

FIN ON THE DRY SIDE 218

(you already have an article, a flow chart of the Joh effect, if you intend to use that please hold this for 7th/8th March)

HEALTH CARE John Hyde

Health professionals claim that eight percent of Australian Gross National Expenditure is health care. A 10% improvement in the quality of it would not show in the national accounts (whereas 10% more spending would), but that much improvement could be almost a one percent rise in living standards---if it did not increase the population by encouraging us to live longer. There would appear to be room for improvement Australia gets by with 1300 bed days per 1000 population per year (reduced by strikes from 1400 last year); health maintenance organisations in the United States, which concentrate on health rather than sickness get by with 420.

The figures need to be taken with a grain of salt but they are good enough to show that health is a huge industry in which savings might be made.

Considerably more is paid to hospitals than doctors and most hospital beds are to be found in the public sector. Except in Queensland, where hospital costs are paid entirely by the taxpayer, a little user sovereignty is achieved by private payment of some costs, but mostly through over-regulated health funds. Medicare dominates hospital/patient and doctor/patient relations everywhere. Private hospitals are forced to compete unequally with the public sector giants which offer 'free' treatment. Bulk-billing doctors offer 'free' treatment to the wealthiest patients. One would expect such a system to be a a taxpayer's nightmare and it is.

A more efficient health care system, one giving more health for the dollar, is important---probably more important than an efficient car industry, but harder to measure and harder to achieve. The important measures of efficiency are essentially economic concepts and most health care providers seem to think that economics like AIDS is better avoided. They imply that they alone do not respond to the rewards and punishments which economists say influence human behaviour. Members of the religious nursing orders may well be genuine in their disdain for worldly rewards and punishments but others plainly are not.

To prevent people dying in the streets, the majority of the public want important health services to be available without cost to those who cannot pay but this does not make health care different nor does it mean that the relevant services need be provided by the government. From the same regard for the destitute we insist that everyone has access to food and shelter but we do not subsidise food and houses for wealthy people, nor do we provide lollies and beach cottages for anyone. Food and shelter are no less 'essential' than health

care.

When all services are 'free' there are no market signals to identify efficiency.

Doctors and hospital beds must be rationed---if not by price, then in some other way. Supply is matched to demand by queuing---elective surgery must wait and waiting rooms are full; by favouritism---it pays to be in the know; and by bureaucratic intervention. Free service implies infinite demand but a non-monetary price is imposed on patients by spartan Doctor's surgeries and hospital procedures which suit the institution rather than the patient---natural market responses to an oversupply of patients.

Since any free service inevitably causes dead weight losses there will never be perfect allocation of health care. Nevertheless, Dr Ross McLeod (AIPP Policy Paper No9) seems to me to have found way around much of the inefficiency while still having a proper regard for the needs of the indigent.

McLeod says, 'no Australian resident suffering sickness or injury should ever be forced to forego treatment and care by the lack of the means to pay for it.' From there he describes a system which retains as many of the appropriate economic incentives as possible. His system should be tolerably cost effective; at least more so than the present shambles.

He accepts the universal health cover concept with private competing health funds and subsidies for the poor or expensively sick. In this his proposal is like Medibank Mark II which Malcolm Fraser abandoned to fiddle the CPI.

Private sector doctors, hospitals, paramedics and insurers are preferred. And there are to be no restrictions on competition among them, other than those regulations which directly relate patient safety.

Health funds may strike premiums which are actuarially based; that is they may require higher premiums from people who have a greater likelihood of illness, as life insurance companies do now. Some premiums are to be subsidised by the taxpayer---those with the worst combination of low incomes and high premiums will get the biggest subsidies.

Consider the incentives these simple but radical changes will introduce.

* The government won't snap to attention as it would when faced with a vociferous lobby but it will save itself some of the political pain associated with taxes by subsidising only up to the most cost effective insurance packages.

* Patients---even when subsidised---will have incentives to find the cheapest insurance offering the widest and most reliable cover. In order not to prejudice future premiums most will also

have a financial incentive not to be hypochondriacs.

* To hold and capture clients health funds will have incentive to find the doctors, hospitals, physiotherapists etc. which enable the funds to offer the best services at the lowest premiums. This will be a most important discipline.

* Doctors, hospitals etc. will have incentives to deliver the best service at least cost for fear of being struck off the funds' lists of preferred providers but to stay in business they will have to satisfy only one fund and as many patients as they need.

If the proposal were adopted patients and taxpayers would make large gains, but listen for the squeals of those service suppliers who suspect they are not among the most efficient.