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# What is Medicare Select?

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## Introduction

In its final report to Government, the National Health and Hospitals Reform Commission (the Commission) outlined three options for reforming the structure of the Australian health system. Two preserved the structure of the health system established with Medicare in 1984, but they proposed changes to financing arrangements and the roles of the Commonwealth and state and territory governments. The third option proposed more significant reforms that, if implemented, would result in a fundamental restructure of the Australian health system. The proposal, called Medicare Select, was foreshadowed in the Commission's interim report (where it was labelled as Option C). It was described as a compulsory social health insurance system along the lines of those operating in many European countries.[1] In the Commission's final report, the proposal was branded as 'a uniquely Australian governance model for health care that builds on and expands Medicare'.[2]

Perhaps because the description of the proposal has changed, there is much confusion about what, precisely, Medicare Select is. Therefore, this paper addresses key questions about the Medicare Select proposal in order to help explain what is and how it would change the Australian health system if it were implemented. In particular this paper:

- examines the differences between Medicare and the Medicare Select proposal
- explains how Medicare Select differs from managed care and 'privatising' the health system
- identifies other countries with similar systems, and
- outlines the potential benefits and risks of implementing Medicare Select in Australia.

## How would Medicare Select differ from Medicare?

Medicare Select would share some features of Medicare. It would be a universal, tax-funded health insurance scheme; it would be financed through general revenue or a designated levy, like Medicare. Individuals' contributions would still be independent of health status, and they would continue to be charged co-payments for some health services. The Commonwealth

1. National Health and Hospitals Reform Commission (NHHRC), *A healthier future for all Australians*: *interim report*, NHHRC, Canberra, December 2008, p. 295, viewed 4 August 2009, http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/BA7D3EF4EC7A1F2BCA25755B001817EC/$File/NHHRC.pdf

2. National Health and Hospitals Reform Commission (NHHRC), *A healthier future for all Australians*: *final report*, NHHRC, Canberra, June 2009, p. 10, viewed 4 August 2009, http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/1AFDEAF1FB76A1D8CA257600000B5BE2/$File/Final_Report_of_the%20nhhrc_June_2009.pdf.

Government would continue to exercise some control over co-payments by setting maximums levels for certain health services or products, for example pharmaceuticals.

Despite the similarities, Medicare Select differs from Medicare in substantial ways. Under Medicare Select, the Commonwealth Government would become the sole public funder of health services. It would then distribute funds to intermediary bodies called 'health and hospital plans'. The government would operate at least one plan, which would compete on equal footing with plans operated by not-for-profit or for-profit organisations.

By establishing these plans, the Commonwealth Government would separate the funding or purchasing functions in health care from service provision. Economists refer to this as a 'purchaser-provider split' and many suggest that it increases efficiency, largely because single funders tend to have lower administration costs and substantial power in negotiations with providers.

Under Medicare Select, membership of a plan would be compulsory thereby ensuring universal access to basic health services. All people would initially be members of a government operated plan but would be free to choose another one after the scheme began. Plans would be required to accept anyone who wished to enrol. There would probably be some restrictions on when and how people could change plans, as there are in other countries with similar systems.

Plans would be responsible for purchasing all health services covered under a Universal Service Obligation (USO). The range and extent of services covered under the USO would be determined by the Commonwealth Government but it would include basic health care such as hospital, dental, general practitioner and community health services.

Plans would use funds distributed by the Commonwealth to purchase health services on behalf of members. Commonwealth funding for each plan would reflect the risk profile of its membership. Plans with large numbers of high-risk members, for example elderly people with chronic illnesses, would receive more funding than those with large numbers of young, healthy people.

Plans would compete for membership based on premium prices, product range (they are likely to offer a number of different insurance packages), quality and reputation. Some plans might choose to target niche markets and offer products tailored to the needs of certain groups, such as people with diabetes or those living in rural and remote areas. Plans would also be free to offer insurance packages covering additional services, that is those not included in the USO such as more comprehensive allied health or dental services. Members would pay an additional premium to purchase these packages.

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 they had a contract with their plan.

The Commission acknowledges that many of the details of the Medicare Select scheme would have to be determined. Some of the most important ones are:

- the scope and extent of the USO
- the role of the state and territory governments in health care provision
- the best method for calculating and distributing risk-adjusted payments to plans
- how to prevent and respond to market failure, particularly in rural and remote areas where it is difficult to establish a competitive market
- the regulatory framework for establishing and operating health and hospital plans
- regulations on when and how often people can change plans; this has important implications for calculating risk-adjusted premiums and ensuring continuity of care, and
- the best way to educate people about the scheme so they can make an informed choice about plans.[3]

The Commission does not cost the Medicare Select proposal, so it is difficult to compare its overall costs with the existing Medicare system.

## Are there schemes similar to Medicare Select operating in other countries?

While the Commission describes the Medicare Select proposal as 'uniquely Australian', it has many features in common with social health insurance (SHI) schemes operating in Europe such as: transparent funding arrangements where contributions are independent of risk; competing health plans or sickness funds that purchase health services on behalf of members; and choice of health plan and health service provider.[4] Countries with SHI systems include:

- Austria
- Belgium
- France
- Germany

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3. NHHRC, *A healthier future for all Australians: final report*, p. 159.
4. RB Saltman, R Busse, and J Figueras, eds, *Social health insurance systems in Western Europe*, European Observatory on Health Systems and Policies series, Open University Press, Berkshire, England, 2004, viewed 12 August 2009, http://www.euro.who.int/document/E84968.pdf

- Israel
- Luxembourg
- the Netherlands, and
- Switzerland.

Medicare Select most closely resembles the Israeli and Dutch 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 a SHI plan; people are able to change health plans, and; voluntary supplemental insurance is available for an additional premium. [5]

Although the Medicare Select proposal is new, it is the evolution of a model first outlined in 1989 by Dr Richard Scotton, one of the architects of the original Medicare scheme, Medibank.[6] Scotton explained that his proposal, widely known as the Scotton model, was most like the Dutch scheme, although the Dutch scheme has also evolved over time.[7]

## Is Medicare Select a form of managed care?

Proposals to use managed care in the Australian health system are normally controversial, particularly amongst medical practitioners.[8] Many see it is as the defining characteristic of the health system in the United States of America (US) and argue that it has placed limits on patient choice and restricted doctors' autonomy in an effort to reduce costs.

However managed competition, not managed care, is the key feature of Medicare Select. Managed competition is a market mechanism that uses budget holding and competitive purchasing arrangements to improve efficiency.[9] Managed care simply means using the

5. European Observatory on Health Systems and Policies, 'Country information: Israel', European Observatory on Health Systems and Policies website, viewed 4 August 2009, http://www.euro.who.int/observatory/ctryinfo/ctryinfo; RE Leu, FFH Rutten, W Brouwer, P Matter, C Rütschi, 'The Swiss and Dutch health insurance systems: universal coverage and regulated competitive insurance markets', *The Commonwealth Fund*, vol. 104, 16 January 2009, viewed 7 August 2009, http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2009/Jan/The-Swiss-and-Dutch-Health-Insurance-Systems--Universal-Coverage-and-Regulated-Competitive-Insurance.aspx

6. RB Scotton, 'Integrating Medicare with Private Health Insurance: The Best of Both Worlds?', in *Economics and health: proceedings of the eleventh Australian conference of health economists*, Monash University, Clayton, Melbourne, 1989.

7. RB Scotton, 'Managed competition: issues for Australia', *Australian Health Review*, vol. 18, no. 1, 1995, pp. 82–104.

8. D Marcus, *Prospects for Managed Health Care in Australia*, Research Paper, no. 25, 1999–2000, Parliamentary Library, Canberra, 20 June 2000, viewed 10 August 2009, http://www.aph.gov.au/library/pubs/rp/1999-2000/2000rp25.htm#major

9. AC Enthoven, 'The history and principles of managed competition', *Health Affairs*, vol. 12, supplement, 1993, pp. 24–48.

resources available from constrained budgets to achieve the best possible health care outcomes. It most often involves the use of evidence-based clinical guidelines to inform clinical decision-making and control the costs of care.[10] While competition is the defining characteristic of managed competition, it is highly probable that plans would implement some forms of managed care in an effort to control costs under Medicare Select. Managed care can be used as a tool in managed competition, but it is not synonymous with it.

There are many forms of managed competition but the essential components are:

- the use of intermediary budget holders to purchase health services for enrolled members
- budget holders have capped budgets, either because they receive payments from government for each enrolled member, or because they have to compete within a regulated market for premiums
- open membership – risk selection, or cherry picking low risk members, is prohibited
- market success depends on budget holders' ability to control costs whilst still ensuring high quality care. Some of the ways they do this is by favouring providers that: focus on health promotion and disease prevention; effectively co-ordinate care for people with chronic diseases; and charge competitive prices. [11]

Many countries have begun to use market or quasi-market mechanisms in the health sector in an attempt to slow growth in expenditure. However not all have opted to use managed competition. Over the last two decades the British Government, for instance, has established an 'internal market' with the National Health Service where budget holders purchase services from public and private providers. Because budget holders do not compete with one another, the internal market is not a form of managed competition.[12]

## Would Medicare Select mean privatising the Australian health system?

If Medicare Select were implemented in Australia, the roles of the public and private health sectors would change, but this is not akin to 'privatising' the system. A privatised system would mean abolishing Medicare and replacing it with private insurance and a public safety net, much like the system in the United States of America.

Under Medicare Select, the Commonwealth Government would continue to play a central role. It would become the sole funder of health care, and it would continue to regulate the

10. RB Scotton, *Managed competition: the policy context*, Melbourne Institute Working Paper No. 15/99, June 1999, Melbourne, p. 15.

11. Scotton, *Australian Health Review*

12. RB Scotton, 'Managed competition: the Scotton model', *Healthcover*, vol. 7, no. 3, 1997, pp. 25–29.

health system, set broad policy goals and support research and clinical education.[13] The Commonwealth would also continue to provide some health services, such as biosecurity, ambulance services and some highly specialised medical services. The Commonwealth could also become a budget holder, or plan, under Medicare Select, but this is not an essential design feature. State and territory governments could also become plans and continue to provide health services, but they might also choose to relinquish any ongoing responsibilities for health.

The role of the private sector, however, would expand under Medicare Select. Most budget holders would probably be from the private sector, as existing private health insurance funds would be most easily able to take on the required functions. Private providers, particularly of hospital services, would also be expected to expand their operations as access would not be limited to those with private insurance.

In discussing his own proposal for managed competition—the precursor to Medicare Select—Scotton argued that this type of scheme would resolve the overlapping and uncertain roles of the public and private sectors in the Australian health system. It would integrate Medicare and private insurance and end the ongoing and often unhelpful debate about the relative shares of public and private coverage.[14] Many other commentators, however, are likely to disagree and see any expansion of the private sector as another step along the path towards a fully privatised system.

## What would be the potential benefits of implementing Medicare Select in Australia?

The Commission outlines three main arguments in favour of introducing Medicare Select in the Australian health system. They are:

- it would empower consumers. This competition would encourage plans and health care providers to respond to consumers' needs and preferences
- it would encourage plans to find more innovative ways of delivering and funding the highest quality care. If they did not, they would find it hard to attract and keep members, and
- it would stimulate health service providers to deliver the highest quality for the most efficient price. If they did not, they would not attract members or win contracts with plans.[15]

13. NHHRC, *A healthier future for all Australians: final report*, p. 156.
14. Scotton, *Economics and health*, 1989; Scotton, *Managed competition: the policy context*, 1999.
15. NHHRC, *A healthier future for all Australians: final report*, p. 155.

The Commission also points to a number of other potential benefits of Medicare Select, including[16]:

- continued roles for both the Commonwealth and state and territory governments
- retaining a mixed system of public and private financing and provision, which reflects community preferences
- preserving universal coverage, and
- incentives to focus on prevention, early intervention for chronic diseases, and better integration and coordination of services, as health plans would be responsible for people's full health needs.

## What would be the potential risks of implementing Medicare Select?

The Commission does not outline the potential risks associated with introducing Medicare Select in Australia, but some commentaries on Option C, which is an earlier version of Medicare Select, highlight some of them. Perhaps the most important is the significant transaction costs associated with shifting to a managed competition model.

According to Professor Henry Ergas, a former OECD economist, the issues associated with transitioning to a managed competition model would be substantial enough to threaten the viability of the scheme.[17] He outlines a number of issues that need to be resolved before such a model could be implemented in Australia. The Commission picks up most of them in its final report. However Ergas also suggests that existing private health insurance funds might not be well prepared for the scale of change required. He explains that private health insurance funds would need to significantly expand their functions to operate as plans under a managed competition model. At the moment, funds offer only limited coverage for preventive and out of hospital services and are prevented from insuring general practitioner services. Ergas' main point is that funds would need to undertake this expansion while also adjusting to the new funding arrangements. This would prove challenging for some.

When commenting on the managed competition outlined in the interim report (Option C), Shaun Gath, the Chief Executive Officer of the Private Health Insurance Administration Council, points out that many smaller funds would probably be reluctant to take on responsibility of funding the full range of health care services if managed competition was implemented. They would also struggle to compete with large funds and new commercial

16. NHHRC, *A healthier future for all Australians: final report*, p. 158.

17. H Ergas, *Strengthening the governance of Australia's healthcare system: Option C – how others do it and how we could do it*, Menzies Centre for Health Policy, Australia National University, 15 April 2009. Note: this presentation focused on Option C in the NHHRC interim report, but it is much the same as the Medicare Select proposal in the final report.

providers that would be likely to enter the market. As a result, they would either exit the market, merge with larger funds, or be confined to offering supplementary insurance (that is insurance for services not covered in the USO).[18]

Gath also suggests that the introduction of managed care would be a potential risk in a managed competition model.[19] The two largest existing private health insurance funds—Medibank Private and BUPA—would be best equipped to implement managed care because they have large market shares, are well resourced, and have the capacity to become providers as well as contract with providers across the nation.

According to Gath, there would also be significant start-up prudential risks for private insurance funds choosing to become plans primarily because they would need to negotiate contracts with the full range of health service providers. In most SHI systems, contracts with providers are negotiated collectively by 'peak organisations' because the costs of negotiating individual contracts with each provider is prohibitive. Collective contracts, however, reduce competition between providers and competition is one of the key drivers of efficiency in SHI models.

And finally, Gath highlights the problems that arise from the 'consumer information challenge' in health insurance markets. He argues that choosing a health plan would be no more challenging than choosing a private health insurance fund under the existing system, but warns that at least 55 per cent of Australians, those currently without private insurance, would be faced with the important choice of choosing a fund or plan for the first time.

18. Some would argue that reducing the number of private health insurance funds in Australia would be beneficial.

19. S Gath, *Strengthening the governance of Australia's healthcare system: Option C – how others do it and how we could do it*, Menzies Centre for Health Policy, Australia National University, 15 April 2009. Note: this presentation focused on Option C in the NHHRC interim report, but it is much the same as the Medicare Select proposal in the final report.