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Spending spree not sustainable

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THE pity of the past few weeks' health reform saga is it will do nothing to place our health system on a sustainable basis.

Substantially more money will be thrown at the system. And the increased spending will produce some improvements in outcomes, especially on politically sensitive waiting times in emergency wards and for elective surgery. But with the underlying issues of governance unaddressed, it is only a matter of time before all the difficulties re-emerge.

The basic problem is that there is too little in the system to ensure costs are taken into account in decision-making, while there is a great deal that induces reliance on care options that are more costly and less effective than they need to be. Given such distorted incentives, no amount of funding will ever prove sufficient.

To emphasise the role of incentives is not to suggest that health care ought to be allocated through the unfettered play of market forces. The reality is any sensible healthcare system will at least partially insulate consumers from the cost of the health care they require.

Particularly for the most costly forms of treatment, consumers will have insurance, with subsidies for low-income consumers. No matter how health care is arranged, the effect of thus protecting consumers from the cost of care must be to reduce their incentives to buy wisely, as they receive little or no benefit from so doing.

At the same time, and despite access to the internet, most consumers lack the expertise to select care options, especially for high cost, complex treatments. Individual consumers are also poorly placed to negotiate with suppliers and to monitor the cost and quality of sophisticated health services.

As a result, markets for health care are necessarily different from those for conventional goods and services. But this does not mean the solution lies in central planning.

Rather, the distinctive characteristics of health care create a need for intermediaries who act as smart buyers on behalf of consumers. If the system is to provide the community with value for money, those buyers' agents must have incentives to manage costs and risks and to balance cost-effectiveness and consumer preferences. If there is a perfect way of meeting these desiderata, it remains to be discovered. Our system, however, ignores them altogether.

Although GPs act as gate-keepers and referrers, their role, quite properly, is to provide medical advice, rather than to be cost-aware care managers. The private health insurers, too, are essentially passive, with a reach limited to hospital and ancillary cover, and the insurance function - of receiving claims and paying them out - as their primary focus. As a result, the burden of responding to what price signals there are falls mainly on consumers, who struggle to manage it sensibly.

To make matters worse, those signals are a jumble of distortions. Public patients in public hospitals are not charged for the services they receive. Especially now that hospitalisation is not the life-threatening experience it once was, setting the price at zero predictably gives rise to queues: a mechanism the late Ross Parish appositely described as "allocation by ordeal".

Consumers can sidestep queues by purchasing private health insurance, but even here, prices are distorted by a welter of

policy interventions, including the PHI rebate, the Medicare Levy Surcharge, Community Rating (which prevents insurers from charging consumers on the basis of risk) and the Life-time Health Cover provisions (which allow insurers to charge more to those consumers who take insurance later in life).

The result is premiums neither signal costs nor reward users for avoiding unnecessary use of medical services. At the same time, PHI does not even provide insured consumers with certainty about the costs, as gap payments are large, often difficult to predict and in many areas of practice, rising. Prices, therefore, do not play a useful role in guiding decisions about hospital services.

In contrast, users face significant charges for visits to GPs and for pharmaceuticals. Users also face substantial fees for residential aged care, though not for community care. Moreover, those aged care co-contributions are rising markedly. For example, while new entrants to low-level residential aged care paid approximately 40 per cent of their residential care costs in 1995-96, that share is now 60 per cent of a much higher total.

The unsurprising result is distorted outcomes. Co-payments under the pharmaceutical benefits scheme discourage use of medicines while increasing use of hospital services. Charges and queues for GP services have the same effect. And residential aged care fees encourage consumers to turn to community care, even when it is costlier and less effective, and to public hospitals. As for hospitals, nothing prevents capacity from being expanded in private hospitals when expansion in public hospitals might be cheaper or vice versa.

All this translates into cost pressures, which will become even more acute as new, more expensive, treatments become available and as our population ages.

So we need much stronger incentives to control spending, manage supply and set economically rational price signals for consumers and providers.

Empowering the demand side is the essence of the managed competition approach adopted in the Netherlands, Switzerland, Germany and Israel. It relies on strong health funds that compete to attract customers by providing a comprehensive range of services, with effective, independent regulation of service quality and insurer viability.

The funds negotiate with service providers so that consumers and the community get value for money. They set co-payments and deductibles so that consumers benefit from prevention and sensible use of services. Transparent public subsidies ensure all consumers, regardless of income or health status, can afford high quality care.

No one would claim that moving to such a system would be easy. Nor would the results be nirvana. But they are far preferable to our unending cycle of spending splurgesand disappointed expectations. The latest spree may have bought some time in that cycle. Let's use it to start on real reform.

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