

The Best, Worst Health System

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HEALTH is a public and private obsession. We agonize over the national weight (too heavy), alternative therapies (unsafe), public hospitals (centres of infection—if you can get in), wonder drugs (too expensive), post-modern depression (we've all got it) and the woeful health of our healthcare system.

WE ARE SPENDING MUCH MORE ON HEALTH

In 2001/02 we spent almost one tenth of our national income on health. That is a massive \$66 billion. In the last decade that spending has grown by 7.5 per cent per annum. In government-subsidized programs the growth was even faster—9.2 per cent. We are typical of developed countries, as Table 1 shows.

Despite this effort, dissatisfaction persists among the general public and the medical professions. The Australian Consumers Association believes 'we have got a system in constant crisis'. But is our system so bad? Or are we just victims of our own galloping expectations?

BI-POLAR PHILOSOPHIES, COMPROMISE SYSTEM

An extreme model of national health provision would be a fully public system. The number and quality of doctors, hospitals, pharmaceuticals etc would be state controlled. Patients would exercise little choice. The current Canadian system is close to this.

The other extreme is a fully private system where all medical goods and services would be open to competition and unsubsidized.

Neither of these two extreme models is now applied in the developed world, as illustrated by the Chart. All countries have a mixed health system with a substantial state presence. As

an aside, note that per capita *public* spending in the USA is the highest in the Chart.

So Australia has a mainly private medical profession, often operating in public hospitals and paid by the taxpayer and prescribing subsidized drugs. Consumers have a right to use private facilities and unsubsidized drugs. There is also a very large alternative medicines sector, which is virtually entirely private and less regulated.

The Australian health system is an evolving historical accident.

COMPROMISE IS INEVITABLE AND OK

It was inevitable that a compromise system would evolve in Australia. The two ruling political philosophies of left and right are much closer than the hot air discharged in our numerous parliaments would lead one to believe. Changes in government produce only marginal shifts in health programs—not revolution.

Although evolving, our compromise system is not unstable. The reason for this is that its mixture of fairness to the less well-off and its relatively high quality and range of choice discourages attempts at dramatic upheaval. In broad terms, it is acceptable.

Nor is this irrational. Public provision of health services removes economic incentives. It leads to queuing as demands for the 'cheap' service hit unavoidable budget constraints. For example, almost one third of patients for non-emergency surgery in the state dominated UK system will wait for more

than four months. The figure for Australia is less than 20 per cent and is 1 per cent in the USA.

On the other hand, ill health is not distributed according to income. Only 3 per cent of UK patients had problems meeting their medical bills compared to 10 per cent in Australia and 18 per cent in the USA.

Our system is no worse than those enjoyed by others in the developed world (and much better than those which apply to the other five billion people). On a simple measure, it helps deliver the second-highest, disability-adjusted life expectancy in the OECD. Although some would like revolution, systemic change in either direction would not be acceptable to the majority. Nor would it appease current dissatisfaction.

BUT IS OK GOOD ENOUGH?

All this is not to take the view of Voltaire's fictional doctor, Pangloss, that 'all is for the best in the best of all possible worlds'. Improvements can be made to any system and ours is no exception.

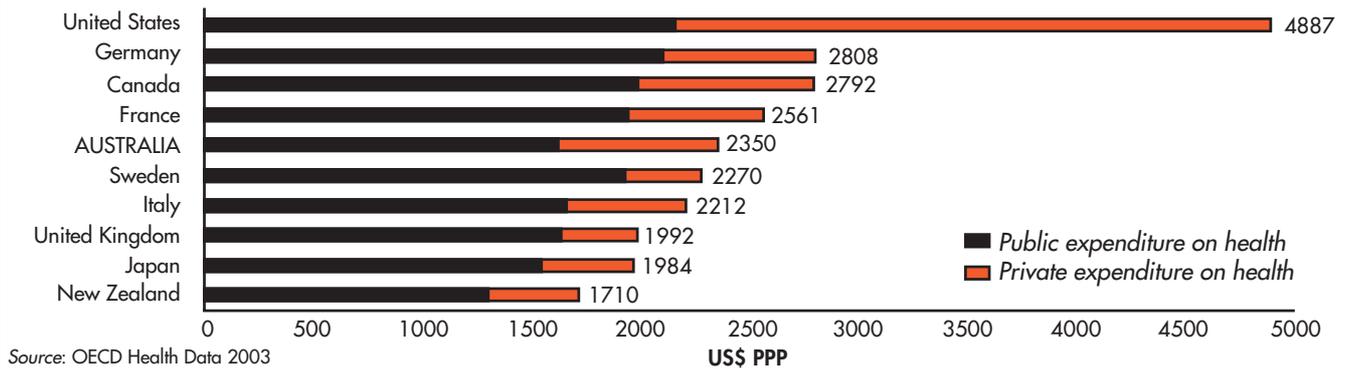
Table 1: Growth of expenditure on health, 1990-2001

Real annual per capita growth rates, 1990-2001 (%)

	Health spending	GDP
Australia	3.8	2.4
Canada	2.3	1.6
France	2.5	1.5
Germany	2.0	1.2
Italy	1.9	1.4
Japan	3.8	1.1
New Zealand	3.0	1.5
Sweden	2.1	1.5
United Kingdom	4.2	2.0
United States	3.2	1.7

Source: OECD Health Data 2003.

Chart 1: Health expenditure per capita, US\$ PPP, 2001



In Australia, any sort of reform is now very difficult given the political games played and the balance of power in Federal Parliament.

There is no doubt that Australians want more spent on their health because they keep doing just that. We should not be trying to restrain demand.

Reform should not be in the direction of more government intervention and spending. We have proved to ourselves that it does not reduce waiting times or dissatisfaction levels.

The best approach is to focus on a limited range of changes to the current system that would improve supply and allow consumers to express their preferences better. The focus could be on greater efficiency and choice rather than grandiose reforms that cannot be implemented.

FOCUS ON EFFICIENCY AND CHOICE

There are numerous ways in which efficiency and choice could be improved and the following are only illustrative.

Our *national hospital bill* is twice that spent on medical care and three times that spent on pharmaceuticals. Hospital waiting times are a constant source of complaint. Our average length of stay in hospital for some major categories of treatment is up to 40 per cent longer than in New Zealand. Perhaps we could learn something here. We also have rigid manning levels imposed on parts of our hospital system that do not always reflect need. Improved productivity is not just for industry.

Excessive *paperwork* is a cost that governments refuse to address in the health system—except to exacerbate it. The Productivity Commission estimated that 5 per cent of GPs' income is absorbed by these costs. Add this to the stress and profound irritation felt by professionals, who waste their precious skills filling up forms devised by remote officials.

The *medical indemnity* system is a black hole. State governments can transform this disaster area if they stop listening to lawyers and enact radical tort law reform in standard of care, limitation periods and caps on damages. This is a classic case where governments should long ago have brought down the curtain on a legal and judicial farce.

Pharmaceuticals are wasted on a massive scale. National television campaigns are regarded by the public as second-rate entertainment and have no lasting effect. Our PBS pricing no longer holds Australian prices below international prices and should be reviewed. Culling the huge PBS list might reduce the 87 per cent of scripts that are now covered by the scheme. Together with some increase in the co-payment rate, this could slow the 10 per cent annual increase in PBS spending and discourage waste.

The medical profession has the power to drive or restrain health spending. Although evidence of supplier-induced demand is not strong, the profession needs backing to resist *excessive demands* for drugs and medical procedures.

CONCLUSION

Ours is not 'a system in constant crisis'. Manufacturing crises is an art form among special interest groups and there are plenty engaged in the health debate. Ours is a health system that is evolving with new technologies and drugs and adjusting to new consumer demands.

The persistent dissatisfaction is not because our health system is starved of resources—it isn't. Nor is it just that they are poorly allocated—though they are. The fact is that most people want more from the system but don't want to pay and ultimately they want what they cannot have—perfect health.

We can certainly improve delivery of health care to consumers but the way to do that is to work incrementally on the system and offer more private choices.

AFTERWORD

No conceivable system can guarantee good health without the co-operation of the individual. It is as true of our society as of poor countries that prevention beats cure every time. It is as foolish to be gluttonous as to fail to wash one's hands in clean water. We spend \$600 million a year on cholesterol and triglyceride reducing drugs and much more on other obesity care. We need to look at ourselves as well as the health care system.

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