MEDICARE SELECT: ENTRENCHING INEQUALITY IN HEALTH CARE?

By Ian McAuley and Peter Frank

DISCUSSION PAPER

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Main Points

In its Final Report, the National Health and Hospital Reform Commission made a number of recommendations for change to Australia's health policies and programs.[1] Some of these are very worthwhile but one of its main proposals, 'Medicare Select' is decidedly less so.

This proposal would involve all Australians becoming enrolled in a government-funded health care plan, but with the option of moving to an individual (private) 'plan'. Government funding would be directed to the private plan on a per capita basis, and the private plan could involve extra services funded by private insurers. The 'plans' would be managed by private corporations or not-for-profit organisations.

What does the Commission mean by a plan? Many Australians have a health care plan developed for them by their general practitioner, to address their particular health issues at a given time. This is not what the Commission is talking about. The Commission's 'plans' are not so much about managing your health, as about managing the cost of providing you with health services.

> *'Plans would negotiate contracts with public or private health service providers that would provide services to members. Providers would compete for contracts based on price and quality of service. People would be free to choose public or private health service providers as long as the provider had a contract with their plan.*[2]

The language the Commission has used to describe Medicare Select is clearly referring to 'managed care' - systems of financing and delivering health care to enrollees in programs that are:

> *'...intended to reduce unnecessary health care costs through a variety of mechanisms, including: economic incentives for physicians and patients to select less costly forms of care; programs for reviewing the medical necessity of specific services; increased beneficiary cost sharing; controls on inpatient admissions and lengths of stay; the establishment of cost-sharing incentives for outpatient surgery; selective contracting with health care providers; and the intensive management of high-cost health care cases. The programs may be provided in a variety of settings.*[3]

In the US managed care is delivered both through Health Maintenance Organisations (HMOs) (where care is provided only through those hospitals, doctors, and other providers with which the HMO has a contract) and Preferred Provider Organisations (where providers who have covenanted with an insurer or a third-party administrator, provide health care at reduced rates to the insurer's or administrator's clients).

According to the Parliamentary Library, 'Medicare Select most closely resembles the Israeli and Dutch Social Health Insurance (SHI) schemes. In these schemes: funds are collected and distributed centrally by the state rather than paid directly to health plans; it is compulsory to be a member of an SHI plan; people are able to change health plans; and voluntary supplemental insurance is available for an additional premium.'[4]

While 'Medicare Select', as presented, may have superficial appeal, it has several shortcomings:

- The primary shortcoming of 'Medicare Select' is that it appears to have been designed to secure an ongoing major role for private insurers, who will continue to impose an excessive bureaucratic and financial overhead on health care, without adding commensurate value.
- Secondly, it is based on a misunderstanding of the role of 'choice' and planning in markets for health care, for we cannot know what our future health care needs will be.
- Thirdly, it is likely to result in cost escalation, to the benefit of providers; this is an outcome of the intrinsic moral hazard and weak purchasing power associated with private insurance.
- Fourthly, it makes it easier for a government, over time, to redefine Medicare as a bare bones program for the poor or indigent, thus entrenching a two-tier health system.

The Commission itself acknowledges that further work is needed, recommending that the Government commit over the next two years to 'exploring the design, benefits, risks, and feasibility around the potential implementation of 'Medicare Select'.

The report reflects the narrow terms of reference provided by the Commonwealth Government. Comprising mainly people closely associated with present arrangements in health care and health insurance, the Commission may have had difficulty envisaging fundamental changes to bring the disparate elements of health care into an integrated system, making efficient use of available resources and with a minimum of bureaucratic overhead.

Economic reform in Australia - why is health care always left out?

Over the last thirty years Australia has shown an extraordinary capacity to take on economic change: for example, tariff reductions, bank de-regulation, the privatisation and commercialisation of government services and an overhaul of sales taxes. Members of the community will have different views on the wisdom of these policies, but the point is that Australia has demonstrated its ability to come through these changes without major disruption, and that voters can be persuaded to accept them. Governments can override the vested interests of pressure groups and still get re-elected – as did the Hawke-Keating Government when it reduced industry protection, and the Howard Government when it introduced the GST.

A glaring exception is health care, an area in which governments of all persuasions have become increasingly timid about introducing fundamental reform. Thirty-five years ago the Whitlam Government was forced to resort to extraordinary measures to introduce Medibank. After Medibank was subsequently weakened, the Hawke Government resurrected its essential elements in Medicare.

Medicare was the last major reform, and that was twenty-five years ago! Since then we have gone backwards, if anything. The Hawke-Keating Government failed to address the problem of fragmentation of health care services and was ambivalent about the role of private health insurance. The Howard Government, elected in 1996, was determined to see private health insurance restored to its formerly strong position, and did so at extraordinary public expense through a mix of direct subsidies, tax incentives and free advertising, all without consideration of subsequent fiscal and economic costs.

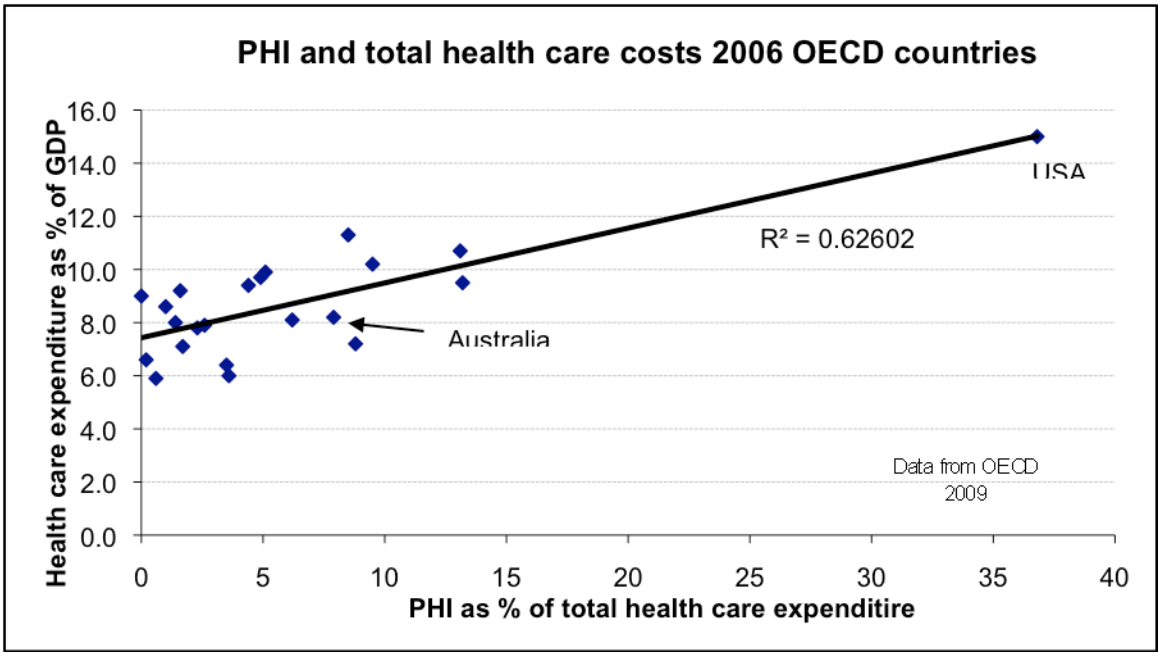
The Rudd Government inherited the Howard Government health policy, and while hinting at significant reform in the pre-election period, it too has been rather timid so far. As Ross Gittins commented in the Sydney Morning Herald, 'It's surprising that Labor - the party that brought us the Medibank then Medicare revolutions - now seems so relaxed about the need for further reconstructive surgery on the health system.'[5]

Rudd did establish the National Health and Hospitals Reform Commission, but tied the Commission's hands by ruling out any inquiry into the role or operations of private health insurance.[6]

This restraint does not seem to have worried the Commission, for it has accepted without any analysis an ongoing role for private health insurance. In both its draft and final reports it has stated 'We want to see the balance of spending through taxation, private health insurance and out-of-pocket contribution maintained over the next decade.'[7]

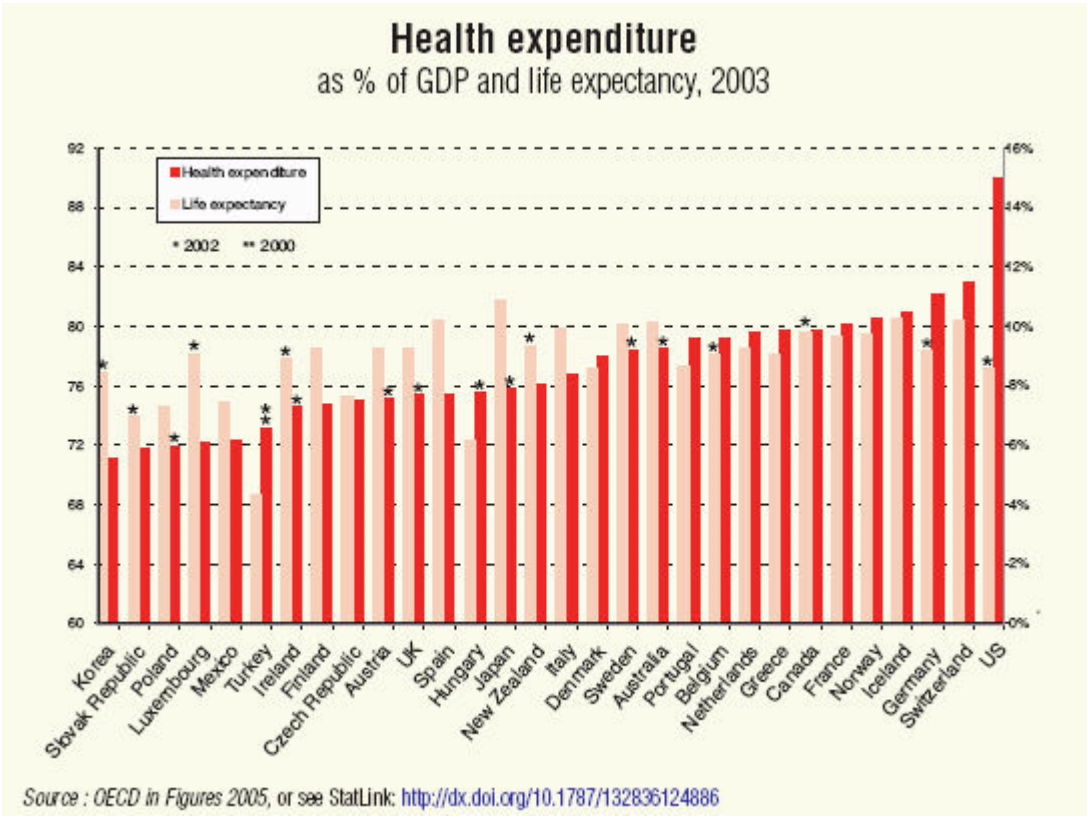
Private health insurance has come to be seen as 'part of the furniture', as institutions such as industry protection and centralized wage fixing had been in the past. To question its value is considered bad taste, or at worst a sign of affection for some sort of Soviet-style 'socialized medicine'. Although the Productivity Commission, in 1997, called for a broad inquiry into health financing, no government has yet taken up this challenge.[8]

This is in spite of mounting evidence that private insurance not only fails to add value to health care, but actually adds to the burden of health care costs, without contributing to health outcomes.[9] The general finding of comparisons among OECD countries is that the more countries depend on private insurance, the more they pay for health care, without any associated health care benefits. **The most recent OECD data indicates an escalation in health costs in countries with high expenditure on private insurance and comparative stability in health costs in countries with single national insurers, such as the Nordic countries and Canada.**

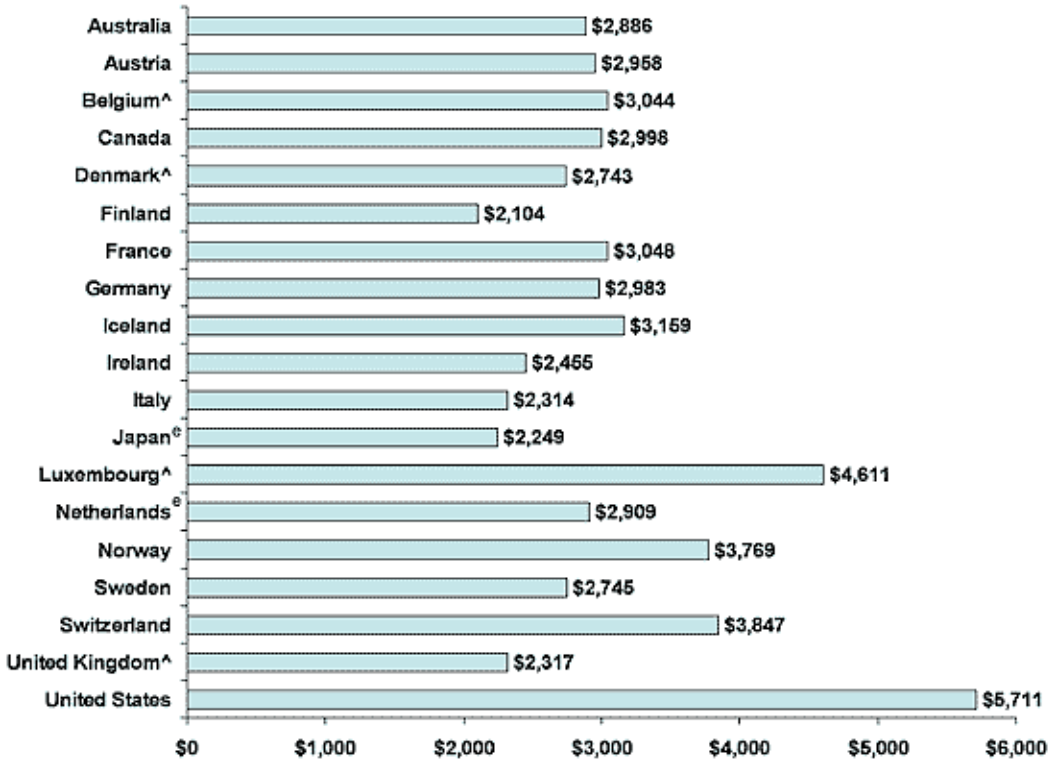


Private health insurance is nothing more than a high cost financial intermediary, creaming a surplus from public and private payments for health care. Private insurance is the worst-of-all-worlds solution, for it muzzles market signals, while it lacks the market power enjoyed by single national insurers.[10] If the global financial crisis has not convinced us of the ways financial institutions let down the public interest, then we should look more specifically at the way private health insurance has been so damaging to different nations' health care systems and to their wider economic interests.

The prime example is the US, where health insurers have fuelled an extraordinary campaign of fear with notions of 'death panels' and harsh rationing (as if the US insurers do not themselves ration harshly), all in order to sustain their privileged position. In the US the insurers have so far spent $380 million in their fear campaign.[11] Health care costs in the US have reached 15% of GDP, even while 40 to 50 million are left uninsured. By contrast, health care costs in Australia are 9% of GDP.[12] Health care costs in the US are crippling its international competitiveness, and the lack of universal coverage is resulting in inequities that are beyond the capacity of decent people to tolerate.



Total Health Expenditures Per Capita, U.S. and Selected Countries, 2003[13]



^Break in series; see 'Comparability over time' at http://www.irdes.fr/ecosante/OCDE/411.html. [e]OECD estimate. Notes: Amounts in U.S. $ PPP. Source: Organisation for Economic Co-operation and Development. *OECD Health Data 2006*, from the OECD Internet subscription database updated October 10, 2006. Copyright OECD 2006.

Another example is the Netherlands, which in 2006 introduced compulsory enrolment in private insurance. It has seen a rapid escalation in health care costs as insurers find themselves in a weak bargaining position against service providers, assured that they will be subsidised by permissive government policies.[14]

An evaluation of the first two years of the Dutch insurance system, based on Dutch Central Bank statistics, national opinion polls, consumer surveys, and qualitative interviews with policy makers has drawn some sobering conclusions:

> *'The first lesson ... is that the new Dutch health insurance model may not control costs. To date, consumer premiums are increasing, and insurance companies report large losses on the basic policies. Second, regulated competition is unlikely to make voters/citizens happy; public satisfaction is not high, and perceived quality is down. Third, consumers may not behave as economic models predict, remaining unresponsive to price incentives. Finally, policy makers should not underestimate the opposition from health care providers who define their profession as more than simply a job.'*[15]

This analysis of The Netherlands experience should sound a warning for us, for it is one of the examples the Commission uses as a model of what it has called 'social insurance'. The Commission has taken liberties with the term 'social insurance'. Social insurance schemes, as they operate in many European democracies, are built on shared funding and universalism, but few would call the Netherlands scheme social insurance, for it involves different people enrolling in different funding schemes – as does 'Medicare Select'.

Also, the Netherlands has some protections not mentioned in the Commission's report: the insurers are not-for-profit mutuals, subject to prohibitive disincentives against moving to a for-profit status, and service providers are subject to widespread price controls. In spite of these conditions, health care costs are rising much faster than in other European countries, and the rate of cost escalation has been hidden behind an accounting *legerdemain* which has allowed insurers to count a depletion of reserves as 'income'.

Full public funding should not be regarded as the only alternative to private insurance. Countries as diverse as Sweden and Taiwan make judicious use of capped consumer co-payments to overcome the 'moral hazard' of insurance. (Advocates of private insurance often prefer to forget about moral hazard, the tendency for people to over-use a service when it appears to be free at the point of delivery. Private insurance is therefore not a market solution; on the contrary, it offers people a way to buy themselves out of the discipline of markets.) The Centre for Policy Development paper 'Out of Pocket' outlines one possible way to use copayments to overcome moral hazard while addressing the equity and access problems that copayments can cause for low income people.[16]

Further, there is absolutely no suggestion that without private insurance there will be no private sector delivering health care. Most countries with single national insurers rely on the private sector for providing health care. (Advocates for private insurance also often conveniently forget the distinction between *funding* and *providing* health care when they suggest that without private insurance the 'private sector' will collapse.)

The NHHRC has failed to consider what Australia's health care arrangements could look like with a single national insurer – with private insurance playing either a very minor role (as in the UK and Nordic countries) or a supplementary role (as in Canada and France). The private sector can still thrive in delivering services, choice can be maintained or improved, equity can be improved and costs can be contained.[17] Whether through its own limited vision or constrained by the government's timidity, the Commission has not questioned the role of private insurance, and has simply proposed that it become embedded in a system it calls 'Medicare Select'.

Medicare Select

Details of 'Medicare Select' can be found in Part 6.6 of the Commission's Final Report[18] and in a summary prepared by the Parliamentary Library.[19]

It is based on 'choice' between competing plans. In the words of the Commission:

> *'All Australians would automatically belong to a government operated health and hospital plan, but could select to move to another plan, which could be operated by a not-for-profit or private enterprise. Health and hospital plans would receive funds from the Commonwealth Government on a risk-adjusted basis for each person. ... Through contracting arrangements with public and private*

> *providers, plans would purchase services to meet the full health care needs of their members. This would entail a strategic approach* [the word strategic is not defined] *to innovative purchasing, focusing on people's health care needs over time, and across service settings, rather than on the purchase of individual elements of the service.'*

As presented its looks appealing, for its language deftly combines universalism, choice and service integration. But it needs critical consideration, on four grounds:

1. It expands the role of private insurers as a bureaucratic intermediary between consumers and providers;
2. It is based on a flawed notion of 'choice' and planning and is a poor way of integrating services;
3. It leaves the purchasers (the plan managers) weak in the face of strong suppliers, and hostage to the inflated demands of members, leading to an inflation in health care costs;
4. It is a policy that could move Australian health care yet further towards a two-tier system.

1. Plans - the new term for bureaucracy

Most Australians are light users of health care most of the time. Medicare statistical tables indicate that 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.

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

Very few of the light users want or need a 'plan' in the form of an organisation that sources service providers for them. They can and do take responsibility for their own health care. The Commission, however, while making a strong rhetorical point about people taking responsibility, slides with ease into the notion that we all need a 'plan'.

The idea of 'plans' may reflect a bias in the composition of the Commission, dominated by people involved in health care and health financing, for such people are most familiar with the heavy users of health care. By definition they would be less aware of the non-users and the light users.

Alternatively, the idea of 'plans' may be a means of finding a role for private insurers to act as intermediaries. Although the introduction, quoted above, refers generically to plans operated by 'not-for-profit or private enterprise', later in the report the Commission, in explaining the 'plans', says:

> *'As is the case now with private health insurers, 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).'*

In other words, the term 'plans' is almost certainly a euphemism and synonym for private insurers.

It beggars belief to expect that insurers, with objectives and a corporate culture drawn from the finance sector, should become competent in health care. We would be highly puzzled if Gail Kelly, CEO of Westpac Bank, announced that the company was going to move from providing mortgage finance to contracting with and overseeing builders as part of their customer service. Engaging for profit corporations to provide a link between users and providers of health services appears to create, by definition, a conflict of interest as corporates must maximise returns for shareholders, which is not an improper goal per se but one which can be at odds with the overarching public policy goal of maximizing health outcomes for citizens.

Insurers are part of the financial sector, not the health care sector. No doubt some health insurance funds would like to expand their role from passive financiers to more active care managers, but such a transformation is not going to add value to health care.

The Commission says that the providers of health and hospital plans would have 'a motivation to invest in wellness and prevention to encourage and support members in healthy living'. The idea is noble, but the Commission does not explain what this motivation would be. One motivation could be that healthy members make fewer claims resulting in higher profits for the insurer. For actual health providers such GPs, motivation could be provided by funding preventative health approaches in the same manner as any other defined health service. And funding parameters could be set by the government to encourage delivery of wellness/prevention services.

Unfortunately, the more an insurer (or any other 'plan' provider) succeeds in conveying the preventative health message, and getting people to take responsibility for their own health, the less those people who are low users will feel the need for a private plan manager – why pay the extra if your needs are adequately met by the public system? It's just not good business practice.

2. What does 'choice' mean in health?

Choice drives markets for cars, breakfast cereal, entertainment and many other products in a market economy. It is easy for some people to see 'choice' as an end in its own right, rather than as a means to an end. We exercise choice to our benefit only when we are reasonably clear about what we want.

No one has a clear picture of their future health care needs. Tomorrow I may be diagnosed with a serious acute condition such as cancer, or a chronic condition such as diabetes. I may be involved in a car accident. I may live a long and healthy life and die gently in my sleep. It is absurd, therefore, to suggest that I, or anyone else, should be in a position to make a wise choice about a plan for my unknowable future needs.

That is not to deny the benefit of a care coordinator – someone who can help bring services together. But such coordination, surely, should apply to an individual's health condition at a particular point in time. If, say, I am a diabetic who has a car accident, I may want to have a long term relationship with a care manager specialising in diabetes, and a short term relationship with a care manager specialising in accident rehabilitation.

What seems to be implied in the Commission's suggestions is not choice of plans centred on choice of care, but rather, choice of plans centred on choice of financier. In other words it's a mild modification (in terms of means of funding) of the present arrangements, which provide 'choice' only between look-alike private insurers. Over half the population who are presently without private insurance would be faced with choosing a plan for the first time. This could prove quite a challenge, given that the majority of Australians have remained with their default super fund, despite being given the option 4 years ago of transferring to a more appropriate, better performing alternative fund.

3. Can plan managers control providers' costs?

The Commission says:

> *'Through contracting arrangements with providers, health and hospital plans would purchase the services to meet the full health care needs of their members. This would entail a strategic approach to purchasing, focusing on people's needs over time, rather than on the purchase of individual elements of the service.'*

That's another lofty ideal, but experience in the US, the Netherlands and increasingly in Australia (where 'no gap' policies have allowed an escalation of specialists' fees) demonstrates that health insurers have to be permissive towards the demands of service providers. That situation results in part from the concentrated market power of service providers, and in part from the essential moral hazard of insurance. Single point public insurers can overcome that moral hazard by using their own market power – as is done in Australia's Pharmaceutical Benefits Scheme whereby the Commonwealth uses its power to countervail the market power of the pharmaceutical firms. Once purchasing is fragmented, however, cost escalation ensues.

4. Towards a two tier health care system

Australia is already drifting towards a two tier health care system. The notion of universalism started to unravel in the early 1990s, when the health ministers of the time came to see health care in terms of distributive welfare rather than as a shared public good. Our particular arrangements with private insurance, whereby private hospitals receive most of their funding through private insurers, has tended to re-enforce a two tier system. The Rudd Government, in spite of its stated commitment to social inclusion, has actually tried to strengthen the incentives for high income earners to use private insurance for hospital care, thereby insulating themselves from the limitations of the public system.

As has been pointed out in previous Centre for Policy Development publications, such as *A Health Policy for Australia: Reclaiming Universal Health Care,*[20] a universal system is not necessarily a free system for all. Rather, a universal system is one in which we all share the same high quality services, even if we pay in accordance with our means. A policy which, through generous subsidies or tax breaks, encourages the well-off to use a separate hospital system can hardly be called 'universal'.

To its credit, the Commission sees plan managers as being free to purchase services from either private or public hospitals, thereby breaking down these barriers. It is doubtful, however, whether such inter-sectoral competition could come about: when he was Premier of Victoria Jeff Kennett tried to get private hospitals to take public patients, but he met with strong resistance.

The government operated health and hospital plan risks becoming an increasingly minimalist scheme, such as Medicaid in the US.

This could happen under three plausible scenarios:

- A government of either 'left' or 'right' persuasion may come to see public funding of health care purely in terms of distributive welfare – a program for the poor or indigent, similar to Medicaid in the US.
- Second, any government under intense budgetary pressure may cut back on health care funding. It's a strange feature of our economic debate that some people refer to public funding as being 'unaffordable', while advocating even more expensive means of funding health care, such as private insurance.
- Third, just as in the days of the cold war, when Communist ideologues had a pathological hatred of the private sector, today a mirror image of politicians and their supporters have a pathological hatred of the public sector; many of whom have surfaced most visibly in the growing conflict over President Obama's plans for reforming health care in the US, or in Australia, in the dental industry's knee jerk opposition to 'Denticare'.

Such a drift as envisaged above is entirely possible because the Commission has failed to articulate a detailed view of what it believes should comprise the publicly funded universal service obligation.

Conclusion

The Commission's deliberations have resulted in many useful recommendations on issues such as indigenous health, mental health, the use of health data and strengthened primary care.

In some other areas, while it has identified problems, its solutions appear somewhat bizarre, such as its 'Denticare' scheme. It is commendable that, with its Denticare Australia recommendation, the Commission implicitly recognises the need to address the woeful state of dental health in Australia. Unfortunately, however, it perpetuates the artificial separation of dental care from overall healthcare. Instead of taking the opportunity to move towards an integrated system of health it leaves this proposal more exposed to the predictable opposition from significant parts of the dental profession, and its solution would see funds churned through both the tax system and private insurance.

The Commission has correctly identified fragmentation as a problem in health care. But it has not addressed the fundamental problems in program design that have caused such fragmentation. The main programs – hospital funding, the Pharmaceutical Benefits Scheme, and the Medical Benefits Scheme – are built around the interests of suppliers (hospitals, pharmacists and medical practitioners) rather than the interests of consumers, but the Commission recommends retention of these programs in their present form. Its recommendations on primary health care centres, for example, make no mention of bringing pharmacists or dentists under the umbrella of primary health care.

Its solution to fragmentation seems to be to rely on 'plans' under 'Medicare Select', rather than any proposals for fundamental program redesign – which, if done properly with a citizen focus, would achieve much of what plan managers are supposed to achieve, without the cost of entrenching another layer of bureaucracy.

The Centre for Policy Development has proposed practical and achievable solutions to the fragmentation of the health system. Regional Health Organisations[21], and a single payer system[22] facilitated through a Health Credit Card[23] could be used to achieve many of the benefits touted for Medicare Select with none of its shortcomings.

The failings of the Commission's Report do not reflect any lack of competence by its authors. Rather, they reflect, in part, the narrow terms of reference given to the Commission. The question is really about why the Commonwealth precluded any cost/benefit analysis of private health insurance. And why did they call it the Health *and* Hospitals Reform Commission – is the Commonwealth so attached to its program structure that they see hospitals and health care as separate?

In part, the Commission's Report reflects what Mike Steketee, in *The Australian* on August 15, called an 'insider influence'.[24] A report by a body such as the Productivity Commission would have been able to demonstrate more detachment, and more questioning of underlying assumptions about the present health system.

There is overwhelming support in Australia for government involvement in health care. Polling also indicates that health care is one of the few services for which Australians would be prepared to pay higher taxes. Further, the popular misconception that the health system is coming apart at the seams provides a context in which a courageous government could tackle vested interests and focus on long term reform while also managing the demands of the daily news cycle.

The Commonwealth needs to show the same political courage that previous governments have demonstrated in earlier important reforms. To guarantee the ongoing delivery of efficient and effective health care for all Australians it must take on the vested interest groups and move to a single health insurer, eliminating the inevitable shortcomings of staying with the recommended public/private insurance model. In doing so it would maximise the chances of overcoming the major problems in the health sector which have not been satisfactorily addressed by the 'Medicare Select' proposal, namely:

1. High administrative costs.
2. An inability to contain service providers' costs.
3. An inability and a disincentive to provide public goods.
4. Difficulties in achieving equity ('community rating').
5. Fragmentation of health services delivery.[25]

Tariff reform was a much more difficult political challenge, for it imposed high costs on many people employed in manufacturing. Many people lost their jobs, many had to relocate and many small firms went under. Unlike tariff reform, however, health reform should not cause any health workers to fear for their livelihoods. No doctors, dentists, nurses or pharmacists need fear unemployment, because our problem for the foreseeable future lies in a shortage of skills. Perhaps some jobs in private insurance or government agencies may not have such an assured future in a reformed system, but the voting community is unlikely to shed tears if those who have been doing no more than adding to bureaucratic overheads have to make way for those who can provide more real value at a lower cost.

Notes

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