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**NEW ZEALAND'S HEALTH SYSTEM: STILL
OPERATING BEHIND THE BERLIN WALL?**

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NEW ZEALAND'S HEALTH SYSTEM: STILL OPERATING BEHIND THE BERLIN WALL?

Question: What sets our health system apart from most of our other mechanisms for meeting our needs?

Answer: The Berlin wall.

This was the response of one of my economist colleagues to a presentation about New Zealand's health reforms a couple of years ago.

The presentation was by a committed health professional. He had been practising in one of our larger hospitals for many years. His description of the problems he had experienced was humorous, eloquent and convincing. It also poignantly conveyed the depth of his frustration and despair. One transparency showed a cartoon of himself trapped inside a small monkey's cage, unable to put his skills to effective use.

As I recall, he was concerned about the pursuit of commercial objectives for hospitals, the bewildering 'business speak' of his new managers who did not seem to understand how hospitals actually worked, and the 'new right' terminology behind the reforms. He could tolerate at a pinch the offensive concept of professional capture, but was worried that it had been elevated to a dogma that was overriding genuine professional concerns. In his mind the problems were due to the reforms, not the system. More money and greater professional control would solve the problems.

As I see it, there is no doubt that our two large nationalised industries, health and education, are major sources of community dissatisfaction. Yet we are still nowhere near to arriving at an accurate diagnosis of the problems and getting a consensus on effective solutions.

The greater professional control sought by our health professional could simply exacerbate concerns about professional capture and disempowered patients. At present, too much of the health sector looks like a closed shop. To what extent do our occupational licensing arrangements protect patients as opposed to providers? Do they block attempts to attract offshore professionals to New Zealand? Why do

we regulate to protect pharmacists from competition when other government agencies are doing everything they can to reduce the cost of pharmaceuticals?

More funding would not alleviate taxpayers' concerns about the absence of proper incentives to provide value for money in the health sector, as illustrated by periodic manifestations of gross waste in building programmes and computer systems. Nor can more money solve the problem that sooner or later all health systems have to deny services to some who would benefit from more treatment. The resources needed to provide health services are scarce and sometimes costly. Under all systems services must be rationed. No society could afford to spend millions of dollars prolonging for a few days, weeks or months the lives of each and every elderly or terminally ill patient. Harder, equally inescapable rationing decisions arise where the quality of life of someone with a chronic condition can only be improved at great cost.

In addition, members of the public have no peace of mind about what level of care they are entitled to receive in return for their tax dollars. Allocations become a matter of political pressure, and we end up with high-profile cases on the Holmes programme. More money cannot solve this problem either.

The health professional's presentation was well received by his audience. But my not unsympathetic colleague questioned his analysis. He wanted to ask why we have this idea that health services are so unusual that health professionals have to operate in a quite different environment from accountants, lawyers, architects, veterinarians and other professionals. The history of government failure is littered with mistaken attempts to treat issues ranging from agriculture to labour markets as special. Even vast tracts of the health sector such as the manufacture of pharmaceuticals, chemist shops, dental practices, laboratories and indeed most primary care are run on normal business and professional lines. Why do we somehow conclude that secondary care has to be a nationalised industry?

Professionals don't view profit as a dirty word when it accrues as professional income, and they commonly work for for-profit organisations. What is a GP practice if it is not a for-profit business? The profit motive once attributed to Crown Health Enterprises (CHEs) cannot explain why hospital professionals have to endure so much more frustration.

Why is it that a raft of factors sharply divide the hospital professional's position from those on the other side of the Berlin wall? In most walks of life, professionals can practice on their own or join a firm which may be run by non-specialists. If they are in a firm whose managers do not know how to get the best value out of their skills, their remedy is to find another employer, or start their own firm.

At least in a for-profit environment, professionals don't normally feel any serious frustration about the level of funding. The professional is there to supply the services that clients want to buy. Clients, professionals and their managers can agree about this. Whether professionals get funding for better facilities is essentially determined by their ability to persuade clients that the extra services are valuable and to persuade colleagues or managers that client demand justifies the expense.

In contrast, our hapless health professional has few choices except to try to pull the levers of a politicised and unresponsive system. His story reminded my colleague of the apocryphal tale of the Soviet factory worker who could not contain tears of frustration on reaching the age for compulsory retirement. He had not been permitted to do a decent day's work in his entire working life.

No doubt the factory worker, like our health professional, felt comfortable with a politically organised system, but wished that better people were in charge. In an ideal world that might be a solution. If governments, politicians and bureaucrats were perfect we wouldn't need private enterprise and markets. However, governments are not perfect and cannot be made perfect. It is no accident that they stumble from one folly to another when they take on too much.

The task of the public policy maker is to ascertain the point at which further government intervention is undesirable, taking the imperfections of governments and markets into account.

Governments should focus on the core activities of the protection of life, liberty and property and the provision of public goods that cannot be better provided privately. Examples of situations in which public good issues arise include defence, law and order, communicable diseases, basic research and environmental problems such as pollution. Governments also have a role in providing a social safety net.

The flip side of this is that, as a rule, private goods are best supplied and funded privately. Outside the public health area, most health services are private goods. The consultation with my GP and my hip operation are rivalrous and excludable – they do not satisfy the criteria of a public good. They deny someone else the opportunity to use the same services at the same time, and I can be excluded from the services if I do not pay.

This basic public policy analysis pushes us toward private provision and funding of most hospital services. There is a big gap between analysis and current reality.

When we look systematically at what the government is doing in health, the key features remind us of life behind the Berlin wall – near-blanket suppression of the price mechanism and dominant state ownership and control. It is true that New Zealanders have access to private health insurance, and that some hospital services are provided privately. Nevertheless, the Berlin wall analogy is apt. Lord Beveridge, one of the architects of Britain's National Health System, saw it as taking Britain "halfway to Moscow". Recent statistics support his assessment. British sufferers of a range of life-threatening conditions have amongst the lowest survival rates in Europe. A recent editorial in *The Sunday Times* ruefully observed that:

For many people with a life-threatening illness, the widely held view that the NHS offers a world-class service is tragically untrue. For those whose condition requires surgery, the shock of discovery is acutely distressing. International comparisons show the discrepancies clearly. British sufferers from breast and colon cancer have a lower chance of survival than in most of western Europe. Anyone with heart, respiratory or kidney disease is also at a disadvantage.

What are the systemic problems that arise when the price mechanism is suppressed and state ownership and control dominate?

The first problem is that without a price system it is impossible to determine the best use of a professional's skills. This is because there is no way of assessing value for money. The value-for-money problem arises because a state-controlled system faces two imponderables, the determination of cost and value. Take cost first. In the absence of competitively determined market prices, administrators don't really know the economic cost – that is, the opportunity cost – of the resources used in supplying services. They have an estimate of course, but it is based on arbitrary

allocations of common costs such as overheads. Only competition can resolve the problem of which allocation represents the true opportunity cost. But even if professionals and hospital administrators knew their true costs, they would not know whether the services represented value for money. This is because they have no ability to look inside patients' minds. Value is a matter of subjective judgment on the part of those receiving hospital services.

Another problem is that when the provision of services is determined through political mechanisms, patients are disempowered. Others decide how their tax money is to be spent. Power shifts to the politicians, bureaucrats, administrators or health professionals who make funding decisions.

This contrasts with the normal way we get the services we need. Applied to health, this would involve us meeting routine health expenses out of current income or savings. Health insurance could cover low probability but high cost events. When we pay directly or through insurance for services we are concerned to obtain value for money. Under a competitive system of private health insurance, people would be attracted to insurers that best tailored their policies to their requirements and could be relied upon to meet valid claims. Competition for premiums would force private insurers to address the needs of the insured rather than those of politicians or other intermediaries, and insurers would have incentives to keep the costs of services down.

Mandatory state funding further disenfranchises people by depriving them of the security of a legally enforceable insurance contract. The state takes our money in taxes but fails to give us any certainty about what it will provide in return. Private insurers could never get away with this.

Politicians and bureaucrats try to justify tax funding on the grounds that 'no-one should be deprived of necessary services because of a lack of money'. As already noted, this is sheer dishonesty. No nation can spend unlimited amounts on health. Worse, each dollar the government takes from us in taxes to spend on health actually reduces the amount the nation can spend on health by substantially more than a dollar, because the deadweight cost of taxes results in a loss of national income.

State ownership of hospitals also disenfranchises patients. There are several ways in which a government hospital system can retain patients even if it does not provide value for money. One approach would be to ban private hospitals – we have not gone this far. A second, more subtle, approach, would be to regulate them out of existence. A third is to make public hospitals free to the user, while depriving private hospitals of access to a comparable level of state funding.

Our state hospitals provide critical care facilities free to the patient. Private insurers do not have access to such facilities at this price and so cannot compete in this area with the public hospital system. This commercial reality essentially restricts private hospitals to the provision of elective and other non-urgent surgery. These services are rationed in the public system via queuing.

It is this feature that allows public hospitals to become local quasi-monopolies that limit the choices of hospital professionals and patients alike, even if they fail to provide very safe care or value for money.

The absence of a price system in the delivery of health care produces other perverse outcomes. Our subsidies bias decisions in favour of expensive hospital care and expensive drugs rather than prevention in the form of changes in lifestyle and earlier visits to general practitioners. For example, obese people with a tendency towards diabetes do not face health insurance premiums that they can reduce if they lose weight or stop smoking. People may delay consulting a general practitioner because they know they can get access to 'free' hospital care if the need becomes critical.

Our frustrated health professional, and many others working in politicised systems, are seldom very conscious of their inherent difficulties. They tend not to think 'outside the square' until the state becomes so over-committed that it can no longer sustain the system. In a recent book for the New Zealand Business Roundtable, David Green made the point that the welfare state subtly deprives people of their independence, leaving them feeling powerless and frustrated while not understanding why.

Green argues that a good health system would need to satisfy the 'three inseparables' that he sees as essential for a civil society. These are: personal responsibility to provide for oneself, one's family and dependants, and those in

need; voluntary association to achieve common objectives; and a government that is confined to maintaining the conditions for individual freedom and choice. Private hospitals, private insurance, private funding and private charities with a government safety net would conform far more closely with this prescription than a largely nationalised hospital system.

Rationing under private arrangements would be highly decentralised. First, risks would be pooled by private insurance, friendly societies, health plans and the like. Second, to the extent that insurance cover was not available, families would determine for themselves how much family wealth to commit to the care of one member at the expense of the rest. Third, voluntary organisations would ration their resources amongst cases that they regarded as deserving. The proliferation of options, arrangements and organisations would do much to depoliticise rationing decisions for much of the population. Individual cases of hardship would continue to make newspaper headlines, but private organisations could respond. The essential point is under a civil society, rationing decisions are spread much more widely around the community than under a politicised system.

The proponents of state ownership and control argue that it is unacceptable to ration health services according to income or wealth. But government funding and provision do not solve this problem. In our democratic society we cannot stop those who want to pay for more care out of their own pockets from doing so, whether or not they use private insurance as a vehicle. If necessary they can buy extra care overseas.

Reflecting on David Green's proposals, David Stewart, former dean of the University of Otago Medical School, has considered the degree to which greater reliance on personal and family responsibility and the role of the voluntary sector is a realistic option. He postulates that the persistent role of the state in health reflects widespread pessimism about the risk to which people could be exposed under a private system. However, he tends to agree with Green that the basis for these perceptions may not be strong. He suggests that if dissatisfaction with outcomes under current arrangements grows, public opinion may favour a reduced role for the government as a provider of hospital services before it would accept reduced state funding.

A shift to privately owned hospitals would appear to be very desirable. It is difficult to understand the ideological commitment to government ownership of bricks and mortar. Many of our health professional's problems can be attributed to the problems of working in a politicised system. The public good analysis provides no argument for such a policy. Some private hospitals might be for-profit, others non-profit, just as some insurance companies have been non-profit and others for-profit for many years.

If we also moved to put greater emphasis on private insurance, higher insurance premiums for higher risk people would give them an incentive to reduce risks by changing their lifestyles. Elements of co-insurance would reward the insured who avoided more expensive hospital care by an earlier visit to a GP.

Three questions about a system that relies more on private insurance must be answered. They concern the treatment of pre-existing conditions, those who cannot afford premiums, perhaps because they are already a high risk, and those who could have insured but did not.

- Those who are already ill with expensive conditions could be catered for as at present. That is, they would be state-funded and rationed through bureaucratic processes, although contracts for their care could be entered into with private providers.
- Those who could not afford premiums because of high risk relative to their incomes could have their premiums subsidised explicitly rather than implicitly as at present. However, it would be desirable that the subsidy was structured so as to give the recipients an incentive to increase their incomes and to make any lifestyle changes that would reduce their health risks.
- Those who could have insured but failed to do so and who failed to qualify for private charitable assistance would have to fall back on a minimum state safety net. They could be billed for the costs of services, perhaps with payment being a charge against future income. In hardship cases, rationing would have to be bureaucratically determined.

One of the most powerful reasons for relying more on private funding and insurance is that it would lead to far better decision making about the levels and

types of health spending that people really want. At present we largely have to rely on voting for the alternative programmes offered by competing political parties. This is a very crude mechanism for establishing people's preferences. With lower taxes and greater after-tax income, most people could vote with their dollars, spending them either on out-of-pocket health expenditures or on insurance. Rather than having to argue whether or not 8 percent of gross domestic product (GDP) is the 'right' level of health spending, the answer would be determined by the aggregate decisions of individual citizens, just as it is for other essential services like food and housing. The political process could then be reserved for matters that need to be decided collectively, like public health and the state safety net.

Finally, let me anticipate the objection that the approach I have talked about would 'Americanise' the New Zealand health system. This is purely political posturing. There is much that is good about the quality of health care in the United States, but there is also much to avoid. To the best of my knowledge, no one advocates an American model for New Zealand. Its excesses stem from the unlimited demands on it that result from Medicare and Medicaid, the tax deductibility of insurance premia, and excessively defensive medicine. The last is the result of a tort system that denies the sanctity of contract and allows outlandish awards of damages for opportunistic claims. Nothing in these excesses makes greater reliance on private insurance unsound.

A reorientation of health policies along the lines I have been discussing was outlined in a report for the Business Roundtable in 1991 by Sue Begg and Patricia Danzon on *Options for Health Care in New Zealand*.

As the aftermath of the collapse of the Soviet Union has demonstrated, there are many risks involved in dismantling a socialist system. We should see the problem of moving our schools and hospitals away from a politicised system in the same light. Half-hearted reforms that leave everything under state ownership and control and comprehensively suppress the price system are likely to produce disappointing outcomes. The ACC reforms have gone further in breaking down the state monopoly, even though they leave in place a heavy regulatory regime, and we are already beginning to see very substantial gains.

It is no surprise that the health reforms to date have caused so much frustration for so little gain. My purpose today has been to explain why the frustration that many in the health sector are experiencing is systemic. More money can paper over the cracks for a while, but it cannot alter the inevitability of rationing of expensive procedures and treatments, or the weaknesses inherent in a system which lacks the incentives and disciplines in the systems we use for meeting most of our other needs.

My main message is that we should stop looking across the pre-1989 Berlin Wall for our model of how to organise hospital care. Where private goods are involved, the standard mechanisms that we find in the private sector outperform political mechanisms in meeting the community's needs. And such an environment, in my view, would provide far more personal satisfaction for health professionals, and greater scope for them to be innovative and enterprising and see their human capital properly valued. It is the most promising escape route from the monkey's cage.