The unbearable weirdness of health care

Paper to accompany presentation to Australian Health Care Reform Alliance Summit, March 2018

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The rambling homestead – neither broken or cracked, but in a mess

The conference organizers pose the question "Broken or just cracked? Does our health system need to be rebuilt or can it be repaired?"

It's a tough question. In terms of gross indicators, we're doing reasonably well: it's certainly not broken. We do very well in life expectancy – among the most prosperous 20 OECD countries we are pipped only by Switzerland and Japan. We have some of the world's lowest smoking rates (Iceland, Norway and Canada do better), and as the government boasts we are leading the world in vaccination rates against human papillomavirus, meaning we will be one of the first countries to eliminate cervical cancer. In a 2017 study the Commonwealth Fund, comparing 11 "developed" countries, ranked Australia's health care in second place (the UK was in first place), marking Australia highly for outcomes, but comparatively poorly for equity.

We achieve this without spending too much money – at around ten percent of GDP our health care outlays are in line with most similar countries, and we certainly spend far less than Switzerland and the USA, both of which are highly reliant on private health insurance – an expensive and inequitable way to fund health care. American policymakers seeking reform of their expensive and outrageously inequitable model often refer to Australia as a good model.

On the other hand our obesity rates are among the worst – among similar countries only Finland, New Zealand and the USA have higher rates. Our asthma rates are high. We have high rates of avoidable hospitalization.

Within Australia there are wide disparities in the distribution of health care resources and outcomes. Aboriginal Australians, and people living in remote regions (often the same people), have health outcomes and lifestyles significantly worse than other Australians.

We should remind ourselves that we have the tremendous advantage of a young population. With a median age of 39 years, among the same 20 countries only the USA has a slightly younger population (38 years): the median age in most other countries is in the 40s – in the high 40s in Germany and Japan. We *should* be doing well in terms of both outcomes and costs.

In 2015 the Productivity Commission produced a research paper identifying many areas of possible productivity improvement in health. Its general message was that there needed to be much more evaluation – of technologies and workplace practices – and that such evaluation should be used to guide patients, practitioners and administrators who make decisions about therapeutical choices. Also it advocated removing some restrictive regulations, particularly those applying to retail pharmacy. It cited institutional and funding structures as impediments to productivity improvements, and suggested that large-scale reforms may be required "to make real and enduring inroads into allocative and dynamic efficiency".

That's an economist's way of saying we need to do what we're already doing better (improving *technical* efficiency), and we need to make sure we're doing what is most effective (improving *allocative* effiiency). For example, even if our hospitals are working at the best possible levels of

technical efficiency, it may be far better to allocate more effort to primary care, prevention and promotion rather than to hospitals.

So in response to the question, "Broken or just cracked? Does our health system need to be rebuilt or can it be repaired?" my tentative answer is that it isn't "broken"; it's still working. It's probably cracked, but bureaucrats have filled the cracks with plenty of spackle and plaster.

The more basic question relates to that word "system", and as one who has worked as an industry analyst I don't see a "system". The Australian Institute of Health and Welfare describes our health system as "a multifaceted web of public and private providers, settings, participants and supporting mechanisms". That's a polite way of saying it's a mess.

My metaphor for health care is an old rambling country homestead that's been extended and modified over the decades – sometimes when the fashion was Federation, sometimes when the fashion was minimalist, sometimes when the seasons were bountiful, other times when seasons were tough, sometimes when the family patriarch was a miser, other times when the patriarch was a spendthrift. To visitors the plumbing, heating and wiring are incomprehensible and the kitchen is a no-go area of vintage appliances and Heath-Robinson contraptions. It's all familiar to family members, who admit, however, that it bears little resemblance to what they would build today.

When one examines health care through the lens of an industry analyst it looks just as incoherent as an old country homestead. Weird in other words. The analyst sees an industry:

- with an anachronistic structure, organized almost entirely around the interests of suppliers rather than customers, with strong barriers to entry maintained by professional lobbies;
- in which funding is truly weird, with many sources of funds, bits of socialism, bits of free markets, bits of insurance, bits of user-pays, but with no coherence;
- which has been bypassed by the structural reforms which have transformed almost all other Australian industries over the last thirty years;
- in which, contrary to the trend in other industries, new technologies have been associated with cost increases;
- with strong quality control on inputs and procedures, but comparative neglect of gross indicators of quality.

Some may take offence at seeing health care as an "industry". Is not that too hard-headed, too instrumentalist? Are there not some special aspects of health care that set it apart from such crude analysis?

Health care shares with other industries dominated by professionalism and safety an understandable degree of risk aversion and conservatism. The airline and aircraft industries, for example, are extraordinarily conservative: don't be fooled by the glitz of their advertisements.

That means practices, divisions of labour and institutional structures, which were probably quite functional when they were introduced, tend to hang around past their use-by dates. They become reinforced in professional courses, and in laws and regulation. Those who work in health care soon learn to navigate this complexity, and in time take it all for granted.

There come to be significant personal and institutional investment in these ways of working. Many parties profit financially from regulations and practices which, in the name of safety, restrict competition. People who have spent years of study and have accumulated a wealth of workplace experience are open to developments within their professions, but can feel threatened by reforms which may change professional boundaries. That happens in all professions.

These practices, divisions of labour and institutional structures assume a permanence. Administrators, professional staff, users ("patients"), politicians and public servants become used to and comfortable with the way things work. It becomes hard for people to see their dysfunctions and inefficiencies, particularly their allocative inefficiencies.

It's hard to raise issues of allocative inefficiency in an industry where everyone is working flat out – generally overworking – and doing the best they can in the face of restrained resources. To illustrate the issue, in an area separated somewhat from health care, we may consider the good work police forces are doing in combating the supply of hard drugs, but it's fairly clear that the battle has to be won on the demand side.

So it is with health care: it's not easy to tell a group of hard-working dedicated professionals that a re-direction of resources may lead to better outcomes. But while some may see overwork as an indicator of professional dedication – and indeed it is – from a broader perspective it is a serious problem. Noone benefits from overwork.

The inertia of our health care arrangements makes change difficult. Change takes resources that are already stretched. Sometimes change comes about only in response to crisis, but crisis-induced reform is a poor substitute for carefully-planned reform.

There comes a time however in the old homestead when another re-wiring, another repair of the termite damage, another new roof, another renovation of the kitchen, won't do. There has be a re-design.

So, through the lens of an outsider, I will elaborate on these aspects of health care that look so strange to an industry analyst. I won't go into explanations about how they came to be this way.

1. Industry structure – a relic from times past

A provider-based structure

Imagine if, when your car needs repairs, you must go to one mechanic for a basic diagnosis and routine service, to another in an entirely different business for specialized service, and to a third type of establishment for major repairs. In addition, the mechanics are not permitted to provide parts; they may specify what parts you need but you must buy them from a specialized parts stockist – possibly while your car is out of action and you cannot get around. The parts stockist has better knowledge about parts than the mechanic, but is not permitted to gainsay the mechanic's

specifications. They are all quite separate businesses; in fact there are government regulations prohibiting most forms of business integration. Within each establishment only highly qualified mechanics can perform any service on your car; other staff, no matter how experienced, may not do so much as change a light bulb or windshield wiper blade.

The health care industry is burdened with the legacy of ancient customs. The separation of pharmacies from physician's premises, for example, dates to the Holy Roman Emperor Frederick II in 1280. Before there were enforceable laws on trade practices and consumer protection, such separation made sense because it overcame the conflict of interest which can arise when doctors sell profitable medications. And pharmacists did dangerous things with chemicals – best to have them separate.

Our public hospitals date to colonial times, generally as state-subsidized charities for the poor. Doctors worked in public hospitals on an unpaid honorary basis – a system of *noblesse oblige*, or as economists would say, they cross-subsidized public patients from high fees imposed on the well-off in doctors' rooms and in private hospitals. Those arrangements held until the middle of last century, when public hospitals became the more inclusive institutions we now know, but we still see remnants of the old culture in the differing remuneration practices in public and private hospitals.

Private hospitals have a completely different business model from public hospitals. While public hospitals operate as integrated businesses, with their own specialist staff, pharmacies and emergency departments, and provide training, for the most part private hospitals provide premises for visiting medical staff to ply their trade as independent contractors. There is little competition between private and public hospitals because of these differences and because they have almost completely different funding sources.

The Commonwealth, for its part, operates its own major programs, the Medical Benefits Scheme (Medicare) and the Pharmaceutical Benefits Scheme (the PBS) almost as entirely separate programs, with different budgets, different payments systems and different types of patient co-payments. Even the program databases are separate, which means opportunities presented by developments in data analysis – the big data analytical techniques that warn the map on your car navigator about likely congestion – are not used in health care.

There are obviously concerns for privacy in use of health care data, but in most areas of our lives where we interact electronically commercial firms and some government agencies already hold a heap of information on our personal lives. Is privacy in health care so important that we refrain to track repeated prescriptions of pharmaceuticals that may be used as feedstock for illicit drugs? And would people really object if data matching threw up possible health hazards, such as expiry immunity from a vaccination, or conflicts in prescribed medications?

Health care has many legacy structures, that are not always oriented to users' interests. There was a time when auto companies, for example, were organized around their input specializations – a casting division for all engines, a pressing division for body panels, an assembly division, a sales division etc. Such structures made sense when competitive advantage was based on exploitation of scale economies in manufacturing, but by the 1980s in most industries they had given way to customer-oriented divisions.

It was fifty years ago, in 1960, when Theodore Levitt of the Harvard Business School described a consumer-oriented transformation. Businesses which had previously defined themselves by the products they produced redefined themselves by the needs they satisfied. Gillette does not make razor blades; it provides services for skin care; Canon does not make cameras; it helps people record

images. And so on. This transformation is generally described as moving from a production orientation to a customer orientation.

The transformation was also recognized by governments. In the 1980s the Commonwealth moved its budgetary processes away from an input focus to an output and outcome focus.

Health care, however, has remained largely untouched by these transformations. It still has provider-based divisions.

From a consumer's point of view our health care arrangements are a mess, with physical separation of services, duplication of records (often resulting from minor misspellings), separation of partial records between different providers, split Commonwealth-state responsibilities, and a lack of continuity of care. There are high search costs, high bureaucratic costs ("transaction costs" in economists' terms), and high risks of conflicting therapies.

From a provider's point of view, however, our program structure could not be more favorable had the lobbyists designed it themselves. For example the Commonwealth Department has separate divisions for pharmaceuticals, medical services and private insurers: each provider group has an easily identified point of influence. In projecting health care expenditure in the *Intergenerational Report*, the Commonwealth's categories are still based on provider categories – hospitals, medical, pharmaceuticals and private insurance subsidies, as if these divisions are to persist in perpetuity.

"Patients"

It's a weird word. One thinks of passive compliance, submission, people *patiently* waiting for service. Then there's the word "beds" as an indicator of a hospital's capacity. Not "places", but "beds", with connotations of supine passivity.

Fortunately it's a long time since that model has dominated. But it still has some currency, particularly among people who believe a medical practitioner can prescribe a "cure", involving no more user effort than taking a few tablets. Why do two thirds of GP consultations involve a prescription for medications? Why do people on long-term stabilized medications – contraceptives, anti-hypertensives – need frequent GP re-authorization? Why do we accept that employers (and university lecturers) can make people who are suffering short-term conditions obtain a medical certificate – as if people have to have someone else tell them they have a cold?

In most industries consumer interests are served through price and quality competition. Those firms which do not adapt go out of business, while others take their place. Such "creative destruction", to use the terminology of Joseph Schumpeter, generally serves consumers well. Pan Am Airlines is long gone, Kodak no longer makes cameras, and Blockbuster video shops have quietly disappeared, but there is no shortage of airlines, cameras or ways to watch movies. As old firms go, new ones take their place, usually providing better products for consumers. (At least that's the economic model: in reality many poorly-performing firms hang around far too long.)

In some industries delivering human services, however, such creative destruction cannot not apply as easily as it does in other markets, because the establishments delivering services are fixed in place in relation to the customers. Hospitals are often local monopolies (what economists call "natural monopolies"), and have to stay open, even if their performance is sub-standard. To borrow a term from the global financial crisis, hospitals are "too big to fail".

Another problem in health care is that most consumers, most of their lives, have limited contact with health care, and, fortunately, the service they get is very satisfactory. They therefore have little

incentive to become involved in influencing public policy. The distribution of health care is skewed towards a few heavy users.

It is only if we have the misfortune to suffer a chronic condition or an accident that we become seriously involved with health care during our active lives. Otherwise our experience of health care is likely to be in our dying months or years, when we have lost the energy and motivation for political involvement.

In this regard, it is informative to compare health care with education, another large publicly-funded program. We all experience education in our youth and most of us have some involvement with our children's education through parents' committees, parent-teacher evenings, and, of course, feedback from our own children. In almost every country there are politically active university students with a strong stake in education. Health care has no broad consumer constituency, the only exception being provided by some groups with chronic illnesses who have regular and ongoing contact with health care providers – which means that among consumers, those with chronic conditions tend to command the most policy attention. Without strong consumer voices, provider lobbies find it easy to gain the attention of ministers and their advisers and to ensure public policy is dominated by their interests. Although Australia has some outstanding public health successes – seat belts and smoking as prominent examples – public health always struggles for support.

Otherwise the main stakeholders are professional groups, with an interest in the *status quo*, corporate interests who see health care as one of the few growth industries, and finance ministers and their advisers seeking to cut spending, often at the expense of cost-shifting to other tiers of government and on to compliant "patients".

2. Financing health care – bits of socialism, bits of markets, bits of insurance

Weird ways to share

One would hardly expect to find health care operating as a *laissez faire* unregulated market. It has too many departures from the economists' ideal markets which are characterized by low barriers to entry, well-informed consumers, clear indicators of quality and so on.

Also there is generally a public policy idea that we should have some way to share health care costs with one another. That belief may come from norms of social morality, from a realization that we all face the possibility of needing expensive interventions, or from a belief in the responsibility of government to provide a "social wage", which generally includes schooling and health care.

Whatever the origin, an observer of a country's health care arrangements would expect to find some mechanism of sharing at least the most expensive services. A society that embraces socialist principles may be expected to provide tax-funded free services, while one embracing more market-based principles may be expected to operate on a safety net basis, with people required to pay from their own pockets before the safety net operates. And whatever the mechanism, one would expect policymakers to have designed systems with low bureaucratic overheads and without incentives for over-servicing or neglect of those who cannot afford care.

What we find, however, is an extraordinarily confused set of arrangements – certainly not a "system". A GP consultation may be free if we can find a clinic with direct billing. Otherwise we are left paying the open-ended gap: Medicare pays only part of the bill and that's only the part with a clearly-defined price. Care in a specialist's rooms generally involves a high co-payment, while care from a similar (or even the same) specialist in a public hospital is free.

With private insurance it's even worse: apart from "no gap" and "known gap" policies the insured is left bearing all the open-ended risk. Financial corporations call themselves "heath insurers", but all they do is to pay a known part of the bill, leaving their customers effectively uninsured. There is little encouragement of risk-sharing, because government policy actually specifies quite low limits of excesses firms can offer.

Those who choose private insurance are subsidized between 26 percent and 35 percent for their premiums, while those who rely on their own resources and pay for private hospitals from their own funds receive no such support. This is a strange outcome, in view of the fact that private insurance has been supported and promoted mist heavily by parties on the "right" of the political spectrum, with platforms extolling the virtues of "self reliance".

"Private health insurance" isn't insurance, and it isn't self-reliance. It's simply a complex mechanism that sees competing financial intermediaries take fourteen per cent of contributions as administration and profit, compared with overheads of four percent if the funds had been passed through the tax system and a single national insurer with a capacity to exercise some control on service providers' charges.

It gets weirder still, because people with private health insurance are actually encouraged to jump queues for elective procedures, thus pushing everyone else back along the line, increasing pressure on government-funded public hospitals. (Quite opposite to the political rhetoric.) The government subsidizes, at a fiscal cost of $11 billion a year, a mechanism that adds stress to government-funded public hospitals.

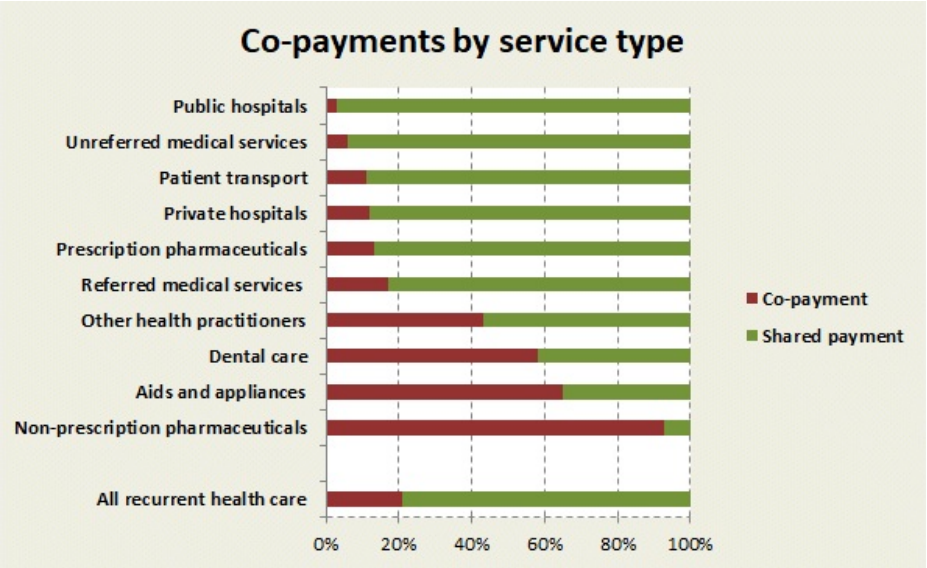
Yes, $11 billion, not the $6 or $7 billion journalists and politicians often cite, because there is another $2 billion identified in budget papers as revenue forgone because the rebates are not subject to income tax, and another $3 to $4 billion in revenue forgone by exempting those with high incomes from the Medicare Levy Surcharge (MLS).

The MLS provides a reward of up to 1.5 percent of income for people with high incomes who hold hospital insurance. Someone with an income of $500 000 enjoys a subsidy of $7 500 to hold private insurance, which leaves about $3 500 change after he or she buys the most expensive insurance on the market. Never in the days of high protection for our manufacturing industries was one given a cash subsidy proportionate to income to buy a Holden!

The incentives in the MLS exemptions are particularly weird, because they encourage people to take junk polities to avoid the surcharge – policies they never intend to use because they know they have the backing of good public hospitals. The insurers don't mind because they get some money out of it and it makes some sense within the present policy framework because there is no way those with private insurance could be shut out of public hospitals: private hospitals just don't provide the range of care people may need. But the overall policy makes no sense.

Then there are other funding mechanisms allowing queue jumping. Accident compensation schemes are separate from general funding schemes, and if you're a professional sportsperson who smashes up your body on the football field you'll get straight to the front of the queue for first class service, and be ready to go out and smash up your body (or someone else's) as soon as possible.

While private insurance provides the worst examples of weird and distorting incentives, there is plenty of weirdness throughout our health care arrangements in the balance between individual out-of-pocket payments and payments by insurers (Medicare and private insurers). The graphic over the page shows for different aspects of health the divisions between shared payments (mainly public expenditure) and individual out-of-pocket co-payments.



Out of all these services, apart from the free services of public hospitals and direct-billed services, the only one that involves genuine insurance principles, with people's risk limited, is the Pharmaceutical Benefits Scheme. All others, even the Medicare Safety net, can leave people bearing open-ended risk.

Co-payments are generally higher in areas not served by medical practitioners, most notably dentistry. It's hard to see the logic for its exclusion from Medicare. (Political historians explain its exclusion by reference to the fiscal struggles in the Hawke Government's expenditure review committee, but the purpose of this paper is to point out the weird and dysfunctional aspects of our health care arrangements, not to give them an air of respectability by offering political explanations for their endurance.)

Also, co-payments tend to be higher for lower-cost services. That may have some logic in that, being lower-cost, there is less need for third party support, but it can also result in people using expensive services in preference to others because the co-payments are low or non-existent.

Arrangements such as free public hospitals and direct-billing (so-called "bulk billing") have assumed a certain sacredness, as demonstrated in the 2016 federal election campaign, when proposals for a modest $5 co-payment for Medicare services met with strong resistance. An observer noticing the outrage may have reasonably believed that the whole community was impoverished, but the reality is that around two-thirds of Australian households have at least $30 000 in reasonably liquid assets, and older Australians on average have financial assets in excess of $100 000.

At the same time as people were grizzling about the proposed $5 co-payment, the established $40 co-payment for pharmaceuticals is simply accepted by the community.

Admittedly the $5 co-payment was seen as a wedge to break the Medicare model. That perspective, probably correct, illustrates the fact that there are no clear funding principles built into our health care arrangements, and that there is a deep suspicion of any government that tries to change funding arrangements. A $5 co-payment was going to wreck the cashless convenience of direct billing; once a doctor is collecting $5 he or she may as well collect $10 or $30, and once co-payments are high enough the health insurers' desire to cover GP and related services would start to look attractive. In Australia those who seek to destroy Medicare do it by stealth.

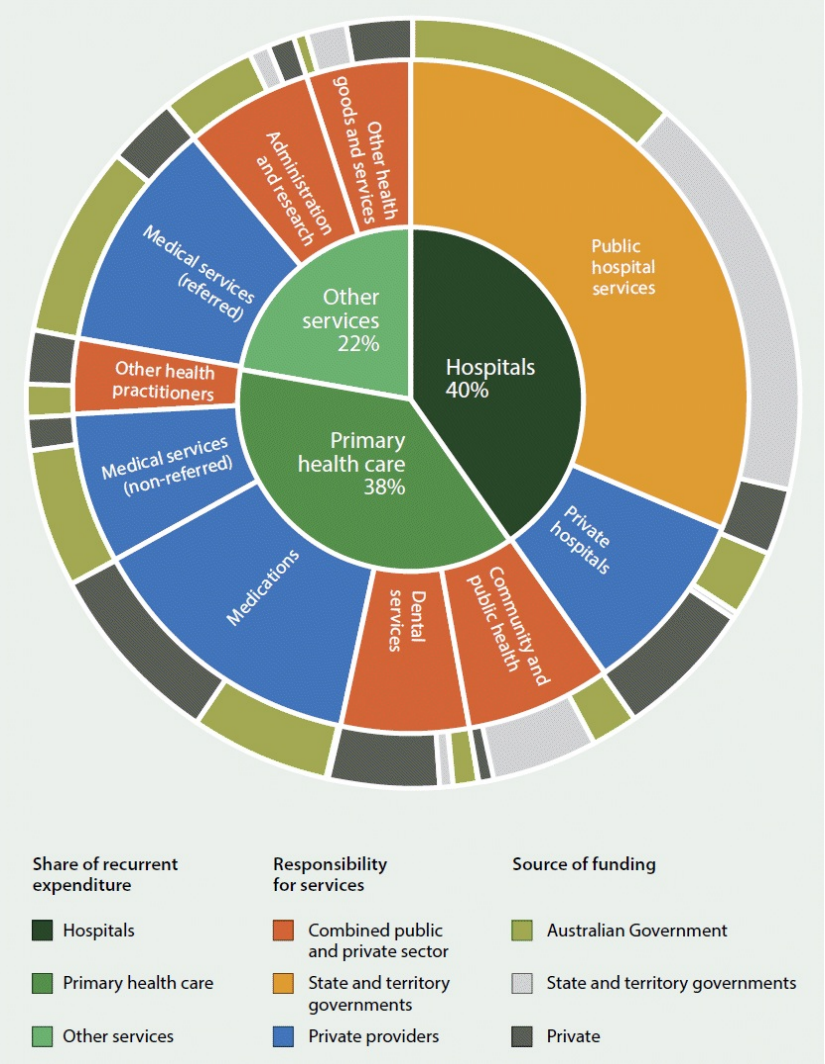
There may be good reasons for having different co-payments for different services, but they are certainly not explicit or understood by people who use health care. And it is highly unlikely that such complexity has come about through any process of intelligent design.

Just as one is tempted to choose rat runs to avoid road tolls, the existence of a mixture of free and priced services is bound to result in resource misallocation – overuse of "free" services, and under use of others. The insurance industry uses the quaint term "moral hazard" to refer to the over-use of a service that's free at the time of purchase.

Governments on the right promote private insurance on the basis that programs such as Medicare are becoming unaffordable, while conveniently ignoring the fact that private insurance is a more expensive way to fund health care than Medicare. Perhaps they believe that somehow, because private insurance is private, by some magic there will be a better allocation of health care resources, but moral hazard distorts all services that are free at the time of delivery. There is no difference between the thinking "Medicare will pay for it" and "BUPA/Medibank Private/NIB will pay for it.

Weird thinking.

Somehow we have developed byzantine and inconsistent ways to fund health care. The diagram alongside, copied from the latest edition of the AIHW publication *Australia's Health* gives us a glimpse into that complexity.



Each channel of funding, private or public, carries its own administrative costs. Each has its own boundaries, which means re-allocation of funding to improve overall system performance (if administrators can think in system terms) is likely to be resisted.

These complexities persist perhaps because health care has never had the benefit of basic structural reform.

3. Fifty years without scrutiny

A notable feature of the Australian economy over the last forty years has been a high degree of structural change, generally initiated by the Commonwealth Government. We have dismantled protective tariffs and quotas, implemented vigorous competition policy, privatized most public utilities, deregulated the financial sector and restructured indirect taxes.

Although many industry sectors, most notably manufacturing and finance, have been subject to substantial reviews, health care has never been subject to fundamental examination. There have been specific Productivity Commission Inquiries into aspects of health care, such as private and public hospitals, retail pharmacy and technology in health care, but health care as a whole, particularly its funding, has escaped scrutiny.

It is just on fifty years since the last significant review of health care funding. That was the enquiry headed by Justice Nimmo in 1969. The Nimmo Report provided the groundwork for the Whitlam Government's introduction of Medibank in 1974, the forerunner of Medicare embodying the principles of tax funding, universality and free or nominal charged service provision.

Since then there have been changes in health care funding, but such changes have not been supported by processes of research and consultation, such as the once-established green paper-white paper process. The Fraser Government essentially demolished Medibank, the Hawke Government resurrected it as Medicare (with a few changes), and in 1999 the Howard Government brought in a raft of incentives to support private insurance.

Those incentives and subsidies, which, in modified forms, still form the basis for support for private insurance, were based in part on a Productivity Commission inquiry. But the Commission was asked only about *how* private insurance was to be supported, not *whether* it should be supported.

The Rudd Government established the National Health and Hospitals Reform Commission (NHHRC) – but the Commission was restrained from consideration of the role of private insurance, and its chairperson was a senior executive of a health insurance firm. (Those who claim to have inside Canberra knowledge say that before the 2007 election Rudd did a deal with health insurers to exclude them from any inquiry.)

In an extraordinary statement Prime Minister Tony Abbott, speaking about the rebates for private health insurance, said the rebate "is an article of faith for the Coalition. Private health insurance is in our DNA". Such thinking accompanies an idea that programs such as Medicare are for the not-so-well-off, or the "indigent" to use the American term. There is something morally improper in the well-off using publicly-funded health care. Such thinking contrasts strongly with the universalist principles articulated by the Whitlam Government, but those who reject universalism don't articulate their principles. Rather they support measures such as the Medicare Levy Surcharge exemptions to establish a two-tier set of funding, without explanation. This means that the principles of public funding of health care – universalist or charity – never get examined.

Another article of faith, held by many journalists and promoted by health insurers, is that private hospitals can be funded only through private insurance. Occasionally, such as in the Abbott Government's Reform of Federation discussion paper, there is a suggestion that private and private hospitals should be brought together with the same funding models, but such heresies have short half-lives.

And there is an assumed permanence in the division of funding responsibilities between Commonwealth and state governments – a division that stands in the way of integrating primary

care with hospital care. There are respectable arguments for shifting most health responsibility to states (as in Canada), and there are respectable arguments for a Commonwealth takeover of state health care functions, but it would take an act of violence to the principles of logic and evidence to justify the current arrangements. We have a COAG process for referral of powers, and we have achieved some extraordinary reforms in the past, such as the wartime transfer of income tax responsibility from the states to the Commonwealth. But our present split funding model remains inviolate.

The Commonwealth's *Intergenerational Report* does look at health care funding, but its concern is only with the fiscal costs of health care. That is, the costs which pass through the budget. It has no concern with costs borne by state governments or by the community at large. It's a narrow fiscal approach, contrasting with the Productivity Commission reports into manufacturing, which were about the community-wide economic costs of industry protection: fiscal flows, such as budgetary subsidies and tariff revenue, were incidental considerations.

If there were general satisfaction with the ways we presently fund health care, our "don't-fix-it-it-ain't broke" complacency and incremental tinkering at the margins may be understandable. But people are far from satisfied with our health care funding arrangements, particularly private health insurance.

Dissatisfaction is mainly about two aspects of private insurance – rising real premiums and gap payments. While such dissatisfaction is understandable, it has two dimensions, relating to conflicting objectives. Competing private insurers have little capacity to control providers' costs: that's the fundamental weakness of a health funding model based on competing private insurers. So if they are to offer affordable policies they can do so only by offering policies with high, and generally open-ended, co-payments. Some insurers may enter preferred-provider arrangements with private hospitals, offering "no-gap" or "known-gap" policies, but then members complain about losing choice, which is one of the main reasons people hold private insurance. The insurers cannot win.

And that's the main point. They *cannot* win. They cannot reconcile these conflicting objectives in the way a single national insurer can. Although there is evidence that some large insurers may have breached consumer protection laws, the point is that even if the insurers operated with the highest imaginable ethical standards, they cannot do what a tax-funded single national insurer can do.

Some who are familiar with the Australian situation may suggest that the Commonwealth, too, is constrained in offering true health insurance, because they are constrained by the 1946 Constitution "conscription" amendment. That's why, the argument goes, the Commonwealth can apply proper insurance principles to the PBS, which involves provision of a physical product, but not to labout-intensive services. But the Commonwealth, or the states for that matter under revised funding arrangements, can provide clinics with offering free services or with defined copaymemts. That was the model of the Whitlam Goverment's community health centres, which got underway in Victoria and the ACT. Or they could contract such services to private cooperatives – they don't have to be government-owned.

As for the attractions of private insurance, a well-run government service can provide all the benefits people hope for (but don't necessarily get) from private insurance. The main attraction is "security, protection, peace of mind". The private insurers have failed on that count in a way that a well-embedded Medicare can. Choice of doctor is another attribute, and there are good economic reasons to allow such choice in cases where continuity of care is important – maternity and chronic disease management. And there is the attraction of private rooms, which should be a therapeutic

standard anyway. Just why the cost of a few partitions should stand in the way of protecting against cross-infection, and in the way of giving people the necessary comfort to make a speedy recovery and free up a place, is truly weird.

Before getting into detailed design, or peripheral questions about “private” or “public” insurance, we need to go back to basic questions.

A basic question that remains unasked is “to what extent do Australians want to finance their health care through shared arrangements, and to what extent do we want to take some personal responsibility through out-of-pocket uninsured payments for our health care?”. There are related questions about the choice between universalist or means-tested funding.

If these basic questions are put to the community, through a thorough process of consultation, with research outlining consequences for income distribution and taxation levels, we may be able to move to a better-designed and less weird system. Australians may opt for a “socialist” or “social wage” model with only nominal co-payments, such as Britain’s NHS, or for a safety net, along the lines of Sweden’s model where people have reasonably high out-of-pocket costs but the assurance of public funding for expensive services. They may opt for universalism or means-testing.

Then the question of mechanisms of sharing can be put, but it is unlikely that Australians, properly informed of the economics of insurance, would opt for private insurance as a means to fund health care.

When the Nimmo Report was presented in 1969 Australia was a very different society. Incomes were much lower and more equal. Life expectancies were 12 years lower. The health care task was mainly about acute conditions, often with stark binary outcomes of cure or death: long-term managed chronic conditions were less common. There were health insurers, but they were operating on a mutual not-for-profit model – and even then, as Nimmo pointed out, they were entrenching inequities into health care funding.

Fifty years is a long time to wait for reform.

4. High technology – in a cottage industry

In most industries we have seen new technologies bring about dramatic reductions in unit cost. The unaffordable luxuries of yesterday are today’s items of mass consumption.

For some goods and services declining unit costs and declining prices can lead to falls in total outlays, while in others they can actually lead to increases in total outlays.

In health care, the consensus view, reinforced by a rigorous study by the Productivity Commission in 2005, is that new technologies, while reducing unit costs in some cases, have generally resulted in increased costs in health care.

Health care has traditionally been a labor-intensive industry, but many new technologies, including drug therapies, have high capital or other sunk costs and comparatively low marginal or variable costs. The cost of developing a new pharmaceutical typically runs to hundreds of millions of dollars, while the variable cost per unit is very low. The manufacturing cost of a bottle of aspirin and a bottle of a new anti-hypertensive are not very different. There are similar cost functions for other technologies such as imaging.

Payment systems which rely on a fixed fee per service have some logic for labour-intensive services, but they are rarely appropriate for products and services with high fixed costs and low unit costs. When the manufacturer has a low variable cost but receives a high price absorbing part of the fixed costs, there is an incentive to over-sell.

On the other side of the ledger, where payments are made, the public servant or hospital administrator, concerned with containing expenditure, may impose quantitative restrictions on prescription of a drug or use of an instrument of diagnostic equipment. Such restrictions result in what economists refer to as “deadweight loss”, because the restriction results in a denial of profit for the supplier and of benefit to the excluded patient – a benefit which would have accrued had the price been lower but still sufficient to cover the variable cost. In health care fee-for-service reimbursement, often kept in check with quantitative restrictions, remains the dominant payment method.

There must surely be opportunities for smarter purchasing of products with high fixed costs and low unit cost. Technologies have moved on, but payment systems haven’t.

In its 2005 inquiry the Productivity Commission found that, with the exception of PBS pharmaceuticals and some diagnosis technologies, there is little use of rigorous technology assessment in health care. In fact, in general, while there is a great deal of rhetoric about “evidence based medicine”, its application in health care is confined mainly to the PBS. The Productivity Commission also found evidence that new technologies are not being used as cost effectively as they might be.

Where there is a huge technology deficit in health care is in the use of the management technologies which have become commonplace in most other industries. We would be very surprised to find that our electricity supplier or airline did not keep our details on electronic records and analyzed our habits with customer relation software. By comparison most of the health care industry resides in the industrial dark ages. It is only in the last few years that there have been moves to develop electronic patient records.

Furthermore, there is a whole class of possible new technologies clustered around the borderline between medical and management technologies, such as those which can monitor certain biometric information and transmit it from home to the person’s medical practitioner, or those which can detect a geographical cluster of health-related conditions. Other industries are well ahead of health care in developing protocols and standards to make best use of similar technologies and of big data. With 400 million Medicare services a year (a figure that doesn’t count hospitalizations) there should be plenty of data to feed ongoing evidence-based research.

Another practice which has become commonplace in most industries is the shortening of process time, most notably in what are known as Just-In-Time (JIT) systems. We have become used to rapid despatch of orders with on-line suppliers. Even the conservative book publishing industry is turning to printing on demand. Yet the health care sector is slow to take up improvements in process time improvements.

We do not even have estimates of the number of days people occupy expensive hospital beds, at risk of hospital infections, while they wait for test results to turn around. It’s extraordinary that in an age when we can have bespoke products made on the other side of the planet and delivered in a few days, and when we can have real time traffic data on our cellphones, that diagnostic test results can still have a long turnaround time.

To the observer health care and technologies have a weird relationship. Cutting-edge technologies are used in establishments with cottage-industry management systems. We find similar anomalies when it comes to quality control.

5. Quality control – health care as a health hazard

One of the stormiest political issues in recent times was the poor management of the Commonwealth's home insulation scheme. One unfortunate outcome of that scheme was the death of four insulation installers.

That figure should set a context for the number of deaths resulting from preventable adverse events in health care. A 1995 study of hospital patients in New South Wales and South Australia found that 17 percent of admissions were associated with an "adverse event", resulting in disability or a longer hospital stay. These were generally caused by individual or systemic problems in management, about half of which were preventable. In about five percent of all these cases, or almost one percent of all admissions, the patient died as a result of adverse events. That would indicate about 19 000 preventable deaths a year, not to mention permanent disabilities.

Similarly Jeff Richardson of Monash University cites research showing that around 25 patients in Australia die each day from preventable adverse events, suggesting an annual figure of 9 000 deaths.

As this range of estimates shows, it is difficult to estimate the number of adverse events with precision, but the number is high. A comparative perspective on these figures is provided by the 1500 motor vehicle deaths each year, which, quite reasonably, we generally consider to be too high.

In all cases – insulation, road safety and health care – governments are or have been heavily involved, but policy attention, or at least political outrage, seems to be in inverse proportion to the magnitude of the problem.

What should be of even more concern is evidence that, at a gross level, health care may be far less effective than we have been led to believe. In the debates about health care in the USA there has been a great deal of concern for the uninsured, most of whom are almost completely shut out of health care other than emergency room treatment. It has long been known that the uninsured have worse health outcomes than other Americans, but researchers from the University of California compared the health outcomes of the uninsured with those with insurance who had similar demographic and economic characteristics to the uninsured. They found no significant difference in health outcomes between the two groups. The reasons are subject to argument: it appears that those with access to health care do indeed benefit from care, but that in aggregate these benefits are offset by the harm suffered by those who experience adverse events.

Such evidence is not conclusive, but if it were manifest in any other industry it would surely prompt a major research effort and urgent development of corrective actions.

It is easy to rationalize high rates of adverse events and deaths. One rationalization is that they occur to people who, almost by definition, are not in the best of health and are likely to be older; it is therefore unreasonable to compare them with deaths resulting from construction or transport accidents, but such a rationalization cannot explain away such high figures. Another is that health care is intrinsically complex and therefore safety cannot be codified in routine procedures supported by high levels of redundancy, as can be done in airlines and similar technologically complex industries.

There are, however, means of making even the most complex operations safer. There are established quality procedures in what are known as "high reliability organizations", which are represented in situations as diverse as nuclear power generation and aircraft carrier operations. A culture of reliability is developed when there is trust and open communication, when accidents and incidents are traced back to systemic rather than proximate causes, and when there is more emphasis on tracing causes of problems rather than allocating blame. It is reasonable to ask if such a culture is common in health care establishments.

Another weird aspect of health care is that for most procedures, whether they are paid for by patients, private insurers or public insurers, payment is not contingent on the quality of the service. If, through misadventure, or failure of a treatment, a someone has to return to a clinic or a hospital, he or she will probably incur another outlay. Not many industries could get away with such a payment system. Even lawyers have adopted contingency fees for certain cases.

Conclusion

This paper is about what an industry analyst, an outsider, may find when examining health care. He or she sees something weird, in its organizational structures, in its payment arrangements, in its insulation from the pressures for economic reform, in its use of technologies, and in its quality control. There seems to be a great deal of institutional inertia in the industry.

There is no one model of a well-functioning industry, and every industry has certain unique characteristics that appear strange and dysfunctional at first sight, but which have some sound underlying logic. To the analyst there seem to be too many oddities in health care, however. Many may have had an underlying logic in the past, but their relevance has become questionable.

Some of these arrangements and practices relate to an understandable technical conservatism in an industry where a misadventure can lead to death or a lifetime of disability, but health care is not unique in facing such risks.

And some can be explained by fashions, political ideologies and fiscal conditions at the time policies were developed. But an explanation is not a justification, and the whole point of reform is to cut through these imagined impediments.

Our health care arrangements are coping, but they're carrying a lot of baggage, and they don't come together as a system. In many aspects, particularly public hospitals, they're stressed. The fiftieth anniversary of the Nimmo Inquiry is coming up very soon.