NOW IS THE TIME FOR ALL GOOD PEOPLE TO COME TO THE AID OF MEDICARE

Victorian Healthcare Association Annual Conference
Melbourne, 9.30am, 23 October 2009

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When Tony Abbott said that the Liberal Party was the best friend Medicare ever had, I took it with a grain of salt. But he may be right, if we consider the report of the National Health and Hospital Reform Commission (the Commission) appointed by a Labor Government. If the Commission's proposals on Denticare and Medicare Select were adopted, private health insurance (PHI) would be in a dominant position and Medicare put at risk.

The Labor Party used to regard Medicare, highly regarded around the world, as one of its greatest achievements.

The Government has been remarkably solicitous about the interest of PHI. Consider what the Rudd Government has done for PHI.

- In Opposition, Kevin Rudd declared in a letter of November 2007 to the Australian Health Insurance Association that Labor was 'committed to retaining the existing PHI rebates, including the 30% general rebate and the 40% rebate for older Australians' (John Breusch and Nabila Ahmed, Australian Financial Review, 1 May 2009)
- Appointed a senior executive of a major PHI fund (BUPA, trading as MBF/HCF) to chair the Commission. Mike Steketee in The Australian referred to this as the 'insider influence of PHI'.
- The Rudd Government instructed the Commission not to enquire into the operation of PHI (Samantha Maiden, The Australian, February 25, 2008). 'The PHI rebate will remain unchanged' Kevin Rudd said when the enquiry was announced. Despite this, PHI interests used the Commission as a platform to advance their cause.

I have had some experience in government enquiries and it is rare for an enquiry to go down a path, particularly a contentious one, without the nod from the Minister.

Has the Rudd Government been so influenced by PHI lobbying that it doesn't really understand what is at stake in the Commission's proposals? Perhaps some members of the Commission don't understand either!

In any event, Medicare is at great risk if the government accepts the proposals of the Commission on Denticare and Medicare Select. If it moves only partially in this direction, it will prepare the ground for a Coalition Government to complete the job. This is despite the clear and unmistakable evidence around the world that countries that have high levels of PHI do not effectively control costs, for the simple reason that PHI organizations are too weak and too compromised to efficiently restrain costs. Single payers are more effective that multiple payers in controlling costs. In evidence to the United States Senate Committee on Ageing, 30 September 2009, Mark Pearson, Head, Health Division, OECD, said that the US system 'is not a system set up to bend the cost curve, unlike many other OECD countries'. In plain speak, what he said was that PHI funds in the US do not contain costs.

The Commission said that it aims at 'fundamentally redesigning' our health services. But the major fundamental redesign it proposes will be to advantage PHI and undermine Medicare.

The Commission proposes that under Denticare 'everyone would have the choice of getting basic dental services … paid for by Denticare either through a PHI plan or through public dental services.' Denticare would be funded by an increase in the Medicare levy of 0.75% of taxable income ($3.9 b). This is a blatant make-work proposal on behalf of financial intermediaries. Part of the funds from the Denticare levy collected through taxation would be churned a second time through PHI companies who have administrative costs, including profit margins, of about 15%. This is three times the administrative cost

of Medicare. The most sensible course to fund dental services would be to extend Medicare to particular dental services in the same way that Medicare funds medical services.

The other leg-up for PHI that the Commission suggests is Medicare Select. The Commission seemingly has deliberately allowed Medicare Select to be projected as a firm proposal when on closer examination, it seems that it is only a suggestion which requires further study. Or at least that is what one Commissioner, Stephen Duckett, said. In Crikey on 31 July 09, he said 'The Reform Commission did not recommend Medicare Select; it recommended examining the issue.' I can understand why Stephen Duckett, who knows more about health policy than most, would have reservations about Medicare Select. In any event, the ambiguity seems to have worked a treat, designed to put the issue into the public domain without too much ownership by the insurance industry. Medicare Select is off and running. I notice that even the chair and a board director of Medibank (Pte), a Commonwealth GBE are extolling the virtues of Medicare Select. (The Australian, September 5/6, 2009)

Medicare Select envisages all Australians being enrolled in a Government funded plan, but with the opportunity of moving to a selected plan to which Government funding would be directed on a capitation basis, and which could involve extra services funded by, yes you guessed it, private insurers. The 'plans' would be managed by private corporations or not-for-profits. In effect this would be a 100% PHI rebate – not 30%, not 40% that we have at present, but 100%.

Ian McAuley has highlighted some major problems of Medicare Select. McAuley says that Medicare Select

> 'First, … appears to have been designed to secure a place for private insurers who would most probably continue to impose a bureaucratic overhead on healthcare without adding value. Most Australians, most of the time, do not need a healthcare 'plan'. Second, it is based on a misunderstanding of "choice" for we cannot know what our future healthcare needs will be. Third it is likely to result in cost escalation to the benefit of providers; this is an outcome of the intrinsic moral hazard associated with private insurance. And fourth, it makes it easy for a Government to redefine Medicare, the Government program, as a bare bones program for the poor or indigent, thus establishing a two-tier health system.' (www.cpd.org.au/paper/medicare-select-entrenching-inequality-health-care.)

The Commission has drawn selectively on overseas experience to support its case for Medicare Select. Ignoring countries as diverse and as successful in healthcare as the Nordics, Taiwan, Japan, UK and New Zealand, the Commission is obviously impressed with the Netherlands as an example of 'social insurance'. A few years ago the Netherlands Government introduced compulsory private insurance. It is still early to make a final assessment, but the early signs are ominous. It is a weak reed for the Commission to rely on.

The University of Texas and the University Nijmegen in the Netherlands (Rosenau and Lako), conducted a highly-regarded review of 'an experiment with regulated competition and individual mandates for universal healthcare – the new Dutch Health Insurance System'. (Apparently the US interest was sparked by the possibility that the Dutch experiment might have some useful lessons for the United States in its healthcare reforms.) The results of the review were published in the Journal of Health Politics, Policy and Law, Vol 33, No.6, December 2008. The review reported as follows:

> 'Our assessment of the first two years is based on Dutch Central Bank statistics, national opinion polls, consumer surveys and qualitative interviews with policy makers. 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 [un]responsive to price incentives. Finally, policy makers should not underestimate the opposition from healthcare providers who define their profession as more than simply a job.'

Not many surprises there.

The Commission ignored this assessment which was published six months before its own report. It also ignores some key features of the Netherlands experience.

- In the Netherlands most prices are strictly regulated. That doesn't happen in Australia. Because service providers' prices are regulated in the Netherlands, moral hazard is manifest in strongly increasing utilisation.
- All insurers are not-for-profit, unlike Australia.
- Children are still provided with free care outside the private insurance system.
- Costs are rising faster than in most other OECD countries.

The record of PHI around the world raises alarm bells. Wherever there is extensive PHI, costs rise without compensating benefits and with the US at the top of the list of waste and inequity at the hands of PHI.

Our experience is no different. The $5 b corporate subsidy to PHI is one of the worst pieces of public policy it is possible to imagine. Yet the Commission wants to use more public money to extend their role. The PHI industry relies on lobbying and political pressure rather than debate or logic to defend its interests. I am yet to find a senior official in Canberra who will privately defend the Government's support of PHI.

If people want to buy a Mercedes Benz or private health insurance, that is their right, but why should the community subsidise them to jump to the top of the queue, undermine the public universal system and push up costs. The Australian auto industry receives a $6 b subsidy over four years. The health insurance intermediaries get $5 b p.a in government support in Australia. (The $5 b includes the $4 b subsidy, takes into account the persistent under-valuation of the cost of the subsidy and the cost to revenue of the taxation rebate.)

If public hospitals were better funded and there were better programs to provide health services outside hospitals, the case for private health insurance would decline dramatically. People take private health insurance mainly because they are not confident that public hospitals could meet their future needs. This is despite the fact that almost all Australians will concede that Australian public hospitals, despite their problems, are top-class and in the event of serious illness, that is where they should go.

In the appendix to this address, I outline the inefficiency, inequity and the problems of PHI in Australia and elsewhere.

PHI, through gap insurance, has facilitated the biggest increase in Australian specialist doctors' fees in a quarter of a century. Specialists have been exploiting gap insurance under PHI 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 PHI fuels increases in costs. The Medicare schedule is becoming increasingly irrelevant as a result of PHI.

It is suggested that managed competition in health insurance will improve markets and choice. But what we need most in Australia is competition in the delivery of health services, particularly amongst doctors and pharmacists who benefit from widespread restrictive practices and closed shops.

PHI companies are not healthcare providers. They are part of the financial world along with Merrill Lynch, Citibank, AIG Insurance, Bear Stearns and Lehmann Bros. At the time when the world is more sceptical than ever about the morality and competence of financial intermediaries, our 'Reform' Commission wants to give them a vastly expanded mandate. We should have learned from the ideological excesses of financial intermediaries over the last few years.

Just as the financial press and commentators were missing in action in the lead-up to the global financial crisis, so they are missing in action on the role of PHI in this country and particularly in the United States. They confuse ideology with facts. They have a blind spot about the virtues of markets, despite evidence of failure in health 'markets' around the world.

The argument stated or implied in Medicare Select is that somehow markets will provide a better solution than Medicare. This is an ideological view not based on evidence. As Dr John Deeble put it in his Chalmers Oration (23 July 2009) at Flinders University Medical School, p.15, 'I know of no [health] financing scheme in the world that has ever changed the way that services were delivered or the way in which providers have been paid.' He said that 'custom is very powerful and the demand for healthcare per se is very little influenced by price'. We prefer a provider we know. Further, competition and sometimes the services we seek in the so-called 'market' are not even available as is the case in many parts of Australia. We buy health insurance primarily for peace of mind and very often not for rational reasons. We have very imperfect knowledge about prices and the quality of services that providers offer. Because many of our health decisions are economically irrational, the benefits of markets and competition are grossly exaggerated.

My concern about the attacks on Medicare should not be interpreted as an acceptance of Medicare's performance and that we don't need to see many reforms and the Commission highlights some, eg primary care, indigenous health and mental health. But we must be careful not to throw out the baby with the bathwater. I have been speaking to you and others for several years about the need for changes in Medicare and related health architecture, and most importantly of all, political will to implement change and stare down the vested interests that abound in health – PHI, AMA, APG and health bureaucracies, both Federal and State.

Medicare after all is a funding device. It largely takes as given, the provision of existing health services. It works on the demand for health services rather than the supply.

Medicare, as a payments organization, should be much more proactive as a public insurer which takes into account future risks and possible costs, and adjusts premiums accordingly. It is far too passive. It does not adequately use its buying power and clout to contain costs and improve services, although as I mentioned the more PHI increases in scale the more Medicare's buying clout is reduced.

Medicare should establish an independent, professional and rigorous body like the PBAC in Australia or the National Institute of Health and Clinical Excellence (NICE) in the UK, to advise on the medical services that should attract Medicare benefits.

Medicare holds a great deal of statistical information. But it publishes little of it and fails to facilitate a public debate about how information might be used and interpreted to improve policies and performance. For example, Medicare should publish information to empower consumers in making decisions about their own health and the competence of providers, making health services more people-centred. There is little public accountability by health providers in this country. I can get more information about buying a washing machine, than about the competence of my medical provider.

Medicare should publish details on major and costly variations in clinical practice across Australia in such fields as coronary angiography, cataracts, colonoscopies, caesarean sections and joint replacements. The variations in practice patterns are often enormous and inexplicable.

In cooperation with the Federal Government, Medicare should impose budgets on GPs for pathology and imaging referrals. Fee-for-service is a perverse incentive, particularly for chronic and continuing care. Almost every incentive is to do more. Medicare should provide incentives for groups of practitioners to employ salaried staff.

Beyond Medicare, we need to be more proactive to make health services people-centred in such areas as

- **Improved health governance between the Commonwealth and the States**; (Unfortunately, the Australian Government has thrown away a lot of its leverage by making substantial grants to States for public hospitals. It is a strange way to negotiate.) Services should be delivered to the most local level possible and close to where people need the services. I continue to advocate the establishment of a Joint Commonwealth-State Health Commission in any state where the Commonwealth and a particular state could agree ('a coalition of the willing').
- **E-health** which would greatly facilitate and enable patient focus.
- **Effective governance in hospitals**;

- **Overhaul of co-payments** to encourage more responsible and more equitable use of health services by individuals;
- **The re-orientation of health services** to wellness, primary care and self-care.
- **Major up-skilling, multi-skilling and teamwork across our whole workforce.** This would put the focus on patient needs rather than provider interests;
- **Large scale engagement of the community** at every level of healthcare, eg citizens juries. We need to do what the Canadians did in the Romanow Royal Commission, establish the values that people believe should guide health services.
- **Health programs that are focused on outputs**. Our health programs are provider/input focused when in most modern enterprises the focus is on outputs. We don't need hospital, pharmaceutical or medical service programs, so much as programs for the chronically ill, mental health sufferers and indigenous people.

Many of these changes are necessary to improve Medicare and the architecture surrounding Medicare. The last thing we need is an attack on the fundamentals of Medicare and an extended role for PHI which is proving so calamitous in almost every country in which it gains a foothold. **The Rudd Government should quickly and clearly reject the Commission's recommendations on Denticare and Medicare Select** and then get on with the worthwhile proposals of the Commission**.**

We must be ever vigilant to prevent finance companies displacing health organizations. PHI should remain in the financial market where it belongs instead of intruding into fields where they add no value and push up costs.

The Commission is laying the grounds for the eventual demise of Medicare, perhaps not under this government, but down the track. The end result would be a two tier health service – a public tier for the poor and a private tier for the wealthy. Equity would go. Efficiency would go. And social solidarity would be a thing of the past.

In the last few years, we have seen a great deal of financial innovation in new products and new plans. Many have added no social value at all or have been damaging to society and the economy. We have a classic example of it in Australia in taxpayer-funded PHI. But these companies want the government to further advance their special interests at the expense of Medicare - a universal system which has kept costs within reasonable bounds.

Now is the time for all good people to come to the aid of Medicare.

John Menadue AO

John Menadue is a Director of the Centre for Policy Development. He was formerly Secretary of Prime Minister and Cabinet, Ambassador to Japan and CEO of Qantas. He conducted reviews of the NSW Health Service in 2000 and the SA Health Service in 2003.

For a Senate Submission by John Menadue on the need to reform both the demand and supply of health services, see www.cpd.org.au/article/managing-demand-and-supply-health.
See also 'Medicare Select, entrenching inequality in healthcare', McAuley and Frank, http://www.cpd.org.au/paper/medicare-select-entrenching-inequality-health-care.

APPENDIX

Private health insurance (PHI) -

- **Favours the wealthy** who can jump to the front of the hospital queue. 80% of the wealthiest 20% of Australians have private health insurance. Only 25% of the poorest 20% of Australians have private health insurance (Melbourne Institute of Applied Economics and Social Research Report to the

Victorian Department of Premier and Cabinet, in 'Shared Future', 2004, p.60). Yet it is apparently regarded as good Labor policy – a Government which has a Minister for Social Inclusion!

- **Increases usage of health services**. As the Productivity Commission put it 'increased levels of PHI have been associated with a marked increase in the number of services performed and reimbursements of their services'. (PC Report on Medical Technology, 2005 p.26)
- **Favours financial intermediaries** whose administrative costs, including profit margin, are about three times that of Medicare. No wonder these intermediaries have to keep pushing up their premiums every year at 2% or 3% ahead of the inflation rate.
- **Is a disincentive in the provision of public goods** like prevention. Money spent by a private insurance firm on public health issues will provide benefits to competing health insurance firms.
- **Has not taken pressure off public hospitals** and has allowed private hospitals to attract highly professional staff away from public hospitals.
- **Has opened up new areas of demand**, eg increased rate of joint replacements.
- **Takes us down the dangerous path of subsidised private insurance** with widespread economic consequences. The subsidy from General Motors to its employees' health scheme has contributed to General Motors' bankruptcy.
- **Is a dishonest and inefficient way of promoting so-called 'choice'**. The Australian Government and the Department of Health and Ageing seem incapable of understanding or accepting that the funding and delivery of healthcare are quite different issues. The Royal Automobile Club doesn't need to enter into the crash repair business to ensure consumer choice. We don't need subsidies to private insurance firms to promote private health delivery. Private hospitals in Australia would be up to $2 b a year better off if part of the subsidy was paid directly to them and not via financial intermediaries. The money for Australian veterans for example is from a single Government payer, the Department of Veterans Affairs. The money follows veterans wherever they choose to get treatment, either in a private or public hospital. Two thirds of veterans choose a private hospital. There are some areas where private hospitals perform better than public hospitals, eg elective surgery. Yet when Kevin Rudd made a deal with the private health insurance industry before the last election, he and Nicola Roxon defended this decision as a means of promoting choice. It is nonsense. A single payer can promote choice in health delivery. It was a mistake several years ago for Medicare to withdraw subsidies to private hospitals. They should be restored as a means to promote cooperation, rather than competition between public and private hospitals.
- **Focuses on our fears about the future.** Advertising is directed to creating uncertainty eg run-for-cover advertising by the Howard Government. A great deal of what we all pay in insurance is not logical. We pay too much for so-called 'peace of mind'. A 1998 ABS Health Insurance Survey revealed that 'security, protection and peace of mind' are twice as important as choice of doctor in decisions to hold private health insurance.
- **Weakens Medicare's capacity to control cost and quality.** In 2003, the OECD published a case study on PHI in Australia (Colombo and Tapay, p.39). It reported '(private) funds do not exercise control over the quantity, quality and appropriateness of care provided .. Private funds have not effectively engaged in cost control. PHI appears to have led to an overall increase in health utilisation.' (See also CPD.org.au 'Paying for healthcare' Ian McAuley, April 2007). By contrast, the Commonwealth, as the single buyer of pharmaceuticals under the PBS has been remarkably successful in containing costs.