Agenda, Volume 5, Number 2, 1998, pages 201-212

Associations of Health Consumers: The Key to Health Care Reform

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HEALTH care reform in Australia has reached an impasse. The public sector, professional medical bodies, and private health insurers face one another in a glorious stand-off. Medicare retains popular support but is structurally incapable of containing demand for health services or restricting expenditure growth even though its available resources are limited. Private insurers are unable to curb health treatment costs, even as they face declining and ageing enrolments. Doctors' organisations lament the high turnover of general practice, the rise of medical entrepreneurs, and the long waiting lists at public hospitals, but fiercely resist the introduction of contracted arrangements with insurers or alternatives to fee-for-service payments in primary care.

None of these three components of the health system — Medicare, professional bodies, private insurers — can unilaterally generate a solution to the system's complex structural and financial crisis. Neither the medical profession nor the insurers are capable of winning sufficient political support to dismantle Medicare. Only one in three Australians may now be privately insured, but their political influence remains strong enough to preclude the dismantling of private insurance. The professional bodies retain significant political influence, but they can no longer dictate exclusively the shape of the health system: some anti-competitive features of guild self-regulation, once enshrined in legislation, have now yielded to the onset of competition policy.

The key to comprehensive health care reform in Australia now lies with the development of new structural mechanisms which can assign to consumers the capacity and the incentive to contain health costs and to integrate service delivery systems.

This article sets out a case for a health care reform strategy based on associations of health consumers within a framework of managed competition. Associations of consumers would be voluntary entities that purchase on behalf of their members (or enrolled populations) comprehensive, cost-conscious health care packages through contracts with preferred providers; they would aim eventually to integrate financing and service delivery (insurance and provision) in the form of prepaid, budget-capped health care. With freedom of entry and exit, consumers would

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have the option of joining competing associations that offer price and service-quality advantages. Consumer governance in such associations is proposed as the best form of regulation against practices injurious to consumers.

The proposed reform strategy comprises a combination of public policy change and immediate enterprise initiatives that may be undertaken in civil society by voluntary associations or alliances of associations. David Green (1996:98) has called such initiatives 'private action plans', by which he means initiatives that can be undertaken in the present which are not dependent on prior public policy change, but which have the effect of creating conditions which are favourable for, or facilitate, further public policy innovation. In health care reform in Australia, the development of associations of consumers is the *sine qua non* of public policy change: without such associations, reform proposals will continue to lack the capacity to create public confidence that alternative structures can be implemented and will genuinely work in the interests of consumers.

Managed Competition

The strategy incorporates the system of managed competition developed by A. C. Enthoven (1978, 1993).

Its features are the following:

1. Information asymmetries between doctor and patient require the intervention of intermediaries or agents which make available comparative price and service quality data to patients, and enable patients as consumers to purchase (individually or collectively) their preferred services.

2. The purchases facilitated by consumer intermediaries must be fully costed. Costs for episodes of treatment or care must be specified and transparent so that intermediaries may substitute lower-cost for higher-cost purchases.

3. To offer integrated and cost-effective care, consumer intermediaries must be able to package a mix of services and insurance products to meet a variety of consumer preferences.

4. Consumer intermediaries must be able to compete for subscribers or enrollees on the basis of package price and service quality.

5. Consumer intermediaries require a framework of internal and external regulation to limit the impact of adverse selection and moral hazard.

The Rationale of Reform

The value of Enthoven's system of managed competition lies in its use of consumer intermediaries, who (unlike Medicare, private insurers and professional medical

bodies) have both an incentive *and* a capacity to contain health costs and to integrate service delivery.

Medicare provides medical benefits for general-practice consultations but has no structural capacity to integrate primary care (which may be dispersed among a variety of providers) or to curtail overservicing. It provides hospital benefits, but its only means of containing costs is rationing of services (exercised indirectly by state governments). It has no capacity to substitute lower-cost regimes of care for higher-cost regimes.

Private insurers reimburse medical, para-medical and hospital expenses incurred by consumers, but have no means of containing the unit costs of these expenses, and no incentive to coordinate or integrate service delivery. There is no capacity for insurers to identify and manage disease risk before it becomes an episode of illness. The community rating of premiums prevents insurance providers from offering packages to attract new and diverse subscribers. The present regulatory regime for health insurance invites adverse selection.

Medical practitioners are remunerated on a fee-for-service basis for highly compartmentalised interventions. They are not reimbursed or rewarded for collaborating with practitioners across disciplinary boundaries to develop integrated care regimes or to monitor health outcomes. Health information records remain the personal property of practitioners, and are not transferable across disciplines or service-delivery types. Fee-for-service incorporates powerful financial incentives to overservicing, and discourages preventive care

Design Features[1]

1. Health consumers would have the option of joining an association of their choice. Membership would be voluntary, with freedom of entry and exit. Associations may be constituted on the basis of community of interest or geographic region.

2. Associations would not be permitted to reject members on the basis of health status or risk. A registration entity would probably be required to register associations, with authority to impose severe penalties on any association which rejected membership on the basis of age or health status.

3. Members who choose to join an association would have their Medicare contribution paid to the association of their choice. This contribution would receive a risk-rated adjustment, based initially on factors of age and sex, and in subsequent years on additional factors related to health status. The amount received by each association would be a per capita based proportion of total Medicare expenditure for each enrolled member, with a risk-rated adjustment.

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[1] Some of the features identified here have been canvassed by R. B. Scotton (1990, 1991, 1995) in proposals for the introduction of managed competition in Australia. Scotton's work, however, has lacked the associational focus proposed here, and has looked to public policy change as the sole agency for health care reform. It has therefore lacked a transitional strategic orientation.

4. Members would also have their share of Pharmaceutical Benefit Scheme (PBS) expenditure allocated to the association of their choice, using the same formula (a per capita-based proportion of total expenditure, with a risk-rated adjustment).

5. Associations would be free to levy their own membership fees, copayments and/or insurance tables. These must be transparent and publicly available to facilitate consumer choice.

6. Associations would be required to meet the full costs of all public and private hospital services, medical services, and those pharmaceuticals covered by PBS. Para-medical services such as dental, allied health and optical services, domiciliary care services, and pharmaceuticals not covered by PBS would be optional.

7. Associations would be free to contract with providers of hospital, medical, domiciliary and pharmaceutical services on a cost-related basis for episodes of treatment or care. They would also be free to provide such services (or combinations of them) directly without regulatory restriction.

8. Contracted providers of services to associations would be required to enter records of consultations, treatments, health maintenance strategies and drug prescriptions in an information system that is the property of the association. This information system would be transferable across practitioner and service delivery types with the aim of enhancing outcome monitoring, and could be tailored to objectives such as improved pre-admission and post-discharge reviews, reduced infection rates, fewer post-surgical complications, and lower readmission rates. Marketable health-value advantages could be developed around these outcomes.

9. Associations would be free to provide primary-care arrangements directly for members on a pre-paid or non-fee-for-service basis and to devise their own remuneration systems for practitioners. The development of integrated primary care teams comprising general practitioners, nursing and domiciliary care staff would enable associations to reduce or prevent hospitalisation and to substitute low-cost post-acute domiciliary care for high-cost hospital in-patient services. They would make possible the introduction of preventive-care strategies based on epidemiological screenings, risk appraisal and containment, targeted intervention for at-risk members, comprehensive immunisation procedures, case management and harm minimisation interventions.

10. Health consumers who elect not to join an association would have their Medicare entitlements preserved as at present for medical and public hospital services.

A Transitional Strategy

The weakness in many proposals for reform of the Australian health system is the absence of an effective transitional strategy. In particular, the inability to identify

non-state agencies of health care reform to initiate and then complement public policy change consigns many proposals to irrelevance. The following is a suggested transitional strategy involving immediate enterprise initiatives on the part of associations.

1. Existing organisations which have enrolled memberships (voluntary associations, cooperatives, friendly societies, business associations, credit unions, clubs, and churches) would be encouraged to explore ways in which they might act as agents on behalf of their members in purchasing health services or health insurance products. Their initial educative focus would be to introduce their members to the concept of enhanced market purchasing power for consumers of health care through the intervention of consumer intermediaries.

2. Some of these organisations would be existing health insurance providers (friendly societies, employer-sponsored bodies such as the Lysaght Hospital and Medical Club, trade union sponsored entities like the NSW Teachers Health Society, or regionally-based entities such as the Yallourn Medical and Hospital Society). Others would be existing health service providers (hospital cooperatives and associations, friendly society dispensaries, or rural entities such as the Victorian Bush Nursing Association). Others would be member-benefit associations which currently have no health-related function (clubs, credit unions, purchasing cooperatives). Through a process of alliance forming, new entities comprising sizeable aggregates of health consumers could be assembled with significant market purchasing power.

3. Associations would make available to their members comparative price and service-quality data. These data would be used to secure discounted price arrangements on services not listed in the Medicare benefits schedule (dental, allied health, optical, non-PBS pharmacy items, and some home-based care), and arrangements concerning medical services which are listed in the schedule but which are priced in excess of the scheduled fee. Associations would package these arrangements in various formats.

4. Associations would develop information and health record systems which are transferable across practitioner and service delivery types. An association would favour practitioners and providers who voluntarily agree to enter records of consultations, treatments and appointment schedules in its member health record. The record would not be a substitute for practitioner records: it would be a patient-held record issued by the association and would remain the property of the association. It would serve as a *de facto* membership card of the association.

Use of the record by practitioners and provider organisations would form the basis for preferred-provider arrangements. The size of an association's market purchasing power would shape the willingness of practitioners and providers to use the record. With sufficient purchasing power, providers could be required to pay a fee

for participation in the record system, which would be used to finance the development of the system.

5. With an information system transferable across service delivery types, associations could then proceed to develop new service-delivery systems. Even within the current system of payment for medical services, associations could introduce new models of primary care. These could take the form of contracts with, or direct employment of, primary-care teams comprising general practitioners, nursing, allied health and domiciliary-care providers, with coordinated arrangements for after-hours and home-based medical care. Shared arrangements could be introduced between primary-care teams and hospitals concerning pre-admission and post-discharge services, similar to current 'shared care' maternity arrangements between general practitioners and hospitals.

6. Associations which have in place some degree of integration of information and service-delivery systems could introduce billing and payment systems for episodes of treatment or care which are inclusive of various practitioner and service types. These systems may entail a single billing and transaction payment for members, with the association allocating payments to providers for the component parts of an episode of care.

7. Associations of health consumers would be well placed to participate in current publicly funded coordinated care arrangements. In 1996 the Commonwealth Department of Human Services and Health commenced twelve coordinated-care trials which will aim to assemble comprehensive packages of care for people with complex health needs. (The trials are part of a program initiated by the Council of Australian Governments to test alternative service-delivery and funding arrangements which have the potential to prevent or reduce hospitalisation and provide cost-effective substitutes for long durations in institutional settings.) Associations of consumers would be the ideal mechanism for trialling and developing such arrangements for wider application.

8. Associations would also be well placed to tender for a range of existing federal and State government-funded health services (Home and Community Care services, Community Aged Care Packages, maternal and child-health services) where a capacity for coordination of service delivery is favoured.

Public Policy Changes

The aim of these immediate enterprise initiatives is to develop the capacity of associations to win public confidence that alternative structures within the health system can be satisfactorily put in place. Without this confidence, significant public policy change will be unlikely: reform proposals will be too easily subject to political campaigns which play on fear of uncertainty.

The reform strategy proposed here is conceived as an optional participation in alternative structures. The shell of the existing system is retained for those who decline to exercise their option to join an association. Medicare would thus be retained as a system of universal health coverage, though the following seven policy shifts would, as a package, substantially alter the forms of health-care financing and delivery that are possible within it.

1. The Medicare levy and current Medicare entitlements would be retained, but consumers would be permitted to have their Medicare contribution and their share of PBS expenditure (with a risk-rated adjustment) paid directly to the association of their choice. In turn, associations would be required to meet the full costs of all public and private hospital services, medical services, and those pharmaceuticals covered by PBS.

Since the purpose of consumer associations would be to maximise service benefits to their members, it would be self-defeating for associations to be for-profit entities. It is likely that some investor-owned organisations would wish to assume at least some of the functions proposed here for associations in a regime of managed competition, but the potential conflict in a for-profit entity between the interests of investors and the interests of consumers would undermine the possibility of winning the public confidence required for reform. For this reason, it is proposed that only not-for-profit entities would be permitted to register as associations of health consumers eligible to receive Medicare-generated funds. (Investor-owned enterprises would, of course, be free to trade as managed-care enterprises, but would not be eligible to receive Medicare contributions. It might be objected that this exclusion is an unnecessary restriction on competition. The political reality is that the participation of investor-owned organisations in this scheme would render it politically unachieveable.)

2. Private health insurance would be deregulated. Since associations would receive risk-rated Medicare contributions for each enrolled member (a per-capita proportion of total Medicare expenditure adjusted by factors of age and sex), higher-risk members would attract a higher Medicare payment. This would to some extent offset the impact of risk selection within a deregulated health insurance market. Associations adopting insurance tables which discouraged higher-risk members would lose the Medicare payment that follows these members.

Associations which offered insurance would be permitted to introduce behaviour and outcome-related rebates, bonuses and penalties as incentives for members to manage their own health risks. It should be permissible, for instance, for tables to differentiate between smokers and non-smokers. Bonuses and penalties should be permissible related to compliance with health-maintenance strategies involving immunisation, screenings, dietary and exercise patterns, and weight loss. Rebates could be offered to at-risk members who avoid illness or hospitalisation over a number of years.

Insurers which are not associations would also be permitted to offer flexibilities of this kind. They would be free to seek low-risk clients, but they would not be eligible to receive risk-rated Medicare contributions.

3. Public hospitals would be required to develop a pricing regime for in-patient and out-patient services on a full cost-related basis for episodes of treatment or care. Although the market purchasing power of associations may be sufficient to instigate this regime, a legislative requirement to this effect may also be required.

4. All regulatory restrictions on the capacity of associations to contract with or directly employ medical, dental and pharmacy practitioners would be removed. Associations would be permitted to trade freely in the services of these practitioners. Similarly, there would be no restrictions of the capacity of associations to own hospitals, medical or dental practices or pharmacies.

A great deal of regulatory reform is required in this area. Friendly societies are currently not permitted to own hospitals. Pharmacies and dental practices may be owned only by self-employed practitioners (with an exemption for friendly societies). For many years, Victorian legislation prohibited new pharmacies from opening within five kilometres of an existing pharmacy. The Pharmacy Guild of Australia is currently conducting a campaign to have the National Health Act amended so as to restrict the dispensing of PBS prescriptions to those pharmacies which are owned by self-employed pharmacists. A legislative recognition of associations as the coordinating instruments in the health system would provide a catalyst for sweeping away this regulatory morass.

5. All restrictions on the supply of health practitioners would be removed. Professional bodies and specialist colleges have long sought to restrict supply in order to enhance their market power. In the absence of more rational means for containing health costs, governments still seek to restrict demand by rationing the supply of practitioners (limiting opportunities for practitioner training), thereby colluding with the professional bodies against the interests of consumers. The consumers most disadvantaged by these practices are those in rural areas that face severe practitioner and specialist shortages.

6. Associations would assume ownership rights to the health records of their members, and legal liability for their care management. Providers of services to associations would be required to enter records in an information system that is the property of the association. The association would be responsible for managing the care of each of its members, and the association (and not its providers) would assume liability for care management. For consumers who elect not to join an association, the current arrangements concerning ownership and access rights to health records would apply.

Aged Care Reform

Associations of health consumers could also assume responsibility for long-term care (nursing home and hostel accommodation) (Richardson, 1997). Association members over the age of 40 could elect to have a per capita-based proportion of total Commonwealth expenditure on nursing homes paid to their associations. This contribution may or may not be risk-rated. Continuous membership from the age of 40 would oblige associations to provide the full cost of nursing home care; partial or discontinuous membership from the age of 40 would mean provision of part of the cost on a pro-rata basis. Portability would be enshrined, as in the case of long-service leave.

Associations would be free to develop supplementary benefits of their choice, in the form of fees, copayments or insurance tables. They would also be free to determine their own eligibility requirements. Current arrangements would apply for those who choose not to join an association.

The issue of transitional arrangements would require careful consideration, but need not present insurmountable difficulties. It would be possible, for instance, to delay the obligation on associations to provide for long-term care for a period of three years from the commencement of managed competition to allow associations to accumulate the required funds. The Commonwealth would continue with its present arrangements in the interim.

The case for integrating health-care and aged-care provision within the coordinated service delivery and financing systems of consumer associations is compelling. Primary-care delivery systems which manage transitions between home-based and institution-based care should become the focus for consumer choice, because it is these delivery systems that determine cost-effectiveness and service outcomes.

Consumer Governance

A health system based on associations of consumers within a regime of managed competition would be characterised by minimal external regulation but strong internal regulation through consumer governance. Consumer governance is proposed here not as an optional extra, nor as a throwback to once fashionable New Left notions of participatory democracy. It is proposed simply because it is a fundamental requirement for comprehensive health-care reform, for three reasons.

First, providers and politicians in Australia have waged a century-long battle for control of the health system. The outcome of this battle has been a systematic structural separation of financing and delivery, a highly fragmented service system, a de-alignment of supply and demand, and legislative protection for the market power of providers. One observer has described this outcome as the '"East Berlin Circa 1989" model of health care in which providers intimidate patients, terrorise governments, and steal all the money' (Paterson, 1996:40). Structures of consumer governance are essential to bring down this Berlin Wall, and to establish in practice, as well as in principle, a patient-centred health system.

Second, consumer governance is the only governance structure in health care provision that is fully compatible with an 'active agency' model of health maintenance and financing. This model, whereby individuals as consumers are engaged as active agents in modifying their behaviour to manage health risks, is counterposed to the 'casualty' model of health care, in which illness is viewed essentially as an act of God (Goldsmith et al., 1995:15). Active agency implies the facilitation of self-direction in health maintenance and illness prevention, not passivity. It implies a culture of self-help. An association of consumers is a self-help organisation, conferring the status of *member*, not *client*. Facilitating this cultural shift in health care requires a structural mechanism with a matching culture.

Third, if associations of consumers are to be self-help organisations, they must also be self-regulating. Consumer preferences in health care are increasingly diverse, and associations will adopt various philosophies of care. They would be free to determine their own values and organisational direction, within a framework of core provisions. Many would be based on communities of interest, and would employ the community resources, infrastructure and volunteer networks of those communities. Many would seek to integrate the provision of cost-efficient health care with the strengthening of community supports for the ill, the infirm and the isolated. As consumer-governed, self-regulating entities, associations would make their own judgments about which practices enhance good health, and which practices are injurious to good health. They would have low tolerance levels for incompetent or lazy practitioners or poorly performing programs.

Aboriginal health is a case in point. The National Aboriginal Community Controlled Health Organisation (NACCHO) is the peak body of over 100 Aboriginal health services in Australia. It operates in an environment where health outcomes have been, and remain, incidental to the financing and delivery of services. In a regime of managed competition, NACCHO could register as an association of consumers with a clear community of interest, assume control over health-maintenance and illness-prevention strategies, and pursue health outcomes in new and co-ordinated ways.

Case Study: Seattle's Group Health Co-operative

Group Health Co-operative in Seattle is a consumer-governed health maintenance organisation in the United States (Davis & Andrews, 1992). It has 477,778 enrollees and 7,344 staff (FTE), including 1,007 physicians and other medical staff members and 1,533 staff nurses. It contracts with a further 1,950 non-staff medical practitioners (1993 figures). Medical staff form a self-managing group which contracts directly with the cooperative for remuneration for services. The contract determines the size of the medical salary pool which is calculated as a fixed payment per enrollee. The medical group works with its own capitated budget (also a fixed payment per enrollee) within the global budget of the cooperative (which is also drawn from a fixed payment per enrollee). The cooperative has 30 primary-care centres, two hospitals, an in-patient centre, a skilled nursing facility, and five spe-

cialty medical centres. It contracts with 38 other health institutions for selected specialty services.

The cooperative was formed in 1947 as a pre-paid health maintenance organisation. Its initial group of medical staff were drawn from a group practice in Seattle whose members were black-banned by the American Medical Association (AMA) for contracting medical services to industrial plants during World War II. It was not until 1951 that the Washington State Supreme Court ordered the AMA to end its boycott of the contracting medical staff, and permit their re-admittance to membership.

The cooperative is governed by an elected eleven-person board of trustees. All are consumers and all are volunteers. There are 23 local advisory councils that advise the cooperative on various matters: a majority of council members are elected consumers.

As a health maintenance organisation, Group Health (1993:3-4) describes itself as a provider of 'comprehensive, coordinated medical care for a fixed, prepaid fee with minimal copayments'. As a managed care organisation, it describes its purpose as 'the full integration of healthcare delivery and healthcare financing' with five characteristics: 'comprehensive coverage, co-ordinated services, strict performance standards, consumer involvement, and predetermined payment'.

The Australian Experience

Most Australians under the age of 50 know little of the history of friendly societies as consumer-governed associations which contracted with medical providers for per capita-based payments for medical services and established pharmacies which employed salaried pharmacists. Two generations of Australians know little of the establishment and financing of bush and community hospitals by voluntary public subscription.

Between the beginning and middle years of the 20th century, the medical and pharmacy guilds fought a long battle to free themselves from the regulatory regimes placed on them by their patients through the friendly societies. By the late 1940s the battle had been won by the guilds. The crucial blow for the societies was dealt by the Chifley Government's health insurance scheme: the Labor governments of the 1940s believed that a state-run system of insurance was preferable to a system that was voluntary and associational. To install this system, it was necessary to sever connections between the financing of services and the provision of services.

The friendly societies that survived this dual onslaught from guilds and the state have today largely been reduced to insurance houses divorced from the actual provision of health care. There are some important exceptions to this generalisation; but, in the main, the once-important connection in Australia between associational endeavour and health care has been lost for two generations.

Health care reform in Australia will involve a combination of comprehensive public policy change and entrepreneurial enterprise initiatives in a variety of settings. But it will also involve rediscovering a culture a self-help and mutual aid, and em-

bodying its principles in contemporary organisational forms and policy arrangements.

Reform in health care and aged care, now such a mass of dilemmas for governments and insurers, and the subject of deep-seated public anxiety, will depend upon our capacity, and our willingness, to rediscover this culture of self-help and mutual aid.

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