Financing options to sustain Medicare: are we committed to universalism?

Policies addressing health care financing should reinforce Australia's commitment to the principle of universalism

The United Nations-initiated Sustainable Development Solutions Network (SSDN) has recently proposed the inclusion of universal health coverage (UHC) as a priority of the 2015–2030 Sustainable Development Goals to alleviate global poverty.[1] Australia has established itself over a number of decades as a member of an elite group of mainly high-income countries that have been declared to have achieved UHC. Since 1975, through the social-national insurance programs, Medibank (1975–1981) and Medicare (since 1984), universal access based on need for medical services and pharmaceuticals has been the bedrock of Australian health policy. One therefore wonders whether the current SSDN discussions are relevant to Australia?

In addressing this question, UHC should be viewed as part of a continuum of levels of financial protection, in which population coverage, the type of services covered and levels of reimbursement are, in practice, never fully comprehensive.[2] In Australia, the lack of coverage for dental services is a case in point, where, in an ostensibly universal health system, there has been long-term persistence of health inequities resulting from a lack of access to dental services, resulting in significant disadvantage, particularly in rural, low-income and Indigenous populations.[3] Ultimately, UHC is never perfectly attained and the extent of financial protection it affords a population is something that can be eroded over time. It would be a mistake to view UHC as a one-off and irreversible achievement.

The trade-off between the need to secure the financial sustainability of the health system and that of maintaining fairness and universal access to services is inevitable. Cost-saving strategies have predictably gained centre stage, and discussion has consequently turned to areas where government funding can be cut. This was shown by the recent debate about proposals in the 2014 Federal Budget to introduce a $7 general practitioner copayment. However, two main problems have not been properly acknowledged in these discussions:

1. The already high level of reliance by government on out-of-pocket costs and the burden experienced by individuals and households with chronic and long-term conditions

According to the SSDN, at least 5% of gross domestic product (GDP) should be spent on health care to achieve UHC[1] — a target that Australia meets comfortably. In the financial year 2011–12, it spent 9.5% of its GDP on health, slightly above the average for Organisation for Economic Co-operation and Development countries.[4] However, the share of health expenditure paid by Australians in the form of out-of-pocket costs has risen steadily over the past decade; it is currently 17%.[4] This is higher than for most other high-income countries and is proving to have a profound effect on regular users of the health care system, such as those with chronic illnesses and the elderly.[5,6] Research in Australia has shown that many in these groups are incurring debilitating levels of out-of-pocket costs and, as a consequence, they experience economic hardship and impaired quality of life.[6] Further, such costs have proven to be a barrier to optimal care, leading, for instance, to non-adherence to medication.[5]

The SSDN stresses that UHC financing options that reduce out-of-pocket spending should be promoted to ensure equality of access to necessary health care across the entire population.[1] The significant opposition and eventual retraction of the $7 GP copayment proposal seemed to show the limit to which the Australian public can accept a greater burden of costs being shifted to patients. Nevertheless, this is not the end of the story, as legislation to increase pharmaceutical copayments is awaiting Senate consideration, and the freeze on Medicare rebates to GPs remains in place.[7]

2. The high and increasing amount of funding allocated to private health insurance subsidies

During the financial year 2014–15, the Australian government paid just over $5.9 billion for the private health insurance rebate delivered through the tax system or directly to private health insurance funds.[8] This figure has been increasing steadily over many years, rising from $1.4 billion in 1999–2000.[9]

The rationale for government support for the private health insurance system is that it reduces pressure on the public sector by encouraging those who are able to afford private health cover to take responsibility for insuring for the cost of such treatment. Indeed, the amount of additional funding injected into the health system by the private insurance net of government subsidies during the financial year 2013–14 was about $11.2 billion — a 2 for 1 multiplier of the public subsidy given to the industry.[10]

A feature of Australia's private health insurance system is that community rating is mandated by regulation. This means that private health insurers are unable to adjust premium levels according to the individual risk profile of a policyholder, and so are unable to explicitly discriminate through their pricing against high-risk individuals who are likely to be regular claimants on their

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policies (eg, people with chronic conditions). This regulatory constraint enables some degree of equity in access to private insurance. However, the requirement to set premiums on the basis of average community risk rather than individual risk exposes private health insurers to the problem of adverse selection in which they attract a predominance of high-risk individuals; ie, in this scenario, bad risks drive out the good risks.[11] Government support through subsidies of health insurance premiums and tax rebates for individuals with health insurance coverage can therefore be seen as a charge to the community for ensuring the sustainability of a private health insurance industry that is faced with a regulatory requirement to community rate.

The financial burden of providing support to Australia's private health insurance industry is likely to grow in the foreseeable future. In the 2015 Budget, the federal government asserted an ongoing commitment to this rebate, and its cost is estimated to increase to around $7 billion over the next 3 years.[8] Research has shown that government support for private health insurance bears significant opportunity cost — eliminating the private health insurance rebate in Australia could lead to public sector savings that far exceed those predicted by increasing out-of-pocket primary health care costs for the patient.[9] As the subsidies overwhelmingly benefit the wealthier households, redeploying some of these resources to relieve the pressure on individuals caused by increasing user charges would be a progressive measure.

It is against this background that one should view with caution recent interest in an expanded role for private health insurance in primary care. Reports of activity in this area show this role to be potentially akin to America's managed care programs that encompass priority and expedited appointments and fee-free care for policyholders.[12] Moreover, the 2014 National Commission of Audit has suggested making private health insurance for basic health services compulsory for higher income earners to make Medicare more sustainable.[13]

As outlined in the SSDN report,[1] there are many ways a country can mobilise money to meet the financial pressure associated with increased health care demands, apart from user fees and private health insurance (Box). Some solutions are less controversial to implement, such as improving spending efficiency in primary health care through the Choosing Wisely campaign.[14]

Maintaining the health of UHC in Australia requires regular check-ups, and the current global discussion of UHC provides an opportunity to reflect on the direction that we are taking. In its most recent assessment, the federal government asserted that a strong, sustainable Medicare requires well-off patients contributing more to the cost of their health care than those less well-off.[15] It seems that the current direction in which we have been looking to finance our growing health care needs in Australia is at odds with this mission, and more generally with global initiatives to establish and sustain UHC.

The fundamental reason for establishing Medicare in Australia was to provide equal access to affordable health care for anybody in need. With increasing pressures on public finances, and current policies that increase the role of private health insurance and patient contributions to the financing of health care, it is time to take a step back and to reinforce our commitment as a nation to the principle of universalism.

Financing universal health coverage (adapted from the Sustainable Development Solutions Network report)[1]

Raising revenue through taxation

- Revise tax policy to prefer taxes that potentially improve public health; eg, reducing fossil fuel subsidies, taxing harmful emissions to improve air quality
- Reforming legislation on tax havens, corporate tax rates and financial transparency of multinational corporations

Make spending more efficient

- Invest in cost-effective preventive care
- Reduce the use of services and treatments that offer little or no benefit by implementing Health Technology Appraisal programs and routine assessments of value in practice
- Reassess purchasing plans and provider payments; link payments to value in practice and institute globally set budget caps
- Task shifting to non-physician health workers, and increased used of information technology in hard-to-reach locations ◆

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