

## Is Medicare Universal?

### Introduction

The term *universalism* is currently undergoing a revival in the Australian policy debate. Politicians and commentators from across the political spectrum are using the term in reference to the recently proposed changes to Medicare. Much of the debate focuses on whether Medicare has ever been universal and whether the proposed changes will affect that universality. This publication provides a short discussion of the meaning of the term universalism within the context of the Australian welfare state and Medicare.

### Definition of Universality in the Context of Social Welfare

Universal benefits and services are benefits available to everyone as a right, or at least to whole categories of people (for example 'the aged'). In contrast, selective benefits and services are reserved for people defined within the context of the policy as in need (usually in financial need). These are sometimes referred to as targeted benefits: the mechanism for targeting is often means testing. The arguments about universality and selective welfare benefits refer to similar issues as those contained in debates about 'institutional' and 'residual' welfare. Definitions of these two terms are provided in the boxes.

There are, however, some important differences between universalism and institutional welfare systems and selective and residual welfare policies. Institutional and residual welfare are principles: universality and selectivity are methods. A residual system might use a universal service where appropriate (e.g. a residual system of health care might be associated with universal public health measures such as fluoridation of all water); an institutional system needs some

selective benefits to ensure that needs are met.

The intention behind the provision of universal welfare services is that they are accessible to everyone (usually on the basis of citizenship within a nation state) on the same terms.

### Institutional Welfare System

An institutional welfare system is one in which the costs of the risks of the market place (e.g. unemployment) and other needs (e.g. health care) are accepted as social costs. In an institutionalised welfare state, welfare services (including health services) tend to be provided for the population as a whole, in the same way as public services like roads or schools might be. In an institutional system, welfare is not just for the poor or needy: it is for all citizens.

### Universality or Selectivity?

The primary objection to universal welfare provision is the cost. Universal services are considered to be poorly targeted because they do not focus assistance to those most in need. There are of course other objections forwarded from an individualist or classical liberal philosophical position. Selectivity is often presented as being more efficient because (it is argued that) less money is spent to better effect. Clearly there are also problems with selective services. For instance because recipients have to be identified, such services can be administratively complex and expensive to run, they can contribute towards the creation of poverty traps and erode political support for the welfare state. Moreover, selective welfare services sometimes fail to reach the people most in need.

### Universalism and Bulk Billing

If we define universal health care as equal access for every Australian to bulk billing, then the current national health insurance system, Medicare, cannot be considered as universal. This is because there is no guarantee in either policy documents or legislation that all of those eligible for Medicare will have access to bulk billing. Moreover, there is currently no way that any Commonwealth government could guarantee universal access to bulk billing. The 'civil conscription' clause in the Australian constitution prevents a national government from coercing or conscripting medical doctors; in lay terms: the government cannot force doctors to bulk bill. The civil conscription clause has been the most significant barrier to the creation of a national health system in Australia.<sup>1</sup>

Indeed it was the civil conscription clause that prompted the Labor Government, under the leadership of Gough Whitlam, to develop Medibank in the 1970s. Whitlam made it clear throughout his parliamentary career that he considered the current state of the constitution as the most significant barrier to the development of a UK style national health scheme, which he favoured. Medibank and the Community Health Program (which while less discussed in contemporary times was an important and controversial component of the Whitlam government's health policy) were designed to circumvent the civil conscription clause and provide a basis for the development of a national health system based on government funded and provided universal health insurance. Whitlam's goal was to break the nexus between access to health care and capacity to pay: that is, to build a health system in which access

to health care was based on health needs rather than wealth:

The quality and courtesy of medical attention differ very greatly according to one's capacity or willingness to pay. The fear of debt deters many people from seeking medical attention sufficiently early or undergoing a full course of treatment. The fear of ill health is the greatest economic hazard in our community. The present constitutional position is quite unsatisfactory in which the Commonwealth has to pay more and more for the running of hospitals and still has no say in running them, patients are unable to afford medical and hospital treatment and the medical profession participates in any scheme only on its own terms.<sup>2</sup>

To circumvent the constitution, Medibank (on which Medicare was based) was developed as a national health insurance scheme. Thus the Medibank, and now Medicare, rebates are payments to patients not doctors, and bulk billing is one of the mechanisms through which that 'insurance' payment can be made directly to medical practitioners by the government.

Consequently bulk billing has never been universal and the constitution has so far prohibited any national government from making it universal.

### Universalism and Medicare

Although bulk billing is not universal, Medicare itself has always been characterised as a universal health insurance system. The reason for this characterisation is that the two cornerstones of Medicare are based on universal access and insurance for those covered by Medicare. These are:

- free and equal access to public hospital treatment (provided through the Australian Health Care Agreements between the Commonwealth government and individual states and territories), and

- universal access to the Medicare rebate for out of hospital services.

Leaving aside the issue of access to public hospital treatment, Medicare does not guarantee universal access to GPs or other medical practitioners. However, it does guarantee universal access to the Medicare rebate.

### Residual Welfare Systems

Within a residual welfare system welfare provision is considered to be a safety net, available only to those defined within the policy context as most in need, usually when the market or family has failed. Australia is often characterised in international literature as a residual welfare state.<sup>3</sup>

While bulk billing may not be universally available, it is a key plank of the Medicare system. Certainly it could be argued that one of the primary aims of Medicare was to promote bulk billing by doctors and thus promote the de-commodification of health services. That is, the take up of bulk billing by GPs was seen as a way of breaking the nexus between access to health services and capacity to pay. The steady increase in the percentage of Medicare services bulk billed from the introduction of Medicare in 1984 until 1996 provides some evidence that bulk billing was seen as a central and important component of the Medicare system. Other evidence of bulk billing's importance for the national health insurance system, Medicare, is provided in various statements and speeches made by the Labor government during the 1980s.<sup>4</sup>

Despite the importance of bulk billing to Medicare; a decline in bulk billing does not necessarily challenge the universality of Medicare. As noted above, it is the Medicare rebate that is universal not bulk billing. However, it can equally be argued that a decline in

bulk billing contributes to the creation and widening of health inequalities. Without easy access to bulk billing, access to medical services increasingly relies on an individual's capacity to pay rather than on their health needs. Consequently the quote from Whitlam's 1957 Chifley lecture cited above, over 40 years later continues to resonate for those reflecting on the current status of health service provision in Australia. Moreover, if access to bulk billing is means tested, or if low income and chronically ill patients are provided with access to a more substantial Medicare rebate, then the Australian health system will take on the characteristics of a selective (targeted) and residual (safety net) health system. This contradicts the original intention of Medicare; it was first and foremost designed as a *universal* and *institutionalised* health insurance system— where individual and population health and the risks associated with ill health were seen as collective risks that should be collectively insured against. One of the reasons for the popularity of Medicare is its universalism (that is, universal access to the Medicare rebate). It is an old adage amongst social policy analysts and theorists that one of the benefits of having a universal system of welfare services and benefits is that it will be supported and thus defended by most of the society in which it operates. Consequently, universal, institutionalised welfare systems are much more difficult to dismantle.

1. Commonwealth of Australia *Constitution Act 1900*.
2. Cited in Gough Whitlam, *The Whitlam Government 1972–1975*, Viking Press, Ringwood, 1985, pp. 331–2.
3. There is some debate about this classification. Castles has argued that rather than a residual welfare state Australia is a wage earners welfare state. See Francis G. Castles, *The Working Class and Welfare: Reflections on the Development of the Welfare State in Australia and New Zealand 1890–1980*, Allen & Unwin in assoc. with Port Nicolson Press, St Leonards, 1985.
4. See in particular *Health Legislation Amendment Bill 1983*, Second Reading Speech, The Hon. Neil Blewett, House of Representatives, Debates, 6 September 1983 and Senate Hansard, The Hon. Senator Grimes, 9 December 1983, p. 3600.

**Amanda Elliot**  
**Social Policy Group**  
**Information and Research Services**

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