Medicare and its Discontents

Stephen Leeder and Ed Webber

In October last year, **healthcover** was asked whether it would be happy to receive an article about Medicare in the form of a conversation between two strong defenders of the program who have been able to view it from quite different positions. One of them is **Professor Stephen Leeder (SRL)**, who earlier this year concluded his term as Dean of the Faculty of Medicine at the University of Sydney to take up a position as Visiting Senior Research Fellow at the Earth Institute at Columbia University, New York City. Leeder has been a staunch - although not uncritical - defender of Medicare. His conversational partner is **Ed Webber (EDW)**, a resident of NSW who has written regularly about his experiences and observations (including occasional contributions to ***healthcover***) from the perspective of a patient with a keen eye. Webber, originally from the US, suspects we are headed down the road towards US-style health care.

healthcover, existing as it does as a forum for debate, responded to their inquiry in the affirmative. In doing so, we suggested a number of issues an outsider might like to see them address. Leeder and Webber advise they have taken these issues into consideration in their contribution, which is published below. For the information of readers, their contribution is accompanied by the issues we referred to them. Medicare has assumed an iconic quality, becoming the rallying point for those who hold that universal health insurance is the best way to secure equitable access to health services. Introduced 18 years ago, it was initially endorsed by only the Labor Party. In 1996 the Coalition parties promised to retain Medicare as part of their election platform. Since then, however, the Coalition has made substantial (and ongoing) changes which critics insist have attacked Medicare's essential features of universality and equitableness.

"No requiem needed for Medicare, but it needs preventive medicine via doses of reality"

SRL: I think the first point we might agree on, Ed, is that Medicare has shown a remarkable resilience and that a requiem for it is not appropriate. Nor is it necessary. Australia has an enviable reputation for healthy living and good care when illness or an accident strikes.

We pay about the same for health care as most countries of equivalent affluence - more than the UK and less than the US. The World Health Organization and other health agencies judge us to be high performers. Yet the experience of many sick people confirms that we might do better in the way we care for them, especially for those who have long term illnesses that stretch into old age.

Medicare (by which I mean the entire publicly-funded health service in Australia) has coped with large increases in demand since its inception. Despite more than a decade of unrelenting opposition from the current Federal Government in the run-up to their election to power in 1996, and despite the opposition of much of organised medicine and private sector interests in health, Medicare has survived.

It remains a universally-funded and immensely accessible system. This is despite attempts to change it to a safety

Issues for consideration

These are the matters **healthcover** invited Leeder and Webber to take into account in their exchange about Medicare:

1. What tone do you wish to project? Will the Leeder-Webber exchange be simply a requiem for Medicare, or will it harbour some optimism by envisaging a rebirth (and, if so, under what circumstances) arising from society's rediscovery of humanitarian principles and/or fiscal reality?
2. Is Medicare's experience simply an example of a broader cultural ("aspirational") shift in the population at large? After all, the population did not have to respond so positively to the **Howard** government's private health insurance incentives. Was the population too greedy to pass up the 30% rebate or were they misled by a "scare campaign" promoting Lifetime Health Cover? On the other hand, are the Howard government's initiatives genuinely "taking pressure off the public system" but at the same time, transferring resources to the private sector such that pressure on the public system is maintained?
3. On that point, to what extent do *both* major political parties bear some responsibility for what has happened? If their policies are wrong, why do they both acquiesce in the development of an overtly two-tiered system which uses public monies to heavily subsidise the private system? Does it simply allow the wealthy to be "milked" at the user's rather than the governments' expense? (Note Labor's undetermined stance on the future of the 30% rebate.)
4. Apart from discussing broad principles (equity, access, etc), can discussion between you produce firm examples of unwanted outcomes from the arrangements that we are seeing implemented today (i.e. anecdotes rather than just philosophy)? Are the Howard government's private health insurance initiatives sustainable, and if not, why not? In terms of health services research, what research should the government be supporting?
5. What positives can be listed among the Howard government's initiatives?
6. What prognosis do you have for Australia's health financing arrangements (including Medicare) and outcomes for Australians 10 to 20 years down the track?

net and to impose co-payments at the time of use of health services. especially for general practice and pharmaceuticals.

It works well in a pluralistic system such as we have always had in Australia - two thirds public and one third private. It also serves the needs of the Commonwealth and states - despite the mutterings of both players - as a predictable playing field for health service finance games.

Medicare was introduced for a clear purpose. The principle behind Medicare is straightforward: you pay according to your income, by tax and levy, when you are well and receive all necessary care when you are ill with no need for further outlays.

Medicare is not free - we all pay for it. It is there for all, rich and poor alike. Alternate arrangements - public subsidy for private insurance - lack Medicare's efficiency and humanity. Under Medicare, the rich pay more and are just as entitled to use Medicare as the poor.

The notion that the rich should also take out private health insurance is a furphy; a piece of ideological junk that clutters clear thinking. With private health insurance, the rich pay the same premium as the poor and many people holding private insurance are Aussie battlers and not rich. Medicare avoids that problem. The rich pay more for Medicare than the poor through their taxes and through the Medicare levy.

$2.2 billion (the approximate cost of the 30% rebate for private health insurance) would buy heaps of GP visits. It would cover the cost of a lot of immunisation. It could be used wisely in promoting Indigenous health. It would pay for the running of a major public hospital for about three years. Subsidies could be limited to those who really need them. Pressure could be taken off the Pharmaceutical Benefits Scheme by redirecting the insurance subsidy to it instead.

I think it is important to remember how well Medicare does. The evidence from the history of Medicare is that it has coped with extraordinary increases in service volume with remarkable economy. Medicare now supports 30% more services per person than in 1986 for a cost increase slightly less than CPI. It has funded an 88% increase in the overall number of public admissions per person while the average real cost of public hospital admissions has risen by only 4% between 1985-86 and 1997-98.

In assessing the efficiency of Medicare - or of any other system, including US Medicare - you need information about inputs and outputs. We have some useful information about the costs of health care but surprisingly little information about outcomes beyond gross indicators such as mortality.

The silence of the vast majority of people using our health service is impossible to interpret. The voting behaviour of the public in favour of Medicare suggests that many people are satisfied with what comes out. Whether they would be as happy if they knew what goes on in health care we cannot say.

In passing, remember that we know very little about what the community wants from its health service. It is highly unlikely, however, that everyone wants the same thing and unlikely that the same person would want the same thing at all times. Surveys have shown that community members favour expenditure on prevention rather than medical services until they are given a scenario where their health is in need of medical intervention. Their priorities for expenditure then change.

My belief is that there is little justification for spending public money on health care that does not work or is inferior to addressing the same problem by another method. I accept that patients and their families need to be involved in determining the expected outcomes of care and that these may not have much to do with the usual measures of success. Nevertheless, it is reasonable that the community express a view about the expenditure it sanctions on medical interventions in extreme settings.

Whether the efficiencies achieved by a greater emphasis on evidence based care and the better integration of hospital and community care will render the health service sustainable is not clear.

Debates in the US, driven by ethicists such as **Daniel Callahan**, of the Hastings Centre in New York, centre on the limitation of expectations of the health service. Callahan's view is that at present avarice is rampant. According to Callahan, only by especially older people moderating their demands for repair and replacement at huge expense will we return the health service to sustainability.

The general point that can be derived from the debate is that sustainability requires the exercise of restraint, and that this is especially critical in a system that is meant to meet needs universally and equitably.

Jonathan Lomas, of Ottawa, has written that much can be done by involving the community in these decisions, supported by his own experience in Canada. Community involvement can assist in limiting the demand side of health care. Payers and patients can be asked for their view as to what conditions should be paid for. Panels of patients can be asked which patients with particular problems should have access to those services.

None of this is to suggest that Medicare is perfect or has no need for refurbishment or that it is adequately funded. Considerable evidence can be adduced to suggest that weaknesses deserve urgent attention. It will change and like all human institutions, one day it will die. I do not believe it has yet lived beyond its useful lifespan. I still see it as an expression of values that I believe history will judge to be humane and substantial. I judge it to be a success, even after international comparison. I do not think I am alone in that belief.

EDW: I agree. There is, as we both well know, far too much whining, especially by the ALP, about what ails the physical part of the body politic already. But as one who uses the publicly funded sickness care system regularly, I am aware of multiple bruises and shocks it has suffered in recent years.

For all the headlines about allocation of public money for health, the readily observable fact of the matter is that the bulk of it goes into buildings and parking lots. It's called the edifice complex, and not a few of our leaders should see a doctor about it. A side effect of said edifice complex is that the money effectively changes hands along the money trail from public to private.

A fact of the matter is that neither tall buildings nor big parking lots have anything to do with whatever ails the body politic. They do manage to keep the body corporate healthy, though, in keeping with the magic mantra of development. "I've got to develop," says a corporation feeling poorly.

For that matter, health is cheap. It's the medicine and expert application that is expensive. For another, Callahan in New York and Lomas in Canada are talking about chalk and cheese. There are no private hospitals just across the border in Ontario, and to extend our PM's "American road" metaphor - the road he wasn't going to take us down - the mis-titled New York State Thruway is the longest private toll road in the

world.

SRL: These "shocks and bruises" you mention can take subtle forms. Recently I was at a conference on technology evaluation where I noted that the name of the Commonwealth Medicare Services Advisory Committee had been changed to Medical Services Advisory Committee. This committee assesses the value of devices and equipment proposed for addition to the Medicare Benefits Schedule. Likewise, the Medicare Agreements between the Commonwealth and the states are now called Australian Health Care Agreements. I don't mean to over-interpret these changes, but like the removal of the words "equity" and "community" from the Federal Government's health lexicon, I am suspicious.

EDW: As **Confucius** said, "the first thing we must do is rectify the language.

SRL: Not just the individual words, either. I mean, what did you make of the assertion that the public subsidy for private health insurance was designed to "take pressure off the public system"?

EDW: This has not happened. Quite the reverse, in fact. But that's how Honest John and company sold the caper while failing to mention that the private health industry has never had any problems with utilising publicly funded facilities. In fact, as often as not they go to the head of the queue that he's so ostensibly worried about.

This is not to say Honest John worked the con alone. In fact, our ostensibly independent media went right along by publishing figures ostensibly citing the number of Australians without health insurance. The numbers varied from newspaper to newspaper, albeit more in line with the phases of the political moon than reality. The number of Australians without health insurance from beginning to end of the exercise was, and still is, zero.

Contrary to the government's explanatory advertisements - with charts for the dumb - Medicare is a health insurance policy and all the Australians that Honest John ostensibly speaks for are covered by it. There was no need to "run for cover" provided by the private sector. In fact, there was a host of reasons not to, but neither leaders nor scribes were about to tell us that.

For that matter, I can't recall ever seeing an advertisement for Medicare and/or the public health system, yet the bulk of the private sector's advertisements for health insurance have been, admittedly indirectly, publicly funded.

Throughout the entire talkfest, the Loyal Opposition has been just that. Except for the customary whining to make the public feel they were not alone, the ALP and Democrats alike went along with the program. The word "theft" never passed their lips.

Could it be that they all have private health insurance and/or saw the tax rebate in a private and personal light? It should be said, though, that some have seen fit to point out in Parliament that the private health insurance rebate has actually cost more, with less effect to public health, than if it had stayed in the public coffers in the first place. Is this sound economic management? More to the point, whom is it intended to benefit?

As to whether we can see unwanted outcomes from the arrangements currently being implemented, robbing Peter to pay Paul is still robbery, which tends to feed the essential problem of two systems ostensibly doing the same thing rather than solving or even alleviating it. The sustainability of public money to private health funds depends on how knowledgeable the public is or wants to be. And as ***healthcover***'s Editor has pointed out (in his issues for our consideration published above), it has proven to be a gift to be ignorant of what really ails it - wilfully at times, I might add.

International experience in health service funding

SRL: It's probably worth discerning whether universal health insurance is necessary for high quality, equitable health care. In the UK, health services - with the exception of a relatively small but significant private sector - are paid for from taxes but there is no insurance system into which those taxes are paid. That is roughly the case with Australian public hospitals (Hospital Medicare) but it is not the case with Medical Medicare, which pays for fee-for-service medical care outside public hospitals.

In Australia, at least two thirds of our total health expenditure (which generally goes under the title of Medicare) is derived from taxes paid by us to Commonwealth, state and local governments. The Medicare levy, which many people think is their health insurance premium, contributes only 11% to government spending on health care (AIHW 1998).

I do not know what will happen with the Medicare levy now the GST has been introduced.

EDW: I do know what happened when pensions were indexed to the CPI, though. As compensation in lieu of indexation, Honest John took petrol out of the shopping basket by which pensions are indexed. When you're not winning the game, change the rules!

SRL: So in Australia we have a substantial insurance arrangement inside Medicare despite the fact that premiums paid through the levy do not cover the costs. I have been a strong advocate over the years for increasing the Medicare levy to the point where it generates all the money spent by government on health care.

At present there is no actual price signal sent to the paying community as to what health care costs. I do not agree that the price signal should be applied at the point of use. At that point it is inequitable and too late. If we are to have a serious public discussion about the cost of health care, it should occur at the point of payment. Such a debate is difficult when the costs of health care, as in the UK and largely in Australia, are buried in the taxes we pay.

EDW: True. Another thing that's buried, albeit in consolidated revenues, is the sin tax on tobacco and alcohol. 70% is not small change, and it would be well if our leaders put our money where their mouth is. This is unkind of course, but not less true.

SRL: These observations do not directly address the question: Is universal health insurance a necessity? By international comparison it is clear that it is not necessary, but it does fulfil several important functions which should force us to pause for thought before eliminating it.

Firstly, if properly constructed, universal health insurance could be a useful price signal for discussion in the community about whether we are spending enough, too much or too little on health compared with other things such as armed services and education.

Recently we have witnessed a cut of over $1 billion applied to university support and a rebate for those holding pri-

vate health insurance. How are we, as a community, to interpret such sizeable shifts if we have no idea what we are already paying for health care and for education and whether these transfers are what we want?

The large problem with the way in which taxes are spent is that ordinary people cannot see where the money goes. They can look at the buildings, save that a social democracy like Australia is not supposed to be a spectator sport.

Secondly, universal insurance, with its implied support for universal access to care when needed, fits well with fairness and equity. It fulfils an emblematic function, rather like a national flag, signalling what we believe in.

In the US, equity is not highly valued. In Australia, it is commonly argued that it is, and the notion of an "Aussie fair go" is written deeply into our lore. I don't think this value is fully captured by the word "mateship" but there is something of that in it.

A system of universal health insurance, however, is made viable not by genteel altruisms but by the middle class perceiving that it is value for money. A universal health insurance scheme that implies that the rich and the middle class will need to find additional ways of getting adequate care will not survive. These people will opt out, no matter how genuine their altruistic interest in helping their less affluent brethren.

The current efforts to reinvigorate the private health insurance industry with massive subsidies and various other tinkering and tampering and representation of the sector, in government advertising featuring the health insurance "umbrella", as equal in size to Medicare are steps towards the ultimate demolition of universal health insurance.

There is no point to universal health insurance unless we as a society value equitable access to health care for everyone. Medicare was *not*, repeat *not*, a safety net when it was established 18 years ago, yet increasingly it is being defined and treated as such. Its history has been rewritten. The community should be told what is happening.

If Australia's notion of social justice is replaced by self-sufficiency and selfishness, then we would no longer want a health care system capable of meeting the needs of all. In that case, universal health insurance or any other system that uses public funding for health care that is free at the point of use is ethically unnecessary.

True, it may remain a good way of government exercising constraint on fee-for-service medicine through the Medicare Benefits Scheme, but whether this alone would necessitate the retention of universal health insurance I do not know.

EDW: Your reference that in the (not exactly) United States, equity is not highly valued is well taken. In fact, the origin of **Jefferson**'s "pursuit of happiness" as the pursuit of property and social justice there only came about when the patient class became impatient to the point, more or less, of civil disobedience. The now maligned 1960s saw, after all, the largest academic generation of working class origin in history.

But let's look at Medicare in the US. I used to be an American. It surely goes without saying that Australian Medicare has, by and large, been seen as a form, albeit imperfect, of socialised medicine which America's rulers have always considered to be alien, godless or both.

An aspect of the American health system which certainly appeals to our Prime Minister is the American version of Medicare. The operative word is *version*, even if the name is the same. American Medicare is means-tested. One must be old or poor - preferably both. That goes without saying if you are black or Hispanic in a country where Spanish is only spoken in "certain neighbourhoods". Not that it would make much difference because, as the founder of the Keynsian economics not currently in favour in the corridors of power rather presciently put it: "In the end we're all going to die anyway".

Unlike ours, American Medicare has a cap. Enter the future rationing of health that our leaders whisper about? Not quite, but the devil is in the detail. Medical treatment does not stop at the cap. Rather, any health care beyond the cap simply gets charged to the deceased's estate. It's very economically rational, to say the least, and certainly must appeal to all that the Prime Minister holds sacred and that his Health Ministers pay homage to.

A story that is interesting to me and to any public medical practitioner I tell it to has to do with when I was last in America. It also has to do with the closest thing to socialised medicine that America has: the Veterans Administration.

I was staying with a friend and had a more than merely nagging back pain. Not an ache, but pain. Said friend, being a master at working the system up to and including her minority status (I speak more and better Spanish than she does), asked if I had any of my military records with me.

I did have my discharge papers, so she advised me to bypass the local GPs and public hospital entirely and go to the VA hospital in Reno. She also told me it would be just like being in the army again (she was an air force kid and knew of what she spoke) and that I was to use her address rather than mine in Australia.

She was right. I spent the entire day at the VA hospital just getting processed! The next day my back was x-rayed, and the VA doctors (none of whom were American, I might add, but my German isn't bad either) told me the x-rays showed me to have normal arthritis for a man my age. They gave me some pain-killer and that was that.

A year later in Sydney I had the same pain (obviously in the same back). I went to a GP who bulk billed. He referred me to a back specialist who also bulk billed, who referred me for x-rays, also bulk billed. The x-rays showed quite a bit of osteoporosis as well as a crushed vertebra. "It's an old crush," the specialist said. He then asked me if I had done anything in my younger life that might have caused it.

Analysis of the two experiences told me - admittedly at the risk of being thought to be cynical - that what motivated the VA's reading was something which obviously had nothing to do with the Australian specialist's reading: it was my military record which got me into the VA hospital in the first place, specifically the parachute badge.

GPs in private practice assure me that no doctor would allow possible liability to interfere with diagnosis. Medicos in public practice, however, read the story pretty much the same way I do.

SRL: You're a man with some familiarity with the world of odds and bets, I believe. How do you see health insurance from that perspective?

EDW: As I have said elsewhere, I do know how to read most games. Having spent 20 years in middle management in the emporiums of chance in Nevada, it comes with the territory.

There is an interesting aspect to private health insurance and the insurance business in general that the current Federal Government takes such pride in

championing. What makes it doubly interesting is that our good and honest PM - who "speaks for all Australians" - is also and equally and publicly against gambling. In a country that will bet on damned near anything, that's quite a revelation: When we buy insurance, particularly of the healthy sort, we are making a bet although we may not think so.

We may also think that actuaries offering coverage are not the same as odds-makers selling protection. Actuaries do wear better suits, but that's as far as the difference goes.

Albeit there is one other essential difference: Making a bet in the insurance casino is a house game. Not only does the house control all the odds as well as the state of play, but the player can only make a bet against *himself*. Taking said facts of insurance life into account, it therefore stands to reason that what a smart player should be looking for is the insurance company that consistently offers the best odds possible. That house, if only because it is the only truly national one, happens to be Medicare.

Doctors may call us health consumers; insurance salesmen may call us investors in the future. But the fact of the matter is that we are all players. Insurance being the casino it is, we must also seek the house that offers and plays with the longest odds.

Private insurance casinos, because of limited market share, can only play with and, therefore, offer short odds. The house offering and playing with the longest odds is Medicare, the moreso because we as a nation own it. Which is more than any American with an IQ above room temperature can say about anything in the most privatised country in the world.

Then again, America is not really a democracy; it's a corporation, albeit with a great many and so-called lesser shareholders. In such light, it's no wonder that while American expatriates may get homesick, very few even think of getting sick home.

SRL: I can accept your analysis. In the light of that analysis, it's interesting to reflect on the advertising campaign run three years ago to encourage the uptake of private health insurance.

Advertisements for private health insurance that had been invigorated by the government subsidy suggested that foot massage and other feel-good therapies are now available on private health insurance. A TV commercial for Medibank Private showed people (could they possibly be patients?) in hospital who were healthy, smiling and clad in surgical gowns jiggling and jubilating over their cash refunds, though the refunds rattled hidden in a bedpan. Perhaps the bedpan was a metaphor for waste, for no health care system in the world can sustain the provision of services that go beyond the proven and the essential.

EDW: Because they feel better now? The corporations do, anyway.

SRL: A central ambiguity resides at the heart of the health insurance debate and it is this: Australia has a universal public health insurance system in which Medicare underpins the majority of health care. Yet $2.2 billion of public money is now spent subsidising private health insurance.

This ambiguity expands when private health insurance is commended to the electorate - an electorate that demands Medicare's continuation - as "taking pressure off the public system". If that were the intention, the $2.2 billion would have been used to better effect by direct investment in the public system. It is as though the Federal Government owns Qantas and now agrees to pay for one third of all the tickets purchased on Virgin.

But that analogy falls down, in that the publicly funded system, which covers the bulk of the "passengers", is also the no-frills system that is catering for the vast proportion of emergency care and chronic illness services. The private system predominantly manages elective and day-only surgery, with additional business-class comforts. Fair enough if people wish to pay for frills, but should other taxpayers pay one third of those costs?

The ambiguity has grown because of confusion around the nature of Medicare. However much some may wish to rewrite its original purpose to be that of a safety net, Medicare was introduced to be universal. The idea that unless young people "run for [private] cover" they will have no health insurance in the future is true only if Medicare is not there or is turned into a charity system for the indigent. If that is not the intention, then the advertising for lifetime cover was disingenuous.

Fortunately, for the sake of equity there is no convincing evidence that care in the private system is superior to public system care in health outcome or financial efficiency. Heart patients, who get more procedures in the private hospitals, have no better outcomes. Comparisons of the administrative costs of public and private health insurance reveal a three- or four-fold higher cost than for Medicare in the smaller multiple private health insurance companies. The administration cost of private health insurance is now more than $700 million a year. The lie that somehow private care is efficient and that public care is wasteful is another furphy. Administration soaks up more than 11% of all private health insurance funds. For Medicare the figure is around 3%.

The government subsidy for private health insurance has had a paradoxical consequence. The portion of total health costs ($54 billion in 1999-2000) paid by government rose from 65.5% in 1997-98 to 67.3% in 1999-2000. If pressure has been taken off anything as a result of the private health insurance supplement, it is the private contribution to health care!

Moves to boost private health insurance, while encouraging consumers and producers to regard it as a market commodity like socks or a refrigerator, inexorably led to tighter control, coming ready or not. Would Treasury permit an investment of $2 billion a year in private health insurance without taking a healthy interest in how it is spent? And are they disinterested in Medibank Private's losses now?

EDW: Let me return to my patient's eye view. Another practical difficulty of the current system that I have experienced is its non-portability. Private insurers and insured can move from place to place, private to public. The public, staying with the public and ostensibly national coverage of Medicare, can not.

As a matter of fact, it seems to be all but illegal for a public patient to seek medical services elsewhere than his neighbourhood of record. It is not the done thing, say, for someone in Sydney's western suburbs to present himself to a public hospital on the northern beaches.

Knowing one's assigned place in the great scheme of things is, of course, a less than gracious way to phrase it, even if by not playing the rules, one would in effect be equalising the all-round pressure on the health system in the offing.

This restriction on "impatient" movement, however, does not apply to shopping for the doctor of one's choice, because GPs are in private practice and, therefore, work by different rules up to and including charging whatever the traffic in the neighbourhood will bear.

GPs' refusal to bulk bill has more to do with GPs' office overheads than with health, and that fact alone cancels the notion of freedom of choice that everybody in charge of being healthy likes to talk about - bulk billing being a step along the socialist road in opposition to free enterprise, etc.

Be that as it may, one thing I have noticed is that bulk billing was not the done thing until the rebate was worth it to the GP. Needless to say, the patient class was never consulted as much as the doctor class.

That said, bulk billing strikes me to have passed, by and large, into history, primarily because GPs were not getting enough money to continue it. That's a simplistic view, of course. Still, it's not simplistic to say that the current government's overall handling of its Medicare account has not kept pace with CPI. In other words, it has not paid as much attention to public business as it has to private concerns.

A case in point is that the rebate for a specialist consultation is - and to my knowledge always has been - higher than for a GP consultation. It is also the case that more of the graduates of our medical schools finish up as specialists and fewer as GPs. To say that the system is specialising us to death may seem churlish, but few of said specialists are willing or capable of working an emergency room.

As I said in my *Immodest Medical Proposal* for a "smart" Medicare card [**healthcover** 2001; 11(1):60-2], Iceland's answer might be a bit too socialist for the powers-that-be. The proprietorial aspects of the matter are compounded - unnecessarily I think - if and when we go beyond politics and delve into copyright within and without the health system itself. All of the software for NSW's "smart" patient record of the future (how far into the future is another matter), for instance, is being set up and will be implemented by an American software firm. It owns the software and therefore all the contents within it. It was more than passingly interesting that the authors of the article "Lords of the New Feudalism" (*The Australian* Higher Education Supplement, October 23, 2002) did not even mention health and/or records thereof in their learned discussion of the Agreement on Trade-related Aspects of Intellectual Property vis-a-vis the World Trade Organisation.

That said, unlike Australian copyright, it is possible under US copyright law - unknown to many Americans, I might add - to copyright virtually anything without it being published. I own the copyright to an Australian-theme restaurant, for example, and am thinking of copyrighting my health history before my GP does.

But I digress. I do see in the future a "smart" card containing patient records. Such is a foregone conclusion, I think, hence it's not really the issue to address. On that, even the ALP is in agreement.

The real issue is who and/or what will own and control it - public or private - and in the current socio-political climate more should be said about the matter than has been to date. As **healthcover** noted in an introduction to my *Immodest Medical Proposal*, others suggest that the so-called (touted, really) public concern about privacy is a bit of a red herring at best, and at worst a symptom of private sector anxiety, which is all the more interesting in that the technology already exists at the national level within the Health Insurance Commission (HIC).

The consequences of current changes

SRL: What practical consequences do you see then, Ed, as a result of changes to current health service funding?

EDW: One example is the cuts applied to the Commonwealth Dental Program several years ago. The program was seen by Canberra to be too expensive. Somehow it is now cheaper for the government to issue public referrals to privately employed dentists. Given that said referrals have a cash cap, what does this have to do with the dental health of the nation?

At the risk of being churlish, aside from subsidising dentists it also placed more pressure than before on the public health clinics, as observation of most public dental clinics will attest. The word "most" is used because it did not affect public facilities in more affluent neighbourhoods, where people probably vote along so-called conservative lines anyway.

SRL: Yes, I sense a standoff between the states/territories and the Commonwealth over public dental care. Why should teeth and gums be regarded as non-corporeal organs? The answer probably lies - to the public detriment - in the professional demarcation between doctors and dentists. But with a Commonwealth budget cut of $100 million to the states and territories in 1996, public dental care went pear-shaped. States would not pick up the slack, hoping a public outcry would lead to a reversal of federal policy. It did not. The Prime Minister has argued that the states, who will now receive much of the GST, should pick up the costs.

John Spencer, Professor of Social and Preventive Dentistry at Adelaide University, has written a superb paper for the Australian Health Policy Institute at the University of Sydney entitled "What options do we have for organising, providing and funding better dental care?" Public subsidy for teeth at present is maximal for the rich and least for the poor. The subsidy for public dental care for adults is approximately $177 million a year, while the private dental insurance rebate is approximately $316 to $345 million a year. Higher income adults using private dental insurance and dental care receive nearly five times the subsidy received by aged pensioners seeking public dental care. Spencer estimates that a funding increase from $177 million to between $446 and $611 million a year on public dental services is required for public dental care to achieve similar patterns of use to that of non-eligible Australian adults.

EDW: The privacy issue was a scare tactic, in other words, as part of what may well be a broad cultural shift away from public to private and to any and everything in general. Privatisation has been a quasi-religion for some time after all, regardless of which of the major political parties has been in government.

SRL: Let's go a bit wider. What prognosis do you have for Australia's health financing arrangements, including Medicare, ten to twenty years from now?

EDW: Who, moi? Then again, the old Jewish saying to "never ask the doctor; ask the patient" didn't get old without some truth in it.

In a nutshell - and I am not at all alone in saying this - I see the Americanisation of our health system, just as I see the Americanisation of the country. For one thing, it will be more profit-driven

than health-driven. It will also be - albeit primarily because of the same impetus - even more of a two-tiered system than it is today.

Before the prognosis, though, comes the diagnosis, and as I say, the symptoms of the Americanisation of Australia and/or its health system have been there for some time. Maybe it helps to have been an American to spot them. Maybe it does not, although the use of "noted American expert" has certainly become a growth industry in the media of late (un-noted ones being another matter, of course).

If Medicare be a safety net, as our Prime Minister (who ostensibly speaks for all Australians) would have it, what does it catch if not those Australians whom private health interests and its insurance salesmen do not want? Accepting that to be a symptom, as I do, the only valid prognosis for Australia's health system down the road is that it will become two totally different and separate systems rather than one.

What I see as part and parcel of what is really happening to our health system under the care and guidance of John Howard's economic rationalism vis-a-vis privatisation is that not only is health being given a monetary value but a temporal one as well. GP consultations are broken into short and long and their monetary value is judged accordingly. Half an hour is somehow worth more than ten minutes. The fact that neither money nor time has anything to do with health is disregarded.

Among other things, neither the doctor nor the patient can afford to tell a joke. Such digressions are not allowed! It's an interesting symptom, to be sure, although on the health level what has really been happening is that the doctor's ability to gain money rather than the patient's ability to gain health is the criterion that is being applied.

The very same symptom is evident in government, wherein said corridors of power it is assumed that more money automatically means more health whereas what it really means is more money for medicine. And it should not go unnoted that money is invariably the medicine of choice for whatever system is feeling poorly. But as a comparison of the Australian and American systems shows, monetary medicine has nothing to do with people's health. In fact, such an attitude feeds the problem far more than it comes even close to solving it.

SRL: Yes, it is as well to remember that Americans spend more on medical care, as a proportion of GNP, than we do in Australia - 14% to our 9.0%, in fact. Yet we have better life expectancy and greater equity.

EDW: Not that this is anything new, of course. Rather, what I have been trying to point out is that our leaders - be they in medicine, academe or government - have been and continue to be very selective about which symptoms they want to address and which symptoms they don't. Such selectivity with the symptoms that present can - and does - make for some very faulty diagnoses at times, not to mention prognoses thereof. Obviously, medicine can be adjudicated, as can many things in a Cartesian world, but health - be it of a system or of a human inside it - is a bit trickier. And there are a lot more variables continually at work within one person, let alone millions of people.

Mind you, I am only making these observations on symptoms, diagnoses and prognoses from within the limits of my own experience and/or education. I would find it more than interesting to hear your views as an accredited epidemiologist. Are we witnessing an epidemic of sorts - a building up of capitalist antibodies, if you like?

SRL: Oh I think these symptoms, diagnoses and prognoses are by no means limited to health and medical care. They are part of a more general trend - a move away from a concern for uncomfortable intangibles like health and education in favour of quantifiable things like medical care and accreditation.

While clearly important in itself, the way we pay for health services is also a social statement of great power. If we value the health of all citizens irrespective of their social utility and ability to pay, the way we pay for health care will differ from how we would meet these costs if we consider that those people with more resources are entitled to better care. Much else follows. Valuing the individual on economic and social status grounds means, for consistency, an approach to society and the physical environment in which the rich individual is much freer than others in their actions and impact. This cuts fairness off at the knees.

I have several other concerns for the future. First, in negotiating the next round of bilateral five-year Health Care Agreements between the Commonwealth and each state and territory, it is plausible that the Commonwealth will seek to recover the billions it pays for private health insurance by decreasing the support it offers for public hospitals. If there are attempts to reduce the grants to the states, it is essential to establish whether there has been effective service substitution. Increased private hospital activity for conditions that would not otherwise fall to the public sector to treat is no reason to reduce support for public hospitals. Other indicators, such as numbers of patients treated (they could be treated for anything) or numbers of people insured are inadequate markers.

Second, there is a problem because Medicare does not cover allied health services (physiotherapy, speech therapy) and dentistry in the community. The need for these services will increase in line with the more care we give to patients with chronic illness in the community. These services are now only met by private health insurance or out of pocket payment and are not equitably available. This creates an inequitable and artificial niche for private insurance.

Third, the popularity of the private health insurance subsidies may freeze them in their current form. If private health insurance subsidies are to be maintained, they could be directed preferentially - and with better effect - to those who at present need private health insurance the most but who are the least able to afford it. While we may aspire to expand Medicare's coverage, current realities mean that older people in need of allied health professional care in the community may wish to maintain private health insurance. On equity grounds, the subsidy provided to them should be larger than that given to younger hale and wealthy members. Subsidised "lifetime rating" is a convoluted way to achieve this transfer.

The private health insurance subsidy, along with health financing arrangements in general, deserves seriously to be reviewed, as recommended by the Productivity Commission. This country is affluent enough - and once had sufficient social goodwill - to introduce Medicare. It is time to reaffirm that commitment.

Health policy: Who needs it?

SRL: Policy, like the people whose opinions it is expected to collate and reflect, comes in many shapes and sizes. In 2001 I attended a square "roundtable" that was convened in Canberra to discuss with **Senator Rosemary Crowley**'s Senate Committee inquiring into the future of health care financing. I argued that we needed a national health policy and was met with a spirited joust from another knight, one of bureaucratic persuasion. "We have dozens, if not hundreds, of national health policies," he said, "that cover everything from standards for incontinence pads to the Medical Benefits Schedule."

Experienced managers might claim that anything that attempts to go beyond the sackful of such national policies in search of something more coherent is like searching for a unified field theory. Time and time again, serendipity, the play of the dice of chance, opportunity, and forces beyond the frame of the most imaginative strategic plan affect what happens.

So why, unless one is completely "off message" with reality, seek a policy for health at a national level? The reason for a national policy can be derived from experience and it is this: "Meet me at no particular place," runs the old song, "And I'll be there at no special time". Despite the intrusion of chance and unpredicted external events, there remain many decision points, crossroads or "crises" as the Chinese call them, where we are presented with real choices. It is when these choices arise and windows of opportunity open that broad, guiding policy can be useful; that planning is a possibility.

That a bridge can be built despite strikes, bad weather, union politics and more is testimony to the fact that big blueprints, plans and policies are not folly but are essential for large-scale progress.

The development of a comprehensive Australian health policy that seriously takes into account knowledge about health determinants and health-state inequalities still awaits us. While not denying the difficulty of the task, a comprehensive health policy that expresses the central aspirations of Australians with regard to health and health care and defines the limits and priorities is essential.

The central players in this debate should be our politicians. There are many others to invite to the policy table. If we succeed with an area as expensive and as value-laden as health, we can predict confidently that much else will follow with great benefit to the community.

POINT OF VIEW

Chronic illness: "We need detailed funded policies, not more words"

Paul F. Gross[§]

A large number of treatises on the need to introduce new policies for disease management and chronic disease have emerged in Australia since the mid 1990s when the National Health Targets strategies were delineated by the national government.

Since then, the flow of reports and working party activity in Australia has accelerated:

1. Following the WHO Global Strategy *Health for All by the Year 2000* and its revised strategy into this century, the National Health Priority Action Council (NHPAC) was intended to better coordinate the care and funding of specific chronic conditions and disease that have a high economic, social and health burden. It has produced reports listing the many barriers, gaps and opportunities for improvement of Australia's health[1].
2. The National Public Health Partnership produced a strategic framework for the prevention and control of chronic, non-communicable diseases in Australia in June 2001[2]. Its Executive Summary recorded the hope that *"... leadership to translate the framework into action will be the responsibility of the National Public Health Partnership Group (NPHPG)*[which had written an earlier report[3] in collaboration with the NHPAC] *working in close collaboration with the National Health Priority Action Council"*.
3. The Department of Health and Ageing created the *Sharing Care Initiative* in the 1999-2000 Budget[4]. It was part of the federal government's Enhanced Primary Care (EPC) package that included 28 new Medicare Benefits Schedule items to encourage GPs to develop care plans, case conferences and hospital discharge plans; the Commonwealth Carelink program; funding for the second set of coordinated care trials; the Falls Prevention in Older People initiative; the Information Technology initiative; and programs for GP education, support and community linkages. It was funded

[§]Director, Health Group Strategies Pty Ltd, Sydney. This paper is drawn from a larger report on chronic illness in Australia. See: "Chronic illness on Earth, health insurers on Venus and governments on Mars: Why glacial speed is not a smart policy option", Health Group Strategies Pty Ltd, Sydney. February 2003.

tion only after settlement means that so many years have usually elapsed since the event that the information is almost useless for retraining and disciplinary purposes.

It is also difficult to know what are the exact indicators of a real problem for the purposes of identifying a claim as worthy of assessment. The American state Medical Boards tend to only assess cases with payouts of over $US 300,000. This is despite the fact that all insurers (and the Boards themselves) agree that there is no real correlation between the size of the mistake and the amount awarded.

Given that these factors are currently unknown, the Committee has proposed that a two year pilot study be undertaken by the NSW Medical Board to assess these factors. At the end of this time a report should be prepared for the Minister for Health outlining the costs and benefits of mandatory reporting and proposals for a model for reporting and analysis of cases.

IT and health records: Chipping away at a "smart card" solution

An Immodest Medical Proposal

In a story commencing on page 37 of this issue, health services researcher **Kathy Eagar** wonders whether, given her experience in the Illawarra Co-ordinated Care trial, people really do have strong objection to sharing their personal health histories among the myriad of care providers who might be involved. Eagar said that in that trial, "2000 out of 2000" people consented and later evaluation showed them to be content with their experience. She added: "So we need to be very careful, when we argue the consumer privacy line, that we're really not talking about protecting the privacy of providers rather than the privacy of consumers."

Just before Christmas **healthcover** received a letter from a 62-year-old disabled pensioner with multiple sclerosis. He had been referred a copy of **healthcover** and, possessing an ongoing critical interest in the functioning of the health system, was moved to comment in his letter: "The first thing I noticed is that the contributors are either doctors or politicians - *argumentum ad authoritatum* from my point of view. Would you, however, consider a contribution from neither of these vested interests in the health debate but from the patient class?" Enclosed was an article chronicling his unsuccessful attempts to interest the major players in a "smart" Medicare card carrying a persons's medical records. The writer added: "The enclosed has already been buried by the Senate and every other medical journal in the country." We publish his contribution below.

E.D. Webber

On April 18, 2000 the *Sydney Morning Herald* carried a small piece headlined "Medical database 'inevitable'". I agreed with the conviction expressed in that headline, albeit for a reason different from that which justified the headline.

In 1994 (or thereabouts - the paper is certainly brown from age) *The Australian* published a letter from me expressing the opinion that we should be able to carry our medical records within our Medicare cards.

Subsequently I elaborated on that opinion and argued it in a piece I called "A Modest Medical Proposal".

It went something like this: If my Medicare card contained access to medical data the way my bank card does for financial data, I could carry my medical records with me everywhere I go in Australia.

I wouldn't have to submit to, and pay for, tests every time I see a different doctor. I wouldn't have to carry my records from specialist to specialist or pay for the privilege of having them forwarded. I wouldn't have to fill out forms every time I was admitted (interesting word game that) to a hospital.

I couldn't effectively withhold information by simply changing venues. I couldn't increase access to the drugs I like according to the numbers of doctors I scam.

I couldn't make whatever is wrong with me to be any more or less than what it is, nor could any doctor. I could be diagnosed even before I am transferred from ambulance to hospital, even if I cannot speak.

If, however, my Medicare card contains only data pertinent to claims and payments and my medical data remains a mystery accessible only by doctors and others ostensibly interested in my well-being, does not that tell me that I cannot be responsible for my own health even if I want to be?

Does it not also say that the real function of Medicare is a purely financial one rather than medical? And if so, what a waste of technology my Medicare card is in the so-called clever country!

It is admitted that full implementa-

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tion (I can see no reason for semi-implementation) sounds suspiciously like Big Brother, with all of its Orwellian socio-political implications. We all remember the flap not so many years ago about the possibility of the Government introducing an Australia Card.

All that hue and cry has subsided. We now have our photographs on our drivers' licences and some credit cards, just as they have always been required on our passports.

And it should be noted that these documents are not owned by individuals but by the issuing authorities. Surely this is not the case with our Medicare card. Or is it?

"A Modest Medical Proposal" has been favourably known since the mid 1990s to **Phillip Adams**, **Hugh Mackay**, **Peter Baume** (as Head of the Department of Community Medicine at the University of NSW), **Stephen Leeder** (Dean of Medicine, University of Sydney) and the NSW Doctors Reform Society. Not so favourably, it has been rejected by every medical professional journal in the country to which it has been submitted.

I also submitted it to the Senate's inquiry into ownership of medical records, where it and any other notion that might have encroached upon the power of doctors and other professionals defending their proprietorial rights to ownership of the medical record was buried. (Although I did get a copy of the inquiry's report with my name in the back as one who had made a submission.)

The Australian chapter of MENSA had enough interest in the idea of "smart" Medicare cards to consider it for discussion, which is more than can be said judging from the response by the Health Insurance Commission, which administers the Medicare card system and its sole claims and payments function.

In one letter, the Commission advised that 1. the technology for such a project is available, but 2. the Government (at that time the Australian Labor Party) had no intention of introducing a "smart" Medicare card. And that was that.

In the light of the foregoing, the media statement by ALP Shadow Minister for Health **Jenny Macklin** reported in the *Sydney Morning Herald* on April 18 last that "new information technology is coming to health, ready or not" is as droll as the announcement that federal Minister for Health **Dr Michael Wooldridge** had "last year (1999) appointed a working party to explore the possibility of a transfer system of patient data".

Admittedly it was nice of Macklin to point out that "currently there is no single record that contains a person's health history" and that "there is no computerised network to link general practitioners, hospitals and other health care providers, and consumers have little or no access to their medical records".

But it was hardly intelligent, in that her own party was responsible for precisely that state of affairs when in government, and on a par with her opposite number establishing a working party to "explore possibilities" (although that is better than nothing). In other words, for her to accuse the present Government of a lack of leadership is simply a pot calling a pot a pot.

In fact, I personally delivered a copy of my "A Modest Medical Proposal" to the electoral office of her predecessor, **Michael Lee**, years and an election ago.

To give credit where it is due, pharmacists now have computerised linkages to curtail patients' storages of favourite drugs which did not exist before.

Neither side of parliament can seriously claim that my modest proposal, put forward years ago, is particularly revolutionary. Iceland, which is now compiling a DNA databank to identify diseases at a time when NSW is working on one to identify criminals, has had a computerised health card for more than a decade.

To Macklin's credit, she did state that "privacy safeguards for on-line medical records were crucial". On that issue she and my "A Modest Medical Proposal" agree, albeit again for different reasons.

My reason relates to one vested interest group that she omitted from the short list of relevant health care providers that she mentioned: the private health insurers.

The AMA's private health insurance partners would like nothing better than to have access to a national health database - not with the health of the nation in mind, but their own health.

Forget about actuaries offering coverage; focus on odds-makers selling protection. Access to a national health database would be a handy means of shortening the odds - making certain that people were assigned to higher risk groups through what can only be called insider trading. The game can then be seen for what it is.

It takes us right back to the Senate's inquiry into ownership of medical records, but only after a fashion. The fashionable way to view that Senate inquiry would be to see it having something to do with proprietorial rights. And on the surface that is true enough.

But it is the potential use of such rights that is at the core of the argument today as it was then. Putting it simplistically, the doctors didn't want to be held liable. The patients asked: "Why not?" The doctors replied: "Because we own the evidence that might be used against us."

The Senate, in its infinite wisdom, decided to avoid the hard choices and cut the argument down the middle. Private patients' records are now the property of the doctor of record and public patients' records belong to the patient. A bit of a Gordian knot, really, if or when a patient goes from being public to private and vice versa.

In other words, the privacy safeguards which Macklin says should be addressed are still as open to interpretation as they were at the Senate inquiry years ago.

Obviously Iceland solved the problem. But none of our health spokespeople bothered to ask them how, for fear of being given an embarrassingly socialist answer.

Given that Australia really has two health systems - public and private - it is not surprising that nobody asked. In that our private system has no problem making use of our public system's facilities, there can surely be little question but that the patient's proverbial rights to privacy are not really what the private sector is interested in.

Given the (embarrassing) fact that the expertise of our current Government amounts to that of a cost accountant (why else would one Minister's staff have asked how much my "smart" Medicare system would cost rather than how much it would save?), it comes as no surprise that Health Minister Wooldridge went for the "working party of experts" approach rather than pursuing policy.

Working parties of experts are fine enough, save when they belabour the bloody obvious by burying it in the offing, which is exactly what happened with my - and others' - modest approach.

As **McKenzie Wark** succinctly pointed out (but unfortunately in the *Higher Education* pages of *The Australian* where it would be missed by most):

"In a lot of social sciences the ordinary can only appear if it can be made into a problem. If there are victims, there can be experts who can pronounce on the problems of the victims and acquire power if not over solving the problem, then at least over the knowledge of it."

On the medical profession's attitude against patients owning their own medical records via their "smart" Medicare cards, **Gore Vidal** was more succinct with his observation some 20 years ago that "like all priests, medical doctors do not look kindly upon parishioners betraying too intimate a knowledge of holy affairs".

It was in such a vein that I made my own "A Modest Medical Proposal". In the light of Jenny Macklin ostensibly having seen the light and expressed a willingness to come to the "inevitable" party (with or without the benefit of the deliberations of Health Minister Michael Wooldridge's working party), I would now like to offer my "An Immodest Medical Proposal".

The germ of it probably came from watching the original run of *Star Trek* years and a country ago, but a visit to my vet confirmed it. Notwithstanding that the vet keeps his patients' records in a computer database, I am now required by law to microchip all animals which I own and I am required by law to exert proprietorial control first and foremost ahead of the police or dog-catcher.

I have no choice in the matter. Nor, I might add, does any dog-owning doctor.

My "An Immodest Medical Proposal" - and I am quite willing to accept a deluge of hate-mail from doctors, dog lovers and civil libertarians alike - proposes (immodestly) that we accept the new information technology and discard Medicare cards altogether, along with the doctors' proprietorial notes that are safeguarded within 19th century filing cabinets.

Instead, we should do what veterinarian carers of the lower part of the food chain are already doing.

AMC accreditation to extend to medical colleges?

The Australian Medical Council (AMC), in association with two volunteer medical colleges, is currently trialling an accreditation process which could lead to a requirement that the training programs of all medical colleges be accredited if their members are to be recognised as specialists for funding purposes.

Currently, AMC accredits Australia's medical schools to satisfy medical registration boards that a school is producing safe and competent medical practitioners. Accreditation means that graduates of the medical course can be registered as medical practitioners in any Australian state or territory.

The AMC, after working on guidelines for some 18 months, started pilot projects evaluating the training programs of the Royal Australasian College of Surgeons and the Royal Australian & New Zealand College of Radiologists in the latter half of 2000.

The pilots are expected to be completed by July 2001. The AMC will furnish the colleges with reports on their training programs.

At present there is no formal process for ongoing accreditation of college training programs. Recognition, for funding purposes, of specialist qualifications issued by the various medical specialty organisations has been the responsibility of the National Specialist Qualifications Advisory Committee (NaSQAC).

Meanwhile, the AMC has announced the outcome of accreditation reviews at the University of Western Australia and James Cook University, Townsville.

Accreditation of the new medical course at the University of WA's medical faculty has been extended until 2007 subject to the faculty's response to two areas of concern raised in the report of the visiting AMC team which reviewed the course's implementation:

- A review of the faculty's plans for assessing the medical students.
- Mechanisms for co-ordinating teaching and student support at the major sites of clinical teaching.

The new course was introduced with AMC accreditation in 2000. AMC says: "The course emphasises student participation in the education process, allows students to study optional areas in depth, and gives students experience in a wide range of hospital and community health settings."

The review team's report highlighted the following as strengths of the course:

- The rural week in Year 1.

Said AMC: "Halfway through the first semester, all students spent one week in a rural town in Western Australia exploring health issues. The visits have been very successful, giving medical students an insight into the strengths of and problems confronting rural communities and improving students' communication and interviewing skills and their abilities to work in groups."

- The new Centre for Medical and Surgical Skills, which is a training facility equipped with state of the art surgical and anaesthetic equipment as well as simulation and virtual reality models.

Said AMC: "The centre will play a role in training surgeons, anaesthetists and other health care professionals, as well as providing clinical skills training and assessment for medical students. It is a collaborative venture between the WA Health Department, the Royal Australasian College of Surgeons, the Royal College of Surgeons of England, the Hills Surgical Trust and the University of Western Australia."

- The use of a wide range of public and private hospitals for clinical teaching and the support for teaching, particularly from the three major associated general hospitals, the Royal Perth, Sir Charles Gairdner and Fremantle Hospitals.

The visiting team also reported on the faculty's current medical course, which is being phased out. AMC said the team met students of all years of the course and reported that the faculty was