

## The future of Medicare: what's in store?

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Australia's universal health insurance scheme, Medicare, began operating on 1 February 1984. After 30 years it is well regarded by most Australians, and all major political parties publicly declare their support for it.<sup>1</sup> The Coalition government repeatedly says it is the best friend Medicare ever had. Labor, which introduced Medicare, has claimed: 'Labor is Medicare—we built it, and we're the only party that Australians can trust to protect and strengthen it'.<sup>2</sup> The Australian Greens have said that Medicare is 'one of Australia's greatest public policy success stories'.<sup>3</sup>

Despite these public professions of support, there has been considerable speculation in the media in recent months about the future of Medicare. Some have claimed that the end of Medicare as we know it is imminent, and that the Abbott Government plans to means test Medicare, limiting access to bulk-billing general practitioners and medical investigations to those on low incomes.<sup>4,5</sup> If Medicare was means tested, it would undermine one of its core features, universality, and justify claims that the scheme had come to an end.

Concerns about the future of Medicare have been sparked by the Abbott Government's National Commission of Audit, which it established in late 2013 soon after coming to power to conduct a 'thorough review of the scope, efficiency and functions of the Commonwealth government'.<sup>6</sup> With health care accounting for 16% of federal government expenditure in the 2012–13 financial year, and medical services and benefits the largest and fastest growing single area of expenditure (accounting for 41% of the total), Medicare is very likely to be under the microscope.<sup>7</sup> In fact, the Government has already said that it wants to have a 'national conversation about modernising and strengthening Medicare'.<sup>8</sup>

Statements like this strike fear into the hearts of Medicare advocates. Many are sceptical about the strength of the Coalition's commitment to Medicare. It was not until after the Coalition lost the 1996 federal election (considered 'unlosable' by many political pundits) that the party dropped its staunch opposition to Medicare; some suggest that this was only because it was popular with the electorate.<sup>9</sup>

More recently, the current Minister for Health, Peter Dutton, has made comments that have heightened fears about what the Coalition may do with Medicare. In his first major speech on health policy, Dutton said: 'the universal health system means that there will always be value in leveraging people into supporting their own health needs in the private sector'.<sup>8</sup> Unsurprisingly,

the Leader of the Opposition, Bill Shorten, replied during a doorstep interview in Canberra on 25 February, warning against going down 'the American path where the people who can get the best quality healthcare are the richest people in the country'. Shorten went on to claim that 'the Abbott Government is itching to further cut healthcare and to attack Medicare'.

Polarised debates like these suggest people are either 'for' Medicare and therefore 'against' the private sector, or vice versa. These debates are stale, unproductive and out of kilter with the reality of health service delivery and financing in Australia today.

Australia has a mixed health system, with both the public and private sectors involved in financing and delivering care; it was like this even before Medicare was implemented. Rather than getting caught up in debates about Medicare, we should instead be debating how we can preserve Medicare and the principles it was founded on (i.e. universality, equity and efficiency) in the context of a strong and substantial private sector. Refusing to debate the inherent challenges of operating a mixed public–private health system almost guarantees that we will not do it well.

If we are going to have a national debate about healthcare in Australia, we should, for example, be debating what role private health insurance should play in the context of Medicare. It is commonly thought that universal cover can only be achieved through a single national insurer or funder. This is not correct. The Netherlands, Israel and Germany, for example, all have a mixture of public and private insurance and universal, or near universal, cover. To advance the debate about universality in the Australian health system, we need to discuss how, or if, private health insurance helps ensure universal access to care. We will then be in a better position to evaluate the impact of any potential reform options, such as allowing people to opt out of Medicare as long as they have private insurance or limiting the role of private health insurance so that it only covers services not funded under Medicare.

It is not easy to separate questions about universality and equity in Australia's mixed health system. Although Medicare is thought to be equitable because it is financed through our progressive taxation system, many people also receive tax-funded rebates for private health insurance. Whether this is equitable has been debated frequently over the past decade. The recent application of a means test for private health insurance subsidies has only partially resolved the debate.<sup>10</sup> We now need to discuss why

these rebates are needed and what, if anything, can be done to reduce them.

The growing reliance on copayments, or user fees, to help finance healthcare also raises questions about equity in our health system. With approximately 17% of total health expenditure financed by individuals, critics often point out that this disadvantages people on low incomes.<sup>11,12</sup> Therefore, a national conversation on Medicare must include debates about the role of copayments and their impact on equity. It should also consider how effectively the array of safety nets currently in place protects people from high out-of-pocket expenses.

Questions about improving efficiency in any health system are challenging, but the challenges are compounded in our mixed health system. In the hospital sector, for example, approximately 44% of hospitals are owned and run by not-for-profit or private organisations where the government has limited capacity to influence the efficiency of operations.<sup>13</sup> In other major areas of health expenditure, such as medical services and pharmaceuticals, the federal government has some mechanisms it can use to improve efficiency (e.g. by determining rebates for medical services and playing a role in setting pharmaceutical prices). However, the federal government has little control over medical fees, the volume of services delivered and the retail price of pharmaceuticals. Thus, debates about efficiency that focus solely on Medicare are unlikely to go far towards addressing these problems.

To shore up the future of Medicare, we first need to change the nature of debate about it. Medicare itself is not the problem, or at least not the entirety of it. We need a national debate that centres on what Medicare achieves, and how it does this within the context of the broader health system. A debate along these lines is much more likely to lead to changes that strengthen our health system for the future.

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