Integrated Health Care Begins with Values

Ian McAuley

Health care in Australia is delivered through a complex mixture of programs, with different channels of finance, with different principles of allocation, and without any coherence in underlying values. Most proposals for reform, including the policy options of the major political parties, do not address these fundamental inconsistencies. This article argues that reform proposals should be based on consistent principles and values.

The 2004 federal election illustrated, once again, the paucity of Australia's health care debate. Neither the government or the opposition offered a health care policy — that is, a set of programs held together by consistent guiding principles and reflecting underlying community values.

Labor's main proposals were Medicare Gold, offering free public or private hospitalisation to people aged 75 or over, and generous enticements for medical practitioners to use bulk-billing. But if Medicare Gold was so good for the 75-and-over age group, why not make it universal? If free hospitalisation was important, why not free pharmaceuticals or dental care? Labor's spirited defence of bulk-billing was also at odds with its support for higher copayments for pharmaceuticals.

The Coalition's proposals were yet higher subsidies for private insurance and support for an open-ended medical safety net. The Coalition, traditionally, has espoused values of self-reliance. But its generous subsidies are available only to those who place their fate in the hands of private insurers. Those who save for their own private hospitalisation or dental care are left unsupported.

And those are just the election offerings. They do not start to describe the mess of programs that constitute Australia's health care.

A Mess, not a System

Politicians, journalists and lobbyists often refer to Australia's health care 'system', but that is a loose use of language. A system has coherent design; but neither from a user's nor a provider's perspective, is there any evidence of coherent design in health programs.

A User's Perspective

From a user perspective the way health care is funded and provided is quaintly absurd. For example:

1. A minor ailment with a general practitioner consultation usually involves visits to two separate establishments — a surgery and a pharmacy. The general practitioner's consultation may be provided free if it is bulk-billed, or there may be a contribution, over which there is no price control. The prescription, however, will require a copayment of a fixed amount. But if the remedy is a non-PBS drug or appliance, even if it is just as efficacious, the consumer is left to the whims of a highly imperfect market.
2. For those with private insurance (generously subsidised by the Commonwealth) a certain number of dentist services will be free, the number depending on the level of cover. But past that restricted number, people are left bearing the open-ended risk. It is not really insurance but, for ancillary services, a limited assistance for small outlays. The more self-reliant, who choose to save for their own dental and similar expenses, do not get the benefit of any subsidy.
3. A stay in a public hospital is free; there is no copayment. 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 copayments for most of these services. Pharmaceuticals used in the private hospital will be funded under yet a

different program, the Pharmaceutical Benefits Scheme (PBS), with fixed copayments.

In most industries we see value as starting from the consumer or user. Not so in health care: the starting point is the provider. But this need not be the case; just as successful private corporations have turned to a consumer focus, so too could health care (Moore 1994).

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. Health care providers 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.

For example, bureaucrats in federal Treasury are always concerned about the rapidly rising cost of the PBS; they do not have any incentive to think about the savings that drug therapies make elsewhere in the health system and in the economy more widely. For example, insulin enables people with diabetes to lead active, productive lives.

Similarly, Labor's Medicare Gold would integrate private and public hospital services and bypass the bureaucracy of private insurance, and therefore be 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 the present fragmented arrangements 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. Trapped in a narrow budgetary perspective, Labor was unable to show its wider economic benefits.

The reality is that whatever funding arrangements are used — public insurance, private insurance, or direct payments — taxpayers will supply and pay for older Australian's health care. But in the face of criticism, Labor was frozen like a rabbit in a spotlight because it did not have a system perspective to present to the electorate.

How did Australian Health Care get into this Mess?

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 really insurmountable or just excuses for inaction? Australia has a sound record in achieving useful federal/state cooperation in other areas.

2. Legacy and Politicisation – A Deficit of Imagination

Second is the legacy of programs. State government involvement in hospitals goes back to pre-federation days. Commonwealth involvement in the PBS dates to the post-war years, and its heavy involvement 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.

In general, the lines of demarcation are based on professions, institutions and technologies, rather than users' needs; these divisions being hospitals, pharmaceuticals and ambulatory services.

By contrast, a user-based set of programs would build a system starting with the consumer. If program division is necessary, then such divisions may be based on identified groups of users — perhaps according to intensity of use (chronic, acute and

occasional), demographic profiles (youth, the ageing, and others), or regions. The program for war veterans illustrates such an approach, but this still has to work within the demarcations of supplier-based programs.

Politicians and policy advisers do not re-visit their long-held perspectives. Labor has a sentimental attachment to bulk-billing; but if free general practitioner consultations are so important, why should there be payments for pharmaceuticals? The Coalition has a senseless infatuation with private health insurance, and is unwilling to accept that it combines the worst aspects of socialised 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 role of public servants has become one of providing ex post facto justification and rationalisations for government decisions, rather than the provision of critical evaluation and advice.

Or the explanation may be more mundane. As Charles Lindblom said in his description of policy formation, policymakers do not look at whole systems but are content to "muddle through", seeking incremental change in response to problems, rather than basic system change (Lindblom 1959).

Lindblom's work is often taken as a defence of such an approach to policy development, but in his work he makes it clear that muddling through is flawed:

"... the method is without a built-in safeguard for all relevant values, and it also may lead the decision maker to overlook excellent policies for no other reason than that they are not suggested by the chain of successive policy steps leading up to the present."

He also warns about ignoring possible consequences of policies, and of confusing means and ends, which is particularly relevant in the case of private health insurance, because supporting private insurance has become an end in itself, rather than seeing it as one possible means of channelling funds to private providers.

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 leave the task of integration (if any) to others. It has its place — it is a tolerably good practice for day-to-day operations in certain organisations, such as supermarkets and factories. But it discourages system-thinking and innovation. In the wave of public sector 'reforms' that started in the mid-1980s MBO was embraced enthusiastically, even as its original proponent, Peter Drucker, was warning about its limitations (Micklethwait & Woolridge 1997).

4. The Budgetary Obsession – Bookkeeping Displacing Economic Analysis

Fourth is the obsession with official budgets. As illustrated with Medicare Gold, politicians tend to evaluate programs in terms of their budgetary impact, rather than their wider economic impact. An obsessive level of this was witnessed during the 2004 federal election campaign, the measure of all policy proposals being their four-year fiscal burden, rather than any proper cost-benefit analysis.

This limited focus is built into the Coalition's *Charter of Budget Honesty*, which not only prescribed a narrow budgetary focus on election commitments, but also generated the *Intergenerational Report* – a document with a narrow financial, rather than a broader economic perspective, placing budgetary control above all other notions of value.

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. Perhaps the *Charter of Budget Honesty* needs to be replaced by a *Charter of Economic Honesty*, which would require governments and oppositions to evaluate proposals in relation to their entire economic impact.

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 in both Commonwealth and state governments. In the private sector there are professionals who treasure their autonomy, not-for-profit organisations 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 copayments, and private insurers deceitfully claim that without their presence the private system would collapse even though huge benefits would accrue from direct government funding of public hospitals.

Does Australia have to accept these five factors for all time? Do we have to limit our aspirations to muddling through with 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 set of programs? Such a dismal future is inevitable unless Australians engage in a thorough debate about the values and principles we wish to see embedded in our health care system.

Values and Principles in Health Care

For all the changes in health programs over the last 20 years, there has been no evidence of their expression 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 privatisation 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, but we are left to guess the actual reason. Both parties have vigorously defended the present coddled protection of pharmacies from the disciplines of competition. But why, after doing so much to keep the wholesale price of drugs low, is a high cost corner-shop industry allowed to add to their cost?

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 Australians have given thought to and articulated our values more practical aspects of principles, then (and only then) should we begin on a detailed design.

There is a spectrum of values that could underpin public policy (see Table 1). At one extreme is a non-interventionist approach, relying on ‘individual responsibility’ where people are left 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 penalised.

Table 1

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 cardholders.
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.

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.

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. Hearing the Deputy Prime Minister during the 2004 election campaign defending a 'two tier' health care system was the most explicit statement of such a shift.

There is also the option of community-wide 'social insurance', with uninsurable copayments or excesses to control moral hazard (incentive for over-use or over-charging). While Australians 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 (Rawls 1971). 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.

At the other extreme Australians may opt for a completely free system, without copayments, reflecting a strong community value of 'sharing' — desirable in its own right.

There are finer distinctions that can be made, but for simplicity they can be summarised in the following terms of underlying values and principles.

The fact that such a mixture of principles can be found and inferred from existing programs illustrates the fragmented nature of our health care delivery.

No amount of effort at reform will 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' (Reich 1988).

We are a long way from such a process. A useful starting point may be to ask the fundamental question: "What part of our health care do we want to fund from pooled sources, and what part should be left to individual payments?" (At present the individual share is about 20% but it varies from 0 to 100% across programs.) That would force Australians to look at our underlying values. There is a defensible case for more individual payments, and there is a defensible case for more pooling, but there is no case for the present mish-mash of payments.

Once the Australian community has made such a decision, the rest should fall into place fairly easily. To the extent that Australians are willing to pool their funds, the overwhelming case is to do so through the public revenue system (through general taxation or a specific levy), with those contributions made to a single national insurer — for reasons of cost control, administrative efficiency and equity. Theoretically, such an insurer could be a contracted private corporation (with issues in monopoly control), a government business enterprise, or a government department. Only those who dogmatically assert a preference for the private sector, regardless of economic wisdom, could see support for private insurance as a desirable end in its own right. A better way of sharing costs across a community, other than using our public revenue system, has yet to be invented.

While centralisation of pooled funding is desirable for economic reasons, there is no reason why delivery of health care cannot be through a variety of mechanisms — public, private, cooperative etc. It is in the delivery end of health care that choice can be important to consumers. Although the rhetoric of 'choice' is presently used to justify support for private insurers, there is little to choose between these various financial corporations, particularly in view of their necessary heavy regime of regulation.

Perhaps, to start this process, politicians could help by going back to their own parties' fundamental ideologies — which both sides seem to have lost touch with. If they, did a Liberal policy might encourage microeconomic reform, such as removal of pharmacists' protection, and more individual responsibility without the market-numbing distortion of insurance. The Liberal Party may emphasise public health and education as means of encouraging people to take more responsibility for their own wellbeing. A Labor Party policy might embrace more sharing 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.

Ian McAuley is a lecturer in public sector finance at the University of Canberra and helps the consumer movement on health care economics.

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