Medicare Select – Another layer of bureaucracy in health care?

Paper to accompany presentation to *National Health Care Reform* Conference, November/December 2009

Ian McAuley University of Canberra and Centre for Policy Development

Summary

The Commission's "Medicare Select" is not described clearly, being shrouded in vague language and in undefined terms. On analysis it is shown as a means of allowing private health insurance to displace Medicare. While it would offer a "public option", that would be a weakened residual of Medicare, lacking the market power of a single insurer.

"Medicare Select" is justified largely on the basis of offering "choice", but the choice on offer is simply between funding intermediaries, necessarily offering similar products. In effect this is choice of brand names, rather than choice of care.

There is no evidence that the Commission has considered the costs and benefits of "Medicare Select". Rather, it has assumed that all consumers need a financial intermediary (an insurer) in health care: it has not considered at all the role of normal market transactions in health care. It has glossed over the economic problem of moral hazard in insurance, and has ignored the evidence that such moral hazard is best overcome with a single national insurer. And in focussing on competition between financial intermediaries, apart from proposals to introduce competitive neutrality between public and private hospitals, it has ignored the need for competition among health care providers.

"Medicare Select" is based on a misunderstanding the working of markets, in particular a confusion between policies which are supportive of the private sector and policies which are supportive of markets.

"Medicare Select" – another name for private health insurance

If the NHHRC's "Medicare Select" proposal were a student assignment, I would ask its writers to re-submit it with clarification. It is vague: its main ideas are expressed in undefined terms, namely "health and hospital plans", "social insurance", "strategic purchasing" and "choice". And it has no costing – not even a first-order estimate.

Those vague words are what philosophers call "floating signifiers" – words that don't point to any agreed-upon meaning, but which mean whatever those who hear them want to make of them. We use such constructions in small talk, when we don't want to offend. Politicians and advertisers are adept users of floating signifiers. They should have no place, however, in a serious policy proposal. Is it that the Commission members could not reach agreement, so deliberately left these terms vague, or is it that they are used as euphemisms to mask a radical change to Medicare – perhaps even its destruction?

The Commission is vague about its ownership of "Medicare Select". It is introduced enthusiastically as "the new model we are proposing", but, as one member of the Commission, Stephen Duckett, has stressed "The Reform Commission did not recommend Medicare Select; it recommended examining the issue".[1]

What, then, does "Medicare Select" really mean?

We get some guidance from the Commission's Interim Report, in its "Option C", which involved compulsory enrolment in "social insurance" – another term left undefined. In the Commisison's final report it says that "Medicare Select" draws on "features" of social insurance, without defining what "social insurance" is, and without specifying what those "features" are.

In the context of health care, the term "social insurance" generally refers to universal compulsory insurance, either through a single national insurer (as in the Nordic countries, UK and Canada), or through other non-government agencies such as mutual funds or for-profit private insurers (as in the Netherlands). In a study by Mary Foley, commissioned by the NHHRC, the term "social insurance" is defined more narrowly. Her definition pecifically excludes government insurance, referring only to private insurance.[2] This explains why "Medicare Select", in spite of its vagueness, has been met with enthusiasm by private insurers and their spokespeople. Board members of Medibank Private, and of Bupa, have given "Medicare Select" strong endorsement.[3]

In short, "Medicare Select" is a proposal to displace Medicare with a significantly widened reach of private health insurance.

The final report shies away from compulsory enrolment in private insurance, but there is compulsory enrolment in a "plan", which would be, in effect, health insurance. Everyone would automatically belong to a government operated "health and hospital plan", but could select to move to another "plan", operated by government, a not-for-profit enterprise or private enterprise.

Nowhere in the report do we get a firm description what a "plan" is. Why is there an implicit separation between "health" and "hospital" care in the name "health and hospital plan"? Is the "plan" a plan for care, or is it simply a funding plan? The report admits that there are "a number of design choices about how health and hospital plans might work that we have not been able to fully address". We get a strong hint, however, that the "plans" would simply be budget-holders, because the Commission says "through contracting arrangements with public and public providers, plans would purchase services to meet the full health care needs of their members".

Further on there is reference to the need to resolve "the potential role of private health insurance *alongside* health and hospital plans" (emphasis mine). What does "alongside" mean? In the same section, it suggests that private health insurance might "complement" health and hospital plans? Yet, earlier on, the Commission says "as is the case now with private health insurance, people could purchase from private health insurers additional coverage not included under the universal service obligation (such as extended allied health coverage, advanced dental care, enhanced hospital amenity and access)". This list is a mixture

of complementary and supplementary benefits: for example, does "access" mean queue jumping, at someone else's expense?

And, of course, while the report suggests leaves open the question of support for private health insurance, it does make it clear that the plans would be supported by distributing funds on a risk-adjusted basis, in the way that public funding in the Netherlands is distributed to insurers. (In order to protect the "plans", however, it proposes that they not cover the truly high risks in "some highly specialised areas of medicine (for example transplant surgery)". In other words, the public sector would still take on the high risks, in order to protect the "plans".)

So, it appears that a "plan" is a new financial intermediary, which would operate in the way that insurers operate, but with the potential for private health insurance to provide other levels of insurance. In reality, however, it is hard to see the distinction between the two types of financial intermediaries – "plans" and insurers. Just as Medicare is an insurance mechanism, so too would these "plans" in reality be insurance packages. Indeed, the enthusiasm with which private health insurers have greeted "Medicare Select" leaves us with little doubt as to who would be providing these "plans".

It is possible that the Commission is giving itself a degree of semantic latitude, for in both its interim and final reports, it has said (without any analytical justification):

> "We want to see the overall balance of spending through taxation, private health insurance, and out-of-pocket contribution maintained over the next decade."

Presumably, use of the term "plan" to refer to insurance is the Commission's way of maintaining a semblance of consistency with the above statement.

So, what it appears to be proposing is a universal "plan", similar perhaps to the present Medicare, but with the option of transferring one's funding entitlement to another budget-holder, which would still be bound by the same universal service obligation. One could top-up what the plan provides with extra insurance, or, presumably, direct payments (but the report is silent on the role of direct payments).

The Commission, presumably, sees benefits in competition between "plans", but it is hard to imagine what these benefits would be. All "plans" would have to cover the same universal service obligation, and would be funded to do so – no more and no less. Of necessity, therefore, because of this constraint, they would have to be very similar, but with different brands. The Commission has not shown how consumers benefit from competition when all that's on offer is a number of brands offering similar products.

It's a basic proposition of economics that market competition should work to the benefit of consumers, who benefit from price competition and innovation. Competition, it should be remembered, is not an end in itself. But in these "plans" there is no apparent role for price competition – there are no prices. And it is hard to see what innovations can occur in financial intermediaries.

The Commission does suggest that the plans could be involved in a "strategic approach to innovative purchasing, focusing on people's health needs over time", but it provides no

explanation or examples of what "innovative purchasing" could entail. There isn't a great deal of scope for innovation in shuffling money between a funder and provider.

There would be a cost involved. We know that Medicare, with its powerful position in the market, can keep its administrative costs to around five percent of outlays, while the private insurers incur management expenses of 10.5 percent, on top of which is a profit margin of 3.3 percent.[4] In all that's about a ten percent difference. That difference is not because private insurers are less competent than public insurers; rather, it is the cost of competition – duplication of services and the exertion of effort to maintain market share.

If, say, 45 percent of Australians moved from the Government "plan" to one of the other "plans" (45 percent being the proportion of Australians presently holding private health insurance), they would transfer the same proportion of Commonwealth and state funding with them – about $30 billion.[5] A ten percent administrative overhead added to that, to cover the costs of "plans", would add around $3 billion a year to our health costs. That's not to include the far greater costs involved in loss of the concentrated purchasing power of a single national insurer, a point covered further on. Nor does it include consumers' search costs.

In other words there would be a large transfer of funds, in the order of $30 billion, to private insurers – not in itself a cost to the community – but there would be a consequent rise of about $3 billion a year in administrative costs, and an even larger cost associated with the loss of Medicare's strong market position.

I am not claiming high precision in this costing; rather my intention is to point out that there would be costs involved, and in any public policy idea the proponents should be able to put up at least a *prima facie* case that the benefits justify the costs. Competition comes at a cost, but in most markets – for cars, clothes, restaurants – that cost is easily outweighed by the benefits to consumers. There is no evidence of consumer benefits in choosing between look-alike "plans", however. Consumers do benefit from choice of care, but that's not what's on offer.

The other part of the Commission's claim, that a "plan" could focus on people's health needs over time, is unrealistic. For a start, the "plans" would be constrained by having to cover the universal service obligation. Even more basically, no-one knows what their health care needs are going to be over time. At any time in one's life one can develop a chronic condition, be involved in an accident, or develop an acute illness. In such situations there is a case for a care plan related to that condition, provided by people with relevant therapeutic expertise, but that is not a role a funding organization can fill. (Imagine, as an analogy, if the ANZ or National Bank said it was going to enter the business of building houses for its borrowers.)

In fact, most Australians most of the time are light users of health care. In any one year fourteen percent of Australians have no medical consultations. Thirty percent – almost a third – have three or fewer consultations, and a half have six or fewer consultations. (See Table 1 over the page.) Very few such light users want or need a "plan" for their care management.

The Commission, however, while making a strong rhetorical point about people taking responsibility, slides with ease into the paternalistic notion that we need a "plan" administered by some third party.

Table 1: Use of Medicare Services 2006-07		
Number of Medicare services	Percentage of people enrolled in Medicare	Cumulative percentage
0	14	14
1	9	23
2	7	30
3	6	36
4	5	41
5	5	46
6	4	50
7 to 10	14	64
11 to 20	19	83
21 or more	17	100
Source: Medicare statistical tables		

It is possible that the report reflects the fact that the Commission is heavily representative of people who are so close to health care provision that they find it hard to take a detached view. The chair is from the private health insurance industry, and, without suggesting any conflict of interest, it would be difficult for someone with such a background to imagine health care without a strong role for a funding intermediary: the intermediary which comes to mind is private health insurance. And health care providers tend to have a skewed perspective on health care, for their experience is with the heavy users; by definition they are hardly aware of the light users who largely attend to their own needs.

While "Medicare Select" is very short on the sort of clarity which would allow for a thorough policy analysis, it is possible, to delve into the assumptions behind "Medicare Select", and to raise the awkward questions which have been glossed over in the report – the questions which may be raised by a more detached outsider – and in doing so give some ideas for real health reform, rather than simply imposing yet another financial intermediary between users and providers.

The assumptions behind "Medicare Select"

Although the Commisison fails to spell out its assumptions, it is possible to infer these with reasonable confidence.

Assumption 1: Someone else will pay the bill

There is a strong assumption that health care costs will be paid by a third party – an insurer. Insurers, particularly health insurers, find it difficult to imagine a world in which people pay for services in normal market transactions.

In the September edition of *The Atlantic* David Goldhill has written an article with the provocative title "How American Health Care Killed my Father".[6] He says in a few words what academics often bury in the language of "moral hazard", "price elasticity", and "principal-agent theory". Goldhill says:

> "Perhaps the greatest problem posed by our health-insurance-driven regime is the sense it creates that someone else is actually paying for most of our health care—and that the costs of new benefits can also be borne by someone else. Unfortunately, there is no one else."

To the "left" that someone else is the government, to the "right" that someone else is the private insurer. Their shared assumption is the notion that there will be an intermediary between the consumer and the provider of health care. A national health scheme, a private insurer, a "plan".

The Commission, in its enthusiasm for "plans", shares that assumption.

Goldhill goes on to say:

> "... a guiding principle of any reform should be to put the consumer, not the insurer or the government, at the center of the system. I believe if the government took on the goal of better supporting consumers – by bringing greater transparency and competition to the health-care industry, and by directly subsidizing those who can't afford care – we'd find that consumers could buy much more of their care directly than we might think ..."

This is the direction in which we, at the Centre for Policy Development, have been trying to turn the debate on health care. To what extent should we be paying for health care from our own pockets, without insurance, and to what extent should we rely on collective funding?

It's a question which has never been put to the Australian community. Rather, the political debate is dominated by the almost meaningless question of the balance between private and public funding of health care – where do we want the balance between private and public funding?

Unfortunately the Commission has not raised this basic question of the role of direct payments.

It is possible, indeed probable, that, in view of our generally rising prosperity and our greater exposure to competitive markets over the years, we would be willing to pay more from our own pockets. That is, without dependence on private or public insurance, provided the markets in which we operate are fair, provided there are provisions for those with limited means, and provided that systems of co-payments do not skew choices away from efficient resource allocation. Sweden, for example, has recently moved from a free system to one with a well-designed set of co-payments, and without the distortion of private insurance (which would dull the market signals of co-payments). Even the Netherlands, which seems to have been influential in the Commission's thinking, requires people to pay the first €155 (about $250) of health care before insurers pay.

Our main health care programs were introduced in very different times. In the late 1940s when the Commonwealth was trying to bring in universal public insurance and when the

Pharmaceutical Benefits Scheme was introduced, average annual male earnings (in 2009 prices) were only $20 000. In 1972, when the Whitlam Government was elected with Medibank as a key plank of its platform, annual male earnings were just under $40 000. Now they are $70 000.[7] Family incomes would have risen even faster.

We know there are different views on the question of where to draw the line between collective and individual funding. There are articulate arguments for a system which is completely free at the point of delivery, and there are articulate arguments for more open, uninsured transactions. One of our Fellows Jennifer Doggett, has pointed out that while we do spend significant amounts from our own pockets, there is no coherent set of principles in the design of co-payments, with the result that there are huge inequities and distortion of resource allocation.[8]

Unfortunately, when we pose this question in publications, Senate hearings, and in conferences, there is often a hysterical response, particularly from health insurers, as if we are advocating some form of Soviet-style "socialized medicine". There are insurers and politicians who cannot break from the notion that private insurance equates to self-reliance, overlooking the fact that people buy insurance to buy out of the discipline of markets (and that our current private health insurance incentives actually discriminate against self-reliance.) Insurance of any kind, private or public, is intrinsically paternalistic.

If anything, in raising that question, we are opening up the possibility of an expansion of market forces, but defenders of private insurers don't see it that way; if they're "private" they must be doing something good. As John Kay, one of Britain's leading economists has said in this year's annual Wincott Lecture:

> ".... both supporters and critics of the market economy have often confused policies that are pro-business with policies that are pro-market."[9]

Assumption 2: "Strategic purchasing" will result in cost control

The Commission places a great deal of faith in insurers' capacity to deal with service providers.

An intrinsic problem with insurance, private or public, is what economists call "moral hazard". That is, the knowledge that at the time of purchase of a service, it is free or heavily subsidized. The notion "NIB/HCF/Medibank Private will pay for it" is no different from the notion "Medicare will pay for it".

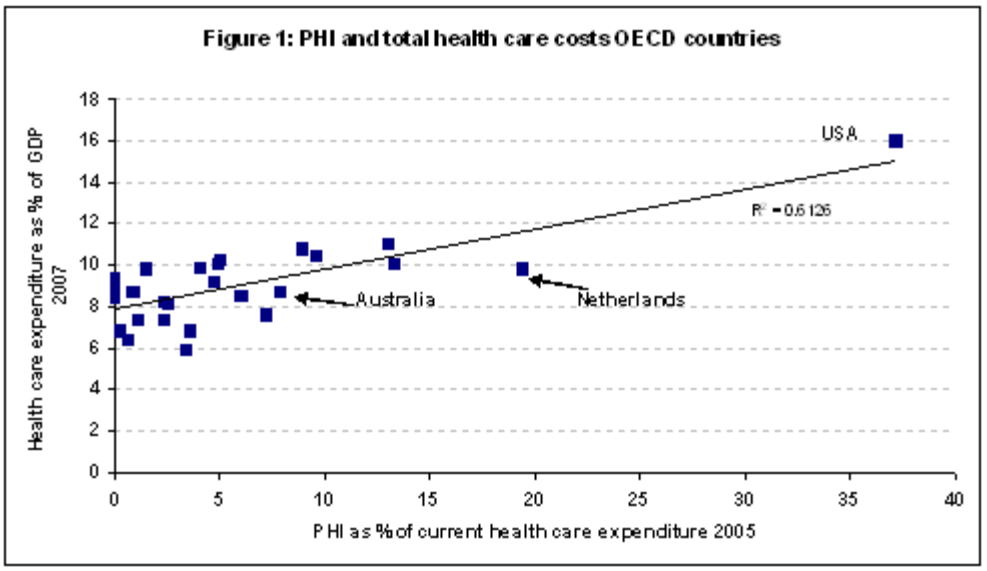
Moral hazard is a problem in all markets dominated by insurance, but it is particularly acute in health care. In part this is because we lack the knowledge to judge what we need; our natural risk aversion is likely to favour more treatment over less and to rely on expert opinion. In part it is because there are powerful provider groups who can dominate markets. If a vehicle smash repairer starts to quote too high, or will supply only gold-plated service, the car insurers will go elsewhere in a competitive process. But it's much harder for insurers to face up to powerful groups such as the specialist colleges and pharmaceutical firms.

The usual policy response, practised in many countries, is to use a single health insurer to counter the power of provider interests. In economic theory it shouldn't matter whether that

single insurer is private or public, but most governments would baulk at the idea of granting a monopoly to a private firm. In this regard those who criticize private health insurance are often portrayed as being anti-private sector, or pro-big government, but this is a misrepresentation. What counts is the notion of a *single* insurer; its ownership is a secondary issue.

Unsurprisingly, in her work for the Commission, Foley found that "Countries with social health insurance systems [which she has defined as non-government] generally have higher health expenditures than tax-funded systems". It's a strong finding, and we would expect her paper to conclude with a strong case for a single national insurer in Australia, but that does not appear in her conclusions.

We find the same when we examine OECD data: the more dependent a country is on private insurance, the more expensive is their health care. Among high-income OECD countries there are not many differences in health outcomes, but there are big differences in the costs of health care, and a major explanatory factor is the extent to which health care is financed through private insurance. (See Figure 1). Private insurance buys more expensive health care, but it doesn't buy better health care.



On this chart the Nordic countries are all down the left-hand end of the scale; they have very little or no private health insurance and affordable systems. The stand-out countries on the other end of the chart are the USA and the Netherlands.

We draw attention to the Netherlands because it seems to have been an inspiration behind "Option C" in the Commission's interim report and therefore behind "Medicare Select", but it is a poor model for Australia.

The Dutch have indeed brought in compulsory enrolment in private health insurance, but their health system already had high enrolment in health insurance, primarily in not-for-profit mutual funds. (Unlike Australia their insurers are not going down the path of de-mutualization, and there are strong financial disincentives preventing de-mutualization.) Only about two percent of the population was uninsured before the changes. Their changes have

been more about price de-regulation and risk-pooling between insurers, not a switch from public to private insurance.

At first sight, when one looks at Figure 1, the Netherlands appears to be moderate cost, but its rate of cost escalation has been very high; between 1997 and 2007 its health expenditure rose from 7.9 to 9.8 percent of GDP, almost the highest among OECD countries. Its cost pressures are still mounting: insurers are bearing losses, hidden, in part, by once-off accounting innovations.[10]

So it is strange, in light of the evidence, that the Commission has not suggested a single national insurer model, as is successfully used in many other countries. Rather, it has suggested that there be a number of competing "plans", which would have to face the strong power of provider interests. They do not acknowledge this problem; but they do give a hint of the problem when they say that the plans would be involved in "a strategic approach to innovative purchasing".

They offer no explanation of what they mean by "strategic". Are they using the term in a military sense, as defined by Thomas Schelling[11], meaning they would use every possible stratagem to exert market power over providers? Or is the word simply something to add flavour to the text – one of the seven vague meanings of the word identified by Fred Hilmer and Lex Donaldson?[12] And, as raised earlier, what is "innovative" purchasing? Only through circumvention of the laws of economics is it possible for fragmented purchasers to dominate over powerful providers. If one insurer does not meet the providers' terms, others will, and will pass the costs on in terms of premiums.

Perhaps the Commission has been guided by a notion that private insurers are less permissive than public insurers. The Government is seen as a soft target, while private insurers have to be mindful of the premiums paid by their customers and (in the case of corporatized insurers) the interests of their shareholders: they have to be tough.[13] There is no evidence to support this proposition, however. It could equally be argued that a government's responsibility to citizens provides a stronger motive to attend to their interests than the weaker corporate responsibilities to customers and shareholders.

Indeed, there is strong evidence that people tend to buy more insurance than is rationally necessary.[14,15] Insurance is what economists call a "superior good"; the higher our income, the more we buy, even though, rationally, the higher our income the more capacity we should have to self-insure. By contrast, our demand for insurance is not particularly sensitive to price. That is not to say we do not shop around for insurance, but we tend not to make a rational consideration about whether to insure of not. If the cost of my insurance with firm X rises, then I may look around at firms Y and Z, but I will not consider dropping insurance altogether. So private insurers have no difficulty in absorbing systemic cost pressures coming through from suppliers. Indeed, if those costs rise quickly enough, that rise may be sufficient to entice people into insurance.

Economists can be led into the belief that competition will sharpen insurers' cost consciousness. If insurers were truly cost conscious, however, they would do everything to avoid moral hazard and adverse selection. They would give generous discounts for high-deductible products, thus encouraging a degree of risk-sharing with customers; a customer willing to bear the first $1000 of risk, for example, should be a much better risk and therefore

more profitable than one who demands first dollar cover. But insurers do not offer such products, or if they do the deductibles on offer are absurdly low. Health insurance is distorted by a regulation setting the deductible limit at $500, and demand for these products is often driven only by the Medicare Levy Surcharge. But in the less regulated general consumer insurance industry – car and house – high deductibles are virtually non-existent. Even though they should be highly profitable for insurers, they do not offer $10 000 deductible policies for cars, or $100 000 deductible policies for houses.

The explanation lies in an understanding of firms' objectives. Firms tend to seek growth rather than profit.[16] Of course a certain level of profit is necessary to placate shareholders, but growth is of benefit to the managerial élites. Provided any particular line of business, such as selling first dollar insurance cover, isn't actually making a loss, it is good business if it increases revenue. For the managerial class, it's better to be running a large firm with mediocre profit than a small firm with high profit.

That's why claims that insurers have an incentive to reduce claims have a hollow ring. There is a great deal of rhetoric about insurers wanting to promote healthy lifestyles, but to do so beyond a few token measures can undermine the essential marketing tool of insurance, which is fear of illness. If we all believe that our health is in our own hands, if we believe that we are unlikely to require any services that Medicare cannot provide, then we are not very good prospects for insurers.

And, even if an insurer were to succeed in encouraging healthy lifestyles, the benefits of claim reduction would accrue to all insurers, not just to the firm spending its resources on such promotion, for it would be hard to confine the message to the one insurer's members.

By contrast, a single insurer has an incentive to overcome these problems. It has no need to increase its market share, for it already has the whole market. It has every incentive to reduce claims, for those efforts won't accrue to its competitors. And it is responsible to the taxpaying public, through the tight fist of government treasury departments.

It is necessary, again, to stress that the case for a single insurer is not a case for a "free" tax-funded system. It is a case for a single insurer to cover only those costs we want to insure. A single national insurer may be comprehensive, as in the UK, or it may be compatible with a thriving market, providing a safety net for catastrophic outlays.

Assumption 3: All competition is good competition

It is naive to assume that all competition is desirable.

Turning again to John Kay's Wincott lecture, he says:

> "... there are three elements to the triumph of the market economy. The first I will describe under the heading of 'prices as signals': the price mechanism is generally a better guide to resource allocation than central planning. The second element is 'markets as a process of discovery': a chaotic process of experimentation is the means through which a market economy adapts to change. The third heading is 'diffusion of political and economic power'. The economic point here is that prosperity and

> growth require that entrepreneurial energy should be focussed on the creation of wealth, rather than the appropriation of the wealth of other people.

It's a concise description of the way market competition brings us benefits, and, by simple extension, of where market competition, in itself, fails. To look at Kay's three elements in the context of health insurance:

> First, health insurance, be it the basic cover embedded in "plans" or extra cover, suppresses price signals. Insurance is the mechanism specifically designed to dispense with the discipline of pricing at the time of purchase.
>
> Second, while "a chaotic process of experimentation" is a marvellous thing in most markets, in financial markets it can lead to disaster, as events of the last year have shown. We expect insurers to be conservative, even dull, and they do not let us down in that expectation.
>
> Third, we want any business to add-value, rather than appropriating wealth. While we must bear some administrative overhead in health care financing, we want that to be as small as possible.

While the Commission advocates brand-name competition between insurers, it largely overlooks the lack of competition on the supply side, taking as given most of the sanctioned restraints on competition such as those applying to retail pharmacy and specialist medical colleges. It is surprising that the Commission has not paid more attention to these areas, because they are where competition can bring real benefits to consumers.

To its credit, the Commission does suggest bringing in competitive neutrality between private and public hospitals, but otherwise the Commission assumes, in disregard to the basic economics of supply and demand, that a fragmented set of "plans" can and will enforce provider competition, a point covered in the previous section. It ignores entirely the way various provider groups have been able to shield themselves from competition policy.

Another aspect of market operations not covered by the Commission is the distortion introduced in situations where some people have access to a "plan" or other insurance for health services while others do not. The problem is that one person's choice to have his or her payments covered by a third party – a "plan" or insurer – has negative consequences for those who do not have such access.

To illustrate, consider a world with two people – you and me. I have a generous, first dollar cover insurance, while you decide to go for self-reliance and cover your own health care costs. My health care needs may less serious that yours, but because I have the benefit of insurance cover, I am not put off by the price and will gain priority access to scarce health care resources. The doctor will be able to charge my insurer more than would apply in an open market, and you will have to match that price, or go without. My choice of generous insurance restricts your choice. (A formal treatment of this phenomenon is at the Appendix – "The case for prohibiting insurance where supply is restricted".)

This is not just an abstract argument. As John Deeble has pointed out, "... by subsidising medical gap insurance it [private health insurance] has helped support the largest increase in specialist fees for a quarter of a century."[17]

John Menadue explains:

> "Specialists have been exploiting gap insurance under private health insurance to secure large increases in remuneration. They now charge on average 50% above the Medicare scheduled fee. It is hard to find a better illustration of how private health insurance fuels increases in costs."[18]

That is why many economists argue against products such as gap insurance. If there are co-payments, they should apply to all with a prohibition on their being covered by insurance, otherwise those with insurance will drive up the price of services. It is also why many economists argue that, if private insurance is to have any role, it should be only for services which are in plentiful supply and which are not therapeutically essential; that is for *supplementary* services (such as more comfortable accommodation) rather than for *complementary* services (or therapeutically useful services), in the language of health economics.[19]

If the Commission could clarify its ideas – what they understand by "social insurance", how they see "plans" as different from present private insurance, why we need yet another administrative intermediary between consumers and providers, why they believe "choice" of intermediary is important, why they disregard the evidence of the benefit of a single national insurer, and what they mean by "strategic purchasing", then it may be possible to make a more definitive assessment of "Medicare Select".

But it is clear, by any meaning one can put on these terms, that "Medicare Select" is a further step, a large step, towards a "two tier" system of health care.

Towards two tier health care

To give the Commission its due, it acknowledges the absurdity in the present arrangements which link public hospitals to public funding and private hospitals to private insurance. (There are departures from this pattern, such as those individuals who pay for private hospitals from their own pockets without insurance and Department of Veterans' Affairs purchasing of private services, but these are minor).

The "Medicare Select" proposals deal with this problem, by putting all hospitals, private or public, on the same footing. To this extent they would undo the present arrangements which, for hospitalization in particular, contribute to a "two tier" or "gated community" of health care.

But we don't need "Medicare Select" to achieve this reform. At the Centre for Policy Development we have been arguing for many years that these separate funding pipelines for public and private hospitals are inequitable and inefficient. There is no reason why state governments (or any other possible government funder) should not buy services from private hospitals – Victorian Premier Jeff Kennett had this in mind more than ten years ago, and the Department of Veterans' Affairs offers a good model of public funding and private provision.

That reform of private hospitals is undone by the "opt out" nature of Medicare Select". The Commission leaves two crucial issues vague. One is the definition of the "universal service obligation", and the other is the role of private insurance.

Even if the universal service obligation is clearly defined at the outset, it could be progressively whittled back:

- by a government obsessed with budgetary costs while being less concerned with community costs. The more tightly the universal service obligation is defined, the less the government would have to outlay for its own "plan" and to transfer to other "plans";
- by a government which re-defines health care as "charity" rather than as something shared. Health care has redistributive benefits, but it should not be seen as a social welfare function. That's the path to a thinned-down program for the poor or "indigent";
- by a government with an intrinsic hostility to the public sector.

Such whittling back can occur through a static definition of the universal service obligation, which fails to keep up with emerging standards, meaning, over time, the universal service obligation covers only services which are standard in 2010.

The other vague point is the future of incentives for private health insurance. In its discussion of "Medicare Select", while it acknowledges that private insurance incentives could be changed, the Commission says nothing about how private insurance incentives should change, and, as mentioned previously, does not demonstrate if and how "plans" are any different from private insurance.

The Commission's Interim Report, in its Option C, suggested compulsory enrolment in private insurance, but compulsory private insurance does not appear in "Medicare Select", because people have the public plan as a default. There is a thin line, however, between compulsion and a set of strong incentives. If we were simply to re-name the Medicare Surcharge Levy as a "fine" for not holding private health insurance, then we could easily say that private health insurance is compulsory for high income earners. (We say that in Australia we have compulsory voting, but the fine for not voting is only about $50, while the Medicare Surcharge Levy is at least $700.)

The Commission's enthusiasm for private health insurance is evident in its "Denticare" proposals. The Commission does not explain why a government should go to the trouble of collecting taxes, and then churning those funds again through private insurance, rather than adding dental items to the Medical Benefits Scheme. But that is essentially what "Medicare Select" involves – it collects taxes and then, rather than controlling the outlays through the budgetary processes, hands them over to another financial intermediary – all in the name of "choice".

At the Centre for Policy Development we have been trying to get public policy focussed on the idea of universalism in health care. The Commission in its notion of a "universal service entitlement" seems to equate universalism with free provision, be that through a public or private insurer operating a "plan", at least for that entitlement.

We see universalism from a more basic perspective, and that is the notion that we should all have access to the same high quality services, even if, according to means, we may pay differently for them. That's why we have been opposed to the linking of private hospitals to

private insurance, and it's why we see equity problems in markets where some are covered by insurance while others are not.

To use an analogy from airlines, most large commercial aircraft have two or three classes of comfort, with very different fare levels, but, because all passengers are in the same aircraft, all are provided with the same level of safety. That's the form of universalism which should apply to health care, and it is best achieved by all sharing the same facilities, even if some pay more than others and if some can buy higher standards of comfort and other services which are not therapeutically important.

Conclusion

Strangely, in much of its discussion of the purchaser/provider split, and for a single source of government fundingthe Commission's "Medicare Select" proposals provide argument for a single national insurer. But the Commission's conclusions are drawn back to the notion of a multiplicity of private insurers. "Medicare Select", therefore, looks more like a business plan to expand the role of private insurance, rather than a means of providing any improved consumer benefits.

In sum, "Medicare Select":

(1) Entrenches an even larger bureaucratic intermediary between consumers and providers.

(2) Is based on a naive notion of "choice".

(3) Leaves the purchasers (the "plans") weak in the face of strong suppliers, and hostage to the inflated demands of members, leading to an inflation in health care costs.

(4) Is the vehicle which will move health care further towards a "two tier" system.

It is poorly thought through, and ignores the evidence which shows the system-wide costs of private health insurance.

But the main policy shortcoming of "Medicare Select", indeed of the Commission's whole approach to health care reform, is its failure to address the very basic question of the role of market forces in health care, for insurance, private or public, whether it's called a "plan" or "insurance", is not a market solution. To the extent we want markets to operate, we should have an area protected from the distortion of insurance. And to the extent we want insurance, we do best with a single national insurer.

Endnotes

1. Stephen Duckett "Fine print alert for those concerned about Aboriginal and rural health, and Medicare's future" *Croakey* 30 July 2009

2. Mary Foley "A Mixed Public-Private System for 2020" – a paper commissioned by the Australian Health and Hospitals Reform Commission July 2008

3. Mark Metherell "Medibank backs system shake-up" *The Age* 27 August 2009.

4. Private Health Insurance Administration Council O*perations of the Private Health Insurers Annual Report* 2007–08 www.phiac.gov.au

5. From AIHW *Health Expenditure Australia* 2007-08, Table A6.

6. David Goldhill "How American Health Care Killed my Father" *The Atlantic* September 2009.

7. Historical wage and CPI data from the Reserve Bank Australian Economic Statistics 1949-50 to 1994-95. (RBA 1996). Later data from ABS, Figures rounded, and do not reflect minor definitional changes.

8. Jennifer Doggett "Out of Pocket: Rethinking health co-payments" CPD 2009.

9. John Kay "The future of markets" 2009 Wincott lecture http://www.wincott.co.uk/lecture2009.htm

10. Pauline Vaillancourt and Christiaan Laako "An Experiment with Regulated Competition and Individual Mandates for Universal Health Care" *Journal of Health Politics, Policy and Law* 2008 33(6).

11. Thomas Schelling *The Strategy of Conflict* Harvard 1980.

12. Frederick Hilmer and Lex Donaldson *Management Redeemed* (Free Press NSW 1996).

13. For this explanation in the Dutch context, see Johannes Stoelwinder and Francesco Paolucci "Sustaining Medicare through consumer choice of health funds: lessons from the Netherlands" *Medical Journal of Australia* Vol 191 No 1, July 2009.

14. A finding of behavioural research. See, for example, Justin Sydnor "Sweating the Small Stuff: The Demand for Low Deductibles in Homeowners Insurance" University of California, Berkeley 2005.

15. Slovic, P; Fischhoff, B; Lichtenstein, S "Response mode, framing and information processing effects in risk assessment" in R M Hogarth (Ed) *New directions for methodology of social and behavioral science: the framing of questions and the consistency of response.* (Jossey Bass 1982)

16. There are many writings on corporate objectives. For a comprehensive treatment, see Alfred Chandler and Richard Tedlow *The Coming of Managerial Capitalism: A casebook on the history of American financial institutions* Richard Irwin 1985.

17. John Deeble "Le plus ça change: recollections of a retiring health economist" Chalmers Oration July 2009, Flinders Medical School.

18. John Menadue "Now is the Time for All Good People To Come to the Aid of Medicare" paper delivered to the Victorian Healthcare Association Annual Conference, October 2009.

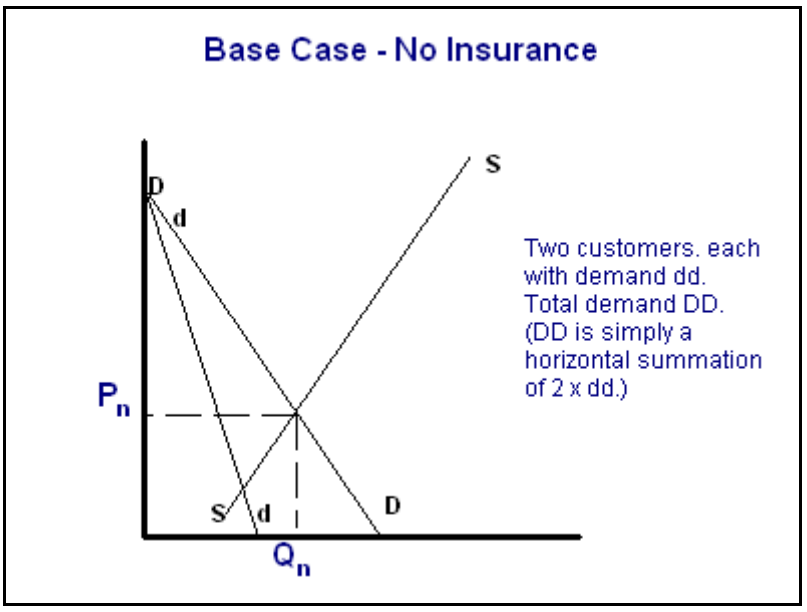
19. See, for example, Joshua Gans and Stephen King *Finishing the Job: Real-world policy solutions in health, housing, education and transport*. Melbourne University Press 2004.

Appendix: The Case for Prohibiting Insurance where Supply is Restricted

In markets where there are supply side constraints such as restrictive trade practices or mandated barriers to entry, there are efficiency and equity grounds for prohibiting customers from taking insurance.

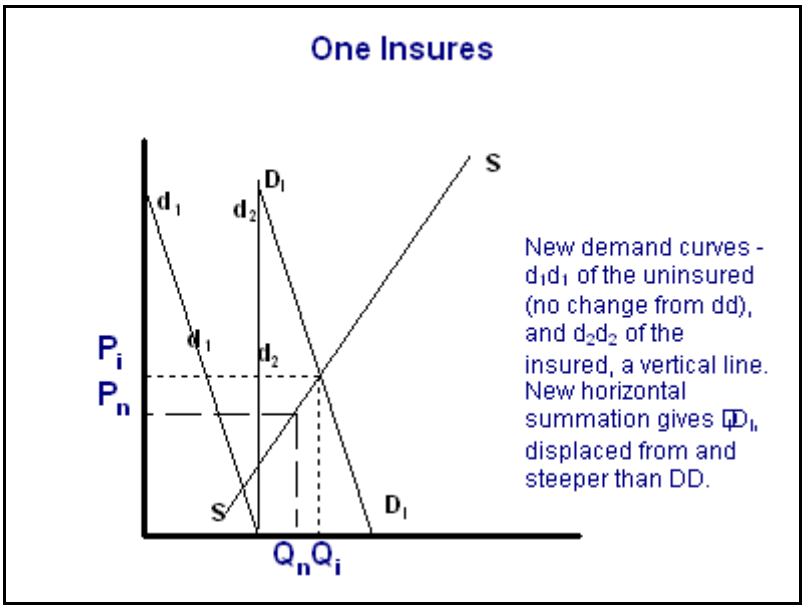
Base case

Consider a market with two customers. To allow readers to follow the argument easily I am using a two customer argument, but the argument can be generalized to any scale. Each customer has an identical (fairly inelastic) demand function, dd, and the total demand function is DD, a horizontal summation of the two identical demand curves, which intersect an industry supply curve SS. The equilibrium point is P_n, Q_n.



Breakaway - one customer insures

One of the customers now takes out insurance. I have assumed that this insurance provides "first dollar" cover, without any co-payment or other rationing device. This means that the demand function for that customer is entirely inelastic, rising vertically from the point where his or her original (uninsured) demand function crossed the Q axis. This is denoted by the curve d_2d_2 in the diagram alongside, while the other customer's curve remains unchanged.

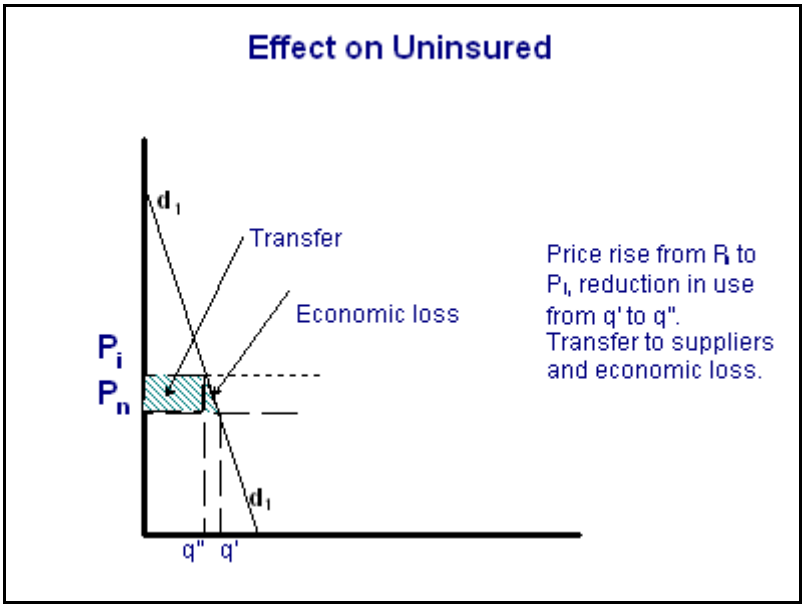


The new demand curve for the two customers is D_iD_i. That is the original DD curve, pivoted outwards. The price has risen from P_n to P_i, and the quantity has risen from Q_n to Q_i.

In a market without barriers to entry we would expect, over the medium term, an outward movement of the supply curve, until the price P_n was re-established. That is the usual situation of over-supply which results in a market where demand is elevated by moral hazard. But in this case I am modelling a situation in which there is no outward movement of the supply curve.

Effect on customers – the uninsured

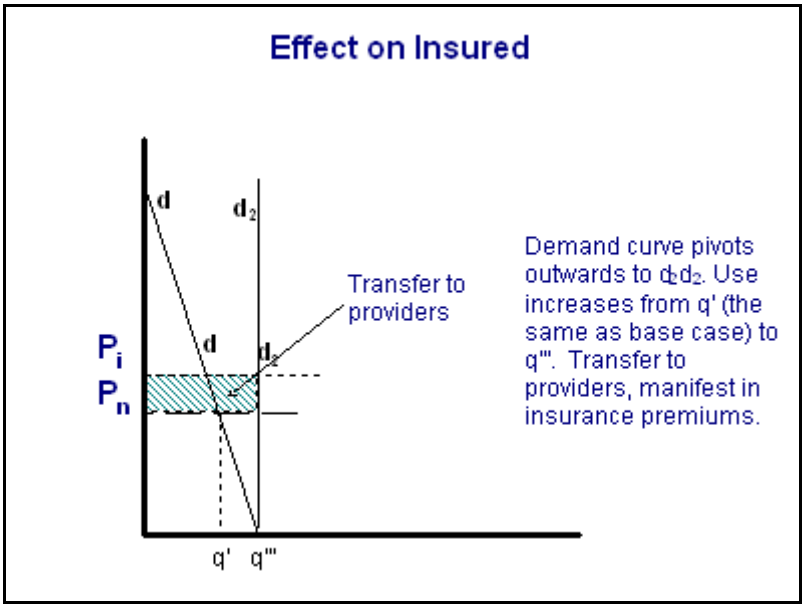
For the uninsured customer there are both equity and efficiency effects. The price rise from P_n to P_i results in a reduction in use. There is a transfer to producers and a certain amount of economic loss. This is modelled in the diagram alongside.



In effect, the uninsured is operating as a price taker in a market where the price has been forced up by a group of customers who have the backing of the buying power of insurance.

Effect on customers – the insured

The insured customer has greater access to resources, as is shown in the diagram alongside. There is more use of services, and a transfer to providers, which is manifest in insurance premiums being higher than they would have been if the price had remained at P_n.



This effect can be confirmed empirically, such as studies in health care which suggest that patients with access to insurance use more procedures or more expensive procedures than those without insurance. (Such empirical observations, however, still allow for the possibility that causality operates in the different direction; people use insurance because they correctly perceive they may need more procedures.)

One might suggest that this rise in premiums will bring about its own equilibrium; rationally those who insure will realise that their actions are driving up the price level. But this upward pressure on the price level is essentially an externality. Once we break from the two person model to a large number the individual cost associated with this moral hazard of insurance is negligible.

Practical applications

This analysis applies to markets in which there is a supply side constraint. It cannot be generalised to all markets in which insurance operates, because in most markets there is no such restraint. For example, house and car insurance do not necessarily drive up the price of houses and new cars, because insurance is marginal in those markets, and there are no barriers to entry. In some other markets, such as car crash repairs, insurance may dominate the market, but a reasonably open market on the supply side prevents the accumulation of supernormal profits.

It is in markets such as health care and legal services that this analysis is most likely to hold. In these markets there is often a restraint on the supply of key resources. In health care, for example, these constraints include GP registration, entry to specialist colleges and ownership and registration of pharmacies. Even if these constraints are lifted the supply side response may be so slow that excess profits may persist indefinitely.

One could suggest that the process will be kept in check by adverse selection. In spite of the price rise applying to everyone, there will be benefits for low risk customers remaining uninsured while high risk customers take out insurance. In spite of the price rises, provided those price rises are not sufficient to persuade low risk customers to insure, then the process will be self-limiting. But this limitation may come at a high level of insurance; people are likely to be risk-averse in health insurance, partly because they cannot predict their future demands as easily as with other classes of insurance, and partly because consumers' decisions in insurance often do not conform with economic rationality; for example people put a high value on first dollar cover because of the subjective benefit of pseudocertainty.

In terms of public policy, it suggests that in such markets either insurance should be prohibited because of its effects on the uninsured, or, if it is permitted, there should be a mechanism to ensure the price does not rise above the level which would exist in a free market. Such an outcome can theoretically be achieved with price control or an entirely free market. In health care price control has considerable legal and administrative difficulties, and results in the inefficiency of rationing through queuing. A free market would result in greater equity and an elimination of deadweight loss associated with the uninsured, but waste associated with over-consumption by those with insurance.

A practical and equitable public policy is to provide centralised catastrophic insurance, with price control exercised through the market power of that insurer, and to prohibit any

supplementation of that insurance. Even if supply side restrictions are sustained this would produce efficient and equitable outcomes.