TRIM HEALTH AND FIX THE BUDGET

"The Australian" - 28 November

Costs are rising, and doing something about that may cause political damage

DAVID UREN
ECONOMICS EDITOR

WHEN John Howard appointed Tony Abbott as health minister in 2003, he was given the dual missions of getting health off the front pages of the newspapers and neutralising Labor's traditional political advantage in the portfolio.

He had some success. He sorted out a raging scandal on medical-indemnity insurance and extended a generous Medicare "safety net", designed to protect those with large health costs. Bulk-billing rates rose.

For the first few years he was very successful, narrowing Labor's lead on health issues in Newspolls from about 12 percentage points to just two. However, it blew out again to similarly wide margins in the final two years of the Howard government.

The task the current Prime Minister's Health Minister, Peter Dutton, confronts is much more difficult. Where Abbott was able to build support for the Coalition's management of health with fresh spending, Dutton's job is to rein in the growth of health costs while minimising the political damage.

State and commonwealth health spending has doubled to $90 billion, rising at an annual rate of 7 per cent, over the decade since Abbott first became minister. Health has been the biggest single source of growth in government outlays over that period.

Unchecked, public health costs will rise from their current 6.5 per cent of GDP to about 8 per cent over the next decade.

As both the Grattan Institute and the Productivity Commission have shown in reports over the past week, the budget faces deep structural pressures. The government cannot hope to gain control of its budget unless it can impose limits on the growth in health spending.

Health is an economic nightmare. With widespread insurance, there are few price signals so normal market disciplines do not work. Consumers are blind to the cost of their treatment, leaving waiting lists as the main form of rationing treatment.

There are information asymmetries: if the doctor says a procedure is essential, neither the patient nor the ultimate funder is in a position to question it. Many health suppliers, including pharmaceuticals, are monopolies, while there are rigid job demarcations and restrictive work practices. As a result, government has its finger in every corner of the health system.

The Productivity Commission's report on ageing included the startling estimate that our health system is 20 per cent less efficient than it could be, based on what other countries achieve. There is huge variation in costs. Among hospitals, the least-efficient can charge 50 per cent more for the same procedures than the average, and the most efficient 50 per cent less.

The health funding reforms of the Rudd and Gillard governments were marred, like so much else in their tenure, by poor process. Kevin Rudd stunned the states with his demand that they must hand over some of their GST if they wanted health reform.

In the final settlement with Julia Gillard, the states declared they wanted to keep control of community health, but there are now murmurings from some states that Labor's federally funded Medicare Locals can do the job. The duck-shoving of responsibility from one tier of government to the other continues.

The heart of that reform was a shift in the funding of hospitals from block grants channelled to hospitals via the states to payments for the procedures hospitals actually conduct. A new authority was established to work out the fair price for performing those procedures.

While funding outputs beats supporting institutions, the need for an authority to monitor the cost of each hospital procedure highlights the challenge of managing health costs. The Productivity Commission argues that providing subsidies for each procedure — a feature of Medicare as well as hospital funding — is an incentive for overservicing. It suggests alternatives, such as fixed funding allowances per person in a local area. Another option is requiring small co-payments for doctor visits, as recommended by the Australian Centre for Health Research.

Breaking down restrictive work practices would yield savings, increasing the scope of work that nursing assistants and nurses can undertake while liberalising the rules around referrals.

The Productivity Commission believes hospitals perform many procedures for which there is not firm medical evidence and says better communication of research findings can help.

Both the commission and the Grattan Institute believe big savings can be made in the Pharmaceutical Benefits Scheme. The Grattan Institute has quantified these at $1.3 billion a year.

All such measures carry political costs. An early pointer to the government's preparedness to confront them will come with the privatisation of Medibank Private.

Analysis commissioned by the insurer shows the requirement for all premium increases to be approved by the health minister leads to higher average costs. It encourages each fund to submit a bid close to that of the least efficient insurer. Without an incentive to compete on price, the insurers compete on product offerings, which raises the overall cost. The insurers argue that a more competitive market would be achieved by substituting some form of price monitoring for government price control. But it is far from clear that the government will make that leap.

Asked by a radio interviewer about the risks in privatisation, Abbott responded that the health minister would continue to approve all premium increases to make sure they were "not just a bit of commercial rouging".