TARGET30

REDUCING THE BURDEN FOR FUTURE GENERATIONS

Saving Medicare But NOT As We Know It

Jeremy Sammut

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Executive Summary

Since the turn of the century, real combined federal, state and territory government spending on health (adjusted for inflation) has increased by 80% from $53 billion in 2000–01 to more than $90 billion in 2010–11. High rates of economic growth during the 'long boom' of the 2000s contained growth in government health expenditure as a share of national income. Despite spending the best part of double on health today as compared to 10 years ago, public health expenditure rose from 5.6% of GDP to 6.4% over the period. Now that the boom is over and a new era of lower growth has begun, paying for continued expenditure growth will prove more difficult for governments.

The private health reforms of the Howard Coalition government (1996–2007) were ostensibly designed to shift health costs off government budgets. These reforms, which included the private health insurance (PHI) rebate, the Lifetime Cover community-rating system, and the Medicare levy private health surcharge, have not fundamentally altered the balance between public and private financing of health services in Australia. Between 2000–01 and 2010–11, non-government health expenditure increased by 0.2% of GDP (from 2.7% of GDP to 2.9%). This was outstripped by the 0.8% of GDP increase in government health funding, which was principally responsible for increasing total national health expenditure to 9.3% of GDP (or $130 billion) in 2010–11.

The trends of the last decade portend the fiscal challenges facing the health system in an ageing Australia. The *Intergenerational Reports* issued by federal and state governments show that in the coming decades, health will be the area that will unsustainably increase the size of government—exhausting government's ability to tax and spend.

If long-term sustainability and affordability problems are to be addressed, it is time to start cutting Medicare (Australia's 'free and universal' taxpayer-funded health care scheme) down to size by (1) boosting the efficiency of public health services; (2) better targeting of public health spending; and (3) expanding the role played by private health care financing.

Health policies that will advance The Centre for Independent Studies' TARGET30 campaign goals of shrinking government, improving public services, and reducing fiscal burdens on future generations include:

- downsizing the bloated federal Department of Health and Ageing
- lowering state health department overheads by devolving full managerial responsibility and financial accountability for the operation of public hospitals to the local level
- privatising select public hospital facilities to create a contestable and competitive public hospital sector
- allowing local hospital managers to hire and fire clinical staff on flexible terms, circumventing state-wide employment conditions for doctors and nurses that restrict public hospital productivity
- restricting the number of private patients treated in public hospitals
- restoring in-hospital nurse training and permitting universities to conduct specialist training
- scrapping expensive new Medicare programs that have proven wasteful and inequitable, including the GP Management Plans and Better Access to Mental Health programs
- defunding ineffective 'nanny state' public health initiatives targeting 'lifestyle diseases' (including closing down the National Preventive Health Agency)
- reintroducing the Medicare co-payments for GP consultations devised by the Hawke government in 1991 and abandoned by the Keating government in 1992
- imposing a means test on Medicare entitlements consistent (at the very least) with the means test introduced in 2012 for the PHI rebate.

Implementing these practical TARGET30-recommended strategies—contracting out, stronger financial management, enhancing public sector productivity, eliminating 'churn,' expenditure reviews, levying user-chargers, and revising eligibility for public programs—would create a more cost-effective health system than we currently have.

But given the magnitude of the fiscal challenges facing the health system, 'big bang' health reforms that establish large non-government sources of health funding and limit government exposure to rising health expenditure need to be on the national agenda.

Younger Australians could save up and pay for future health costs over time by reconfiguring Medicare spending into two new streams of funding for ('superannuation-style') Health Savings Accounts (HSAs), and high-deductible private health insurance vouchers.

Creating a New Medicare for Generations X and Y would permit the existing Medicare scheme to be transformed into an age-limited and targeted program for the current generation of retirees or near-retirees.

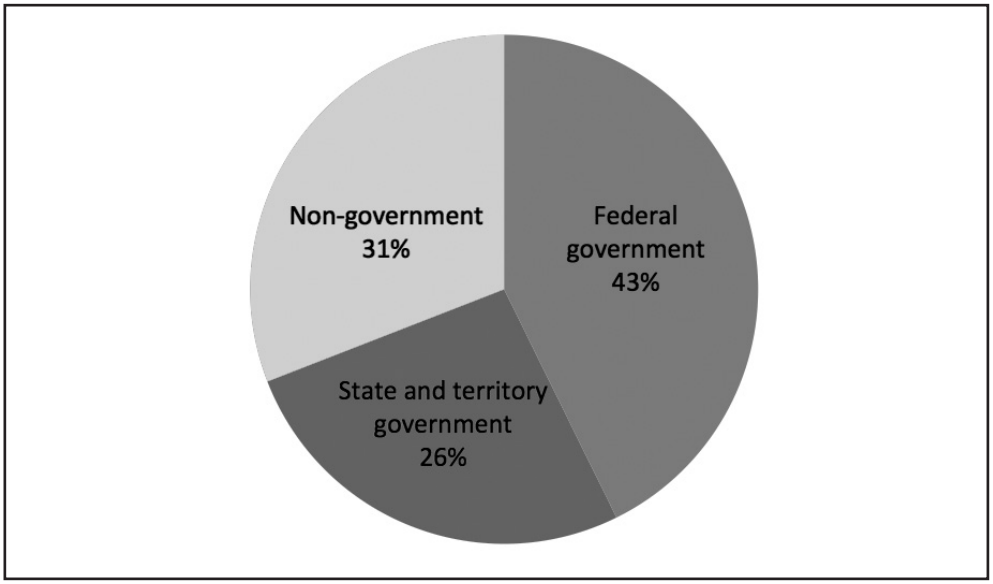
Introduction: The cost curve

Health spending trends in the last decade portend the fiscal challenges facing the health system in an ageing Australia. Since the turn of the century:

- Annual real (adjusted for inflation) national (public and private) health expenditure increased by 68% from $77.5 billion in 2000–01 to $130.3 billion in 2010–11.
- Real average health spending increased 70% faster (5.3% per year) than real average GDP (3.1% per year).
- The share of national income consumed by health increased from 8.2% to 9.3% of GDP.[1]

Over two-thirds of total national health spending (69.1%) is expended through government programs (compared to 67.7% in 2000–01). Federal government spending accounts for $55.6 billion of total national health expenditure; state and territory government spending accounts for $34.4 billion; and non-government spending (private households and private insurance) accounts for the remaining $40.2 billion (Figure 1).

Figure 1: Where the health dollars come and go



Source: AIHW (Australian Institute of Health and Welfare), *Health Expenditure Australia 2010–11* (Canberra: AIHW, 2012), Table 3.1, 22.

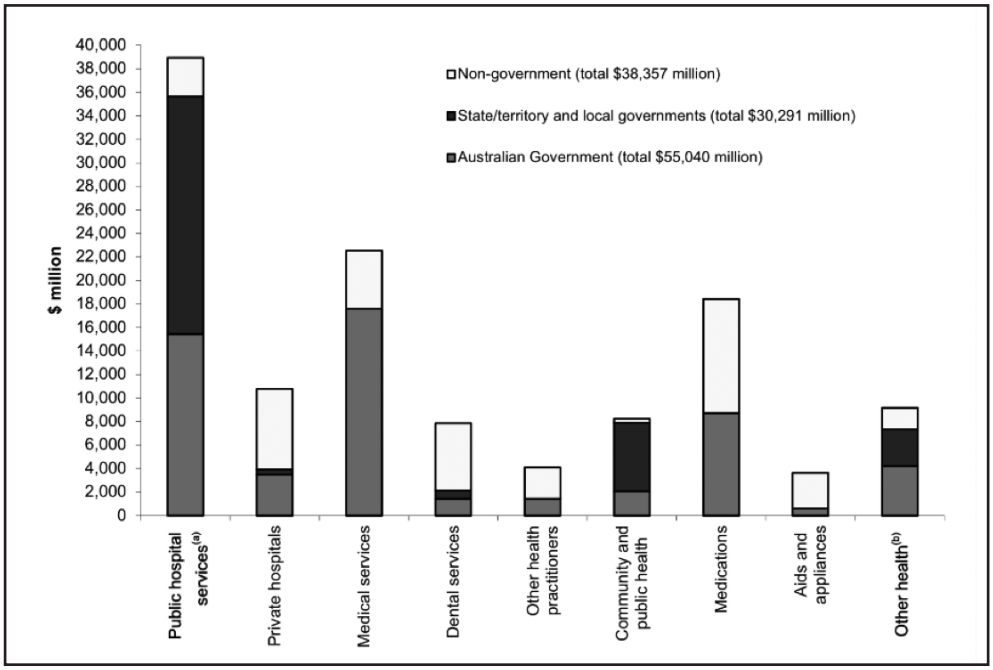
Health spending trends in the last decade portend the fiscal challenges facing the health system in an ageing Australia.

Real combined federal and state and territory government health spending has risen by 80% from $53 billion to $90 billion over the last decade. Despite spending the best part of double on health today compared to 10 years ago, growth in government expenditure as a share of national income was contained, with public health spending as a proportion of GDP rising from 5.6% of GDP in 2000–01 to 6.4% of GDP in 2010–11. Expenditure growth proved relatively manageable due to the high rates of economic growth (and increasing government revenues) achieved during the 'long boom' of the 2000s, which has now ceased. Paying for continued growth in public health spending will prove more difficult for governments in the new era of lower growth underway.

Nearly 70% of the public health spend—$62 billion in 2010–11—was used to fund the three core elements of Australia's 'free and universal' taxpayer-funded Medicare scheme: $35.6 billion on public hospital care; $17.6 billion on the Medical

Benefits Scheme (MBS); and $8.7 billion on the Pharmaceutical Benefits Scheme (PBS)[2] (Figure 2). When this is added to the $6 billion spent by federal and state governments on community health services (which provide some salaried primary care and public health services) and the $4.6 billion spent by the federal government on private health insurance subsidies, these five areas account for over 80% of government health spending.

Figure 2: Health spending by area of expenditure, 2010–11



Source: AIHW (Australian Institute of Health and Welfare), *Health Expenditure Australia 2010–11* (Canberra: AIHW, 2012), Figure 3.2, 23.

Despite high and increasing government spending on health, there is growing dissatisfaction with the operation of public health services.

Since Medicare was established in 1984, all Australians have been entitled to receive publicly funded health services. GP and other medical services are available 'on demand' through the MBS, which is solely funded by the Commonwealth. If GP and other providers of medical and allied health care agree to 'bulk bill' patients (accept the MBS rebate as full payment for their services), consumers are not required to make an additional co-payment. Heavily subsidised prescription medications are also available under the Commonwealth-funded PBS.

Public hospital services are jointly funded by the Commonwealth and state and territory governments. Public hospital care is also available (subject to clinical referral) without user charges at 'point of access.' Since the late 1990s, the federal government has also subsidised private health fund membership by providing a 30% to 40% taxpayer-funded rebate on insurance premiums. The $4.6 billion per annum Private Health Insurance (PHI) rebate is designed to reduce the public hospital caseload by increasing community access to privately insured private hospital services.

Despite high and increasing government spending on health, there is growing dissatisfaction with the operation of public health services. Long waiting times for treatment at public hospitals are a perpetual concern. They are a structural feature of Medicare, a product of its inherent inefficiencies that permit unrestricted taxpayer-funded access to GP and other medical services even for minor health needs. To control the total cost of health care to government, funding for hospital services that treat major illness is capped and access to 'free' hospital care is restricted or 'rationed' by means of elective and emergency queues.[3]

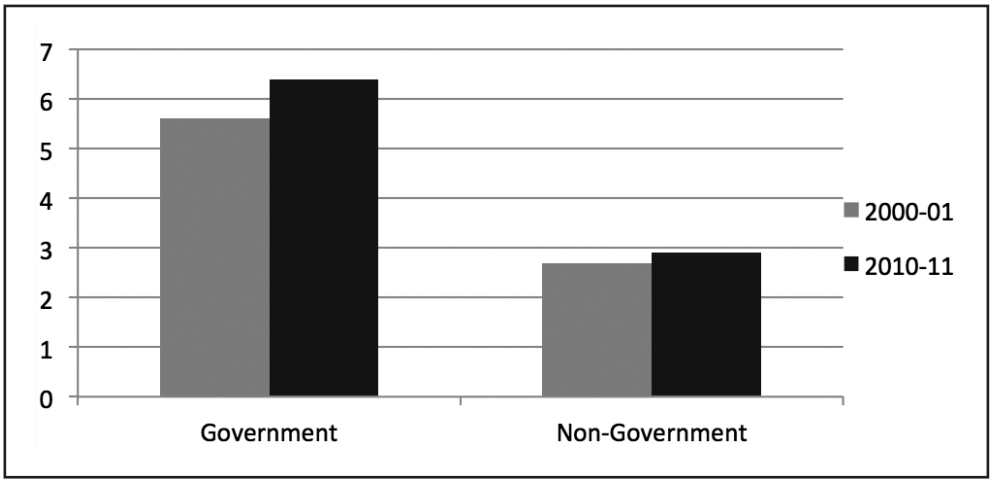
In addition to the so-called 'hospital crisis,' many patients with chronic and ongoing conditions receive fragmented coverage and care under Medicare. Many pay considerable out-of-pocket charges or forgo all necessary care because the MBS primarily covers doctor's fees rather than full courses of treatment for illness. Lack of access to chronic care has prompted criticism of the public system for failing to live up to the promise of 'free and universal' health care—notwithstanding the introduction of GP management plans offering some MBS-funded access to allied health care for chronic patients, nor the operation of the Medicare Safety Net which rebates a proportion of out-of-pocket charges once set thresholds are exceeded in any calendar year.[4]

The 'gaps' in Medicare have spurred increased uptake of private health insurance to secure access to private hospital and private allied health services. However, private patients frequently incur significant co-payments and out-of-pocket expenses for surgical procedures. Because Australian private health funds have to compete against the taxpayer-funded Medicare scheme, they seek to attract members willing to 'pay twice' for health insurance by offering cover for 'extras,' such as dental and optical care, that could easily be funded out-of-pocket. Both the public and private systems therefore skimp on the protection against serious illness. They over-provide for the minor health needs of the majority of healthy consumers, and contain costs by under-providing to the minority of patients with major health needs.

The private health reforms of the Howard government have not fundamentally altered the balance between public and private financing of health services.

Nevertheless, private health funding plays an increasing role in providing health care for the 46% of the population that currently choose to pay for private cover.[5] Expansion of the private health sector has been encouraged by federal government policy since the late 1990s. The private health reforms of the Howard Coalition government (1996–2007) were ostensibly designed to shift the balance in our 'mixed' health system from public to private financing. However, the 30% to 40% PHI rebate, the Lifetime Cover community-rating system, and the Medicare levy private health surcharge have not fundamentally altered the balance between public and private financing of health services. Non-government health expenditure increased by 0.2% of GDP between 2000–01 and 2010–11 (from 2.7% of GDP to 2.9%) and was outstripped by the 0.8% of GDP increase in government health spending over the same period (Figure 3). The proportion of total national health spending provided by private health insurance funds increased by 0.5% from 7.1% in 2000–01 to 7.6% in 2010–11, while the percentage of health expenditure funded by individuals increased by only 0.3% to 18.3%.[6]

Figure 3: Health spending as percentage of GDP—government and non-government sources

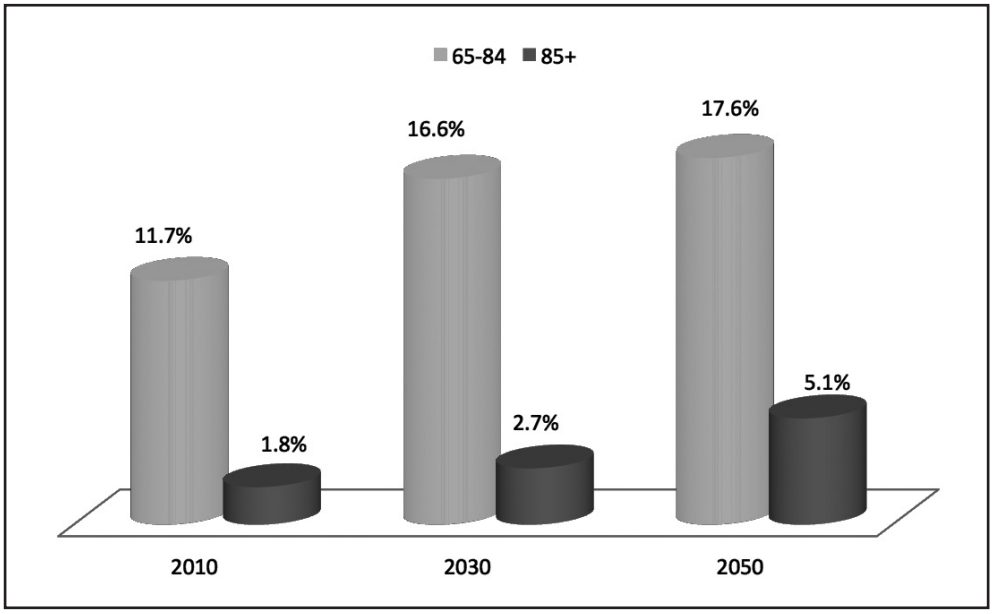


Source: AIHW (Australian Institute of Health and Welfare), *Health Expenditure Australia 2010–11* (Canberra: AIHW, 2012), Table 3.3, 24.

The ageing challenge

Since the early 2000s, there has been intermittent discussion of the unprecedented impact that the ageing population will have on Australian society in coming decades. This discussion has mainly focused on the federal government's three *Intergenerational Reports* (IGR), which have modelled the long-term effects of rising health spending on the sustainability of the federal budget. The IGRs define budget sustainability as the ability to fund the projected cost of existing government programs out of existing sources of government revenue at current tax rates (a 'no policy change' scenario).

Figure 4: Proportion of population aged 65+



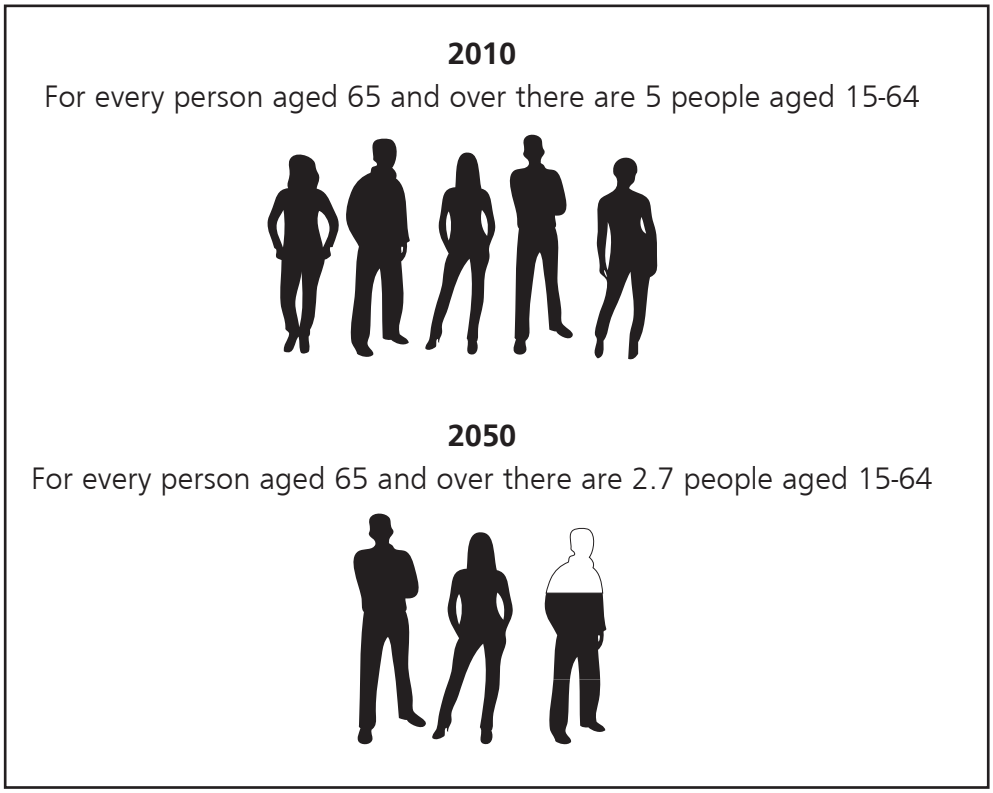
Source: *Intergenerational Report 2010* (Canberra: Commonwealth of Australia, 2010), Table 1.4, 9.

An ageing population increases the number of people using government programs while reducing the number of people whose taxes fund these programs.

The 2010 *Intergenerational Report* found that by 2050, Australia's population will be far bigger—35.9 million—and far older than at present. The number of children will have increased by 45% and the number of working-age people by 44%. But due to the combined effects since the 1960s of sustained declines in fertility, significant increases in life expectancy, and the ageing of the large baby boomer cohort born between 1946 and 1964, the number of old people aged 65–84 will more than double, and the number of very old people aged 85 and over will quadruple.[7] In 2010, 13.5% of the population was aged over 65; by 2050, this proportion will increase to 22.6%, with 5.1% of the population aged 85 and over compared to 1.8% in 2010 (Figure 4).

An ageing population creates fiscal challenges for governments by increasing the number of people using government programs while reducing, in relative terms, the number of people whose taxes fund these programs. Population ageing will radically alter the composition of the Australian population by age group. By 2050, there will be only 2.7 people of working age to support each Australian aged 65 and over. This compares to five working-aged people per aged person today[8] (Figure 5).

Figure 5: Proportion aged (65 and over) to working-age (15–64) population



Source: *Intergenerational Report 2010* (Canberra: Commonwealth of Australia, 2010), Table 1.4, 10.

As the population gets older and the proportion of young people shrinks, the higher cost of caring for the elderly is projected to significantly increase total federal government spending as a share of national income. IGR 2010 predicts that ageing will increase federal spending across all areas of government responsibility in excess of the base level of 26% of GDP in 2009–10. After hitting a low point of 22.4% of GDP in 2015–16, IGR 2010 estimated that federal government expenditure will increase to 27.1% of GDP in 2049–50.[9] The projected 4.7% rise in expenditure will exceed projected revenue by a 'fiscal gap' of 2.75% of GDP. The cost of financing the accumulated budget deficits and public debt (which have blown out to 20% of GDP) would add another 1% to the fiscal gap, resulting in a budget deficit of 3.75% of GDP in 2049–50.[10]

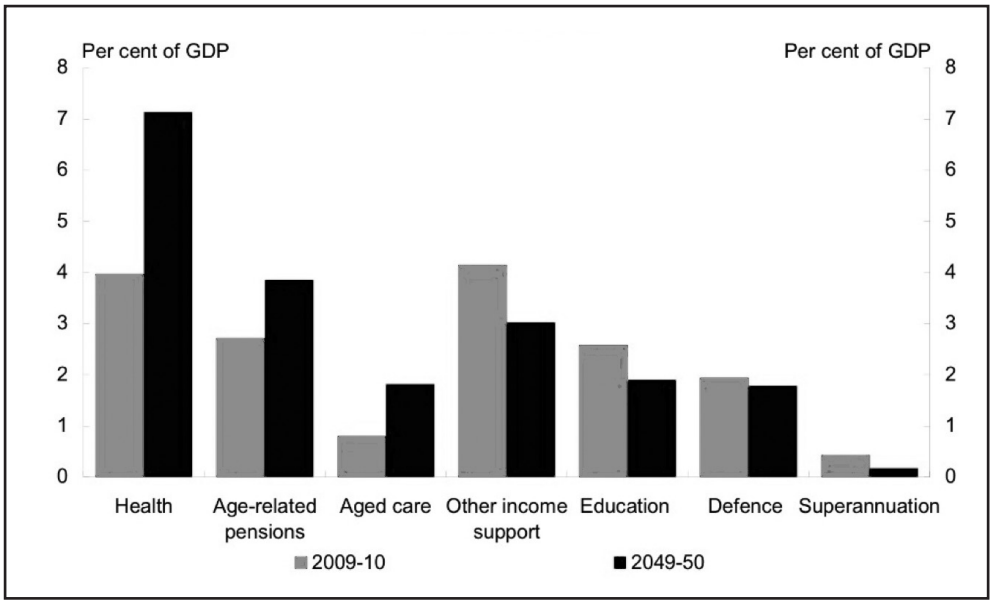
The IGR projections of the future size of government are optimistic.

As the first TARGET30 report showed, the IGR projections of the future size of government are based on current policy settings and assume 'no policy change' on either the spending or tax side of government.[11] The projections are therefore optimistic because they do not factor in the likelihood of new government programs. The CIS TARGET30 projections suggest it is realistic to anticipate total government spending increasing to over 50% of GDP by mid-century. Governments faced with additional financial burdens of this magnitude would be under even greater pressure to control health costs by restricting public funding for health, with an inevitable impact on the availability of health services.

Escalating federal and state health costs

Addressing the cost of health is crucial to budget sustainability. Rising public health spending is forecast to make a disproportionate contribution to increases in government expenditure compared to other policy areas—and will be chiefly responsible for the intergenerational inequalities associated with population ageing.

Figure 6: Projections of federal government spending by category



Source: *Intergenerational Report 2010* (Canberra: Commonwealth of Australia, 2010), Chart 6, xvi.

Intergenerational inequalities arise when one generation fails to provide for their retirement costs because they choose to live beyond their means during their working lives.

Intergenerational inequalities arise when one generation fails to provide for their retirement costs because, in effect, they choose to live beyond their means during their working lives by using current income to fund current consumption rather than save for future needs. The modern welfare state is a giant system of living beyond one's means that diminishes personal responsibility and self-provision. 'Pay-As-You-Go' taxpayer-funded health systems like Medicare spend all the tax dollars collected and allocated to health each year and nothing is saved or invested for the future. Failure to pre-fund health and other retirement costs leads to the accumulation of 'generational debt'—large unfunded liabilities for old-age entitlements—which imposes heavy financial burdens on younger generations expected to pay higher tax to fund the publicly funded government services and other benefits enjoyed by the elderly.[12]

Ageing-related spending currently accounts for a quarter of total federal government expenditure. Due to the increased cost of the Commonwealth's pension, and health and aged care programs, IGR 2010 projects almost half of federal expenditure will be consumed by ageing-related spending by 2050.[13]

Rising health cost is the single most important source of increased expenditure, and is expected to account for two-thirds of the total 4.7% projected rise in federal government spending. IGR 2010 estimates that federal expenditure on health will jump from the current 4% of GDP to 7.1% by mid-century (Figure 6).

The *Intergenerational Reports* have focused exclusively on the impact of ageing on the federal budget. In 2005, the Productivity Commission modelled the impact of ageing on public spending. But unlike the Commonwealth IGRs, the commission included detailed projections of both state and federal government spending. It found that across all levels of government, spending would rise by 6.5% of GDP,

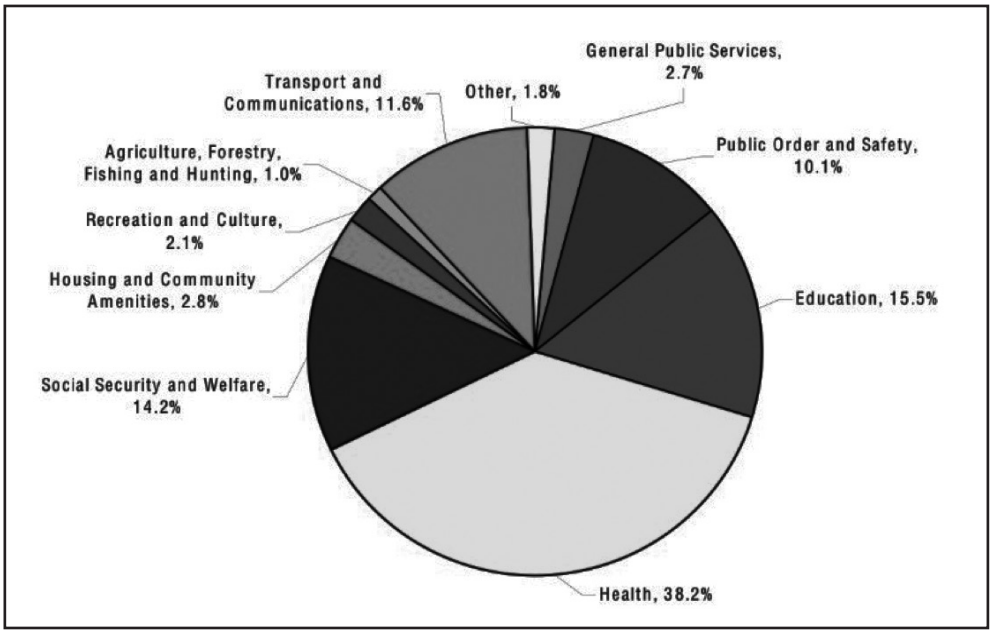
with health costs contributing over two-thirds (4.5%) to the future fiscal pressure and taking total government health spending to over 10% of GDP in the 2040s.[14]

The revenue-poor and responsibility-burdened states face similar fiscal problems as the Commonwealth, especially in health spending.

The NSW government also produces regular intergenerational reports to 'assess the long-term fiscal gap' and 'inform policy makers and the public of emerging pressures that will affect fiscal sustainability.' The NSW IGR 2011–12 found that over the next 40 years, growth in state government expenditure will outstrip growth in revenue, with expenditure growth to be driven mainly by higher health spending (principally spending on the provision of public hospital care) (Figure 7). By 2050–51, an estimated fiscal gap of 2.8% of Gross State Product (GSP) will have emerged, equivalent to $11.5 billion or around 20% of budget expenses based on 2009–10 GSP. Net debt is estimated to increase from 2.3% of GSP in 2009–10 to an unsustainable 119% by 2050–51.[15] This would see interest payment alone rise from 3% to 30% of budget expenses, and necessitate major 'corrective measures' long before reaching this point.[16]

The revenue-poor and responsibility-burdened states face similar fiscal problems as the Commonwealth, especially in health spending.

Figure 7: Projections of NSW government spending by category 2009–10 to 2050–51



Source: *NSW Intergenerational Report 2011–12*, (Sydney: Government of NSW, 2012), Chart 5.2, 5 – 9.

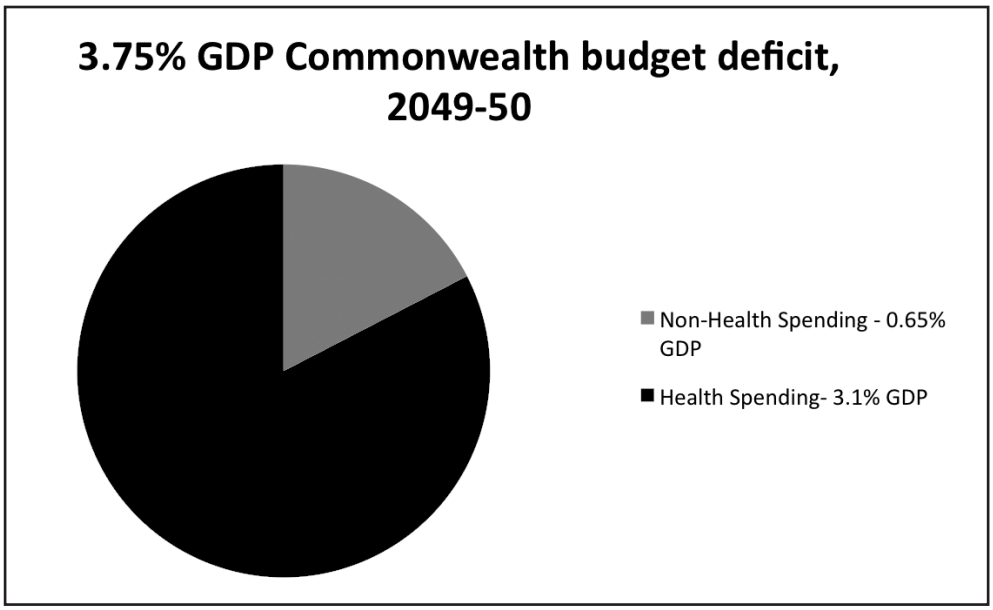
The NSW IGR shows that health is set to make the largest single contribution to increased expenditure across all areas of government. The projections suggest health will account for 38.2% of growth in total NSW public spending, two and half times the size of the contribution of the next single largest area (social security and welfare, 14.2%).[17] With health expenditure projected to increase from 28.1% of the state budget in 2009–10 to 37% in 2050–51, health costs alone account for 2% of the projected 2.8% fiscal gap in NSW.[18]

Inexorable growth in health spending is clearly the main driver of the expenditure pressure that will make big government unsustainably bigger in coming decades at state and federal levels. In the next four years, federal health spending is estimated to rise by 16% to top $71 billon in 2015–16 due to the increased Commonwealth funding for public hospitals, population growth, and 'in particular, the number of Australians aged over 65.'[19]

The Commonwealth and NSW IGRs show that if public health spending could be kept at the current proportion of GDP, fiscal challenges would be reduced substantially. The federal budget deficit would be only 0.65% of GDP in 2050 instead of 3.75% of GDP. But the effect would be bigger because closing the fiscal gap would eliminate the cost of servicing public debt. Likewise, the NSW fiscal gap would fall to a more manageable 0.8% and the budget deficit and net debt would be significantly reduced (figures 8 and 9).

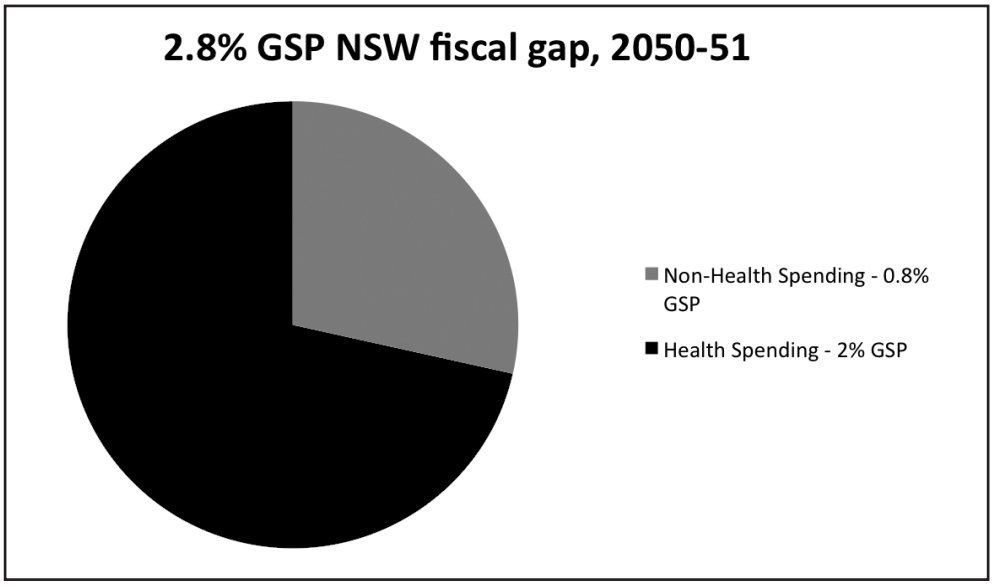
If public health spending could be kept at the current proportion of GDP, fiscal challenges would be reduced substantially.

Figure 8: Projected federal deficit by health and non-health spending



Source: *Intergenerational Report 2010* (Canberra: Commonwealth of Australia, 2010).

Figure 9: NSW fiscal gap by health and non-health spending



Source: *NSW Intergenerational Report 2011–12* (Sydney: Government of NSW, 2012).

Technology or ageing?

The magnitude of the health-driven fiscal challenges facing the nation highlights how outdated Medicare has become. Free and universal, pay-as-you-go health systems

like Medicare are a twentieth-century social policy, and were created during a period when health care was relatively cheap and basic, when most people died in their 60s, and relatively few lived into their 80s and beyond, as is increasingly the norm today. Health will impact heavily on government budgets because health costs are demographically sensitive. Demand for health increases with age, and the older people get, the more health care they will consume to maintain their health and preserve their lives. Advances in high-tech, high-cost medical science also add significantly to ageing-related health spending.[20] This dynamic will put pressure on government budgets, given the public choice to run the vast majority of health spending through government programs.

There is a debate among scholars concerning the role ageing plays in increasing health costs. In recent decades, 'non-demographic factors,' or the greater use of new technologies by all age groups, have accounted for the largest proportion of growth in health expenditure. This trend is set to change as population ageing occurs. The sheer number of elderly people, in interaction with the impact of technological breakthroughs, means 'demographic factors' will become a more important and bigger driver of much larger growth in health expenditure than the IGRs suggest.[21]

The health spending projections contained in the IGRs are based on past spending patterns. Because they assume that non-demographic factors will be the major driver of health costs over the next 40 years in line with the historic trend of the previous 40 years, the IGR projections indicate that population ageing will account for 'only' a quarter of increased health expenditure. Nevertheless, federal health spending on the 65s and over is still estimated to increase seven-fold, and by twelve-fold for those aged 85 and over.[23]

The political economy of Medicare could become untenable.

However, IGR 2010 also admits that the health spending projections could understate the potential impact of ageing. It warns that the ageing-related cost of health to the budget is likely to be substantially higher than stated, as 'there may be interactions between demographic and non-demographic forces.'[24]

This warning reflects the growing body of evidence that suggests the increased supply of increasingly sophisticated therapies and procedures, which will deliver new treatments for chronic diseases linked to old age, will compound the cost pressures associated with ageing. The 'ageing effect'—the interactions between the 'greying' of the population and advances in medical technology—will increase health expenditure far more than anticipated by the IGR.[25]

Using different assumptions that more heavily weighted the role of ageing, a 2005 report by the Productivity Commission estimated that ageing would account for *half* the total projected increase in government health spending, due to the 'potent cocktail' of increasing numbers of elderly amplifying the costs associated with advances in medical technology.[26]

The debate over the health cost implications of ageing isn't just an academic controversy. The so-called 'limited effect' of ageing on health cost is cited as argument for retaining the Medicare status quo.[27] If younger generations are paying more tax to fund the health care of all age groups, this changes the intergenerational equation. Yet the ability of modern medical sciences to discover more ways to help more patients, particularly older patients, at greater cost, suggests the main beneficiaries of higher taxes and higher health spending will not be the proportionately smaller base of taxpayers of tomorrow, but the much larger number of elderly people consuming a disproportionate share of health resources.

Given the massive intergenerational transfers involved, we should not be complacent about the fiscal challenges in health. The political economy of Medicare could become untenable, given the potential for conflict between the generations concerning the burdens that higher health spending will create. Especially when politicians will be keen to win the support of the much larger number of older voters and levy higher taxes on the proportionately smaller working-age population to pay

for 'more services' for the elderly. Nor should we be sanguine about the fact that there are limits to government's ability to tax and spend, and that unsustainable growth in the cost of Medicare has the potential to exhaust those limits as the 'ageing tsunami' hits. This will have real implications for Australians of all ages denied access to the health services governments will not be able to afford to pay for.

Policy vacuum

The IGRs have identified the long-term budgetary challenges the nation faces in health. IGR 2010 rightly states that to make the cost of public health services sustainable, 'major cost drivers need to be addressed and efficiencies found … so that every health dollar will buy more and better quality health services.'[28] These are worthy aspirations. However, the IGRs do not contain comprehensive analysis of the major cost drivers and inefficiencies. Hence, the reports have failed to offer specific policy proposals to 'improve the productivity of service delivery' and 'ensure value for money.'[29]

The IGRs have also failed to address the central issue of unaffordability. No policy that will directly reduce the government's share of health spending and increase private financing of health services has been proposed, nor have any specific measures been canvassed to increase the efficiency of public health services and better target public spending. Despite the plausibility and seriousness of the sustainability problems outlined in the IGRs, the policy response from federal and state politicians has been next to negligible in terms of formulating and implementing comprehensive, long-term strategies.

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The main reason for the lack of interest in comprehensive health reform is that Medicare is a popular entitlement program, verging on a political 'sacred cow.' The electoral sensitivities that surround the scheme account for the lack of political will to consider alternatives to the existing arrangements. The political quarantine now encompasses bipartisan support for its retention, with the non-Labor side of politics having portrayed itself as Medicare's 'best friend' during the Howard government's long term in office.

Policy alternatives are also marginalised due to the popular belief that Medicare promotes social equity by ensuring the poor can access health care. Many politicians, commentators and health experts maintain that in a rich country like Australia, health care should be provided by government as a 'right.' To ensure that cost barriers do not deter low-income groups from using health services, all health care should be funded by taxes and available to all citizens without user charges at point of access. The orthodox view is that the only fair way to finance health care is to maintain status quo and keep Medicare operating the way it currently does.

High and inefficient spending

The orthodox perspective on health policy is problematic, given the impact of Medicare on the cost and availability of health care.

Taxpayer-funded subsidies for health care (like all price and exchange controls) create economic distortions that affect the demand and supply of services. The upward pressure these distortions place on health spending by hiding real costs from consumers is compounded by the community expectation that government should automatically spend rising amounts of national income on health care. Public health expenditure is therefore expected to perpetually increase, commensurate with increases in living standards, to satisfy ever rising demand for more health services.

The problem in health is that when a good or service is provided in the open economy, demand is easier to meet because individuals can choose to spend their own money on the goods or services they need and want, and the competitive

pressures of the market work to lower prices and improve quality. Problems arise when governments either directly provide 'free' or highly subsidised goods and services such as health care, because market forces that restrain demand and efficiently increase supply either do not exist or are dulled, making it difficult to achieve value for taxpayer dollars.

Lack of price signals means governments are forced to resort to blunt expenditure controls to contain the potentially infinite demand for and potentially unlimited cost of publicly funded health care. Because government budgets are limited, 'free and universal' taxpayer-funded health systems such as Medicare have always had to control health spending by 'rationing' health care via some form of queuing by waiting. Rationing in the Australian public health system chiefly occurs in the form of long waiting times for treatment at public hospitals, which is the point in the Medicare system where operational capacity is restricted and cost control imposed via funding caps at state and federal levels.

The orthodox perspective on health policy is problematic, given the impact of Medicare on the cost and availability of health care.

Long waits for public hospital are exacerbated by the structural flaws at the heart of the Medicare scheme. (See below for further discussion.) Medicare is an inherently inefficient and inequitable way to fund health care. It permits excessive public spending on minor or unnecessary medical care (principally GP visits) that are consumed for free or on a low-cost, highly subsidised, and open-ended basis, while restricting spending on major hospital services to enforce rationing. Under Medicare, public hospitals that are required to provide their services for 'free' experience the productivity problems (including excessive bureaucracy and 'capture' by public sector unions) that beset all monopolistic government-owned and operated utilities operating in a non-competitive environment. The high cost of delivering care in poor-performing public hospitals further lengthens waiting times by compromising the ability of the public system to deliver timely and cost-effective care. Wasteful spending in health, as in any other area of government, should not be tolerated. The opportunity costs incurred include the forgone consumption of other goods and services, including people waiting longer for health care and missing out on treatment altogether. It is therefore appropriate that the use and abuse of government health expenditure be closely scrutinised as part of the TARGET30 campaign, which aims to 'ensure the efficient and effective delivery of crucial services that Australians require while curbing the uncontrolled growth of wasteful government spending.'[30]

Averting the fiscal crisis in health

Australian governments, facing many competing priorities, don't have enough money to pay for the rising quantity of increasingly sophisticated health care the community wants to consume each year. The reality is that governments are going to struggle to pay the even larger costs associated with the remorseless ageing of the population and the never-ending medical revolution. As the cost of Medicare inexorably increases, the expectation that government should provide ever-greater access to increasingly costly health care will prove completely unrealistic, given that the government will find it difficult to raise taxes to levels sufficient to fund all areas of expenditure. The stress that unsustainable health costs will place on government budgets is thus likely to lead to stricter funding restrictions requiring more extensive rationing, including longer queues for hospital treatment, slower take up, and diminished availability of new medical technologies.

This will affect the equity of the health system. The 'mixed' public-private nature of the Australian system means the ability to pay ('go private') determines the level of access for different groups. The ability to avoid hospital queues in the public system by securing treatment in private hospitals depends on the capacity of individuals to afford private health insurance or to self-fund their care out of their income or savings. In the future, those with the private means to purchase the health care that

government cannot provide will do so, while those without private means will not have comparable access to the same services. Rising health care costs will also put pressure across all areas of government expenditure and could necessitate trade-offs that crowd out other key services such as education and transport.

The appropriate response to looming 'health and ageing' fiscal crisis is a dual-pronged health care financing reform plan that (1) shifts responsibility for health costs off government budgets, and (2) incorporates design features that boost efficiency. The financially sustainable way to fund health care over the long term is to pre-fund the health care people will want and need in the future by enabling people to save up and pay for it over time using an appropriate mix of self-financing and third-party insurance arrangements. A prudent health policy should also focus on maximising value for money by ensuring that our health dollars are used cost-effectively. Achieving greater personal responsibility for health spending and expanding the private provision of health services are vital reform objectives, because the introduction of choice and competition into the health sector will drive cost-saving improvements in both the allocative and technical efficiency of health care provision.

The structural flaws of the Medicare scheme mean we spend more on health care than is necessary to fund fewer of the services people actually need.

The sustainability of quality health services is obviously an important issue for all Australians, and we all have a stake in trying to find better ways to finance and deliver services. Appreciating the defects within the existing system is key to making the case for reforming the way health care is financed and delivered in this country, based not just on sustainability but on consideration of equity as well. Even if twenty-first century Australia did not face the interrelated demographic and medical technology cost pressures that it does, improving efficiency would remain a crucial reform goal. Hence, the case for comprehensive health reform requires understanding the impact the structural flaws of the Medicare scheme have on Australian health care, which mean we spend more on health care than is necessary to fund fewer of the services that people actually need.

The 'fair go' case for reform

All Australians are entitled to use their Medicare cards to either 'bulk bill' all the cost of GP and other non-hospital medical services to the federal government, or receive a rebate covering a significant proportion of the cost of each services. High subsidies encourage waste on unnecessary consultations and tests because consumers do not have a financial incentive to be cost-conscious consumers. Because the real cost of health services is hidden from consumers, the incentive is to over-consume health care to gain maximum personal benefit and shift the cost to other taxpayers. Doctors and other health professionals also have an incentive to over-provide (irrespective of health needs and benefits) because Medicare pays on a fee-for-service basis that rewards providers who deliver more services. When individuals are paying out of pocket for only 16% of the cost of MBS-funded services and for only 20% of the cost of PBS-funded medications, it is impossible to tell how many billions of dollars are being wasted on unnecessary consultations, tests and prescriptions.[31]

The perverse incentives and intrinsic moral hazard (best defined as the propensity of people to spend third-party subsidies or 'other people's money' less wisely than their own money[32]) that Medicare creates has led to high, ever-increasing spending on the non-hospital sector. This has exacerbated funding and service imbalances at the most acute hospital end of the health sector. The federal government is responsible for 62.4% of total government health spending. But 60% of federal government health

spending is on its own health programs, primarily to pay for the open-ended MBS and PBS. To offset the large and ever-escalating cost of these programs and control the total cost of health care in the federal budget, the Commonwealth has always tightly capped the level of funding provided to the states for public hospital care, the real value of which has dwindled over time.[33] No federal government—under Hawke, Keating, Howard, Rudd or Gillard—has maintained a 50% share of the operating costs of a 'free' public hospital system as the designers of the Medicare system intended.[34]

Due to vertical fiscal imbalance in the Australian federation (caused by the federal government's full power over income tax), state governments have large policy responsibilities and relatively small sources of revenue. The ability to fulfil their considerable and competing responsibilities depends heavily on the size of Commonwealth grants and special purpose payments bestowed on each state. Since the start of Medicare, the state's predictable response to their heavy exposure to the financial risk of growth in using 'free' public hospitals has been blunt expenditure controls. The frontline budget caps on the nation's 750-plus public hospitals imposed by state health departments have led to huge cuts to public hospital bed numbers in the last 25 years (in excess of innovations that cut length of stays) which, in turn, has led to blowouts in waiting times for elective and emergency admissions.[35]

Medicare is a very good way of handing out politically valuable health entitlements and a poor way of insuring people against bad health.

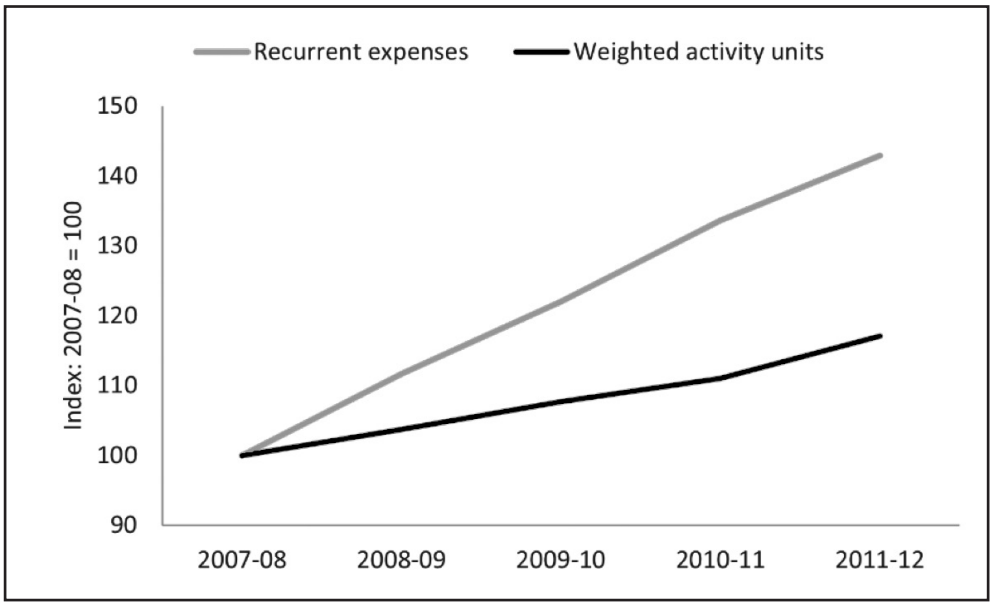
The federal government currently spends approximately half as much money ($17.6 billion in 2010–11) on the MBS as combined Commonwealth and state spending on public hospitals. Over the last 40 years, Australian governments have gone from spending approximately $5 subsidising hospital services for every $1 spent subsidising medical services, to spending $2 on hospitals for each dollar spent on medical care.[36]

These figures reflect developments in clinical practice, such as diagnostic investigations that no longer need to be performed in hospitals due to technological advances. However, these figures also identify the faulty principles of Medicare, which is not a soundly constructed insurance scheme. It is a 'reverse insurance' scheme that misallocates health resources on a non-needs basis, leaving people over-entitled at the primary care end of the health spectrum and underinsured at the acute end. The perverse result is 'inverse care': the minority of patients with major health needs are inadequately covered against the most serious, most expensive illness requiring hospitalisation, because Medicare over-subsidises the medical care of patients with relatively minor and often trivial health needs.

Medicare is a very good way of handing out politically valuable health entitlements to millions of voters, but it is a poor and inequitable way of insuring people against bad health. The lasting effect has been to create an imbalance in funding flows and subsidies available for hospital and medical services, which continues to distort the demand and supply of health services in Australia.

Equity suggests that the money spent on the MBS would be better spent meeting unmet demand for hospital care. But redirecting money into bureaucratic, inefficient and already expensive public hospitals is not the solution. Public hospitals are like other public sector monopolies, and additional inputs into already high-cost and low-performing public hospitals do not produce proportional increase in outputs.[37] A 10% increase in federal funding between 2008 and 2011 produced no real improvement in public hospital elective waiting times, nor did it increase the number of beds available to treat patients.[38] The Queensland Commission of Audit recently found that while expenditure on public hospitals in Queensland had 'increased 43% between 2007–08 and 2011–12, activity increased by less than half (only 17%) (Figure 10).

Figure 10: Queensland public hospital expenditure and activity trends



Source: Queensland Commission of Audit, *Final Report*, (Brisbane: Queensland Government, 2013), 22.

Market-based solutions

Pouring more money into the public health system is a non-solution and unsustainable. When advocates of market-based health care reform studied the cost and access problems posed by health systems in all Western countries, they realised the need for an overhaul to correct the moral hazard and resultant cost and access problems that all subsidised, fee-for-service, third-party insurance arrangements create in private and public health systems.[39]

Pouring more money into the public health system is a non-solution and unsustainable.

Both systems are dogged by the problem of 'first dollar insurance'—the expectation among consumers that private or public insurance should entitle them to receive treatment entirely paid for by a third-party payer no matter how minor the health need or expense. As the increasingly unaffordable US private health system demonstrates, it is impossible to insure people for all health services without overuse causing a cost and premium spiral. In a private system, first dollar cover creates a cost and premium spiral; in a free public insurance system like Medicare, it exacerbates arbitrary and unethical rationing when funding on hospital care is capped.

A soundly constructed health insurance scheme, by contrast, should allow people to pool exceptional risk, and therefore, should not cover minor medical costs from first dollar spent as Medicare does. Instead, subsidies should be allocated on a differential, needs basis and be limited to major health problems and higher cost care. Sound health insurance principles can be put into practice by requiring individuals to self-insure against minor medical expenses and pay for these services using their own money to prevent overuse, while reserving third-party insurance for high cost treatments for complex, chronic and catastrophic conditions.

Given the 'demographic time bomb' and sustainability problems facing Medicare, it would be madness to persist with the wasteful and inefficient Medicare scheme that permits high spending on unnecessary medical care services which don't improve health outcomes, restrict funding for hospitals, and then squander resources on inefficient public hospital services—while the sickest patients forgo timely and essential care. Medicare's structural flaws must be addressed, or else the inequitable service shortages that plague Australian health care will worsen by mid-century. Instead of squandering an increasing proportion of national income on the wasteful public

health spending, we need to conserve our scarce health resources and deploy them in efficient ways that provide the best value for money. This will require individuals to assume greater personal responsibility for managing their spending on health than current arrangements allow.

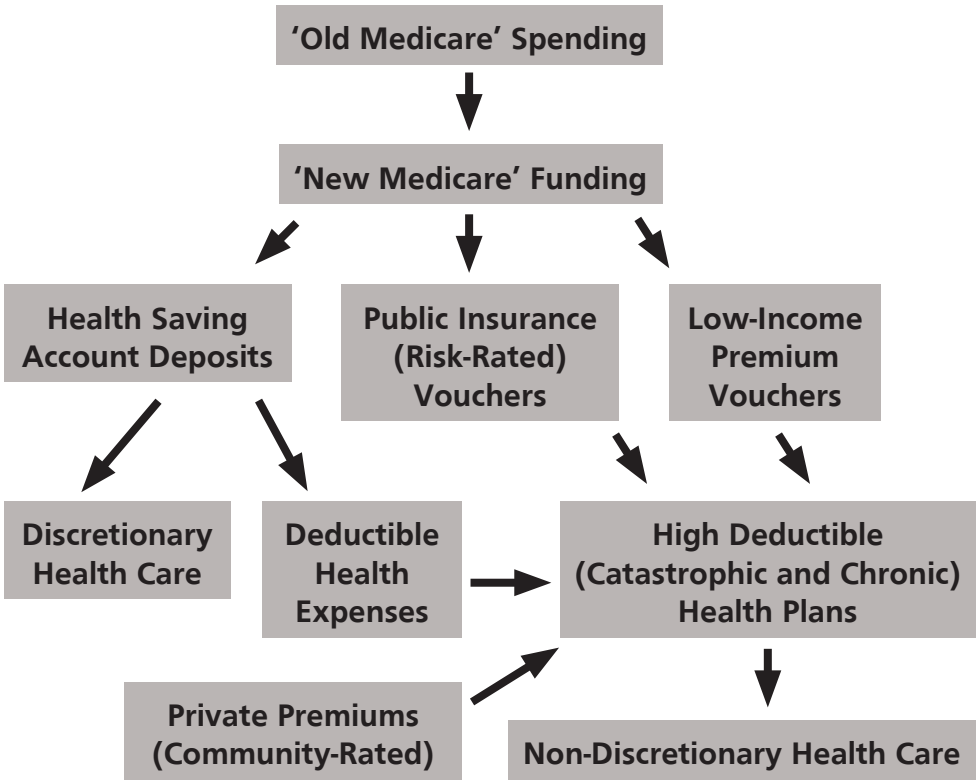
This is not to say that the principle behind Medicare should be scrapped. There remains an important role for public health subsidies in promoting equity, and no person should go without necessary health care due to lack of income. However, what matters is the way public subsidies are delivered, and whether there is a better way to provide Australians with health care than a theoretical entitlement to 'free and universal' access that, in reality, falls short of that promise. Well-designed reforms can ensure all Australians receive more, better and more effective health care for what will become increasingly scarce health dollars in coming decades. Fairness, access, affordability and sustainability can all be improved by changing the way health care subsidies are delivered by shifting to a Health Savings Account (HSA) and a high deductible insurance voucher system.

The sustainability problems in health require rethinking how best to finance current and future health spending based on sound health insurance principles.

Saving for sustainability

The average amount of money spent on health care each year per Australian is just under $5,800. This includes money spent on health services by individuals from out of their own pocket and money spent paying for services insured privately or funded through Medicare. The government-funded share of total health spending per person was 70% or $3795 in 2010–11. The key question is whether government funds are being used optimally. The answer is no. The sustainability problems facing the Australian health system require rethinking how best to finance current and future health spending based on sound health insurance principles.

Figure 11: Redirecting Medicare spending to save as we go



Sound insurance principles could be satisfied, and long-term funding challenges alleviated, by redesigning Medicare and reconfiguring the way existing health spending is used to buy health cover and self-fund health services. To optimise health care financing in Australia, public health subsidies should be redirected by splitting existing Medicare spending into two streams of 'New Medicare' funding (Figure 11).

One stream would be allocated to enable individuals and families to save and pay for their own minor health expenses, via personalised health financing instruments or HSAs. HSAs would be modelled on the compulsory superannuation system (except that funds will be held under management by health insurance funds), with annual deposits (either a tax-credit or transfer payment depending on income) made by the federal government in lieu of existing Medicare entitlements. Deposited funds could only be withdrawn to purchase approved health services for the account holder, their spouse, or dependents. Preservation rules would apply and once certain dollar and age thresholds are exceeded, excess funds (subject to set dollar and age thresholds) could be withdrawn for non-medical purposes. Unspent balances would accrue to deceased estates.

The problem of moral hazard inherent in traditional health insurance needs to be addressed.

The second stream of funding would replace the remaining insurance component of Medicare with a soundly constructed, competitive and high-deductible insurance system, along the lines of the Medicare Select's risk-rated insurance 'voucher' scheme proposed by National Health and Hospital Reform Commission (NHHRC).

The NNHRC scheme is based on the Dutch health care reforms. In 2006, Holland achieved what was hitherto believed to be politically impossible when it replaced its Medicare-style taxpayer-funded health system with a risk-rated insurance voucher system. Insurance vouchers enable people to purchase health insurance plans from competing health insurance funds that cover a mandatory set of minimum services. The benefits of social insurance models of health care financing (such as choice of health funds and competitive purchasing of services) have long been recognised by advocates of NHS reform in the United Kingdom. The benefits of choice and competition have been demonstrated by the early success of Dutch reforms, with the operation of the new system proving to be less costly than predicted.[40] However, the problem of moral hazard inherent in traditional health insurance needs to be specifically addressed, particularly as social insurance systems expose government to the financial risk of an overuse of insured services causing costs to spiral.

The New Medicare

The NHHRC's Medicare Select model partly addresses moral hazard by proposing a mix of taxpayer-funded vouchers plus additional 'community-rated' private premiums, whereby each member would pay the same rate regardless of health status. This is designed to indirectly expose people to the cost of using health care, and this feature is retained in the New Medicare system proposed here. Appropriate government funding of HSAs and insurance vouchers, plus an additional voucher for low-income earners to assist with the cost of private premiums, will ensure equity is maintained.

However, the New Medicare goes further in addressing moral hazard by using HSAs to fund lower-cost discretionary services (defined as non-hospital and non-chronic care) and to allow selective use of prices and co-payments at points of access across the health system to directly expose people to the cost of deciding to use health services. The New Medicare would allow people to self-fund less-expensive health care while maintaining insurance cover against major illness and large medical bills in the form of high-deductible health insurance to cover catastrophic and chronic conditions. High-deductibles (in conjunction with limits on total out-of-pocket expenses) require people to self-fund their own health expenses below set thresholds each year from their HSAs, and are designed to ensure that only the cost of non-discretionary services (defined as most hospital-based care, surgical procedures,

and ongoing treatment for chronic conditions) is paid for by health funds. High-deductibles significantly reduce administration costs (and thus premiums) by eliminating the need to process claims for all but the most costly health expenses.

HSAs would be used to fund health care until the deductible and/or out-of-pocket limit is reached, at which point health funds will pay for most or all medical bills. Ideally, high-deductible insurance plans should be structured to enable cost-sharing above and below the deductible, based on whether health services are discretionary or non-discretionary. If an individual spends excessively on non-discretionary care, their profligacy should not be rewarded by forcing the insurer and other fund members to pick up the bill for additional discretionary care, which should continue to be paid for from their HSA or out-of-pocket. In principle, however, if a person suffers a catastrophic illness, or has or acquires a chronic condition, insurance should pay for their care below the deductible.

The New Medicare would combine greater financial sustainability and enhanced efficiency (allocative and technical), with greater effectiveness and improved equity. Choice of insurer—the portability of vouchers—will encourage price competition and innovation among health funds. A genuine purchaser-provider split in health care will introduce price contestability for hospital care, which will spur meaningful reform of public hospitals, which will have to compete against private hospitals for customers. Greater choice, competition and consumer consciousness across the system will drive efficiency and lower costs at the provider level, as has occurred in other government utilities and sectors of the economy opened up by market-based reforms in the last 30 years. Overall, demographic-related fiscal unsustainability will be addressed by ending waste on unnecessary services; by replacing an inefficient scheme with better needs-based targeting of resources; and by funding care by saving over time using HSAs and a soundly constructed insurance scheme.

The New Medicare is 'big bang' health reform designed to fundamentally alter the structure of the health system.

Ten tips to TARGET30

The New Medicare is 'big bang' health reform designed to fundamentally alter the structure of the health system. 'Small bang' reforms (relatively speaking) that would contribute to the TARGET30 objective (cutting the size of government to no more than 30% of GDP within 10 years) while leaving Medicare largely intact include:

- Downsizing the bloated Department of Health and Ageing, which employes more than 5,000 public servants despite having no direct involvement in the delivery of health services.
- Lowering bureaucratic overheads in Australia's highly centralised public hospital system by devolving full managerial responsibility and financial accountability for operating public hospitals from state health departments to Local Hospital Districts (LHDs) along the lines of the NHS Hospital Trust model in the United Kingdom.[41]
- Allowing local hospital managers to hire and fire clinical staff on flexible terms, including the use of output-based contracts for surgeons, circumventing the state-wide employment conditions for doctors and nurses that entrench restrictive work practices and limit public hospital productivity.[42]
- Privatising select public hospital facilities to create a contestable and competitive public hospital sector to encourage public hospitals that remain in public hands to adopt more efficient private sector methods.[43]
- Restricting the number of private patients treated in public hospitals (currently 10% of public hospital admissions) to prevent 'double dipping'—using public infrastructure and recurrent funding to deliver care that could be provided in a private hospital for only the cost of the PHI rebate to the government.

- Reintroducing in-hospital nurse training to reduce hospital operating costs and enable more staffed beds to be opened at lower cost,[44] while ending the cartelised supply of specialists by breaking the monopoly of medical colleges on training by permitting universities to offer specialist training as a postgraduate degree.[45]
- De-funding taxpayer-funded public health advocacy organisations, starting with the National Preventive Health Agency,[46] as part of a wider review of the $2 billion currently spent on public health, given that the evidence demonstrating the effectiveness of 'nanny state' initiatives targeting 'lifestyle disease' was found to be negligible by major reports in the United Kingdom and Australia in the early 2000s.[47]
- Scrapping the MBS GP management plan rebates to prevent the misuse and rorting by doctors and patients identified by the Professional Services Review;[48] scrapping the MBS Better Access to Mental Health Care program in light of the 2011 evaluation that showed its main effect is to deliver subsidised access to mental health services to people living in well-off suburbs.[49]

Implementing these practical TARGET30-recommended strategies would create a far more cost-effective health system.

- Reintroducing compulsory co-payments for MBS services to share costs with consumers and curb overuse, as devised by the Hawke government in 1991 and abandoned after Paul Keating became prime minister in 1992. Co-payments were set at $2.50 (with exemptions for pensioners). Adjusted for inflation, the compulsory co-payment in today's money would be $4.26. There is obvious scope for increasing the out-of-pocket cost for accessing GP services, given the fact that the value of the updated co-payment is less than the cost of a Big Mac.
- Imposing a means test on Medicare entitlements, consistent (at the very least) with the means test introduced in 2012 for the PHI rebate. The rationale for the PHI rebate means test is that the government should not be helping pay for the health care of the 'rich.' The same principle should apply to Medicare-funded health services.

Implementing these practical TARGET30-recommended strategies—contracting out, stronger financial management, enhancing public sector productivity, eliminating 'churn,' reviewing expenditure, levying user-chargers, and revising eligibility for public programs—would create a far more cost-effective health system than we have. In particular, the proposed public hospital reforms, which pick up the recommendations made in the CIS Health and Ageing Program research reports on hospital governance and performance,[50] would help close the 20% to 25% productivity gap between the least and most efficient public hospitals identified by the NHHRC, and help deliver the estimated 10% to 20% increase in volume of health services that is possible using the same resources.[51]

Medicare co-payments and means tests would yield substantial and immediate reductions in government spending. They would also be highly contentious since they would mark a significant move away from a 'free and universal' health system towards user-pay, and would be characterised as steps towards rendering Medicare into a mere safety net for the poor. These measures have also been long recommended, and yet action has not been taken because of the political difficulties involved in clawing back health entitlements. MBS co-payments and means testing Medicare would create many 'losers' (whereas politicians prefer to use taxpayers' money to reward the maximum number of 'winners'). While billions of dollars could be saved, the changes would be vulnerable to the charge of 'penny-pinching' and 'skimping on health' in the context of the total size of government. They would also be difficult to justify as comprehensive health reforms that address long-term cost, quality and access

issues, particularly as the inefficiencies and related problems inherent in Medicare would remain.

The New Medicare would not create losers and it would address a major national problem—the viability of the health system—in a comprehensive and principled fashion. It would do what needs doing most of all—establish significant non-government sources of health funding and limit government exposure to rising public health expenditure, while using market forces to increase efficiency, lower price, raise quality, and expand the availability of health services.

Demand-side and supply-side

The New Medicare plan is based on the idea that people will behave more prudently when they have to spend their own money to consume health care.[52] In the United States, dealing with the challenges of ballooning health spending has led policymakers to introduce innovative health insurance arrangement designed to address the major flaws in traditional public and private health insurance schemes. In 2003, the US Congress allowed individuals to establish tax-advantaged HSAs to pay for medical expenses on the condition that they also took out a high-deductible health plan. HSA/HDHP coverage has since grown to include 13.5 million Americans in 2012.[53]

Empowering consumers by giving them personal responsibility for using their own health dollars is designed, on the one hand, to control health expenditure on the demand side by encouraging consumers to make rational, cost-conscious decisions about when and where they use discretionary health services. Because HSAs will roll over each year and earn tax-free interest, consumers will have an incentive to eliminate wasteful expenditure so their health savings grow and money is available should illness strike. Health savings accumulated during people's working life will also pay for the higher health expenses to be expected in retirement (including the payment of insurance premiums). Indicative of the mindset encouraged, many US health funds have established online tools to help members manage their HSAs, and to provide information about disease management and the cost and quality of health services.[54]

Consumer-empowerment is designed to have supply-side effects that contain health costs by changing the way health services are produced.

On the other hand, consumer-empowerment is also designed to have supply-side effects that contain health costs by changing the way health services are produced. Efficiency will rise and prices will fall when providers have to compete for patients and are encouraged to discover new ways to deliver value-for-money health services.[55] In both the public and private systems, providers are paid for doing the same things in the same way as mandated by current funding and payment systems. These 'top down' arrangements mean health consumers get access to only the kind and mix of services that funders/payers agree to fund/pay for. The MBS Schedule, for example, proscribes the way patients can and cannot be treated by only paying for certain 'items' of care on a fee-for-service basis. Public hospitals are also prohibited from reorganising their services and providing care outside hospitals even if it is cost-effective and clinically appropriate. This is despite international evidence showing that health systems that break down the traditional divide between hospital and non-hospital care are more efficient. A 2002 study found that the American health maintenance organisation, Kaiser Permanente, delivers far more medical interventions with shorter waiting times and with far less use of expensive hospital beds than the British NHS, because Kaiser provides quite complex procedures in lower-cost outpatient clinics and rigorously manages hospital admissions and discharge procedures. The competitive pressures in the US private health market meant Kaiser focused on discovering ways to provide patients with the faster access to care in the lowest cost setting.[56]

When consumers start shopping around to secure the best price and most effective treatments, and when health funds get into the business of purchasing care on behalf of members, providers will need to be consumer-focused and have an incentive to innovate and find better ways to deliver the right services, in the right place, for the right patients. Health providers can then market and sell superior and more cost-effective models of care to consumers and health care funds. A competitive, consumer-directed health system will have the most profound impact on the way chronic conditions are treated.

The New Medicare vouchers will be risk-rated (based on age, gender, health status, and socioeconomic criteria), meaning their value will increase if a person has a greater chance of falling ill or if they have a pre-existing condition. The higher-value vouchers will encourage health funds to attract higher-risk members and (since they carry financial risk for members' health) to seek to reduce the cost of insuring chronically ill members by ensuring their conditions are properly managed to prevent expensive episodes of acute illness requiring hospitalisation. Chronic care (along with hospital care) will be the remaining form of health service paid for by insurance funds on members' behalf, and will stimulate a reorganisation of service provision. The kind of integrated care (GP and allied health services) that keep chronic patients 'well and out of hospital' will be offered by specialist clinics that will emerge to fill a clear gap in the market. These clinics will not be paid for delivering 'inputs'—on a fee-for-service basis—but will secure contracts according to their ability to deliver innovative and high-quality 'outputs' in the form of cost-effective packages of care that provide ongoing courses of treatment which maintain and improve the health of patients.

Health funds should operate as dynamic 'purchasers' of packages of chronic and elective care from independent producers competing on quality and price.

Improving the treatment of chronic illness from the 'bottom up' is important because the chronic disease burden, and thus the cost of treating chronic illness, will increase as the population ages. The New Medicare will finally force the health system to do what it should—provide all necessary and effective care to the sickest patients without resorting to flawed 'top down' approaches such as the federal government's ill-conceived GP Super Clinics program, the ostensible aim of which was to offer 'coordinated' chronic care.[57]

The key change will be that instead of operating as passive payers of medical bills, health funds will operate as dynamic 'purchasers' of packages of chronic and elective care from independent producers competing on quality and price. Insurers will negotiate contracts with chronic care clinics that will be the default 'medical homes' of members. The same contractual/default output-based arrangements will apply for hospital care provided in either public or private facilities. In the new competitive environment, funds will seek to ensure contracted services are provided at the best price and quality to lower premiums and attract and retain members, and successful providers will have to meet these requirements to win contracts.

GPs and specialists will play a crucial role in the new system. In return for a professional fee, doctors will act as 'agents' for their patients, providing advice regarding the best available treatment option and helping overcome 'information asymmetries' that would otherwise prevent people making informed decisions about deciding to purchase certain health services. This will drastically improve the quality of General Practice in Australia, which has been harmed by successive governments holding down the value of MBS rebates and (along with the increased demand stimulated by bulk billing) encouraged doctors to churn patients and practise '5-minute' medicine to keep their surgeries financially viable.[58]

The creation of a genuine private practice system will also help avoid the excesses of 'managed care' systems. Managed care regimes have been established in the United States to allow insurers to contain costs by strictly limiting the range of services and approved providers members are able to use. As well as generating

resentment by restricting patient choice, these arrangements have also compromised the professional independence of medical practitioners by interfering in the doctor-patient relationship.

Under the New Medicare, no such restrictions will exist because the majority of medical services will be self-funded. Furthermore, because it will be a sound insurance system, the primary objective of health funds will not be limiting access to services but focusing on ensuring that members access all necessary care for major health problems at the lowest price and highest quality.

More things change...

Self-funding is the policy solution applied in other ageing-sensitive areas of government expenditure.

The New Medicare reform plan is not as radical as it might seem. The same principles, applied in different forms, are the policy solution either applied or proposed in other ageing-sensitive areas of government expenditure.

With demand for aged care set to skyrocket over the next 40 years, numerous inquiries—culminating in the definitive 2012 Productivity Commission report into the challenges facing the sector[59]—have recommended that capital and operating costs for nursing home providers be self-financed by requiring residents to pay an accommodation bond. Bonds are financed by requiring residents of aged care facilities to sell the family home, which is the principal asset most Australians use to save over the course of their lives. It is widely recognised by policy experts and stakeholders that releasing the equity accumulated in the family home to fund retirement living expenses is both fair and rational—and the only feasible way of addressing the financial sustainability challenges facing the aged care sector. However, the political will to implement good policy is still lacking, with successive Coalition and Labor federal governments hesitant to allow nursing home operators to charge bonds.

However, both sides of politics support the Medicare levy surcharge introduced in the early 2000s. The purpose of the surcharge is to force higher income earners to take out private health insurance or pay an additional 1% of their income on top of the 1.5% Medicare levy. This policy, in effect, makes it mandatory for those judged able to afford to do so to make an additional personal contribution to the cost of their health care, with the surcharge operating as a quasi-means test qualifying the universal entitlement under Medicare. The levy also operates in conjunction with the Lifetime Cover rules that penalise those who delay taking out private cover by requiring payment of higher premiums for each year a person is un-insured for any time beyond 30 years of age. Combined with the PHI rebate, a range of carrots and sticks has been established amounting to a de-facto 'compulsory' health care self-financing system.

In most developed countries, the increasing cost of the public pension is a major challenge threatening budget sustainability. But this is not the case in Australia, where the retirement incomes policy introduced in the early 1990s requires all employees to contribute a set portion of their income (currently 9%) into their personal superannuation accounts. The operation of the compulsory superannuation system (along with tighter means testing) means Australia does not face as large an unfunded public pension liability as do comparable countries in the OECD. Only modest growth in the cost of the old age pension of 1.2% of GDP is expected by 2050 due to the decision made to mandate self-provision and reduce government financial responsibility for the cost of caring for the elderly. Applying the same approach to supplementing government provision with private provision is yet to occur in health.

Double paying

Shifting from a PAYG to a savings-based health system raises two significant obstacles.

Older people do not have sufficient opportunity to accumulate necessary savings to pay their own way, and have been encouraged to rely on government to pay for their medical bills in retirement. Withdrawing government health entitlements in these circumstances, given the size and electoral influence of the 'grey' vote, is politically impossible.

The second problem, directly following from the first, is that younger generations have to double pay. They must pay through the tax system for the care of the elderly, while also self-funding their own medical expenses and saving to pay for their old-age health costs. Double-paying already exists in Australia in relation to the retirement income system.

There is no dodging these obstacles. Transition arrangements are needed, such as exempting people over certain ages and allowing them to remain covered by the old Medicare. This could be achieved by transforming Medicare into a targeted scheme that will exclusively cover retirees or near-retirees, which could be abolished when the self-funded system matures. Age-related grandfathering should not, however, preclude the use of means tests and co-payments for retirees, given the fact that baby boomers have accumulated large stocks of assets and the elderly have been well looked after by governments in recent years as politicians have sought to win the support of this important constituency. Given the overly generous means and asset tests (which exempt the family home) for the Old Age Pension, only full pensioners, without substantial assets and other income, should be bulk billed. Innovations in a consumer-driven/market-based direction should also be implemented as well. Medicare hospital and chronic care should be covered by voucher (with MBS-funded GPs and specialists acting as gatekeepers), and the scheme could even be de-nationalised by enabling private funds to compete to provide chronic and hospital cover for seniors by converting it into a voucher-based insurance system.

Transforming Medicare into a targeted scheme for retirees or near-retirees means it could be abolished when the self-funded system matures.

Those who do not qualify for the age limit for Medicare would transition to the New Medicare system. There is no avoiding double paying in relation to health if a 'superannuation-style' shift to self-funding is to become a reality. Generations X and Y will have to pay their own way while paying for the health care of many of the baby boomer generation through the tax system, or else they, along with people of all ages, will miss out on the health services that government won't be able to afford to fund. Enlightened self-interest and self-sacrifice are called for. Rather than focus on the entitlements that will be lost, we need to focus on what will be gained by transitioning out of the old arrangements and taking greater control over our own health dollars. This includes double payers enjoying the benefits of a far more efficient and effective health care, compared to the existing faltering and unsustainable public system in which plenty is spent, plenty is wasted, and nothing is saved to pay for future health needs.

Affordability

The taxpayer dollars currently spent in health are not being used in the best way possible to finance the nation's current and future health care needs. The question, however, is whether this public health spending is sufficient to finance the optimal structure promised by the New Medicare.

Ultimately, how much funding—proportion of personal and national income—will be needed is for actuaries to calculate based on health expenditure over the life cycle. Maybe current public funding will not be sufficient and additional government funding will be needed. There is nothing wrong per se with spending

higher amounts of rising national income on a 'superior good' such as health care so long as the spending is efficient. How much we spend or don't spend on health is a choice, and ultimately, a matter of deciding to forgo current consumption to accumulate the resources needed to fund lifetime health costs. Since we already do this to fund retirement-living costs through the superannuation system, there is no reason for not following this precedent and doing the same thing in health. Furthermore, there are good reasons why we should do this, the chief reason being to create billions of dollars of health savings in the personal HSAs of millions of Australians so the cost of health does not create unsustainable financial burdens that result in cuts to health and/or other public services.

To allow money to be set aside for future health needs and close the future fiscal gap, government expenditure should be cut back in other areas to fund the New Medicare. Setting the right policy priorities today is the key to minimising the intergenerational burdens health will otherwise create, because profligate government spending in health and other areas is not just robbing us today but stealing from future generations as well. Other options for funding the New Medicare should include reviewing the recent decision to increase compulsory superannuation contributions to 12% of income by 2019, which was announced by the Gillard government despite a 2007 review by Treasury finding that no increase was necessary to ensure the adequacy of retirement incomes. These contributions would be better used to fund HSAs instead.[60]

Setting the right policy priorities today is the key to minimising the intergenerational burdens.

Initial costs (including start-up costs) also need to be assessed in light of the long-term cost benefits of the New Medicare. HSAs and high-deductible insurance vouchers will make health care more affordable over time due to the impact on the demand and supply. The Rand experiments have shown that high-deductible insurance can reduce health expenditure by 30% compared to people with traditional first-dollar insurance with no adverse impact on health, irrespective of income or prior health status.[61] People with a HSA are 50% more likely to ask providers about cost, 33% more likely to seek alternative treatments, and three times more likely to choose a less-expensive treatment option.[62] The money currently wasted each year on overuse and inefficient Medicare-funded services will be saved, and as HSA balances grow, a higher proportion of health expenses will be funded by saving, not as taxes.

At the same time, insurers will be building up reserves to fund high cost care instead of using members' funds to pay for overuse of over-insured services. High-deductible insurance will therefore be more affordable compared to existing public and private cover. In the United States, consumers opt for HSAs and high-deductible health plans because premiums are far cheaper than traditional health insurance, and they are able to keep and manage for themselves the health dollars that would otherwise be wasted on buying health cover they do not need. A report by the American Academy of Actuaries found that in the short term, 'consumer-driven health plans' reduced costs by 'as much as 12 percent to 20 percent in the first year' compared to traditional insurance; over the longer term, the trend rate was 3% to 5% lower than the 8% to 9% annual increase in the cost of traditional insurance.[63] In 2012, the average premium for a high-deductible health plan was 20% cheaper for singles and 17.5% cheaper for family cover than traditional health insurance.[64]

The great advantage of the New Medicare is it will give future governments increased fiscal flexibility in tight financial circumstances. This includes enhanced ability to limit public liability for health costs by establishing a fixed-cost subsidy—HSA contribution, risk-rated vouchers, and additional low-income 'private' vouchers—transforming Medicare from a defined benefit into a defined contribution scheme. It is for governments to determine the quantity of public resources to allocate to health based on the cost of health and the cost of other priorities assessed against revenue. The New Medicare will also enable governments to control their

share of national health expenditure by better targeting public support. The principal means of doing this will be by adjusting the eligibility for government-funded vouchers. By shifting the income threshold for eligibility, more people could be required to pay for the full cost of their health cover out of private incomes instead of relying on government. In theory, this would make it possible for government spending on health to be kept at existing levels of GDP by increasing the proportion of insurance costs paid by private premiums.

Government has grown bigger and bigger because it has tried to be all things to all people.

Government has grown bigger and bigger because it has tried to be all things to all people based not on welfare criteria but to suit political imperatives. The common claim that people willingly pay through the tax system to fund universal public health services is fallacious. The 1.5% Medicare levy (and the Medicare levy surcharge) raised $8.2 billion in 2010–11 and paid for only fraction of the total cost of Medicare—only 5.1% of the $62 billion governments spent on the MBS, PBS and public hospital services. Yet the Medicare levy has given rise to the myth that people have the 'right' to receive Medicare-funded services because they pay for the scheme themselves. The illusion cultivated is that Medicare is a genuine premium or contributions-based health insurance scheme. What we need is a truly self-funded health system. Governments need to set the right priorities and take responsibility for only those who can't do so for themselves. Since governments will not be able to afford to provide all health services to all people in the years ahead, individuals must take greater personal responsibility and start financing their own health services.

Conclusion

The assertion of true believers in Medicare is that public health services should be quarantined from financial considerations because they are so important a social good. The corresponding assumption is that every problem in the health system is caused by 'lack of funding.' It follows that pouring too much taxpayers' money into Medicare is never enough, because health is one of those motherhood issues, similar to education—you can never be smart enough or healthy enough. Higher government health spending is always demanded, always perceived to be an unadulterated good, and always presented as a moral imperative to prevent Australia going down a socially unjust path. Yet this view of how Medicare supposedly works for the good of all ignores the realities of a 'free' system, and the rationing, queuing and other shortages and inequities the Medicare scheme entails.

The 'magic pudding' mentality that dominates the discussion about health is untenable given the ageing-driven financial challenges ahead. These challenges call for an approach to reform that treats health primarily as an economic problem involving the efficient use of scarce resources, rather than just as a social problem or welfarist issue demanding 'more spending' by government. Western countries with taxpayer-funded health systems are confronting the same sustainability challenges as Australia, and are responding to these challenges by increasingly employing market-mechanisms to improve the performance of their health system and 'bend the cost-curve down.'[65] Market-based health reform is about increasing, not reducing, equity, otherwise the access problems that most affect low-income Australians will worsen as the impact of population ageing hits. It is hardly unfair to expect people to take greater responsibility for their health care and ask them to make rational choices about the money they spend or don't spend on health, given that the New Medicare will provide Australians with the opportunity to accumulate the resources needed to pay for their own care.

Almost $1 in $10 in the economy each year is now spent on health, and 70% of these health dollars are locked up in the inefficient public health system that will consume an increasing proportion of national income as the population ages. Given the sustainability problems facing Medicare, we need to conserve scarce health

resources and ensure they are used to purchase efficient and effective health services. We need to get people saving now to pay for more of their own health care to reduce the burden of health costs. The alternative is to hope future generations will somehow manage to fund public health entitlements, and to pray that the financial reckoning never comes. The fiscal crisis confronting the European welfare states shows how fraught with danger doing nothing is—and how real are the limits on the size of government, and on public debt and deficits. We in Australia should act now to avoid this fate, while we still have time.

The New Medicare will preserve and enhance the principle of fairness (equitable access to 'high quality and affordable' health services for all Australians irrespective of income) at the heart of the old Medicare. But it will fundamentally change how public health subsidies are delivered, fundamentally alter how health care is financed, and fundamentally transform how health services are produced. By improving the sustainability, efficiency and equity of the health system, it will save Medicare—but not as we currently know it.

The New Medicare will preserve and enhance the principle of fairness at the heart of the old Medicare.

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REDUCING THE BURDEN FOR FUTURE GENERATIONS

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