TALKING POINT

Health care financing in Australia: there is no solution

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I cannot accept that there is any single, all embracing solution to the complex social, political, and economic problem of how much, how, and on whom money should be spent in health care. As Californian economist Thomas Sowell says: "there may not be any 'solutions' (to social problems) analogous to academic exercises with prearranged happy endings and no loose ends dangling."¹

Since the Australian Labor party lost office amidst controversy in 1975 that government's Canadian style Medibank has been dismantled. Medibank is now one among many competing private health insurance funds and is no longer the tax funded monolith embracing every Australian. Most families pay nearly \$1000 a year to a fund, obtaining a tax rebate of 30% of the premium. Thirty per cent of any medical expense is met by the federal government, which also pays a small part of hospital expenses. (Pensioners are insured through the funds but pay no premiums; the government reimburses the funds for their expenses.) A growing number of Australians are forsaking this "first dollar" insurance, where the funds pay out on every dollar spent. Three private insurance companies offer cover similar to motor car insurance. For a family premium of only \$100 to \$200 the insured carries the first \$500 or \$1000 of expense, if any. Introduced in 1980, this type of insurance is opposed by the government and the established funds, who see it as inequitable.

Our problems are not that different from those in the United Kingdom. Because of the different system of funding, however, they have different implications—ever increasing labour costs, growing management and administration, too many beds in out of date hospitals, a universal demand for the latest technology, a surplus of doctors, unequal regional distribution of centres of excellence, fraud and misappropriation of funds, and conflicting ideologies on health care and its financing. All these are set against a background of diminishing national economic growth, rising unemployment, and high interest rates.

Competing claims

In the United Kingdom about 6% of the gross national product is spent on health care; in Australia we spend about 8.5%, while the Americans spend about 10%. All governments face competing claims on the national purse and must make political decisions about health spending. Most of the cost goes on hospital care. Only now are we beginning to consider some alternatives to inpatient care: day surgery centres and other day facilities and motel type accommodation for patients who do not need trained nurses 24 hours a day but are not yet able to cope at home, even with their family's help. But we run into trouble if we try to reduce the size of any entity that is a large employer of labour. So our politicians turn their attention to the less militant providers of service, the doctors. Labor party leaders have made the astonishing observation that most health care expenses are the result of decisions made by doctors. Armed with this revelation, they are seeking ways of limiting costs by limiting doctors' decisions to incur expense.

In the United States, professional services review organisations are widely in disarray, their cost benefit proving to be negative, many programmes have been ended, and President Reagan has recommended the repeal of professional service review organisa-

tion legislation.² Canada's governments have a neatly Gallic way of "topping" their doctors' earnings. They will pay a surgeon's fees for a certain number of, say, hysterectomies or tympanoplasties. After that number they decline to pay him for further operations of that nature. As Canadian doctors are paid entirely by the State (via the insurance programmes) it has the last word. It is hardly surprising that doctors have gone on strike in many Canadian provinces over the past year.³

We have not yet had anything so drastic in Australia. Our federal government has, however, emulated Pierre Trudeau in passing the health care buck back to the State authorities. Like the Canadian provinces, our State governments had a cost sharing arrangement with the federal government. Now the State governments receive their share of tax money and are left to spend it how they will. The federal government, responsible for the less expensive medical costs, is not yet sufficiently alarmed to impose any curbs, despite strong words on "cost containment" and its successful bullying of the Australian Medical Association into proposing an as yet undefined quality assurance programme. Because the federal government plays so little part in hospital insurance the State governments have been handed the hottest potato. Curiously, our Labor governed States have imposed massive charges for the use of public hospital beds, which, until a year ago, were free, while non-Labor Queensland is the only State offering free beds. In its struggle to impose regional equity the New South Wales Labor Government is disestablishing Australia's oldest centre of excellence, Sydney Hospital. The State authorities, faced with the massive burden of hospital costs, are using every manoeuvre possible to save money. Doctors attending public hospitals must be accredited, agreeing to abide by the hospital's bylaws, whatever they might be. Refusal by a specialist would mean loss of access to the centre of excellence; compliance means having to accept conditions of service repugnant to many. Even the private hospitals are being asked to submit, voluntarily, to accreditation. It is on the cards that those that do not will find that their patients are no longer eligible for health insurance benefits.

Drugs were once free. Then the price of a week's supply of antibiotics or a month's supply of digoxin became 50 cents. It will soon be \$4.00, at a time when the over the counter cost of most medicines is as close to \$4.00 as makes no difference. The federal government has saved handsomely on this scheme. (Pensioners still get their medicines free, but the selection has been severely curtailed.) Old age homes (nursing homes) are a giant headache. With the proportion of aged people steadily rising, we have a desperate shortage of accommodation for the infirm aged. But as this is not yet a vote catching issue it is hard to get anyone interested. Under the tight control of the federal government, which pays for all inmates, the proprietors cannot make sufficient profit to meet all the safety and health regulations set by federal, State, and municipal authorities. Some homes have closed for lack of funds to meet, for example, the regulations of the fire department.

Abandonment of "community medicine"

Though the concept of community medicine was beloved of the Labor government, which saw it as the answer to high medical costs, it was swiftly abandoned by the conservative Liberals after 1975. But it had already taken a battering in competition with private practice. No Tasmanian who saw it could forget the sign outside one community health centre: it

advised patients seeking care after hours to contact any of the local general practitioners. The centre was open for only 40 hours a week. Perhaps the funding and staffing problems could eventually have been resolved, but the events of Remembrance Day 1975 overtook Labor's medical economics. Community health centres went out with Whitlam.

We have even tried United States style health maintenance organisations, where doctors, free of economic anxiety, may dedicate themselves to caring for their patients without wondering whether their patients can afford it. The net income is split among the doctors and all are satisfied professionally and financially. The ideal has turned sour in the United States because the demand for services by patients is met by doctors' reluctance to incur additional expenses for the organisation. Underservicing becomes the order of the day as doctors strive to keep the organisation in the black. Disgruntled patients turn elsewhere, while the doctors, trapped in the system, find themselves indebted, at times to the tune of millions of dollars. As at December 1981, of the 253 plans in the USA, only 18 broke even and 127 survived by virtue of federal government subsidies. The remainder were in the red.⁴ Michigan Medical Major Health Plan's spectacular \$6 million collapse in January 1982 was perhaps the worst of many that have jeopardised the whole concept. Those that we have tried in Australia have not worked either.

A major problem with our first dollar health insurance system is that, with the payment of medical fees virtually guaranteed through the patient's membership of a fund, the chain store philosophy of "small profits, quick returns" has become entrenched: see as many patients as possible as often as possible to earn as much as possible. As a result, allegations of over-servicing abound, with both governments and the Australian Medical Association claiming that a few bad doctors are "ripping off" the system. The socialists in the profession are protesting that fee for service is encouraging unnecessary surgery and that nouveau riche doctors have been responsible, in large measure, for the enormous income tax evasion scandals recently uncovered by government appointed commissioners and now threatening to bring down the federal government.

On the credit side, however, computed tomography may be done in Sydney "the day after tomorrow" if it is not urgent, and "this afternoon" if it is. Pathology results are delivered by courier on the day the tests are done, with the exception of those that actually take a day or two to perform. X-ray examinations, other than those that need bowel preparation, are done on the day of request. Beds in the best private hospitals are a little difficult to find, needing a wait of a few days. Public hospital beds are downright impossible to find.

Bouncing between the politicians

The overall picture, then, is of a mixed economy, with the government the largest employer and empowered, through

statutory controls, to supervise most aspects of our "free enterprise" existence. We have experienced almost every variety of financing health care. Our national government, liberal in name but conservative in nature, committed to small government but making no headway in that direction, rivals seven State and territory governments that alternate reasonably frequently between Liberal and Labor, the latter having (Fabian) socialist aims for the financing of health care. Because of the tax sharing arrangements between federal and State governments the blame for the inefficiencies and waste bounces between federal and State politicians.

Australians, like Britons, Canadians, and Americans, often claim that they have "the best possible system." These patriotic posturings do nothing to help the debate. The truth, as I see it, is that we have a reasonably good system, bedevilled by some awful faults. So do the British, the Canadians, and the Americans (and the Swedes, the Belgians, the Dutch, the Germans, the French, the Danes, the Swiss, and the Italians). Striving by supporters of each system to achieve a monopoly for their ideal is a sure formula for continuing friction. Tolerance of one another's viewpoints on this highly emotional issue and a dedication to cooperation using many approaches is, I believe, the only way that we, in each of our countries, can improve on our systems.

Let me conclude with some words of Eli Ginzberg, perhaps the doyen of United States health economists. I suggest that these be hung on the wall above the desk of every "self styled expert about health care and health economics":

"An affluent democracy such as ours has the potential for using government to expand and improve the services available. . . . The odds are overwhelming that the major improvements anticipated from health reform would not be forthcoming unless the public were to concentrate most of its political energy and economic resources to this single goal. . . . The gains from such intense preoccupation with health reform will not repay the efforts required. It is better for a nation to moderate its expectations, shape its goals to its resources, and follow a path where it can continue to learn from experience."⁵

References

- ¹ Sowell T. *Knowledge and decisions*. New York: Basic Books, 1980:154.
- ² Anonymous. 15 PSROs fail—8 sent termination notices. *Private Doctor* 1982;11:2.
- ³ Arnold PC. Canada's doctors go on strike! *The Australian GP* 1982;15:7-8.
- ⁴ Garcia-Oller JL. The mythology of health maintenance organisations. *Iatrofon* 1982;5:1-2.
- ⁵ Anonymous. Monetarism and health. *Br Med J* 1982;285:914-5.
- ⁶ Ginzberg E. *The limits of health reform: the search for realism*. New York: Basic Books, 1977:213.

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GMC's Professional Conduct Committee

The General Medical Council's Professional Conduct Committee met in the weeks beginning 22 and 29 November.

The names of two doctors were erased from the Register. Dr Syed Nasir Ali Khan of Uxbridge, Middlesex, had issued numerous prescriptions for dipipanone hydrochloride in return for fees, otherwise than in the course of bona fide treatment. Dr Clifford Edward Salter of Barnstaple, Devon, had been convicted, after pleading guilty, on 12 charges of obtaining drugs by deception and one charge of unlawful possession of a controlled drug, and was sentenced to three years' imprisonment, varied on appeal to 12 months, of which nine months were suspended for 12 months. Dr Salter had also formed a sexual relationship with three patients. Both doctors were found guilty of serious professional misconduct.

Dr Nishat Rahman of Edgware, Middlesex, was found guilty of

serious professional misconduct and his name was suspended from the Register for eight months. Dr Rahman had issued National Health Service prescriptions for dipipanone hydrochloride to his receptionist in the names of patients of his practice.

Dr Ranjit Prasad of Wolverhampton had canvassed for patients. He was found guilty of serious professional misconduct but judgment was postponed.

Dr Paresch Suryaprasad Mehta of Oxford and Dr Andrew Philip Vickers of Sheffield were admonished. Dr Mehta had canvassed for patients and was found guilty of serious professional misconduct. Dr Vickers had been convicted, after pleading guilty, for attempting to obtain money by deception from the Avon Area Health Authority and the Frenchay Health Authority, and he was fined £300.