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# How! Not How Much:

## Medicare Spending and Health Resource Allocation in Australia

Jeremy Sammut


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# Contents

## Key Points

- In the late 1960s, for every dollar that Australian governments spent subsidising GP and other medical services, they spent $4.83 subsidising hospital care. In 2008–09, for every dollar spent on the Medical Benefits Scheme (MBS), the total government subsidy for hospital care was only $1.99.

- The federal government spent $4.9 billion subsidising more than 116 million GP consultations in 2009–10. The total cost of all Medicare-funded medical services to the Commonwealth budget was $15.5 billion in 2008–09, which was almost double the cost of the private hospital system and half as much as the total state and federal government spending on public hospitals.

- Forty years ago, there were no queues for hospital treatment. Today, one in three emergency patients waits longer than eight hours for admission to a bed, and one in three elective patients waits longer than clinically recommended for surgery.

- High spending on mostly bulk billed medical services highlights the fact that Medicare is a 'reverse insurance' scheme that provides 'inverse care.' Medicare is inequitable because patients with the greatest health needs queue for treatment at overcrowded public hospitals, while patients with minor or trivial health needs receive 'free' or highly subsidised GP visits on demand.

- Fundamental structural reform of Australia's health care financing arrangements is needed to end the 'hospital crisis.' Bulk billing should be scrapped and Medicare should be replaced with a soundly constructed insurance scheme that will properly protect people against the risk of exceptional health events requiring hospital treatment.

- To contain health costs and prevent overuse of medical services, individuals should pay for discretionary services such as occasional doctor's appointments out of personal Health Savings Accounts. The money saved in these accounts should also pay for deductibles and copayments to control use of non-chronic care and marginal hospital procedures.

## Executive Summary

In February 2011, the Gillard government announced a new national health funding agreement, which it hopes will end the 'blame game' over the financing of public hospital care. Under the agreement, the Commonwealth will ultimately fund approximately 44% of the 'efficient cost' of each inpatient public hospital service.

In terms of the structural reform of health care financing, the new funding deal is primarily an exercise in shifting the proportion of hospital costs between different government budgets. Since state governments will remain the 'system managers' responsible for setting the overall budget and service limits, the revised funding arrangements will make little difference to the fundamentals of the 'free' public hospital system: access to hospital services will continue to be restricted or 'rationed' to control the cost of health spending in government budgets.

The Gillard reforms are fiddling with the symptoms of a sick system because the funding problems in Australia's taxpayer-funded 'free and universal' health system are far more complex than how much money the federal and state governments contribute to public hospital care. The key issue is how all health dollars are spent by government across the system. This is the key issue because the most serious, inherent service problem in the system—the rationing of 'free' health care by queues for hospital treatment—is exacerbated by the design flaws and structural funding inefficiencies at the heart of Medicare, which distort the demand and supply of health services.

Medicare entitles all Australians to 'free' or low-cost GP and other primary care services on demand. The system encourages unnecessary consultations and tests because consumers can use their Medicare cards to either 'bulk bill' the entire cost to the federal government or receive a rebate covering a significant proportion of the cost of each service. Minor health care services are overused at taxpayers' expense because Medicare over-subsidises the minor costs associated with the often trivial health needs of millions of Australians.

The systemic consequences are far from trivial. High, ever-increasing, and open-ended spending on the non-hospital sector contributes to funding and service imbalances in the hospital sector. Many Australians with serious health needs requiring expensive hospital care do not receive timely treatment due to the expenditure controls—the tight 'caps' on hospital funding—that federal and state governments use to limit the cost of the 'free' public hospital system.

Because health care subsidies are misallocated on a non-needs and highly politicised basis, Medicare is best described as a 'reverse insurance' scheme. Sound principles of insurance are violated and 'inverse care' is provided. Due to the 'public choice' to excessively subsidise the least serious health expenses, patients with the greatest health needs end up receiving the least responsive services. Perversely, Medicare leaves people over-entitled at the primary care end of the health care spectrum, while the cost of the most serious, most expensive illnesses are inadequately covered.

The use and abuse of scarce health resources in the government-approved manner is a neglected issue in the health debate. The Productivity Commission, the House of Representatives Committee on Health and Ageing, and the Senate Community Affairs Committee have all acknowledged the deleterious impact that skewed government funding priorities have on both the consumption of health services and the incapacity of the system to meet the underlying demand for hospital services. The commission, the House, and the Senate have all called for a better informed debate about how our health care financing arrangements should be structured, but alas, we are still waiting for the debate about the how's and why's of government misspending of health dollars to start. Both sides of politics are reluctant to discuss resource allocation because the issue puts the spotlight on the 'sacred cow' of Australian health policy—the universal entitlement to bulk billed medical services, an enormously popular feature of Medicare.

To fill the void and stimulate debate, this monograph traces the evolution of Australian health policy and its consequences across half a century. The major finding is that the political nightmare the public hospital 'crisis' has become for all Australian governments is

a legacy of the health policy upheavals of the 1970s and early 1980s, which culminated with the establishment of Medicare in 1984.

- In the late 1960s, health policy formation descended into a bidding war for the votes of middle Australia. Successive federal governments created politically rewarding health entitlement programs, which aimed to maximise electoral support by distributing subsidises for medical care throughout the community. The politicisation of health quickly ingrained the electorally sacrosanct notion that all medical services, no matter how minor, should be paid for by the government and consumed with no or minimal direct charge to patients.

- The process began when the Gorton Coalition government introduced a new medical benefits scheme in 1970. In response to growing public dissatisfaction with unpopular out-of-pocket charges for doctors' appointments, and to counter the electoral appeal of the Labor Party's plan for a 'free' health system, Gorton promised that voters would only have to pay a specified excess of no more than 80 cents out of their own pocket for a GP consultation where the doctor agreed to charge the government-approved 'most common fee.' A precursor of the health policy of the Whitlam Labor government, the Gorton scheme paved the way for Medibank in 1975, when public hospital care and bulk billed GP, specialist and other medical services became available for 'free' for the first time.

- The Fraser Coalition government's multiple reinventions of Medibank sought to contain federal health expenditure, which had exploded under Whitlam, but the only lasting policy outcome proved to be a very important change in the way public hospitals were funded. In 1975, the Commonwealth agreed to share the recurrent net operating costs of public hospitals with state governments on a 50/50, open-ended, dollar for dollar basis. Under Fraser, the cost sharing arrangement was scrapped, and from 1981, the states were instead given capped Commonwealth health grants. When Medibank was re-introduced and re-branded as Medicare in 1984, the Hawke Labor government recommitted the Commonwealth to the heavy subsidisation of (mostly bulk billed) medical services. To offset the high cost to the federal budget, the Commonwealth limited its financial exposure to the cost of public hospital care by continuing to give the states only capped grants.

- Given the intractable vertical fiscal imbalance in the Australian federation, and the decline in the value of the general Commonwealth financial assistance grants to the states in the post-Medicare period, the division of health funding responsibilities between the Commonwealth and the states was less than ideal. The federal tier of government with the bulk of the taxing powers was not responsible for financing anything approaching 50% of the actual cost of the real demand for public hospital care as the designers of Medicare intended. State governments with relatively small and independent sources of revenue and large and competing service delivery obligations were left heavily exposed to the financial risk of growth in the use of public hospitals. The states' financial problems were compounded by the large fall in private health fund membership that Medicare precipitated. The predictable response by over-stretched state governments to the increased demand for 'free' public hospital care was to implement blunt, bureaucrat-enforced expenditure controls—frontline budget caps and bed cuts—to ration access to hospital services.

In the last quarter of a century, Commonwealth funding caps and 'global' budget caps have led to large cuts to public hospital bed numbers in excess of efficiencies generated by technical innovations that cut length of stays. This in turn has led to increasing numbers of patients being forced to endure unreasonable waits for rationed hospital treatment. We are still

living with the access problems that Medicare's structural flaws have created on the hospital side of health care.

Policymakers, stakeholders and the public need to realise that Medicare is profoundly inequitable. The unrestricted and unnecessary use of minor services, while the very sick wait for a hospital bed, is an unhealthy mix. The money that the Commonwealth prefers for political reasons to spend paying for Medicare-funded medical services could be better used to meet the unmet demand for hospital care. But redirecting money from medical services into bureaucratic and inefficient public hospitals is not the solution. The bottom line is that as long as Medicare remains the program primarily responsible for financing the health care of the nation, hospital funding caps and hospital queues will continue because 'free' hospital care will always have to be rationed. Medicare will continue to leave the 55% of Australians without private health insurance under-insured against the risk of serious illness requiring hospital treatment.

The challenges facing the Australian health sector in the twenty-first century are larger than but closely connected to the waste on both the hospital and non-hospital sides of the health system. The combined effects of population ageing, expensive new medical technology, and ever-rising consumer expectations will place unsustainable burdens of government budgets in coming decades. Given the looming 'demographic time bomb,' it would be madness to persist with an inefficient scheme that permits high spending on unnecessary medical care and squanders resources on hospital bureaucracy. Without change, the community will continue to forgo essential services while spending an increasing proportion of national income on services that don't improve our health.

To avoid this fate, and to resolve the serious access and funding distortions that mar Australian health care, this monograph argues that four key principles should guide the debate about structural health reform:

1. Scarce health resources and subsidised access to health services must be allocated on a needs basis to ensure timely access to essential hospital care.

2. Excessive, universal subsidisation of minor health expenses must cease, and to prevent overuse, most individuals must pay for these services out of their own pockets through personalised funding instruments (Health Savings Accounts).

3. Medicare must be de-monopolised and replaced with a soundly constructed competitive insurance system that properly protects people against the risk and high cost of exceptional health events, along the lines proposed under the Medicare Select health insurance 'voucher' scheme.

4. To promote personal responsibility for health costs, and control usage of health services while avoiding arbitrary rationing, a rational system of insurance deductibles and copayments must apply for non-chronic care and marginal hospital procedures, which can be paid for out of personal 'health savings.'

## Introduction: Panacea for a sick system

For the last quarter of a century, disputes between the Commonwealth and the states over the amount of funding each delivers to the public hospital system have been a constant feature of the health policy landscape. In the Australian federation, the federal government has the majority of taxing powers, including full power over income tax. The ability of state governments to fulfil their considerable and competing service responsibilities depends heavily on the financial largesse or otherwise of the Commonwealth—on the size of the general revenue grants and special purpose payments bestowed on each state. Since the start of Medicare 26 years ago, Commonwealth funding for state-run health services has been provided on the condition that 'free' public hospital services are available to all patients without user charges. In response to rising public dissatisfaction with the performance of public hospitals, state governments have continually blamed the serious service problems—long waits for both elective and emergency treatment—on 'underfunding' by the Commonwealth.

In February 2011, the Gillard government announced a new national health funding agreement, which it hopes will 'end the blame game' by addressing the states' financial grievances. Under the agreement, the Commonwealth will ultimately provide 50% of all new funding for public hospitals (from 2017–18). In 2008–09, the Commonwealth's share of public hospital funding was 39.6%, compared to the states' 51.2%.[1] By 2020, the Commonwealth will instead be paying for approximately 44% of the 'efficient' cost of each inpatient hospital service as determined by an independent national hospital pricing authority. Canberra's contribution will also be delivered in the form of 'activity-based' funding, meaning the Commonwealth will pay for a set proportion of the efficient cost of each service that each state decides to deliver. This means state governments will do more than simply provide the rest of the money. More importantly, state health departments will remain the 'system managers' in charge of setting the overall budget and service limits, which are unavoidable in a 'free' government-run and -funded system. The revised funding arrangements will therefore not alter the fundamentals of the health system. To control total government health expenditure, access to public hospital services will continue to be restricted or 'rationed' by forcing patients to queue for services.[2] In terms of genuine structural reform of health care financing, the new funding deal is primarily an exercise in slightly shifting the proportion of hospital costs between different government budgets, leaving plenty of scope for state governments to continue to blame long waiting times for public hospital treatment on Canberra.

**The revised funding arrangements will therefore not alter the fundamentals of the health system.**

Moreover, what is not being addressed are the funding problems in the Australian health system, which are far more complex than how much money each tier of government contributes to public hospital care. The key issue is how all health dollars are spent by governments across the whole of the system. How and why scarce health resources are used and abused in the government-approved manner is an important, if neglected, issue in the health debate. The reason resource allocation is important is because one of the most serious, inherent service problems in the health system—the rationing of 'free' health care by hospital queues—is exacerbated by the root problem with Medicare: the design flaws and structural funding inefficiencies at the heart of the system, which *mis*allocate health resources to the detriment of the health and welfare of the nation. Medicare's structural flaws must be front and centre of the debate about the future of the health system, because health 'reforms' that do not comprehensively address the issues are merely panaceas fiddling with the symptoms of a sick system. Why real reform of our taxpayer-funded 'free and universal' health system is needed, what real reform of Medicare should encompass, and why political leaders are reluctant to even consider real reforms are the subjects discussed in this monograph.

## Medicare's structural flaws

Medicare's funding inefficiencies contribute to serious problems in hospitals because the system distorts both the demand and supply of health services. These distortions are wasteful, inequitable, and result in bad outcomes for the sickest patients. Minor health care services are overused by the public at taxpayers' expense because Medicare entitles all Australians to either receive 'free' or low-cost GP and other primary care services. The scheme encourages consumers to make unnecessary visits to doctors and undergo unnecessary tests because they can use their Medicare card to either 'bulk bill' all the cost to the federal government or receive a rebate covering a significant proportion of the cost of each service. To meet the extra demand for 'free' services, which bulk billing stimulates, GPs are often forced to churn patients through their surgeries. Patients with complicated issues are churned too, with time-stretched doctors unable to deliver high quality preventative care[3] and comprehensive management of chronic conditions due to the time spent dealing with minor complaints—coughs, colds, runny noses, aches and pains—that could be dealt with as self-care.[4]

To put the problem another way, minor health care costs associated with the non-serious and often trivial health needs of the entire population are over-subsidised. However, there is nothing trivial about the systemic consequences. Excessive Medicare spending on the non-hospital sector contributes to funding and service imbalances elsewhere, especially in the hospital sector. Many Australians with serious health needs requiring expensive hospital care do not receive timely treatment because of the expenditure control mechanisms that Australian governments use to limit the cost of a 'free' hospital system. Care is rationed, and total expenditure is principally controlled by tightly 'capping' the 'global' budgets of each of the nation's 756 public hospitals. As a result, one out of every three Australians who present to public hospital emergency departments is unable to be seen within a clinically recommended time, and one out of every six Australians on a waiting list for elective surgery has to wait for 'too long' beyond the clinically recommended maximum waiting time.[5] These figures are likely to be an underestimate due to allegations of widespread 'gaming'—manipulation of hospital data to artificially reduce recorded length of waits.[6] Given that government budgets are finite and the infinite demand unleashed by the lack of price signals, all 'free and universal' health systems must use some form of non-price rationing to limit the potentially limitless cost. In the Australian context, however, wasteful spending by the federal government on medical services has magnified the rationing of hospital care because the Commonwealth offsets the high spending on bulk billing and controls the total cost of health care to the federal budget by tightly capping the level of Commonwealth funding made available to public hospitals.

**Wasteful spending by the federal government on medical services has magnified the rationing of hospital care.**

The problems with Medicare go deeper than funding flows *per se*; they stem from the faulty principles behind the design of the whole system. Medicare was established by the Hawke federal Labor government in the mid-1980s to provide Australians with a simple and affordable way of protecting themselves against the cost of accessing health care. Under the scheme, all Australians were required to pay a levy on their income according to their means and receive 'free' (or nearly so) taxpayer-funded treatment according to their needs. But these equalitarian ideals are belied by the 'inverse care law' that the scheme has created, which means patients with the greatest health needs receive the least responsive services.[7] Medicare provides inverse care because it operates as what health economist Roger Kilham describes as a 'reverse insurance' system. A soundly constructed insurance system does not insure people for all services no matter how minor the health need and cost; it enables people to share exceptional risk involving major health problems and high cost medical procedures. Medicare violates sound principles of insurance because the least costly, least serious health expenses are excessively subsidised, while the cost of the most serious, most expensive illnesses are inadequately covered.[8]

A sound health insurance scheme should respect the principle that all health services are not equal in terms of improving health. Some services, including those provided both in and out of hospital, have a discretionary aspect that make them less deserving of subsidies to ensure access, and subsidies should be allocated on a differential needs basis.[9] Most Australians are relatively healthy, their interactions with the health system are relatively few and far between, and individual cost is relatively low compared to the cost of services for those who are acutely ill or have a chronic illness. For the vast majority of citizens, except those with severe financial hardships or with complex conditions, no subsidisation is required for discretionary access to services such as occasional GP visits and tests that do not involve life and death decisions and high or ongoing costs. People should insure themselves against the everyday vicissitudes of life by saving their income and paying for minor health costs out of their own pockets. The structural problem with Medicare is that when government pays for the discretionary services consumed by the bulk of the healthy population, and when these services are made 'free' or low cost (thereby stimulating extra demand), the aggregate cost is very large. The total bill involves millions of voters and billions of dollars. In a perverse outcome, to pay for what are politically valuable entitlements, funding is restricted to parts of the system that treat the very sick who languish in queues waiting for hospital treatment. Despite the impact on a minority of vulnerable Australians, politicians rarely hesitate to fully support electorally popular programs such as bulk billing, which distribute financial benefits to the maximum number of voters. Under Medicare, what is good for politicians, for the bank balances of the majority of medicos, and for the hip pockets of many voters is unhealthy for many patients.

Public subsidies for health care are meant to ensure that people, especially those on lower incomes, can access essential health services. It may therefore seem churlish to complain about bulk billing, which enable people to have virtually unlimited access to doctors' surgeries. However, if subsidises are not allocated efficiently, and health funding is not properly aligned with health needs, the community does not receive the right mix of the right services that most improve our health. GP and other non-hospital services are sometimes described as the 'least medically necessary services.' This is not correct. High quality primary care is an essential part of the health system, and people must have the means of accessing these services to maintain and improve their health. The issues in relation to Medicare are whether medical services are being unnecessarily accessed, whether the skills of highly trained GPs are being utilised properly, and whether waste of resources is compromising the integrity and proper functioning of the health system. Due to the toxic entitlement politics of health, Medicare inefficiently and unfairly misallocates health resources on a highly politicised and non-needs basis. The reverse insurance and inverse care that Medicare provides means the socialist ideology on which the scheme is based has unravelled and is mocked by systemic inequities. The official myth that Medicare provides all Australians with 'affordable, accessible and high-quality healthcare' is a national conceit and self-delusion when hospital queues are the daily reality. Nevertheless, Medicare's structural flaws, and the service distortions and shortages that these flaws aggravate at the most acute end of the health care spectrum, do not receive the attention they deserve in the political arena and the media.

**Due to the toxic entitlement politics of health, Medicare inefficiently and unfairly misallocates health resources on a highly politicised and non-needs basis.**

## Filling the void

Though there is constant interest in health policy, the issue of resource allocation is generally ignored with silence, despite some recent attempts to prompt the discussion. Concerns about unsustainable costs, escalating consumer expectations, and the unfocused and uncoordinated approach to health reform has led the Productivity Commission to repeatedly call for 'an independent public review of Australia's health system as a whole and options

for securing better outcomes.'[10] The commission has called for a 'holistic' review because, with government meeting around 70% of national health care costs, the level and nature of government funding is the 'major influence on both the consumption of health services and the capacity of the system to meet the underlying demand.' A public review would shed light on the largely opaque but implicit financial and non-financial costs that Medicare imposes on taxpayers and on patients unable to access unavailable hospital services.[11]

The House of Representatives Standing Committee on Health and Ageing has also called on all Australian governments to adopt a national health reform agenda that addresses 'system-wide issues' and the 'structural and allocative inefficiencies of the whole system, as it currently operates.' The committee's 2006 report on health funding, *The Blame Game,* argued that these structural and allocative inefficiencies—bulk billed medical services that waste health dollars—should be exposed to public scrutiny to encourage an 'improved debate about how health funding arrangements should be structured.' The committee also noted that a debate about structural funding changes and how to minimise waste of resources was overdue because costs will continue to rise, and access to hospital care will continue to diminish, as ageing and new medical technology place pressure on limited government health budgets in the coming decades.[12] *The Blame Game* report echoed the findings of an earlier Senate inquiry into hospital funding, which observed that the public has impossible expectations about the level of access to all health services achievable in a government-run and -funded system.[13] The House inquiry agreed there was a mismatch between the unrealistic community expectations of unrestricted access to 'free' hospital care and the different 'priority set by government for the resources allocated to the health system.'[14]

**The major problems in the health system—which primarily concern the underinsurance of hospital care—are the legacy of the series of policy changes that culminated with the establishment of Medicare.**

Despite the urgings of the Senate, the House, and the commission, we are still waiting for the debate about Medicare's skewed funding priorities to start. In 2007, then Prime Minister Kevin Rudd established the National Health and Hospitals Reform Commission (NHHRC) to review the health system. Unfortunately, the commission's final report released in June 2009, *A Healthier Future for All Australians*, paid no attention to the relationship between the structure of Medicare, the misspending of health dollars, and the long waits for hospital care. This was not the commission's fault since the government deliberately excluded these issues from its terms of reference due to the political salience and enormous popularity of bulk billing. This is typical of the reticence found on both sides of politics. Both Labor and the Coalition are keen to avoid the political landmines that surround a subject which puts the spotlight on the 'sacred cow' of Australian health policy—the universal entitlement to bulk billed medical services.

The remainder of this monograph attempts to fill the void by tracing the evolution of Australian health policy and its consequences across 60 or so years. To stimulate the informed debate we have to have about the how's and the why's of government health spending and the future of the health system, this monograph:

1. describes the structural funding imbalances and related systemic problems within the health and hospitals system
2. clarifies the financial and opportunity costs of Medicare, with a focus on the bad consequences of bulk billing, and
3. suggests the principles that should guide structural health reform.

The discussion that follows shows that the major problems in the health system—which primarily concern the underinsurance of hospital care—are the legacy of the series of policy changes that began in the late 1960s and culminated with the establishment of Medicare. The major conclusion is that the sacred cow of the health debate needs slaughtering.

Bulk billing is far from the great health policy achievement it is made out to be. This core feature of Medicare symbolises the fact that our health system does not do what all health systems should do: ensure that timely access to hospital treatment is available when serious illness strikes.

## National Health Scheme

Since the 1930s, both sides of Australian politics have pragmatically responded to the political demand for government involvement in the funding of health services. Political controversy has centred on the degree and nature of government involvement. Ideology has played a role, with the Coalition parties preferring to promote self-help and private initiative and Labor supporting a nationalised health service.

During the long post-World War II period of Coalition ascendency at the federal level, Australians were expected to mutualise (as opposed to socialise) the risk of ill-health with other citizens through private health insurance, albeit with large government subsidies to support an insurance market characterised by minimal competition.[15] The National Health Scheme was put in place in the early 1950s by the federal Coalition government led by Liberal Party Prime Minister Robert Menzies and Country Party Deputy Prime Minister and Health Minister Dr Earle Page, a former medical practitioner. The scheme was designed to offer a minimum level of protection for those who genuinely could not pay for their own health care, while requiring those who could afford to help themselves to take out private insurance as a condition of receiving government financial assistance with health costs. It was also designed to ensure that federal health spending was used in a manner that kept insurance coverage high, while supporting the financing of state government-run public hospitals.

Prior to the health policy upheavals of the 1970s, around 85% of Australians were either voluntarily insured with a registered health fund or had their health care paid for by the Commonwealth-funded Pensioner Medical Service. For the voluntarily insured, a combination of health fund and Commonwealth medical and hospital benefits covered most of their health expenses up to a government determined limit. A form of soft compulsion applied. Public subsidises were used to guide individual choices in a personally and socially responsible direction: membership of a registered health fund was mandatory to be eligible to receive Commonwealth benefits. A safety net for disadvantaged people unable to pay for premiums ensured that publicly funded public hospital treatment was available without charge, subject to a means test. The means-tested Pensioner Medical Service provided eligible recipients of the old age pension with pharmaceuticals, GP, and inpatient and outpatient public hospital services without charge.

**In essence, public hospitals were renumerated for services rendered by a dual private and public financed 'voucher-like' payment system.**

Under the scheme, patients had freedom of choice of hospital, and public hospitals received a 'steady and reliable' clinically based source of activity-driven income.[16] In essence, public hospitals were renumerated for services rendered by a dual private and public financed 'voucher-like' payment system. Because funding was tied to activity, government subsidies and fund benefits paid for the actual level of services a hospital provided. This meant that waits for hospital treatment for both privately insured and 'public' patients were minimal. The Commonwealth hospital benefit was paid to individuals as a rebate through their health funds, and the combined Commonwealth and fund benefits ensured the nominal public hospital bed charges set by state governments were met. A guaranteed flow of federal funding for hospitals was thereby provided, and this indirectly contained the size of the (still considerable) grants that state governments had to provide to meet hospital operating costs. The Commonwealth benefits and state operational subsidies, in turn, held down the cost of ward charges, insurance fund benefits, and contributions paid by individuals. Public hospital charges therefore did not cover the actual cost of hospital care, and premiums did not cover the full cost of insurance.[17]

The aim of the Commonwealth benefits and state grants to hospitals was to maximise coverage and facilitate access to hospital and medical care by keeping voluntary insurance affordable, while still indirectly exposing individuals to some of the financial cost of using health services through premiums. In 1968, tax-deductible hospital insurance contributions ranged from 25 to 65 cents per week for singles, and 50 cents to $1.30 per week for families, with each contribution level linked to a total benefit payable, including the $2 per day Commonwealth hospital benefit. A contribution of $1 a week ensured that a family was covered for benefits in excess of the 'public' (i.e. lowest cost) ward charges in any state. Commonwealth medical benefits ranged from 80 cents for GP visits and $60 for major operations. Medical fund benefits—and therefore the size of the copayment—varied according to weekly contributions, which in 1968 ranged from 20 to 30 cents for singles, and 40 to 60 cents for families.[18]

The National Health Scheme was not perfect (what health system anywhere in the world is?) particularly for the proportion of the population who could not afford premiums due to financial hardship, notwithstanding the right to public hospital care without charge. Yet many of the problems that emerged were resolved over time. For example, the Commonwealth agreed to pay for the full care and insurance costs of the chronically ill who, as high users of medical services, had previously paid the same proportion of out-of-pocket costs as those with trivial needs.[19] For many years, the poor were locked out of government-subsidised and -insured access to medical care. Targeted reforms, particularly the introduction in 1970 of means-tested, 'free' comprehensive hospital and medical insurance for the unemployed and other disadvantaged families, were designed to improve the fairness of the health system and take the wind out of Labor's push for a universal government-run system.[20]

## Who benefits?

The most important and overlooked aspect are the principles underpinning the National Health Scheme. As best as the mid-twentieth century politics of health allowed (see next paragraph), the scheme was designed to hold governments financially responsible for health care by fully subsidising only the cost of hospital services. This was achieved by drawing an appropriate needs-based distinction between hospital benefits and medical benefits for doctors' fees. Government subsidies available for health care were weighted and restricted by setting the maximum benefit level at 'up to' 90% of the medical fees paid by contributors for the most serious conditions. A 'specified excess' or gap requiring copayments from patients for GP and specialist consultations was built into the scheme to control usage and contain public spending on minor health needs.[21] Health Minister Dr Earle Page was careful to include cost sharing as a key feature of his plan so that direct exposure to health care cost would promote responsible use of services and help avoid the pitfalls of a 'free' taxpayer funded system—arbitrary expenditure controls and rationing to contain the health budget.[22] When very few people were receiving combined medical benefits equal to 90% of the doctor's bill, officials were pleased with the financial sustainability of the scheme. However, the unintended impression the '90% rule' created in the minds of the public was that individuals would only have to pay for 10% of the cost of any medical service. This became a serious political problem when benefit levels failed to keep pace with inflation and fee increases. Out-of-pocket charges (which could be unpredictable as doctors set their own fees) did not fall below 30% of the cost in the post-War period, and dissatisfaction with 'gap' payments, born of the 90% misapprehension, intensified throughout the 1960s. Despite concerns that the subsidies already available for medical fees were causing overuse, and the extra cost would make the scheme financially unsustainable, Commonwealth medical benefits increased periodically. But this failed to solve the gap or the political problems because, as night follows day, doctors raised their fees.[23]

**When very few people received combined medical benefits equal to 90% of the doctor's bill, officials were pleased with the financial sustainability of scheme.**

The perception that benefits failed to meet an adequate proportion of the cost of medical attention for the insured initiated a political chain of events that, over time, eroded the sound principles of the National Health Scheme. However, the scheme was compromised from the start, and trod a fine line between operating as an entitlement program and sound insurance system, because medical fees attracted considerable government subsidies. The participation of the medical profession was won by the Commonwealth agreeing to provide a universal fee-for-service medical benefit. Since the late-nineteenth century, the working class had joined 'friendly societies,' which contracted with doctors to provide members with GP services on a capitation basis. The middle class had paid doctors on a fee-for-service basis out of their own pockets. The new universal medical benefit, which covered both working and middle-class patients, represented a huge victory for the medical profession. The public subsidisation of private practice enabled GPs to free themselves from the hated contractual arrangements with the 'friendly societies,' while ensuring high and regular demand and fee-for-service remuneration for doctors' services.[24] As is the case with any subsidy, the Commonwealth medical benefit distorted prices, while doctors routinely and promptly responded to increases in benefit levels by increasing their fees, which led to premium rises and pressure on government to further increase benefits. Led by the Australian Medical Association (AMA), the medical profession vigorously defended the sanctity of the doctor-patient relationship free of government interference. What the doctors really were defending was their right to charge patients whatever fee they wished while having their incomes under-written by taxpayers. The dogma promoted by the AMA about 'private medicine' and the threat of 'socialised medicine' does not obscure the rent-seeking reality. For good reason did contemporary commentators deem the medical profession to be the main beneficiaries of the Commonwealth's 'doctor's benefit scheme.'[25]

## Levelling in the Seventies

In response to mounting public concern about fee increases and out-of-pocket charges at the end of the 1960s, the Gorton government introduced a new subsidy regime in 1970. Motivated by political considerations, the Gorton scheme was designed to address the gap between medical benefits and fees to counter the electoral appeal of Labor's plan for a 'free' taxpayer-funded scheme. The '90% rule' was abolished and patients were guaranteed a maximum gap of $5 for the most costly services, including specialist consultations and major operations. Most important of all, voters were promised they would pay a specified excess of no more than 80 cents out of their own pocket for a GP consultation where the doctor agreed to charge the government-approved 'most common fee.'

**Health policy formation had descended into a bidding war for the votes of middle Australia.**

Health policy formation had descended into a bidding war for the votes of middle Australia. Rather than establish a soundly constructed health insurance system, successive federal governments in the 1970s preferred to create politically rewarding health entitlement programs. Instead of targeting assistance to those most in need—hospital patients who had faced larger out-of-pocket costs for major surgery due to the diminishing value of fee benefits—the Gorton scheme was designed to maximise voter support for government by spreading the entitlement to increased medical benefits throughout the community. The result was a large increase in the usage of medical services. Disproportionate growth occurred in the use of specialist services, in particular, as many patients sought unnecessary referrals from GPs to see a specialist because the cost was only $5. Commonwealth medical benefit expenditure doubled in two years.[26] Gorton's politically attractive policy did more than counter Labor's health plan—it was the precursor of the health policy of the Whitlam government. The Gorton scheme explicitly endorsed the soon-to-be-ingrained electorally sacrosanct notion that all medical services, no matter how minor, should be paid for by the government and consumed with minimal direct charge to patients. It thereby helped pave the political and philosophical way for the start of Medibank in 1975.

Medibank dramatically further expanded the role of government in the health system. For the first time, 'free' public hospital treatment was promised to all, and 'free' GP and specialist consultations were provided where a doctor agreed to directly 'bulk bill' the federal government and accept 85% of the schedule fee as final settlement of the patient's account. After Whitlam was dismissed as prime minister in 1975, the Fraser Coalition government's multiple reinventions of Medibank retained and discarded different elements of the original scheme in search of a better way of distributing health care subsidies and containing government health expenditures that had exploded under Whitlam. In 1981, the Coalition settled on restricting bulk billing and free public hospital treatment to pensioners and others deemed socially disadvantaged, and the link between fund membership and entitlement to government benefits was restored. The revised scheme established a 30% tax rebate for private health insurance premiums, a 30% flat-rate Commonwealth medical benefit for fees over $20, and a maximum $10 gap per service for persons insured with registered health funds.

**Under Hawke, the Commonwealth continued to only hand out capped health grants.**

Medibank 'Mark VI' marked a break from the Labor Party's 'free and universal' principle and a move towards user-pay and encouraging people to take responsibility for their own private cover. The hardheads in the Fraser government (led by Health Minister and leading 'dry' Jim Carlton) were concerned about the previous decade's overall trend of increasing government spending, declining private financing, and the escalating cost of health expenditure to the federal budget, especially on medical fees. They realised that medical services provided on a free or excessively subsidised basis misallocated resources and encouraged overuse of medical services. The ways to prevent excessive demand and promote cost-consciousness that were identified were:

- Decreases in subsidises
- Increases in gaps for medical fees
- Bans on no gap policies
- Compulsory deductibles
- Insurance for catastrophic illness only
- Exposing consumers to the full cost of care through cost of premiums.[27]

Not only was the problem but also the solution for over-subsidisation and overuse recognised: to control health expenditure, people had to be indirectly and directly exposed to the financial cost of the use of services. However, due to the subsequent political events, the only lasting policy outcome of the Fraser government's health policy was a very important change in the way public hospitals were funded. Under Whitlam in 1975, the Commonwealth had agreed to share the recurrent net operating costs of public hospitals with state governments on a 50/50, open-ended, dollar-for-dollar basis (an arrangement that dated back to the Chifley government's initial foray into a national health system in the late 1940s). This was an example of the Whitlam government's characteristic 'too much, too fast' approach. The accompanying fiscal profligacy, when piled on top of the cost of bulk billing, proved to be neither a rational nor sustainable policy.[28] In 1976, Fraser sought to reign in government expenditure and control the cost of public hospitals to the federal budget by revising the funding agreement. The Commonwealth agreed to fund only 50% of hospital costs 'approved' in consultation with the states. In 1981, the federal government withdrew entirely from the cost-sharing arrangement. Instead, the states were given only 'identified' (capped) Commonwealth health grants.

The Hawke government re-branded Medibank as Medicare in 1984 and extended the changes initiated by Gorton, Whitlam and Fraser to the composition of the Commonwealth's financial responsibilities for health care. The federal government recommitted itself to the heavy subsidisation of medical fees, and in response to the budgetary pressures created by

the reintroduction of bulk billing, the Commonwealth limited its financial exposure to the increasing cost of the public hospital system. The Hawke government extended the funding policy of the Fraser government. Under Hawke, the Commonwealth continued to hand out only capped health grants, which 'in theory,' compensated state governments for the loss of patient revenues incurred in return for agreeing to provide 'free' public hospital care without charge to patients.

The significance of these events has been missed both at the time and in retrospect. To some contemporary observers of the evolution of Australian health policy, bulk billing appeared to be a defensible means of preventing doctors from perpetually boosting their incomes by increasing fees in response to benefit rises. No government can keep paying benefits linked to fee levels they are unable to control and which are determined by others. But getting most doctors to agree to bulk bill at a government-determined fee—still wrongly singled out as Medicare's greatest 'achievement'—was an expensive way to worsen the problem of over-subsidisation and over-consumption of minor health services. Doctors acquiesced when Medicare was re-established in the mid-1980s because the scheme 'filled their mouths with gold.' Against the expectation that had led the AMA to fiercely oppose the Whitlam government's 'socialist' plan, the brief period in which Medibank had operated in the mid-1970s taught the profession that bulk billing would increase medical incomes by encouraging overuse. We are still living with the structural funding inefficiencies and access problems that bulk billing has contributed to the hospital side of health care. The lasting effect of Medicare has been to create an imbalance in the funding flows and in the subsidies available for hospital and medical services, which continue to distort the demand and supply of health services in Australia.

**The feature, and much touted main 'benefit,' that clinched voter support was the promise of unlimited bulk billed GP consultations without charge.**

## Over-entitled

The explanation for why Medicare operates as a reverse insurance system is political. To gain electoral support for the Labor Party's health policy, voters were guaranteed that unpopular copayment gaps for doctors' visits would be completely eliminated. The proponents of a universal taxpayer-funded scheme were ideologically determined to nationalise health care to ensure equality of access to services. But for the average voter, Medicare—'the extension of financial insurance to the 15% of the population who had not purchased it privately'[29]—was not about the pursuit of social democracy. The promise of hospital care without having to pay for insurance premiums was an important selling point. But the feature, and the much touted main 'benefit,' that clinched voter support was the promise of unlimited bulk billed GP consultations without charge. Bulk billing, in short, was a political fix, not a reasoned and equitable policy (which it may have been if strictly limited to the disadvantaged). It was a 'whatever it takes' measure designed to facilitate voter acceptance of Labor policy and advance the underlying ideological objective—the abolition of the private insurance and private hospital industry.

Under the Medical Benefit Scheme (MBS) part of Medicare, 'free' or heavily subsidised GP services are available on demand or a fee-for-service basis. The MBS budget is uncapped and is funded entirely by the Commonwealth. All consultations are eligible for a Medicare rebate, and around three-quarters of GP visits are bulk billed. Competition between surgeries, except in some of the wealthier and in the most remote communities, encourages most doctors to bulk bill or risk losing patients. As a result, copayments by individuals account for less than 12% of expenditure on medical services.[30] The Medicare Levy (which was originally set at 1.25% of taxable income above a certain threshold and since has been increased to 1.5%) raises sufficient revenue to only cover less than 10% of total government health expenditure. This was always the plan of Medicare's designers. The financial purpose of the levy was to fund the additional administrative costs of the system, with the bulk of funding for health services derived from progressive taxation. The political purpose was to entrench public support for Medicare and make it harder for future non-Labor

governments to scrap it. The levy cultivates the illusion that Medicare is a genuine premium or contributions-based health insurance scheme that provides comprehensive security and protection against ill-health. The levy obscures the reality that it is a redistributive social security type entitlement program that relieves low- and middle-income voters, and even some high-income earners who frequently use 'free' GP and hospital services, from having to directly contribute to the cost of their health care.

The levy also created the perception that Medicare was an earned entitlement. This fostered a 'claims mentality,' creating an impression that people have the right to see the doctor as often as they wish at taxpayers' expense so they can 'get their money's worth.' This mentality is so ingrained that politicians are extremely sensitive to any perceived or real threat to bulk billing. In lead up to the 2004 federal election, the Howard Coalition government came under opportunistic attack from the Labor Party as a 'threat to Medicare' because the level of bulk billing had fallen a few percentage points below the long-run average. Fearing the issue would cost votes in marginal electorates, Prime Minister John Howard and Health Minister Tony Abbott responded to the electoral ploy by raising the MBS rebate by 15% to cover 100% of the schedule fee. A range of new practice incentives were also introduced to encourage doctors to bulk bill. The total package came at a large additional cost to total program expenditure. MBS expenditure grew by $1 billion (8%) in the first year alone.[31] Two and half decades of Medicare have conditioned the populace to expect all services for nothing, and the 'what's in it for me attitude' supports the view that the welfare state makes people selfishly preoccupied with their own entitlements. This is the antithesis of the fraternal ethos behind the traditional method of mutualising the risk of ill health. A spirit of mutual assistance motivated the generations of Australians who joined 'friendly societies' (the original private health insurance schemes) from the late-nineteenth century.[32]

**No properly configured health insurance system should therefore cover minor medical costs from the first dollar spent as Medicare does.**

The overuse of medical services that Medicare permits does not occur in other kinds of insurance systems that, to remain sustainable, are designed to pool only exceptional risk and to ensure costs are transferred from higher level users on to those who make negligible use of insured services. No properly configured health insurance system should therefore cover minor medical costs from the first dollar spent as Medicare does. No private insurer, lacking the grasping hand of government in the deep pockets of the taxpayers, can afford the cost of bulk billing without draining their reserves or making premiums unfordable. What Medicare exemplifies is the intrinsic moral hazard that all subsidised, fee-for-service, third-party insurance arrangements can create in both private and public health systems. When price signals are eliminated in the health market, and services are provided with no or only minor out-of-pocket contributions, there is less incentive for individuals to be cautious, responsible, and cost-conscious consumers of health care, 'because nobody spends somebody's else's money as wisely or as frugally as he spends his own.'[33] Health subsidies, like all price and exchange controls, create economic distortions that influence how much health care is consumed by reducing the cost of care relative to other goods and services. The more subsidised health care is with other people's money, the more are the real costs hidden from consumers. The more insulated consumers are from the cost of care at point of access, the more resources are wasted on services and procedures that have marginal health benefits. Health spending, and the taxes and premiums that pay the bills, are higher than they need be. Consumers have no incentive to curb wasteful spending that has few health benefits because they derive no financial benefit from being prudent. The only way to avoid the moral hazard and promote financially responsible use of health care is to make people always spend at least some of their own money to access services. A sound insurance system therefore requires a front-end deductible and/or copayments that members must pay to avoid overuse and trivial (non-catastrophic or non-chronic) claims. Medicare, on the other hand, encourages overuse because there is no user charge for most medical services.

**Table 1: Health expenditure 2008–09 (billions) by area and government**

| | |
|---|---|
| Commonwealth—Public hospitals | 12.8 |
| State—Public hospitals | 18 |
| Commonwealth—MBS | 15.5 |
| Commonwealth—PBS | 8.9 |
| State—Community health | 4.6 |
| Total non-hospital | 29 |
| Total hospital | 35*† |
| Commonwealth—non-hospital | 24.4 |
| Commonwealth—hospital | 13.2*# |

**Source:** Australian Institute of Health and Welfare.[34]

* Includes estimated $ 1.8 billion of Commonwealth private insurance rebate used to fund private hospital.

† Includes $2.4 billion spent on in-hospital drugs.

# Includes $567 million in Commonwealth government payments to states and territories for highly specialised drugs and $214 million Commonwealth government payments for highly specialised drugs in private hospitals.

In 2009–10, the federal government spent $4.9 billion subsidising more than 116 million GP visits.[35] In 2008–09, the total cost of all MBS funded services was more than $15.5 billion. This was almost double the cost of the private hospital system and approximately half as much as government spending on public hospitals. It compares to the $12.8 billion the Commonwealth spent on public hospitals services, including the $11.7 billion provided to the states and territories under the Australian Health Care Agreement (see Table 1). Add the $8.9 billion the Commonwealth spends on the Pharmaceutical Benefits Scheme (PBS) (which is plagued with similar problems of over-subsidisation and overuse as the MBS) and the $4.6 billion spent on the states' community health services, and government funding is anything but 'hospital-centric.' In terms of total public health expenditure, government spending on non-hospital care (MBS, PBS and community health) totalled $29 billion, compared to $35 billion on hospital care. Commonwealth government funding for non-hospital care outstripped spending on hospital care by more than $10 billion.

To put the current spending in perspective, it is useful to compare it with spending patterns in the past. In 1967–68, for every $1 governments spent subsidising medical services (federal medical benefits plus the pensioner medical service), they spent $4.83 subsidising hospital services (federal hospital benefits and state grants to public hospitals). In 2008–09, for every $1 spent on MBS, the total government subsidy for public hospital care was only $1.99.[36] This shift in health spending reflects developments in clinical practice, such as community-based diagnostic imaging technology replacing exploratory surgery in hospitals. But in the Australian context, these shifts also reflect major policy changes that have created a poorly configured system of health care insurance and financing. When the federal government is paying for three-quarters of national expenditure on medical services, when three quarters of GP visits are bulk billed, and when individuals are paying for only 12% of the cost from their own pockets, it is impossible to tell how many billions of dollars are being wasted on millions of unnecessary consultations and tests. What the total cost of Medicare therefore does not measure is the waste (unnecessary use of services by patients), over-servicing (by doctors, including outright fraud), and opportunity cost (misallocation of resources and forgone hospital care) that high expenditure on the MBS involves.

**To put current spending into perspective, it is useful to compare with spending patterns in the past.**

## Underinsured

The success of the Hawke government's second bite at a nationalised health system created another structural flaw and additional imbalances in the health system. The idea that private cover could be ditched in favour of relying on the government scheme was normalised. White-anted was the hitherto robust Australian social expectation that all who could provide for themselves should be self-reliant and dependence on government discouraged.[37] The result, again as Medicare's designers intended, was a large fall in private health fund membership. Coverage fell from 64% of the population in 1983 to 47% in the late 1980s to 30% in the late 1990s. The drop was concentrated in younger age groups who saw little point in paying twice, through taxes and premiums, for cover they were less likely to need.[38]

The effects of the decline in private cover were threefold.

The first effect was that older and chronically ill people tended to remain insured and made the 'risk pool' unhealthy. The loss of the cross subsidy from the young and healthy inevitably drove up the cost of premiums and drove out more people, especially those with lower incomes. The equity of the system declined, as many less well-off Australians were left with no access to private hospitals, no choice of doctor, and no option other than to wait in long public hospital queues. Those who depend solely on Medicare were left over-entitled at the primary care end of the health care spectrum and underinsured against the risk of serious illness requiring hospitalisation. They were forced to take what they were given in a public system that arbitrarily rations 'free' care to control costs.

**The effects of the decline in private cover were threefold.**

The second effect was that the proportion of the cost of the hospital care formerly paid for by health funds was shifted on to government budgets. The more people who opted out of private insurance, the more expensive and impossible it became for state governments to fulfil the Commonwealth's promise of 'free' public hospital care on demand.

The third effect was that public hospitals became dependent on the taxpayer funding channelled through fiscally stressed state treasuries. This led, on the one hand, to blunt expenditure control via cuts to frontline hospital services. On the other hand, centralised control of hospital finances was exploited by the state administrators, who diverted resources away from the coalface to expand the health bureaucracy.

## Financial origins of the hospital crisis

The ultimate result of Medicare is the 'hospital crisis.' The predictable response by over-stretched state governments to the increased demand for free public hospital care 'at point of access' was to ration services. Frontline hospital budgets were tightly capped, and the total funding provided bore little relationship to the actual and increasing demand for public hospital services. Expenditure was administratively controlled by cutting the number of public hospital beds to force patients to queue. To establish centralised financial and administrative control and facilitate bed cuts with a minimum of opposition, local hospital boards were abolished and the public hospital system was bureaucratised.[39] 'Area health' authorities were established to run hospitals in designated regions, and the detailed micro-management of daily activities by centralised agencies has resulted in well-documented negative effects on hospital management, efficiency, and total costs.[40]

In the last quarter of a century, funding caps in the public hospital system have led to huge cuts to beds numbers.[41] The total number of public beds in Australia has fallen by one-third, or by 60% on per 1,000 head of population basis, and the total reduction in beds has been in excess of efficiencies generated by technical innovations that have reduced length of stays. The result was the emergence in the late-1980s of lengthy waiting lists for elective surgery, a problem that persists and continues to cause avoidable suffering. Since the late 1990s, bed cuts have led to the emergence of chronic overcrowding ('access block') in emergency departments. Due to the national shortage of public hospital beds, one in three emergency patients requiring admission in a hospital now waits longer than eight hours before being

admitted to a bed, and an estimated 1,500 avoidable deaths occur each year (more than the national road toll).[42] This is a conservative estimate of the death toll, which does not include the thousands of people who die while languishing on elective waiting lists each year.[43]

The political nightmare that public hospitals have become for all Australian governments has its origins in the structural funding imbalances created by the policy changes of the 1970s and early 1980s. Under the 50/50 cost sharing deal between the Commonwealth and the states in 1975, every extra dollar spent on hospital care costs state budgets only 50 cents of expenditure on competing priorities. The new financing arrangements introduced in 1981 meant state spending on hospitals cost a full dollar and made public hospitals twice as expensive for the states relative to other programs.[44] The cost-sharing deal had been crucial in getting the states to agree to Medibank. The financial burden on state governments was 'vastly eased' by the ability to present the Commonwealth with half the annual bill. But from the Commonwealth's perspective, the deal invited open-ended claims and irresponsible expenditure, since the states were not required to justify the bill.[45] The shift to 'approved' costs in 1977, and then to fixed health grants, was officially justified as a means of promoting greater state government accountability and cost-control. But the end of federal cost-sharing made the states' job of delivering 'free' public hospital care especially financially onerous.

After Medicare began in 1984, the states' financial position barely improved. Capped Commonwealth health grants were supplemented with additional compensation grants for the loss of patient revenues. But both types of grants were pooled with other federal grants and became just another form of federal general revenue assistance to the states. This practice continued under the first Medicare Agreement in 1988 and each subsequent five-year Australian Healthcare Agreement (AHCA). Under the 1999 GST Agreement, AHCA funding was also 'absorbed' into the GST pool and not specifically allocated to health services. Once again, the purpose of pooling all funding was to encourage the states to control hospital budgets, because each dollar that state governments decided to spend or save on hospitals affected their budget result. But because there was no dedicated pot of money set aside for public hospitals, there was no guarantee that the funding identified for health would actually be spent in public hospitals. When faced with competing priorities, state governments could choose to spend pooled funds in other areas of government responsibilities. Not only could hospital funding be moved elsewhere, but increases in Commonwealth funding could be used to substitute and withdraw the states' own source funding. State governments had a particular incentive to 'cheat' or cost shift in this manner, given the broader context of federal-state financial relations and the overall decline in the relative value of general revenue grants in the 1980s and 1990s.[46]

**State governments had a particular incentive to 'cheat' or cost shift, given the broader context of federal-state financial relations.**

Given the intractable vertical fiscal imbalance in the Australian federation, and the big difference in the revenue streams available to the Commonwealth and the financially beholden states, the extent of federal government's responsibility for hospital funding was less than ideal. Because of the capped, pooled funding arrangements, the tier of government with the bulk of the taxing powers in the federation avoided responsibility for financing the actual cost of the 'free' public hospital care, which federal politicians promised Medicare would provide, and the Commonwealth failed to give the states sufficient funding to get anywhere near accomplishing the task. Unrealistically low indexation growth in the first decade of Medicare has also been blamed for establishing a baseline level of Commonwealth funding, which bore no relationship to the real demand and actual cost hospital care. State governments thus had strong financial incentives to limit hospital costs by means of bureaucrat-enforced, supply side rationing via budget caps and bed cuts. Commonwealth funding was indexed for population growth, ageing, and 'utilisation growth.' But it was state governments, with relatively small, independent sources of revenue and large service delivery responsibilities, that were heavily exposed to the financial risk of growth in usage of hospitals above the indexation

formula. The states were also left to make all the hard decisions about policy and funding priorities as an ageing population and the rising technological sophistication of hospital care inexorably drove up the proportion of state budgets consumed by public hospitals. The result was the rise of the so-called 'blame game,' with the state governments blaming lack of Commonwealth funding for the failure to meet Medicare's promise of 'free' hospital services on demand, while the Commonwealth blamed the problems on the states' bureaucratic management of the system.[47]

## Caps, cuts and queues

Rise above the blame game, and the serious funding and associated service problems in public hospitals are attributable to Medicare's design and structural flaws. The best analysis of the funding and service distortions in the system was produced by John Paterson, former head of the Victorian health department. Paterson argued that approximately 60% of the population is basically healthy and satisfied with Medicare. They are happy and content, not only because they are well but because their only contact with Medicare is through the MBS or the PBS, which 'are uncapped *entitlement* programs, where the Commonwealth meets *all* claims submitted' (emphasis in original). Where the system performed the worst was for the 10% of the population with a chronic health problem (mainly due to the fragmented state and federal health programs), and for the 30% of the population that experience an acute illness each year. They are unhappy because their treatment depends on capped programs for which there are long queues, especially in public hospitals. Paterson noted that the reasons federal governments kept the MBS unrestricted was because it was popular and politically rewarding. It was not driven by explicit policy considerations, let alone by clinical considerations. It was motivated by raw politics, since realigning funding flows would have opened up politically sensitive issues. Because the bulk of federal Medicare spending went to people who were neither very sick nor very poor, it kept a lot of voters happy. Meanwhile, the very sick queued for hospital treatment and the financially constrained states copped the blame. From the Commonwealth's perspective, the structure of Medicare was good politics. But it was abysmal social justice and diabolical health policy.[48]

**No federal government—under Hawke, Keating, Howard, Rudd or Gillard—has maintained a 50% share of the operating costs of a 'free' hospital system as the designers of the Medicare system intended.**

The federal response by governments of all political persuasions to the high, ever-increasing, and open-ended cost of the MBS (and PBS) has been to hold down funding to other parts of the system. From 1984 spending on the MBS grew faster than the rest of the system, and above population growth, because the program was uncapped. To pay for the growth, the Hawke government put the squeeze on health expenditure by restricting grants to the states, which failed to keep pace with the demands on public hospitals.[49] Under the first two Medicare agreements (1984–88 and 1988–93), the Commonwealth provided 42.7% and 43.2% of total hospital funding, while the states' share increased from 46.5% to 47.2%. During the third agreement, under the Keating government (1993–98), the Commonwealth's share increased to 46.1% and states' share fell to 45.4%.[50] By the final year of the Howard government's first AHCA in 2001–02, the Commonwealth's share had fallen to 44.1% and the states' contribution had increased to 47.5%.[51] No federal government—under Hawke, Keating, Howard, Rudd or Gillard—has maintained a 50% share of the operating costs of a 'free' hospital system as the designers of the Medicare system intended.[52]

It is important to point out that the 'lack of funding' argument is no longer wholly valid. Since 2003, the state governments have been obliged under a condition of the AHCA to match growth in Commonwealth funding dollar for dollar, which has established a 'floor' level of indexed, recurrent funding. The states have been able to meet this condition due to the additional revenue the GST and the subsequent boom economic times poured into their coffers.[53] Since 2002, spending on public hospitals has increased by $2 billion each year,

driven by state funding growing at a faster rate than Commonwealth funding. Hence, the Commonwealth's share of hospital funding has slipped below 40%, while total government funding has increased from $22 billion to $30 billion.[54] But the revision of federal-state financial arrangements came too late, and the extra funding has not fixed the system. The bureaucratisation of the public hospital system has created systemic problems that no funding increases can solve. In bureaucratised entities, additional inputs do not produce a proportional increase in outputs. By the time additional funding flows through the black hole of the bureaucracy, very little of the additional money makes it to the frontline as extra services. The public hospital system in all states is beset by all the problems typically associated with bureaucratically run government services, including budget blowouts and frontline shortages. Capped budgets have destroyed all market incentives to innovate, boost productivity, and treat the maximum number of patients. Growth in bureaucracy has lowered efficiency and increased administrative overheads. Bureaucratisation has proved counterproductive: beds have been cut beyond the bone and waits have blown out, but costs have continued to spiral, and full value is not received for the spend of taxpayers' money. Despite a 64% increase in funding over the last decades, public hospital bed numbers have remained static, and serious clinical distortions—the inverse care that the health system delivers—have grown worse as increasing numbers of patients have piled up in the corridors of overcrowded emergency departments.[55] Much of the extra funding has been squandered on additional bureaucracy and public sector wage increases.[56] The last decade in Australia has taught the same lesson as the Blair government's massive increase in spending on the British National Health System. By increasing funding, it is possible to transform a lower cost, low performing system into a higher cost, low performing system due to the lack of competitive incentives and market discipline in government-owned and bureaucratically run entities.[57]

**The solution to Medicare's structural inefficiencies is not as simple as saying the Commonwealth should contribute more to government spending on public hospitals and spend less on medical services.**

## Non-solutions and solutions

What the national bed shortage illustrates is the fact that Australian health services are unethically rationed. Given that no 'free' health system can provide all medical and hospital services on demand, the question then becomes how to ration care: whether it is done ethically based on relative need, and where, when and for whom subsidies for health care are provided. Under Medicare, health resources are misallocated, health care has been politicised, and health costs have been controlled by cutting corners in a manner that does the least electoral damage. Bulk billed GP and other medical services for the vast majority of voters is fully funded while expenditure on hospitals, which 'only' affects that segment of the population with serious health needs, is capped. This has left the majority of under-insured Australians reliant on a dysfunctional public hospital system that provides restricted access to rationed services. The outcomes are profoundly inequitable:

- The well, worried and well-off receive unrestricted, subsidised doctor visits, while the sickest and poorest wait for public hospital treatment and are excluded from private facilities.
- Rationing is performed irrationally and immorally based on electoral and not clinical criteria, and it occurs at the most inappropriate point in the health system in the form of elective and emergency queues.
- More Australians die each year due to overcrowding in bureaucratically mismanaged public hospitals than in road accidents.

However, the solution to Medicare's structural inefficiencies is not as simple as saying the Commonwealth should contribute more to government spending on public hospitals and spend less on medical services. The scarce resources the Commonwealth prefers for

political reasons to spend paying for GP appointments and other MBS services could be better used to meet unmet demand for hospital care, but only if these health dollars are spent effectively. That is a big if, given the waste and inefficiency in the bureaucratic state public hospital systems, which are incapable of either controlling costs or increasing productivity.[58] Furthermore, even if funding flows were reconfigured and spending on bulk billing curtailed, queues for free hospital treatment would have to continue. In the British National Health Service, fee-for-service general practice has been replaced with a capitation payment system, and choice of doctor has been limited by forcing patients to enrol with a local practice. Spending on medical services has been capped and access hereby rationed, but queues for hospital treatment remain to limit the total cost of the NHS.

The US private health system also teaches us that it is impossible to insure people for all health services without overuse causing costs and premiums to spiral.[59] To control costs, unpopular 'managed care' regimes have been established, which require patients to seek attention only from doctors who have a service contract with their insurer. To avoid arbitrary government rationing, much-resented restrictions on choice of doctor, or an unaffordable cost spiral, fundamental reform is required, which goes back to the first principles of a soundly constructed insurance system. An optimal structure needs to be put in place incorporating the following design features:

- Individuals should self-insure for minor needs, discretionary services, and more predictable health costs.
- Payment by third-party insurance should be reversed for purchasing high-cost and non-discretionary treatments for catastrophic and chronic illness from competing public or private providers.
- Personal responsibility, consumer choice, and price signals should be restored by using deductibles and copayments to control costs and deter unnecessary use of marginal services and procedures.

## Conclusion: Four principles of health reform

The challenges facing the Australian health sector in the twenty-first century are larger than but closely connected to the waste that is currently occurring on both the hospital and non-hospital sides of the health system. The federal government's *Intergenerational Report* predicts that the combined effects of population ageing, expensive new medical technology, and ever-rising consumer expectations will place unsustainable burdens on government budgets by 2050.[60] Given the looming 'demographic time bomb,' it would be madness to persist with an inefficient scheme that permits high spending on unnecessary medical care and squanders resources on hospital bureaucracy. For this is the reality of Medicare. Without change, the community will continue to forgo essential services while spending an increasing proportion of national income on services that don't improve our health. Under these circumstances, the most likely scenario, given the politics of health, is that governments will ration hospital care even more stringently to contain health spending.[61] The bottom line is that as long as Medicare is responsible for financing the health care of the nation, the 'free' public hospital system will remain a capped, supply driven one that limits costs by queuing. The health system will continue to fail to ensure timely hospital care is available for the 55% of Australians who do not pay for private health insurance.

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To avoid this fate, an informed national debate about health reform needs to focus on Medicare's design and structural flaws, and honestly discuss which services should and should not be subsidised to ensure health resources are efficiently allocated based on clinical need. The serious access problems and funding inefficiencies this monograph

has identified suggest the following four key principles that should guide the debate about the structural reform of the health system:

1. Scarce health resources and subsidised access to health services must be allocated on a needs basis to ensure timely access to essential hospital care.
2. Excessive, universal subsidisation of minor health expenses must cease, and most individuals must pay for these services out of their own pockets to prevent overuse, making appropriate use of personalised funding instruments (Health Savings Accounts).
3. Medicare must be de-monopolised and replaced with a soundly constructed competitive insurance system that properly protects people against the risk and high cost of exceptional health events, along the lines proposed under the Medicare Select health insurance 'voucher' scheme.[62]
4. To promote personal responsibility for health costs, and control usage of health services while avoiding arbitrary rationing, insurance deductibles and copayments must apply for non-chronic and marginal hospital care and be paid for out of personal 'health savings.'

The reform challenge does not stop there. To facilitate public hospital reform, the system must be de-bureaucratised and corporatised by placing each public hospital under the control of an independent board of directors. Each hospital board should have full administrative and budgetary control and be responsible for setting the price of its services in competition with other private and public facilities. These prices will be fully contestable by the insurers who, once Medicare is de-monopolised, will be responsible for purchasing hospital services on behalf of their members. The introduction of market disciplines and incentives into the public hospital sector will improve productivity and encourage innovations that lower costs and improve quality. As in other areas of the economy subject to structural reform, the community will receive more and better hospital services for what, as the cost pressures of coming decades hit, will be our increasingly scarce health dollars.

Straightening out the distortions that mar Australian health care is a huge and politically challenging task. The first step on the road to reform is for policymakers, stakeholders and the public to understand the reasons why the health system needs restructuring. Unnecessary use of minor services combined with hospital queues is an unhealthy mix, not only for taxpayers but for the sickest Australians each and every day. Many doctors, politicians and voters will resent the unavoidable conclusion of this monograph: the entitlement to bulk billed services should be consigned to the dustbin. But so long as we ignore the issues of resource allocation, coverage and equity that surround Medicare, the distortions that compromise the effectiveness of Australian health care will persist. Having recognised what the fundamental structural flaws are, the next step is to do the hard work of converting broad reform principles into practical policy proposals.

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