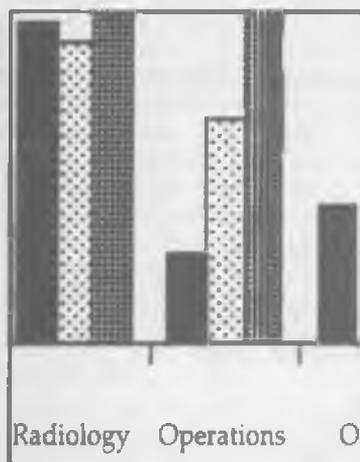


Health Wars

John Deeble is health services fellow at the National Centre for Epidemiology and Population Health at the Australian National University. Until 1989, he was a first assistant secretary in the Department of Community Services and Health. He is often described as one of the two architects of Medicare. He was interviewed for ALR by Julie Power.



You have described the budget changes to Medicare as ill-advised, unjustified and ultimately destructive. Do you still believe this?

Yes, I do, because I don't like watching the creation of a two-class system in Medicare, with one set of conditions for pensioners and one set for other people. I don't like Medicare being converted into a quasi-welfare system because it could lead to something like the pharmaceutical benefits scheme, with Medicare benefits restricted to old people and high users, and nothing for the general population.

So you think there's something in the 'thin end of the wedge' argument?

Well, I think what happened with pharmaceuticals was a good example. I always thought that was a signal that the same could happen to Medicare.

Can you explain what you mean when you say that this is the first step in making Medicare into a welfare system?

Medicare has been involved in managing a big industry, not just looking after the old and needy. It is necessary to do that, because if you are going to control costs, you need to control and influence all expenditure, and not just spending by the few people you are particularly responsible for. If you go chasing the prices and technology in the private sector, you'll end up like the United States: high expenditure and a lot of people left out of the welfare net.

Is that what we are looking at now for the future of Medicare?

To be fair, not yet. We are still a long way away from that. But the conceptual justification has been provided for doing it.

Going to the detail of the budget, has a copayment ever been shown to decrease demand?

Yes. Copayments do in every case decrease demand. They don't decrease demand as much as people expect, because what is a reduction in outlays for government is also a reduction in income for providers. And even though the providers may see less patients, they may increase the servicing of the patients they do see, to make up for the loss of others.

The Canadian and US experience has shown that there is some redistribution of services, because the new services go to those not deterred by price (mainly better off people), whereas the cuts affect mainly poorer people who are deterred by price.

Is there an arrogance in Brian Howe's comments that as the new charge is only a few coins, it won't make much difference?

He can't have it both ways. If it doesn't make much difference, it's just a revenue item. If it does, there is the possibility that it will make a disproportionate difference to the less well off. If you look at it as just a revenue item, then there's no argument that a flat rate charge is less equitable than an income-based levy contribution.

Are you surprised that the government didn't increase the Medicare levy?

No, not given the objectives of the Department of Finance. Its overriding objective was to cut government spending. Raising the levy doesn't cut government spending, it may increase it.

Is there really a need to cut demand?

Our usage growth since 1975 has been almost exactly in line with that of Canada. That doesn't mean to say that both countries haven't got some element of unnecessary servicing, there is some in all systems. The Australian system had kept costs under control because Australia had been gradually cutting medical fees in real terms, to make up for growing usage. So while use was rising, costs weren't. Obviously you can't go on doing that forever, and an alternative had to be sought, but user fees was only one option.

So where was the growth and how would you have tackled that?

Initially, the introduction of Medicare, bringing in 16% of the population not covered before, pushed up use by 2% to 3% beyond the previous growth rate. It slowed down after that to the same rate as in the previous ten years. In the last two years, the growth in GP consultations has slowed down very considerably. The big growth currently is in diagnostic services (pathology and radiology) and operations.

I would have been more cautious about tackling the GP side, because I think a plateau may have been reached. But I would have worked harder on finding incentives and controls in procedural medicine.

Should rising demand be accepted as part and parcel of having an increasingly sophisticated and wealthy population?

Australia has been remarkable in controlling health expenditure to about 8% of GNP for 15 years, almost the only country which has done that. People are more inclined to spend any greater wealth on health services than on other things, but there is more to it than that. Growth is technology driven too. For example, 20 years ago, relatively few 75 year-olds could face hip replacements with confidence - not because the operation was much different, but because anaesthetics and the control of risk factors, like heart conditions, were not really as good as they are now. Now replacement is a real prospect for many people, and it is not unreasonable for those older people to expect that they should have those services which, for technical reasons, were not possible before.

Do you see the dominance of the Treasury dry line accounting for the copayment getting up?

Yes, I do. It's a reward for persistence on their part, because they have been putting the same arguments forward since the beginning of Medicare. The form varies from year to year, but the import is the same. They always favour patient charges. I think pharmaceuticals was the big breakthrough. When the government cut it down to a fairly nominal scheme for anyone but pensioners and high users, that was a major victory for the econocrats.

Would you agree that Medicare is in a state of crisis?

No, I don't think it's in a state of crisis at all. Spending has increased as a proportion of all government spending only because other budget items have been cut. I see the social contract which the government has with the community over Medicare as being a contract to run an insurance system on the community's behalf. Only the government can do this effectively, because only the government has the power both to tax equitably and to bargain with the providers of services, which include the states and hospitals.

Which parts of the package do you endorse?

I don't know if it is proven that we have too many doctors. That's a value judgement. It is true that the number of doctors is increasing faster than the population, and we have to look seriously at migration and the output of medical schools.

I don't dispute what the government is doing in the restructuring. It will probably succeed because there is a sufficient number of doctors to whom it will be attractive. I would have argued, of course, that it could have succeeded without the copayment.

Does the fee for service system you set up encourage doctors to overservice?

Fee for service pays doctors for doing identifiable things. Whether that is overservicing in anything other than a financial sense is debatable. There may be no difference in the service the patient gets from two consultations rather than one, so measuring overservicing is pretty vague.

Brian Howe says he hopes the copayment will encourage people to use the phone more, stop them from going to see doctors for more peripheral things.

It will do that. A minor change like this will have little effect on base demand, and to that extent one shouldn't get too excited about it. I am less concerned about what this \$2.50 payment for bulk bill services will do now than what it means in legitimising a move away from national insurance altogether. The charge for non-bulk billed service will be around \$7.00, so patients will simply be looking for bulk billing doctors more. The difference will increase next year.

However, the other side of the coin is that it's hard to deny people the right to insure against a charge of this size if they want to. And while this government might be able to prevent it, the next government might be quite happy to concede it. Once there's a private and a public system running side by side, there is a big temptation for the government to pull out and return to the private system altogether.

JULIE POWER is a Canberra press gallery correspondent for the *Financial Review*.