Ideas for a health policy

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One of New Matilda's most important functions is the development of policy in areas where the major parties have either failed or given us ad hoc proposals in response to media or pressures by particular groups.

Health is one such area where we want your comments and involvement.

Ian McAuley here describes the confusion and the grab bag of health proposals that we saw at the last election. He outlines the importance of consistent principles in deciding how we spend public money in a field where public demands are practically unlimited.

This discussion paper continues the process which the Policy Think Tank will continue with your involvement and that of health policy experts.

The 2004 election and its aftermath of Labor's soul-searching saw many proposals on health care. Labor offered Medicare Gold and incentives for bulk billing. The Coalition offered higher rebates for private insurance and more support for Medicare safety nets. After the election the NSW Premier called for re-alignment of Commonwealth and state hospital funding, and Labor cautiously backed away from some of its Medicare Gold commitments. Medicare Gold, like so much of Labor's platform, had a life of only a few weeks.

There was a great deal of activity, but in all electors have been left confused, to say the least.

Considering Labor's proposals one may ask why, if there should be free hospitalization for those over seventy four, it should not also be available for others? Why did Labor cling sentimentally to bulk-billing, while supporting higher co-payments for pharmaceuticals?

The Coalition's policies are no less confusing. The Governor General's speech opening Parliament included the Coalition's usual commitment to 'encouraging hard work and self-reliance'. A little further on in the speech is the promise to increase the health insurance rebate for those aged sixty five and over. Health insurance rebates (and the associated one percent tax incentives), however, are only for those who use insurance to buy out of the discipline of market forces. The self-reliant who pay for their own private hospitalization and ancillary services are unsupported. In an Orwellian act of doublespeak 'self reliance' has come to mean 'corporate reliance'.

Similarly, while the speech stated the Coalition's commitment to tax cuts, it didn't mention that the Coalition's policy is to privatise tax collections for health care " after all, private health insurance is essentially a privatised tax. Like official taxes it's redistributive (through community rating), it's collected with a degree of coercion, and for most people it's withheld from pay the same way as official taxes.

Neither party has the courage or imagination to offer a consistent set of principles relating to health care, and far less are they willing to articulate a coherent statement of values. Perhaps this lack of a value-based foundation explains why changes of government see huge changes in health programs, leading not to consistency but to a proliferation of different eligibility criteria, private and public roles, state and Commonwealth divisions, free services and services with co-payments (some open-ended and others capped).

Commenting on John Menadue's paper in New Matilda Professor Carol Gaston link eloquently described the confusion facing users:
'It is obvious to everyone who has to deal with this split system everyday that it works against all the principles we espouse about partnerships, collaboration, integration, seamless, comprehensive, holistic etc. etc. etc. Attempts to obtain a primary health care focus within the current structure is next to futile ... The community are confused. They don't see and are not interested in the funding trails, they just want services which are easy to access and don't require multiple referrals and multiple payment arrangements.'

Speakers at the 2003 Health Summit showed that although much has been achieved in health care, we could do much better. While speakers talked about our health care 'system', it is clear that politicians, administrators and policy advisers don't have a system view. They certainly know their own programs, and they try to achieve coordination with related programs, but they work in a framework which offers no encouragement for system-thinking or integration of delivery. Rather, there are incentives for duplication, cost-shifting and responsibility-ducking.

How we got into this mess has many causes, not least being the legacy of programs designed around provider demarcations rather than consumer needs (such as the division between medical and pharmaceutical services). Policies tend to be developed incrementally, without any consideration of basic principles " a process which policy analysts disparagingly describe as 'muddling through'.

The Commonwealth has much to answer for, particularly its adherence to a supplier-based program structure (medical, hospital, pharmaceutical). This leads to periodic panics about the budgetary cost of the PBS, for example, rather than a more considered evaluation of the benefits of pharmaceutical therapies.

Worse, the Commonwealth has replaced economic evaluation of programs with a set of narrow budgetary costings, constraining the possibility of major reform or reallocation. This started with the Hawke/Keating changes of the eighties, and has been formalized in the Howard Government's Charter of Budget Honesty. The benchmark of evaluation is not a program's economic impact, but, rather, its four year call on budgetary funding.

Thus was Costello able to ridicule Medicare Gold with his claim that it was 'the most expensive election promise ever made in Australia'. Labor, entrapped in the same narrow budgetary focus, failed to point out that, because a single tax-financed insurer has more market discipline than private insurers, Medicare Gold would actually be far less expensive and would provide more efficient resource allocation than the Coalition's open-ended support for private insurance.

If we are to get out of it politicians need to listen to the people who elected them and find out what values they want expressed in health care. From there practical design issues, including the locus of funding responsibility, should become relatively straightforward matters to resolve.

To give meaning to the term 'values', I will outline a spectrum, which could be described as moving from 'right' to 'left' in political parlance. (See Table 1.) At the left end is a free tax-financed system. On the other end is 'self reliance' (distinguished from 'corporate reliance'). Intermediate points include a charity system and a national insurance system.

Table 1. Values and principles in health care policies

Value	Sharing – solidarity in misfortune	Social insurance	Charity – protection of the weakest	Self-reliance
Principles	Universal free services, community-rated through taxes.	Universal protection against catastrophic costs.	Means testing, and separation into two tiers.	Non-intervention (except for overt cases of market failure). No insurance or other cover.
Current examples	Public hospitals, bulk-billed services.	Safety nets, capped PBS co-payments.	Special Medicare rebates for concession card holders.	"Ancillary" services – dental, physiotherapy etc used by the uninsured majority, and by those who have exceeded the caps on private insurance. S2 & S3 pharmaceuticals.

Note that in our non-integrated arrangements there is a highly conflicting set of underlying values. Medibank and Medicare in their original conception were grounded in values of sharing and social insurance, but over time Medicare has drifted towards a charity or 'two tier' model.

Community consultation, in itself, is not likely to result in coherence. As John Menadue points out, we can't have it all; hard choices have to be made. To make those choices people need to be given something more solid than competing grab-bags of opportunistic modifications to existing programs. They need to see the principles and values underlying policy options " in particular the choice between individual and shared payments for health care.

Labor should point out that Medicare, if it is to be sustained in its original form and its extensions such as Medicare Gold, will require higher taxes (with the tradeoff of greater savings in private costs). Opinion polling suggests that people are willing to pay higher taxes, provided they see a connection with their own priorities.

Labor may find that co-payments, provided they are capped, are acceptable in a community which is vastly more prosperous than it was when Medibank was introduced thirty years ago. And if Labor is to give meaning to universalism, it should consider areas not presently covered, such as dentistry and non-PBS pharmaceuticals.

The Coalition should re-examine its infatuation with private health insurance, which does not fit into any value system, apart perhaps from a thoughtless dogma that because it's 'private' it's superior to 'public' arrangements - a dogma with no more empirical or deductive logic than the old Soviet loathing of private activity. Private insurance is administratively expensive, and, because its very purpose is to relieve the insured of the discipline of market signals at the point of delivery, it has incentives for over-servicing and over-pricing. It combines the worst aspects of centralised free provision without the benefits of administrative efficiency and cost-control.

In fact, arguments about choices between 'public' and 'private' are irrelevant in a discussion of values. Such choices should be based on practical concerns such as the existence or otherwise of market failure. Policy development would be helped if questions of funding were separated from questions of delivery. Private insurers are adept at suggesting that without private insurance the 'private system' would collapse, as if a high-cost financial intermediary is essential to the survival of private service-providers. Unfortunately most journalists and even a few academics accept this construct, without considering other means of funding private providers " such as direct payments from users or public insurance.

If the Coalition were to be true to its tradition of support for market solutions it could start by dismantling the protective arrangements for pharmacists and specialists. And if it is sincere about self-reliance, it may encourage more direct, uninsured transactions between users and service-providers " with the safeguards of safety nets and competition policy instruments to ensure fairness in these transactions. By any criteria, that would be preferable to substituting the nanny state with the nanny corporation.

Both parties have shown that Australians can face hard choices " witness Labor's record on tariff reduction and deregulation, and the Coalition's record on the GST. Can they do the same for health care?