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Robbing Peter to pay Paul's doctor

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NO one would dispute that health reform is difficult. But that is not why the commonwealth government's proposals are inadequate. Rather, it is because they do not say, in an honest and transparent way, how we will pay for health care in the long run, how it will be provided, and within what constraints.

All those fundamental questions of architecture the government's proposals obfuscate, while being too clever by half about what proposed tinkering with the plumbing can and cannot achieve.

The reality is that the plumbing is not the problem. Rather, it is whether the health system's design can withstand the demographic, technological and financial stresses it is certain to face. Even if ignoring this fact were good politics, it is bad policy.

This much is now clear from the government's "best and final offer" to the states, released earlier this week. Four flaws stand out.

First, the proposed hospital reforms are still not properly thought through.

Even the government no longer claims they will end the blame game, merely saying they will "reduce" the degree of overlapping responsibility. But how or why they will do even that is unclear.

Doubtless, aspects of the proposal, such as the move to case-mix funding, are sensible. But they are undermined by the lack of clarity about how those payments will be determined and disbursed. The problems are compounded by elements in the proposed arrangements that are simply ill-conceived, including the heavy reliance placed on targets (such as waiting times in emergency wards), and incentive payments related to those targets, which are highly vulnerable to gaming.

Nor are the proposed changes to funding arrangements genuinely attractive to the states, even in narrowly financial terms. While the commonwealth is taking on more expenditure than originally announced, the savings to the states are still 5 to 10 per cent short of the share of GST they are being asked to forgo.

Increasing this gap is the fact that much of the added commonwealth expenditure requires further spending by the states. And the states will also have added expenditure risk, for instance should case mix payments be set on the basis of hypothetical, rather than realistically achievable, levels of efficiency. The government's estimates of the financial benefits to the states ignore these added costs and risks.

Last but not least, it remains entirely unclear how any growth in hospital spending, beyond that provided by the GST, would be funded.

Second, the proposed changes to aged-care funding do not address the current arrangements' key difficulties. As a result, they cannot and will not durably reduce the pressures aged care imposes on hospital costs.

The greatest problem in aged care is the availability of high-care places, that is, of places for older people with severe

disabilities, such as advanced dementia. This is where demand is projected to increase most over the next two decades.

The primary constraint on expanding supply is the commonwealth's restrictions on the charges that high-care suppliers can impose on residents. While these price controls make sense given the limits the commonwealth (in my view, wrongly) imposes on the number of aged-care places, they are an inaccurate instrument. One consequence of the controls is that the supply of high care beds is not keeping pace with long-term demand.

The commonwealth proposes addressing this mainly by providing interest-free loans and other capital funding to aged-care providers for new places. This is not sensible, as it does nothing to preserve existing places and makes taxpayers carry what ought to be commercial risks. Moreover, the scale of this measure, and the others the commonwealth has announced, falls far short of the emerging shortage. As a result, the problems will persist, and with them, the shifting of costs to hospitals.

True, the package proposes payments to compensate states for dealing with aged-care patients in hospitals. But these seem based on current levels of cost-shifting, not on those likely in future. This increases, perhaps greatly, the states' future spending risks.

Third, the proposed changes to funding primary care for diabetes and possibly other chronic conditions are unclear, untested and risky. They too could increase hospital costs.

These changes involve paying GPs a fixed amount per patient, to which would be added a payment dependent on outcomes. Such schemes can have real merit. But international evidence also shows they can induce cherry-picking by doctors (with bad risks ending up in emergency wards), while the performance-related payments lead doctors to focus on managing these patients rather than others who may be more deserving (so they too end up in hospital).

How severe these problems are depends on the scheme's precise design and on the level and structure of the payments. But these have not been disclosed, much less rigorously trialled, making it impossible to have confidence in the outcome. Given the importance of chronic diseases to health costs, this adds to uncertainty about the financial implications of the commonwealth's proposals.

Fourth, nothing has been said about future arrangements for private health insurance, and especially for hospital cover. But this is a crucial piece of the puzzle, both in terms of efficiency and of financing. Indeed, it is the centrepiece of the National Health and Hospitals Reform Commission's core proposal that we move to a scheme of competitive, comprehensive health insurance, as in The Netherlands, Switzerland and Israel. Yet we seem to be moving away from such a model, rather than towards it.

Overall, there is nothing in the commonwealth's proposals that would enhance fiscal sustainability, and too little that would enhance efficiency. Rather, the greatest effect would be to recycle revenue from the states to the commonwealth, leaving many of the current difficulties unresolved or even worsened.

It is an illusion to believe our health system's ills can be cured by robbing Peter to pay Paul. Nor can those ills be treated by artificial deadlines, ultimatums and rhetoric. It is now up to the premiers to ensure the system gets the care it needs and deserves.
