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Medicare at 40: Are We Showing Our Age?

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Abstract

To understand what Medicare aimed to achieve, we need to revisit the medico-politics of the time, and the fear of the spectre of socialised medicine. That determined what could be changed (universal insurance and contributions according to means) and what could not (private medical service provision and fee-for-service). We consider what Medicare has achieved in terms of community acceptance, fairer contributions, affordability at its establishment; and how those aims can be assessed today. While Medicare is undoubtedly a success, there are inflexibilities in its structure that are challenging in ensuring it is fit for the next four decades.

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1. Introduction

Medicare was introduced in 1984, some 10 years after a tax-financed, universal health insurance (Medibank) had been implemented (by a Labor Government) and successively dismantled (by a Liberal Government), so that only low-income groups and pensioners were covered by government benefits (Williams, 2024; Department of Health and Aged Care 2024; Hall, Fiebig and van Gool 2020). For the majority of the population, voluntary private health insurance was supported by tax deductibility and subsidies. By 1983, around 15 per cent of the population had no health insurance cover (Australian Bureau of Statistics 1983). These people relied on the charity of individual doctors, were subjected to the indignity of means tests when seeking hospital care, or went without such care.

The medical profession, or at least the more organised and vocal members of it, did not support this second attempt at universal health coverage. Doctors' groups were stridently against 'socialised medicine' or anything like the British National Health Service in which doctors would be employed by government. So strong were these sentiments that NSW public hospital doctors held a prolonged strike (Adams 1986), the consequences of which (such as the poor availability of orthopaedics in public hospitals) can still be seen in health service delivery today.

The design of Medicare was, therefore, constrained by the medico-political environment of the day including consideration of potential high court challenges (Whitlam 1997).

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This meant ensuring the continuation of private medical practice, with fee-for-service funding and no caps on fees or incomes (Scotton 2001). The funding streams for medical practice continued through the Medicare Benefits Schedule (MBS) and pharmaceuticals through the Pharmaceutical Benefits Schedule (PBS). Public hospitals continued to be funded by state and territory governments, with additional compensation from the Commonwealth to meet the costs of free treatment for all Australians (Department of Health and Aged Care 2024).

2. Features of Medicare

Medicare had, as its primary purpose, the redesign of the financing (i.e. how monies are raised) of health care. It was intended to be fairer, simpler and universal. Fairness was achieved by replacing the system of subsidies and tax deductions with financing via general taxation. The Medicare levy, initially 1 per cent was introduced to cover the additional cost of public hospital care without charge. This was not a hypothecated tax, but a contribution to general revenue, an arrangement that continues to cause confusion. As the scheme was tax-financed, individuals' contributions were made according to their means.

Medicare was universal, with all Australian citizens and permanent residents covered. It was also simpler for individuals and service providers to know what services were covered; public hospitals, MBS for out of hospital medical care, and PBS for pharmaceuticals. Previously, affordability was an issue for many with medical costs being a common reason for bankruptcy. Although there is no control over fees charged by providers for services covered by the MBS, an incentive to bulk-bill was provided by direct payment from government for medical services where there was no out of pocket (OOP) charge to the patient. These were the days before widespread use of credit cards and the direct payment from government meant providers did not need to chase bad debts.

The key architects of the system, John Deeble and Richard Scotton, also aspired to a system where 'financing should be comprehensive, and should promote a high quality of care, the integration of facilities and the most efficient use of resources in the health care industry' (Scotton 2001). That said, they were influenced by the design of insurance to focus on potentially high-cost treatments, and more predictable and regular services such as much general practitioner care and dental care were of less concern (Williams 2024). As we have seen over the subsequent 40 years, the changes that were made did not and would not address these issues of quality and integration.

2.1 The Acceptability of Medicare

In its first decade, the Liberal Party, many parts of the medical profession and the private sector continued to oppose Medicare. Despite this, the program soon gained widespread community acceptance. After years of a platform of undoing Medicare to return to voluntary private insurance, the Liberal Party eventually supported the continuation of Medicare and it was not until 1996 that they regained government: 'No government will now seriously tamper with the compulsory and universal health insurance scheme. The area of concern and debate for the future will not be so much about funding of Medicare, but rather how we improve the delivery of services' (Menadue 2000).

While the Howard administration supported Medicare, it also introduced the private health insurance incentives. Private health insurance had remained in an ambiguous position since Medicare was introduced; it remained regulated with compulsory community rating. One indication of the community acceptance of Medicare was the gradual decline in private health membership, until the carrots and sticks policies started to take place (Hall, Fiebig and van Gool 2020).

2.2 Hospital Funding

Hospital funding remained a contentious issue for Commonwealth versus states/territories, largely orchestrated around the 5-yearly bilateral agreements. These had first been

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introduced in the post World War II period, subsequently altered, but re-strengthened by Medicare. By 2007, hospital funding had become the dominant federal election health issue with the Labor Party under opposition leader, Kevin Rudd, promising to end the blame game. This was operationalised in the National Health Reform Agreement in 2011, with a move to national activity-based funding with an independently set national efficient price determining the Commonwealth contribution (Huxtable 2023).

This has certainly increased transparency around the Commonwealth part of public hospital funding. Most jurisdictions hold that this has led to improved efficiency. It is also increasingly evident that addressing hospital funding without connection to community services is not optimal. Although all governments agree innovative payment models are needed (Department of Health and Aged Care 2023a) so far it has proved difficult to get these models beyond the hospital setting.

2.3 Paying for Medical Services

The MBS and the reliance on fees for services provided by medical practitioners has remained the dominant payment method. However, changes have been made for primary care services with the intent of better addressing the needs of ageing populations with increasing prevalence of chronic disease (s). The Practice Incentives Program was introduced in 1998, as payments that focused on care over time (usually 1 year) rather than one patient–doctor encounter (Kecmanovic and Hall 2015). Subsequently, enhanced primary care and chronic disease items also changed, but these represent a small number in the almost 6,000 MBS items. While new MBS items are generally subjected to a formal economic evaluation, many legacy items had not. Such items have recently been subject to a review (Department of Health and Aged Care 2021). The Medicare Review made 1,400 recommendations, most of which affect MBS items and include the need for ongoing review. Frequent changes to MBS items introduce more complexity for patients and providers (Philip 2023).

The MBS Review concluded that fee-for-service is not always the most appropriate form of payment. An alternate, but not exclusionary, approach has been changing payment to some form of capitation or episodic (i.e. bundled) payment. This began with the co-ordinated care trials in the 1990s through to the Health Care Homes pilots of 2017–2021 (Hall et al. 2023), and is now being followed by the rollout of 'mymedicare' (Department of Health and Aged Care 2023c). What these various pilots have in common is a failure to deliver the promised benefits. These capitated or bundled payments need to be made to the practice that can manage care over time, whereas fee-for-service can be attributed to the individual service provider. Understanding how these new incentives will work is made more complex by the development of corporate medicine where practices are not necessarily owned by the providers who work there.

The reliance on private provision and market forces has led to areas of workforce shortages, including specialists and primary care providers. This, in turn, has contributed to greater difficulty in accessing bulk-billing practices for specialists services and, more recently, primary medical care. The response has been government run or sponsored clinics, super clinics in 2010 (AMA 2014) and urgent care clinics from 2023, as well as increasing bulk-billing incentives (Department of Health and Aged Care 2023b).

3. Assessing Medicare at 40

Universal and accessible, Medicare remains as it started: a universal, tax-financed, compulsory insurance scheme. While Medicare improves financial access to care, the distribution of health care providers limits access for some Australians. Rural and remote residents are more likely to face difficulties in accessing primary and specialist care (Atalay, Edwards and Georgiakakis 2023; Mu and Hall 2020). Low socio-economic status groups have poorer access to specialists (Fiebig et al. 2021).

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Aboriginal and Torres Strait Islander people are poorly served by the MBS, though the Aboriginal Community Controlled Health Organisations provide comprehensive and culturally appropriate services.

3.1 Affordability

Medicare was intended to ensure that no Australian had to forego needed health care due to cost. With Medicare, public hospital treatment remains without cost. However, rising OOP costs for MBS services became an issue that led to the introduction of the Extended Medicare Safety Net in 2004; though its impact had unintended consequences, allowing doctors to raise their fees further and with most benefits flowing to patients living in wealthier areas (Van Gool et al. 2009).

For patients, it can be difficult to find bulk-billing practices, or to know whether they will be bulk-billed by any particular provider. Safety nets make understanding patient cost exposure more difficult. These are reset every calendar year, meaning those whose OOP costs climb in the early part of the year will benefit more than those whose services are incurred late in the year. Safety nets are managed differently for the PBS and the MBS. Yet modern 'smart cards' could streamline these processes. Still 7 per cent of Australians report delaying or not seeing a GP due to cost, and 10 per cent report the same reason for delaying or not seeing a specialist (Australian Bureau of Statistics 2023).

3.2 Simpler

In the beginning, all Australians received the same government benefits—the same entitlement to public hospital treatment, the same rebate from the MBS. Issues of access and affordability have led to targeting of support, as seen in the private health insurance incentives, bulk-billing incentives and the safety nets. Targeting introduces complexity and uncertainty. Revisions of the MBS, while keeping up to date with changing practices, introduce more administrative complexity.

3.3 Fairer Contributions

A tax-based insurance scheme provides for contributions to the insurance pool according to means, at least insofar as the tax base is progressive. Australia relies heavily on income taxation. One of the impacts of the ageing population is that a higher proportion are income-poor (as they have retired) yet are asset-rich. Consequently, a greater proportion are relying on the tax contributions of a relatively shrinking younger cohort of income earning Australians (Australian Bureau of Statistics 2015-16).

3.4 Comprehensiveness and Integration

Medicare, as implemented, covered medical and hospital services; the pre-existing PBS was and is also universal so in 1984 Australians had comprehensive health cover. Dental care had been omitted, and in the ensuing 40 years the importance of this in terms of overall health and the significant financial barriers has become more stark. The role of allied health services in the continuing care of complex and chronic conditions has also become clearer and remains poorly supported by existing arrangements.

4. The Final Assessment

The Australian health care system is widely regarded as a success. It compares well against those of other advanced economies in terms of cost, access, universality and health outcomes. However, it is showing signs of strain around fairness in contributions, access and affordability of services, and the comprehensiveness and co-ordination of services around the patient, rather than the funding of care streams. Increased targeting of support, and frequent updating of the level of benefits, makes for complexity and uncertainty. It is clear to see why, in the context of the 1980s, the funding architecture was left unchanged. The consequence is that reform has tended to be piecemeal and lacking a whole-of-system perspective. Forty years on, this inflexibility is a barrier to Medicare adapting to the changing health care needs of Australians.

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So what is the prognosis for Medicare at 40? After numerous false starts, 40 years of continuous universal insurance is certainly worth celebrating, but for Medicare to continue to deliver on its objectives over the next 40 years, there is a need for more agility, the political will to embrace change and an investment in the research to guide it.

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