Putting the Patient Back in Health

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Nothing is more expensive than something that is free.

This simple adage encapsulates what is truly needed in healthcare reform for the survival of our current system. With ballooning elective surgery waiting lists, incapacitating waiting times to see a specialist or to get seen in the Emergency Department, under-treated chronic illnesses and health expenditure predicted to increasingly consume state budgets, it is clear that that the Australian health system needs serious reform.

It's time we start to ask that people contribute to their own healthcare; publically funded healthcare cannot be completely free to the end user.

Yet the recent controversy sparked by the mere suggestion of a $6 co-payment to see a GP or

attend the Emergency Department demonstrates the political resistance and intense fear-mongering (the leadership of the Australian Medical Association being prominent) that will accompany any reasoned discussion.

Of course, no one is suggesting that treatment should be dependent on the ability to pay. And limited contributions from patients would not necessarily make a significant fiscal impact. But it is absolutely fundamental that we reintroduce price signals to more efficiently allocate resources in healthcare.

The importance of price signals are, indeed, one of the stories of the American healthcare system that has been obscured by the political debate surrounding the Affordable Care Act, better known as Obamacare. Many years before Obamacare was introduced, it was clear that the growth in healthcare spending was slowing. The cause of this slow-down was the trend towards more patient contributions, as the Texas-based National Center for Policy analysis points out:

“Three developments track the slowdown in health care spending very closely: the growth of Health Savings Accounts … the growth of Health Reimbursement Arrangements … and the general trend toward higher deductibles. All three changes mean that patients are paying more medical bills out of their own pockets. And that has produced profound changes — on both the demand and supply sides of the market.”

Ironically, many economists and health policy experts are now concerned that in order to be politically popular the very structure of Obamacare is the opposite to that which is needed to continue this “bending of the cost curve” while maintaining quality. An analysis from the Cato Institute argues that

“the glaring omission in the ACA (Obamacare) is its failure to address… the lack of price competition among providers of medical services. Price is driven down to the level of the producer’s incremental cost as competing producers vie for customers. But producers will lower their prices only if doing so brings them more business. When a third party pays for the consumer’s purchase, the consumer has little incentive to consider price when determining from whom to purchase.”

As an example, a recent study in the prestigious journal JAMA Internal Medicine found a tenfold difference in cost estimates for a hip replacement among hospitals in the US. But you wouldn’t know that – or care about it – if someone else is picking up the tab.

Justifiably, a lot of work in health policy circles has focused on the supply side of health care, which is urgently needed, and to a certain extent more politically palatable. However, a reform agenda needs to be more than solely a business case focusing on ways to force competition amongst providers. Working in healthcare, it is striking that any reform must include the other side of the equation. Price signals are especially needed to optimize the demand for healthcare, bringing appropriate rationalization of what treatments are both needed and are cost effective in the short term, as well as incentivizing people to optimize their own healthcare needs in the long term.

Indeed, price signals, and the discipline brought by individual decision making, is the only thing that can ever hope to untangle the immense complexity of healthcare demand.

It's not just about users putting in their own money; it's about involving them in their own health care choices.

Culturally, and indeed for many health-trained academics, this is an extremely challenging concept. But we have to move away from the concept that people either do or don't need a definite treatment for any given condition or disease.

Sure, if you have appendicitis, you need your appendix removed. But in healthcare, clinical and academic groups squabble endlessly about the effectiveness and necessity of vast numbers of treatments; the patient often being unaware of this uncertainty as they are churned through the system. If, in addition to this uncertainty about necessity, the patient tries to calculate which treatments are more valuable than others the complexity becomes stifling.

All this uncertainty about what is necessary is just on the part of the clinical provider of healthcare. In addition the provider has to factor in the desires , beliefs and often the demands of the patient. Any student of the human condition would realize that beliefs about one's health (and especially the belief in different remedies) are some of the most strongly held beliefs there are.

A recent editorial in the New England Journal of Medicine (definitely not a conservative bastion) describing the new Choose Wisely campaign aimed at reducing needless (and possibly harmful) procedures and treatments saliently warned of 'practice patterns and patient expectations that have been shaped and reinforced by habitual overuse of health care'

Stewardship of finite healthcare resources is now considered part of the professional role of a doctor. In this context is the current business model which promotes churning through bulk-billed patients really the most appropriate? What is the breaking point at which a doctor and patient will question the use of a scan or pathology that is free? Added to that is the difficulty in denying the strident demands of the patient. The rationalization brought by price signals may lead to extra time pressure, medico-legal stress and reduced demand for the services of AMA members; something the doctors' lobby would understandably not want its members to be faced with.

Furthermore, , a new drug, medical device, operation, counselling session or physical therapy program that might be significantly more expensive (and heavily marketed by companies to doctors) but which gives marginal, if any, benefit might not be accepted without question by the recipient if they had to face a proportion of the increased cost.

To understand the forces shaping the health reform agenda, it is necessary to appreciate the distribution curve of the ideology of healthcare academics in Australia. It is centred well and truly on the collectivist left; not so much healthcare-reform-minded economists, but clinical academics. Unlike most every other sphere where reform typically consists of liberalisation, in healthcare this collectivist heritage manifests itself in the solutions offered for inefficient resource allocation;

endless committees regulating the allocation of resources centrally.

Price signals may have a vital role as an alternative method of resource allocation. But the question immediately arises concerning the effect of cost signals on people's health. In such a complex system as health, it's difficult to isolate the effects of price signals, but academic work has shown that when people have to contribute more of the cost, their consumption goes down but their health indicators don't necessarily deteriorate. The classic RAND Health Insurance Experiment (1971-1986) has recently been supplemented by the Oregon Health Experiment which seemed to demonstrate that being given access to free healthcare increased healthcare utilization, but didn't improve fundamental health indicators.

Indeed, in the longer term there is a more philosophical question about whether people should be expected to maximize their own health. The Harvard-backed Institute of Lifestyle Medicine tells us the obvious: 'significant research [indicates] that modifiable behaviors—especially physical inactivity and unhealthy eating—are major drivers of death, disease, and healthcare costs'. The solution offered by public-health academics inevitably consists of more government funding or the expansion of the Nanny State. Never is there any credence given to the alternative whereby people should take even the slightest responsibility for the own health.

The introduction of price signals may also facilitate the political will to address the sometimes mafia-like protection rackets, crony capitalism and shamefully inefficient regulatory mechanisms within healthcare. The effect this rent-seeking protectionism has on limiting supply, and therefore inordinate increases in cost, cannot be ignored. At some stage the Australian Medical Association the Australian Nurses Federation and other lobby groups will have to be engaged and probably taken on. However, the population is far less likely to tolerate protectionism disingenuously masquerading as safety if they are shown how much those cartels costs them as individuals.

Recently, a media-prominent doctor name? exclaimed that 'One of the things we should be absolutely proud of in Australia is that people can go to an emergency department when they're in trouble and not worry about paying anything.' The system is failing and it will be unsustainable in the future.

People are metaphorically patted on the head and told to wait in agony (and sometimes die waiting) for months for their treatment because of an extraordinarily hypocritical dogma propagated by those with the ability to pay for healthcare, yet won't.

Australian governments have made dramatic and successful efforts reforming its welfare system. Following the political calculus that was so effective in welfare reform has to be the way forward for health: the introduction of shared responsibility co-payments for a small number of healthcare interventions. After all, if health care is unreformable, we will eventually learn that it is unsustainable.