

EARLY RETIREMENT FROM THE PUBLIC SERVICE*Revised  
6-7-84*

Lately there has been a lot of talk about fraud and overservicing by the medical profession. While the term "fraud" is properly dismissed as the hyperbole we must accept from people with political axes to grind, it would indeed be surprising if a commodity supplied at no cost to the recipient by a bulk billing doctor was not supplied in greater amount than justified by its cost to the community. Even so there has been remarkably little evidence of overservicing produced - perhaps because overservicing defies precise definition.

However, there is one well documented case which merits further inquiry, not only because the case itself is important, but because it provides evidence about the cost of Medicare. It is early retirement, on a pension or with lump sum benefit from the civil service. If on investigation it is found that Dr. Blewett is unable to regulate even the salaried doctors in government departments, then we must seek yet another change to the health care system which substitutes natural incentives to conserve medical resources for the bureaucratically policed averages and standards on which Medicare relies to prevent "over servicing".

It would be unfair to judge the Hawke Government by Medicare alone. In some matters it is governing more responsibly than its predecessors and there is the argument that Hawke really had no option but to do something truly silly to placate his left wing. Medicare is it.

The over-servicing problem did not start with Medicare. (It is basic economics that when anything is subsidised, more of it will be produced and more demanded than if exchanged at market prices.) Medical services have long been heavily subsidised. Irrespective of to whom it is initially paid, a subsidy will be divided between supplier and consumer in proportions determined by the ratio the elasticities of supply and demand bear to each other. If patients demand medical services irrespective of price, demand is inelastic. If doctors provide services in increasing amounts as its price rises supply is elastic. In the<sup>se</sup> circumstances doctors will get most of the subsidy. If it is the other way about patients will get most.

The government would no doubt like the subsidy to benefit patients alone but without conscripting doctors that is not possible. To call forth a greater supply of medical care, a higher price must be paid than for a smaller amount. Britain tried to keep down the cost of the National Health by restricting doctors' incomes only to find that some of their doctors - those with least ties or most readily saleable skills - migrated to where their skills were more highly rewarded. Fortunately for British National Health, doctors also migrated to Britain from Pakistan and India where medical skills are even less well rewarded.

Australian Governments have wanted to increase the use of medical services above free market levels but not up to the levels demanded at the low subsidised prices at which they were offered to patients. The Government therefore took steps to make the supply of medicine less elastic. Still less does the Government wish to bear the cost of supplying medicine at the level demanded at the new zero (Medicare) price.

One of the restrictions used has been, with the aid of computers, to construct profiles of average medical or surgical practices in terms of the numbers of identifiable conditions treated in identifiable ways. If a doctor was then found to be removing "too many" gall stones, "too many" tonsils or treating "too many" colds he was asked by the medical department to please explain. If his explanation was not then "satisfactory" the doctor was likely to get a call from the Commonwealth Police. His crime: over-servicing; providing patients with needless treatment.

(A group of doctors within the civil service provide medical certificates to persons who retire from the service on medical grounds.) The certificate entitles the retiree to superannuation or to a lump sum payment. A computer can be run over these salaried doctors to see how the very expensive treatment - superannuated retirement - which they prescribe lines up with national averages.

Of every seven privately insured superannuants one will retire because of ill health; six because they have reached pensionable age. In 1977-78 seventy-two percent of civil servants entitled to Commonwealth superannuation retired because of ill health. By 1981-82 this had dropped to a still high thirty-eight percent.

I have been told about the tough life in the civil service but until I saw these figures I had not realised how badly we treat our public employees. I am moved to remorse for my past disregard for their welfare by the knowledge that the biggest single cause of early retirement (32% in 1980/81) is not heart disease but disorders of the nervous system, mainly neurosis. The Commonwealth statistician tells us only three percent of the public suffer psychotic illness. We are driving our civil servants neurotic.

Even though a Commonwealth retiree who can take another job without losing his pension faces an obvious moral hazard, we must believe that the illnesses are genuine; they are certified by Commonwealth Medical Officers. These doctors would surely be disciplined if they were "over-servicing". Surely the AMA would be quick to point to any case of a salaried doctor over-servicing even though he be an AMA member. No, the civil service must be going mad.

If by chance the civil service isn't going mad, then Medicare is mad. If the supply of sickness retirements from within the government's own staff can't be controlled by resort to standards of treatment or, I add, ethics, then neither can the delivery of other medical services. To control demand the government will be forced to resort to full waiting rooms, that is queuing. The best treatment will go free to those who can pull strings; that is to the wealthy, as it does in Britain.