

Still more private health?

As we move in fits and start towards a racially liberalised society, vested interests motivated by factors other than racial grouping will become ever more evident. In particular producer power (as opposed to consumer sovereignty) will become, as elsewhere in the world, an issue of consequence. The reasons why producer groupings, as opposed to consumer groupings, are effective political lobbyists are well known. Producers are relatively few in number, they have focused and well-defined goals. They consequently find it easy, cheap and worthwhile to organise and lobby for the attainment of their objectives. This is true whether we are talking about a handful of mining houses lobbying for a tax break, several thousand retail pharmacists arguing that chemist shops should be owned by “professionals” and not bodies corporate, or several tens of thousands of trade unionists striking for a pay rise.

By comparison, millions of consumers are costly to organise. As each individual in turn has a vast array of differing goals, the attainment of any one of which is to consumers only of relatively trivial value, they tend not to coalesce readily into pressure groups. The consumer must generally look to the market or the State to ensure his interests are optimally served. Since the State is under pressure from producer vested interests, there is a presumption, at least, that the market, if unregulated and not subservient to producer pressure via the State, will be the better safeguard.

Is Health Care Different?

The deregulation and privatisation trends worldwide consequently have significant economic and social arguments in their favour. People often agree on this in general but argue that privatisation should not be extended to health care – after all, it is surely different and the cold calculus of the market should hardly be applied to the allocation of resources in the area of human suffering. Recently several health-care producers (in particular medical academics) have also begun to argue along similar lines. Health care is different and the conditions necessary for the market to operate effectively are absent. Informed and responsible consumers are not present on the demand side (we need physicians, surgeons, pharmacists and so on to take decisions for us as patients). On the supply side these same producers do not compete for custom because professional and ethical codes of practice, often given *de facto* legal status by government-approved occupational licensure boards, prohibit inter-producer rivalry such as price competition, product quality variation or the promotion and advertising of such differences. (This lack of supplier competition is generally argued by the professions to be in “the public interest” and so a protection for the ignorant against exploitation by “quacks”.) Finally, the “health care is different” school argues that supply and demand do not meet in a cash nexus. There is third-party payment by the State or medical schemes. This often results in little incentive for suppliers to act efficiently as they are paid for the service they provide and consumers bear little direct expense.

Regulation has Distorted the Market

The incentive system thus encourages both production and consumption, not conservation or efficiency. To aggravate the situation, existing regulation not only hampers competition between suppliers of care, it also inhibits competition and innovation between forms of third-party reimbursement. There are really two issues here. First, is health care really different? Second, should its privatisation or deregulation have a government health warning attached? (The warning, of course, would be designed by the producers and bureaucrats who often claim to know what is best for others.)

Is health different? How much do you really understand about the recent compact disc player you bought? Or the automatic 35mm camera? The questions are not trivial. Most of our purchases are made with a degree of ignorance. Health care is not a special case. We use agents, retailers, dealers, specialists, doctors, advertising, friends’ advice and so on to gain information before we buy. Economist Dennis Robertson suggested there was “great spiritual comfort in buying a known and trusted brand of

cocoa, rather than a shovelful of brown powder of uncertain origin". My own well-loved physician gives me a not dissimilar feeling of contentment.

On the supply side, of course, competition is minimal but this is an argument for, not against, deregulation of the professions. It is the physicians' and pharmacists' guilds protected by law or custom against rivalry or even investigation by the Competition Board, which are special, not the provision of health care.

Finally, third-party payment or insurance is ubiquitous. It is not confined to health care. Who pays if your house is burgled or your car is smashed? Probably not you. Again it is regulation of health care and the prohibition or discouragement in SA of alternatives which make health care special, not the lack of a cash nexus as such.

Market-Oriented Innovations Increase Patient Power

Consider some US experience with innovative and competitive third-party payment schemes. Health Maintenance Organisations (HMOs) such as the Kaiser Permanente are a burgeoning and successful phenomenon. Patients pay annually in advance for care irrespective of the quantity consumed. Physicians receive either a salary or share of the profits after hospital and other costs have been paid. The incentives are not to over-provide (or profits fall), not to skimp on treatment (or semi-cured patients will return) and to do so efficiently (or patients or their employers will seek out an HMO with cheaper rates next year). Hospital utilisation is lower with HMOs than with conventional insurance plans of the type generally permitted in SA. Even in the government sector in the US, market-related pricing has reduced hospital utilisation. The State scheme for the elderly, Medicare, experienced a 12% fall in average length of stay per diagnostic grouping when it switched from a retrospective payment scheme to a prospective one. Providers had an incentive to minimise costs to maximise their residual surplus.

Central Provision Bolsters the Bureaucrat

SA has two main health care systems: a State-provided scheme and a heavily regulated private one. There is no free market in health care of any meaningful consequence. How then can we find a better way of curing and caring for ourselves? Markets, as Nobel Laureate Hayek reminds us, are "discovery processes". Only deregulation can permit us to find the best system or (more likely) the optimal plurality of systems. The alternative, letting those with vested interests decide, namely the bureaucrats or the medical care producers, is akin to asking an admiral if he believes his navy should have another aircraft carrier.

This Briefing Paper was written by Duncan Reekie and previously appeared in 1990 in Business Day.