

MARKETS, UNIVERSALISM AND EQUITY: MEDICARE'S DUAL ROLE IN THE AUSTRALIAN WELFARE STATE

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The introduction of universal health insurance is one of the most significant recent additions to the Australian welfare state. First as Medibank, now Medicare, it provides universal, national health insurance, free access to public hospitals and subsidised access to medical treatment. It is seen by many as a rare example of Australian social policy developed along European principles of social democracy, rather than the more meagre provision of the Anglo welfare states. While Medicare is substantially more inclusive than the recent reforms in the United States, it retains a much greater role for private provision than the British National Health Service, and when first adopted as Labor Party policy in the 1960s, represented a shift away from a more radical position of nationalisation.

Medicare has been an unusual success story. Australia is the only developed nation to entirely retrench universal health care, after the scheme was first introduced in the 1970s. Medicare was then reintroduced in the 1980s, a time of unprecedented international hostility to the expansion of social security and the welfare state. This article focuses attention on the shift in Labor strategy, from promoting nationalisation to promoting an insurance scheme that left in place much of the institutional structure of the previous private health system.

This is not to deny how Medicare advances equity, nor the crucial role of the union movement and social democratic politics in its success. Rather the aim is to highlight how Medicare combines elements of a quasi-market with strong egalitarian commitments. Its initial defence was often couched in straight-forwardly neoclassical terms of market failure. By understanding how the structure of Medicare built on neoclassical economic ideas, and integrated a more market friendly approach to the

provision of health care, I argue we are better placed to understand the development of universal health insurance. This structure also reflected and facilitated attempts to build a broader coalition of social forces in support of Medicare, something Peter Baldwin (1990) has identified as crucial to the development of welfare states in Europe.

On this account Medicare can be viewed as consistent with a broader Labor Party response to neoliberalism. Medicare's combination of social protection and market provision helps to explain its success in a period where internationally the welfare state was under attack. At the same time these features may make Medicare, or at least universalism under Medicare, more susceptible to future attack. By continuing private provision alongside universal public insurance, Medicare facilitates a 'dual welfare state' (Stebbing and Spies-Butcher 2010) potentially corrosive of social equality. This analysis reflects institutionalist accounts of the political economy of the welfare state, which highlight the importance of more gradual and less visible mechanisms for changing social policy, particularly during periods of market ascendancy (see Hacker 2004; Streeck and Thelen 2005).

I begin the paper by discussing the rise of economic rationalism and the embrace of market economics within the Labor Party. Next I examine the history of universal health insurance, focusing on the development of the Medicare model and its adoption by the Labor Party in the late 1960s. The bulk of the paper then examines how Medicare's use of market principles assisted in its success during both the Whitlam and Hawke Governments. Finally, I examine some of the longer term implications of the Medicare approach, both in terms of the changing nature of the health sector and attempts to unwind or erode universalism.

Economic Rationalism in Australia

Social scientists now broadly acknowledge that the 1970s saw a profound shift in both ideology and the balance of political forces around the world (Harvey 2005). In Australia, this trend was summed up by what Michael Pusey described as 'economic rationalism' (1992). This saw policy makers embrace market models, but unlike the US and British experiences, this happened under a Labor Government in a formal Accord with unions, and did not combine economic reforms with social conservatism. And unlike the New Zealand experience, inequality, and

particularly poverty, did not dramatically increase (see Castles *et al.* 1996; Quiggin 1998).

As a result, Australia had a unique experience of economic reform. Pusey sees the precursors of economic rationalism under Whitlam, particularly in the last Hayden Budget, but argues it began in earnest under Hawke and Keating as they implemented the recommendations on the Campbell Review. The Australian dollar was floated, the Commonwealth Bank and QANTAS privatised, the labour market was decentralised, trade protections were dismantled and fiscal discipline applied through commitments to limit taxation and deficits. It was a radical reshaping of the Australian political economy, developed in cooperation with unions, but with many reforms facing popular opposition.

However, in addition to these economic reforms, Australia also saw the expansion of social spending in the 1980s and 1990s (Wilson *et al.* 2013:626). Medicare was re-established in 1984. Superannuation was introduced and expanded. Payments to families dramatically increased – now rivalling the highest in the developed world (Stebbing and Spies-Butcher 2010:587-8). Labor also embraced neoclassical economics more systematically than many conservatives. While company tax rates fell, new taxes on capital gains and fringe benefits were created. Competition policy not only advanced deregulation, but also enforced new anti-trust legislation through the Australian Competition and Consumer Commission and the Productivity Commission.

Boris Frankel (1997) argues Australia pioneered what later became known as the Third Way. Labor argued this was a response to neoliberalism, combining a commitment to market economics with the concerns of social liberalism, although Frankel (1997) argued it was better understood as a form of neoliberalism, and others as an example of ‘actually existing’ neoliberalism (Cahill 2010). Australian Labor accepted the argument that economic reform was necessary to maintain prosperity, jobs and growth. Having done so, however, its approach was remarkably consistent with the party’s philosophical tradition of labourism, which sought pragmatic ways to advance the interests of workers within the constraints of the existing economic order (see Irving 1994).

The result was a modest expansion of a highly targeted welfare state alongside pro-market economic reforms. However, this masked a significant erosion of a core element of Australia’s unique welfare model – centralised wage arbitration (Castles 2001). This has ‘hollowed out’

Australia's 'wage earner' model of social protection (Wilson *et al.* 2013). It has also contributed to new forms of economic insecurity in a deregulated labour market (Burgess and Campbell 1998; Chan 2013). In this context, Medicare's success is particularly surprising. The scheme extended public provision, increased tax receipts and led to a substantial decline in private health insurance coverage. Much of the scheme's success is due to a concerted campaign by unions (Boxall and Gillespie 2013:120-6). But Medicare's structure also reflects a Third Way strategy of combining markets with equity

From Nationalisation to Medicare: A Brief History of Health Reform

For most of the twentieth century Labor was committed to the nationalisation of health care. However, this was not achieved outside Queensland prior to the wartime Labor Governments (see Gillespie 1991). In 1946 Labor put a series of referenda to overcome constitutional limitations of the Commonwealth's ability to expand welfare provision. Given the poor history of passing referenda, Labor was keen to ensure bipartisan support. Bipartisanship was achieved, but on the condition that a clause be added to the medical power preventing civil conscription. Labor complied and the amended clause was passed (see Gillespie 1991: 223).

Labor quickly moved to introduce a national health scheme, including both free medical and hospital treatment. However, non-compliance from doctors led the Government to introduce monetary and penal penalties. This allowed the medical profession to both unite doctors in civil disobedience (Mackay 1995:356-7) and successfully argue to the courts that the measures amounted to civil conscription (see Meldelson 1999). Labor lost the ensuing 1949 election, partly due to the fierce campaign waged against it by the medical profession, and the scheme lapsed.

The incoming Coalition Menzies Government established a subsidised private system. Benefits were based on membership of a private fund, effectively requiring people to join the funds to access benefits. To ensure equity, a community rating principle was introduced that prevented price discrimination, forcing funds to offer all members the same premium, regardless of age or previous illness. The funds themselves were relatively passive insurance bodies, often dominated by

medical professionals. Fee-for-service medical practice continued, maintaining professional autonomy while the insurers exercised little external control (Scotton and Macdonald 1993:16-7). Insurance coverage during the 1950s and 1960s was relatively high, complemented by honorary provision to those patients whom doctors deemed in need. This meant access was often associated with charity, but lack of access was rare. However, by the mid-1960s a number of problems were beginning to emerge. Rising medical costs undermined the effectiveness of the government rebate and raised insurance premiums. Membership, particularly for low-income earners, began to fall (Scotton 1969).

Despite twenty years of conservative government, Labor remained committed to the nationalisation of health care. This changed in the 1960s when Gough Whitlam looked beyond nationalisation to avoid constitutional constraints. He championed a scheme developed by two health economists – Richard Scotton and John Deeble – based on reforms in Canada. The Scotton and Deeble plan became the basis for Medibank, which was a central plank of Labor's 1969 election campaign (Boxall and Gillespie 2013:38-40). Having achieved a substantial swing in that election, Labor then won office in 1972.

Medibank was effectively two separate schemes. A hospital scheme provided free and universal access to public hospitals, based on the earlier wartime Labor scheme; and a medical scheme provided rebates for medical consultations outside hospitals. The medical scheme also included a bulk billing provision that allowed doctors to accept the rebate as full payment and not charge patients at all. State governments run Australian public hospitals. This meant the federal Medibank scheme acted like an insurer, funding hospital visits and providing rebates for medical consultations.

Even so, Medibank was highly contested. The medical profession fought a long and expensive campaign against the proposal, and the non-Labor parties blocked legislation in the Senate, requiring a double dissolution election in 1974 before a joint sitting of parliament successfully passed the law. Following the dismissal of the Whitlam Government in November 1975, the Coalition Fraser Government set about gradually winding back the scheme, until it was effectively dismantled in 1981. However, the incoming Hawke Labor Government then reintroduced Medibank in 1984 under the new title Medicare (Boxall and Gillespie 2013).

Unlike Medibank, Medicare was given time to become institutionalised. Despite some minor reforms, Labor rejected more significant changes to Medicare that might have reduced benefits or limited access to low income Australians¹, and the scheme remained intact until Labor lost office in 1996. After twenty years of explicit opposition to Medicare, the Coalition won office in 1996 with the promise to maintain universal health insurance, and went on to claim that the Coalition was the ‘best friend Medicare ever had’ (Elliot 2006).² However, the Coalition has maintained strong support for private health insurance, introducing a series of reforms to increase membership. Medicare currently remains in place with bipartisan support.

Medicare replaced the model of nationalisation with a single public insurer. Many in Labor in the 1960s correctly saw this as a shift towards accepting market provision in healthcare and so fiercely resisted the move (Boxall and Gillespie 2013:36-40). However, markets were used to reduce producer power, expand access and overcome political resistance. The use of competitive pressure has achieved many of the limits on producer autonomy that doctors had feared would come with nationalisation. At the same time, the shift to public provision has been incomplete. Coalition Governments have since used similar market mechanisms to reinvigorate private provision, without fundamentally altering the structure of Medicare. This highlights a new welfare state politics in which both extension and retrenchment are more gradual and less visible (Streeck and Thelen 2005).

Using the Market to Advance Access and Equity?

Medicare is not a market model of medicine in the formal sense. Public hospitals are directly owned and funded by the state, and many health professionals are direct salaried employees. The medical insurance provided through Medicare rebates and bulk billing are part of a compulsory insurance model that clearly breaches principles of

¹ The most notable being a proposal from Brian Howe to introduce a co-payment for bulk billed services in 1993, which was rejected by the Labor caucus (see Leeder 1999:35-6).

² Analysis of survey evidence suggests the Coalition’s opposition to Medicare in 1993 contributed more to the party’s election loss than any other issue, including support for the GST (see Bean 1994).

competitive neutrality. However, Medicare is a model that explicitly facilitates the operation of private health markets. The hospital component of Medicare provides directly for treatment, free of charge, in public hospitals. However, patients can hold private health insurance and can opt to stay as a private patient in either a public or private hospital, allowing them to choose their doctor and access improved accommodation. The medical component of Medicare supports private practice by providing funding on the basis of fee for service.

This design reflects the background of the two architects of the scheme – Scotton and Deeble. Both were health economists operating in a broadly neoclassical framework. Importantly, their brand of economics, indeed much of the health economics sub-discipline, differs from other elements of neoclassical economics in crucial respects. First, health economics is applied, and Scotton and Deeble focused on the experience of the Australian health sector in practice, rather than relying on theoretical models. Second, health economics largely accepts a differentiation between (health) needs and wants – reflecting dominant public and medical viewpoints. This suggests a lack of provision reflects an inability to pay, rather than the traditional neoclassical understanding of willingness to pay. Lack of provision can therefore be considered a form of market failure.

Scotton and Deeble's (1968) depiction of the health industry reflected the broader neoclassical literature on market failure. They pointed to asymmetric information between providers (doctors) and consumers (patients), which they claimed led to over servicing. They argued private funds both appeared oligopolistic and anti-competitive, while they also lacked the real scale needed to reduce administrative costs and allow for lower levels of financial reserves.

Their investigations did not lead them to propose nationalisation. Instead they proposed increasing government involvement in ways consistent with the continued operation of a (more competitive) private market. In the hospital system all patients would be entitled to free care as a public patient. However, a private system would remain to allow choice of accommodation or doctor. Scotton and Deeble felt these features were not medical needs and therefore should be subject to normal rules of market provision (1968:11-2).

This distinction highlights a key difference between the Scotton and Deeble approach and nationalisation. Where opponents of private medicine had previously focused attention not only on issues of access, but also issues of class and status, the Scotton and Deeble critique did not deal with the potential problems of allowing patients to access different standards of care or the potential for this to reinforce status hierarchies. By allowing different forms of health care to persist, Medibank potentially limited the extent to which healthcare was ‘decommodified’, or moved out of the realm of the market, as it was in other more explicitly social democratic welfare states (for example Esping-Anderson 1990).

The medical scheme allowed even more explicitly for the continuation of private practice. Instead of instituting a salaried medical workforce to deliver free services, medical care would continue to be provided by independent, self-employed medical professionals. Patients would consult with their chosen doctor who was free to charge whatever fee she felt appropriate. The government would then reimburse the patient 85 percent of a scheduled fee (that is the fee the government felt was appropriate to the service), in much the same way private insurers reimburse for costs.

Alternatively, the doctor could chose to bulk bill the patient, in which case the patient would pay nothing and the doctor would bill the government directly for the 85 percent rebate. Scotton and Deeble (1968: 12) argued that the reduction in administrative costs for the doctor would often be greater than the income forgone in charging a higher fee, meaning many doctors would be financially better off bulkbilling all, or many, of their patients. Even those doctors who choose to bulk bill some patients were free to charge fees to others.

Again, the scheme focused on addressing issues of market failure. Private funds had high administrative costs and little ability to control costs. A single insurer would address both these issues, and would provide the most efficient mechanism to ensure all people had access to basic health care regardless of income. However, the scheme continued to provide patients with choice of doctor, and continued to provide doctors with formal freedom to run their practice as they wished. Scotton and Deeble’s analysis can be seen to pre-empt the more explicitly Third Way analysis of Julian Le Grand (1997), which seeks to combine the

equity and access goals of social democracy with the models and incentives of market provision.

Where Labor's commitment to nationalisation proved unsuccessful, Medicare was successfully implemented. This was not due to a decline in opposition. Resistance from the organised medical profession was as fierce in opposing Medicare as it was against earlier attempts at nationalisation. Its success owes much to the support of organised labour, especially its reintroduction in the 1980s. But its acceptance of private provision also proved critical. Three related factors contributed to this: the ability to gain legitimacy, the ability to use competition to promote access and equity and the ability to use monopsony power as an indirect means of government regulation. It reflects a philosophy which became central to much Labor administration during economic restructuring – that governments could retain control in a privatised economy (Keating 2004).

We're Not Socialists: Markets and Legitimation

Scotton and Deeble's focus on correcting the health insurance market, and on the problems of competition and knowledge within the market, helped to reframe the policy debate. This restricted the ability of the medical profession to frame universal health insurance as a form of socialisation. Some of the more radical elements of the profession continued to attack the scheme as akin to totalitarianism (see Whitlam 1985:346; Scotton & Macdonald 1993:102-7), however these radicals were as effective at splitting the profession as they were at opposing the government.

More broadly, the new scheme allowed Labor to gain new allies. Prior to the election of the Whitlam Government, Labor was able to persuade the anti-communist Democratic Labor Party to support a Senate inquiry into the health system, which served to popularise the Scotton and Deeble plan (see Whitlam 1985:338-9; Sax 1984:79). The DLP rarely supported Labor in the Senate, however the Scotton-Deeble model allowed Labor to distance itself from nationalisation, and allowed for the continuation of the Catholic health system (from which the DLP received considerable political support), reducing DLP concerns.

Likewise, Labor enjoyed the surprising support of the financial press on the issue of health policy. The Australian Financial Review, led by Max Walsh, ran a series of pieces criticising the private health insurance industry and welcoming the changes proposed by Scotton and Deeble (for example Walsh 1968; 1969; 1971). A number of analysts of Australian health policy have noted that support for universal health insurance was greatly influenced by the quality of the academic critique of the private system (Sax 1984:79; Kewley 1973:391; Gray 1984:3). This was no doubt a necessary condition. But it is unlikely more radical proposals based on research of a similar quality but advocating nationalisation would have received such a reception.

The result was a legitimisation of Labor's new policy and a fragmentation of opposition. The anti-Labor campaign was not internally popular within the Australian Medical Association. The AMA failed to reach fund raising targets and suffered a significant fall in membership (Makay 1995:363; Scotton 1993:70). A new doctors group sympathetic to universalism – the Doctors Reform Society – also emerged (see Hunter 1984:997-9). This was not only the result of the framing of Labor policy – a new generation of more socially progressive doctors was emerging who were broadly sympathetic to social democratic politics. But the nature of the proposals did make it more difficult to frame universalism as a Communist plot.

Some evidence of this can be found in the NSW Doctors' strike in the early 1980s. Following the election of the Hawke Government and the reintroduction of Medicare, the NSW Labor Government pressed ahead with more direct forms of intervention by regulating the appointment and payment of visiting specialists in public hospitals. The result was a highly unified profession, mass opposition, escalation of government penalties, and an eventual government retreat (see Larkin 1989; McKay 1986). It was a similar result in many ways to the attempts by Labor to introduce nationalisation in the late 1940s.

A similar broadening of support was required to reintroduce Medicare. Having retrenched Medibank under Fraser, the Coalition parties continued to oppose the reintroduction of Medicare. Passage of the legislation was achieved with the support of a new middle class party, the Australian Democrats, which had only recently split from the Liberal Party, and was led by the former Liberal Health Minister Don Chipp (Warhurst 1997). The framing of Medicare as a universal health scheme

rather than a nationalised health system helped build cross-class appeal amongst the Democrats' base in much the same way it helped fragment the medical opposition. As Baldwin has noted, social policies often succeed where they unite the interests of different class groups around shared risk (1990). Medicare's structure helped highlight this unity of interest over ideological and institutional divisions.

Finally, the framing of health policy as a solution to market failure enabled a more strategic use of economic language to pursue egalitarian goals. As in the United States, the 1980s saw the rise of a consumer rights movement, which proved a key institutional ally of Medicare. The movement argued for cheaper, higher quality and more accessible medicine largely by drawing on arguments similar to those of Scotton and Deeble, and thus advocating for universal health insurance (see Short 1998; Browning 1992). The Labor Government was able to financially support the movement because of the de-politicised framing of the organisations' agenda. However, consumer rights groups were overwhelmingly populated by those on the political left, including those traditionally aligned with the more radical politics of nationalisation. This use of market language to advance the goals of social justice was no doubt intentional, and was noted by opponents of universalism, who attempted, largely unsuccessfully, to undermine the credibility of these organizations (see Browning 1992).

Competitive Universalism?

Medicare maintained private hospital and insurance arrangements as well as allowing doctors to set their own fees. This flexibility may have aided the scheme's success through both legitimisation and cooption strategies, however both elements could be seen to undermine universality and access. The introduction of Medibank and then Medicare did not automatically lead to universal free medical treatment or to the elimination of the private hospital or insurance sectors. However, both during Medibank's short existence, and later under Medicare, universal insurance did introduce competitive pressures that have increased universality in both areas.

Initially producer resistance to the medical component of Medibank saw low rates of bulk billing and a rapid escalation of fees. None-the-less, the Medibank model allowed some doctors to selectively bulk bill low-

income patients (often at significant financial gain given the pervasiveness of bad debts at the time), while a minority committed to universalism bulk billed all patients – fragmenting the professions’ opposition. This immediately improved access to medical services for many (Gray 1991).

As the number of doctors engaged in bulk billing increased, so competitive pressure tended to expand access. Patients could seek out bulk billing doctors. Having even a small number of doctors in an area committed to bulk billing (as many progressive doctors were), would begin to place downward pressure on fees in the neighbourhood generally. In working class areas, an increasing number of doctors became dependent on bulk billing income to maintain their practices. The result was an increasing number of doctors in support of bulk billing (Scotton 1980:208-9). Later geographic analysis also supports this, with the federal electorates with the highest bulk billing rates clustered in working class areas of the major cities (see Health Insurance Commission/Medicare Australia 2006).

These twin effects help explain the consistent upward trajectory of bulk billing rates throughout the operation of universal health insurance. By the late 1980s bulk billing was the most common form of payment for medical services, and by the mid-1990s the method dominated payments to general practitioners (Health Insurance Commission/ Medicare Australia various years).

Similar pressures were generated by the hospital scheme. Here it is perhaps more obvious why a free national provider would quickly out compete the private insurance sector. Importantly, the competitive advantages of free public provision are difficult to remove without attacking free access itself. The Fraser Government undertook a series of reforms that sought to improve the competitive position of the private funds. Each led to a brief upswing, followed by a return to the downward trend, until Medibank was abolished in 1981 (see Gray 1984; Sax 1984) – increasing political pressure to fully reinstate the scheme. Boxall and Gillespie (2013:102-13) argue a key reason the Fraser reforms failed was that they were subordinated to broader macro economic objectives, rather than focusing on the specific dynamics of health.

The struggle over health insurance during the 1970s and 1980s reflects insights from institutional political economy. Large-scale retrenchment of policy is rare in the industrialised world (Pierson 1994). But incremental

reforms often significantly reshape the operation of schemes over time (Streek and Thelen 2005). While this incrementalism was more often associated with the erosion of social protection during the period, in this case it was the reverse. Labor's reforms recast the nature of existing regulation. In introducing Medibank (and later Medicare) Labor maintained community rating. However, its purpose now shifted. Rather than providing a degree of equity in a framework of near compulsory private insurance, it now acted as a significant impediment to private sector competitiveness alongside a strong public alternative.

Public demands for protection from very high health costs produced pressure to maintain community rating, and to provide some form of universal cover for catastrophic illness and injury. The public demanded that the very sick, and those that required very high cost procedures should be protected. This limited the competitive position of the private funds. By requiring private funds to offer the same premium to all members, community rating promoted adverse selection. Premiums represented good value to the sick and poor value to the healthy. There is strong evidence that adverse selection led to rising premiums under Medibank (Deeble 1982). Whether the trend continued under Medicare is in dispute (see Deeble 1999:566-7), but some argue it increased costs significantly (Barrett and Conlon, 2001; Industry Commission 1997:xxxvi).

The main counter-balance to this trend is the fear amongst the relatively well that they might suffer some unforeseen illness or injury. However, the Fraser Government was reluctant to allow news stories of people bankrupted by hospital bills – a key campaigning point of the Labor Party prior to Medibank. Thus, the Coalition maintained a form of catastrophic insurance until 1981. However, this essentially neutralised the main selling point of private insurance to younger, fitter members. Under the Coalition scheme, both Labor and the consumer health movement actively campaigned to alert younger people to this fact (Pierce 1982:89). Only when the Coalition engaged effectively in micro economic reform of health insurance, under Michael Wooldridge, were more effective policies developed, something discussed below.

Advantages of a Single Buyer

Medicare is designed to use monopsony power to exert cost control. This created political advantages. First it made universal health insurance affordable, and reduced the need for additional tax revenues that would induce political resistance. Second, it was key to winning support within the Labor Party. Shaun Wilson (2013) has described Labor's policy strategy as 'small state social democracy', combining social democratic intent with a strong resistance to raising taxes. This grew in the 1980s as most states entered a period of 'fiscal austerity' (Pierson 2001).

Scotton and Deeble claimed that a key advantage of their scheme over the existing private model was its ability to constrain total costs. Both economists had been highly critical of the private funds for having large reserves and high administrative costs. The single insurance model effectively eliminated these. Ian McAuley has estimated that the administrative costs of Medicare are less than 5 percent, compared to over 10 percent in the private funds (McAuley 2005:169). This is not so much the result of poor administration as structural advantages of a single public provider, which achieved both economies of scale and did not have to pay the advertising costs of the private sector.

Beyond this, the new public system was able to partly solve the problem of information asymmetry by allowing public oversight of potential over servicing. The problem here is that patients know less about the treatments they require than do doctors. This effectively undermines consumer sovereignty, as doctors are able to suggest treatments for which the consumer cannot make an informed judgement.

It had been feared that creating a free health system would dramatically increase utilisation rates, based on traditional neoclassical assumptions that as price decreases so demand increases. The Fraser Government certainly argued this. However, work by Scotton demonstrated that close analysis of medical utilisation figures showed no significant effect on utilisation rates (Scotton 1978), while analysis of hospital figures suggested a decline (Palmer and Short 2000:73-4).

This partly reflected the effects of government scrutiny. For the first time there was a central database of what services were provided by which doctors to which patients. This wealth of data allowed the government to monitor utilisation rates and identify over servicing. The ability to distinguish health *needs* from *wants*, along with the government's ability

to better scrutinise and evaluate the servicing decisions of doctors, allowed the state to ration access without using price signals. The state could identify unusual patterns of provision and compare utilisation rates to expert advice on the needs of patients with various conditions (see Scotton and Macdonald 1993).

The cost of treatment was also contained. The spread of bulk billing reduced administrative costs associated with providing medical treatment. As doctors became more dependent on bulk billing, so the state was better able to slow the increase in medical inflation. Medicare generated monopsony power, undermining the market power of medical professionals.

Scotton and Deeble's arguments also proved effective within Labor. Following the defeat of the Whitlam Government, Labor was keen to establish economic credentials, partly by restricting government spending. The ability of Medicare to contain costs (Scotton and Macdonald 1993, 268-9), as well as its ability to reduce overall inflation and therefore be used as part of the Accord to restrain wages, was a significant selling point (Sax 1984:241; Palmer 1989:332-3; Short 1998: 128-9).

Bulk billing has also facilitated what some call the 'proletarianisation' of the profession (see Collyer and White 2001). But rather than becoming employees of the state, doctors have increasingly become employees of larger medical businesses. Medical centres have grown significantly under Medicare. Many doctors have faced rising costs associated with running an independent practice. This may allow new opportunities for the state to employ GPs in publicly run medical centres that focus more attention on community health approaches. Indeed, Labor's recent commitment to Medicare Locals signals this as a possibility.

The Dangers of Incrementalism: Medicare and the Dual Welfare State

Political sociologists have increasingly recognised that policies generally change only gradually. Even during the 1980s and 1990s, where fiercely pro-market governments in the US and UK challenged the existence of the welfare state, much of the original policy architecture remained in place (Pierson 1994). Yet this did not mean stability in outcome. Inequality has risen rapidly over the past 30 years (OECD 2011).

Growing inequality was often associated with policy stasis, or with relatively incremental changes that supplemented existing frameworks rather than transformed them. Pierson and Hacker (2010) argue that this was central in the US, where business groups worked closely with legislators to ensure financial regulation did not keep pace with changes in financial markets, creating new opportunities for profit through policy ‘drift’.

This article has partly explained Medicare’s success in similar terms. Rather than replacing the system of private medicine with a public system, Medicare effectively built a new system alongside the old. This process of policy ‘layering’ reduced resistance by allowing the older system to continue, even though it substantially eroded the competitive position of private alternatives. Labor policy makers kept in place elements of the Menzies era scheme that reinforced this dynamic. Community rating had been introduced in a context where private funds had a virtual monopoly, but was retained in a context where it constituted a substantial disadvantage against a free public competitor. Thus, Medicare’s success was not only the result of a fierce, short-term political campaign, but a much longer process of policy drift, as bulk billing rates increased and private health insurance coverage declined. In the political context of economic restructuring, such a strategy had important advantages.

However, Medicare was not designed to replace private medicine. As private health insurance coverage fell close to 30 percent, even Labor policy makers became nervous. From the mid-1990s policy change increasingly focused on stabilising the system by reinforcing the position of private medicine. This partly reflects Australia’s unique approach to social policy, focusing on tightly targeting assistance and reducing taxation. Efforts to restrict overt forms of taxation have made it difficult to directly fund social provision. Public health provision might contain overall health costs, but expanding public provision usually means increased public spending, at least in the short run.

Labor’s efforts under both the Keating and Rudd/Gillard Governments reflect this logic. The mid-1990s saw a number of regulatory changes designed to reinforce the competitive position of private health funds by allowing greater product differentiation to target younger people. Rudd’s hospital reforms sought to extend competition policy amongst public sector providers in an attempt to lower costs. Indeed Labor’s Health and

Hospitals Commission proposed more radical reforms that would focus the public sector's role on funding individuals based on their risk profile. Individuals would then use this funding to select their own insurer (National Health and Hospitals Commission 2009:155-60). These changes certainly reflect a broader Labor commitment to competition and marketisation. However, consistent with the desire to minimise fiscal pressures, Labor has done little to financially assist the private sector.

The structure of Medicare has also facilitated a new form of partisan contestation (see Spies-Butcher 2014). From the mid-1990s the Coalition accepted Medicare. But Coalition policy has consistently and more aggressively sought to bolster private provision. It has done so in two ways; by extending public funding to private provision and by weakening the community rating principle that has undermined the competitive position of the private funds. In other words, the Coalition has engaged in similar incrementalist reforms that attempt to constrain Medicare to a residual provider alongside a large and profitable private industry.

The most significant changes have been to update the policy architecture of private insurance to accommodate the new realities of a public competitor. In 2000 the Health Minister Michael Wooldridge reformed the operation of community rating. Having studied the Fraser Government's attempts to dismantle Medibank,³ Wooldridge's reforms more directly targeted the source of competitive disadvantage in the private sector. Those without insurance by age 30 are now charged a higher premium when they do take out insurance than those with coverage from an early age. It is widely agreed that this reform has done more to increase private insurance coverage than any other (Butler 2001; Vaithianathan 2004; Palangkaraya and Yong 2005), taking insurance coverage back over 40 percent (Private Health Insurance Administration Council 2012:6).

The Howard Government also reinstated public support for private health insurance premiums. Initially this was confined to low-income earners, but it was soon extended to all. Importantly there has not been a simple return to the Menzies era policy. Then public subsidy came through a tax concession, meaning that the level of subsidy was not only related to how

³ Wooldridge wrote his Masters thesis on the Fraser health reforms under the supervision of Richard Scotton (Wooldridge 1991).

much a person spent on health insurance, but also to their marginal tax rate. This had led Whitlam to famously claim he paid less for health insurance than his driver (Hocking 2012:chapter 4). Instead the new scheme was a rebate at a flat rate of 30 percent (40 percent for older policy holders). However, new tax concessions have been introduced to limit the extent of out-of-pocket costs as bulk billing rates fell in the early 2000s (Australian Government 2005).

The private health insurance rebate has proved particularly expensive as premiums continue to increase above inflation. The rebate has grown rapidly, at over 6 percent per annum (Australian Government 2013:6-30). While the private health insurance rebate appears to have done less to increase coverage than the regulatory reform of community rating, it has had a marked effect on the politics of healthcare. The growing expenditure places pressure on the overall health budget. But as with other public payments, it has created a new constituency eager to defend their entitlement. The Coalition has fiercely defended the rebate, blocking reforms in the Senate and campaigning against Labor attempts to limit access at elections. While Labor has achieved some modest savings through means-testing, the general trend towards greater private subsidy remains, with an annual cost now over \$5.5b (Australian Government 2013:6-30). This generates greater pressure on the remaining health budget, ironically helping to justify the most recent moves by the Abbott Government (Australian Government 2014:13) to reintroduce a co-payment for currently bulk billed medical visits. .

Conclusion

Medicare's success offers important lessons for students of health policy. Having failed to nationalise healthcare during the brief post-War period of welfare state expansion, advocates of universalism faced a daunting political environment. Australia remains the only industrialised country to have retrenched universal health care. And in the wake of that retrenchment, Medicare was reintroduced at the height of the neoliberal assault on the state under Thatcher and Reagan. Even modest success in expanding public provision and social rights is notable during such a period, but the implementation of such a significant change in one of the largest areas of public spending, and indeed the economy, is particularly impressive.

Part of this success is undoubtedly due to the influence, organisation and strategy of Australia's trade union movement, both in civil society and through the Accord. But of equal importance was the structure and strategy that underpinned the program itself. Medicare built around opposition. It circumvented constitutional prohibitions and private interests by leaving in place much of the architecture of the previous private health system. It even co-opted old enemies, creating a broader alliance of support. On top of this it layered a new system of public funding with incentives designed to both limit provider power and expand public provision. Over time that is exactly what happened, building public support as it grew and eventually demanding bipartisanship. This did in reverse, what neoliberal attacks on the welfare state were achieving in the United States and Britain.

The lessons of Medicare, however, are two-fold. While Medicare successfully used competitive pressures and market forms to advance equity and universalism, these same features leave the scheme open to erosion. Given Medicare's strong public support, conservative opponents have shifted strategy, rebuilding the private health system and restricting Medicare's reach. This has seen a puzzling new politics emerge, in which conservative governments extend public support and Labor governments seek to claw it back. It is foreseeable that healthcare may follow the path of education, and see the public sector in permanent retreat as the most affluent and connected opt-out of public provision, and take public funds with them.

If this is the new politics of healthcare, then advocates of universalism will need to adjust their strategies. Allowing everyone to access public health care is not enough. While those with means are encouraged into private alternatives, and subsidised for doing so, the position of public health remains vulnerable. Medicare shows there are opportunities to use competition for universal ends, but also points to the limits of this strategy. Piecemeal attempts to means-test private benefits are unlikely to lessen the threat. Instead a new round of reform is needed to extend the gains that have been made.

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