Three Essays in Disagreement with the Rudd Health System Intervention

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Since the publication of Scotton’s plan for Managed Competition there has been little discussion by Australian health economists of the relative advantages of Commonwealth domination of the health sector. As a result there is little Australian literature drawing upon economic theory and economic history to improve the quality of the debate and help politicians, commentators and the public place the Rudd intervention in a broader perspective. This is unfortunate as the policy has potentially greater significance than any other action taken since the creation of Medibank/Medicare.

The three essays I have written are opinion pieces’ written because I believe both theory and history suggest that Rudd is committing a serious error which will be potentially very damaging. However they are also written to provoke discussion especially amongst members of the economics community.
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Essay 1. The Rudd Reforms: A poisoned chalice in the long run

Abstract

The health reform debate has focused upon issues of short run funding and the promise of efficiency gains. However to achieve an effective and fair health system for future generations we should adopt a longer run focus. There are compelling arguments both from our immediate history and from some of the greatest proponents of political economy to eschew systems dominated by a single authority and to give people real choice. Improvement evolves by comparison between options, from error learning and information. Our health system is currently being driven in the wrong direction.

Synopsis

Rudd’s intervention in the health system shakes the logjam of Federal-State relations but other claims made for it are questionable. The distribution of taxes should adapt to the needs of the health system and not vice-versa; the DRG classification is a good idea but it is only a classification system. It will not integrate hospital, medical and other services. Queuing is the result of supply and demand and can occur with or without DRGs.

The intervention brings with it major risks. With a direct pipeline to relatively plentiful Federal funds 120-150 hospital groups will be devising stratagems for special consideration. States can build hospitals where they need votes and the Commonwealth will pay. They can run down mental, community and social services and let those cast out go to Commonwealth funded outpatient departments.

The chief concern has been articulated in the past by some of the greatest political economists. Their message is ‘do not trust monopolies’; the economy is a dynamic, organic entity which requires diversity, comparison and error learning. A government monopoly will give us error suppression. The track record of the Commonwealth Department of Health which will run the monopoly has been lamentable. It has performed poorly with respect to Aboriginal health.

adverse events, control of specialist fees, equity of access, and the integration of private health insurance.

Maybe Mr Rudd will change all this. But what about the next PM and the next? However, his own track record is not encouraging as judged by the process of this intervention. He received no evidence and serious argument from the National Health and Hospital Reform Commission to justify a government monopoly.

Diversity is possible. It has been discussed in Australia. It can co-exist with the de-politicisation of decision making. This is a better option than politically controlled monopoly.
The Rudd ‘plan’ for the health sector has similarities to the Howard intervention into Aboriginal affairs in the Northern Territory. Both appear motivated by a public expectation of action, any action. Neither was preceded by a detailed, public strategy or cogent argument for the form of the intervention.

The health system needs surgery but if a leg needs to be amputated then a good surgeon should remove the correct leg, not just any leg. A similar principle applies here. So why is Rudd proposing a Canberra monopoly of core health services and without, in reality, any publicly stated plan?

One claim is that the Commonwealth has more money. But we should work out the best way of providing health services and adjust taxes to support it; not jeopardise the health of Australians to accommodate an antiquated tax system.

The main argument has been that our hospitals are inefficient. Are they? And would the Commonwealth proposal improve them? Queues are too long. But it is the Commonwealth, not the States, that reduced its share of hospital funding. Reversing this would, of course, help. But this does not need the creation of a national monopoly.

Historically, tight budgets have forced internal hospital reform, and this led to queues. What then is the Rudd plan for overcoming the trade-off between internal inefficiency (low queues) and efficiency (high queues).

DRG case payments have been suggested as the panacea. They are a good (cost based) classification of patients but have been oversold. Victoria, for example, which first introduced this system, had a Casemix adjusted cost per separation of $4,172 in 2007-09 – 1.4 percent below the national average figure of $4,232. Variation between the major States is small (10 percent) and is largely offset by utilisation. Victoria’s actual per capita spending on public hospitals was above the national average.

Rudd’s proposal could exacerbate problems. The 120-150 networks will each fight to maximise their resources. States seeking favour in an electorate can simply build a new hospital, gain credit, and allow the Commonwealth to pay the yearly bill. States may scale back other services and hospitalise those with a medical/social/emotional problem. The Commonwealth will then pay.

History does not suggest that the Commonwealth is the key to efficiency. Its own track record in health has been woeful but concealed. Successive governments have failed to satisfactorily address Aboriginal health, fair geographic access to services, medical, pharmacy or...
pharmaceutical prices; and patient safety (adverse events); it has failed in its workforce planning, and the integration of private health insurance into the health sector. In part this has been due to the success of interest groups, and the Commonwealth government’s willingness to accommodate them. This is a major reason for depoliticising health, not for concentrating power with the federal government.

In contrast, many of the most important initiatives, including DRG funding, have been driven by the States whose capacity to innovate will be impaired by current proposals for their downsizing.

Rudd can argue that he is fulfilling an electoral promise to improve hospital services. But he would have known that this cannot be done quickly with shortages of beds, nurses, doctors and money. So calls for the States to do better were rhetorical. Magic wands are hard to find in the health system in the short run. Rudd would know this and that his magic wand is access to money denied to the States.

Rudd may (or may not) be more skilled and principled than previous leaders but the evidence is more consistent with a Commonwealth power grab than evidence based policy. And what about the next government, and the next? With monopoly control a future PM can wind back an ‘unsustainable Medicare’ (for example by introducing means tested hospital co-payments) to fund ‘necessary tax cuts’ – as we have seen the Commonwealth government do with pharmaceuticals.

The case for non-monopoly is compelling and has been debated now for 2½ decades in health and 2½ centuries in economics. Various countries have experimented with diversified health systems. But this has been ignored by the Rudd commissioned NHHRC¹.

The case is simple. In the long run progress depends upon innovation which is promoted by diversity and information. Technology has been the dominant driver of health benefits and costs for a hundred years and future technologies are largely unknowable. In this, the health sector is a microcosm of the wider economy and the great microeconomic message of the 20th Century is that enterprises that do not adapt and renew will fail. And the single greatest obstacle to renewal and flexibility is monopoly. (For a brilliant review of the 20th Century see Beinhocker²). This is also true in government. Rudd is on record as noting that ‘big departments become less accountable, less agile, less adaptable and more inward looking’³. But he is converting the country’s biggest industry into a monopoly to be run by an inexperienced department with a seriously flawed track record.

Diversity means that control and responsibility are devolved rather than held tightly by one master manipulator who (as Adam Smith, the founder of modern economics wrote) believes he can manipulate people like players on a chessboard⁴. Diversity means errors and error learning. Monopoly means errors and error suppression.

Proposals have been made in Australia to achieve coherent diversity (my own is in the article ‘Steering without Navigation Equipment’⁵). But discussion and decisions are being driven by short term budgetary consideration (who has the money) and undeliverable promises of quick fixes. But the best interests of future generations would be served by a depoliticised and serious examination of alternatives.
References


Essay 3. Is there a better alternative to a Commonwealth monopoly in the health sector?

Background

The NHHRC and Rudd intervention

The Rudd government’s National Health and Hospitals Reform Commission [1] report into the health sector did not take the core issues of governance, regulation and control seriously. While it considered an immense range of subjects it devoted just one page to the merits of each of three options in its draft and one page to all options in the final report. Its recommendations included a plethora of ideas to improve the health of the young, the old, indigenous Australians, and other elements of the system, all of which were to be implemented by some unknown entity with unknown incentives, regulation and governance.

Unsurprisingly, therefore, the announcement that Rudd will assume effective control of hospitals is not supported by evidence that this will be the best of the many possible options; nor does it consider the possible damage that may be done to the health sector. In fact, apart from the use of DRG Casemix funding of hospitals, the ‘plan’ revealed to date is little more than the beginning of a complete transfer of power to Kevin Rudd.

Its justification is the earlier electoral promise to intervene if States did not improve their hospital service and significantly reduce queues – something Rudd would have known at the time was highly unlikely given the shortage of doctors, nurses, beds and money – the former problems being a consequence of Commonwealth planning and the latter a consequence of the Commonwealth’s failure to transfer resources to the States. With years of experience the States have striven to reduce queues and it may be asked how Rudd can achieve this without a massive injection of funds denied to the States.

Nevertheless, there is a compelling case for rationalising the Commonwealth-State division of responsibilities in the health sector and for many years there has been almost universal agreement that a single level of government should be responsible for the sector. The most superficial complaint is the blame shifting which presently occurs. More substantively, the divided authority inhibits the coordination of services, organisational innovation and diverts bureaucratic creativity into cost shifting.

The issue would not be serious if Australia could boast an outstanding health system. But it cannot. Australians have good health but it is a logical error to attribute this to the way we organise and deliver health services. Numerous factors impinge upon health (nutrition, education,
etc). The quality and number of our health professionals are an important contributing factor but this does not mean that the patchwork delivery system uses them to our best advantage.

The recent debate has been supremely superficial. The dominating consideration has been the short run flow of monies and faith, or lack of it, in Kevin Rudd. But the most complex, costly and – for many – important sector of the economy requires more serious treatment.

**Arguments for monopolies**

There should be little need to document the problems arising from monopolies: it has been the subject of economics for 250 years and most western governments, including Australia, have established legal entities to break up arrangements which lead to an excessive market concentration. Depending upon the context, monopolies may sometimes be inevitable or the best available option, but such cases need careful justification and careful regulation.

What then is the case for creating the country’s largest monopoly under the direct control of an entity – the federal government – which cannot be regulated except by elections which occur infrequently and are the result of numerous other influences. The case has not been made or even properly discussed.

Centralised control has some attractions – ask any dictator. The comment is not flippant. It is easy to make mental pictures of how efficient organisations should be run if people follow ’The Plan’ – and this thinking may underlie the NHHRC report. It clearly underlies a common argument which takes the form that ‘the Commonwealth may...therefore the Commonwealth will...’ although the latter part of the argument is usually implicit. But it was the rejection of this type of thinking which first liberalised western markets and permitted the explosive economic development of the past 200 years. The mindset was encapsulated by the founder of modern economics: Adam Smith, in his famous statement that:

’The man of system ... seems to imagine that he can arrange the different members of a great society with as much ease as the hand arranges the different pieces upon a chess-board … but … in the great chess-board of human society, every single piece has a principle of motion of its own.’ [2]

Allowing flexibility and freedom for people to follow that ’principle of motion’ – or personal motivation – laid the basis for the growth of material and personal wellbeing.

Of course some regulation and restrictions are an unavoidable part of group living and the libertarian vision of universal and unregulated markets is as unrealistic as fundamentalism generally. However recalling the then revolutionary idea of Adam Smith is a useful warning to those who play mental chess.

There are, in fact, few parts of the society where the unregulated market is less applicable than the health sector and it is for this reason that arguments can be found for concentrating power. However the key questions, discussed below, are whether or not this means concentration with only one government and what checks and balances should apply.

The most obvious reason for a Commonwealth monopoly is that it may facilitate the achievement of equity – the same access to health services for all Australians – and avoid differences arising in different States. But not only the chessman but also the ’men of system’ do not always perform as envisaged. The Commonwealth government has controlled payments for medical services since 1974 and huge inequalities in the access to these services still exist. Different people
needing medical, pharmaceutical, and dental services are treated very differently. More generally, regions and population groups have different needs and preferences and a system needs the flexibility to treat people with differences, differently.

As seen below there are more powerful ways of achieving fairness than waiting for a remote bureaucracy to provide it.

The most common argument for a Commonwealth takeover at present is that the Commonwealth has greater fiscal resources and that health expenditures are likely to grow faster than State revenues. The argument is probably popular because it is simple. Hospitals are costly and the Commonwealth has a lot of money. The argument, however, is a poor one. From a long term perspective we need, firstly, to decide upon the best system of health delivery and financing and, secondly, how to fund it. This may mean ceding tax or tax powers from the Commonwealth to the States or elsewhere. The reverse – shoehorning the health system to match a dysfunctional tax system – jeopardises the health of future generations as it is unlikely that having taken over power from the States the Commonwealth will return it irrespective of the consequences, which can always be rationalised.

One gaggle of arguments concern the administrative savings from a single national scheme. The force of this argument depends more upon a conditioned dislike of words like ‘bureaucrat’ and ‘administrators’ than from evidence. No organisation can run without administration and the administrative costs of the Australian health system are about 2.7 percent of recurrent costs: 3.2 percent for the Commonwealth sector, 2.5 percent for the State sector and 11.2 percent for private health insurance [3]. Elimination of the entire health bureaucracy – public and private – would mean, apart from an anarchic system, a saving equivalent to about 7 months growth of health expenditures.

The more serious arguments concern the existence of possible economies of scale, the buying power of a monopsonistic Commonwealth authority the efficiency of the Commonwealth government and the (unmeasured) overlap which exists between levels of government. The latter is a non problem with any true clarification of governance and funding. Economies of scale certainly exist in the collection of tax revenues and use of Medicare Australia (formerly the Health Insurance Commission) to centrally process medical and pharmaceutical claims. But these technical functions can continue under a wide range of schemes with debits and credits electronically transferred to the budgets of multiple State or regional based systems.

It is true that successful monopsonistic purchasing may drive down prices. However the evidence is too weak to make this a strong argument. The medical sector is a Commonwealth responsibility but Australian private specialists’ incomes are 4.3 times higher than the average wage. This makes them the 8th most expensive doctors amongst the 21 countries reported by the OECD. In contrast, GPs have the second lowest incomes (after Hungary) with an income of 1.8 times the average wage [4]. This may indeed be the result of Commonwealth efforts to restrain benefit payments to less powerful doctors. If this outcome was desirable (which is questionable given the shortage of GPs) then centralised fee control could continue in a diversified scheme. However, successful negotiations are possible with smaller monopsonistic bodies than the Commonwealth. New Zealand, for example, buys many of its drugs of two thirds the Australian price [5].

Queues in State hospitals are undesirably long. However no conclusion can be drawn from this single fact. Queues are the outcome of demand and supply where supply depends upon the availability of doctors (Commonwealth responsibility), nurses (Commonwealth responsibility), money (Commonwealth dominated) and the extent to which private insurance and private
hospitals divert the workforce away from the public sector (Commonwealth policy). It depends upon the bed supply, where Australian States provide almost exactly the OECD average number per 1000 population (3.6 versus 3.8) despite a younger population. With these, slightly more discharges are achieved per 1,000 population (162 versus 158) and with a shorter length of stay (6.2 versus 7.4 days per patient) [4].

It is easy to build mental models in which the Commonwealth government is cracklingly efficient in comparison with recalcitrant States (see earlier comments on mental models). However there is little evidence to suggest this is true although the allegation is easily made. To the contrary the Commonwealth has a track record of multiple failures – the health of indigenous Australians, adverse events, workforce planning, program integration, equity of access, the integration of Private Health Insurance into the system.

The point is not to assign blame but to highlight the inevitability of error – human and institutional fallibility – in a complex system. The key question behind this essay is whether, given this, we create a politicised monopoly characterised by error suppression and spin or seek a de-politicised system characterised by error detection and evolutionary change.

**Alternatives to Rudd’s hospital scheme**

Decisions made now will affect the quality of the health service received by future Australians for decades. A major change in the balance of power will have a cumulative effect upon investment, goals, behaviours, and the culture in the health system. It might therefore have been hoped that such a major change as proposed by Rudd would have received at least the thought and discussion that would normally occur before the redesign of a soap powder label. But there is no evidence of this.

To date, most reform proposals have emphasised the achievement of an integrated system, de-emphasising the historically dominant role of the hospital and emphasising preventive and primary health care. No reform option has ever singled out and favoured hospitals alone.

The most recent comprehensive proposal was by Dick Scotton [6] who, with John Deeble, was one of the architects of Medicare/Medibank. Scotton subsequently concluded that Medicare had reached its ‘use by date’ and proposed an Australian version of Managed Care, the scheme which Clinton did not, but Israel and the Netherlands did implement, along with a number of European countries.

The structure and logic of the Scotton plan is simple and elegant. The system is primarily tax funded, as at present, but from one source, the Federal government. Each individual is assigned a dollar amount based upon their health and likely spending. This is the key to equity. The money is transferred to one of the competing public or private ‘Funds’ which organise all of the services for the individual, possibly by contracting. People who do not actively select a Fund are assigned to a geographically based public Fund. Individuals can attend any public facility as at present, but with the possibility of different copayments to encourage use of services contracted by their Fund.

The government’s role is to act as the regulator to ensure that a minimum package of services is provided and not subject to quality erosion. In principle, improvements are driven over time by competition: between Funds and by providers doctors, hospitals, etc) in an ‘internal market’ with the Funds.
The National Health and Hospitals Reform Commission (NHHRC) proposal for ‘Medicare Select’ is (without acknowledgment) ‘Scotton-lite’, ie the Scotton plan less detail and without the residual government Funds which would, initially, dominate the market in the Scotton conception. No substantive argument is offered for the plan and it is doubtful if it was intended as a serious option.

The idea of capturing the dynamism of the market is attractive especially when contrasted with the likely outcome of a government monopoly. In my view, however, the Scotton plan had two broad problems. First, there is an excessively large disjunction between the present and the Scotton scheme and its risks are too great for its adoption without a transitional stage from which we may or may not proceed after testing, trialling and preparation. The risks include the likelihood of ‘competition’ by marketing – cost effectiveness being replaced by ‘cost attractiveness’. This could result in the escalation of costly, marginal, or even harmful technologies. Added to the undoubted increase in administration, costs might easily outweigh the unknown benefits of competition.

Secondly, and related to this, information in the health sector is so poor, ambiguous and, at the individual level, variable in its interpretation that ‘competition’ by itself is a doubtful engine. In the market model and successful marketplace, information is conveyed by price signals but this cannot occur in the health sector.

My own suggestions address these two problems [7]. First, Medicare should be devolved entirely to the States or to large regions (500,000 or more) and its funding and regulation follow the Scotton plan (ie they would be Commonwealth responsibilities). States/Regions would provide or arrange the services and delivery model with great scope for experimentation and innovation.

Depoliticisation should be achieved by the establishment of statutorily independent ‘Health Authorities’ to govern the ‘Funds’ answerable to a single ‘Australian Health Board’ (AHB) which, like the Reserve Bank is statutorily independent but with a government determined Charter. Like the Reserve Bank the AHB would have powers to regulate and, if necessary, to intervene in the operation of Health Authorities. Market competition would not, initially, occur in this market but private health funds could provide services omitted from the Health Authority’s packages.

In the longer term experimentation with ‘carve outs’ of coherent markets could be undertaken in which private Funds provided whole of care health packages in competition with public Medicare.

The second problem – the engine of progress – how to make systems improve and deliver what we want - has been largely ignored. In the absence of effective price signals information should be provided by an ‘Australian Institute of Health Service Performance and Research’ (AIHSPR), a statutorily independent authority similar to the Australian Institute of Health and Welfare but with a different Charter. Its role (which I describe in detail elsewhere [7]) would be to seek and circulate all forms of relevant information. This would include the Health Authority’s success with respect to stated objectives, research into system performance, evidence of new technologies and successful ideas introduced overseas.

This data would be provided proactively, in an appropriately targeted form, to the public, the Health Authorities, health care providers, ill informed commentators and, importantly, the Australian Health Board which under defined circumstances could intervene to required change.

Public dissatisfaction would be registered and reported by the Health Authorities, the AIHSPR and the AHB. Members of the AHB, the penultimate authority could be appointed like High Court judges or members of the Board of the Reserve Bank. The federal government, the ultimate
authority, could change their Charter but this would be by Act of Parliament, requiring debate and public exposure.

My own schematic representation of this system in Figure 2 is similar to, but contrasting with Scotton’s schema (Figure 1). Rather than tracing the flows of money it emphasises governance and information. In the supply-demand schema of a competitive market, price takes central stage reflecting its pivotal role conveying information. In Figure 1 the AIHSPR takes central place for the same reason.

This is a skeletal outline of only one possible proposal. If the health of future generations of Australians is of importance such options should be broadly canvassed.

**Figure 1 Managed competition model: financial flows [6]**

![Managed competition model: financial flows](image-url)
Figure 2 Regulated regional care

Regulated Regional Care
Governance and Regulation

Federal Government

Australian Health Board
Stat. Ind like RB

Australian Institute of Health
Service Performance
and Research
Statutory Authority like AIHW

AIHW
Stat. Ind

State/Regional Health Authorities

Flexible Arrangements

Public or Private Providers

Note: AIHS fulfils role of the price mechanism

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