The Health Market Inquiry is a carefully considered analysis, unlike the dodgy NHI workup

The question now is whether patronage will again triumph over the public interest.

The stark contrast between the dodgy workup for the proposed National Health Insurance (NHI) and the detailed, carefully considered analysis that has gone into the Health Market Inquiry (HMI) reflects two different styles of government. The one, overtly dominated by patronage politics and the other, careful, meticulous and clean – and able to combine solid technical research with painstaking consultation and high-quality engagement.

The HMI report represents only the second such inquiry in the world and differs markedly in scope and comprehensiveness from its United Kingdom equivalent.

In a nutshell, the HMI diagnostic argues, with evidence and rational argument, that the market failures of the private health system derive from a failure of the government to install a coherent regulatory framework. That unregulated private health markets fail, while apparently a surprise to the Department of Health, is one of the most well-addressed aspects in the field of health economics, together with the remedies. While remedies plainly vary according to specific features of a national context, the key measures remain the same.

To date, and in the absence of any analysis, the health department has attempted to attack the failings of the private health system as if they are an inevitable outcome of rampant greed, the capitalist system and the commodification of healthcare. While the regulatory framework in place until now has plainly fostered problematic conduct on the part of private actors, just as the patronage system in the public sector has done the same, the question that valid representatives of the public interest had to answer was whether these outcomes are inevitable and unavoidable.

The HMI has provided a responsible and reasoned answer. The private sector reflects significant market failures, which are neither inevitable nor fatal. The failures are however attributable to government failure – as are the failures of the public system.

Whereas the health department has acted with reckless disregard toward the private sector, either through incompetence or a desire to undermine private coverage to create an impetus for NHI, the HMI recommendations seek to stabilise private health coverage as a central pillar of the system of universal coverage together with the public health system. This in no way inhibits the development of a system of general-tax-funded public sector coverage. Instead, it stabilises it at a time when the government is in no position to make or keep expanded coverage promises.

The HMI concludes, importantly, that the policy framework required to address the market failures involves the establishment of a complete, rather than a partial, set of structural reforms. A partial approach, it argues, will retain the market failures. This is important. Any attempt to cherry-pick reforms will not and cannot work.

So, what was the HMI's diagnostic? It effectively determined that the consumer is unable to make any informed choices in the private health system (not unlike users in the public health system). They can't choose a medical scheme without going through conflicted broker

markets. They can't choose health services because they have no knowledge of any services they are buying and have little option but to accept the advice of structurally conflicted doctor markets.

As medical schemes are under no competitive pressure to contract with healthcare providers efficiently, due to conflicted broker markets and substantial market concentration, they fail to innovate. Furthermore, the HMI has noted substantial conflicts of interest, through ownership structures, between medical scheme administrators, healthcare providers, pharmaceutical manufacturing and distribution.

The integrity of the purchaser-provider split has therefore been broken and funders protect providers from the competition instead of establishing arrangements that are in the interests of medical scheme members. The report explicitly notes that Discovery Health (the administrator), in an environment of rising provider costs, makes profits that are "multiples" of their competitors. It also notes that hospital groups make healthy and continued profits regardless of general market conditions. What this indicates is that an industry that should be carrying the risk for service cost and quality is essentially passing it off on to households who are too atomised and disorganised to manage it.

So a massive, hugely profitable industry, embodying substantial technical expertise says (in so many words) "households must manage health system costs and the risk of poor quality care," because they can't. Well, the HMI takes a different position. It says, not only that they can carry the risk, but they *must* do so. For both the cost and quality of healthcare. But for this to happen, various structural reforms are required to reshape the distribution of risk so that it is carried at the correct levels of the system. This is achieved through measures designed to adjust the power relationship between users of the health system and the various private sector intermediaries.

First, market transparency is enhanced so that consumers can make realistic choices in real-time through simplifying the product offerings (in the case of medical schemes) and public reporting on performance in the case of health services. The simplification of medical scheme product offerings involves two key measures: a standardised easy-to-understand basic benefit which all schemes must offer; and a risk-adjustment mechanism (RAM) that equalises the demographic risk of all schemes.

The RAM pools risks at an industry level and ensures that price competition on the benefit package is based exclusively on differences in the cost and quality of care provided. Transparency of provider performance addresses the requirement for competition on quality of care. Furthermore, the opt-in broker framework ensures that brokers serve medical scheme members and not medical scheme administrators.

Second, to the extent that parts of the private health market retain fee-for-service, or near fee-for-service arrangements, all prices and related features of a price will be subject to a multilateral negotiation framework. Negotiations that incorporate the cost and quality of care negotiated on a bilateral basis would however not be regulated. This overall approach has been mooted in the past, but scuppered through vested-interest lobbies targeting the health ministry. While certain health ministers sought to publicly berate the private health industry for the unsustainable cost increases, behind the scenes they pulled back reforms that would address them.

Third, the regulatory framework required to ensure market transparency and effective competition would need additional strings in the bow compared to the paltry system we have now. The additional regulatory functions include the management of product transparency, provider conflicts of interest, price regulation (only) where fee-for-service markets are maintained, medical schemes governance, provider licensing and reporting and the elimination of conflicted regulators.

A fairly quiet, but clearly important part of the HMI recommendations is for the removal of political appointments into regulators. For those in the private health industry, the perverse regulatory outcomes of patronage appointments into regulators is well-known. The question here is, of course, whether the private interests of the ruling party will be given preference over the public interest.

Overall, therefore, the HMI represents an example of good government and good policy. The question now, is whether patronage will again triumph over the public interest. In many ways, the existence of this report is a sign of a change. I certainly hope it is. **DM**4