Three Ways to Fund our Health System

24 February 2014

The argument over $6 GP co-payments is little more than a distraction from the real task - untangling our incoherent system of health funding, writes Ian McAuley.

Health Minister Peter Dutton is on the right track when he says he wants "to start a national conversation about modernising and strengthening Medicare".

Our health arrangements serve us well, but as John Dwyer, Emeritus Professor of Medicine at UNSW, pointed out in an ABC interview last week, there are inefficiencies to be addressed. There are what economists call technical inefficiencies — too many bureaucrats in overlapping state and federal jurisdictions and in private insurance firms, poor use of information technology, rigid workforce demarcations and a lack of integration between different care providers. That's just to name a few!

More seriously there are what economists call allocative inefficiencies — in particular high attention to treating illness contrasting with neglect of public health measures which could prevent illness.

These problems won't be solved by half-baked ideas such as a $6 co-payment for GP services, a proposal which, in terms of transaction costs alone, is stupid, and which, if it could have any effect in reducing demand, would have its greatest impact on those for whom $6 is a burden. In fact if, as former Coalition policy advisor Terry Barnes suggests, if the $6 were to be covered by private insurance, there would be a huge increase in both private and public costs of health care.

Unfortunately the $6 proposal has commanded attention. It's as if it has been put out as bait to draw attention away from other possible ideas of the Coalition Government, such as an extension of private insurance — which would do much more damage to health care affordability than a small co-payment.

If that is the Government's strategy, Medicare's defenders have taken the bait, digging into hard positions to defend the status quo, conveniently ignoring the fact that there are already significant co-payments in health care (such as the $37 payment for prescription pharmaceuticals), and ignoring the fact that all comparable countries, including those with much more socially inclusive systems such as Sweden, have co-payments before public insurance picks up the tab.

The Labor Party, rather than articulating any coherent principles on health funding, has opportunistically joined the chorus criticising the $6 co-payment.

A national conversation should start with an honest definition of the problem. It is not about an "unsustainable" health budget. Even if we deal with inefficiencies, it is to be expected that as our population ages, and as therapies become available, we will spend more on health care, and whether we spend it from our own pockets or from our taxes is a secondary issue — we will still pay for it. After all, we are spending more on eating out, but we don't construe that as a "problem".

Language counts. Some refer to public spending on health care as "social" spending, as if it is in a different category to spending on "real" government services such as roads and defence, and it has been caught up in the language of "entitlement". As IMF Managing Director Christine Lagarde said on ABC's Q&A last week:

> "Investing in health, investing in education, making sure there are equal opportunities for all, is something where public money is needed ... it is not a question of entitlement."

A national conversation takes time and good faith. A government can lead the process if it helps people extract themselves from hard "positions" and articulate their interests. People need to break from assumptions, such as the idea that the present division of state and federal arrangements will stay, that pharmacies are necessarily separate from GP practices, that co-payments necessarily involve cash upfront (perhaps they could be liabilities to Centrelink), or that without private insurance private hospitals will not survive.

On funding, the basic question to put to the community is the extent to which we want to share our health care costs with one another. Do we want comprehensive sharing, funded through our taxes, or are we willing to pay some more from our own pockets — with protection, of course, for those for whom such payments would be too burdensome?

That question has never been put to the Australian community. Dutton is right — we need a national conversation.

It is possible that we do want a completely free system, and are willing to pay the higher taxes to support it. We may be willing to take risks in most parts of our lives, but because of the randomness of illness and accident we may want to pool our health care costs. We may place high value on social solidarity expressed through a universal free system of health care.

Alternatively, it is possible that, because we are wealthier than in previous times, we are happy to take more personal responsibility. Because health care is skewed towards high users, most Australians, most of the time, could easily pay for all their needs without any support from third parties such as Medicare or private insurers.

We may opt for a safety net to kick in only after we have made a reasonable contribution. Presumably that would be a much fairer and more sensible safety net than the present haphazard mess of free and charged services.

If, in response to community consultation, Australians opt for a high level of sharing and are willing to pay the required taxes — perhaps through a higher Medicare levy — politicians should respect that decision. They should not paternalistically override the community's wishes by asserting we will be better off with lower taxes.

And they should avoid shifting the cost of sharing to private health insurance — a high-cost mechanism which does what the Australian Tax Office and Medicare do at much lower cost and with much greater equity. It makes no sense if, in an obsession with budgetary costs, we save $1.00 in official taxes only to have to pay $1.10 or $1.80 in "taxes" to BUPA, Medibank Private or NIB for the same or an inferior service.

If Australians opt for more personal responsibility, dealing with minor health care transactions as they do with other goods and services, then defenders of Medicare should respect that choice, and not complain when they see fees introduced for some previously free services. Rather they should ensure there are no barriers to those who are too poor or who lack liquidity to cover upfront payments. And governments should prohibit private insurers from covering those payments, for to do so would negate the discipline of markets ("moral hazard" in the quaint language of the insurance industry) and drive up costs for all users.

Those who remember the 1987 election will recall that the Liberal Party proposed a $250 uninsurable upfront payment — about $800 in today's terms. It was sound policy, consistent with their platform of self-reliance, but it was poorly explained, and then as now private insurers had no interest in self-reliance — their business model is about subsidised corporate reliance.

In short, there are three ways to fund health care — on the "left" a completely tax-funded scheme, on the "right" a more market-based scheme with a high level of upfront payments, and in a space of its own private health insurance, which disingenuously combines all the worst aspects of socialism and capitalism, with none of their compensating merits.