

HEALTH AND EDUCATION: GOVERNMENT FAILURE

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Background

There is widespread dissatisfaction with the health and tertiary education sectors in New Zealand – dissatisfaction that has persisted for the past decade despite the reforms attempted during that period. In surveys, health ranks as the number one issue that people want the government to deal with. Education features high on the list as well.

Health and tertiary education did not always stand out in this way. Fifteen years ago there was similar dissatisfaction with shoddy and over-priced goods produced by New Zealand manufacturers, the terms of access to mortgage finance, poor service by airlines, six-week waits for telephone connections, queues for taxis, and much more. Most of this dissatisfaction has dissipated as choice and competition were introduced and governments pulled back from regulating and running businesses.

Some moves in the same direction were made in health and education, and even their critics acknowledge that there were important gains. Public hospitals have become more efficient and consumer-focused, universities and polytechnics have benefited from greater management autonomy, and tertiary enrolments have soared across all socio-economic groups, despite the introduction of fees. Perhaps the most dramatic gains occurred during the brief period when the accident insurance market was opened up to competition.

Moreover, in both health and education, dissatisfaction is mainly focused on areas where government involvement is pervasive. There is far less public concern with the primary health sector which is mainly private – a GP practice is typically a conventional small business – with private hospital services, and with the private education sector.

New Zealand's experience and that of other countries suggest that the reforms initiated in the 1990s were steps in the right direction. Decentralisation, moves away from political and bureaucratic control, the funder-provider split in health, competition and

consumer choice saw gains for institutions, health and education professionals and patients and students alike.

The problem was not that the changes went too far but that they were too timid, piecemeal and inconsistent, and they were eroded over time rather than taken further. The government has remained heavily involved in both sectors. The decision not to allow people to opt out of state cover and use their tax dollars to buy private health insurance greatly undermined the original health reform plan. Not surprisingly, the benefits of change have been limited, the transitional costs have been high and the sectors have remained heavily politicised.

The central problem: government-dominated systems

A few years ago, the late Albert Shanker, long-time president of the American Federation of Teachers (the main US teacher union), made a startling admission. "It's time to admit", he said, "that public education operates like a planned economy, a bureaucratic system in which everybody's role is spelled out in advance and there are very few incentives for innovation and productivity. It's no surprise that our school system doesn't improve: it more resembles the communist economy than our own market economy."

Shanker was speaking of US schools, where the key problem is the quasi government monopoly of schooling. In more recent years, however, there has been a seemingly inexorable trend in the United States towards independent charter schools, for-profit providers and school choice through voucher-type schemes. The Bush administration seems likely to give an impetus to this movement.

By contrast with its schools system, US higher education, despite some weaknesses, is universally regarded as the best in the world. Most commentators agree that key success factors include strong competition between institutions, the large number of private universities, and the relatively high level of tuition costs met by students at many institutions, which makes them demanding consumers.

The US health system, on the other hand, has more serious weaknesses. Contrary to perceptions that they are problems of a 'market' system, most of them stem from extensive government involvement (more than 50 percent of funding comes directly or indirectly from the government) and an out-of-control tort regime. Tax incentives and other regulations distort competition, and the predominance of third-party payments for routine low cost services such as doctor visits and prescription costs means there

are poor incentives to provide value for money. Nevertheless, the quality of US health care is typically high, waiting lists are seldom an issue, there are many mechanisms to cope with the needs of uninsured and low income people (contrary to some accounts), and overt attempts to move in a more socialised direction are routinely rejected.

New Zealand's health system, apart from primary care and elective private surgery, has much more in common with the nationalised health systems of Britain and Canada. Lord Beveridge, one of the architects of Britain's National Health Service, saw it as taking Britain "halfway to Moscow". The NHS provides poor quality health care and is plagued by queues of people waiting for treatment. Canada has similar problems, despite the fact that expenditure on health has risen sharply. Some waiting lists are as long as five years.¹ By 1998 only 20 percent of Canadians considered the system needed just minor change, compared with 56 percent in 1988.²

It is also interesting to note that in Europe private insurance typically plays a much greater role than in Britain, Canada and New Zealand, and that there are many more private providers. In France, one third of the hospitals are private, in Germany half and in the Netherlands 85 percent. Germany and Sweden have begun privatising some of their hospitals.³

From the consumer perspective, the problems with quasi government monopoly provision are well known. The limitations on competition and choice lead to poor quality services and high costs, as the ACC experience clearly demonstrated. The ACC reforms resulted in significant work safety improvements in a remarkably short period of time. When services are highly subsidised or provided for 'free', there is effectively no limit on potential demand and no way of assessing priorities and value for money. Services are rationed not by willingness-to-pay judgments but by denying care, queues and other dimensions of poor quality.

Less often commented upon are the comparable frustrations of professionals in NHS-type systems. True, provider capture exists, and some succeed in 'working the system' and earning inflated incomes. But more typically such systems are characterised by the instability associated with political control and changes of government;

¹ James Brooke, 'Full hospitals make Canadians wait and look South', *New York Times*, January 16, 2000.

² *NCPA Policy*, January 31, 2000, <http://www.ncpa.org/ba/ba311/ba311.html>

³ Annette Tuffs, 'Germany expects more hospital privatisation', *British Medical Journal*, April 15 2000. See also Heinz Redwood, *Why Ration Health Care? An international study of the United Kingdom, France, Germany and public sector health care in the USA*, CIVITAS: Institute for the Study of Civil Society, London, 2000.

bureaucratic red tape (eg ACC forms); uniform and often poor rewards through public sector wage structures; and increasing difficulties in attracting and retaining staff. Health care should not be like this: it is a field that attracts many able and dedicated people who should be able to apply their skills in entrepreneurial ways and be rewarded for their performance. The provider-capture problem has been overdone: both professionals and those they serve have common interests in a better system.

Is health care really special?

Most of the mistakes made in health policy come from regarding health services as somehow special and requiring different means of provision than the vast range of other services that people use every day. The fact that food and health care are essential to life led the Soviet Union to collectivise both, with the result that food shortages became endemic and the life expectancy of Russians is still falling. The reality is that, by and large, food and health care are standard, private goods. Most people can meet routine food and health expenses out of current income or savings. Insurance can cover low probability but high-cost health contingencies for the vast majority, just as people insure against the risk of damage to property and other similar events. Independent general practitioners, dentists, chemists, midwives, radiographers and, yes, hospitals can meet people's needs for health, just as farmers, restaurants and supermarkets meet their needs for food.

This does not mean there is no role for the government with respect to either food or health care. No one wants to see people deprived of adequate food or health care through lack of income, and where family and voluntary means are insufficient the government should provide support through the welfare system or direct subsidies. With both food and health care there is a case for regulation on consumer protection grounds - this includes some forms of professional regulation. With health, there are also some services that are of a public good rather than private good nature: these are things like basic medical research and public health.⁴

More detail could be added, but the essential argument is that there is no justification for the vast edifice of government regulation and control of health (and education)

⁴ Unlike private goods, public goods cannot be charged for directly and normally have to be financed from taxation.

relative to other vital services. Most people, most of the time, are capable of making decisions in their own interests; those who aren't, such as children, mentally handicapped or traumatised people and the very old have family, agents, guardians or professionals who take responsibility for them in general, not just for their health care needs. Situations that are specific to health and require specific solutions are relatively few and far between.

Depoliticising health and education

The basic strategy needed in both health and education is a winding back of government involvement and a more direct connection between those using the services and those who pay.⁵

In a less government-dominated environment, people on middle and higher incomes would pay directly for more of their health care, with offsetting reductions in taxes. Instead of one-size-fits-all approaches there would be more scope for experimentation between fee-for-service models, integrated care, a range of insurance options, cultural forms of provision, more internet-based medicine, joint ventures with other businesses (eg pharmacies in supermarkets), provision of services internationally and so forth. The possibilities are exciting, and there would be tangible rewards for successful entrepreneurs, as in other industries. The state could exit from many service delivery roles, perhaps through management and staff buyouts, but would maintain research, regulatory and targeted funding roles. ACC would be fully privatised.

Some people may object to a smaller government role on the grounds that the poor may not have the same care as the wealthy. But as Steven Schwartz, vice-chancellor of Murdoch University in Perth, points out: "This will always be true. The important point is that the poor do not benefit when the wealthy are kept from purchasing better care. In fact, just the opposite happens. Forcing the wealthy to pay more of their own health care costs should leave more money for the poor".⁶ And in a normal

⁵ For a fuller account, see David Green, *From Welfare State to Civil Society*, New Zealand Business Roundtable, Wellington, 1996; and Patricia Danzon and Susan Begg, *Options for Health Care in New Zealand*, New Zealand Business Roundtable, Wellington, 1991.

⁶ Steven Schwartz, 'Saving Australia's Health Care System: Nostrums or Cures', *Policy*, Centre for Independent Studies, Sydney, Autumn 1999.

professional setting, how many health professionals would not supply some services free or at a highly subsidised price where the circumstances warranted?

Currently both health and tertiary education policy are moving in the opposite direction towards greater central and political control. Many members of the medical profession have never been very comfortable with such efforts by governments over the years to make them effectively state employees. Experience in New Zealand and in other countries tells us that a 'more government' model is doomed to failure and that the sectors will be subjected to yet more disruptive change in due course. The lessons from higher education in the United States and health around the world are being ignored.

Health needs are personal and highly diverse, just like people's preferences for food. Even the funder-provider split was a very inferior solution. Imagine a Food Funding Authority allocating resources for food. We should cut out the middleman. There is no way people will get anything like the levels or types of health care services they want and are prepared to pay for through the crude mechanisms of periodic voting and political representation, as opposed to making direct buying and insurance decisions. It is a safe prediction that the sectors will remain plagued by complaints from dissatisfied consumers, low morale, political struggles, poor rewards and the loss of talented people.

Moves to 'normalise' health by dismantling an NHS-style system may seem remote at this stage. So too did the moves to competition, choice and private provision in many other industries 15 years ago, and until recently the ACC scheme was a national sacred cow. Over the next 15 years the frustrations and failings of government-dominated systems in education and health, together with the costs of increasing demand for higher education and the health implications of an aging population, will force similar changes. For the sake of both those who will need these services and those engaged in providing them, it is to be hoped that changes happen sooner rather than later.