seriously affected.

Another objection to the proposals presented here is that the market will fail because consumers are ignorant and rapacious providers will rob patients blind. Rest assured, however, that once consumers become interested in conserving their health care dollars, businesses will develop to provide them with the information they require to be careful consumers. In the US, patients can already get information on the mortality and infection rates of individual hospitals adjusted for the complexities of their operations (*US News and World Report* 1995: 51).

A fourth objection is that the rich will find a way out. Perhaps this is a good thing. In Chile, the rich are allowed to opt out of the public health system and not pay their equivalent of the Medicare levy (*The Economist* 1998: 19). However, because they are allowed to return when they get old, this produces the worst of all worlds. The young and healthy don't pay and the old and sick throw themselves on the mercy of a penniless health system. The German system is probably a better one. The rich are allowed to opt out but they can never return (*The Economist* 1998: 19).

Given the opportunity, some of our rich might opt out of Medicare for life (although our governments may find this hard to enforce if they blow their money and want back in). A more likely scenario is that wealthy Australians will wish to purchase extra insurance to get red carpet service. Note, however, that this insurance will have to be different from the private health insurance that exists now. It will not be community rated (premiums will be determined by risk profiles), no-claim bonuses will be allowed, and consumers will determine the services covered.

Some people may object to the system because the poor may not have the same care as the wealthy. This will always be true. The important point is that the poor do not benefit when the wealthy are kept from purchasing better care. In fact, just the opposite happens. Forcing the wealthy to pay more of their own health care costs should leave more money for the poor.

So what does the future hold? There are two possible scenarios. Australia can continue as it is now: increasing controls, decreasing choice, limiting access, lengthening waiting lists, and (despite all of this) driving up costs. Or, a system which rewards individuals for saving and investing in their own health care can be established. A competitive health system in which health services are provided for profit and purchased by consumers will produce better access, lower prices, new innovations, and ensure that capital is allocated more efficiently. By rewarding economising, and forcing open competition, we can have a health service in which access and quality are high while prices are low. Government controls have been given a good try, and they have failed. It is time to let the market save the health system. *Policy*

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