Paying for our health

Charles Livingstone and Greg Ford assess Medicare's future prospects and recommend some changes.

Medicare is a highly significant component of the Australian socio-political environment. It is, in many ways, the materialisation of the best of the Australian institution. Australian citizens and residents know that, no matter how ill they or their children are, they will be cared for, without being required to meet the cost through out-of-pocket expenses. There is ample evidence that the Medicare system is effective, efficient, and equitable. In 2000, total health expenditure in Australia was the equivalent of 9.0% of GDP, which compares extremely well to other OECD countries (see Table 1). On any reasonable assessment, our health outcomes are amongst the best in the world.[i] And, it must be clearly stated, Medicare has been spectacularly efficient – delivering increased output for only very modest increases in the share of GDP expended.[ii] Political parties with a serious claim to governing Australia know that they must promise to maintain Medicare, even though, like the current government, they may do so through gritted teeth.

Table 1: Health Care Expenditure, % of GDP

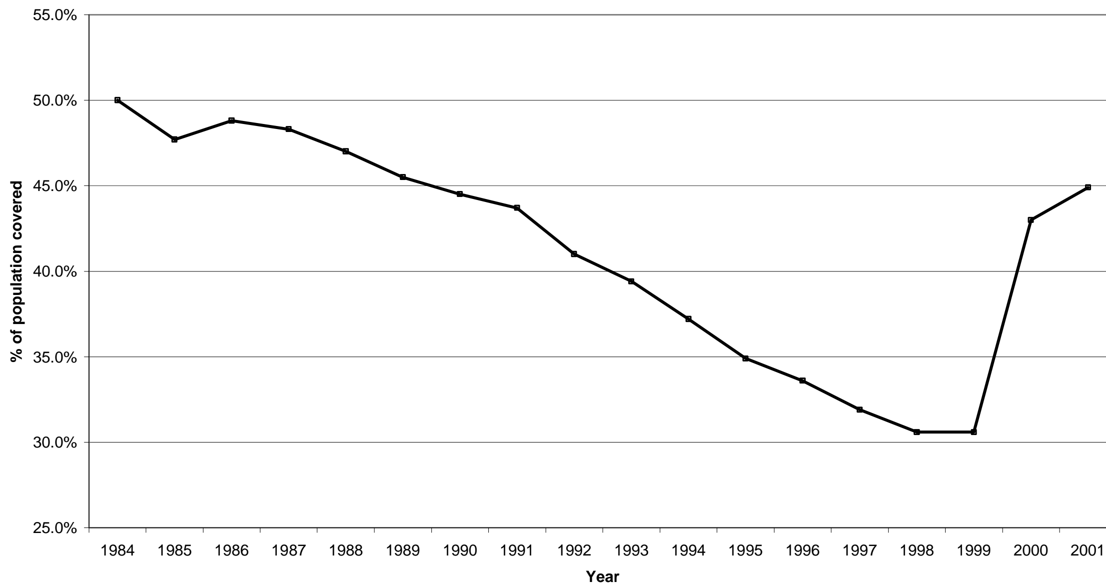
	Australia	UK	USA	Canada	France	NZ
1990	7.9	6.0	11.9	9.0	8.6	6.9
2000	9.0	7.3	13.0	9.1	9.5	8.0

Source: AIHW (2002) *Health Expenditure Australia 2000-01,* Health and Welfare Expenditure Series, No. 14, Australian Institute of Health and Welfare, Canberra., table 32, p. 55

Yet there are some areas where the Medicare system is vulnerable and where new policy responses need to be considered. Mostly, these concern a concatenation of issues associated with the expectations of people about the health system, and with costs and how best to contain them.

Government support for private health insurance

The first area where Medicare appears vulnerable relates to the Howard government's support for private health insurance (PHI). In order to address the PHI issue it is important to recognise that one of the key tactics of the Howard government has been a preparedness to construct crises. This tactic allows Howard and his ministers to look tough and decisive in the face of adversity, whilst introducing policy responses that have all the subtlety and grace of an assault rifle. It seems that these responses then resonant in their simplistic and synthetic logic with a necessarily frightened and badly informed electorate. The Tampa affair and the refugee 'crisis' were one such. The crisis in PHI is another. Using the decline in PHI coverage that occurred between 1984 and 1998 (see Chart 1), the Howard government (with the general support of the Beazley/Crean ALP) embarked on a process which will, if unchecked, ultimately diminish the role of Medicare, in an echo of the actions of the Fraser government's approach to Medibank (Medicare's Whitlam era predecessor) between 1975 and 1982.



Howard's government has introduced a number of measures designed to halt this slide in PHI coverage as though this in itself represented the major crisis for the health care system. It is of course entirely reasonable to conclude that PHI declined over time because it was (and is) an expensive and inefficient product of comparatively limited utility. PHI administration expenses, for example, averaged 11.8% of contribution income in 2000-01, compared to the Health Insurance Commission's expenses of around 3%.[iii]

Nonetheless, the measures introduced under Howard have included age-related penalty rates for 'late joiners' of PHI funds (the Lifetime Health Cover policy), an additional levy for those on comparatively high incomes who choose not to utilise PHI, and the 30% Commonwealth rebate for PHI premiums. These imposts on the purses of the public (both individually as PHI contributors and collectively as taxpayers) are legitimated as somehow relieving 'pressure' from the public health system. Yes despite these claims, demand for care in public hospitals has risen throughout Australia since the introduction of these policies. In Victoria, for example, overall hospital demand has risen from 950,000 separations (episodes of hospital care) in 1999-00 to a predicted 1,066,000 separations by 2002-03, an increase of 12.2%[iv]. During the same period, demand for care in Victoria's emergency departments has increased by almost 14%[v].

As an exercise in industry assistance this is a return to the pre-globalised 1950s (another Howard theme). What other Australian industry has its prices supported by a direct 30% subsidy from government? Duckett and Jackson[vi] have highlighted that the cost to the government of the 30% Rebate is larger than the combined budgetary assistance to mining, manufacturing and primary agricultural production industries. They have also estimated that if all government subsidies to the private health sector were redirected to public hospitals, an additional 1.5 million cases could be treated in Australia's public hospitals each year.

Perhaps the most revealing aspect of the government's determination to support the private health sector, and in turn undermine Medicare, is the amount of public money it is

prepared to spend in this exercise. Research by Butler[vii] indicates that it is the cost neutral Lifetime Health Cover policy and not the 30% Rebate (at a cost of over $2 billion per annum to the taxpayer) that has pushed people into PHI. This is supported by figures from the Private Health Insurance Administration Council[viii] which show that in the first nine months after the introduction of the 30% Rebate (1 January 1999 to 30 September 2000), the proportion of the Australian population with PHI rose marginally from 30.1% to 31%. By contrast, in the nine month period from the announcement of Lifetime Health Cover (29 September 1999) until its cut-off date (15 July 2000), the proportion of the Australian population with PHI rose significantly from 31% to 43%.

Yet the success of the Howard government's attempts to prop up PHI can perhaps be gauged not just by the increase in PHI coverage that resulted from the combination of inducements and penalties summarised above, but also by the continuing controversy over PHI premium increases, and most recently by the news that Medibank Private, the Commonwealth owned PHI fund, has recorded a loss of $170 million and will consequently axe a premium discount program, presenting consumers with a second premium increase within five months.[ix] Given the value of the PHI rebate (more than $2.15 billion in 2000-01)[x] and the additional expense to consumers of PHI premiums (the average annual cost for each of the 8.7 million people covered in 2000-01 was about $820) it is important to understand just how crucial PHI is to the Australian health care system.

Of the contributions made by various funding sources to Australia's health care expenditure governments contributed the lion's share, nearly 70% of the total, with individuals contributing the second greatest proportion at around 18%. PHI, in contrast, contributed a total of a comparatively modest $4 billion, or less than 9% of total recurrent expenditure. And, it is important to note that PHI contributed nothing to research, (governments contributed more than 83%), a modest 11% of institutional expenditure (principally hospitals and nursing homes, for which governments contributed nearly 78%) and about 6.5% of all non-institutional expenditure (government's share of this was around 62%).

In other words, in the overall scheme of things the role of PHI is fairly marginal. Leeder and McAuley have estimated that an increase in the Medicare levy of 0.75% would entirely fund the additional dollars that PHI funnels into the system.[xi] PHI is not particularly important and it could easily be substituted. The 30% rebate is not good policy (even using norms of industry assistance adopted by the Howard government) because it provides no more than a trickle of additional funds to the system generally. It is not the main game; rather, it is a complete distraction. Importantly, the straightforward analysis presented above demonstrates that the principle purpose of the PHI 'crisis' is to persuade an anxious electorate that whatever problems the health system faces should be managed by cutting into the role (and funding) of the public sector.

Demographic and other cost pressures

The air of crisis was recently lifted a notch by the release with the 2002 budget papers of Budget Paper No. 5 (BP5), the so-called 'intergenerational report', which argues that because of the ageing of the Australian population, unsustainable cost pressures will result

in decay of services and/or unrealistic tax burdens on younger people. The report argues that because of these measures it will be necessary to ensure 'fiscal sustainability' by, amongst other things:

- 'maintaining an efficient and effective medical health system, complemented by widespread participation in private health insurance'.
- 'containing growth in the Pharmaceutical Benefits Scheme (PBS). Rapid PBS growth over the past decade means it could be one of the most significant areas of future spending pressure on the Commonwealth'.

The report goes on to assert that by 2041, the cost of the PBS will grow to around 3.4% of GDP from its 2001-2 level of 0.6% of GDP, and that this will represent the largest area of growth in health expenditure.[xii]

Attempts to estimate the cost of pharmaceutical benefits 40 years from now are heroic indeed given the vast number of unknowns that must be factored in to any such calculus. It is, of course, an articulation of government policy and ideology.

The real issue that arises from this, notwithstanding the spin of BP5, is the extent to which the ageing of the population *will* induce increased health care expenditure, and whether we can 'afford' to pay more for health care. Leeder & McAuley argue that Australia's population structure in 2025 will resemble that of Scandinavian countries now, and that those countries cope extremely well with such a structure, expending less than 10% of their GDP on health care. They also point out that changes in people's behaviour can have drastic impacts on health outcomes.[xiii]

So, is it inevitable that PBS expenditures will rise at alarming rates and that the introduction of new technologies will continue to push health care costs through the roof? Certainly, the principal cost drivers in the US health care system, as in Australia's, appear to be technological.[xiv] But as the recent public discussion of the 'intergenerational report' has illuminated, increased PBS costs may represent good value if they act to reduce the cost of other interventions. Between 1989-90 and 1998-99, expenditure on pharmaceuticals in Australia grew by an annual average of 9.2% in real terms, compared to real annual growth of 4% in overall health sector expenditure.[xv] Put bluntly, that may indicate that pharmaceutical costs are out of control (the spin the government used to justify proposed increases in out-of-pocket pharmaceutical expenses for consumers). But it may be more reasonable to look at the overall pattern of expenditure because pharmaceuticals are not prescribed in isolation from the system overall. Better drugs (and technological innovation generally) may prevent hospitalisation or other interventions and may prove extremely cost effective.[xvi]

So even though the pharmaceutical component is growing rapidly, the costs of the system overall are growing more modestly. This does not mean that we should diminish our efforts at cost containment and the development of more efficient services. Rather, we should be aiming at developing a system that maximises the likelihood of efficient practices.

Thus, it is vastly more important that the effectiveness and relative efficiency of interventions (including drugs) be determined than it is that price signals be prominently available to consumers. Price signals are dearly beloved of neo-classical economists and the whole point of increasing out-of-pocket expenses is to modify people's behaviour. But the consumption of health care is not the same as the consumption of widgets. People who face disease, disability or other medically treatable distress, particularly if that distress is suffered by their children or other loved ones, will not respond to price signals if they can (somehow) raise the money to pay. There is ample evidence of this via the much more expensive US system. The rationing effect in such systems is that the poor often don't get timely access to treatment. Many forget that this used to be the case in this country before Medibank. And private systems cost more. Governments may be drawn to them because the expenses are off their books, as it were. But overall, a larger share of national output goes to health care in privately funded systems than needs to be the case to deliver equivalent *or better* health outcomes.

Declining bulk-billing rates

Some commentators have suggested that there is evidence of the meltdown of Medicare as GPs reduce their rates of bulk billing (i.e., imposing no out-of-pocket expense on consumers). Chart 2 shows how the rate of bulk billing has declined and the out-of-pocket costs to consumers have increased.

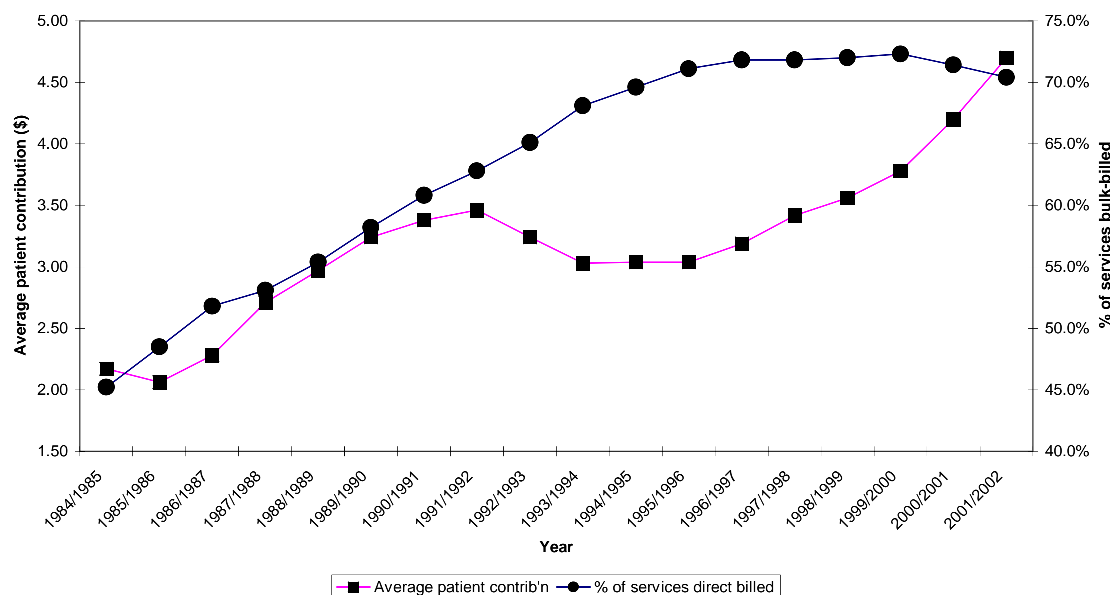
For GP services only, the decline in bulk-billing rates has been somewhat more pronounced, from a high of nearly 80% in 1996-97 to 74.1% in 2001-02. The latest figures, for the quarter ending September 2002, show that bulk billing has fallen to 71.2%.[xvii] Although the headline rate is above 70%, the percentage of services bulk-billed throughout Australia is disproportionately spread, as indicated in Table 2. Furthermore, an electorate-by-electorate breakdown of 2001-02 figures shows that the level of bulk billing varies considerably throughout the country, from a high of 98.3% in the electorate of Fowler to a low of 35.5% in the electorate of Murray.[xviii]

Table 2: Bulk-billing for general practitioners: 1995-96 to 2001-02

Year	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	AUST
1995-96	82.9	77.8	80.3	73.3	79.1	65.7	68.6	63.2	79.3
1996-97	82.7	78.5	81.1	73.9	79.8	66.3	68.8	64.6	79.7
1997-98	82.0	77.6	80.8	73.4	78.2	64.2	66.1	64.5	78.9
1998-99	81.5	77.7	80.6	73.7	77.5	61.9	62.8	64.3	78.6
1999-00	81.6	77.5	79.9	74.0	76.7	59.8	63.5	61.9	78.4
2000-01	80.5	75.7	78.5	72.8	75.0	59.6	64.4	58.6	77.0
2001-02	79.1	72.1	74.9	69.0	71.7	58.3	63.6	50.6	74.1

Source: Commonwealth Department of Health and Ageing (2002b) *Medicare Statistics June Quarter,* Table C3, http://www.health.gov.au/haf/medstats/tablec3a.pdf – accessed on 7 October 2002.

Chart 3: Average patient contributions vs proportion of services bulk-billed, 1984-85 to 2001-02
source: HIC data



Of course, the principle reason that bulk-billing is declining is that the scheduled fees paid to doctors by Medicare for their services have not grown as fast as doctors would like. Thus, the costs of treatment have been shifted from Commonwealth government expenditure to expenditure by consumers, in a further example of health care privatisation at the margins. This is a direct policy responsibility of the Commonwealth, and although there are plenty of issues to deal with in the context of the remuneration of doctors there seems little doubt that bulk billing rates are amenable to increased scheduled fees. One way to tackle this may involve transferring some of the PHI rebate to improved primary care integration, thus increasing remuneration for GPs, with positive effects for the provision of care.

What's the way forward?

Over the next few years there will be no diminution in cost pressures on the health care system. Although an ageing population is not the problem it has been made out to be, and although there may be considerable efficiencies associated with new drugs and some new technologies, these factors will almost certainly increase cost pressures. Equally certain is that the costs of PHI will continue to escalate unless extremely radical reform is undertaken in that sector, and, judging by past and current policy performance in this area, neither the will nor the expertise to undertake such reform are available.

Thus, the continued operation of an accessible and equitable health system requires maintenance of the strong publicly funded and controlled core of our current system. This is because all the evidence indicates that such systems are more efficient, better able to meet social goals such as equity and effectiveness, and much more likely to be capable of an integrated response to emerging health care needs. But that is not to say that the current system should be maintained in all respects.

A number of detailed points require attention in the current system but we would suggest the following as likely to be of some interest over the next three to five years:

- Abandon the PHI rebate – it props up a multiplicity of funds that are vastly less administratively efficient than Medicare and less capable of making rational decisions about health care priorities; and the $2 to $3 billion saved would be much better spent on hospitals and primary care systems;

- Develop a nationally consistent approach to the provision of primary care services at the local level – services provided by doctors but also nurse practitioners and other health care professionals who can provide a range of services in non-hospital settings (including consumers' homes) at considerable savings to the health care system;

- Invest in population health interventions such as health promotion programs that help consumers to better understand the links between diet, behaviour, lifestyle and health outcomes. Smoking reduction alone will have long-term payoffs in better health and reduced health care costs; but there are many other public health issues (such as the looming obesity epidemic) that can be dealt with by such methods; and

- Forget about dividing consumers into those who can afford to pay for health care (whether by PHI or directly) and those who need a 'welfare' safety net, as in the United States where perhaps 40 million or more residents are without health cover. This is a recipe for inequity and disadvantage. If we're all in the same boat, we all have an interest in making it work.

Medicare is a cornerstone of what remains of our fabled Australian virtues of a fair go and social justice. It's not particularly broke and it doesn't need a very big fix. But there are things that could and should be done to make it work better, and plenty of reasons to make sure that governments with an eye on tax reductions and the pursuit of ideological purity don't rip it apart in pursuit of narrow and mean-minded agendas.

Charles Livingstone is a Senior Research Fellow in the Faculty of Health Sciences at La Trobe University, Melbourne.

Greg Ford is Senior Policy Officer, Health Issues Centre, Melbourne.

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[i] see Australian Institute for Health and Welfare (AIHW)(2002), *Australia's Health 2002*, tables S9, p. 360, S12, p.362, S15, pp. 365-8

[ii] J. Deeble, 'Medicare's maturity: shaping the future from the past', Medical Journal of Australia, 173, pp.44-47

[iii] Private Health Insurance Administration Council (PHIAC), Operations of the Registered Health Benefits Organisations, Annual Report 2000-01, p.11; Health Insurance Commission, Annual Report 2000-01, Financial Statements Chapter 7

[iv] Department of Treasury and Finance (1999-2002), *Budget Paper No. 3, Department of Treasury and Finance*, Melbourne.

[v] Department of Human Services (1999-2002) *Hospital Services Report,* Department of Human Services, Melbourne.

[vi] S. Duckett and T. Jackson (2000) 'The new health insurance rebate: an inefficient way of assisting public hospitals', *Medical Journal of Australia,* Vol. 172, pp. 439-442.

[vii] J. Butler (2001) *Policy Change and Private Health Insurance: Did the Cheapest Policy do the Trick?* NCEPH Working Paper Number 44, National Centre for Epidemiology and Public Health, The Australian National University, Canberra.

[viii] Private Health Insurance Administration Council (PHIAC), Industry Statistics, Membership and Coverage, data published on the internet at http://www.phiac.gov.au/statistics/trends/index.htm.

[ix] ABC News Online, 28 September 2002

[x] AIHW (2002), Table S51, p.404

[xi] S. Leeder and I. McAuley, 'The future of Medicare and health service financing', Medical Journal of Australia, 173, pp.48-51, 2000. Using Leeder & McAuley's logic, we calculate that PHI channelled about $3 billion additional to the health system in 2000-01; PHIAC, p.48; AIHW, p.404
[xii] Budget Paper No. 5, 2002-03, 'Overview'
[xiii] Leeder & McAuley, 2000
[xiv] Prof. Jeff Richardson has made this point on a number of occasions as do Leeder & McAuley, 2000
[xv] AIHW, 2002; table S43, p.396
[xvi] Leeder & McAuley (2000) make this point and suggest that technological innovations may generate a multiplicity of unforeseen effects. F. Cunningham 'Medicare: Diagnosis and prognosis', Medical Journal of Australia, 173, pp. 52-55, 2000, makes similar points about emerging new technologies.
[xvii] These data and those for chart 3 are drawn from Health Insurance Commission (HIC) data published on the internet at http://www.health.gov.au/haf/medstats/index.htm
[xviii] Source: Stephen Smith MP, Shadow Minster for Health and Ageing, Senate Question from Senator Evans to Senator Patterson, 29 August 2002.