Making Medicare Select Real

A roadmap for reform to put people at the centre of health care

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This paper represents the personal views of the three authors and does not necessarily reflect the views of the organisations to which the authors belong.

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Introduction

Medicare Select is the name given by the National Health and Hospitals Reform Commission (NHHRC) to their proposed long term direction for the structure and governance of the Australian health system. The Commission presented this concept as their preferred structure under a single government funder and recommends that the Commonwealth Government commit to a 2 year review to develop the details of the model.[1]

This paper has been sponsored by Medibank Private as an independent account by the three authors of a vision and practical roadmap for the Medicare Select model.

Specifically, the authors were asked to make the following appraisal of Medicare Select:

- Describe how Medicare Select could work including high level design options,
- Outline risks and key design decisions,
- Present a number of practical pathways to evolve toward Medicare Select including steps and sensible sequencing to build necessary competencies and mitigate risks, and
- Demonstrate how the steps proposed in the Healthy Australia Accord are relevant to and could be built on to move to the Medicare Select model.

This paper represents the personal views of the three authors and does not necessarily reflect the views of the organisations to which the authors belong.

The authors have each in different ways previously recommended consideration of health system governance models similar to Medicare Select. In this paper the authors have brought together their various interpretations of the model to provide an outline of how Medicare Select could work.

Essentially, Medicare Select, as explored in this paper, is a uniquely Australian model which builds on the current universal entitlements of Medicare to support a more integrated health system where all government health funding can be organised around the needs of individual consumers, across the continuum of care and across the multiplicity of health care providers, public and private, who comprise the Australian health care system.

The financing model creates strong incentives to improve health outcomes, especially for those most in need. The Commonwealth provides the national framework and States continue to have an important role in the public delivery of health care.

While Medicare Select has some elements in common with European social health insurance systems, it is not social health insurance, as Medicare Select is an extension of the current Medicare, tax funded, rather than funded through levies on employers.

The model potentially supports a more sustainable universal health system through greater transparency, reduction in duplication, supporting appropriate care in the most appropriate setting, competition, innovation and choice. Through greater consumer voice, the system would be more responsive and innovative to meet consumer priorities and changing needs.

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[1] National Health and Hospitals Reform Commission, *A Healthier Future for All Australians*, Commonwealth of Australia, 2009.

1 Why Medicare Select

After 16 months of consultation and review, the NHHRC came to the conclusion that the Australian health system has reached a critical “tipping point” requiring urgent, substantive reform. The Commission therefore recommends major restructuring of the governance and financing of the health system. The first level of reform recommended for immediate implementation is called the Healthy Australia Accord, which realigns funding and policy responsibilities between the Commonwealth and state/territory governments, particularly in relation to public hospitals and primary health care. While the Accord is primarily designed to alleviate the pressures on state public hospital systems and to strengthen primary health care, the Commission suggests that the Accord will not be sufficient to address the significant challenges facing the system.

What then are the problems that Medicare Select needs to resolve?

The purpose of Medicare Select is to support an equitable, sustainable, universal health system for the long term by dealing with cost escalation, integrating funding to better enable care of chronic disease, addressing the fragmentation of the health system across jurisdictions and offering consumer choice. The competition elements of Medicare Select are required to support innovation, consumer empowerment and the ability of the health system to be adaptive and responsive to changing demands.

Australia, like other developed countries worldwide, is experiencing major shifts and acceleration in the demand pressures on our health system. These pressures come from an interplay of a rapidly ageing population, a shift in the burden of disease from acute to chronic conditions, the continuing development of new medical technologies and treatments and consumer expectations.

These demand shifts not only raise questions of the sustainability of our health system but also require new models of care. This in turn raises the question of what range of services should be included under the universal access principles of Medicare to address changing health need and practice and how should they be financed.

It is estimated that as much as 70% of our health spend is now taken up treating chronic conditions. For many of these conditions, such as diabetes, the burden of disease could be reduced by effective prevention strategies and case management, while other conditions, such as cancer, require the development of far more complex care models for diagnosis, treatment and management, involving care inside and outside hospitals, and both require a team of health professionals.

As health expenditures in Australia and elsewhere continue to increase at rates greater than GDP, all developed countries are grappling with how to finance their health systems to achieve access, quality and containment of costs. This includes considerations of the most appropriate mix of government and private financing, the extent of copayments by individual consumers and the application of safety nets.

In Australia, these challenges are complicated by the Federal structure of our health system. The current universal Medicare entitlement, which guarantees free public hospital care and subsidised medical and pharmaceutical services for all Australian citizens, is achieved through a mix of health funding programs divided between Commonwealth and state governments.

The states are responsible for the delivery of free public health care (public hospitals and community health) with the Commonwealth contributing to meeting the costs of public health care through the Australian Health Care Agreements between the Commonwealth and the states.

The balance of the current Medicare entitlement is funded directly by the Commonwealth through the Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS), most of which are delivered in the private sector by a range of providers from individual health professionals in private practice to group practices and large companies. In addition, the Commonwealth is responsible for funding residential and community aged care, again largely delivered by the private sector. The Commonwealth also pays premium rebates for private health insurance which supports access to private hospitals and private dental and allied health services for the 45% of the population who are insured.

For the consumer, the mix of Commonwealth and state funding, public and private financing and delivery structures, and the divide between inpatient and out-of-hospital care, make for a highly fragmented system which is difficult to navigate to find the right care. This is particularly a problem when the consumer requires co-ordinated care across a range of settings and over time. The funding streams and structures favour acute, episodic hospital care over community based delivery, with public hospital emergency departments acting as the default option for gaps and inadequacies of access elsewhere in the system.

The issues of consumer access to the right care are further exacerbated by the increasingly important role of private hospitals in providing surgical and other procedures, while public hospitals concentrate on the demands of emergency care. As surgeons and other medical proceduralists concentrate more and more of their work in the private sector, in private hospitals and private ambulatory clinics, how to ensure universal access to surgical and other procedures becomes a major consideration.

At the same time, care outside hospitals - primary health care and community health and support services - is fragmented, funded through a multiplicity of programs and generally lacking the organisation structures and comprehensiveness necessary to provide early intervention and co-ordinated care management. Funding streams tend to favour one-off episodic care and consumers who require more than this are likely to be referred to acute care services for want of appropriate alternatives. There are also significant gaps in universal service cover for dental and allied health services with consumers needing to take out insurance to cover at least some of these costs or to pay out of pocket, resulting in highly variable access to these services.

The Role of Medicare Select

The health reform debate has thrown up many options for restructuring the Australian health system to address the issues outlined above. Much of the debate has focused on the pressure on public hospitals and the respective responsibilities of the Commonwealth and the states. This debate has canvassed the view that the Commonwealth should “take over” public hospitals. A second dimension of the debate has been proposals for the Commonwealth to strengthen primary health care, given it is already predominantly funded by the Commonwealth through rebates for GP services under the Medicare Benefits Schedule (MBS). A third dimension has been advocacy for a single government funder, with debate about whether government funding should be pooled at a national, state or more local level to overcome the fragmented funding and delivery silos.

In the context of this debate, the model which the NHHRC has called Medicare Select has emerged as a possible organising structure which could bring together a number of disparate objectives to create a coherent, sustainable health system.

This paper will explore the potential of a Medicare Select model to deliver the following benefits:

- A system which builds on Medicare's current entitlements and maintains existing public and private financing streams, public and private provider structures and consumer choice.
- A framework which brings together all aspects of the health system, public and private, hospital and community based, to support the organisation and delivery of care around the consumer.
- A model which supports a single government funder but also provides a mechanism, through health and hospital plans, for services to be innovatively purchased on behalf of consumers to meet their individual needs, delivering the right care, at the right time and place to achieve good value and outcomes.
- A risk adjusted funding model that aligns the health and hospital plan's incentives with the consumer's requirements, so that consumers with the most needs and the greatest disadvantage attract the greatest funding and are offered service solutions which result in better health outcomes.
- A system that is responsive to consumer preference and need as funding follows the individual to their chosen plan.
- The states are able to continue to own and operate public health care services and to plan state wide services. Public hospitals are strengthened by transparent funding models, while services outside hospitals are also better developed.
- Constructive use of the contribution of private health insurance and private hospitals.
- The Commonwealth is responsible for health financing, regulation and national policy frameworks, with funding devolved to organisations at arm's length from the Commonwealth government, allowing a level of competition to contain costs, support innovation, increase responsiveness to consumers and to depoliticise day to day health funding and delivery decisions.

2 Overview of Medicare Select

The essential elements of Medicare Select, incorporating and building upon the NHHRC's final report, are:

- The Commonwealth will become the single government funder for all service entitlements under Medicare, including MBS, PBS and access to free public hospital care, (i.e. the funding for all Medicare programs would be pooled nationally, rather than split between the states and the Commonwealth.)
- All Australian residents would be entitled to Medicare as at present. Entitlements covered under Medicare will be determined by the Commonwealth and could also include new funding programs such as a range of new primary health care options and dental services.
- The NHHRC proposes that residents would access their Medicare entitlement either by being automatically covered by a government plan or by opting to join alternative complying Medicare Select health and hospital plans which could be operated by state governments, private health insurers, or other non-government organisations. In this paper, the automatic Medicare enrolment is assumed to be with Medicare Australia which would not function as a health and hospitals plan but would pay core Medicare entitlements according to the MBS, PBS and a to be established Hospital Benefits Scheme (HBS). Medicare Select plans would then compete to attract enrolments on the basis of their service offerings.
- A Universal Service Obligation (USO) would define the Medicare benefits to be covered by Medicare Select health and hospital plans and could also incorporate access guarantees based on the proposed National Access Targets. Health and hospital plans would be required to offer open enrolment (i.e. accept all comers).
- An alternative model, beyond that recommended by the NHHRC, would have all residents required to select or be randomly assigned to a health and hospital plan with a default minimum benefits package as defined by the USO.
- Medicare Select health and hospital plans, which would act as fund holders and strategic purchasers for their members, would receive risk rated payments from the national Medicare Select funding pool based on the characteristics of their members which influence the need for health services such as age, gender, rural and remote areas of residence, chronic disease, and social disadvantage. The funding would follow the consumer to their selected plan, with those most in need attracting the highest funding weights under the risk adjustment.
- The risk adjustment model would be designed to create strong incentives for plans to develop appropriate strategic purchasing models for those with special needs such as the chronically ill.
- Plans would compete for members based on a range of factors including limiting of copayments, extra services, excellence in customer service, prevention and health support programs, preferred service provider networks and quality information. This paper also outlines options where plans could compete on price to the consumer.
- Plans will be required to purchase services for their enrolled members to meet the USO. For episodic care, the established national schedules for paying MBS, PBS and hospitals could apply. Health and hospital plans should, however, have the incentive and flexibility to implement innovative product designs which integrate these funding streams to fund an appropriate mix of services for particular groups of patients, (for example, those with chronic and complex care needs) or to support an appropriate service offering (for example, in rural and remote areas). After a transition period there could be gradual implementation of appropriate provider competition in relation to national schedule rates.

- Financing would be from general taxation revenues of the Commonwealth with commensurate reductions in tax sharing and special purpose payments to the states. Under the NHHRC recommendations, the cost to the community of Medicare would be transparent, either as an annual allocation from consolidated Commonwealth tax revenues or as a tax levy set as a percentage of individuals' income. A further option not mentioned by the NHHRC, is that a tax levy could be a hypothecated tax whereby the levy revenues are fully applied to finance Medicare. The NHHRC has estimated that the current total government contribution to health care costs is equal to 14% of individual taxable incomes and is an indicative level of such a levy if income tax is the total source of funding. There would be a proportionate reduction in general income tax under any levy option so that the overall individual tax burden is unchanged.
- One option under a hypothecated levy model, would be that a component of the levy could be paid by consumers directly to plans on a community rated basis, with concomitant tax adjustments to compensate the individual. This would allow for price competition between plans that may be necessary to achieve sustainability by putting downward pressure on plan prices.
- People would continue to have the opportunity to carry Private Health Insurance (PHI) cover for a broader range of services and offerings, such as access, amenity, extra services beyond their Medicare entitlement.

3 Healthy Australia Accord as a Pathway to Medicare Select

What is the Healthy Australia Accord?

The NHHRC's governance recommendations for immediate implementation, called the Healthy Australia Accord, recalibrate Commonwealth and state/territory government roles within a strong national framework.

Under the Accord, the Commonwealth would take policy and full public funding responsibility for primary health care, including state community health services, and would also take a substantive role in funding public hospitals. Under the proposed funding shares between the Commonwealth and the states, the Commonwealth would be directly exposed to the efficient cost of inpatient and emergency department care and therefore the funding risk of the increasing demand for public hospital services, unlike the current arrangement where Commonwealth exposure is capped under the Australian Health Care Agreements.

The Accord identifies a large number of health system matters which would be dealt with on a national basis, including workforce planning, education and training, prevention, quality and safety, ehealth, performance reporting, technology assessment and private hospital regulation.

The Accord also identifies a number of areas in which the Commonwealth should take full responsibility, namely aged care (including the Home and Community Care program and Aged Care Assessment teams), the proposed Denticare program, purchasing for Aboriginal and Torres Strait Islander people, and funding of clinical education and training.

Initially under the Accord, the Commonwealth:

- continues to fund and control the Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS)
- will fund 100% of an efficient price for outpatients and community health services provided by state public health care systems and be responsible for primary health care policy , and
- will fund 40% of an efficient price for public hospital inpatient and emergency department services.

The Accord builds on the current COAG Partnership Agreements for Health under which all states/territories commit to introduce a nationally consistent episode based funding regime for public hospitals. The Accord takes this further by providing for Commonwealth payments for public hospital services (inpatient, outpatient and emergency departments) to be made principally on an episode basis, using an "efficient" pricing mechanism. Under the Accord model, public hospitals will be paid more like private hospitals for the work they actually do, rather than through a block budget.

Platform for a Single Government Funder

The Commission highlights that the Accord provides a platform to move readily to a single government funder over time, simply by increasing the 40% Commonwealth contribution for public hospital inpatient and emergency services to 100% of an efficient price. The systems and processes which the Commonwealth would need to fund its share of public health care under the Accord would be the same as required for 100% Commonwealth funding. It is likely that the payment model would take the form of a national Hospital Benefits Schedule (HBS) for Commonwealth payments to public hospitals, similar to the MBS and PBS. Some adjustments to the efficient price could be developed to reflect the differences in efficient cost of delivery in different circumstances e.g. in different states or areas of remoteness.

Meso Levels of Governance

Building the platform for a single government funder is a necessary but not the only precursor to building the Commonwealth's capacity to implement Medicare Select.

As the single government funder, the Commonwealth could simply pay benefits for public hospital care as it already does for services provided by GPs, medical specialists and aged care providers. However, this model would not support local innovation, strategic purchasing to ensure services are matched to clinical needs and outcomes, or connectivity between care settings to provide a continuum of care for individuals, such as those with chronic illness, who require a package of integrated, team-based care over time.

Medicare Select interposes an intermediate entity, between the single government funder and the provider institutions, to be the sophisticated purchaser and service agent for plan members seeking to access the health system. The European Observatory on Health Systems and Policies[2] refers to this intermediate level as a "meso" level in health governance.

There are many examples where the single government funder (the national government) passes funding to a meso level. For example,

- In Spain and Italy, nationally raised funds are passed on to provincial health authorities on a weighted population basis to fund and operate health services.
- In the English NHS, primary care trusts purchase the full range of health services for their designated populations from public hospital trusts and GPs and sometimes from the private sector.
- In the Netherlands and some other European social health insurance systems, health funding is nationally pooled and reallocated to health insurance organisations on a risk adjusted basis to purchase mandated services for their members who are required to enroll with these organisations.

In Australia, some advocates for a single government funder have favoured regional health authorities as the preferred meso level which would effectively replace the states. Regional health authorities would receive a population based budget for all publicly funded health care and would fund and operate services for the population within their geographic boundaries.

Medicare Select, on the other hand potentially maintains an important role for the states as the owner/operators of public hospitals and health services, while a range of health and hospital plans would provide competition and consumer choice that goes beyond specified geographic boundaries. One way of viewing Medicare Select is to consider health and hospital plans as similar to regional purchasing authorities but that consumers can select a plan as their purchaser rather than the purchaser being determined or restricted by where they live.

[2] Figueras, J., Robinson, R., Jakubowski, E. (eds), *Purchasing to improve health systems performance*, European Observatory on Health Systems and Policy Series, Open University Press, 2005.

Building Capacity

To build its capacity to become the single government funder, the Commonwealth will need to consider how new, smart payment models can be developed as an adjunct to national funding schedules. The proposed primary health care reforms and the full transfer of aged care programs to the Commonwealth provide the opportunity to develop new payment models for these services, particularly where individuals require a package of services from a range of care providers and over time. The Commonwealth will also need to develop an efficient hospital payment model which could be administered by Medicare Australia. The states and territories would also need to build capacity in their public hospital and health services to respond to the new Commonwealth funding models –- in other words to build capacity to be purchased from.

The move from the Accord to Medicare Select could be staged with early entry for identified groups such as those with chronic and complex care needs. These groups could be identified on the same basis as those that would be eligible for voluntary enrolment for primary health care as recommended by the NHHRC. Organisations which wish to establish Medicare Select health and hospital plans, such as the states or PHI, could opt to enroll these groups and receive a risk adjusted payment to purchase services to address their special needs as a first stage implementation.

Other Aspects of the Accord which support Medicare Select

Other aspects of the Accord which could build capacity to support the Medicare Select model include:

- The establishment of national functions for prevention, quality, workforce, ehealth, and performance reporting will increase transparency of the health system, providing greater visibility of what is being funded, at what price, with what outcomes and what possible alternatives. This more transparent environment will arguably support health and hospital plans in their roles as strategic purchasers.
- The establishment of national payment systems, national access targets and national performance benchmarks will provide part of the basis for defining the Universal Service Obligation which all health and hospital plans will be required to offer under Medicare Select.
- The engine which the Commonwealth will need to build to support efficient, activity based funding of state public health care services will provide a data base which will inform the risk adjustment model of Medicare Select, particularly in relation to modeling the propensity of identified population subgroups to use the system, and the pattern and costs of that utilisation.
- Experience with the Accord will help identify gaps in services and market failures in delivering health services which will need to be addressed by health and hospital plans.
- A strengthened primary health care sector with new models of funding, more comprehensive services and new structures for service delivery and co-ordination, will provide a basis for purchasing of these services by health and hospital plans.
- The national focus on prevention will create the environment, information and regulatory mechanisms to support prevention and early intervention programs by health and hospital plans.
- Consumer empowerment through initiatives which support transparent performance reporting, health information and health literacy will support consumers to be discriminating in their choice of health and hospital plan and similarly empower their use of plans to obtain services appropriate to their needs. The development of the person-controlled electronic health record will assist people to take greater responsibility for their health.
- The introduction of sub-acute programs and Denticare will address known gaps and, together with the strengthening of primary health care, will provide the initial funding for health and hospital plans to purchase across the care continuum.

- The development of more transparent funding and performance regimes for public hospitals and health services may encourage states and territories to develop these services as more autonomous enterprises with the skills and processes to be capable of being purchased from by an arm's length funder. As Medicare Select will require public health care services to respond to purchasing by a range of health and hospital plans, it may be necessary for the Commonwealth to mandate more autonomous, professional governance for these organisations as a condition of funding under the Accord. State health authorities could then develop as purchasers as a precursor to establishing a state operated health and hospital plan.
- Episode based funding and National Access Targets will support some competitive purchasing between public and private hospitals and will change the dynamic of public hospitals (being paid for services provided rather than a budget), strengthening their capacity to identify and reduce costs and to cooperate in purchasing models across the care continuum.
- The introduction of Denticare under the Accord would introduce the concept of the involvement of private health insurers in purchasing elements of a Universal Service Obligation for enrolled Australians. This would be part of building the capacity of alternative health and hospital plan operators.

Risk that the Accord could work against Medicare Select

There are a number of ways in which the Accord could be implemented which could work against the implementation of Medicare Select. As indicated above, the development of the mechanisms for the Commonwealth to become the single government funder could embed direct payments by the Commonwealth to providers without the development of more flexible purchasing approaches by health and hospital plans which would support innovation and outcome orientation.

Under the Accord, the Commonwealth would be at risk to the total funding pressures of the system without the countervailing incentives which Medicare Select would offer, to contain costs or promote community sensitivity to the total health spend. The main constraint on health spending would be the states' capacity to fund demand and cost increases of public hospitals.

If state financing contributions are reduced over time with the 40% Commonwealth contribution increasing incrementally to 100% there would be less discipline on states to contain public hospital costs and utilisation, while the Commonwealth would not have full control. There are arguments that the move to 100% Commonwealth funding should be in one step when Medicare Select is ready to be implemented.

Other risks of the Accord, include:

- A constructive balance between public and private provision can not really be achieved until purchasing can be introduced through Medicare Select
- The states may withdraw from operating public hospitals and health services, especially if the Accord moves to 100% Commonwealth funding of an efficient price for public health care services, without the Medicare Select purchasing scheme
- There is a risk the Commonwealth could implement control strategies and structures detrimental to the subsequent implementation of Medicare Select.
- Commonwealth funding could become too prescriptive with the Commonwealth attempting to "run" health care without an intermediate level which has closer relationships with individuals, providers and communities.

4 Determining the Universal Service Obligation

The Commission recommends that under Medicare Select, health and hospital plans will offer cover for a mandatory set of services, similar to the current Medicare entitlement, for hospital, medical and pharmaceutical services. This publicly funded entitlement is referred to as a Universal Service Obligation (USO).

To minimise risk in the transition to Medicare Select, it would be practical to include cover for the current Medicare entitlements as an initial offering as follows:

- Medicare Benefits Schedule (MBS)-cover for 85% of the schedule fee for medical and some allied health services outside hospitals, full cover where practitioners bulk bill, cover for 75% of schedule fees for medical services in hospital when a private patient, and safety net cover for medical bills above certain thresholds.
- Pharmaceutical Benefits Scheme (PBS)-cover for subsidised scripts filled in retail pharmacies with a safety net, high cost drug cover and other funding arrangements.
- Free public hospital care-this could include equivalent services purchased from private hospitals where this is necessary to meet access targets.

In addition to these core elements of the current Medicare offering, the initial Medicare Select USO could also include a number of elements which would be established under the Accord and which could be fully functional by the time voluntary take up of health and hospital plans is implemented under Medicare Select. These elements include:

- New Commonwealth funding programs based on the Commission's recommendations for primary health care, especially in relation to options for patient enrolment with a primary health care "home" and the introduction of a range of alternative fee structures to the current fee-for-service model of the MBS (including a bundled funding package over time)
- Performance benchmarks and targets, and especially the proposed National Access Targets which would become an essential element of the core USO cover. By guaranteeing access as part of the USO and requiring health plans to ensure that access is in accordance with national standards, the Medicare Select entitlement would go well beyond the current Medicare cover.

The USO could also over time include other programs adopted by the Commonwealth to address identified gaps, such as the proposed Denticare.

A critical issue for the USO, especially at the outset, will be the relationship between purchasing by plans and the national payment systems for MBS and PBS and, after the Accord is implemented, the national hospital funding system. Also the extent to which the USO supports access to a private hospital and the consequences for attracting financing through private health insurance will also need to be addressed.

MBS arrangements

In the first instance, the MBS as a fee-for-service schedule could continue to operate as a consistent national scheme but alternative payment models would also be allowed based on the NHHRC recommendations for voluntary enrolment with a primary health care service and for various blended, bundled and performance based payments. Health and hospital plans would also have the flexibility to use the MBS component of the USO to purchase alternative solutions for particular types of patients such as in rural or remote settings where there are no or insufficient resident health professionals to provide these services.

Under this suggested approach, Medicare Australia would continue to operate the core MBS system. Alternatively this could be a transition arrangement and health and hospital plans could take on responsibility for making MBS payments. Private health insurers which establish health and hospital plans would already have the systems for making medical payments in line with the MBS in relation to medical gap payments under current private health insurance arrangements.

The largest policy question over time would be whether the MBS could become a funding pool at the health and hospital plan level with full flexibility for plans to purchase these services. In some countries (e.g. Germany) hospital and medical payments are set at a national level and are not determined by the social health insurance plans while in others (e.g. the Netherlands) payments are set for some services (typically more complex and emergency care) but plans can negotiate competitive payments for others (e.g. procedural and elective care).

PBS arrangements

It is most likely that the PBS would largely function as it does now as a national scheme for subsidisdising pharmaceuticals, with safety net provisions and cost-benefit evaluations as the basis for inclusion of pharmaceuticals on the Schedule. As for MBS payments, payments would go through health and hospital plans which will create incentives for plans to keep members healthy. Plans should also have the flexibility to address program interface issues, for example in relation to high cost drugs in hospitals or the issuing of PBS prescriptions in hospital outpatient services.

Place of Private Hospitals and Private Health Insurance (PHI)

In the first instance, the Medicare Select publicly funded USO could guarantee hospital cover, within access target time frames, to free public hospital care as a public patient. This could include purchasing from private hospitals where public hospitals are unable to meet the access targets. Individuals could still require PHI to access private hospitals in the usual way.

Another approach would be for a proportion of hospital workload to be subject to competitive purchasing involving both public and private hospitals. In the first instance competition could be restricted to, say 10%, of public patient hospital DRGs and this could increase over time as purchasers and providers develop the skills and capacity to operate in a competitive purchasing environment. The principle could be that high volume procedures are subject to competitive tendering, with a fixed national hospital fee schedule for public patients for emergency and complex care. Special unit funding for high level specialty services, such as organ transplantation, could be funded outside health and hospital plans, by the Commonwealth on the basis of agreements with the states on state-wide service planning.

Over time it can be envisaged that health and hospital plan cover could be extended so that individuals could elect to use their USO towards the cost of private hospital care with PHI providing top up or gap cover. The impact of this on PHI could take many forms and would require further evaluation of the need to modify the current regulatory structure for PHI.

The ultimate role and extent of PHI will largely depend upon Commonwealth Government policies for incentives and penalties for Australians to take out private health cover and its perceived value in terms of access and amenity. Currently PHI contributes $7.9 billion of privately raised funds towards the total $103 billion Australian health care spend. The balance of PHI expenditure on health care, $3.6 billion, is financed by the Commonwealth through the private health insurance premium tax rebate.[3] If PHI customers could use the USO public funding to access private hospitals, then the current premium rebate could play a role in financing the USO. Commonwealth policies would need to consider what incentives and tax and other penalties would be required for PHI to maintain or increase its level of contribution to the total health spend.

If Medicare Select evolves to offer full portability of the USO to access private hospitals, it would provide the opportunity for PHI to be based on the principle of offering “extra for extra” i.e. complementing rather than duplicating the public ‘insurance’ entitlement. PHI would offer access to increased amenity, increased convenience (beyond the USO access guarantees), doctor of choice in hospital as a private patient, and cover for services not included in the USO. Under these arrangements, PHI could support a much wider service offering than it does currently, especially in the emerging areas of growing need, such as the treatment of chronic disease and age related illnesses.

[3] Australian Institute of Health and Welfare, *Health Expenditure Australia 2007-08*, AIHW, Canberra, 2009.

5 Financing of Medicare Select

The options for financing Medicare Select can be considered under three broad models:

1. Financing from Commonwealth consolidated revenues

2. Financing by a health levy on individuals' incomes, with and without hypothecation

3. Financing through taxation or levy and a direct consumer contribution

Option 1: Fully funded from Commonwealth tax revenues

Under this model, the funds for all government funding programs included in the Universal Service Obligation would be pooled at the national level, funded from the consolidated revenues of the Commonwealth, and allocated to health and hospital plans on a risk adjusted basis according to the characteristics of each enrolled member.

The risk adjustment should be undertaken by an independent authority established by the Commonwealth.

The risk adjustment will take into account factors such as age, sex, socioeconomic and other determinants of social disadvantage, rural and remote location, prior health care utilisation and health risks such as for people with chronic illness. The purpose of the risk adjustment is to counter any incentive for health plans to select only good risk members.

The objective is that the risk adjustment will create strong incentives for health and hospital plans to enroll the most disadvantaged and those with special needs as these members will attract the highest levels of funding and they offer the opportunity to improve outcomes through care planning and coordination. Plans will also be incentivised to contain the funding risk of high need consumers by purchasing service solutions which provide appropriate care and good outcomes.

There could also be arrangements for risk equalisation adjustments between plans based on claims experience. Such adjustments would protect plans against catastrophic events and address any shortcomings in the initial risk adjustment process. It is envisaged that, in the first instance, this second level of risk adjustment would smooth out any unpredicted swings between plans during the initial implementation phase, but over time the second level of risk adjustment would be reduced in favour of refining the initial risk adjustment methodology.

All Australian residents of 6 months or more duration (the current eligibility for Medicare) will automatically have their Medicare entitlements paid by Medicare Australia unless they opt to enroll in a plan of their choice.

Under Option 1, plans would compete for members on the basis of their service offerings rather than on price, as the payment into the plan in respect of each individual will be fully determined by the risk adjustment process and paid by the independent regulator on the individual's behalf. Plans will need to demonstrate value to attract members; if there is no added value or convenience, people will stay with Medicare Australia.

Competition for members will be on the basis of qualitative offerings such as:

- Value of special programs developed by the plan to address the service requirements of high need groups such as the chronically ill or service solutions for rural and remote communities, such as outreach services, telehealth options or patient transport to care.
- Support of service innovation such as new approaches to delivering and funding primary health care.
- Customer service, such as case management, navigation through the system and provision of relevant information to assist informed decision making.
- Wellness and prevention programs including encouraging healthy behaviours, understanding and managing risk and early identification and intervention.
- Offering a personal health record service to assist members manage their personal health data.

There could also be some pricing competition in relation to reducing gap payments for services where the USO allows for patient copayments.

Plan enrolment guarantees the USO to the individual member regardless of the level of the risk adjusted payment. All plans will be required to accept all applicants (open enrolment) and to cover the USO as a minimum.

Plans will enter into contracts with providers to secure the USO, the core of which will initially be funded on a standardised national basis, largely using episodic payments under the MBS, PBS and HBS programs.

The cost to the nation of the Medicare Select USO would be transparent as an annual appropriation of the Commonwealth Parliament as part of Commonwealth Government annual budgets. The community would better understand the cost of health and that it is not a “free” good.

Option 2: Funded by a Health Levy on Individuals’ Income.

This model increases the transparency of the health spend with individuals contributing say 14% of their pretax earnings to fund Medicare Select’s USO. There would be commensurate reductions in general tax rates so that the levy would be neutral in its tax impact on individuals. Decisions to increase the overall health spend will potentially have a more direct consequence on citizens.

The health levy could be a hypothecated tax or a contribution to consolidated revenue as for the current Medicare Levy. If a hypothecated tax is used, the tax pool to finance government funded health care would be automatically linked to the growth in the economy as expressed by individuals’ incomes. Increases in health spending greater than movements in salaries and wages would then require explicit political decisions to alter the levy or other measures to finance the increases.

While Treasuries generally eschew hypothecation, the advantage of this model is that it makes health-spending decisions transparent for the community as a whole and provides something of a circuit breaker in the traditional stakeholder driven politics of health spending for governments.

All other aspects of the Option 2 structure are as for Option 1.

Option 3: Funded through Taxation or Levy and a Direct Consumer Contribution

Both Option 1 and Option 2 were entertained in the Commission's description of Medicare Select. Option 3, as outlined here, is based on the Netherlands' system. Under this model, the competitive tension between plans is increased by funding part of the USO health spend by a premium paid to the plans by individual consumers. Plans would then compete for members on price as well as by the quality of their offering to members.

Under Option 3, about half the health spend , say 7 percent, would be met from taxation, either by a levy on incomes or from consolidated revenue, while half would be funded by individuals' paying a significant community rated premium of the order of $2,000 per annum. Plans would compete on the price of this premium to attract members. Plans could reduce the price of premiums to the extent that they are more effective purchasers of care and lower administrative costs.

The cost of the premium would be made neutral to individuals through adjustments to personal taxation. Where individuals have low or no incomes and pay little or no tax the personal tax adjustment could take the form of a rebate so that these individuals may exercise their right to select a plan and pay a community rated premium. Alternatively, the levy and direct contribution would only apply for those over the Medicare low-income threshold. Currently this is at $17794 for individuals and $30025 for families plus $2757 for each additional child.[4]

Under some similar models, such as in Germany,[5] if the costs of a plan blow out, then the plan can raise additional premiums from its members but members are free to change plans. Again, the regulatory arrangements would need to ensure that the disadvantaged and lower socio-economic groups were protected in these circumstances.

The benefit of this model is that it further enhances the transparency of funding health care and creates stronger competitive forces on plans to contain costs while ensuring the USO is delivered for its members. Price competition on plans involves all Australians, bringing to bear competitive forces across all citizens, whereas competition based mainly on service offerings is weaker as it applies only to the users of health services.

The direct consumer contribution model is more complex than the previous two options and could be seen by the electorate as a weakening of Medicare, with individuals being required to pay directly for their Medicare cover rather than having it all covered by the government. While it would in fact be cost neutral to individuals through tax adjustments it might not be perceived this way.

[4] Press Release: Increase in the Medicare Levy and Medicare Levy Surcharge Low-Income Thresholds. The Hon Chris Bowen, Assistant Treasurer and Minister for Competition Policy and Consumer Affairs. Cited 22 November 2009.

[5] Schang, Laura. *Morbidity-based risk structure compensation*. Cited in Health Policy Monitor – International Health Policy Trends. Germany, 2009.

Determination of the Size of the Funding Pool

The three options offer different approaches to how the government spend on health care will be determined. Options include annual parliamentary appropriations determined in the budget context, a hypothecated, fixed funding pool, options for increasing the levy on individuals' income to meet cost increases or to extend coverage, or increases in copayments under the USO. The Commonwealth may also be required to enter into multilateral agreements with the states where the level of Commonwealth funding is guaranteed over say an initial five year period.

Benefits of the Financing Structure

All three financing models improve transparency, both in the amount the nation is prepared to spend on publicly financed health care and what range and type of services will be funded. Most importantly, the risk adjustment in all three models links funding to those most in need, while the competition between plans and between providers promotes consumer responsiveness and cost containment.

The financing structure of Medicare Select also has the potential to, at least partially, depoliticise health spending and delivery issues by interposing a fair, needs-based distribution of funding and independent agencies which purchase health care on behalf of individuals. This has certainly been the experience in some European countries, where health systems financed under social health insurance arrangements similar to Medicare Select have measurably higher levels of community satisfaction.[6]

There will be differing views about the relative merits of the three different financing models. The two year review process recommended by the NHHRC to develop the Medicare Select model would need to fully explore all three approaches.

[6] Mossialos, E., Dixon, A.,Figueras, J., Kutzin, J.(eds), *Funding health care: options for Europe*,European Observatory on Health Systems Series, Open University Press, 2002.

6 Health and Hospital Plans

For Medicare Select to be effective, there will need to be enough health and hospital plans to ensure adequate choice, We expect that there could be 10 to 12 major plans including government and non-government options. For efficiency a proliferation of plans, such as in Germany which has over 200 plans, should be avoided. In the Netherlands for a population of 16 million, there are 4 major national plans and 11 smaller plans including regionally based offerings.

All Australians would initially be enrolled with Medicare Australia for the standard Medicare entitlement. Organisations which have the potential to develop Medicare Select health and hospital plans include:

- State/Territory Governments:- It could be an attractive option for a state to establish a health and hospital plan with a particular focus on their residents, although state plans, as for all plans, would need to be open to all including from outside a state and would need to cover services delivered outside a state. The option of establishing a Medicare Select plan would afford states the opportunity to purchase across the care continuum and to influence the organisation of health care services across all sectors, not just the public sector. States which established a Medicare Select plan would need to have clear separation between the administration of public hospitals and health care services and the purchasing and plan management functions of the state health and hospital plan.
- Private health insurers: PHI organisations may opt to establish Medicare Select plans in addition to their private health insurance offerings. Their PHI members may find it convenient to have their Medicare Select plan with the same organisation and it would be open to PHI organisations to offer PHI products which dovetail and supplement the Medicare Select USO. PHI Medicare Select plans would also accept members who do not carry private health insurance. The larger PHI organisations would be in a position to offer nation wide plans but it would also be open to smaller, more regionally based health insurers to participate. One option to encourage smaller organisations would be for the Commonwealth to provide a financial safety net for smaller plans, especially during the set up phase.
- Non government organisations: Not-for-profit organisations currently involved in health and aged care may also seek to establish plans. The Catholic Health Association has signaled that its members would be interested in establishing a Medicare Select plan focused on the needs of the disadvantaged. Again, some form of safety net underwriting could be offered to support the operational risks in the set up stage for not-for profit organisations with low capitalisation. This would need to be subject to the scrutiny of the ACCC to ensure Australian competition policy applies.
- Government Operated Plans: Options for government operated plans could focus on the special needs of particular groups. For example, the Department of Veteran Affairs already functions as a purchaser of health services for war veterans. The Northern Territory could establish a Medicare Select plan with a focus on remote services across the top end including Queensland and Western Australia.
- Commercial Entrants: For-profit organisations such as private health care providers or other commercial organisations could seek to qualify to operate a health and hospital plan under Medicare Select.

Where a plan operator also operates vertically integrated health services competition issues, such as exclusive or preferential access, will need to be addressed through clear rules and regulations.

The pathways to Medicare Select will require steps which enable organisations to develop the capacity to be strategic purchasers and to operate the fiduciary models required of health and hospital plans. Arguably private health insurers would be well placed to become health and hospital plans as they already operate episode based payment systems, contract with hospitals and other providers with preferred provider networks and elements of pay for performance and quality, many are developing wellness and disease management programs for their members and all operate under a regulatory framework in relation to solvency reserves and other financial requirements.

In the UK when the devolved purchasing structures of primary health care trusts were introduced, the provider organisations, the hospital trusts, tended to have the upper hand in determining how health funding would be spent. The National Health Service responded by investing in developing the commissioning expertise and systems of primary care trusts. Similar investments will be required by both government and non-government organisations to establish health and hospital plans under Medicare Select.

7 Commonwealth and State Government Roles

Commonwealth Government

Under Medicare Select, the Commonwealth would be responsible for all national functions identified by the NHHRC, such as clinical education and training, leadership in relation to joint jurisdiction initiatives, such as the National Workforce Agency, and regulation of Medicare Select.

For Medicare Select to be successful, the Commonwealth will need to develop a comprehensive regulatory regime which will have the confidence of the states, health care providers and the community.

A specialist, independent agency should be established to undertake the risk adjustment and allocation of funds to plans.

In addition health plans will need to be regulated to ensure compliance with the USO requirements, non-discriminatory enrolment of members (that is, plans must enroll all comers) and competition requirements. An Ombudsman function will also be required. It will also be necessary to determine the structures which will be responsible for ongoing design of the system, planning of services and performance reporting on the health system.

Options range from establishing a single Medicare Select regulatory agency to building on existing structures. For example:

- DOHA to determine national service plans, what is in the USO, and negotiation with the states to establish approved state health plans
- Medicare Australia to develop and maintain MBS, PBS and HBS funding schedules
- PHIAC to monitor compliance of health and hospital plans with the USO, solvency requirements and other requirements for the operation of plans.
- ACCC to regulate the competition requirements.
- AIHW to handle performance reporting.
- The private health insurance Ombudsman to also act as ombudsman for plans.

State Governments

There are several schools of thought about the position of the states under Medicare Select. One view is that without funding control, states will vacate the field altogether, as has occurred as the Commonwealth progressively took over funding and policy responsibilities for universities. An alternative option is that a state could plan, own and operate public hospitals and health services and take an active role in shaping the state's health system. This could be further enhanced by the state establishing a health and hospital plan, effectively pooling what were previously Commonwealth and state funding programs at the state level for those Australians who select that plan.

Under Medicare Select, the states could still exercise an important role to ensure the effective organisation of health care within the state. States could have the following responsibilities:

- Ownership and governance of state public health care services
- Funding responsibility for the costs of public hospital services above the efficient prices set through national fee schedules.

  States will need to continue to offer their public hospital services free to public patients and this may need to be guaranteed through some form of Commonwealth-state health care agreements, as well as by arrangements between states and health and hospital plans.
- Funding responsibility for any services which go beyond the Accord or Medicare Select.

  This could include ambulance and public health/disease surveillance services, managing the interface of public hospitals with universities and research institutes, and new service initiatives which the state may support beyond the nationally agreed service offerings.
- Financing for major capital expenditure for new public hospital facilities and upgrade of existing facilities, noting that the proposed efficient price for public hospital services under the HBS would include a capital component.
- Service planning and performance monitoring, including planning and development of state wide services, including super specialty services, which could be incorporated in Commonwealth-state agreements.

Governance of Public Hospitals

Under Medicare Select, the states should move to establish public hospitals as more autonomous statutory entities, for example by corporatisation or by establishing community trusts. One approach could be as in the English NHS where qualifying public hospitals are set up as autonomously governed trusts.

More autonomous public health care entities would negotiate directly with health and hospital plans. The state health administration role would then focus on health services planning including role delineation of health facilities, performance monitoring, and regulation of the public health care entities. The state would have reserve powers to step in to take control of a public hospitals entity in prescribed circumstances.

8 Conclusion

The design issues canvassed in this paper highlight the further work which is required to develop and test the Medicare Select model, while many of the more immediate reform measures contained in the proposed Healthy Australia Accord would put in place elements of the model.

By unpacking the essential elements of Medicare Select and describing the way Medicare Select would impact upon and link in all key elements of the Australian health system, this paper has endeavoured to demonstrate that Medicare Select offers potential solutions for a sustainable Medicare which has the flexibility to address the demographic and other challenges of the next 25 years.

The authors recommend that the Commonwealth commit to the NHHRC recommendation to invest in further development of the Medicare Select model over the next 2 years.

9 Glossary

Abbreviation	Term
ACCC	Australian Competition and Consumer Commission
(The) Accord	The Healthy Australia Accord
AHCA	Australian Health Care Agreements
AIHW	Australian Institute of Health and Welfare
COAG	Council of Australian Governments
DOHA	Australian Government Department of Health and Ageing
DRGs	Diagnosis Related Groups
GDP	Gross Domestic Product
GP	General Practitioner
HBS	Hospital Benefits Schedule
MBS	Medicare Benefits Schedule
NHHRC	National Health and Hospitals Reform Commission
NHS	National Health Service (UK)
PBS	Pharmaceutical Benefits Scheme
PHI	Private Health Insurance
PHIAC	Private Health Insurance Administration Council
UK	United Kingdom
USO	Universal Service Obligation