

# The great money identity: total health expenditure = total health incomes



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The definitive publication on health expenditure, *Health expenditure Australia 2012-13* by the Australian Institute of Health and Welfare, reports health expenditure in two key ways: who pays (Commonwealth and state governments, private health insurance, consumers via out-of-pocket) and on what the money is spent (hospitals, medical services, pharmaceuticals). The latter category can help you focus on efficiency, for example, how much does each hospital stay cost? It can also get you thinking about power, since what funds are spent on can also be seen in terms of which providers receive them.

As Canadian health economist Bob Evans said many years ago, total health expenditure is also total health incomes (Evans 1984). In other words, every dollar of health expenditure is a dollar of someone's income. The income can be taken as salary (public hospital staff are an example), fees for service (most medical practitioners and allied health professionals) or income (and profit) from the sale of supplies (pharmacies, manufacturers).

This great money identity has obvious implications when it comes to setting health policy. If a government is looking to constrain total health expenditure it must also look to constrain health incomes. The exception is if the government is shifting expenditure responsibility to another level

of government or to consumers. Such stratagems rarely save money as their object is to shift who pays and that's what they achieve. Shifting costs to consumers, as well as usually being less effective than income-constraining strategies, also has very adverse effects on equity because low income households are disproportionately affected (Duckett and Breadon 2014).

Health incomes can be constrained either by reducing the average income of the affected group or by reducing the number of people receiving incomes. Both create political waves. Reducing average incomes never pleases anyone and will attract opposition, sometimes disguised as opposing reductions in access or quality. Reducing total employment (or constraining growth in employment) can also attract opposition – many unions fight to retain membership. Again, this can be dressed up as opposing potential reductions in access. Similarly, shifting work from one profession to another, lower-paid group faces the same opposition, typically phrased as opposing quality reductions.

Quality and access concerns may be real, of course, and not simply political shrouding. Yet past overuse of these concerns to disguise self-interest has left us with a 'boy who cried wolf' problem, enabling the concerns to be dismissed, even when they are justified.

As well as trying to destroy cost containment policies, affected groups whose incomes are at risk may also propose cost-shifting strategies as an alternative, especially through shifting costs onto consumers (Evans 1990).

## The place of politics

This analysis of the interaction of expenditure control and income reduction highlights that health care is highly political. Some say we should aim to "keep politics out of health care". Such claims are naive, probably impossible to achieve and possibly undesirable. Instead, politics should be confined to appropriate health care decisions. We should recognise political rhetoric and claims for what they are and seek to limit the adverse impacts of political activity.

Politics will inevitably play a place in health care, not only because around one in every 12 Australians earn their income from the health sector (Duckett 2005), but because it consumes a large proportion of government budgets and is therefore a legitimate area of public policy.

Democratic political debate can lead to a contest of ideas, generating policy innovation and improvements. Medicare arose from such a contest (Scotton and Macdonald 1993) and is now a settled part of the Australian health policy environment. Similarly, it took a change of government in

Victoria to translate activity-based funding from an idea to policy that now enjoys bipartisan support (Duckett 1994).

Yet not all political involvement in decision making is good. It is clearly bad when it involves micro-management and involvement in operational decisions. Political decisions should be challenged when they unduly favour political interests over economic or system rationality; when the focus of policy is entirely on short-term, electoral considerations against longer-term decision making; or when political decision-making creates oscillation in policies and system instability.

Wilson provides a useful framework to help us respond to the play of politics in health care (Wilson 1995). He distinguishes between the degree to which the benefits and costs of political proposals are diffuse (widely spread) or concentrated. When both benefits and costs are diffuse, the outcome is simply a matter for the democratic political process. Matters become more interesting when the situation is better described in terms of the other cells of what is a two-by-two table – diffuse vs concentrated for benefits vs costs.

Where both benefits and costs are concentrated, it becomes a contest between competing interest groups – one seeking to accrue benefits, the other to avoid costs. It might be a contest between health professions about roles, with one group opposing role expansion of the other. The contestants can seek to enlist public allies, such as consumers, by dressing up their arguments in the rhetoric of access and quality. There is a role here for disinterested, independent parties to intervene to try to provide a factual base for some of the arguments or to advocate



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in the public interest. Grattan Institute plays this role in the health sector (Duckett, Breadon et al. 2013).

The shabby politics of clientelism (Hicken 2011) occur when the benefits are concentrated but the costs diffuse. An Australian example is the costs of medications on the Pharmaceutical Benefits Scheme, where Australia pays far more than it should compared with countries such as England and New Zealand (Duckett, Breadon et al. 2013). The benefits of the high prices accrue to a handful of pharmacy manufacturers, importers and wholesalers, and 5,000 or so pharmacy owners; the costs fall diffusely on taxpayers and consumers. The public interest political strategy is to shine disinfecting light (Brandeis 1914) on the back room deals, increasing the political cost to government of continuing cosy relationships that might buy peace with interest groups but at a cost to consumers.

Finally, the third cell of Wilson's matrix is where benefits are diffuse but costs are concentrated. An example might be reforming tax and spending policies, where all taxpayers benefit at the expense of a privileged few who have tax breaks. The



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relevant political strategy here is to increase the voice of the diffuse beneficiaries, potentially building advocacy coalitions.

Late 19th century German politician and public health advocate, Rudolf Virchow, famously said that "Medicine is a social science, and politics is nothing else but medicine on a large scale" (Virchow 1848). Politics and health care are interwoven, not least because of the great money identity discussed above. Political involvement is not all bad but it should be recognised for what it is and advocates for the public interest need to be able to counter the damaging aspects of the play of politics. ■■■

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