# Values in health policy: how a value-based system can resolve public/private divisions

**Paper for Manning Clark House Conference "Reinvigorating Australia", 27 October 2004**

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## Introduction

In this conference we have been asked to consider the balance between public and private provision, and between public financing and user charges. These important questions cannot be answered in any coherent, consistent way unless we ask what values and principles we wish to underpin public policy.

Those basic but more challenging questions, I suggest, have had too little attention in our ongoing political debates about health care.

In the federal election there was a rush of proposals – Medicare Gold, higher private insurance rebates, incentives for bulk billing, shifting of Commonwealth/state responsibilities.

But neither Labor nor the Coalition has presented a coherent vision of health policy. At one stage Julia Gillard did suggest the need for a basic re-think of our health policies, but the political climate was not supportive of any such broad system-wide thinking. Consideration of alternatives was narrowly focussed on budgetary costs (rather than on broader economic costs and benefits) and on an unstated assumption that the present arrangements will continue without fundamental change.

In the washup to the election Bob Carr, in calling for reform, described the nation's health care system as a mess.

It is, indeed, a mess, but it is generous to call our present arrangements a "system". Rather, I suggest, it's a collection of separate programs – hospital, medical, pharmaceutical and public health services – with some degree of coordination, but without the sort of integration which would earn the name "system".

These different programs have different sources of public and private funding (ranging from all public to all private) and different arrangements of co-payments (ranging from free provision to complete individual responsibility). They have fundamentally different design principles, and there is no unifying set of values which underpin their operation.

In this presentation I would like to:

- illustrate that mess – how confused and illegible it appears to the user;
- show how it has come to be that way;
- suggest a way we can get down to a more fundamental re-design, embodying coherent values and consistent principles which reflect those values.

## A mess, not a system

*A user's perspective*

From a user perspective the way health care is funded and provided is quaintly absurd. Consider some examples:

> A minor ailment with a GP consultation usually involves visits to two separate establishments – a surgery and a pharmacy. The GP consultation may be provided free if it is direct billed, or there may be a contribution, over which there is no price control. The prescription, however, will require a co-payment, fixed in amount. But if we are to buy a non-PBS drug or appliance, even if it is just as efficacious, we are left to the whims of a highly imperfect market.
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> (Could we imagine, for example, the absurdity if we had to make separate transactions in different establishments to have our car serviced and to buy parts?)
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> If we are part of the better-off minority with private insurance, generously subsidized by the Commonwealth, a certain number of dentist services will be free, the number depending on our level of cover. But past that restricted number, we are left bearing the open-ended risk; it's not really insurance but, for ancillary services, a limited assistance for small outlays. And the more self-reliant, who choose to save for their own dental and similar expenses, do not get the benefit of any subsidy.
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> A stay in a public hospital is free; there is no co-payment. Treatment for the same condition in a private hospital will involve at least two different contracts – one with a doctor (and more if there are many specialities), the other with the hospital. There will probably be open-ended co-payments for most of these services. Pharmaceuticals used in the private hospital will be funded under yet a different program, the PBS, with fixed co-payments.

*A provider's perspective*

Most of those who are intimately involved in health care do not see these absurdities; they have grown up with these divisions. They see their own components, and generally do their best to manage their own programs. They have no system-wide notion of health care, and no incentive to think in system terms.

As a case in point, bureaucrats in Federal Treasury are always concerned about the rapidly rising cost of the PBS; they don't have any incentive to think about the savings which drug therapies make elsewhere in the health system and in the economy more widely – for example the ability of people with diabetes to lead active productive lives.

Another example is provided by the reaction to Labor's Medicare Gold. Because it integrates private and public hospital services and bypasses the bureaucracy of private insurance, Medicare Gold is more economically responsible and affordable than the Coalition's proposals to extend private insurance. Economically it would result in a better allocation of resources than our present fragmented system, and, because it relies on official taxation rather than private insurance (which is simply a high-cost off-budget taxing mechanism), it would be more equitable and lower cost.

But the Coalition and those with vested interests in the present arrangements were able to ridicule Medicare Gold because of its heavy call on budgetary outlays. Labor, trapped in a narrow budgetary perspective, was unable to show its wider economic benefits. The reality is that whatever funding arrangements we use – public insurance, private insurance, or direct payments – we will provide and pay for resources to provide health care for older Australians. That's a simple statement of economics from a system-wide perspective, but in the face of criticism the Labor Party was frozen like a rabbit in a spotlight because it did not have a system perspective to present to the electorate.

## How did we get that way?

There are at least five factors contributing to this fragmentation.

*1. Federal/state demarcations – the old excuse*

First is the set of federal demarcations between Commonwealth and state responsibilities. Are these insurmountable as we assume, or are they excuses for inaction? Bob Carr's call for some level of rearrangement is only the latest in a number of similar pleas.

*2. Legacy and politicization – a deficit of imagination*

Second is the legacy of our programs. State government involvement in hospitals goes back to pre-Federation days. Commonwealth involvement in the PBS dates to the postwar years, and in medical services dates to the Whitlam Government reforms. Private health insurance has roots in mutual assistance; it successfully evokes this image to mask its present reality as an expensive and highly subsidised branch of the finance sector.

Our lines of demarcation are based on professions, institutions and technologies, not on users' needs. There is a great deal of historical inertia in these separate programs. (By contrast, a user-based set of programs may be divided between chronic, acute and occasional users, rather than the present divisions.)

Politicians and policy-advisers do not re-visit their long-held perspectives. Labor has a sentimental attachment to bulk billing – but if free GP consultations are so important, why should there be payments for pharmaceuticals? Or, conversely, if we can pay for pharmaceuticals, why should GP consultations be free? The Coalition has a senseless infatuation with private health insurance, and is unwilling to face the fact that it combines the worst aspects of socialized medicine (the moral hazard of free provision) and of *laissez faire* capitalism (inequity, duplication, resource misallocation and economic rent-seeking behaviour); it makes no sense from any ideological or value-based perspective.

Part of the problem may be that the Commonwealth, in its politicization of the public service, has lost the voices that can pose these basic questions. The role of public servants who once gave policy advice has become one of providing *ex post* justification and rationalizations for government decisions, rather than the provision of critical evaluation and advice.

*3. Managerial "reforms" – in the way of a system perspective*

Third is the fashion of "management by objectives" (MBO) – a process whereby each manager is supposed to look after his or her own space of responsibility, and to leave the task

of integration (if any) to others. It has its place – it's a tolerably good practice for day-to-day operations in certain organizations, such as supermarkets and factories. But it is inimical to system-thinking and innovation. In the wave of public sector "reforms" which started in the mid-1980s MBO was embraced enthusiastically, even as its original proponent, Peter Drucker, was warning about its limitations.

*4. The budgetary obsession – bookkeeping displacing economic analysis*

Fourth is the obsession with official budgets. As illustrated with Medicare Gold, politicians of both colours – Coalition and Labor – tend to evaluate programs in terms of their budgetary impact, rather than their wider economic impact. We have just witnessed this at an obsessive level in the 2004 election campaign, the measure of all policy proposals being their four year fiscal burden, rather than any proper cost-benefit analysis.

This obsession is built in to the Coalition's "Charter of Budget Honesty", which not only prescribes a narrow budgetary focus on election commitments, but which also generates the "Intergenerational Report" – another document narrowly focussed on budgetary expenditures, rather than the community's economic costs and benefits. That is, a narrow financial perspective rather than a broader economic perspective. It would be unfair to load all the blame on the Coalition; the roots of this budgetary obsession tend to go back to the mid 1980s during the Hawke/Keating administration.

This focus leads governments to find clever but costly ways to shift costs off-budget, the most attractive one to the Coalition being the use of private insurance, even though as a means of collecting and sharing revenue it is inferior to official taxes in every aspect (and has no benefits of market forces, because insurance, by its very nature, suppresses the price signals which markets use to allocate resources).

The result of such cost and responsibility shifting is that programs become hybrids of public/private delivery and funding, with little overall coherence in design or objectives.

*5. Self-interest – the stakes in the present arrangements*

Fifth and finally is self-interest. Much is at stake in any reform. While policy advocates may agree that system integration is desirable, there are many vested interests in the current arrangements. In the public sector there are health administrators at both tiers of government. In the private sector there are professionals who treasure their autonomy, not-for-profit organizations and corporations running hospitals and nursing homes, and a resurrected private insurance sector.

Any hint of reform unleashes tales of dire consequences – welfare groups cling sentimentally to bulk billing while ignoring other co-payments, private insurers deceitfully claim that without their presence the "private system" would collapse (without acknowledging the huge benefits which would accrue from direct government funding of public hospitals).

Do we have to accept these five factors for all time? Do we have to limit our aspirations to muddling through – a little more public involvement under Labor Governments, a little more

private involvement under Coalition Governments? Some incentives for bulk-billing here, more subsidies for private insurance there, another safety net for an identified group – all the time making for a more disintegrated system.

Such a dismal future is inevitable unless we engage in a thorough debate about the values and principles we want to see embedded in our health care systems. Let me outline a framework of options.

## Values and principles in health care

For all the changes in health programs over the last 20 years, they have not been expressed in terms of coherent values or principles. Coalition governments have tended to use the rhetoric of "individual responsibility", but in reality they have been promoting corporate dependence and privatization of tax collection through private insurance. Labor has made much of its commitment to bulk billing, but it has been vague on its purpose; bulk billing as advocated by Labor could be justified on the basis of welfare, cost control or public health – we are left to guess the actual reason. Both parties have vigorously defended the present coddled protection of pharmacies from the disciplines of competition. Again, we are left to guess why. Why, after we have done so much to keep the wholesale price of drugs low, do we allow a high cost corner-shop industry to add to our costs?

Public policy should proceed from articulation of underlying values, through statements of principles, to details of programs giving effect to those principles. For the most part, however, the political processes have generally been confined to the last step, with people left to work out the principles by inference.

Once we have given thought to and articulated our values, then we can get down to the more practical aspects of principles and then (and only then) should we come to detailed design.

Coming back to the theme of this conference, on the private and public balance, I do not necessarily see the basic question in terms of the private and public sectors. Framing of the debate in public/private terms, rather than in terms of more basic principles and values, has led to a degree of confusion and poor public policy.

For example, private health insurance has justified its existence on the basis that it is important to sustain the "private system". But that's a misleading presentation, for there are no separate private and public systems. There are private and public providers working alongside one another. And there are three different channels of funding – government, individual and insurers. Any perception of an assault on either the "private sector" of the "public sector" is bound to evoke defensiveness on both sides, and a strong marshalling of defences of the status quo.

Perhaps, rather than framing the choices in public/private terms, when it comes to financing we should be asking is what costs we want to share, and what costs we want people to pay from their own resources.

That question is not easily answered. It cannot be asked in the heat of a five-week election campaign; it goes back to more fundamental questions about values. But until we get some consensus on that question, issues of practical design such as use of co-payments, price

regulation, and the role of private providers will continue to be resolved in ways which are piece-meal, inconsistent, wasteful and subject to whims of fashion.

There are several valid reasons we may want to share some or all of our health care costs; we need to articulate them, however, because different reasons are associated with different values.

In this final part of this presentation I would like to outline the values which could underpin public policy:

> At one extreme is a non-interventionist approach, relying on *individual responsibility* – we leave people to the whims of fortune, without any recourse to pooled funds. (While the Coalition uses the language of "individual responsibility", their policies on private health insurance reflect a value of corporate paternalism; the nanny corporation, in being given the role of collecting and re-distributing funds, takes the place of the nanny state, and those who save for their own health care contingencies are penalized.)
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> An intermediate point is the notion of *protection of the weakest,* a charity system for the unfortunate "indigent" – to borrow the US terminology. This involves strong means-testing, and tightly-defined safety nets. Health becomes just another normal good, with most people paying for most of their health care most of the time, without recourse to any pooled funds.
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> It is very easy for programs such as Medicare to drift into a charity model, because publicly-funded health care certainly does have redistributional benefits, even if it is not primarily designed as a redistributional scheme. (It was revealing, in the recent campaign, to hear the Deputy Prime Minister defending a "two tier" health care system; this was the most explicit statement of such a shift. And is the new super-grouping of Medicare payments into a welfare portfolio yet another manifestation of that drift?)
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> Or we may choose community-wide *social insurance*, with systems of uninsurable co-payments or excesses to control moral hazard (incentives for over-use or over-charging). While we may accept the outcomes of private markets for many choices, in health care we are all vulnerable and are more likely to accept some degree of pooling. Because insurance of all types involves a degree of moral hazard, there is a strong case for having a single national insurer. This was the vision for Medibank in 1972 and Medicare in 1983.
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> At the other extreme we may opt for a completely free system, without co-payments, reflecting a strong community value of *sharing*.

There are finer distinctions we can make, but for simplicity we can summarize them in terms of underlying values and principles.

| Value | Principles | Current examples |
|---|---|---|
| Individual responsibility | Non-intervention (except possibly for overt cases of market failure). | "Ancillary" services – dental, physiotherapy etc used by the uninsured majority of the population, and by those who have exceeded the caps on private insurance. |
| Protection of the weakest | Charity – means testing, and separation of the system into two tiers. | Special Medicare rebates for concession card holders. |
| Social insurance | Protection of all against catastrophic costs. | Safety nets, capped PBS co-payments. |
| Sharing | Free services, community-rated through taxes. | Public hospitals, bulk-billed services. |

The fact that we can find such a mixture of principles and infer such a mixture of values from existing programs illustrates the fragmented nature of our health care delivery. Worse, we often find policies that pick and choose to suit interest groups. For non-prescription drugs in Schedule 2 (pharmacy only) and Schedule 3 (pharmacist only), the individual is abandoned to a *laissez faire* situation, but the pharmacist is protected from the forces of competition.

I suggest that no amount of effort at reform is going to yield useful dividends until those who advocate and develop policies start to ask basic questions about principles and values, and from there reconstruct health care as an integrated system. These values will ideally emerge from informed community consultation and engagement, rather than from opinion polling and focus groups. It needs a patient process of education and consultation – a process Robert Reich refers to as "civic discovery".

Politicians can also help by going back to their own parties' fundamental ideologies – which both sides seem to have lost touch with. If they did we would expect the Liberal Party to articulate values towards the top of this list, Labor towards the bottom. A Liberal policy might encourage microeconomic reform, and more individual responsibility without the distortion of insurance. A Labor policy might embrace more tax-financing and control on service-providers' fees. Presented with such options based on values and principles citizens may be in a better position to make a democratic choice than when they are presented with two grab bags of isolated programs.

Where does this leave the private/public mix?

In terms of *service provision*, whatever values we embody into our policies, there will probably be a mixed set of providers into the foreseeable future. Perhaps we should think of differentiating the "private sector" more finely, into small professional practices, not-for-profits, community-owned cooperatives, for-profit corporations. There is always something strange about a classification that bands together the local surgery, Mayne Nickless Health Care and Pfizer Pharmaceuticals.

In terms of *financing*, the question is not so much private or public, but rather individual or pooled funding. There are valid arguments on both sides of shifting the mix.

As a coda, to the extent that we choose to pool, whether it be for a universal “free” system or for safety nets under a primarily market system, the overwhelming case is for doing so through our taxation system, rather than the clumsy, inequitable and high-cost surrogate known as “private health insurance”. Only those who dogmatically assert a preference for the private sector, regardless of economic wisdom, could see private funding as a desirable end in its own right – an ideological stance no more logical than the old soviet ideology of a blind opposition to the private sector. We are yet to invent any better way of sharing costs across a community than using our tax system. As Oliver Wendell Holmes said “Taxes are what we pay for a civilized society”.

## Acknowledgements and references

I have not made specific references in this paper, but I would like to acknowledge those whose ideas have been most influential in developing this line of argument.

In terms of the values underlying public policy, see the work of Robert Reich, particularly his book *The Power of Public Ideas* (Ballinger, 1988), in which Reich and others, mainly from Harvard's Kennedy School of Government, dispute the barren theory known as "public choice", and point to the importance of values and principles in designing public policy.

An untiring champion of system thinking and program integration in public policy, countering the fashionable notions of Management by Objectives, is Alistair Mant, an Australian who is very much involved in work with Britain's NHS. Many will have come across his work *Intelligent Leadership* (Allen & Unwin 1997).

Professor John Dwyer, in many forums, has demonstrated the financial and other costs of the present fragmentation of our health care programs. The Health Summit he organized in 2003 (www.healthsummit.org.au) demonstrated both the extent of the problem and the gains to be enjoyed from greater integration. At that same conference, Professor Jeff Richardson spoke about contrasts between Australian and European health care – how many European systems embodied values of social solidarity.

I would also like to acknowledge assistance from Mary Walsh, Jill Iliffe, Martyn Goddard, Penny Ramsay and Prue Power in preparing this paper.

In this paper I have made several statements about the negative role of private health insurance. For a fully researched and detailed analysis see the paper "Stress on Public Hospitals – Why Private Insurance has made it worse" on the Australian Healthcare Association website: www.aha.asn.au. While private insurance still plays a minor role in Australia's health care funding (11 percent), it is one of the most distortionary influences in health funding, and is demonstrably associated with a loss of cost control.