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Chopping and Changing Medibank

Part 2: An Interpretation of the Policy Making Process

The changes to the health insurance scheme which were announced and implemented in 1976 provide an opportunity to analyse the policy making process in Australia. Two paradigms are used to analyse this process: pluralist and marxist. It is concluded that the marxist paradigm is the more useful in trying to understand the 1976 Medibank changes.

In an earlier article[1] I outlined the public processes that occurred between the Fraser government's announcement of a decision to restructure Medibank and the implementation of those changes. This period provides an interesting example of the policy making process in Australia. In a relatively short period, a policy option was identified, accepted and implemented. Policy analysts are concerned with all phases of this process but in this article I will examine one of these, namely the question of acceptance of the need for change to Medibank and the nature of the changes that were accepted.

Hall *et al.* have identified two major paradigms used to analyse the policy making process: pluralist-democratic and marxist-class[2] and these will be used in this analysis.

A PLURALIST INTERPRETATION

The political system, according to pluralist theorists, is characterized by a number of competing interest groups which jockey continuously to obtain their desired ends. Because these are *competing* interest groups, no one group has obtained or indeed, is able to obtain, dominance or hegemony in the system. Power, according to the pluralists, is diffused throughout the system.[3]

The use of pluralism as a frame of reference presupposes interest groups which are active. Certainly there were a number of groups that had an interest in the Medibank changes: the ACTU, the AMA, the private hospitals, the voluntary health insurance organizations and the

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social welfare lobby groups, to name the most obvious ones. In the Medibank dispute the ACTU and organizations such as the Australian Council of Social Service were opposed to the changes to Medibank. Although it is quite consistent with pluralist theory to expect changes to policies with changes in governments, prior to the 1975 election, the Leader of the Opposition Mr Fraser had said that Medibank would be maintained. Given these statements one would hypothesize that interest groups which supported some changes would first agitate for reversal in the government's stated policy of the continuation of Medibank and, if that were achieved, agitate for changes in a desired direction.

The organizations representing private hospitals were relatively inactive during 1976 contenting themselves with an advertisement stressing the benefits of 'private hospital' insurance a week before the scheme was introduced.

In its Annual Report, the AMA described the events of 1976 thus:

> Strong pressure, including a 24-hour national strike, was exerted on the Government by the trade union movement to modify its Medibank proposals, and attempts were made to provoke the AMA into entering the controversy. The Association declined to be drawn since it had nothing to gain from a public argument on such issues.

The statement reflects accurately the AMA's public role. The *AMA Gazette*, for instance, a fortnightly magazine of approximately twenty pages, carried fewer than ten pages on the changes during the entire year.

Hall *et al.* identify a number of sources of interest group influence:

(i) the direct manipulation of, or control over, electoral support for a particular party;

(ii) the existence of a financial relationship between political parties and a very small number of interests;

(iii) the interdependence of government and those interest groups which are directly involved in implementing government policies;

(iv) the presentation of information about unmet need or policy failures to authorities anxious to anticipate public criticism;

(v) the challenging of a government's competence by gathering information on unmet need or ineffective policies; alternatively, the challenging of the impartiality and justice of their policies by appealing to considerations of the public good; and

(vi) the formulation of partisan analyses designed to convince an authority that partisan demands are in accord with its predispositions and interests.[4]

Of that list the most obvious source of AMA influence, given its relative inaction, was through the interdependence of the AMA and the government.

Even though an interest group may have influence, it still must persuade the government to take action. Hall *et al.* have identified three major criteria for identifying whether an issue will be likely to be advanced successfully: legitimacy, feasibility and support.[5] Legitimacy relates to the answer to the question: is this an issue with which government considers it should be concerned? During the four weeks between the government's election and the establishment of the Medibank Review Committee there was no new discussion on the issue of legitimacy. The government, however, partly justified its concern on the grounds of excessive expenditure on Medibank. The issue of feasibility was only raised by opponents of the changes to Medibank who argued that the changes were complex, confusing and resulted in greater costs to the public. The ability, or likelihood, of a government to act on a particular issue also depends on the support that either the government or the issue has. As indicated above, analysis of the opinion polls indicates that there was no widespread support for the specific issue of changing Medibank. Thus the government, in acting, was relying on its general, or diffuse, support to carry the debate.

An analysis of the process exclusively within a pluralist perspective leaves certain questions unanswered. For instance, why was the government prepared to risk its 'diffuse support' for an issue which, when it was first announced, was not the subject of public discussion? In his statement of 8 December, Mr Fraser said that Medibank would be continued until it could be assessed properly. Why did he change his mind within one month? Mr Snedden was repudiated when he suggested that some people might have to pay for Medibank. Why was this not the case five months later? Why did the AMA not attempt to influence public opinion during 1976? Why did it not even overtly attempt to influence the government to the extent of establishing the Medibank Review Committee?

The answers to these questions cannot be found using a pluralist interpretation.

A MARXIST INTERPRETATION

According to the marxist interpretation, the political system is dominated by a single class. Although there may be differences within the

dominant class, these are constrained within narrow limits. The government, like other aspects of the 'state', acts at the behest of the dominant class. Traditional marxist analysts point to the homogeneity of the decision making group, both within and without the formal governing systems, and describe this as a ruling class. Social change, within a capitalist system, occurs as one result of the ongoing class struggle between the ruling and working classes.

THE WORKING CLASS STRUGGLE

One of the most significant events in the 1976 Medibank changeover was the Medibank strike. In marxist terms it showed that there was indeed a dichotomy between working class and ruling class on this issue, and that the working class viewed the government's proposals as an attack on their standard of living. The relative lack of opposition to the strike at the ACTU congress indicated that the working class was united in opposition to the changes. That the government made no conciliatory gestures to the union movement and, indeed, even castigated the trade union leadership for its actions simply provides evidence that the changes were part of a class struggle.

Probably the clearest indication of the class dichotomy may be seen in the results of the opinion poll conducted on 27 July 1977. In that poll respondents were offered a choice between the ACTU proposals and those of the government, a choice that emphasized the class nature of the government proposals with, on the one hand, a scheme which would spread the burden of paying for the health insurance scheme evenly over the whole population and, on the other, a scheme which would ensure that the rich would pay the least.

In the detailed analysis of support for a 1.6% levy or the more complex 2.5% with a ceiling and opting out provision, opinion divided on class lines (see Table 1) with a majority of persons classified as professional, managers and small business owners supporting the government scheme whilst a majority in what can loosely be called working class groups supporting the ACTU scheme. Similarly it was only amongst high income earners that a majority supported the government scheme (see Table 2).

It is increasingly recognized that events in the health system do not take place *in vacuo*.[6] There is no reason why health services should be regarded as 'apolitical', nor can they be. Most of the commentators at the time of the Medibank changes attempted to analyse them in narrow health services terms; using that basis it is indeed hard to understand why the changes took place. However, an assessment using a marxist

TABLE 1

PREFERRED MEDIBANK FINANCING ALTERNATIVE BY CLASS

	Professional, Manager, and Small Business Owners %	*White Collar Clerks* %	*Skilled Workers* %	*Semi-Skilled* %	*Unskilled* %	*Total Sample* %
Prefer 1.6% levy	33.05	52.1	52.5	54.3	50.9	49.1
Prefer 2.5% levy with ceiling and opting out provision	55.93	32.1	28.1	24.1	22.5	31.1
Undecided	10.53	15.7	19.1	21.3	25.2	19.4
Total	100.0	100.0	100.0	100.0	100.0	100.0

Source: Morgan Gallup Poll No. 128, 17-24 July 1976; the question was phrased in terms of the choice between the two alternatives. They were not characterized as the ACTU or government scheme but rather described in detail. Classes have been grouped to provide larger cell frequencies than those provided by the Morgan Gallup Poll; classes grouped were relatively homogeneous in terms of response. Classes grouped by Morgan Gallup as 'others', farm owners and farm labourers, have not been shown.

TABLE 2

PREFERRED MEDIBANK FINANCING ALTERNATIVE BY ANNUAL INCOME

	Under $4000 %	*$4000-$5999* %	*$6000-$7999* %	*$8000-$9999* %	*$10,000 or more* %	*Total Sample* %
Prefer 1.6% levy	41.8	52.0	54.0	51.1	44.3	49.1
Prefer 2.5% levy with ceiling and opting out provision	21.1	27.6	28.1	32.9	45.1	31.1
Undecided	36.4	20.2	17.3	15.8	10.6	19.4
Total	100.0	100.0	100.0	100.0	100.0	100.0

Source: As for Table 1.

perspective makes the motivations clearer. Tom Uren, then Deputy Leader of the Opposition and a former Minister in the Whitlam government, made the same point with regard to the 1977 Australian Budget:

> I believe that the general public are at a serious disadvantage when it comes to assessing the Budget. This is because we have become accustomed over the years to looking at the Budget *as a tool of economic management,* and as the principal event in the annual economic calendar. The Fraser Government does *not* use the Budget as a tool of economic management. The conservative forces have used this Budget—as they have used their other Parliamentary powers—*as a weapon in the class war* that they have waged aggressively over the last two to three years in Australian society.
>
> Never in the history of this nation have we seen such a class leader as Malcolm Fraser. Never before have the powers of the State, the Constitution and the institution of Parliament been used so aggressively by the power elite against the people. Many commentators including newspaper editors have puzzled over why this Budget is so empty, why it hasn't really addressed itself to the problems of recession, unemployment and inflation. The competitive business sector spokesmen have reacted with dismay and confusion, as to why *their* Government has given them nothing in the Budget. I believe that this confusion arises because these people too, are analysing the Budget as a piece of economic management. Looked at as a part of the conservative forces *political* strategy, the 1977 Budget makes much more sense.[7]

Commentators should never have been in doubt as to where the government's sympathies lay, but it was up to an Acting Minister for Health to finally enunciate the true situation:

> *Interviewer*: Well the funds have expressed concern that people will go from the funds to [Medibank], certainly in the short term because it will be so much more . . . advantageous. Now surely the government must be worried about this too?
>
> *John McLeay* (Acting Minister for Health): Well these are truly matters of speculation. I personally don't believe that that is likely to happen. People go to the funds for special purposes, freedom of choice, etc., and [I believe] that they will stay *with us,* with the private funds [emphasis added].[8]

The changes to Medibank in 1976 begin to make sense only when they are assessed in terms of their class implications; the actions and decisions of the government are not understandable if one attributes

objectives directed toward rational health service management but can be explained as part of a political strategy in support of the corporate class.

The political objectives of the corporate class were most clearly enunciated by the Leader of the Opposition Fraser in his policy speech when he promised to undertake

> . . . actions which will give the private sector room to start expanding production and providing jobs [and that his government would] introduce a number of major reforms to direct resources away from government and back into the hands of individuals and business.[9]

The introduction of Medibank in 1975 had resulted in a significant increase in the proportion of health expenditure paid through the federal budget and this, in the view of the corporate class, should be reversed as part of a general winding down of the government sector.[10] Rapid increases in health care costs which were evident at the same time were also expected to further increase the commonwealth commitment.

The corporate class thus required a revision of the Medibank scheme in order to reduce the size of the federal budget and indeed, this reduction in the absolute size of the budget (and not only the size of the budget deficit) appears to have been one of the major objectives of the revised scheme.[11]

It is important to note that the changes to Medibank were announced as part of a fiscal policy review involving cut backs in a number of other government programs.

THE SUBSIDIARY BENEFICIARIES

As with any major change one can expect a number of groups to benefit from the revisions and, indeed, two groups of beneficiaries of the 1976 Medibank changes can easily be identified: voluntary health insurance organizations and the organized medical profession.

The role of the voluntary health insurance organizations was much enhanced by the new arrangements. These organizations had lost their major purpose of insuring consumers against the costs of health care with the introduction of Medibank in 1975. Although a number of smaller health insurance funds ceased operating with the introduction of Medibank, the large funds introduced a host of new insurance schemes, not previously provided. The new schemes provided insurance against the deductibles not covered by Medibank, and for ancillary and para-medical services. The cost of these new services was exactly the same as the (subsidized) cost of health insurance prior to Medibank.

As a large proportion of the population obtains health insurance cover by means of automatic deductions from wages or salaries, the health funds were relying on inertia to keep their same level of activity. The decline in the level of contributions was not, indeed, too traumatic nor was the decline in the overall level of activity of the funds. (See Table 3.)

TABLE 3

TRANSACTIONS OF VOLUNTARY HEALTH INSURANCE ORGANIZATIONS

	Insurance Contributions Received $m	*Total Benefit Payments (including commonwealth contribution)* $m
1970-71	236.2	366.8
1971-72	297.3	504.0
1972-73	315.7	595.0
1973-74	381.2	654.9
1974-75	567.5	913.9
1975-76	437.8	627.7
1976-77	980.9	889.9

Sources: Department of Health, *Operations of the Registered Medical and Hospital Benefits Organizations*, Canberra: AGPS, various years (issues for 1971-72, 1972-73 and 1973-74, produced by Department of Social Security); Department of Health, *Annual Report of the Director General of Health*, Canberra: AGPS, various years.

But it is interesting to note that the health insurance organizations have an important role as sources of finance for the corporate sector. The health insurance organizations are all required to maintain 'reserves' for three major purposes: to provide for unpaid claims because of the lag between date of service and date of claim; to allow for a deterioration in underwriting experience which takes place before contribution rates can be adjusted (and thus to allow for epidemics and so on); and to provide for the physical capital of the organization in the absence of equity capital.[12] The level of these reserves was the subject of criticism during the debates leading up to the introduction of Medibank in 1975. However, as one commenator concluded, no one should have been surprised at these excessive reserves:

> Until 1970, government policies—which include a moral commitment to underwrite the organizations—stimulated rather than restrained the growth of reserves. However, the generation of excess reserves is more the automatic result of the structure of the system than the outcome of conscious policy. The fragmentation of re-

serves into some 180 separate funds, each of which must be maintained at an 'adequate' level, inevitably raises the overall amounts held.[13]

These excess reserves are thus available for investment in stock and debentures.

TABLE 4

INVESTMENT OF RESERVES BY HEALTH INSURANCE ORGANIZATIONS

	1974-75		*1975-76*	
	$m	%	$m	%
Commonwealth Bonds, etc.	28.17	13.38	29.77	13.50
Local Government and Public Utility Investments	49.20	23.38	52.70	22.18
Registered Mortgages	17.53	8.32	17.86	7.50
Registered Debentures	42.58	20.23	54.21	22.77
Preference and Ordinary Shares	4.38	2.08	4.55	1.91
Money on Deposit or at Call	66.46	31.58	76.72	32.22
Other	2.12	1.00	2.25	.94
Total	210.44	100.00	238.05	100.00

Source: Department of Health, *Operations of the Registered Medical and Hospital Benefits Organizations*, Canberra: AGPS, for years shown. Table shows total investment of reserves other than in fixed assets, for medical and hospital benefits organizations.

Table 4 shows that the investments of the health insurance organizations are used for promoting, either directly or indirectly, the capitalist accumulation process. The investments in commonwealth bonds and local government and public utility investments are primarily directed towards the provision of the social capital infrastructure necessary for capitalist enterprise. The direct investments in the corporate sector include investments in finance companies (who provide loans to both consumers and producers) as well as production companies. It is interesting to note that the largest fund in Victoria (the Hospital Benefits Association (HBA)) only holds unsecured notes in two companies: Ford Credits Australia Ltd and General Motors Acceptance Corporation Ltd—the finance companies of the two major transnational motor vehicle companies.

Of course, it should not be implied that the benefits of investments all accrue to the corporate class. The health insurance organizations

receive their *quid pro quo* in interest and other arrangements (thus, for example, HBA invests in a number of companies which, by a happy coincidence, happen to participate in the HBA's Group Health Insurance Scheme, thus facilitating collection of contributions).

The second major group to benefit was the organized medical profession. The effect of the original introduction of Medibank can probably best be seen by applying O'Connor's categorization of the United States economy (a monopolistic sector, a competitive sector and a state sector) to the Australian economy.[14]

The Australian monopolistic sector includes the banks, the insurance companies, the large manufacturing companies, the major retail stores, the oil companies, etc.—the list in Australia is strikingly similar to that of the United States. This, indeed, is to be expected as many of the corporations in the Australian monopolistic sector are transnational corporations, often with headquarters in the United States. The Australian market sector also resembles its United States equivalent with local service providers, small manufacturing and repair companies and local retailers spread throughout the country.

The state sector in Australia, just as in the US, may be divided into two subsectors: one wherein goods and services are produced directly by the state (the state operated subsector) and one wherein goods and services are produced under contract to the state (the contractual subsector). Prior to the introduction of Medibank, health insurance in Australia was part of the contractual subsector[15] with health insurance being provided through a large number of heavily subsidized 'voluntary' or 'private' health insurance funds. The implementation of Medibank in 1975 shifted the responsibility for health insurance to the state operated subsector. With this shift, the capacity for monitoring the activities of the medical profession became much greater. All doctor-patient contacts for which a rebate was claimed were recorded by Medibank and were available for analysis, thus facilitating the regulation of the profession. In due course, medical services themselves could be regarded as part of the contractual subsector.

The AMA has a strong commitment to the maintenance of a predominant role for doctors in health service delivery, a view which has been translated into strong support for fee for service practice and guarded acceptance of the establishment of health maintenance organizations. This in turn, requires that health insurance be maintained, preferably outside the state operated subsector.

The changes in 1976 shifted responsibility for health insurance into the monopolistic sector and hence preserved both unfettered fee for

service practice and the opportunities for investment of reserves and other funds: a coincidence of benefits for both the medical profession and monopoly capital. It is not surprising that special provision in the 1976 changes was made for the development of health maintenance organizations—a mode of service delivery which preserves medical dominance within a framework of a corporate domination.[16]

It is important to note that the two subsidiary beneficiaries, the medical profession and the health insurance funds have close formal links. For instance, the largest fund in New South Wales, the Medical Benefits Fund (MBF) was formed in 1947,

> in an effort to forestall any attempt by Federal Labor Government to introduce a national scheme for reimbursing medical practitioners by salary or capitation fees. One thousand doctors in New South Wales each donated ten pounds to establish what was called a 'Medical Benefits Fund'.[17]

Control of the MBF remains in the hands of these 'medical members' of the fund and their chosen successors. The HBA simply has formal representation from the Victorian branch of the AMA on its board. It also cannot change certain of its rules (including the representation one) without the permission of the Victorian branch of the AMA.

SOME FINAL COMMENTS ON THE MARXIST INTERPRETATION

Despite the clear relevance of using a marxist perspective to evaluate changes, a number of difficulties often preclude its use. For instance, the place of the medical profession in a marxist analysis is still a subject of debate. On the one hand, the medical profession could be regarded as part of the ruling class; such a view is based on the class origins of members of the medical profession, their high 'status' and the monopolistic nature of their profession's control over the health system.

Alternatively, the medical profession can be regarded as technocrats delegated by the ruling class with control over a specific section of the economy. This delegation can be revoked at any time when the interests of the ruling class are threatened. This view, now gaining credence in the United States, cites as evidence corporate support for health maintenance organizations and in some cases national health insurance, despite the opposition of the American Medical Association. Without agreement as to the composition of the ruling class, marxist policy analysis can only take place on a *post hoc* basis with the actions of the government or ruling class being interpreted in the appropriate way.

Another major difficulty relates to the predictive value of marxist analysis. Can one, for instance, predict developments in health policy in the future in terms of the competing interests of the working and ruling classes? Certainly the Fraser government acts very differently from previous Liberal-Country party governments, as Tom Uren's comments quoted above emphasize. Fraser himself has seen his government as different from previous Liberal governments and he has developed a philosophy distinctly different from his Liberal predecessors. Whether Liberal governments in the future will follow this mould is a matter for conjecture. However it is true to say that at least whilst the Fraser government remains in office, class interests will be paramount.

CONCLUSION

The changes to Medibank in 1976 provide a clear example of the class struggle operating within Australian society. The restructuring was introduced by the political wing of the ruling class for the benefit of both the medical profession and the corporate class generally. The changes were opposed by members of the working class using their traditional form of opposition: the strike. Despite this and the lack of support from 'the general public', the changes were introduced with resultant undesirable consequences for the health system as a whole.

What are the lessons for reformers? Socialist reformers have come to expect frustration and opposition in trying to implement radical (and even reformist) programs. However, they had not generally expected that reforms would be quickly undone. Although the history of Australian social reform is clearly one of incrementalism[18] that policy may now have to be abandoned.

If the corporate class will not even allow moderate incrementalism, then radical reform will have to be implemented and entrenched and there may be no point in socialists heeding calls to be silent lest they damage the chances of incremental reform.[19]

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