

Can we sustain health spending?

Australian governments currently spend relatively little on health. Are cutbacks really what's needed?

The assertion that health spending is unsustainable has been made with remarkable regularity, most recently by the Federal Minister for Health, Peter Dutton.¹ Despite publication of a major review by the National Health and Hospitals Reform Commission² less than 5 years ago, the Minister has called for a far-reaching debate about the health system.³ Consistent with the rhetoric, the recent federal Budget has introduced copayments and foreshadowed cutbacks that are expected to reduce federal health spending by \$8.6 billion over the 4-year forward estimates.⁴

The evidence usually cited to demonstrate the unsustainability of health spending is its impact on government finances. Between the 2001–02 and 2011–12 financial years, health expenditures by all levels of government rose from 19.8% to 25.6% of total tax revenues,⁵ and projections by the National Commission of Audit prior to the recent Budget suggested that federal spending alone could rise from \$65 billion in 2013–14 to over \$120 billion in 2023–24.⁶ These trends are commonly linked to the ageing of the population to conclude that significant structural reforms are needed to reduce spending on health services, and the recent budget measures may be seen as a first step in this direction.

Despite these projections, the unsustainability thesis is remarkably weak. Economies are flexible and the composition of spending varies significantly over time and between countries. At the time of federation, agriculture, manufacturing and the services sector accounted for 19%, 12% and 31% of gross domestic product (GDP), respectively. By 2011–12, the shares were 2%, 6% and 56%, respectively.⁷ Technological change reallocates resources, and the expansion of industries is usually seen as desirable because it employs the displaced workforce and generates additional benefits. The anomalous concern with the costs and not the benefits of an expanding health sector implies comparative lack of concern or confidence in the benefits despite evidence that better health is one of the diminishingly few ways in which we can improve the quality of life of the population.

The flexibility of economic systems is also apparent when countries are compared. Australia currently devotes 9.5% of GDP to health, while the proportion in the United States has reached 17.7% (Box). The efficiency of the US health system may be questioned, but there is no suggestion that it has impaired the economy or sapped the vitality of the country.

The US case is interesting for another reason. Despite having the largest health expenditures in the world, when compared with the wealthy countries

of the Organisation for Economic Co-operation and Development (OECD) the proportion of the population above the age of 65 years in the US is the smallest. In contrast, the country with the oldest population – Japan – spends little more than the OECD average on health. This illustrates a common error: the belief that health spending is tightly linked to the demographic structure and that ageing necessarily drives health expenditures. Historically, this has not been true, as health expenditures have been driven by technology and the increasingly generous provision of health services as GDP rises.¹²

Nevertheless, the pressure from ageing is likely to intensify. By 2050 the proportion of the population above 65 years of age in Australia is likely to rise from 14% to 22% and the proportion over 80 years to double from 4% to 8%.⁸ The pressure is likely to be exacerbated by expensive health technologies targeting individuals rather than broad disease categories. However, even with the slowing in the rate of per capita GDP growth to the average 1.4% per annum that occurred between 1970 and 1990, by 2050 GDP per capita will expand by 65%. Even if total health expenditures rose to the US level of 17.7% of GDP there would be an expansion of non-health-related per capita GDP of 50%, which could be devoted to the improvement of the material standard of living. This is not a paradox. Even if GDP grows more slowly than health expenditures, the absolute (not percentage) increase will be greater than the absolute increase in health expenditures. A 65% rise in GDP from a (index) base of 100 will increase resources by 65 points. A 200% rise in health expenditures from a (index) base of 9.5 increases resource use by 19 points. Resources for other uses would rise by 46 points. Given the evident sustainability of health spending for some decades, it might be asked why health has been targeted for cutbacks. At 6.6% of GDP, public health expenditures by all governments in Australia are the tenth lowest of the 33 countries in the OECD database and the lowest among wealthy countries in the group (Box). Even US governments, which channel 8.3% of GDP into public health programs, outspend Australian governments. Further, as indicated in the Box, Australia has been relatively successful in restraining the growth of health spending.

A possible reason for the Minister's concern is that, irrespective of comparative statistics, health spending in Australia — or public health spending in particular — may be inefficient. For example, a survey by Runciman and colleagues¹³ found that compliance with indicators of appropriate care was highly variable as judged by a retrospective review of medical records and telephone interviews with at least 1000 Australians. However, neither this nor the many other problems with the organisation and provision of services are likely to be resolved by increased copayments or reduced public

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Health spending, older population and taxes for selected countries

	Total health spending*			Public spending		Population aged 65+*	Taxes†
	1980 (% GDP)	2011 (% GDP)	PP increase	2012 (% total‡)	2011 (% GDP§)	2011 (% total)	2012 (% GDP)
Australia	6.1%	9.5%**	3.4	69.7%**	6.6%**	13.7%	26.5%††
France	7.0%	11.6%	4.6	76.9%	8.7%	17.1%	45.3%
Canada	7.0%	11.2%	4.2	70.1%	7.4%	14.7%	30.4%
Japan	6.4%	9.6%	3.2	82.5%	7.8%	23.3%	28.6%
Sweden	8.9%	9.5%	0.6	81.7%	7.7%	19.3%	44.2%
Netherlands	7.4%	11.9%	4.5	79.8%	9.5%	15.9%	38.6%
United Kingdom	5.6%	9.4%	3.8	82.5%	8.1%	16.2%	35.7%
United States	9.0%	17.7%	8.7	46.4%	8.3%	13.2%	24.0%
OECD	6.6%	9.3%	2.7	na	na	15.4%	34.1%

GDP = gross domestic product. PP = percentage point. OECD = Organisation for Economic Co-operation and Development. na = not applicable. AIHW = Australian Institute of Health and Welfare.

*OECD.⁸ †OECD.⁹ ‡World Bank.¹⁰ §OECD.¹¹ **AIHW.⁵ ††2011 figure, as 2012 figure was not available.

spending. Both options would increase pressure for private health insurance (PHI) to cover the gap, and there is little or no evidence that private insurers would be more willing than the public sector to undertake the reforms needed to improve the quality of care. In principle, managed care might be used by private health insurers to achieve this goal, but the evidence of its success is limited and it appears unlikely that this is an option that Australian governments would be prepared to pursue, at least in the short run.

It is possible that copayments are seen as a way of controlling total costs; however, the effect of the recent budgetary measures on economic costs — resource use — will be miniscule. Evidence unequivocally indicates that copayments have a relatively small effect on service use. The \$6 copayment initially proposed by the Australian Centre for Health Research¹⁴ was estimated to reduce service use sufficiently to save \$750 million over 4 years — 0.3% of federal health spending, 0.14% of total health spending. The greater part of the 4-year federal budgetary saving of \$5.5 billion on Medicare Benefits Schedule items and \$866 million from the Pharmaceutical Benefits Scheme will therefore be a result of cost shifting to the public, not reduced service use. However the burden of private spending falls unevenly on the public: it self-evidently falls on the sick. Bulk-billing primarily assists those who are on a low income. The principle effect of its elimination will be a redistribution of income from this group to the healthier, wealthier members of the community. Copayments will, additionally, divert patients from lower-cost general practitioner care to higher-cost outpatient care. Those who defer needed treatment are likely to eventually need more expensive specialist care.

Perversely, in the longer run, eliminating bulk-billing is likely to increase GP fees and expenditures by reducing competitive pressures. An increase in the copayment from \$7 to \$10 is less likely to adversely affect an individual GP practice than the cessation of bulk-billing and the initial introduction of a copayment. Inflation of fees will be accelerated when the government succumbs to pressure to allow PHI to cover the widening gap. Increased GP fees may be independently desirable given the low level of GP

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incomes — the lowest relative to average wages listed by the OECD after Estonia and Hungary. However, a more equitable remedy would be to increase, not decrease, the rebate.

Reduced budgetary expenditures are not a necessary response to unsustainable spending or a solution to demonstrated inefficiencies. Rather, they are a response to budgetary pressures arising from inadequate tax collections and the failure of successive governments to implement suggested reforms. The 26.5% of GDP raised by all forms of taxation in Australia in 2012 was the fourth lowest of the 34 OECD countries after Chile, Mexico and the US. Proportionally, Northern European countries collect 40%–75% more than Australia. The result of lower taxation is lower levels of community services and infrastructure, and a long-term structural problem for government finances — outcomes which are strikingly evident in the US.

The damage to be inflicted on the health sector by reduced public spending is part of the price Australians will pay for the persistent failure of government to address this problem and to raise taxation to a level that allows improvement in the economic infrastructure, better community services and spending on all of the health services which — after careful evaluation — have been shown to provide cost-effective health benefits to the Australian community.

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