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Talking sense on health spending

HENRY ERGAS THE AUSTRALIAN DECEMBER 15, 2014 12:00AM

IT'S the season for miracles. Unfortunately, today's Mid-Year Economic and Fiscal Outlook is likely to show they are in short supply. But if divine intercession is too much to hope for, surely a sensible discussion about public spending is not. And with MYEFO adding to the focus on the proposed GP co-payment, health expenditure should be a good place to start.

Not that the ''sturm und drang'' about the co-payment has done much to clarify the problems. Rather, as on Matthew Arnold's ''darkling plain'', where ''ignorant armies clash by night'', loud claims that health spending is spiralling out of control have run into equally strident assertions that everything is for the best in the best of all possible worlds. Predictably, both positions are gross exaggerations; but it is clear that there are real issues of efficiency and fiscal sustainability in health spending that need to be tackled.

That is not to suggest our current spending is profligate. Taking, for example, the 15 highest income advanced economies, Australia has the 12th lowest level of health outlays per capita and yet has the fourth lowest levels of premature mortality and the second highest levels of life expectancy.

Moreover, at least at an aggregate level, we do a reasonable job of aligning costs with benefits. For example, our health system spends around $180,000 to reduce by one year the number of years of life lost before the age of 70. That ''outlay per life-year saved'' almost exactly matches economists' (admittedly contentious) estimates of the value of an additional year of life, implying the spending is worthwhile.

What is true, however, is that health spending has been rising more than twice as rapidly as national income. And although commonwealth health outlays have increased more slowly than those of the states, their inflation-adjusted trend growth rate of 4.3 per cent a year is still significantly above that of the commonwealth's tax base.

Yes, there are parts of the health system where spending seems to be stabilising: outlays on the Pharmaceutical Benefits Scheme have fallen well short of budget forecasts, with projections exceeding actual expenditures by a cumulative $2.8 billion since 2010-11. But looking forward, demographic trends will put renewed pressures on spending, as each percentage point increase in the share of the population aged 65 and over raises total health outlays by around $3bn.

That is not an argument against those outlays; but it does make it crucial the system deliver value for money. Underscoring that need are increases in survival rates for sufferers from chronic disease, which mean the health system incurs the costs of those diseases over longer life spans. And estimates that 10 per cent of current spending does not benefit patients, and may actually harm them, suggest there is scope to better manage the system's resources.

A modest price signal, which ensures consumers take some account of the costs they impose when they use the system, can help achieve that goal. But it must not be so high as to deter low-income consumers, or those with serious health conditions, from obtaining the services they require. The changes Tony Abbott announced last week, which bring the proposed GP co-payment more closely into line with those in the PBS, are a desirable move in that direction.

Of course, whether Abbott's measures will pass the Senate is uncertain. Contrary to some commentary, they do require amendments to legislation, as the current statute limits bulk-billing to situations where no charges are imposed; with the government intending to preserve bulk-billing incentives even when GPs impose the co-payment, its package will need Senate approval.

However, even were the legislation amended, the budget gains from the co-payment, although well worth having, are relatively modest. That is because the most rapid growth in the Medicare Benefit Schedule has not been for visits to GPs, where Australians' frequency of use has increased only slightly since 2007-8. Rather, it has been for services such as pathology, where nearly 90 per cent of visits are bulk billed, and imaging, with a core bulk billing rate close to 80 per cent.

However, those services, whose use is rising more than twice as rapidly as that of GPs, are excluded from the proposed co-payment. Instead, the government will limit its spending mainly by freezing the amounts their providers are paid. It is, in that respect, following in its predecessor's footsteps, as Labor had already paused indexation of most of the services at issue.

That approach is certainly understandable, as allowing inflation to erode the real value of payments is scarcely visible and so relatively uncontroversial. And it reflects the government's broader budget strategy, with changes to indexation (including on spending for foreign aid) accounting for 40 per cent of the fiscal improvement announced in Joe Hockey's May budget.

But it is surely disappointing that we would rely on freezing payments, rather than on reforming systems, to put the budget on a viable basis. And the fact that once the pips squeak, pauses to indexation are so often followed by rises that more than recover lost ground, makes counting on inflation to whittle away at public spending a poor substitute for structural reform.

But structural reform requires some degree of consensus; if we can't sensibly discuss a tightly limited $5 co-payment, what hope is there for an intelligent debate about the enduring changes our health system needs? And if that debate greatly exceeds our political system's capabilities, how credible are the prospects for a serious discussion of tax reform?

Good thing that the future, in Mort Sahl's wise words, lies ahead. And good thing that there could be a miracle. If anyone up there is worried about timing, right now would be just fine.