

A comment on the response from Graham Wright

Graham Wright's letter raises a number of issues about the current Australian health care system. Wright implicitly questions the homogeneity of the responses from the economist contributors. This homogeneity should not be surprising if one considers the premises and approaches of the discipline.

The nostrums from economics, of course, should not determine health policy. Decisions about the role of the private sector in the health system are as much about ethics as about economics. In Australia, we have basically decided that some sorts of choices in the health system should not be subject to determination by markets. We have decided that it is illegitimate for the organ donation system to be run on a for-profit basis, that is, decisions about allocations of organs for transplantation are made on a clinical basis rather than some form of auction.

Different people in Australia will have different views about what sorts of health care decisions ought to be made within a market context, and what sorts of decisions ought to be made outside the market, normally in the public sector. Different value positions will also inform what is seen as appropriate or inappropriate in the public/private mix and to what extent subsidies are seen as appropriate. Consider possible arrangements for elective surgery. In one system, everybody in the country has a six-week wait for elective surgery. In an alternate system, some people have a six-month wait and some people, who are able to purchase faster access, have a two-week wait. Is one system more ethical than another? Is one system illegitimate? In part the answers to those questions might depend on where you sit (are you one of those who can afford the faster access?) and in part, it might depend on the size of the difference in the waiting list between the slow group and the fast group. If the slow group wait was six years instead of six months, people might have a different perception.

In broad terms, the Australian public have accepted differential waits for access to elective surgery for people who can pay more relative to others. They have also, in recent years, accepted that it is reasonable to subsidise both groups. The slow treatment group gets a 100% subsidy (via public hospitals), the fast treatment gets a subsidy of around 30% via the Health Insurance Rebate.

There is also an economic overlay to the choices about subsidy and the role of the public and private sector. Economics, sometimes called the dismal science, is a discipline about choices. Fundamental to the economic approach to choices is clarification of objectives. One of the issues about the Health Insurance Rebate is the question of what is the rebate trying to achieve? When it was first introduced, the government claimed it was designed to reduce demand in the public sector. This then leads economists to think about whether the rebate is the best way of supporting the public sector. Most economists conclude that it is not. If on the other hand, the rebate had been cast as a way of supporting the private sector, economists might have judged the efficacy of the rebate differently. If it was assumed that there was to be public funding for the private sector and the objective was to maximise the number of people who would use the private sector, then the choices would be limited to subsidising health insurance, subsidising private hospitals directly, incentive payments on surgeons, etc. The rebate might be seen as the best way of achieving that objective.

Few economists would question whether there is any role for the private sector. Most economists believe that there is a role for the private sector in providing services at a higher amenity level than the public sector provides and that it is ethically and economically reasonable for some people to spend their private money to purchase faster access to care. There may be differences amongst economists as to whether it is legitimate to subsidise the faster access.

Also fundamental to an economists' way of thinking is that if society spends a dollar of income on product x, it is not available to spend that same dollar on product y. This is known as the opportunity cost of a decision, that is, in considering the cost of a decision one has to consider the alternate use of those same resources. Graham Wright's letter needs to be considered in the light of those concepts.

In Wright's fourth paragraph he suggests that "they do not deprive others of their right to access". In a sense the 30% subsidy can be put to other uses and therefore does deny others their right to access. Thus, what has to be considered in looking at health insurance policy and the cost of the rebate, is the issue of opportunity cost. As indicated above, most economists would argue that the rebate (whether you agree with Deeble or Wright's estimates of costs), could have been more wisely invested in expanding the public sector to achieve the espoused objectives.

Citing my paper in the Australian Health Review, Wright also questions whether it is appropriate for there to be a subsidy for private patients in public hospitals. In particular, he postulates "why then should any Australian be required to pay for a basic public hospital bed". In fact, no Australian is required to pay for a basic public hospital bed. All Australians have the right of access to public hospital treatment. The fees charged for private patients in public hospitals are only charged for those persons who elect to have a different style of treatment, namely, treatment by a doctor they have chosen rather than by a doctor that the hospital has chosen to treat them. Because these are different products, it is legitimate for public hospitals to charge a different fee for that different product. From an economists' point of view, the question then becomes what is the appropriate fee for the hospital to charge? One could justify a subsidised fee, one could justify an unsubsidised fee. The choice of what is the appropriate fee depends in part on what the objectives are. The fact that people could purchase an alternate product (treatment by a doctor chosen by the hospital), does not give any insight into the appropriate level of fee.

There are a number of other questions about Wright's paper, which presumably others will address. It is easy to understand why most economists, and indeed most authors in the Australian Health Care Agreement series, have tended to argue in a similar way. It is hoped that the discussion about the basis of economics at the start of this response helps to understand why this theoretical base leads to these sorts of arguments and conclusions.

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