

Sticky or Stuck: the role of policy networks in constraining change to Australia's healthcare financing system

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Declaration of originality

I, Jodette Kotz, hereby declare that the thesis presented here is the outcome of the research I have undertaken during my candidacy, that I am the sole author unless otherwise indicated, and that I have fully documented the source of ideas, references, quotations or paraphrases attributable to other authors.

25 November 2023.

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Abstract

In Australia, there has been a considerable change in the burden of disease with a reduction in morbidity and mortality from infectious diseases and an increase in chronic conditions, placing increasing pressure on the healthcare system. Chronic conditions generally require coordinated treatment by a team of health professionals due to their complex causality and comorbid complications. The structure of the financial system in Australia, however, does not support coordinated care. This is a significant issue for the sustainability of the system and for improving patient care.

Previous research in Australia has found that the mix of incentives determining who can pay for services and how - known as the 'payment and access rules' - creates a barrier to the integration of care needed to treat chronic conditions. While there have been numerous attempts at reforming the payment and access rules in Australia, none have succeeded. Thus, it is crucial to improve understanding of where the barriers and blockages lie to improve efficiencies and care coordination.

While much is known about the design of the system, and its flaws, there is little empirical evidence available to understand how we got here and the interests at play in shaping Australia's healthcare financing system. Furthermore, while the literature on healthcare policymaking points to the importance of understanding policy networks, power and legitimacy, these approaches have not been applied to this area.

This research aims to improve understanding of the role that collectives of organisations (actor networks) have played in constraining change in Australia's healthcare financing policy over time and identify lessons for how these barriers may be overcome. In doing so, it develops a conceptual theoretical framework drawing on network, resource and path dependency theories to interrogate the role of the actor network: its interests, use of power, legitimacy and resources in key attempts where private health insurers have duelled with medical practitioners to reform (or constrain reform) of Australia's payment and access rules.

This research aim was achieved by employing a mixed methods design with a case study approach, focusing on three case studies in Australia where reform of the payment and access rules was considered by the parliament.

This dissertation advances our understanding of how actors within Australia's health policy network have progressed their strategic interests using resources, power, legitimacy, and influence to constrain changes to the payment and access rules. It also uncovers the inner operations and

strategic interests of the key players in Australia's health policy network and how these have changed over time. It shows how actors have set norms for debating health policy by slowly constricting reformers' ambitions during each policy event. Moreover, it demonstrates the role of actor networks in cementing Australia's healthcare financing policy, showing the coalescing of network resources to build legitimacy for constraining change. Finally, it concludes that consumers have not had a strong voice in the policy process for several decades and better consumer outcomes may result if there was a strong and independent consumer group participating in health financing policy development.

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Abbreviations

AMA	Australian Medical Association
Actors / Nodes	An organization or entity that engaged in the policy event.
Benefit/s	The amount paid from the insurer for a specific service
BHC	Broader Health Cover
CDM	Chronic disease management
CDMP	Chronic disease management plan
CPI	Consumer Price Index -
Department of Health	Federal Department of Health and all former names of the department, Department of Health and Family Services, Department of Health and Ageing, Department of Health.
Government	Federal or Australian Government
GP	General practitioner
HIRMAA	Health Insurance Restricted Members Association Australia
Insurers	Healthcare Funds or Private Health Insurers that operate to provide benefits under the Private Health Insurance (Prudential Supervision) Act 2015.
MBS	Medicare Benefits Schedule
Medibank	Medibank Private
Medical Practitioner	Registered medical practitioners, colloquially referred to as 'Doctors', can use the protected title of medical practitioner. This includes operating as a general practitioner, specialist or other similar activities. In this research, doctors and medical practitioners are used interchangeably.
Members	Persons holding private healthcare insurance
Mixed model	Mixed model of public and private insurance that operates in Australia
Minister for Health	Federal Minister for Health or the Health portfolio.
Lock-down or lock-in	Lock-down effects described in path dependency. Sometimes referred to in the literature as lock-in.
OECD	Organisation for Economic Co-operation and Development
Patients	Persons utilising the health system
PBS	Pharmaceutical Benefits Scheme

PHI	Private Health Insurance
Regulations, rules and laws.	Any law whether it be an Act of Parliament or a secondary instrument that regulated the payment and access rules.
VHI Association	Voluntary Health Insurance Association, changed its name to the Australian Health Insurance Association and then to Private Healthcare Australia Referred to as the Australian Health Insurance Association throughout the thesis.

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1 Introduction

This dissertation focuses on the challenge of maintaining a sustainable and viable healthcare financing system in Australia, which arises from tensions within a mixed model of insurance and the rules determining who can pay for services and how (known as the 'payment and access rules'). More specifically, the study explores the role of actors and their networks in influencing the institution of Australia's payment and access rules over time, with a focus on the structure of the policy actor network and the resources, power and legitimacy of organisations that have constrained attempts at reforming these rules. The research aim was to improve understanding of the role that collectives of organisations (actor networks) have played in constraining change in Australia's healthcare financing policy and to identify lessons for how these barriers may be overcome.

In Australia, there has been a considerable change in the burden of disease with a reduction in morbidity and mortality from infectious diseases and an increase in chronic conditions (Australian Bureau of Statistics, 2022). A chronic condition has been defined by the Australian Government as an 'illness that is prolonged in duration, does not often resolve spontaneously and is rarely cured completely' (Australian Institute of Health and Welfare, 2012, p. 2). As the population ages, a larger proportion of people are seeking services for chronic conditions (Australian Institute of Health and Welfare, 2022).

The changing patterns of disease are placing increased demands upon the Australian healthcare system (Dennis, et al., 2008). Policymakers and researchers promote coordinated care by teams of health practitioners in healthcare settings as a more efficient arrangement to manage chronic conditions both in Australia and overseas, as the nature of chronic conditions is that they generally need coordinated care by more than one medical practitioner due to complex causality, lengthy illness and possible comorbid complications (Goodwin & Smith, 2011; Ramsay, et al., 2009; Velasco-Garrido et al., 2003). However, these teams and outputs can be costly, and with staffing costs contributing to almost 70 per cent of health expenditure, they must be incentivised to function as effectively as possible (Anand & Barnighausen, 2012, p. 187; Velasco-Garrido, et al., 2003).

Previous research in Australia has found that the mix of incentives from the payment and access rules effectively creates a barrier to the integration of care needed to effectively manage chronic conditions (Productivity Commission, 2015; 2017). The payment and access rules currently pay medical practitioners per service delivered (known as a fee-for-service model). Fee-for-service models incentivise medical practitioners' quantity of care rather than quality (Dennis et al., 2008; Doggett, 2015; Paolucci & Garcia-Goni, 2015). A change to allow direct contracting would allow for

payments for quality and care to be provided as part of a coordinated team by insurers. Changing the payment rules would address one of the barriers to increasing the effectiveness of care by incentivising the coordination of services from separate levels of the system (e.g. primary care, acute care and post-acute care) (Amelung et al., 2017; World Health Organisation, 2016).

There have been numerous attempts at reforming the payment and access rules in Australia; however, none have succeeded. A recent example is from 2013 when Medibank Private, the largest private health insurer in Australia, initiated a pilot program to improve its members' access to general practice services (Duckett, 2015). This was the first time that a private health insurer in Australia had directly contracted general practitioners, which are usually paid by the individual. In this pilot, Medibank Private contracted the Independent Practitioner Network (IPN) Medical Centres Pty Ltd, a large corporate provider operating a network of general practices, to provide services for their members, guaranteeing access to general practitioners, no out-of-pocket fees, and improved coordination of care for people with chronic conditions (Medibank Private, 2014).

Reactions to the pilot program within the community were mixed. The then federal government supported the pilot because they wanted insurers to provide preventative care for their members. Medical practitioner groups, however, strongly opposed it, claiming it was akin to the managed care systems used in the United States and would reduce their clinical and billing autonomy (Harrison, 2015). This attempt to change the payment model to allow private health insurers to contract medical practice services ceased in July 2015, leaving the system unchanged.

This was the last attempt by an Australian insurer to alter the purchasing of general practice services, and the result is that Australians with chronic conditions continue to receive their healthcare in an uncoordinated manner, and expenditure on healthcare is increasing above what is necessary (Duckett, 2015; Paolucci & Garcia-Goni, 2015; Productivity Commission, 2017). Both the government and insurers have made many attempts to reform the payment and access rules over the years, starting with very ambitious reforms and reducing to much smaller modifications still with limited success. As a result, the operation of the payment and access rules has effectively remained the same. Other countries have been able to reform their payment models to move away from a pure fee-for-service payment for medical providers; however, moving away from a fee-for-service payment model to another model has proved impossible in Australia (Productivity Commission, 2017; Wise, et al., 2021).

Why the Medibank Private pilot ceased and why previous efforts to reform the operation of the payment and access rules in Australia have failed are key questions that are largely unanswered, creating a gap in the literature. In order to identify where the barriers and blockages lie in improving

efficiencies and care coordination, we need to understand how we got here and what interests are preventing reform. This requires an understanding of what role the actor network has played in Australia during unsuccessful attempts to change the operation of the payment and access rules (Kotz, 2021).

Previous studies examining the role of networks in healthcare policy development in Australia have primarily focused on determinants of health, political influence and service delivery (Lewis, 2006; Baum, et al., 2013; Cullerton, et al., 2016; Steihaug, et al., 2016). However, none have considered the role the network of actors has played in influencing outcomes in Australia's health financing policy. A greater understanding of the role actors' play in preventing changes to the operation of the payment and access rules can inform the development of successful implementation plans to redesign the healthcare system that would support coordinated care for people with chronic conditions and be more efficient.

In this thesis, actors are understood as the range of organisations that are constantly competing to influence healthcare financing policy in Australia, including the private hospital sector, specialty practitioner and disease groups, medical service provider groups, private health insurers and consumer bodies, and the individuals that represent them (Alford, 1975). These entities, which have different ways of operating and differing strategic goals, seek to influence health financing policy and the healthcare system for Australians through various advocacy strategies.

The thesis interrogates three case studies that capture key attempts over time by private health insurers to reform the payment and access rules to enable insurers to pay medical practitioners by directly contracting them for services rather than using the fee-for-service payment model (Jan, 2015; Paolucci & Garcia-Goni, 2015). I examine how the policy network surrounding the provision of healthcare in this unique environment has operated over time to reduce and curtail the ambition of reformers, influence public policy outcomes, and ultimately contribute to a failure to change how the payment and access rules operate.

To set the context, this chapter outlines the environmental factors driving the need for change in the Australian healthcare system (section 1.1). The impact of the current payment and access rules upon Australian insurers and patient care is detailed in section 1.2, followed by a discussion on the impact of the failure to reform the payment and access rules upon the private health insurance sector in particular. The aim and contribution to research are outlined in section 1.4; the theoretical approach is outlined in section 1.5, followed by my positionality (1.6). A summary of the remaining chapters is provided at the conclusion of the chapter.

1.1 What is the problem? Why should we care?

Australia's healthcare system is arguably high-performing by international standards. In 2017, the Commonwealth Fund comparison of health systems ranked Australia second overall, behind only the United Kingdom (Schneider, et al., 2017). Average Australian life expectancy is one of the highest in the world (OECD, 2017), and mortality from heart disease (the leading cause of death) has decreased (Australian Bureau of Statistics, 2022). However, Australia's healthcare system is facing significant problems. While mortality rates are declining, there has been a significant rise in the prevalence of chronic conditions. Chronic conditions are Australia's leading cause of poor health and death (Australian Institute of Health and Welfare, 2022). In 2014–15, more than 11 million Australians, or around half the population, had at least one chronic condition and over 25 per cent had two or more (Australian Institute of Health and Welfare, 2016).

The prevalence of chronic conditions is increasing and is placing greater demands upon healthcare systems globally, creating an imperative for funders (public and private insurers) to find ways to manage expenditure as efficiently as possible (Dennis, et al., 2008, p. S53). Healthcare as a proportion of gross domestic product increased in all except three OECD countries between 2008–2018 (Organisation for Economic Co-operation and Development, 2018).

Like other healthcare systems around the world, Australia is experiencing continued growth in healthcare use (Smith & Walshe, 2016). Demand for health services has increased, and between 2014–15 and 2018–19, hospitalisations increased by 3.3 per cent per year (averaged), faster than the population growth over the same period (Australian Institute of Health and Welfare, 2022). This increased usage, combined with greater demands for improved technology and an ageing population, has led to an average yearly health expenditure growth rate by all sources of 3.4 per cent in the ten years to 2020–21 (Australian Institute of Health and Welfare, 2021).

A large part of the literature on improving the efficiency of the health system focuses on improving coordination to manage the impacts of the changed patterns of disease from episodic to chronic conditions (Biggs, 2013; Dennis, et al., 2008, p. s53; Lake & Staiger, 2010, p. 62; Wranik, 2012). The OECD and health system scholars have found that the structure and provision of healthcare services can be aligned to promote greater coordination for people with chronic conditions (OECD, 2015; Stoelwinder, 2014). Many potential structures for organising healthcare systems to manage chronic conditions better have been analysed; see Koch et al. (2017), Russell et al. (2009), and Wise et al., (2021) as examples. The methods used to purchase care can either promote coordinated, patient-centred care for patients with chronic conditions or provide another barrier (Glasby, et al., 2006; Walshe, et al., 2016).

The issues inherent in the structure of the Australian system include:

- Duplication and waste because multiple levels of government have a role in funding healthcare;
- Cost-shifting between levels of government;
- Funding arrangements that prioritise treating illness instead of preventing it;
- A lack of financial incentives to deliver safe and high-quality healthcare; and,
- Inadequate continuity of care when several healthcare providers are involved (House of Representatives Standing Committee on Health and Ageing, 2006).

The structural inefficiencies of the current payment model contribute to the fragmented care experienced by people with chronic conditions and the long-term escalation in costs in the health system (Fitzgerald, 2015; Jan, 2015; Productivity Commission, 2015; Sivey, 2015). Under the current policy settings, private health insurers and governments cannot influence medical practitioner behaviour to encourage the coordinated care that people with chronic conditions need. This fragmentation presents a barrier to achieving economies of scale, more efficient care, reduced duplication of services, greater coordination of services, reduced administration overheads, and increased market influences (Walston, et al., 1996, p. 83). These rules also prevent the containment of downstream costs for the insurer. Insurer's outlays under the current payment and access rules are driven by the behaviour of third parties (health professionals), where there are no incentives to prevent unwarranted spending.

1.2 Impact of the current payment and access rules on private health insurance

1.2.1 Sustainability of the private health insurance industry

Premiums for private health insurance in Australia have increased commensurately to fund the ever-increasing benefit outlays. Insurance is purchased by individuals in Australia (Australian Institute of Health and Welfare, 2017; Private Healthcare Australia, 2016), and it has been argued that it is becoming increasingly unaffordable, with premiums increasing beyond CPI and wage inflation every year for the past decade (Australian Competition and Consumer Commission, 2014; Private Healthcare Australia, 2016; Silvester, et al., 2018). The increase in private health insurance expenditure also finds its way back to the federal government through its subsidy of insurance premiums and contributions to medical services. The combination of sharply increasing premiums and increasing out-of-pocket costs has also become a political problem, with two separate parliamentary inquiries in the last decade and multiple government reviews into ways to increase the value of private health insurance.

The escalating premiums and out-of-pocket costs are creating what is known as a ‘death spiral’ in the insurance sector. A death spiral is when people adversely select out of insurance schemes, leaving an ever more expensive group of members. Compounding the adverse selection problem is that the population who are forgoing insurance or purchasing cheaper products are the younger and healthier policyholders (Keane, 2020). Over the decade to September 2019, the proportion of people aged 65 and older (e.g. more likely to utilise benefits) who held a private health insurance policy increased by almost 60 per cent (Duckett, et al., 2019). All other age groups grew by 10 per cent or less. The number of people aged 20–39 with private insurance dropped from 2015 to 2019 (Duckett, et al., 2019). The number of policies that exclude some services increased from 7 per cent in June 2007 to 40 per cent in December 2017, and in 2018, more than 80 per cent of policies required a co-payment for treatment (Australian Prudential Regulation Authority, 2018).

Adverse selection is common in insurance markets, where people who perceive their risk as low are less likely to purchase insurance than someone who believes themselves to be high-risk (Nguyen & Worthington, 2021). Without intervention, only high-risk (or extremely risk-averse) people will pay for insurance and pool their risks, and those who believe they are low-risk will not (Donato & Onur, 2018). The trend of declining membership has continued reducing insurer income since the 1990s, but rather than allow direct contracting, government policy has focused on ‘propping up’ insurers through a set of ‘carrots and sticks’ (including tax penalties and premium rebates to encourage people to take out hospital cover (Paolucci & Garcia-Goni, 2015). A considerable amount of the literature on private health insurance in Australia, therefore, focuses on the impact of the ever-changing ‘carrots and sticks’ to make private health insurers more viable.

Under the current policy settings, insurers are unable to control outlays driven by the behaviour of medical practitioners, and there are few incentives to prevent unwarranted spending (Deloitte Access Economics, 2012). Medical practitioners determine the care a person needs and can bill according to their desired income, irrespective of the cost to insurers (Evans, 1995). In addition, there are few levers to effectively incentivise primary care providers to choose a treatment pathway that coordinates care (Colombo & Tapay, 2003; Donato & Onur, 2018; Kotz, 2021). This barrier to incentivising primary care prevents insurers from developing plans for patients who require coordinated services from the health and social system or different levels of specialisation (Medibank Private, 2015; Mollica & Gillespie, 2003; Song, 2014). Fragmentation presents a barrier to achieving economies of scale, more efficient care, or reducing the duplication of services (Walston, et al., 1996, p. 83; Viscusi, et al., 2005).

To improve viability, insurers need to improve patient outcomes, the system's efficiency, and the product's perceived value. It is, therefore, vital to address the key factors that drive ever-increasing expenditure: the payment (fee-for-service) model and medical practitioner autonomy.

Excessive spending and structural inefficiencies are reducing the sector's viability (Deloitte Access Economics, 2012). In order to produce a more viable and valued product, private health insurers need to incentivise more efficient care. Failure to change the payment model retains a suite of incentives that discourages the coordination of care and an inefficient system. There have been a considerable number of reviews, proposals, and research into the barriers to coordination for patients and the need to make patient care more efficient for private health insurers see, for example, Fitzgerald (2015), Ginanne (2007), House of Representatives Standing Committee on Health and Ageing (2006), and the Productivity Commission and Melbourne Institute of Applied Economic and Social Research (2002). Despite the evidence favouring creating policy parameters to incentivise coordinated care through direct contracting of medical practitioners, there has been no change in the operation of the payment and access rules in Australia since they were established in 1984.

1.3 Failure to reform the payment and access rules

In Australia, governments are the major source of funds for healthcare; however, they lack the power to regulate the delivery of healthcare services and must instead influence medical providers to coordinate care through their purchasing role (Productivity Commission, 2014; p. 11.4; *The General Practitioners Society in Australia v Commonwealth*, 1980). Policy changes to increase coordination in Australia have proved difficult, and past initiatives, including Chronic Disease Management Plans, Health Care Homes and Medicare Locals¹, have not delivered the behavioural changes from medical practitioners required to provide consumers with more coordinated care (Department of Health, 2019; Horvath, 2011; Professional Services Review, 2006; Russell, 2018). The federal government policy changes have been politely described as 'pragmatic incrementalism,' seeking to improve the system within its current settings rather than implementing a whole-scale reform of the funding and structural arrangements. Thus, the barriers to coordination remain (Productivity Commission, 2017).

The difficulties in securing successful reforms in healthcare systems are well known. Around the world, there is a long history of reform failure in healthcare systems (Centre for Health Economics Research and Evaluation, 2007, p.2). The likelihood of systems remaining stuck, with no whole-scale

¹ The Australian Government established a program of 61 Medicare Local organisations to improve coordination and integration of primary health care in local communities and make it easier for patients to navigate their local health care system in 2011. This program was placed under review in December 2013 and replaced by 31 Primary Health Networks in 2015.

reform post legislative change, was also noted by researchers (see, for example, case studies in the USA, UK, the Netherlands and New Zealand (Centre for Health Economics Research and Evaluation, 2007; Quandango, 2004)).

In the absence of successful government-led systemic reforms, private health insurers have attempted to change the way they pay medical providers in Australia (Productivity Commission, 2017). However, these attempts have been piecemeal and have not led to greater efficiency or coordination across the system (Department of Health and Ageing, 2011; Biggs, 2015).

Thus, Australia appears to be stuck with payment and access rules established when diseases were generally infectious and intermittent. It is a system that is ineffective for the management of chronic conditions as it purchases episodic rather than holistic care from individual providers rather than a team. Different models to organise care services have been proposed; however, it has proved impossible to choose a new model that may improve efficiency in the system and the provision of care.

While much is known about the challenges for Australia's healthcare financing system, less is known about why attempts at reform have continued to fail. This is a gap in the literature that this thesis seeks to address. Recently, the George Institute for Global Health stated that vested interests had played a part in creating barriers to reform and that 'a redesign of the way in which we pay doctors and other health providers may well look good on paper but is doomed to go nowhere without a workable plan for implementation that has strong support from key stakeholders,' (Jan, 2015) but did not expand on the interests at play. This research explores the role of networks in preventing change to the payment models that would allow direct contracting and examines the impact this has had on the potential for future change.

1.4 The aim and contribution of the research

In aiming to understand better the barriers to changing Australia's health financing policy, this research intends to answer the following questions:

1. What role have collectives of organisations (actor networks) played in enabling or constraining policy change in Australia's healthcare financing policy?
2. Is there a relationship between any change in the structure of the actor network (i.e. who has power and what relationships exist between actors) and success in attempts to alter the operation of the payment and access rules that set how insurers can pay medical providers?

3. What does this tell us about the role of private health insurance in health financing in Australia?

It is important to note that this research does not investigate how the integration of funding between medical providers and private health insurance should occur, which is a larger topic. Rather, the research focuses on understanding the role of actor networks in influencing Australia's healthcare financing policy over time through an examination of three key case studies of major attempts to change the operation of the payment and access rules.

1.4.1 Research scope

This research examines the interests of actors and their role in a network in reducing the ambition of reformers and constraining change to the institution that is the operation of the payment and access rules. The payment and access rules are major public policy, constituting important rules of the political game, manipulating the allocation of economic and political resources, altering the potential resources in the political strategies actors can employ, and, through this, impacting upon the ensuing policy development (Kay, 2005; Pierson, 1993).

There have been a large number of proposals requesting changes to the payment and access rules to allow greater integration of the healthcare system. Therefore, to understand the strength of the institution the actors are attempting to manipulate, only significant policy events, where alternatives are offered and would bind actors (as defined by Knoke & Laumann (1983)) by allowing for direct contracting, were analysed. Since the payment and access rules that prohibit insurers from directly contracting general practice commenced at the time of the introduction of Medicare, the universal healthcare system, the period from which case studies are drawn is 1984 through to the commencement of this research in 2017 (33 years). Given that policy is contained in legislation, the policy event must include a proposal to amend the relevant act considered by the parliament of the time as 'significant'. Three such policy events have occurred since the introduction of Medicare. They form the case studies for this research and aid in making sense of how actors within Australia's health policy network advance their strategic interests using resources, power, legitimacy, and influence to constrain changes to the operation of the payment and access rules in the health system.

1.4.1.1 Case 1: Hospital and Provider Contracting - 1995

This attempt was a proposal allowing insurers to directly contract with medical providers and hospitals, setting fees and changing payment models. This case commenced in late 1993 when a package was put to parliament that included the capacity for insurers to contract with providers and introduce a single billing system with known costs. Insurers were supportive, medical providers

vigorously opposed it, and the bill was sent for further federal parliamentary scrutiny via a committee process.

Despite considerable evidence being provided during the committee's inquiry into the bill, the bill's passage through the Senate was very prolonged. The proposed legislation was widely debated over four sitting days in the Senate Chamber. Single billing was dropped altogether before the legislation passed parliament.

Whilst the resulting legislation provided for private health insurers to contract with medical providers, very few contracts were signed in the initial period after the reforms, and provider contracting ceased.

1.4.1.2 Case 2: Broader Health Cover - 2007

Under this proposal, the then federal government envisaged changing the payment and access rules to allow health insurers to cover general practice services, hospital substitute services, chronic disease management programs, and health and wellness programs. In particular, private health insurers would be able to integrate care through contracts with teams of providers for patients with chronic conditions. This broadened the role of insurers, allowing them to cover treatments outside the hospital system for the first time.

The bill to legislate these changes was also sent to a parliamentary committee for further scrutiny on its introduction into parliament. The bill passed through parliament, and most of the commentary from the committee occurred after its passage.

Providers were concerned that chronic disease management programs were a move into managed care and sought assurances that this was not the case. Consumers were more concerned about the changes to allow coverage for 'hospital substitute services' than chronic conditions, and insurers supported the proposals.

The result was a very slow uptake of chronic disease management programs, although the use of chronic disease management programs has grown in recent years. Insurers can support a plan for a patient but cannot fund service provisions directly or link plan activities with other general practice activities in primary care, severely limiting the degree to which insurers can incentivise coordination between medical providers and other health providers.

1.4.1.3 Case 3: Medibank Private GP Access Program - 2013

In November 2013, Medibank, Australia's largest health insurer, commenced a pilot model of healthcare provision by contributing to the payment for general practice services. Effectively, the insurance function and general practice healthcare services were provided by the same organisation

through the insurer's administrative funds rather than member premiums (as these cannot be used for primary care treatment).

Medical practitioners challenged the legitimacy of this model and sought support through parliament. In March 2014, former general practitioner and member of the Greens, Senator Di Natale, introduced a bill to outlaw the practice, creating greater barriers to the pilot's objectives. This was referred to a parliamentary committee for further scrutiny, and the bill was rejected by parliament.

Despite being supported by the then government, the pilot suddenly ended. In a discreet announcement on 22 May 2015, the nation's largest health fund stated that it had 'redefined its involvement in primary care' and would cease its GP Access program trial on 31 July (Rollings, 2015, p. 2).

1.4.2 Contribution to knowledge

Much has been written from a theoretical perspective about the value of changing the payment and access rules in Australia (Wise, et al., 2021; Dennis, et al., 2008; Schoen, et al., 2007), although comparatively little has been written about the role and interests of actors and their networks in enabling or constraining changes to the payment and access rules. Internationally, public policy network research has focused on health financing at a macro level, emphasising the creation or blockage of universal health coverage (Fouda & Paolucci, 2017; Rizvi, et al., 2020).

To the author's knowledge, this is the first study of the role of actor networks in influencing healthcare financing policy in Australia. This research advances our understanding of how actors within Australia's health policy network advance their strategic interests using resources, power, legitimacy, and influence to constrain changes to the operation of the payment and access rules. It also uncovers the inner operations and strategic interests of the key players in Australia's health policy network and how these have changed over time. Moreover, it shows how actors have set norms for debating health policy by slowly constricting reformers' ambitions during each policy event. The thesis finds that consumers have not had a voice in the policy process for several decades.

The research demonstrates the novel application of network theory with resource dependency theory to reveal how the operations of the networks and actors influence Australia's health financing policy. It shows the role of actor networks in reinforcing path dependency in Australia's healthcare financing policy, showing the coalescing of network resources to build legitimacy for constraining change. Revealing how the actors use mechanisms that contribute to path-dependent policy outcomes will provide policymakers, advocates or consumers who may seek to change the operation

of the payment and access rules with evidence to develop reform plans that have greater potential for success.

As far as the author knows, network approaches have not previously been applied to study healthcare financing policy rules in Australia, and this research will bring to light how network theory can be used to analyse how the structure of the network, the use of resources by actors, and power relations between actors, contribute to the current financing policy in Australia. This knowledge will allow groups who wish to effect reforms to develop strategies or methods of influence that are better placed to achieve integrated care. The findings regarding the operation of the network could be extrapolated to other public health issues, both in Australia and other countries with similar political systems.

1.5 Theoretical framework

The examination of how actors in policy networks have limited prospects of reform in Australia's healthcare financing policy over time is investigated through a theoretical framework combining network, resource dependency and path dependency theories (discussed in chapter three).

First, network theory is used to identify patterns of relationships, such as hubs, cliques, or brokers, and link those relations with the resilience of the operation of the payment and access rules.

Network theory identifies resource usage and the mentalities of actors and combines this with their use of power, legitimacy and strategies as they coerce and influence decision-makers to obtain their goals. Network theory allows for an in-depth understanding of how a network and the interactions of actors within it have influenced policy outcomes (explained in more detail in chapter three). Network analysis methods examine how the policy network operated in each case to influence healthcare finance policy outcomes and its role in enabling or constraining changes to the operation of the payment and access rules in Australia (Berry, et al., 2004; Rhodes, 2006).

Resource dependency theory (RDT) is utilised as a complementary theory (Taylor, et al., 2018) to capture the role of power and agency. RDT assumes that organisational choice is constrained by multiple external pressures (Klien & Periera, 2016). It provides a framework to bring in the environmental context when analysing the 'mindful deviation' of actors. Within this theory, organisations are not self-supporting nor self-contained, and the environment must be drawn upon to provide support (Davis & Adam Cobb, 2010). In a political arena, actors can draw upon other actors in diverse fields to bolster their advocacy positions and achieve their strategic aims through networks (Hall & Taylor, 1996). In exchange for the ongoing provision of what the organisation needs, an outside group or organisation may require particular activities in return (Pfeffer & Salancik, 1978). RDT theory also notes that organisations prioritise building legitimacy and approval via external

stakeholders (Callen, et al., 2010). Combining RDT and network theory allows for exploring the relationship between the network of actors and their environment.

Finally, path dependency theory was included in the theoretical conceptual framework due to its relevance in analysing and explaining the persistence of public policies in the face of intentional reform (Kotz, 2021; Torfing, 2009). Path dependency proposes that once a policy position has been taken and the industry has adapted (become as efficient as it can), it is increasingly likely that it will take further steps in that same direction – demonstrating increasing returns (Pierson, 2000; Mahoney, 2001; Pierson, 2004; Aberg, 2015). The main point of increasing returns is that ‘the relative benefits of the current activity compared with other possible options increases over time’ (Pierson, 2000, p. 252). In political rather than economic life, the question of what is an ‘efficient’ way of operating for an industry can become grey as distributional issues come into play. The question can shift from whether a policy is efficient to focus on for whom it is efficient or beneficial (Bennett & Elman, 2006). Feedback or benefits, in whatever form, come from the environment. These may include increased profits solidifying a company decision or increased power and legitimacy, these being concepts also found in RDT (Arthur, 1994).

This theoretical framework allows for an examination of the role of actor networks in resisting or seeking to reform the operation of the payment and access rules over time. These theories are explained in further detail in chapter three.

1.6 Positionality

This research began with an interest in changing the structure of the financing system for healthcare in Australia. For over two decades as a senior government official and later as a lobbyist, I have been advising governments on financing systems, advocating for a more efficient health system that can integrate and improve care. My role as a lobbyist showed me the impact that actors in the network can have on healthcare policy at many levels. In a previous role as CEO of Parkinson’s Australia, a national charity representing Australians with Parkinson’s disease, I witnessed the impact of fragmented service provision on those who needed coordinated care. I wanted to use this research to bring to the fore all of the varied opinions, thoughts, and ideas from the most senior influencers in this policy space to enable the development of new strategies for approaching reforms that can coordinate care and improve the lives of Australians.

1.7 Thesis chapters

This thesis is divided into ten chapters. The first has provided a road map for the reader to follow, setting the context, research questions, scope and relevance. The second chapter provides a more

detailed discussion of the Australian healthcare financing system. The third and fourth chapters outline the theoretical and methodological approaches adopted in this research, respectively.

The subsequent segment contains three chapters that present the results of each of the case studies examined in this research. They present the empirical evidence and interrogate the role of the network in the policy event, dissecting structure, power, resource usage, impact upon the health system and reduction in ambition for future changes.

Chapter eight analyses how the actor network formed a pattern of operating over time across the three cases and dissects the role of the network of actors and the use of power in limiting the prospect of system reform. Chapter nine draws together the empirical analysis, presents the contribution to knowledge, and outlines ideas for future research. Chapter ten provides a short conclusion.

Chapter 1. Introduction

Chapter 2. Australia's healthcare financing system

Chapter 3. Theoretical framework: Policy networks and power

Chapter 4. Methodology

Chapter 5. Case study one: Medical practitioner contracting - 1995

Chapter 6. Case study two: Broader Health Cover - 2007

Chapter 7. Case study three: Medibank Private's GP Access program - 2013

Chapter 8. How the network shaped policy

Chapter 9. Stickiness and stuck

Chapter 10. Conclusion

2 Australia's healthcare financing system

This chapter explains the operation of Australia's unique mixed model healthcare financing and outlines the impact of this model on the healthcare system. It commences with a short overview of the unusual characteristics of healthcare markets (section 2.1) and then explores the unique mixed model funding of the Australian system, with an overview followed by a short history to situate the system (2.2.1). It then demonstrates the impact of the current policy framework upon private health insurance in Australia (2.2.2). A more detailed explanation of the benefits of integration and coordination of healthcare follows, drawing on international examples (2.3), before a discussion on how to incentivise medical practitioners to coordinate care from the literature (2.4).

2.1 Healthcare markets

This section begins by outlining the unusual market characteristics of the healthcare system to shed light on the environment within which actors attempt to influence healthcare financing policy in Australia.

It is argued that the market for healthcare provision is different from other markets (Arrow, 1963; Cutler, 2017; Savedoff, 2004). Arrow, in 1963, explored the dissimilarities between the provision of health services and the provision of goods in other markets. He found that broadly, market failures in the healthcare market stem from uncertainty, which leads to two forms of information asymmetry: firstly, the medical problem may be difficult to identify and, secondly, the outcome of applying a particular intervention may be unknown (Arrow, 1963, p. 941; Savedoff, 2004). Thus, the cost is potentially also unknown or unknowable upfront. The most prudent method to manage uncertain events is to insure against them. Health insurance is not insurance against a lack of good health but against the treatment costs of healthcare (OECD, 2018).

The OECD contends that health insurance is an appropriate way to 'distribute the financial risks associated with the variation of individuals' healthcare expenditures by pooling costs over time' (OECD, 2018, p. 7). Insurance forms a key part of any healthcare system, and private health insurance is common to most health systems across the world (Nicolas & Vera-Hernandez, 2008).

When analysing healthcare insurance markets, additional issues come to the fore. Firstly, the usual purchaser/seller relationship does not exist. The usual marketplace has two fundamental actors: a buyer and a seller. However, in healthcare, a third actor, the insurance provider (whether private or public), is involved in purchasing the good (Cutler, 2017). This is known as the three-player market. The three-player market in healthcare necessitates three transactions to procure the good. The first

is that money must be given to the insurance provider, who then pays a medical provider for the consumer's healthcare goods. The third actor in the system also changes the relationships in the industry from dyadic to triadic, meaning that each of the three players – providers, insurers, and consumers – need each other.

Funds for insurance generally come from individuals, directly or indirectly. In a voluntary system, the money comes primarily directly from the individuals, and in a universal system, everyone is covered, and the government ensures that individuals contribute. Unlike other markets, the individual does not pay for the entirety of the service; thus, price signals that would ration healthcare do not come into play. This creates a 'moral hazard': a term used to describe a condition where someone other than a buyer pays for the buyer's purchase. The buyer has no price indicator and, therefore, consumes goods oblivious to the resource costs they impose upon the economy (Breyer, 2009, p. 33).

There is an inexhaustible demand for healthcare, though not a corresponding willingness to pay. In order to ensure that pooled funding arrangements do not become excessively burdensome on the contributors, trade-offs between who receives healthcare services, which services are offered, how much of the cost is covered and by whom must be made (World Health Organisation, 2010, p. 12). Insurers need to employ methods to contain healthcare expenditure. As a result, various methods are used to ration the use of health care (Scheunemann & White, 2011). Rules around purchasing services determine how many and what types of services are received (Cutler, 2017). These are called 'payment and access rules' and they structure healthcare provision by determining who pays what, to whom, and for what. The payment and access rules can influence how much integration between various players can occur.

2.2 The unique mixed model of insurance in Australia

Various methods for structuring insurance in health systems exist, with two key models being Bismarck and Beveridge. The Bismarck model is a traditional German system in which several insurers, generally funded by employer-based schemes supplemented by the government, provide benefits to patients to pay privately owned providers. Under this model, patients have direct access to specialists. In the other system, the Beveridge model, there is a single insurer financed by taxation where providers are publicly owned, and access to tertiary-level services is generally via referral through a gatekeeper. The Australian public system, Medicare, has many of the characteristics of the Beveridge model; it also has private health insurance, creating a mixed model (Colombo & Tapay, 2003).

Both the public and private systems in Australia are based on pooled arrangements. Individuals are levied for the universal healthcare system and may also be levied in the form of premiums for private health insurance. Cover is provided to all Australian citizens, and private health insurers must cover anyone who takes out insurance. Unlike normal insurance products, the price for cover cannot be adjusted for risk. Demand is rationed in the public system through waiting lists (where the service is free or very low cost). The private system has much shorter waiting lists but often an out-of-pocket cost for the patient. The combination of characteristics has created two insurers in the system operating in a very similar manner.

The legislative and policy framework of Medicare establishes the payment and access rules controlling how insurers pay medical practitioners. Payment is by a fee-for-service model for primary and tertiary care, with government contributions determined by the Medicare framework. Under the fee-for-service model, general practitioners and medical specialists have autonomy in setting fees and clinical decision-making.

2.2.1 History of the mixed model of insurance in Australia

Organised Medicine in Australia commenced in the mid 1800's with the British Medical Association (BMA), the predecessor of the AMA and was structured to manage the provision of services in a similar manner to the English system (AMA, 2012). The organisation of medical practitioners began much earlier than proposals for a national health insurance scheme which commenced in the early 1900's with various iterations being considered by governments with limited success (Gillespie, 2002; AMA, 2012, p48). However, and consistent with research into medical dominance in other countries (see Willis, 2020), the following century saw the rise of the medical profession to a position of economic dominance in the health system (Gillespie, 2002; Boxall, De Voe & Short, 2003).

World War Two gave organised medical a considerable increase in power in policy debate around health provision due to its ability to manage shortages of medical personnel as a result of the war efforts (Gillespie, 2002, p 115). Emboldened by their newfound power, the AMA engaged in fractious debates over various national health schemes, opposing compulsory health insurance (AMA, 2012; Scotton & Macdonald, 1993). Despite this opposition, Medibank, a compulsory, tax funded insurance scheme was implemented by the Whitlam Labor government in 1975 (Boxall, 2010). Medibank became the first Australian compulsory national health insurance program, and it functioned for a short period of time until the Fraser government dismantled it, reverting the health system back to the Voluntary Health Insurance scheme in 1981 (Boxall, 2010; De Voe & Short, 2003).

The current mixed model structure in Australia is inextricably linked to the instigation of the Voluntary Health Insurance scheme in 1952–53 by the then Federal Health Minister Earle Page

(Shamshulla, 2011, p. 25) who was also a member of the BMA. Whilst private health insurers existed before the Page scheme, it was the registration of insurers as agents for Voluntary Health Insurance and the funding of their business by Commonwealth benefits, tax deductibility for member contributions and underwriting of benefits for the chronically ill by the federal government that effectively engrained insurers as a part of the health system (Colombo & Tapay, 2003, p. 9; Shamshulla, 2011). These changes occurred at the same time that the workforce began to segregate between hospital and non-hospital care. General practitioners subsequently lost their contracts with the insurers, and the workforce fractured further as their hospital visiting rights were removed (Milton, 2003, p. 16; Harris & Zwar, 2014).

The relational structure of the insurance industry was more complex than it appeared on the surface. Health insurers were (on the whole) set up by charitable institutions or hospitals, with medical providers controlling their boards. This created a close relationship between insurers and medical providers. This relationship between insurers and providers led to allegations throughout the late 1960s and early 1970s that the insurers were merely pawns for flushing money through to providers (Richardson & Scotton, 1989). Those raising concerns regarding the lack of oversight of healthcare provision by insurers argued that insurers should be active managers and not passive payers of monies (Shamshulla, 2011). To effect this change, insurers would need to contract medical providers for outcomes rather than pay for services rendered, reducing medical practitioner autonomy (Willcox, 1993).

The introduction of universal healthcare (Medicare) in 1984 meant that private health insurers needed to compete with another insurer for patronage. Under the original design of this new model, private health insurance would support the public hospital sector by providing hospital (secondary/tertiary level) services (Willcox, 1993, p. 326). At the time, it was considered important to prevent the private sector from gaining control of the primary sector, and the payment and access rules were designed to discourage this behaviour (Doggett, 2015). This further reinforced the segregation that commenced in the 1950s. After the introduction of Medicare in 1984, private insurance coverage began to decline as people dropped their insurance (Duckett & Nemet, 2019). The first warnings that the industry was in a 'death spiral' started in the early 1990's. It was clear at this point that changes were needed to the relationship between private health insurers and Medicare in Australia to maintain a system that included insurers (Burns, et al., 1997).

2.2.2 Private health insurance: In need of a role

There is little research that provides in-depth understanding of the policy rationale of maintaining private health insurers, potentially because the various policies that combine to regulate and

structure the mixed model are vague and internally inconsistent (Harris, 2013; Private Healthcare Australia, 2017). This has led scholars such as Kay (2007) to say that private health insurance in Australia needs a role. Private health insurance within the Australian healthcare system has a complicated relationship with Medicare, as it is neither a competitor in its own right nor supplementary; it is effectively a duplicate system looking for a unique role in order to be valuable (Stavrunova & Yerokhin, 2014).

The private health sector has remained a large part of the Australian tertiary healthcare system. In 2016–17, 41 per cent of all hospital separations (hospital stays) were funded by private health insurance; 51 per cent were funded by the public system, and the remainder were self-funded (Australian Institute of Health and Welfare, 2017). In aggregate, private health insurance funded around 8.8 per cent of Australia's total health expenditure (Australian Institute of Health and Welfare, 2018).

The federal government subsidised private health insurance consumers through a contribution of \$6.7 billion in 2021–22 towards premiums and further contributions via Medicare for in-hospital treatments (The Treasury, 2022). The federal government, therefore, has a unique interest in ensuring that the private part of Australia's healthcare system operates as efficiently as possible (Duckett & Willcox, 2015).

In Australia, the two major political parties that have alternatively formed the federal government (the Australian Labor Party and the Liberal-National coalition) both support the existence of private health insurance (Duckett & Nemet, 2019; Plibersek, 2012, p. 263). In a recent statement to parliament, the then-coalition government stressed that they felt a 'healthy and stable private health insurance system is essential for the stability of Australia's overall healthcare system' (Department of Health, 2018, p. 2). 'Encouraging private health insurance cover provides consumers with a greater choice of care options and relieves pressure on the state public hospital system' (Department of Health, 2018, p. 2). The 'mixed model,' however, allows the community to provide their legislators with mixed signals (Fiebig, et al., 2006/1). They want increased health services, lower costs, affordable private health insurance for when they wish to be treated privately, and the ability to choose the public system when it is advantageous (David, 2017; King, 2018). These desires are problematic for both public and private insurers, as the inexhaustible demand for healthcare clashes with the growing need to contain expenditure.

The increasing demand and costs of services, combined with restrictions that curtail incentivising models of care that are possibly more efficient, is reducing the viability of private health insurance (Leeder & McAuley, 2005). Reforms to change the payment and access rules for private health

insurance will also impact the operation of Medicare. Changes to Medicare are notoriously politically difficult (King, 2018). The Australian public universally accepts Medicare, and any proposed changes (such as the 2014 attempt to bring in a patient co-payment for primary care services) have been met with strong resistance (Boxall, 2019; Hall, 2015; Australian Broadcasting Corporation, 2015). Nonetheless, improving care coordination, patient outcomes, and the efficiency of the healthcare system are goals worth pursuing on their own.

To summarise, the creation of Medicare in 1984 without a clear role for private health insurance led to a health financing system called a mixed model with two main insurers. Both operate using the Medicare payment and access rules, which establish a fee-for-service payment model, granting medical practitioners billing and clinical autonomy. To contain costs and coordinate care, many have suggested changes to the payment and access rules to allow a different payment model, which can be achieved by integrating the insurer with the provider (Amelung, et al., 2017; Valentijn, et al., 2013). However, integration can reduce medical practitioner billing and clinical autonomy and is explored in detail below.

2.3 Integration in health systems

The key to the effectiveness of a multidisciplinary team in Australia is the role of the general practitioner. General practitioners are the first point of contact for most Australians seeking healthcare and determine the majority of decisions around patients' long-term health needs – called the treatment pathway. General practitioners will either treat the issue with their own resources or, where required, refer patients to other service providers, including specialists or diagnostic testing. General practitioners in Australia provide the gatekeeper role, determining who can access what services under Medicare at the tertiary level, and their decisions drive much of the activity in the healthcare system. This section discusses integration in the healthcare systems and identifies small programs in Australia where healthcare providers and insurers have been integrated.

What is integration in a health system?

Valentijn et al. (2013) argue that vertical integration is 'needed' to counter the fragmentation of service provision in healthcare systems and that using vertical integration can improve the continuity, comprehensiveness, and coordination of services across the care continuum. One of the main goals of integration is to improve the coordination of care, theoretically improving quality, efficiency, and access. It may even provide for cost containment (Amelung et al., 2017; Casalino, 2014; Cooley, 2009; Mechanic & Gaus, 2018).

The economic meaning of vertical integration hinges on shared ownership of various parts in the vertical chain of production (Robinson, 2001). In a healthcare system, vertical integration models integrate services from separate levels of care (e.g., primary care, acute care and post-acute care) (Amelung, et al., 2017). An integrated health service has varied definitions. The World Health Organisation defines it as:

The organisation and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money (World Health Organisation, 2008).

Integration can be horizontal or vertical and can focus on the level of the organisation, service delivery, back-end operations or processes (Goodwin & Smith, 2011). Vertical integration can involve a variety of changes to the structure of the healthcare provision. In many studies, vertical integration is associated with interactions and relationships between primary care and hospitals (Amado, et al., 2022). Ramsay (2009) describes two broad types of vertical integration:

- Organisations that are a part of different stages of the care pathway become part of one organisation. or
- Insurer and provider organisations form part of one organisation.

Robinson and Casalino (1996) propose a slightly broader view and describe two different models of organisational integration:

- Vertical, using unified ownership; and
- Virtual, using contractual networks.

Vertical integration using financing mechanisms involves consolidating the funding of primary and tertiary healthcare services at one level or into one entity, culminating in one funding source. Under this integration model, an insurer would directly contract primary and tertiary care, which is currently prohibited in the Australian healthcare system (The Commonwealth Fund, 2017; World Health Organisation, 2008; 2016).

Governments in many countries began attempting substantial reforms to their health systems in the mid-1970s to contain budget expenditure on healthcare (Pierson, 2001). Reflecting changed economic situations and changed disease patterns, the models have varied between integrating through pooled purchasing at a regional level in New Zealand through to compulsory insurance in Germany and the Netherlands that covers both primary and tertiary care (Gauld, 2014; Hall, 2010, p. 66; Jackson & Gauld, 2018; Kroneman, et al., 2016; Ministry of Health, 2016). Some healthcare systems overseas have moved towards greater levels of integration between the tertiary and primary sectors (Smith & Walshe, 2016). Efficiencies were found at an organisational level by Miller and Luft

(1994) in their study of health management organisations in the United States and at a population level by Balicer et al. (2018) in their analysis of the impact of vertical integration on a cohort with a lower than average socio-economic status in Israel.

The US managed care model is known for integration. It provides the funder of healthcare services the ability to view patients' needs more holistically, both at a patient level (understanding the complete needs of a patient through their medical records, coordinating care among various physicians and developing preventative care plans when issues are identified) and at a population level by understanding the prevalence of disease, types of provider usage and whether usage is coordinated across primary, secondary, and tertiary level services (Amado, et al., 2022). The system also allows insurers to limit expenditure by giving them greater ability to determine what treatments should be provided and, therefore, funded (Song, 2014).

In Australia, various private health insurers have created programs to create closer linkage with healthcare providers:

- Establishing private general practices without preference to members or payment: BUPA established its first clinic in 2014 (BUPA Australia Health Pty Ltd, 2017).
- Establishing contracts with specific general practitioners and providing favoured access to members: Medibank commenced a pilot program in 2013 (Medibank Private, 2014).
- Linking general practices services to aged care facilities: The BUPA conglomerate owns general practices co-located with aged care facilities. Members and non-members can use these services.
- Connecting with state governments or Primary Health Networks to provide services to members and non-members: Medibank Private contracted with the Victorian Government (Victoria is a state of Australia) to trial an integrated model of care for people with chronic conditions.
- The establishment of 'preferred provider' contracts between insurers and allied health professionals (private health insurance members are incentivised to choose the preferred provider) (Duckett, 2015; Rolfe, et al., 1973).

However, none of these linkages created a systemic long-term change between insurers and medical practitioners, and some have ceased.

2.4 Maximising societal benefits from the provision of healthcare services

The cost of medical care is not solely determined by the nature of the illness but depends upon the willingness of the doctor and the capacity of the healthcare market to provide services (Arrow, 1963, p. 961). One of the perverse incentives created through the provision of insurance is the reward for the overprovision of healthcare services (Fineberg, 2012). The ability to pass on costs to a third party also removes the incentive for patients or physicians to factor costs into their treatment decisions (Arrow, 1963, p. 962). These two perverse incentives add to inefficiencies in the system.

Primary care in Australia is currently funded to provide episodic care and does not necessarily support the long-term participation of a chronic care 'team' (Menadue & McAuley, 2013). To manage care for chronic conditions, the incentive structure needs to cater for teams and 'groups' of people who care for a common person. Factors that influence collaborative working arrangements include the structure of the system, the location of team or group members (dispersed or together), the degree of support from the member's home or host organisation, and the impact of different professional cultures, all of which can be positively influenced by well-designed incentives (Witz, 1992).

Good incentive design requires evidence of what motivates healthcare providers (Scott & Connelly, 2011, p. 273). Incentive design needs to be analysed within medical practitioners' decision-making framework (Duran-Arenas, et al., 1992, p. 549). The main existing incentives in the healthcare sector can be summarised as deriving from income, professional affiliation, professional recognition, autonomy and career development (Nancarrow et al., 2013, p. 8; Duran-Arenas, et al., 1992, p. 549).

Therefore, funders of healthcare (governments and private health insurers) need to devise incentives to influence service provision to achieve the desired outcomes (coordinated and efficient care). In Australia, there is general agreement that governments should be involved in the rule-making of the provision of health services, and the government should set the incentive structure through the payment and access rules (Waterford, 2014). This is one of the quintessential problems for government; society determines that there is a problem and imposes an obligation on the rulers to address it (Rose & Miller, 1992, p. 181).

2.5 Conclusion

The peculiarities of the healthcare market stemming from information asymmetry, pricing practices by providers that do not share risk, and the inability of consumers to determine the quality of the product prior to purchasing combine to create a requirement for governments to intervene to ensure the provision of healthcare services in a manner that society perceives as equitable.

The unique mixed model in Australia has left private health insurance without a specific role as it almost mirrors the operation of the universal healthcare system, Medicare. The combination of a lack of clear value and the operation of the payment and access rules has led to costs escalating and healthier people reducing their coverage or exiting private health insurance altogether, reducing insurers' income. The current operation of the payment and access rules prevents the level of integration required to develop incentives to increase efficiencies in the system through coordination of care. As explained in the introduction, little is known about why numerous attempts to reform these rules have failed over the years. Greater efficiencies in healthcare provision are needed in Australia for private health insurance to remain viable without additional financial support from the government. For reforms to have a chance at success, we need to understand the interests and networks that have shaped the rules over time.

3 Theoretical framework: Policy networks and power

3.1 Introduction

This chapter presents the theoretical and conceptual framework that guides this study investigating the role of actor networks in constraining reform to Australia's payment and access rules. As explained in the introduction, while much is known about the challenges facing Australia's healthcare financing system, less is known about why it has been so difficult to achieve reform. This problem requires an understanding of the interests at play and how actors, through their networks, have worked to constrain reform of this institution over time.

Recognising that theoretical diversity can support a deeper understanding of political phenomena (Sabatier, 2007), these three theories were chosen for their explicit focus on the operations of actors in political networks (network theory), power relations as actors exchange resources (resource dependency), ability to explain the mechanisms supporting the retention of institutions or policies (path dependency), and their capacity to complement each other. The resulting analytical framework (Table 3.1) shows the connections of the concepts and premises, the resultant interaction between the three theories, and the variables in focus. I deployed this structure throughout the remainder of the thesis to collect, examine and explain the empirical data.

First, network theory was chosen as it supports examining how actor networks operate in their environment when engaged in political debates. Network theory is used to identify patterns of relationships of the actors, such as hubs, cliques, or brokers, and links those relations to the outcome of interest, in this case, the resilience of Australia's payment and access rules. A focus on the patterns of relationships between actors enables an investigation of the structure of the network, which is important for understanding who controls the use of resources by actors and who has the power in the network to lock down or change a policy (Berry, et al., 2004; Rhodes, 2006). Actors at a regulatory policy level are generally organisational-level actors or interest groups (Cullerton, et al., 2016; Peterson, 1993). For this research I drew upon Alford's identification of the sets of interests in healthcare: organisations representing medical practitioners, private hospitals, insurers, and the community (Alford, 1975).

Resource dependency theory (RDT) is the second theory brought into the framework, which provides a focus on the external environment, allowing for the examination of power, agency and legitimacy (Taylor, et al., 2018). Crouch and Farrell suggest that actors can draw upon and transfer ideas (resources) through their interactions with other actors, and how 'close' other actors are to others

can influence the costs of acquiring these resources (Russell, et al., 2009, pp. 27-34). This perspective allows for considering agency and the actions of multiple skilled individuals and/or organisational actors who coordinate their activities via a network.

Finally, path dependency theory is included in the framework due to its relevance in analysing and explaining the persistence of public policies in the face of attempts at reform (Kotz; 2021; Torfing, 2009). Combining path dependence mechanisms with RDT and network theories reveals the interests of actors in the network, their use of the role of power, agency and resources during policy events where proposals to change the institution, that is, the operation of the payment and access rules by one group, are thwarted by another over time (Crouch & Farrell, 2004; Garud & Karnøe, 2001).

Table 3-1: Theoretical framework: Variables in focus

Variables	<i>Theoretical framework</i>		
	Network Theory	Resource Dependency	Path Dependency
	<i>Structure, power and resource usage</i> - Who was in the network? - Did a change in structure impact the outcome? - Who controls the network? - Who did the government side with, and with whom did the public side? - Who used what resources and with whom? - Who set the norms or rules of the network?	<i>Resources</i> - How important were the reforms to consumers, providers and insurers? - Did actors actively pursue strategies to better their interests? <i>Environment</i> - What was occurring in the general environment that impacted actors' strategies? - How did actors in the network interpret their environment? <i>Power</i> - Who were the most powerful actors in the policy event? - Illumination of the control over the allocation of the resources by actors - Did any actors have greater access to decision-makers? - Whose arguments resonated better with the public?	<i>Increasing returns</i> - Was a large and influential constituency created? - Were successive attempts at reform a failure? - Was there positive or negative feedback to actors in the system, and did this feedback alter or build upon itself? <i>Lockdown</i> - Was it prohibitively costly (resources) to divert from the current path? - Were politicians unable to make changes to the system?

This chapter first outlines policy network theory (section 3.1) and introduces how power in the network is conceptualised in the research (3.1.1). It then introduces resource dependency theory (3.2) and explains how RDT variables of the environment (3.2.1), resources (3.2.2), power and legitimacy (3.2.3) complement network analysis and are operationalised in the research. Finally, it introduces path dependency theory as a complementary approach (3.3), outlining how investigating mechanisms of path dependency (3.3.1) enables a greater understanding of the influence of actors and their networks on limiting reform to the operation of the payment and access rules in Australia over time.

3.1.1 Policy networks

Policy network analysis is a variation of network analysis commonly used when considering political science issues (Rhodes, 2006). Policy network analysis came to the fore in the 1990s when researchers constructed a group of meso-level systematic tools, which were used to build a set of hypotheses about how the structure of a network and the interactions of actors within it can influence policy outcomes.

Early research applied networks to visualise hierarchy, specifically how the world system was ordered, reflecting the structure of the regulatory network at the time (Baumgartner & Burns, 1976; Galtung, 1971; Wallerstein, 1974). These early works focused on networks among lobbying and interest groups, policy managers, politicians and political advisors who held detailed policy positions and acted to influence the policy process (Rhodes, 1981). The underlying hypotheses included observations on the impact of adding and excluding particular vested interests in the network and policy-making process (Rhodes, 1981).

Policy networks were conceptualised as a group of actors that have connections with government and dependence upon other societal or state actors. The definition of a policy network has been debated and refined as the field matured. In earlier works, the policy network was described 'as a sectoral system of interaction which links public and private actors through resource dependencies' (Benson, 1982, p. 148). Kenis and Schneider then provided a more nuanced definition, describing a policy network as a group of public and private actors connected by links that are used for exchanging information, trust, expertise, and other political assets (Kenis & Schneider, 1991). The term 'policy networks' was then refined to (more or less) 'constant patterns of relationships between actors that form around policy problems and/or policy programs' (Kickert, et al., 1997). The difference is that the network is formed around a policy.

Policy networks can consist of informal relations and structural patterns or as a way of governing to coordinate action. I follow Sabatier (2007) for this study and define a policy network as a group of people, organisations, or both interacting frequently over a decade or more to influence policy development and implementation in a particular policy arena. This complements the thoughts of Keck and Sikkink (1998), who argued that advocacy networks have existed for a long time as a structure that assists cooperative and impactful advocacy (Ward, et al., 2011).

The literature on policy networks generally considers two questions. The first asks how policy actors operate to obtain decisions that fit their strategic goals. This literature considers the behaviours and machinations of actors in policy arenas, such as the use of resources to influence policy outcomes (Saward, 1990) and patterns of behaviour and structure (Jenkins-Smith, et al., 2018). Actors are selective and strategic when making resource investments or decisions, and using a utilitarian premise, each actor anticipates the plans of other actors when selecting their own strategies (Christopolous, 2000; Hall & Taylor, 1996; Ostrom, 2005). The second body of literature considers how policy outcomes are influenced by actors' roles and the network structures themselves (Berry, et al., 2004; Knoke, 1990, p. 9; Marsden, 1990, p. 127).

Some theorists argue that policy networks, because of previous political choices, create certain interactional practices, models of interest mediation and decision-making. This 'sedimentation' of prior policies, which are likely to benefit stronger actors, is a process that closely mimics the concept of 'lock-in' (Arthur, 1989; Knoke, 2016) used in path dependence by economists to explain the persistence of certain technologies, notwithstanding the availability of other options in the environment.

From a resource-dependence viewpoint, the policy network analysis discipline starts from the hypothesis that for actors to achieve their goals, they need to exchange resources with one another within policy networks (Rhodes, 1981; Kenis & Schneider, 1991). The power-dependent relationships that emerge from interactions to exchange resources illustrate who will become core members of a network, who will be positioned at its periphery with occasional and usually limited influence, and who may be excluded altogether (Marsh & Smith, 2000).

Policy network analysis has developed to seek to understand actors' roles in policy development (Knoke, 2016). It illustrates and explains the structure of actors' interactions during the policy-making process and supports an understanding of the roles of the actors where a multitude of actors influence system outcomes (Broadbent & Vaughter, 2014; Jenkins, 1978). The three case studies in this thesis interrogate how the network operationalised to debate the reforms, who formed relationships with whom (structure), what strategies were deployed, and what resources were used

to answer the question about the role of actors in the network (how actors operated). The influence of the structure of the network upon the level of change achieved during the reforms is also evaluated.

3.1.2 Power from position in the network structure

Knoke (1990, p. 9) tells us, 'An actor's power—its ability to produce intended effects on the attitudes and behaviours of other actors—emerges from its prominence in networks where prized information and scarce resources are transferred from one actor to another.' Particular actors, or subgroups of actors, might have more negotiating power than others (Ensminger & Knight, 1997) and, as a result, be more successful during the policy debates and further their strategic goals. Discussing social networks and power, Knoke (1990, pp. 3–4) differentiated 'between two dimensions of power: influence, and domination.' Domination is when one actor exerts control by offering or withholding some benefit or harm to another actor, 'where influence is exercised when one actor intentionally transmits information to another that alters the latter's actions from what would have occurred without that information' (Knoke, 1990, pp. 3-4). For an actor, achieving collective action that secures an outcome consistent with one's strategic goals can be considered a success in a network (Arts, 2003).

However, many forms of power coexist, and empirically, it can be difficult to distinguish them. Thus, Knoke contends that social networks reflect these relationships, and when brought to the fore, they illustrate relational power among actors (Knoke, 1990). Dependency situations may not be symmetrical, and resource exchange can link actors vertically across different levels of authority or horizontally across different actors within networks. Indeed, and as highlighted by (Lin, 2001), the resources actors hold or can obtain may influence the hierarchical relationship.

Policy reforms can establish power differentials by selecting winners and losers. Winners are likely to benefit from the decision, and actors who do not win are expected to be disproportionately worse off (Nowlin, 2016). Power in a network is only useful if it can achieve a strategic goal; in this research, either changing or maintaining the payment and access rules. Political power can be defined as the power whose exercise is targeted towards the outcome of collectively binding decisions, regardless of whether the locus of power is within the realm of state and government or elsewhere (Arts & van Tattelhoeve, 2004). Following Lewis (2006), this thesis applies Lukes' concept that to be powerful, an actor should have demonstrated the capacity to either:

- a. Shape ideas around the policy,
- b. Initiate policy proposals,
- c. Substantially change or veto the proposal, or

- d. Substantially affect the implementation of the proposal (Lukes, 2005).

Policy development is a fluid, non-linear and sometimes protracted process. An actor's influence may vary during the debate and reform (Tuohy, 2018). The capacity to obtain a government's agreement to invest its political capital into reforming a system shows influence; however, shaping these ideas to remove or change the reforms also demonstrates the exercise of power (Dur & De Bievre, 2007; Topp, et al., 2021). Often, in policy and political studies, power is assessed through analysing preference attainment. The individual or group whose preferred position was chosen by the decision-maker is deemed to be the more powerful as they have influenced the government of the day. However, this research, consistent with the findings of Aberbach and Christensen (2014) and Tuohy (2018), argues that what is legislated may not be 'what is done or implemented,' and a test of how much the operation of the payment and access rules *actually changed* post legislative amendment was added to identify true power in the system (see more in chapter four on case studies).

3.2 Resource dependency – the role of power, the environment and legitimacy

The second theory in the framework is resource dependency theory (RDT). RDT focuses on an organisation's need to access resources from other actors in the environment and describes how resource scarcities force organisations to look for innovations that use another resource (Pfeffer & Salancik, 1978). Whilst often used to analyse corporate behaviour, RDT has also been drawn upon to understand public policies in education and community participation in primary healthcare (Connolly & James, 2006; Head & Alford, 2015; Zakus, 1998).

RDT is established on three core premises: that the social context (the environment) matters, that organisations employ specific strategies to improve their autonomy and pursue their interests, and that power is critical for interpreting these strategies (Taylor, et al., 2018).

There are two main reasons for selecting this theory. First, resource dependence is an appropriate lens as its basic principle is that the lack of resources motivates organisational action and 'mindful deviation.' RDT shows how organisations behave when obtaining and preserving the resources needed for their existence (Leblebici, et al., 1994). As argued above, private health insurance in Australia is operating in a regulatory framework that threatens its survival.

Second, RDT focuses on relationships and power. The lens of relationships is explored by considering how actors interpret their environment and how this interpretation influences their strategies to enrol, coerce, and convince others to achieve their goals (Klien & Periera, 2016; Pfeffer & Salancik, 1978). Scholars using resource-based theories have shown that firms use networks to manage resources to improve product value and knowledge (Das & Teng, 2000). RDT has been used to

research the formation of alliances when organisations are faced with public policies that negatively impact viability (see Bingham and Walters (2013) and Walker and Hayton (2016)), the use of consortia and advocacy by industry for obtaining government financial support (Van Rijnsoever, et al., 2014) and, in the health sector, the environmental determinants in the uptake of nationally prescribed technologies (Kazley & Oscan, 2007).

RDT is applied at an organisational level, including organisations that represent interest groups. The vast majority of organisations in the health sector belong to member bodies and operate as a block or singular entity when debating policy. Whilst it is not novel to apply RDT at an organisational level, it is novel to consider how the organisations in the sectors of the Australian health system interact when engaging in policy events that impact the operation of the payment and access rules. Unlike other industries, sectors in the health industry all need to collaborate or interact with each other since no one group possesses the resources required to perform the desired activities on its own (Cutler, 2017). RDT complements network analysis through its focus on resources and power.

3.2.1 Role of the Environment

The concepts of organisational boundaries and environment are important in RDT. Under RDT, activities within the organisation's control are internal to its boundaries, whereas activities outside its control are considered part of the environment (Pfeffer & Salancik, 2003). Interdependence with other stakeholders and organisations is derived from the availability of resources and demand (Scott, 1992). Emerson defined dependence as a state in which an actor depends on the actions of other actors to achieve their goals (Emerson, 1962).

Like other businesses, private health insurers are not completely self-directed and independent because they need resources such as money, materials, and services. They depend on providers, hospitals, members, and those that determine the regulatory settings (Cutler, 2017). To survive, insurers must interact with those who control these resources.

Organisations are constrained and affected by their environment and will attempt to alter their dependencies by creating different types of inter-organisational arrangements (Klien & Periera, 2016; Pfeffer & Salancik, 2003). RDT suggests that when organisations are regulated by the state, the importance of the economic environment diminishes, and the importance of the political and administrative environments increases (Pfeffer & Salancik, 1978, p. 203). As a result, the organisation's behaviour will adjust. Organisations will attempt to gain advantages from government regulators and political activity to improve their situation (Hillman, et al., 2009). Private health insurance in Australia is highly regulated, and theory suggests that power accrues to those that

control or significantly influence the political or administrative environments (Colombo and Tapay, 2003; Pfeffer and Salancik, 2003; Private Healthcare Australia, 2017; Vaithianathan, 2004).

3.2.2 Role of Resources

According to RDT, an organisation's susceptibility to influence by other organisations is partially determined by the extent to which it has come to rely on certain kinds of exchanges for its operation (Pfeffer & Salancik, 1978, p. 46). The resources within an organisation's environment facilitate the interconnectedness of the network, and these connections are crucial to the organisation's ability to acquire resources (Das & Teng, 2000). The uncertainty of the environment and shortage of resources can restrain organisations or challenge their existence, and the greater the shortage, the more critical the resource can become to the organisation (Froelich, 1999; Pfeffer & Salancik, 1978).

The resource-based view focuses on analysing various resources held by the organisation (Amit & Schoemaker, 1993). Dependence on environmental resources can include anything identified as valuable by an organisation. 'Resource' is a broad term, ranging from physical to non-physical assets such as information and social or political support (Verbruggen, et al., 2011).

At the centre of the relationship between consumers, private health insurers, and practitioners is the flow of resources, or more specifically, the flow of money to provide treatment (Cutler, 2017). However, the resource that determines who controls the treatment pathway is the health financing policy called the 'payment and access rules.' The payment and access rules prevent private health insurance benefits from being paid directly for general practice treatment items (Doggett, 2015).

The Australian health system relies on the decisions of the general practitioner, who determines the most appropriate course of treatment, called the treatment pathway. General practitioners currently control the pathway due to the payment and access rules in the Australian system. Practitioners have always argued for clinical autonomy: the right to refer and treat as clinically determined by that practitioner (McCredie, 2007). This right, enshrined in legislation, gives the interest groups representing clinicians some power. General practitioners hold considerable power in determining what treatments a patient receives and, therefore, how much an insurer is billed. An insurer's business is uniquely reliant on general practitioners' decisions as they can influence patients' treatment plans, long-term health needs and use of tertiary services.

Perceiving the payment and access rules as an institution that actors in a three-player sector attempt to control (to reduce their vulnerability) allows for the analysis of the actors as they attempt to alter their levels of dependence. Alternatively expressed, changes to the rules would allow insurers to

contract medical practitioners directly and influence the treatment pathway to incentivise coordinated care, and potentially reduce costs. Medical practitioners oppose this change in role.

RDT allows for the illumination of the control of the allocation of resources by actors. Control can be achieved through the actual use of the resources or by determining who controls their use. The actor who controls or significantly influences the payment and access rules has a major power source in the system.

3.2.3 Role of Power

Under RDT, organisations that can prove adept at reducing constraints and the uncertainties of the environment and can manage contingencies accompanying the flow of critical resources accrue power (Casciaro & Piskorski, 2005). If these critical resources are successfully obtained, this increases the relative power of the organisation, its ability to influence, and its long-term stability. Consequently, an organisation's actions can have a material influence on its longevity.

Power and its inverse, dependence, are fundamental as inter-organisational forces of RDT. Power amasses to actors who are in control of resources. Dependence, on the other hand, is recognised by others and is influenced by the concentration and importance of resources supplied (Emerson, 1962; Malatesta & Smith, 2014). RDT argues that 'when the net exchange between organisations is asymmetrical, some net power accrues to the less dependent organisation' (Pfeffer & Salancik, 1978, p. 53). However, if the net exchange is symmetrical, and the two organisations are equally dependent on each other, 'neither possess a particular power advantage, reducing the likelihood that one organisation will dominate interorganisational influence' (Pfeffer & Salancik, 1978, p. 53).

Power is therefore a relational phenomenon – people exert power over other people, and a person's power (or ability) to do or not do anything becomes a social relationship about the personal power or ability of the other person (Bernhagen, 2002). According to Malatesta and Smith (2014), under RDT, power and dependency are inversely correlated. Organisation A's power over Organisation B equates to Organisation B's dependence on Organisation A. However, a firm rarely operates with only one other, and stakeholder relations do not occur through dyadic ties without reference to other relationships. Organisations do not simply respond to each individual organisation but to the interaction of multiple variable effects from the whole stakeholder group (Taylor, et al., 2018). Indeed, because one organisation's stakeholder group will differ from another organisation's stakeholder group, each must be considered individually, and responses cannot be extended to predict another organisation's behaviour (Rowley, 1997).

Power is not just wielded by governments or organisations alone, and an assortment of decentred theories of governance have grown to explore how governance beyond the state operates, arguing that there are multiple sources of power upon which actors can draw. For example, Castells (2000), Black (2002), Ostrom (2010)). Streeck and Schmitter (1985) concur that power is broader than just that which is wielded by the states. It is also wielded by markets, communities, and associations. 'Power is everywhere; not because it embraces everything, but because it comes from everywhere' (Foucault, 1984, p. 93). Social science theorising developed from viewing power solely as a stable object or 'thing' to considering it as a thing that can flow through a network (Foucault, 1980) or is used by networks (Latour & Woolgar, 1986). Relations, particularly power relations, occur within a network of influences.

A decentred governance system (where power does not rest primarily with the government) may mean that actors cannot negotiate to obtain greater dependence within a stable structure of inter-organisational action, and organisations may then need to employ another class of strategies (Pfeffer, 1992; Streeck & Schmitter, 1985). These strategies often require the greater power of the larger political system (Raab, 2002). In order to harness this power, organisations 'may use political means to alter the condition of the external economic environment' (Pfeffer & Salancik, 1978, p. 189). Organisations that are constrained or affected by their environment will try to reduce their dependence, and this can take the form of creating different network relationships and structures with a view to altering the power balance to be in their favour during policy events.

3.2.3.1 Legitimacy

Resource dependency theory draws upon Parson's (1960) work on interest groups and coalitions by extending his concept of legitimacy. Parson contended that legitimacy was a central concept for understanding the relationship between organisations and their social environment (Thelen, 1999, pp. 392-399). Legitimacy is important to unpack as it provides a wide sense of the role of power within the network and policy change.

Legitimacy is difficult to define and is more often described than defined. Maurer described legitimacy in a hierarchical sense where one argues their right to exist to a peer or subordinate (Suchman, 1995). Suchman (1995) argued that Pfeffer expanded on this concept to include the notion of cultural conformity, or congruence between the social values connected with the organisation's behaviour and the norms of suitable conduct within the wider social environment.

Suchman (1995, p. 571) takes a broad view of legitimacy:

‘Legitimacy is a generalised perception or assumption that the actions of an entity are desirable, proper, or appropriate within some socially constructed system of norms, values, beliefs, and definitions.’

Legitimacy is a factor in an organisation’s environment (Taylor, et al., 2018). The multilayered nature of legitimacy suggests that it will function differently in diverse social settings, and how it operates may rely on the type of problem for which it is the proposed solution (Suchman, 1995).

Strategic legitimacy studies portray legitimacy as a resource that organisations can operationalise, sometimes competitively, from the environment and that they use to pursue their strategic goals (Ashforth & Gibbs, 1990; Dowling & Pfeffer, 1975; Suchman, 1995). Insurers and providers pursue conflicting positions. Insurers are pursuing an agenda that allows them to directly contract medical providers to increase integrated care and become more viable by changing the operation of the payment and access rules. Medical providers wish to maintain their current control over the treatment pathway, described as clinical and billing autonomy, and therefore resist these changes (McCredie, 2007).

Correctly understanding the environment and the level of interdependence, resources, the complexity of the network and its power relationships is key to developing strategies to alter legitimacy and, through this, the relevant institution (Sandstrom & Lundmark, 2016). In the three-player market, one actor’s attempts to improve their legitimacy may come at the expense of another actor’s legitimacy. However, diminishing another’s legitimacy could also come at the expense of one’s own long-term legitimacy and long-term goals (Ashforth & Gibbs, 1990). The interdependent nature of the three-player sector in healthcare means that legitimacy may be more complex to extract, constraining actors when they invoke strategies to increase legitimacy at the expense of other actors. This unusual set of power dynamics is explored in the case studies in chapters five, six and seven.

RDT and institutionalism note that organisations are concerned with increasing or securing legitimacy and acceptance from their stakeholders. RDT allows for examining the role of resources, power and legitimacy and how these can be used by actors in the network (Davis & Adam Cobb, 2010; Taylor, et al., 2018). The normative expectations of the community are analysed in this thesis through differences in legitimacy for actors’ positions during the policy debate and the subsequent impact upon government support for reform.

The inclusion of RDT with network analysis enables a deep understanding of how the actors in the network behave as they attempt to influence the operation of the payment and access rules and,

through this, the flow of money for healthcare treatment. However, RDT does not specifically reference the impact of past events upon future events; thus, path dependence mechanisms are brought in to examine how the actor networks have limited the prospect of reform in Australia over time.

3.3 Path dependency theory – the role of increasing returns and institutional lock-in

The third theory in the framework is path dependency. Path dependence focuses on the influence of past events upon the present. As Putnam puts it in his seminal 1993 work, 'Where you can get to depends upon where you're coming from, and some destinations you simply cannot get to from here' (Aberg, 2015, p. 19; Putnam, 1993, p. 179). A basic description of path dependence is that social institutions often follow a specific path: an open period where there are a number of credible options, a critical point or event where an action results in one of those options being chosen, and then self-reinforcing feedback that constricts actors to maintain that path (Bennett & Elman, 2006; Fouda & Paolucci, 2017). Path dependency theory has previously been used to analyse the impact of networks to explain why some regional economies become locked in, whilst others can reinvent themselves; see Coe and Yeung (2015) and Martin and Sunley (2006). Path dependence was combined with network theories to study the role of actors in generating policy change during a collision of large national systems by Djelic and Quack (2007). This third theory is included in this research's theoretical framework as it allows for analysing and explaining the persistence of public policies in the face of attempts at reform through the exploration of how a network of actors used increasing returns and constraints, the strength of the operation of the payment and access rules, and the influence of actor networks in limiting healthcare reform in Australia (and enforcing path dependency).

3.3.1 Role of increasing returns and constraints

Path dependency is recognised as a plausible argument to explain inertia, stability, and irreversibility in a wide-ranging set of situations (Mahoney, 2000). Path dependency research can be traced back to David's (1985) and Arthur's (1989) notions of path dependence, which emphasised the importance of self-reinforcing processes activated by minor actions leading to a (potential) lock-in (Sydow, et al., 2015). The main point of increasing returns is that 'the relative benefits of the current activity compared with other possible options increase over time' (Pierson, 2000, p. 252). Feedback (or relative benefits), in whatever form, comes from the environment. It may come in the form of increased profits solidifying a company decision or increased power and legitimacy strengthening the actors' policy positions. Positive feedback can reinforce the status quo, and as an increasingly larger constituency becomes invested in the system, the costs of exiting will also increase (Pierson, 2000, 2004).

Brady et al. (2016) hypothesised five intertwined mechanisms to explain why policies are expected to show signs of path dependence.

- *Mechanism one: Regulatory policies create large constituencies* interested in preserving or increasing programs and benefits (Korpi & Palme, 1998).
- *Mechanism two: Regulatory policies mobilise actors and organisations* with a vested interest in the policy as they obtain resources from the programs (Skocpol, 1992).
- *Mechanism three: Regulatory policies function as institutions* that ensure certain ensuing reforms and policies are more efficient and, therefore, likely to be chosen and implemented. As explained by Pierson, ‘Policies, grounded in law and backed by the coercive power of the state, signal to actors what has to be done, what cannot be done, and establish many of the rewards and penalties associated with particular activities’ (Pierson, 2004, p. 35).
- *Mechanism four: Social policies influence normative expectations* about the role of the state in the economy and society and in delivering social equality (Brady & Bostic, 2014). That is, the legitimacy of the policy is derived from these expectations.

Fifth, mainly due to the four above, a path-dependent policy will *constrain politicians from retrenching or removing rules* that benefit certain groups (Brooks & Manza, 2007). These mechanisms are explored through the case studies to understand the role of actor networks in shaping Australia’s payment and access rules over time.

3.3.2 Role of institutions and lock-in

Institutional theory provides a lens that broadly allows us to examine institutional change and endurance (Peters, 2011). Historically, it was thought that institutions provide a ‘stable, valued, recurring pattern of behaviour’ (Huntington, 1968, p. 12). Institutional theory has accordingly prioritised stability rather than change and structure rather than agency (Lowndes & Roberts, 2013; Olsson, 2016; Thelan, 2003). Some theorists argue that institutions can suffer lock-in effects, as once a policy position has been taken and industry has adapted, it is increasingly likely that it will follow the same direction (Pierson, 2000; Aberg, 2015; Mahoney, 2000; Wilsford, 1994, p. 275). Indeed, Kay (2005) argues that the institutions are path-dependent and that researchers need to explain the operation of the institutions and their interaction with the broader political environment.

An institution can become ‘locked-in’ or might be resistant or susceptible to environmental shocks depending on mechanisms that either sustain or weaken it and its replacements (Bennett & Elman, 2006, p. 257). Alternatively, institutions can be transformed by endogenous and exogenous forces, and large transformations can follow from smaller or more gradual changes (Lowndes & Roberts, 2013). Both change and stability are the products of human agency, and apparatuses concerning

power, legitimacy and functionality can become causes of institutional change or formation (Lowndes & Roberts, 2013; Thelen, 1999, pp. 392–9). An institution founded on power can be destabilised in three ways: a reduction in power, a decrease in the legitimacy of the actors that uphold it, or a lessening of an institution's appropriateness due to changes to other institutions in the broader environment (Bennett & Elman, 2006; Doyle, et al., 2016). Conversely, institutions can be strengthened when they have distributional impacts that improve the power of actors concerned in maintaining them (Thelen, 1999).

March and Olsen contended that institutions are the primary independent variables in considering political decisions and policy outcomes (March & Olsen, 1989). North (1990a), Ostrom (1999) and Pierson (2000) suggest that actors act in an environment that is collectively restrained, and these constraints take the configuration of institutions. Institutions, as defined by Hall and Taylor (1996, p. 938), can be 'the formal or informal procedures, routines, norms and conventions embedded in the organisational structure of the polity or political economy.'

Researchers commonly use three levels of institutions: the macro or constitutional level, the public policy or community choice level, and the personal decision (operational) level (Kay, 2005). Pierson argues that 'most institutionalist scholars have tended to focus their attention on formal institutions at the macro or constitutional level' (1993, p. 596). However, this research considers the institution operating at a policy level, as major public policies can constitute important rules of the political game, manipulating the allocation of political and economic resources and altering the potential resources to be used in political strategies actors can employ, and, through this, impacting the development of certain policies in the future (Kay, 2007). In this thesis, the institution is the operation of the payment and access rules, which determines how healthcare is provided in Australia.

3.3.3 Capacity to create change

Path dependency theory has been criticised as a strict interpretation that suggests that path-dependent processes imply that the future of a policy is controlled by its past, and so progression is deemed to be deterministic (Aberg, 2015). Accepting that lockdown without any change is rare, Pierson (2000) and Thelen (2003) argue that a greater understanding of what creates reproductive processes will help answer the question of what causes political paths to become amenable to altering policy choices, implying that there is a potential to change or shift a policy. Russell et al. (2009) concur and note the capacity for endogenous and exogenous changes that may alter the course or break the path. Under this viewpoint, path dependency is disturbed when a condition necessary for stability is challenged or when an exogenous event occurs (David, 2013; Pierre, 2009).

Consistent with the idea of altering paths is the work of Garud and Karnøe (2001, p. 9), who suggest that a locked-in policy can be changed as new ideas emerge when actors mindfully deviate from an existing policy and imagine something different, using consideration of past, and current environments. In addition to exogenous events creating the necessary factors to alter a policy, Garud and Karnøe stress the relevance of strategic, deliberate and mindful actions of actors (Sydow, et al., 2015, p. 155). These actions may occur even if the actors cannot control the deviation entirely (Meyer & Schubert, 2007, p. 28). This perspective allows for considering agency and the actions of multiple skilled individuals or organisational actors who coordinate their activities with each other, complementing network theory.

Crouch and Farrell expand upon Garud and Karnøe's theory and propose an adapted version of path dependency that shows how actors respond to the environment. Complementing the concepts used in network theory and RDT, they suggest that actors can draw upon and transfer ideas (resources) through their interactions with other actors and that how 'close' other actors are to each other can influence the costs of acquiring these resources (Crouch & Farrell, 2004, pp. 27-34).

3.4 Conclusion

This chapter has established the conceptual, theoretical framework guiding the research, which draws on three theories to explore the role of the actor network: its interests, use of power, legitimacy and resources in its strategies to attempt to reform (or constrain reform of) the payment and access rules in Australia's healthcare financing system. Changing the payment and access rules to allow insurers to contract medical practitioners directly can incentivise medical practitioners to improve quality and coordinate service provisions for people with chronic conditions (Biggs & Buckmaster, 2007; Jan, 2015; Paolucci & Garcia-Goni, 2015). It could also improve the efficiency of Australia's healthcare system (Kotz, 2021). However, major attempts to alter the operation of the payment and access rules to incentivise integration in Australia have been largely unsuccessful. Why reform has been so challenging is poorly understood and requires an investigation of the actors and their networks over time.

The propositions contained in the three theories were brought together in a framework to examine and reveal the role of the network in Australia's health financing policy. First, network theory was chosen as it supports examinations of how actor networks operate in their environment when engaged in political debates. Network theory is used to identify patterns in the actors' relationships, such as hubs, cliques, or brokers, and links those relations to the outcome of interest, in this case, the resilience of Australia's payment and access rules. A focus on patterns of relationships between actors enables an investigation of the structure of the network, which is important for understanding

who can control the network (norms, resource usage, information flows) and who has the power in the network to lock down or change a policy (Berry, et al., 2004; Rhodes, 2006). Resource dependency theory (RDT) complements network analysis by focusing on the external environment, and allowing for examining power, agency and legitimacy (Taylor, et al., 2018). Finally, path dependency theory is included in the framework due to its relevance in analysing and explaining the persistence of public policies in the face of attempts at reform (Kotz, 2021; Torfing, 2009). Path dependency theory is used to explore the impact of the network on limiting ambitions for reform of Australia's payment and access rules over time.

The three theories were chosen as they enable an explicit focus on actors' operations in political networks and power relations as actors compete for resources, their ability to explain the mechanisms supporting the retention of institutions or policies, and their capacity to complement each other. Combined, they illuminate the role of actors in preventing reformers from securing systemic change to the operation of the payment and access rules. This is a critical issue for the health system as retaining the current system constricts insurers, both public and private, in Australia's mixed model and is a barrier to improving coordinated care and efficiencies in the healthcare system.

Chapter four outlines the methodological approach of the research by presenting the research design, detailing the use of case studies, network analysis, and qualitative data through interviews. The results of the three case studies are presented in chapters five, six and seven.

4 Methodology

4.1 Introduction

This chapter outlines the methodology used in this research to answer the research questions. I outline a mixed methods approach to examine the role of actor networks over time in attempts to reform Australia's healthcare financing system. The chapter begins with an outline of the research design in four phases – case selection, network analysis, interviews and data triangulation (4.2). It explains how the three case studies were selected for the research (4.3) and were confirmed through pilot interviews in phase 1. It then outlines the network analysis methodological approach (4.4) and explains how network maps were developed for each case study in phase 2. The chapter then discusses the qualitative interviews for the cases (phase 3) and the triangulation of the data sets (phase 4) in sections 4.5 and 4.6, respectively. It then outlines limitations and ethics approval for this research.

4.2 Research design

This research applies mixed methods through network analysis and qualitative interviews in three case studies representing key attempts to reform Australia's healthcare financing system over time.

The overall purpose of mixed methods studies is that combining quantitative and qualitative approaches provides a better understanding of research problems and complex phenomena than either approach alone (Creswell & Plano Clark, 2007). Mixed method approaches provide a breadth and depth of understanding and corroboration (Johnson, et al., 2007). In this research, a mixed methods approach supports combining the rich, subjective insights of actors in the network (their perceptions of power and relationships) into complex realities generated by qualitative inquiry with the standardised, generalisable data generated by network models (quantitative research) (Regnault et al., 2018).

As outlined in chapter one, this research is designed to answer the following:

1. What role have collectives of organisations (actor networks) played in enabling or constraining policy change in Australia's healthcare financing policy?
2. Is there a relationship between any change in the structure of the actor network (i.e. who has power and what relationships exist between actors) and success in attempts to alter the operation of the payment and access rules that set how insurers can pay medical providers?

3. What does this tell us about the role of private health insurance in health financing in Australia?

Quantitative network models were developed to answer research question 2; however, while these methods provide answers regarding the structure of the network, they are limited due to a lack of attention to the qualitative aspects of relationships, such as norms, mentalities of actors, strategies and understanding of the social environment (Luke & Harris, 2007; Froehlich, et al., 2020). The research methods draw upon qualitative approaches, including document reviews and key informant interviews (Froehlich et al., 2020) to understand the actors' perceptions of the relationships and answer questions regarding the role of the actors in the network (research question 1) and the role of private health insurance in Australia's health financing system (research question 3).

Qualitative methods are suitable as the research objectives relate to understanding rather than only measuring (Oinas, 1999). Using a mixed methods approach is appropriate as it allows for using data obtained by one method to illustrate results from another (i.e. exploring the network model during the semi-structured interviews) and providing richer insights than would be achieved by using one method alone (Creswell & Plano Clarke, 2018; Tariq & Woodman, 2013).

Three case studies are investigated to enable a deep dive into specific policy instances and to compare over time the influence of the network of actors on the payment and access rules as they engage in each of the policy case studies. This created a multiphase sequential design that integrates network analysis with qualitative interviews (Creswell & Plano Clarke, 2018).

Incorporating a case study approach with network analysis methods allows for a more contextualised approach appropriate for incorporating and examining the network's operations, behaviours of actors, use of power, and environment during the policy events and over time (Bennett & Elman, 2006; Yin, 1994).

The use of both network analysis and qualitative interviews also allows for the consideration of the fundamental tenets of policy networks: how the structure of the network and the operations of the network impact policy outcomes (Berry, et al., 2004; Jenkins-Smith, et al., 2018; Knoke, 1990; Saward, 1990). Data for these were collected over three phases, applying quantitative and qualitative methods, which were triangulated and integrated in the fourth phase. After establishing the case studies (phase 1), the quantitative data consisted of network maps generated from key documents in each case (phase 2). Qualitative data was then gathered from key informants via semi-structured interviews to investigate the structure of the network; power, legitimacy, and resource usage by actors; the importance of the resources and impact of

the social context (environment) to the strategies deployed by actors; and whether politicians were restrained from reforming the system.

The use of mixed methods in network analysis is common. The methods in this research follow policy network methods used by Wishaar et al. when analysing network operations in the development of tobacco control in the European Union (2015), in combination with methods used to understand the operations of policy networks in health systems in Australia (see Baum et al. (2017), Browne et al. (2017), and Cullerton et al. (2017)). Through the construction of case studies, network mapping and analysis and semi-structured interviews, data was triangulated in the final integration phase (phase 4). This enabled a comprehensive understanding of the role of the actors in the network in restricting reform to the operation of the payment and access rules and helped validate the research findings by checking that different methods or different observers of the same phenomenon produced similar results. It was also used to investigate inconsistencies and data not expected to align (Nightingale, 2020).

To summarise:

Phase 1: Case selection (qualitative). In this phase, a selection framework and establishment of the case boundaries were conducted. Three historical attempts at reforming the operation of Australia's payment and access rules were selected (see below), which informed the three policy case studies.

Phase 2: Network models were created using key documents for each of the three case studies (quantitative, see below). Nodes and ties that form the network structure were defined and then captured using the Gephi software package, using established network approaches. This produced network maps and measurements that show the role of actors in the network. A timeline of events was also created from the document review, providing the first qualitative data on the actors and their environment. Both of these documents were used in phase 3.

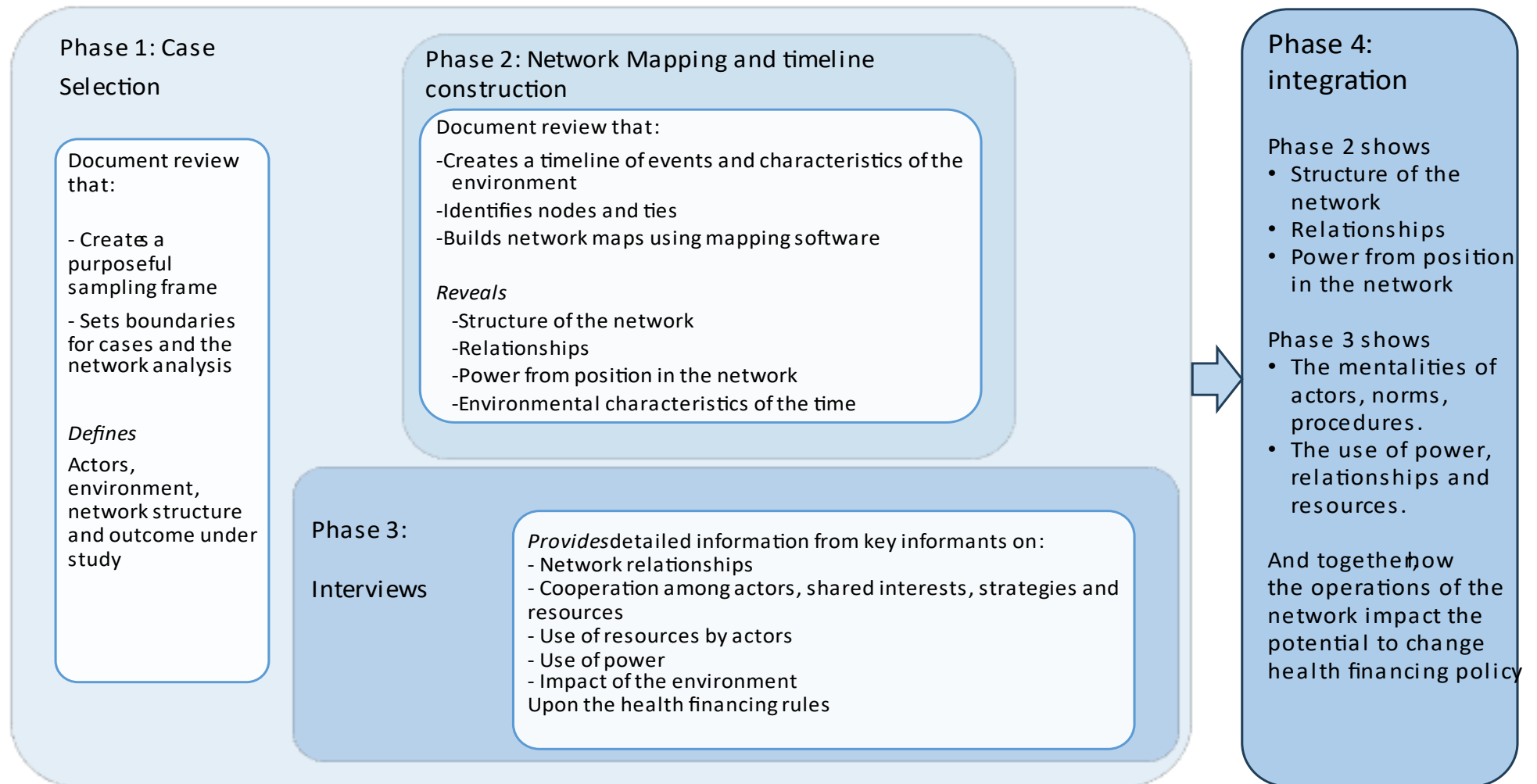
Phase 3: Semi-structured interviews were conducted with key actors in each case study to understand better how actors operated within the network to achieve their goals (de Leewe, et al., 2018). Interviews provide a deeper and more nuanced explanation of the networks' operations and how actors used resources and power to influence the outcome (qualitative, see below).

In **phase 4**, triangulation of data combined the network analysis findings described in phase 2 with the qualitative interview data from phase 3. The combination of these data sets allowed for the examination of the structure of the network and the operations of the network in each of

the case studies, together providing a detailed account of the influence of powerful actors on constraining attempts at reforming Australia's healthcare financing policy over a long period.

Figure 4.1 shows the interaction of the phases.

Figure 4-1: Multiphase sequential design



4.2.1 Epistemology

Okesina (2020) suggests that a researcher's paradigm shapes their selection of research methodology. From an epistemological position, I take a pragmatic approach, drawing on both quantitative (positivist) and qualitative (interpretive) methods to understand social phenomena (Marsh & Stoker, 2002). This follows a pragmatic paradigm (Shannon-Baker, 2016), which supports a combination of methodologies or mixed methods approaches tailored to specific phenomena. In this case, a combination of worldviews enables an understanding of the structures of actor networks and how actors perceive who has power and uses power, legitimacy and resources to influence change.

4.3 Phase 1: The use of case studies

Case studies were used in this research as the case study method allows for a study that provides both a holistic understanding of the event and a thorough view of proceedings (Pierson, 2004, p. 19; Bennett & Elman, 2006, p. 260). Case studies are apt for the examination of infrequent occurrences; they can help locate absent variables that may underlie dependent events, and they provide for the study of interaction effects with only one or a few cases (Bennett & Elman, 2006).

In network analysis, the boundaries of a network should be defined before data collection. A boundary is important as it defines the set of actors under consideration and allows the researcher to describe and identify with the population under study. Defining a boundary is important, particularly when the potential set of actors is not a small, closed group, as an incorrect boundary can bring bias into the research (Wasserman & Faust, 2008, pp. 30–31; Butts, 2008).

Three significant proposals for reform that would have allowed direct contracting of medical providers by private health insurers form the case studies used in this research. Many reforms have been attempted over the decades, requiring a sampling process for the cases, which should follow a form of reproduction logic and keep as many variables as possible consistent. This can be achieved either by selecting cases that produced similar results or by selecting cases that generated distinct outcomes but for a predictable reason (Yin, 1994). In replication, the purpose is to achieve external validity or determine whether the findings can be generalised to other contexts about the phenomena in focus (Yin, 1994).

Selecting cases where either a key independent or dependent variable differs but other important explanatory variables are as constant as possible can lead to valid causal inferences

(Barakso, et al., 2014; Lijphard, 1971, p. 686). This purposive sampling 'does not attempt to replicate the full population. Rather it draws subjects to maximise variation in the independent variable of interest, so that the relationships being looked for will be clearer' (Shively, 2011, p. 103).

Knoke and Laumann (1982, p. 263) define a policy event as 'any proposal in the policy process that offers alternatives that would become binding on the industry participants.' Three proposals to change the payment and access rules by legislative amendment that were scrutinised by a parliamentary committee were found. The period for each case is the date the policy change was announced through to when the implementation of the changes was formally reviewed or one year after the changes came into effect, whichever occurred first. Agenda setting and review in health policy appear continuous, with numerous reviews leading to a policy announcement. Creating a boundary from the announcement date of the proposed change allowed for analysis of the actors once the parameters around the policy event were clearer and more defined. This boundary allowed for analysis of the impact of the network upon the development of the enacted policy, from announcement to enactment, and then through to implementation within the resource limitations of the current research.

These cases are all similar in that there was an attempt to change how private health insurers could pay medical practitioners by altering the operation of the payment and access rules; however, the system remained unchanged. As discussed in chapter one, all three cases proposed changes in the policy development phase, although the potential impact and ambition of reforms diminished as time progressed. The final legislated changes to the payment and access rules reduced significantly across the cases until the third case, where a change to the payment and access rules did not occur. After all cases, direct contracting of medical practitioners by PHI as a way of operating did not occur. The case selection framework is set out in Table 4.1 below.

Table 4-1: Case selection framework

	Potential to change integration (direct contracting)	Significant political conflict	Potential for changes to the payment and access rules	Was the bill subject to public and political analysis?	Deemed important by two or more commentators at the time	Involved three or more major stakeholder groups	Change in actors to the previous attempt	Outcome
Case1 (1995): Allow insurers to contract medical providers	Yes	Yes	A bill was put before parliament by the government	Yes, it was sent to a parliamentary committee for review	Yes, the Australian Medical Association (AMA), insurers and consumers	Yes	N/A – baseline	Some integration was permitted but did not occur.
Case 2 (2007): Allow insurers to manage and coordinate care through the payment of a program	Yes	Yes	A bill was put before parliament by the government	Yes, it was sent to a parliamentary committee for review	Yes, the AMA and insurers	Yes	Yes	A small amount of integration with a limited group of health providers was permitted; however, medical providers were excluded.
Case 3 (2013): Allow insurers to make payments to partially fund GP services	Yes	Yes	A bill was put before parliament by a non-government senator	Yes, it was sent to a parliamentary committee for review	Yes, the AMA, insurers and consumers	Yes	Yes	A pilot scheme that partially integrated general practice and one private health insurer operated for 18 months, then ceased.

The case selection framework revealed three key cases, briefly described below and in more detail in chapters five to seven.

4.3.1 Case 1: Hospital and Provider Contracting - 1995

This case study was a proposal by the government at the time that would allow insurers to directly contract with medical providers and hospitals, setting fees and changing payment models. The policy event commenced in late 1993. Insurers would be allowed to contract with providers, and a single billing system would be introduced (with known medical providers' costs upfront). Insurers were supportive, medical providers vigorously opposed it, and the bill was sent for further Federal parliamentary scrutiny via a committee process.

The resulting legislation allowed insurers to contract with medical providers; however, provider contracting ceased after significant resistance by medical providers.

4.3.2 Case 2: Broader Health Cover (BHC) - 2007

The then federal government envisaged changing the payment and access rules to allow private health insurers to cover general practice services, hospital substitute services, Chronic Disease Management Programs, and health and wellness programs. Insurers would be able to integrate care through contracts with teams of providers for patients with chronic conditions.

Medical providers were concerned that chronic disease management programs were a move into managed care and gained assurances that this was not the case. The bill to legislate these changes was also sent to a parliamentary committee for further scrutiny. The changes allowed for insurers to support a plan for a patient, but insurers are unable to fund service provisions directly or contract medical providers as a part of a plan, limiting the amount of coordination between medical providers and other health providers.

There was a very slow uptake of the chronic disease management plans.

4.3.3 Case 3: Medibank Private GP Access Program - 2013

In November 2013, Medibank, Australia's largest health insurer, commenced a pilot model of healthcare provision by contributing towards the payment for general practice services.

Medical practitioners vigorously challenged the legitimacy of this model. In March 2014, former general practitioner and member of the Greens, Senator Di Natale, introduced a bill to outlaw the practice, thereby creating a greater barrier to coordinated care. This was referred to a parliamentary committee for further scrutiny, and parliament rejected the bill.

Despite being supported by the then government, Medibank's GP Access Program suddenly ended in July 2015.

The combination of the cases showed the enduring nature of the fundamental structure of the policy network (Sabatier, 2007), but moreover, it allowed for the examination of whether the structure of the network would transform over time as policy proposals became smaller in ambition and more targeted in their desired changes. As illustrated in the results chapters, testing the role of the network over time through these three key cases revealed how the capacities of actors, their application and acquisition of resources, and the development of strategies changed over time (and ultimately constrained reforms). Additionally, using a case study method holding as many variables constant as possible allowed for examining how power has been used to prevent change to the institution that is the operation of the payment and access rules in Australia's healthcare financing system.

4.3.4 Case confirmation

The author interviewed three key and influential researchers in the field to understand whether the case selection framework above provided the best cases to answer the research question.

Interviewees were chosen from a small group of researchers who showed an interest in healthcare funding during the period 1994 to 2014 and were available for interviews.

Interviewees discussed the nature of health funding in Australia, the decisions to improve the viability of the private health insurance industry, and the need to improve care integration. Within the parameters set above, alternate cases were not identified.

Phase 1 allowed for the creation of the network boundary, defining the period and the policy event at the centre of the debate under review. In network analysis, once the boundary is defined, data collection can commence using a sampling technique to determine which nodes are a part of the network.

4.4 Phase 2: Creation of the network analysis model and timeline of events

This section first outlines the principles of network analysis, including homophily, connections, density, modularity, degree and centrality. It then explains how network maps were constructed for each case study in phase 2.

4.4.1 The principles of network analysis

Network analysis can be described as a unique set of methods applied to map, measure and analyse the relationships between actors (organisations or individuals) (Scott, 1990; Borgatti, et al., 2009; Scott, 1999). Applying mathematical algorithms and network model software (e.g. Gephi or UCINET), scholars have considered how various forms of relationships between nodes in a system either aid or

constrict the choices and behaviour of actors, as well as how the network functions as a whole and the actors capacity to adapt (Marsden, 1990; Bogatti, et al., 2002; Wasserman & Faust, 1994). Policy networks are basically networks that contain policy actors. Policy network analysis, therefore, is a form of network analysis (Knoke, 2016; Kickert, et al., 1997). Whilst it is sometimes criticised for being a fragmented set of theory and methods (Dowding, 1995), a network analysis mapping study found common themes: there is a focus on cliques or ties (e.g. resource, communication, or informational) amongst nodes (e.g. individuals or organisations) with a view to understanding why actors develop specific linkages, how differing environmental circumstances impact those linkages, and what consequences flow from the relationships and the positions of actors within the structure of the network (Oliver & Ebers, 1998).

Network analysis is based on three principles: actors and their behaviours are mutually dependent, not autonomous; ties between actors can be conduits for the spread of physical resources; and the structure created by the patterns of association among actors can support or constrain the behaviour of actors in the network (Wasserman & Faust, 1994, p. 4; Raab & Kenis, 2009).

The tie (connection) between actors is the primary unit of analysis in a network, joining the members of any one group or subgroup (Knoke, 2001). The pattern of existing and absent ties between the nodes in a network establishes its structure. 'The perceptions, attitudes, and actions of organisational actors can be shaped by the larger structural networks within which they are embedded, and, in turn, their behaviours can change these network structures' (Knoke, 2001, pp. 63-64) (Knoke, 2011, pp. 63-64).

4.4.1.1 Homophily

One of the reasons actors exist in compact, unified groups with sturdy connections is the principle of homophily, which is the propensity of actors to interact, associate, and connect with others who have like histories and characteristics (Robins, 2015). In network analysis studies, homophily is a key concept that structures how networks operate. It encourages and shows trust among actors (McPherson, et al., 2001).

Homophily structures group and subgroup formation and connections in a variety of environments, and similarity among group members have been detected in a wide variety of characteristics, including gender, age, political alignment, education, social status, and organisational roles (Gompers, et al., 2016). Strong connections lead to a superior ability to influence the norms, values and behaviours of the connected actors (Kadushin, 2012). Homophily has a unique impact on policy development as people with similar professional backgrounds or status are inclined to gather

together in tight-knit groups; this can limit the diversity of views and restrict opportunities for other actors, thus preserving the interests of those in power Granovetter (1973).

4.4.1.2 Connections and cohesiveness

Actors have strategic goals that they may choose to share with other actors in the network (Hall & Taylor, 1996). The existence of a shared goal is not a necessary condition for an actor to connect with other actors in the network. Networks grow because the actors need one another, and this can be a short or long-term need depending upon an actor's strategy and dependency upon others (Emerson & Nabatchi, 2015).

The majority of networks have a condensed grouping of robust linkages. Actors entrenched in a condensed and highly interconnected network have similar access to identical information or resources, and they may all be constrained by each other, which means no one actor can obtain an advantage. The structural holes theory (Burt, 1992) suggests that other people's cohesiveness is a disadvantage in competitive environments.

If an actor is a 'bridge or broker' between the dense network and another network (or between subgroups of a network that are not linked with each other), the actor can obtain information or resources from a more diverse group that does not have access to one another (Bernado & Lubell, 2016). Granovetter's 'strength of weak ties' theory is like Burt's structural hole theory (Granovetter, 1973). The 'strength of weak ties theory' suggests that as the strength between two actors increases, there is an increased likelihood that their connections will intersect and that they will have shared linkages with third parties. Brown et al. demonstrated the impact of ties on policy, finding that the actors within the five strongest cliques in the networks held similar positions on Aboriginal health issues (Browne, et al., 2017).

In the second arm of this theory, Granovetter claims that weaker links (bridging ties) provide a possible avenue to obtain novel resources or information, thus allowing for the development of new policy ideas. Both Granovetter and Burt use a similar underpinning frame; however, Granovetter argues that a link's strength determines whether the tie is a bridging link. Hebbert et al. extended this theory (2006), demonstrating that tie strength is not static and that actors will use it deliberately to ensure active but less useful connections do not overwork them as they undertake their work. Bridging nodes can be a source of information but may not necessarily be powerful actors – this will depend upon the structure of the network and other environmental factors, such as political will, as discussed by Cullerton et al. in their studies of nutritional networks in Australia (Cullerton, et al., 2017).

4.4.1.3 *Network closure*

A network described as closed is a highly connected network. These connections can be direct by the presence of numerous strong linkages or indirect via a node coordinating many other nodes. The first demonstrates the level of activity within the network; the latter illustrates the hierarchy within the structure. This research applied the network measures of density and centralisation to identify network closure, as detailed below.

4.4.1.3.1 *Density*

Density is a good measure of the structural feature that is network closure (Friedkin, 1981) (Cullerton, et al., 2017). Network density is an often-used concept within network analysis and is 'associated with the general notion of network cohesion' (Scott, 2000, p. 71). An overall density measure can be derived by dividing the number of ties of connections by the maximum number of connections (Sandstrom & Carlsson, 2008). In a network in which all actors are completely connected, the density measure will be 1.0, and in a network in which only half of the potential connections exist, the density index will be 0.5 (Fisher, et al., 2013). Networking density provides information about the overall activity and measures the flow of resources within the network. A density above 0.5 is considered strong, and around 0.25 is medium (Ingold, 2011). Biggart's (2001) research into credit associations demonstrated that stable communities with stronger social relationships provide an environment for successful peer group lending.

The capacity to seek other ideas expands as the density of the network expands, and the level of dependence upon actors for resources changes as density changes (Bernardo & Scholz, 2010; Granovetter, 1973; Frank & Yasumoto, 1998; Mascia & Cicchetti, 2011).

Density measures have been widely debated in the literature, perhaps due to their widespread popularity (Sandstrom & Carlsson, 2008). As a basic premise, the denser the network is, the higher the presumed level of network closure, which suggests an increased flow of resources and information (Luthe, et al., 2012; Brockhaus, et al., 2014). However, numerous difficulties are linked to using density measures on their own (Friedkin, 1981; Moody & White, 2003). To mitigate concerns around the use of the density measurement, two other network attributes, size and modularity, must be considered when drawing conclusions regarding density. The use of size and modularity to validate the accuracy of the density index has been proposed by Sandstrom and Carlsson when discussing the performance of policy networks (Sandstrom & Carlsson, 2008). The impact of modularity upon the ability of a group of actors to solve problems caused by climate change was shown by Luthe (2012). In studies in the health sector, density is often applied to answer questions around the diffusion of information or positional power; see Mascia and Cicchetti's (2011) findings

that denser networks were less likely to adopt new evidence-based medicine in a study of six Italian hospitals and Cullerton et al.'s (2017) research identifying the potential for actors to influence Australian national nutrition policy.

4.4.1.3.1.1 Size of the network

The number of nodes pertains to the size of the network and the number of actors in the network (Granovetter, 1973). It shows how large or small the pool of actors is. It is one of the characteristics used to describe the actors' environment: Is the network broad and rambling or tight and small (Burt, 2000)? This can show whether information will travel quickly or slowly through many or few nodes (Smith-Doerr & Powell, 2010).

Network size directly affects the interpretation of density (Scott, 2000). Larger networks require greater levels of cohesion to obtain similar levels of density. This demonstrates the limited comparative validity of density as a measure and is sometimes called a travelling problem when using different cases (Zech & Gabbay, 2016). However, if the size of the networks is appropriately acknowledged, this can be managed. In this research, the networks are of similar sizes, varying by two or three actors (nodes); therefore, this problem does not require further management.

4.4.1.3.1.2 Modularity

The existence of subgroups should be analysed alongside the density measure. Some networks can be structured as a single cohesive set of actors (Barnekow & Jansen, 2006); alternatively, the network may be fragmented and divided into several tightly formed subgroups with limited interaction among them (Sandstrom & Carlsson, 2008). Previous network analysis in health policy has shown the propensity for clusters to form to influence policy outcomes (Friel, et al., 2019; Lofgren & Boer, 2004; Weible & Sabatier, 2005).

The constructions of subgroups will impact the explanations that can be formed when also using density as a measure. For example, a network that consists of two very distinct subgroups could produce a high-density measurement if large amounts of interactions occur within each of the subgroups (Newman, 2006). Alternatively, a network may be divided into a few larger subgroups and may be fragmented if there is little or no communication between them. As a result, the number and features of the subgroups within a policy network need to be scrutinised. Subgroups are important to identify as they show who is working with whom.

As demonstrated by Browne et al., analysing the network structure and subgroups allows for the examination of whether there are collectives that share the same norms, policy positions and information and whether it is a group or an actor as an individual organisation setting the policy

agenda (Browne, et al., 2017). The presence of subgroups in this research was determined by their interactions with each other and their positions on reforms to the payment and access rules in the policy events (Leifeld, 2013; Leifeld & Haunss, 2012).

Subgroup analysis demonstrates where power lies in the network. Changes in subgroup membership across cases may point to differences in legitimacy and create the potential to change the payment and access rules.

In summary, if the network density in the cases is analysed considering both the size of the networks in the cases and the presence of subgroups, it can be considered a valuable measure of network cohesiveness (Scott, 2000; Wasserman & Faust, 1994).

4.4.1.3.2 Centralisation

Network centralisation is calculated using the centrality measurements of each actor in the network, explaining the variations between them. To explain the ordering and structure of a network, the centrality of each individual actor is calculated (Ward, et al., 2011).

Whether the network is hierarchical in structure is empirically measured by centralisation. A hierarchical network is suggested when there is high degree of network closure (Burt, 2000). When a network has a high level of centralisation, significant discrepancies can occur in the amount of activity or importance of actors, for example, the presence or absence of a strong coordinating node, which should be examined (Ingold, 2011).

Network centralisation was calculated using two steps. First, the centrality measurements of each of the individual nodes are deducted from the uppermost centrality score (the most central actor), and then these scores are totalled. Second, that total is divided by the maximum possible sum of differences (Scott, 2000; Wasserman & Faust, 1994). This statistic shows the proportional asymmetry or how 'star shaped' versus circular the network structure is (Sandstrom & Carlsson, 2008). The asymmetry of the network indicates how equally or unequally actors are connected.

At a nodal level, each of a network's actors can also be given a different level of importance, known as centrality, which indicates how much they share information resources and other valuable items within the network (Borgatti, et al., 2009). There are three methods to measure centrality degree, closeness, and betweenness. Degree centrality considers the number of direct connections, betweenness centrality quantifies the actors' interconnectedness, and closeness centrality considers the distance of one actor from the rest of the actors (Ward, et al., 2011). This is based on the concept that an actor's centrality depends on the extent to which the actor is located between other actors (Hanneman & Riddle, 2004).

The concepts of degree, closure and betweenness centrality have been the focus of considerable debate by various researchers (Hafner-Burton, et al., 2009). The benefits and issues related to all of these measures were examined in detail by Freeman (1979), Freeman et al. (1979), and Friedkin (1981), among others. All three measures capture the structure of influence. Whilst each measure considers a different question related to the group's social structure (Friedkin, 1981), each measure can emphasise the power held by actors.

Wasserman and Faust emphasise the advantages of betweenness and degree measures individually (Wasserman & Faust, 1994). They contend that degree centrality often correlates with closeness centrality (who is close to who). However, betweenness centrality is argued to be better for exposing the power situations where the control of norms and the flow of information resources are important (Bonacich, 1987). Betweenness centrality is also considered more nuanced than the other two, and the decision regarding which measure to use should be made considering the research at hand (Freeman, et al., 1979).

For policy networks, centrality equates to influence. If an organisation does not hold a central position in the network, it is problematic for it to be regarded as influential as, theoretically, its power is limited (Freeman, 1979; Yan & Ying, 2009). When compared with other organisations in the policy network, an actor with a high centrality (degree) metric, a high betweenness centrality, and a low path distance to a decision-maker has an increased level of influence and, therefore, power (Laumann, et al., 1985). The three centrality measures are explored below.

4.4.1.3.2.1 Degree

How central actors are to the network operations was analysed through the mean degree. This is the average number of links that pass through an actor (Freeman, 1979). This allows for consideration of whether the actor is a central figure controlling the network. More central actors have a greater influence on organisations' agendas (Friedkin, 1991). Changing a central actor may change policy outcomes, and this was analysed across the cases; alternatively, the central actor's solidification may indicate that the institution is locking down and path dependency is being established (Farrell & Newman, 2019).

The highest level of network centralisation possible is 100 per cent, where all actors are connected to one actor, whereas a complete circle with no star formation would have a centralisation measure of zero per cent. A star-shaped pattern is frequently used as an illustration of the structure of the network to explain centrality. The node in the middle of a star is the most central actor, as connections are organised through and around this node (Ward, et al., 2011). The opposite illustration, the circle, reveals a network where all nodes are structural equivalents (Hafner-Burton,

et al., 2009). In a circle setting, the actors are equally connected, equivalent, and located between other nodes.

4.4.1.3.2.2 Betweenness centrality

Betweenness centrality in network analysis measures how often a node lies on the shortest path between any two random nodes in the network (Freeman, 1979). Alternatively expressed, betweenness can be calculated as the percentage of shortest paths that pass through the node and measures the amount that an actor lies between the other actors in the network (Zhang & Luo, 2017). Betweenness centrality demonstrates the level of interconnectedness between actors. It tells us who has key relationships and identifies power within the network (Barabasi & Reka, 1999).

Betweenness centrality is, therefore, a good measure of influence as it considers the whole network, not only the local interactions or subgroups of which the actor is a part (Hanneman & Riddle, 2004). It is important to consider degree and betweenness centrality together, as an actor may have a low betweenness centrality score but a high degree measure. This combination indicates that the node has a high level of interaction within the subgroup it belongs to but is not as well connected to the nodes that belong to the other subgroups within the network. Nodes with a high degree but low betweenness may have a high level of influence in their subgroup but not across the greater network (Hanneman & Riddle, 2004).

4.4.1.3.2.3 Closeness centrality

Closeness centrality determines the nodes that can disperse information quickly and effectively through a network. The closeness centrality of a node provides a measurement of its inverse distance (its average farness) to all other nodes (Luke & Harris, 2007). A high closeness measurement indicates shorter distances to all other nodes (Boudin, 2013).

Closeness centrality, when used with degree and betweenness centrality, tells us more about the relationships of the individual nodes. If a node has high closeness but low degree, the node will have ties to some active/important actors; however, if there is high closeness but low betweenness, the node may be near to many actors, but many others also are (Hanneman & Riddle, 2004). High degree and low closeness scores indicate that the actor is embedded in a subgroup distant from the remaining nodes in the network. Finally, the most powerful position is to have high degree and high betweenness. Such a node monopolises the ties from a key node to many other nodes. This situation is relatively rare (Zhang & Luo, 2017).

4.4.2 Development of the network map

Once the cases were established, key documents were collected and coded to construct the network maps. The section below explains how nodes and ties were defined and documents were coded to construct network maps.

4.4.2.1 *Defining the nodes*

Network analysis is the examination of ties among nodes (actors). As these studies are social (instead of physical or biological), actors characteristically denote individuals, organisations or states (Ward, et al., 2011, p. 246; Carpenter, et al., 2004).

Nodal analysis has been used to explore resource usage by actors (or their agents), the mentalities and resources of nodal action, or the way actors try to enrol, coerce, and convince others to achieve their goals, for example, understanding the sharing of academic resources in healthcare allowed for the revelation of subgroups that form around information distribution (Jessani, et al., 2016) and the exposure of coercing behaviour in international fora (Farrell & Newman, 2019). Network analysts apply the theory that the position of the node, in relation to other nodes, and their linkages or ties to argue that the structure of the relationships can shape the behaviour of the actor and influence other actors (Cao, 2009; Marsden & Friedkin, 1993; Granovetter, 1973).

Actors at a regulatory policy level are generally organisational level actors (Peterson, 1993; Cullerton, et al., 2016). For this research, a node is an actor at an organisational level. This will use the professional network concept consistent with Alford's identification of the three sets of interests in healthcare: the dominant interests of the medical profession, the challenging interests of the corporate managers, and the repressed or downplayed interests of the community (Alford, 1975). Organisations are formally organised, to greater or lesser degrees, and have resources to use internally and for their relations in the network (Carlsson, 1996). This research focuses on organisations rather than individuals, primarily as the actors have all formed alliances, groupings or other representative bodies that, whilst differing on micro detail, operate at an organisational level or as a block in political arenas (Cullerton, et al., 2016). Therefore, the organisational level actor, where this exists, is the unit of analysis (nodes) for the network model (Ansell & Gash, 2008).

This research focuses on nodes at the organisational level, but its methods also allow the analysis of the impact of key individuals within the nodes to be conducted (Knoke, 2001). Whilst it is appropriate to examine the network at the organisation level, individuals within organisations need to be included because organisations are a conglomerate of individuals, and organisations act through individuals (Slaughter, 2017). The role of individual actors was examined in terms of their role as individual specialists or representatives of the organisation (Grabher, 2005). Individuals embedded in

organisations maintain agency to choose who they work with and make calculated and strategic decisions that may control information exchanges, thus shaping and adjusting the network to advance particular interests (Howlett, 2002; Marsh & Smith, 2000; Shearer, et al., 2014).

This process of identifying nodes commenced with organisations engaging with the government legislative and review process in each case, which is an established method (Howlett, 2002; Howlett, et al., 2017). Consequential organisations were identified through appearance before, and submission to, a parliamentary committee that reviewed the policy event. However, as proponents and opponents also actively engaged the media to promote their position (Hilton, et al., 2017), the list of consequential organisations was verified and expanded upon by including 'media' in Australian newspapers. The process of extracting documents built upon the search concepts used by Chambers et al.'s (2012) and Sabot et al.'s (2017) work in network analysis. Two electronic databases, the Parliamentary Library Catalogue and Trove (the National Library of Australia's digital archive of newspapers), were searched for the three cases using the following keywords: '(managed care AND (1994/1995) or (2006/2007) or (2013/2014) AND (private health))'. A separate search was conducted using a key descriptor for each case: 1995 'private health' AND 'Lawrence'; 2007 'Broader Health'; 2013 'managed care.' The search was limited to articles in the English language.

This process excluded X (formerly Twitter), Facebook and other social media, as it would have been difficult to include these resources due to time constraints. In addition, these media avenues were only applicable in the third case.

The search resulted in 749 documents for case one, 167 for case two, and 421 for case three. Duplicate documents were then redacted (case 1: 121, case 2: 48, case 3: 28), and non-relevant articles were also redacted (case 1: 432, case 2: 66, case 3: 285), leaving a much smaller group of documents (case 1: 196, case 2: 44, case 3: 89) respectively. A few documents from the original search results for each case were not able to be located, and therefore, the results may not total (see Appendix 12C for a list of documents). Whilst a smaller number of documents remained, the potential scope of the boundary was still significant. These documents were then analysed to determine whether a linkage (or a tie) between actors occurred, using the process discussed below.

4.4.2.2 Defining the Ties

Ties often capture dependency and exchange relationships (Pedahzur & Perliger, 2006). Network analysis studies can examine particular social processes, such as why actors establish relationships with other actors and not others or why there may be more ties between certain actors in a system (Leifeld & Haunss, 2012). Network linkages can function as a resource, and networking can be a

question of resource exchange. Alternatively expressed by Lin (2001, p. 143), a network can be ‘a series of interactions between two (or more) actors in which a transaction of resources takes place.’

Philosophies of transitivity or structural balance suggest that particular patterns of positive (support) and negative (animosity) ties can occur between actors in a network (Hafner-Burton, et al., 2009; Wasserman & Faust, 2008). Basically, ‘the friend of my friend is my friend, and the enemy of my enemy is my friend’ (Hafner-Burton, et al., 2009, p. 567). In network theory, structural equivalence predicts that actors in similar structural positions in relation to other nodes will behave similarly. There is a greater likelihood of actors forming ties if they are not in competition for resources (Cao, 2009; McPherson, et al., 2001; Silverman, 2000, p. 567), as was observed in a study of a Canadian municipal public health department which found that accessibility and trust increased the perception of a person’s expertise (Yousefi-Nooraie, et al., 2014). Thus, network analysis can show how the structure of the network and forming ties with ‘friends’ can be used to improve power and create legitimacy among actors; see Cullerton et al. (2016).

The number of unique links shows us the actors’ level of cohesiveness or individuality. In policy networks, perceived influence increases collaborative ties – in other words, actors seek to connect with nodes they perceive as powerful (Henry, 2011). It shows the capacity of powerful actors to influence the provision of information, beliefs and norms (Hansen, et al., 2010). The resulting level of ‘reachability’ shows us how knowledge could be diversified by developing linkages with actors who are connected to broader domains or other subgroups, as was found by Wipfli et al., who showed that communication with a network of international tobacco control advocates increased the probability of official adoption of the Framework Convention on Tobacco Control (Steel & Weber, 2001; Wipfli et al., 2010). Unique links tell us about the identification of power spread in the network. A node with larger amounts of unique links will be more capable of drawing solutions to policy problems from other neighbouring arenas (Berardo & Scholz, 2010; Crouch & Farrell, 2004).

The procedure for determining ties among nodes was adapted from work by Fisher et al. (2013) and Leifeld (2013), who linked actors through congruent policy statements, and the approach used by Browne et al., who generated ties when actors identified relationships in their submissions (Browne, et al., 2017). This model was expanded by including documents found in general print media. The documents were analysed to ascertain relationships within the network. Documents that indicated one actor had discussed or interacted with another actor were recorded as a network interaction between the nodes (tie), specifically:

- A quote by an actor stating congruence with another actor.
- A statement by one actor indicating agreement with another actor’s position.

- Co-authorship of a document by actors.
- A statement by an actor noting the co-development of a policy position or working together with another actor.
- Copying or acquisition by one actor of another's policy positions verbatim (Leifeld & Haunss, 2012).

Network maps were developed for each of the three cases using the ties from the documents. The documents often did not describe which way information flowed between actors, and, as a result, undirected networks were created.

4.4.3 Gephi software for the network model

To consider the relative capacities of the actors to influence the payment and access rules in Australia, the data from the document review was then input into the network analysis software Gephi. Gephi allows for the exploration and visualisation of networks and their associated graphs. Many software packages could have been used to conduct the network analysis; Gephi was chosen as it is open-source and free. Using Gephi, the average degree, average weighted degree, network diameter, graph density, modularity, and average Eigenvector centrality for each case were calculated. In addition, a page rank was run where needed to account for complicating factors in the resulting network. The Gephi system also provides the number of nodes and links. A detailed explanation of the measurements is in Appendix 12-B.

4.4.4 Development of the timeline of events

Along with identifying the structure of the network (ties and nodes), a timeline document outlining the key events that occurred during the case was also derived from the document analysis. The timeline outlined environmental factors, including which political party was in power, whether there was an election during the time of the case, the size of the industry, membership, and fund expenses as a proportion of income. These timelines are provided in chapters five, six and seven.

Document reviews are particularly useful for considering what aspects of a strategy were successful or why it did not achieve its stated aims (Posovac & Raymond, 1992). Documents are written with a purpose in mind, are presented in a particular manner and are based on certain assumptions about the people they affect or the environment in which they belong (Grix, 2001). Through analysing these characteristics, the documents informed the research about the environment in which the debate occurred and the network operated (Payne & Payne, 2004).

4.5 Phase 3: Interviews

Qualitative interviews were included to collect data on the actors themselves and their individual viewpoints on the behaviours of actors (strategies to improve their independence), the relationships between the actors, the patterns of relations as structures (power), and the societal context of the network (understanding of the environment) as qualitative research always contains the setting in which actors are operating (Loblich & Pfaff-Rudiger, 2011; Gulati, 1998). Relational approaches in network analysis focus on the processes by which actors in a network influence each other to achieve an outcome; in this research, limiting the scope and prospect of reform of the payment and access rules (Wasserman & Faust, 2008, p. 7). Qualitative research methods can be advantageous when considering the processes, content and subtleties of policy networks rather than just the network's structural elements (Lechner & Dowling, 2003; O'Donnell, et al., 2010).

The interviews allowed for an understanding of the actors' personal perception of power, their allies and adversaries' power, various actors' resources, strategic needs and operating methods (Pfeffer & Salancik, 1978; Garud, et al., 2010). This perception informed the actors' assessments of the environment in which they operated. As the objectives of this research are related to understanding rather than only measuring (Oinas, 1999), ignoring these perceptions by using only quantitative data may result in an incorrect understanding of the actual balances of power and issues facing actors during the policy event.

Since under RDT, an actor's interpretation of the environment is of key concern, an interpretative paradigm was used to explore actors' interpretations, allowing their understanding of their environment to come to the fore. This is key to understanding their perspectives of legitimacy and the actions they undertook to achieve their strategic intent. Using an interpretative approach to understand subjective perceptions requires a qualitative approach.

Qualitative research is driven by theory, and this research uses a framework consisting of network, resource dependency and path dependency theories. The core premises of each were transformed into categories used to guide the design of the semi-structured interviews (see Table 4.2 below). As explained above, network analysis concentrates on actors, their relations with each other, and, in this research, the context of the network. Under each main category, subcategories were transformed into interview guidelines.

Table 4-2 Framework for the design of the interview guidelines

Actor's details	Network characteristics	Relationship to theoretical variables
Biographical characteristics	Who is in the network (nodes) -density	Environmental context (environment)
Role of organisation in the network	Relationships in the network (ties) -structural balance/equivalence -structural holes or linkages	Structure of the network (power) Perception of the who is powerful (environment and power)
Resources and strategies used to control the policy debate	Cooperation with others (Resource usage and strategy) Development of subgroups (Modularity)	How the network operated when the policy change was debated
Role of the resource to actors (Importance of the policy under debate)	Shows shared interest; movements in alliances (if any); attempts to create or change legitimacy (Homophily)	Perceptions of legitimacy Alliances in the network Level of Dependency Creation of barriers to change
Goals and successful achievement of outcome	Shows who has the power to control the path (Centralisation)	Ability to control reform of the system Role of insurers in Australia Self-reinforcing feedback

The interviews were based on a semi-structured schedule informed by the theoretical framework (see Appendix 12-A). In particular, the author focused on the relationships that formed the structure of the network, the mentalities of actors – their assessments of power, legitimacy and use of resources by themselves and other actors in their network – and the environment in which the policy event occurred with a focus on barriers to changing the operation of the payment and access rules.

The document review results used to create the original network enabled the identification of many organisations to be interviewed. Participants with a focus on the most powerful and connected characters (from the network analysis), those who could either shape or initiate policy or substantially change or vet other's proposals (Lewis, 2006), were interviewed.

Although there may be gaps in knowledge among participants, the research design using a collection of respondents enabled a reasonably accurate understanding of the cases (Heaney & Lorenz, 2013).

At all times, there was a need to be very conscious of why the person agreed to an interview, as there may have been alternate agendas, both personal and political.

The scripts were coded using thematic content analysis to identify salient points, patterns or themes (Creswell, 1998; Silverman, 2000), detailed in section 4.5.2.

4.5.1 Interviewee selection

The document review process identified that some of the main organisational actors were present in each of the cases; however, the individuals present in the nodes varied from case to case.

A stakeholder matrix of potential interviewees that were identified from an initial search of the documents was constructed using three key parameters: 1) the person publicly participated in the case as a representative, 2) they were locatable, 3) each of the stakeholder groups, in Table 4.3 (below), were covered. Initial interviewees were identified from the documents for the interview. Then, using a purposive snowball approach to increase the objectivity and accuracy of the data collected, additional actors were approached for interview and asked to nominate other influential actors for interview (Friel, et al., 2019; Korstjens & Moser).

Interviewees were presented with a network map developed from the document review process and were asked to identify if there were missing actors. In each case, interviewees identified other actors they felt were part of the policy event but who provided advice to the government that the rest of the network would not have had access to (e.g., advice straight to cabinet or ministers). Although this process elicited additional actors, none were considered by the interviewees to be key actors in the policy development process.

Table 4-3 Stakeholder groups and interviewees

Stakeholder Groups	Case 1 (No. of interviewees)	Case 2 (No. of interviewees)	Case 3 (No. of interviewees)
Healthcare medical provider	2	2	2
Consumers	1	1	1
Federal government	2	2	2
Private health insurance providers	2	2	1
Total	7	7	6

4.5.2 Data collection

Data collection occurred from July 2020 until June 2021.

Interviewees were contacted via LinkedIn messaging or email. Interviewees were provided with a pictorial presentation of the network and the timeline. The timeline and network map for each case are included in each case chapter.

The data collected from the interviews was audio-recorded with the participant's approval, and a verbatim transcript was made for subsequent analysis.

The author conducted twenty semi-structured interviews using the interview guidelines above. Two interviews were online, and the rest were in person.

Guest et al. (2006) believe that when interviewing, data saturation can occur within the first twelve discussions, and very few new phenomena are likely to emerge with additional interviews. The 'theoretical saturation' principle is generally used to justify sufficient sample size in qualitative research (Corbin & Strauss, 2008). The idea came from grounded theory and has also been termed 'data saturation' or 'thematic saturation' and has been widely used in a broad range of qualitative studies (Glaser & Strauss, 1967; O'Reilly & Parker, 2012). Twenty interviews were conducted, at which point it was evident that further phenomena were unlikely to emerge.

The interviews were coded using a hybrid approach of inductive and deductive thematic analysis, a versatile method for analysing qualitative data that can bring rigour to exploring social phenomena (Fereday & Cochrane, 2006; Kiger & Varpio, 2020). Thematic analysis searches for themes that emerge as important for describing the phenomenon (Daly, et al., 1997). The process involves the identification of themes through 'careful reading and re-reading of the data' (Rice & Ezzy, 1999, p. 258). It is a form of pattern recognition within the data, where emerging themes become the categories for analysis. Thematic analysis in this research allowed for examining the varied perspectives of different actors in the network, producing unexpected insights (Nowell, et al., 2017). The process follows Nowell et al.'s (2017) six-step thematic analysis approach.

The coding process involved recognising an important issue or moment prior to interpretation (inductive) (Boyatzis, 1998). This allowed the information to be identified, themes developed, and, through this, data organised. In addition, a deductive template approach described by Crabtree and Miller (1999) was used to apply predetermined codes to organise the text. The predetermined codes

complemented the framework for the design of the interview guidelines (Appendix 12-A) and were derived from reading the documents from the time.

To thoroughly understand the data, the interviews were transcribed into text manually and re-read before coding. At this point, the documents relating to the cases were also reviewed for a full immersion into the case (Rice & Ezzy, 1999; Nowell, et al., 2017; Tobin and Begley, 2004). I coded the text by matching the codes with data segments selected as representative of the code. The text analysis was guided, but not limited, by the preliminary codes. Inductive codes were allocated to sections of data that contained new themes observed during the coding of the transcripts of the interviews (Boyatzis, 1998; Braun & Clarke, 2021; Fereday & Cochrane, 2006). The text was then sorted into the analytical framework, revealing a cluster of themes for each case.

4.6 Phase 4: Triangulation of data sets

In this phase, to ensure methodological rigour, the quantitative and qualitative data sets were triangulated. The network analysis findings were combined with the qualitative data obtained from the timeline of events and semi-structured interviews. Data triangulation involves using multiple data sources to collect and interpret diverse viewpoints or standpoints about a phenomenon (Denzin, 1978) and using multiple sources of data or information to increase a study's validity (Merriam, 2009).

Network analysis builds a picture of influence and shows the strengths of certain network positions during policy events and strategies of influence (Lewis, 2012). The combination of qualitative and quantitative data collection showed not only actors' connections but also who had high structural autonomy and exercised control within the network and how this was used to restrain attempts to change the operation of the payment and access rules (Burt, 1992).

The theory of constant comparison analysis, originally developed for grounded theory research, was applied to analyse data as it was collected over several stages (Glaser & Strauss, 1967). The documents selected in the case selection phase (phase 1) underwent the same thematic analysis as the interview transcripts outlined in phase 3 and provided insights into the actor's mentalities and the social environment that framed the policy event. They also provided details on the relationships and the structure of the network. The quantitative network analysis metrics were translated into a working analytical framework to integrate the quantitative data sets collected during phase 2 (see Table 4.3 below).

Table 4-4 Network modelling and thematic analysis

Statistic	Shows	Reason	Link to research	Shows
Size				
Number of nodes	Size of the network	Number of actors	How small or large the pool of actors is and whether this changes between cases	Environmental context – is the network broad and rambling, or tight and small? Will information travel quickly or slowly?
Number of links between actors	Level of interconnectedness between actors	Number of relationships between actors	Who has key relationships	Identification of power in the network
Number of unique links	Shows the level of cohesiveness or individuality	Shows the capacity for powerful actors to influence the provision of information, beliefs and norms	Reachability: The diversity of knowledge can be achieved through relationships with actors that belong to other spheres or other sub-networks (Steel & Weber, 2001).	Identification of power spread in the network Capacity to develop policy alternatives (from other adjacent fields). Fewer links mean less capacity (Crouch & Farrell, 2004)
Cohesiveness				
Number of subgroups	Whether there are subgroups	Identifies subgroups in the network	Who is working with who	Whether there are collectives that share the same norms, policy positions, etc. Whether groups or individual organisations are setting the policy agenda – power in the network. Changes in subgroup membership will show differences in legitimacy.
Density	The extent to which actors are interconnected	Who is working with who – as a proportion	Who brings together information? Ease of sharing resources.	Density: Actors in a dense network have more difficulties accessing diverse forms of knowledge as most actors have very similar backgrounds and values (Granovetter 1973;

				Frank & Yasumoto 1998; Valente et al., 2007). Level of dependence upon actors for resources (ideas) Changes in density can show changes in legitimacy depending upon the relationship with the decision maker.
Mean average distance between nodes	How 'close' the actors are to each other	Average number of steps to go from one actor to any other	The capacity to draw upon resources of other actors or share resources	Actors in 'closer' networks have a greater capacity to draw upon resources and share assets.
Centrality				
Mean degree	How central actors are	Average number of links that pass through the actor	Is the actor a central figure – controlling? Changing who is in this position may change outcomes.	Who has power in the network? Central actors can disperse their view of the policy to more actors and have a greater influence on the agenda of more organisations.
Mean betweenness	How central actors are	Average number of unique paths that pass through the actor	Is the actor a gatekeeper (controlling resources and the narrative)	

The themes from the network analysis were integrated with the coded responses from the interviews in phase 3 and grouped into categories and subcategories, expanding the framework. This created a large data set from which a final thematic analysis occurred. The methods revealed which actors held what positions in the network, what roles this enabled them to play, and how much power and resources they held and used.

4.7 Limitations of the methods

The issues with developing the boundary and the initial maps of the network through reviewing documents of the time include:

- There is a chance that an actor (a node) was not captured in print.

- Some actors may have shared resources or made ties and connections that are not captured by the documents.

These issues were moderated by checking the accuracy of the maps with actors who were present at the time using semi-structured interviews.

Problems with the network method research raised in the literature include the impossibility of finding inaccessible actors (Hanneman & Riddle, 2004). These weaknesses, which are important to recognise, are not thought to weaken the outcomes of this research because the nature of the policy networks is that the unit of analysis must be connected, not isolated (the network that produces the policy cannot consist of one actor) (Sandstrom & Lundmark, 2016). Validity in network analysis studies deliberates the accuracy of a measure – whether it measures what it is designed to measure (Wasserman & Faust, 1994). The methods in this research rely on key informants whose capacity to provide complete or accurate information may be limited. When recollecting a policy event, there is an obvious risk that people may forget or justify their behaviour. One potential issue with the interview method used in this research is that a considerable period has elapsed since the policy event took place. However, the fact that many actors participated and responses can be reconciled with documentation from the time reduces this shortcoming. After the interviews were conducted, all data were analysed to gain an overall understanding of the operations of the network for that case.

4.8 Ethics

Social research involves complex procedures and multiple actions, particularly when the research encompasses a population that may be keenly aware of the potential impact of such research. Apart from moral obligations, a researcher may also confront ethical issues.

To ensure these concerns were addressed, the participants were informed about the nature of the research through a written information sheet. This document explained the study's purpose, the data's confidentiality, the benefits and risks, and the participation requirements. All personal information has been kept confidential, and participants were also informed of their withdrawal rights during the research phase.

Each participant was given a unique identification code (for example, Key Informant 1) to protect their anonymity, and all data was only identified by this code before transcribing. Actual names were not used. However, given the nature of the topic, there was a reasonable chance of interviewees being identified. This is primarily due to the policy positions and recollection of history that interviewees will hold. Participants were informed of the risk of potential identification even if key identifiers, such as actual names and locations, were removed from the final thesis and publications.

Ethics approval 2020/363 was obtained from the Australian National University Human Research Ethics Committee before commencing data collection.

4.9 Conclusion

This chapter has explained the research design and methodology used in this research. Using a network approach enables an examination of a network of actors and the network's structure on policy events proposed to change the operation of the payment and access rules. Mixed methods, combining network analysis with interviews, enable an investigation of the actors' interests and mentalities and how an actor's position in the network allowed them to wield influence and power through the position's capacity for deploying information and resources. Examining who is connected to whom allows for exploring who exercises influence and power, how resources are used within a policy network, and how this contributed to the reduction in ambition and constraining of reform to the operation of the payment and access rules.

The next chapter presents the results from the analysis of the first case: Case 1: 1995 Hospital and Provider Contracting, colloquially known as the Lawrence reforms.

5 Case Study 1: Medical Practitioner Contracting (1995)

5.1 Introduction

This chapter presents the findings of the research for the first of three case studies – Medical Practitioner Contracting (1995), as outlined in chapter one. In this case, the then Labor government attempted to change the payment and access rules to allow insurers to directly contract with medical providers (doctors), setting fees and changing payment models. This measure was a part of a reform program that also allowed insurers to contract with hospitals, allowing Diagnosis Related Groups (DRGs)² to become a method of calculating a fee for an admission to hospital and changes to the equity provisions (risk equalisation processes) that supported community rating. All parts of the health system had something to gain or lose depending upon the final package of reforms. A detailed description of the case is below.

This chapter presents the findings of the research on how the actor network influenced the proposed reforms. The chapter demonstrates how the network quickly formed into two major subgroups around the reforms: the insurers whose interests were to develop a more integrated system and the other, medical providers whose interests were keeping the current payment model. I find that power shifted during the policy event from the insurers to the medical providers who eventually prevented change to the operation of the payment and access rules.

The chapter proceeds as follows. Section 5.2 explains why this proposal for reform came about, drawing on documents and interviews. Section 5.3 traces the Bill through parliament and identifies key actors and their interests in influencing the package of reforms. Section 5.4 presents the findings of the network analysis as a network map of key actors and their ties, and adds interviewee reflections on this network map. The chapter then details the operations of this actor network throughout the case drawing on interviews and document analysis, including the relationships between actors, who had power, the costs of change, claims to legitimacy, and how this ultimately influenced the outcomes of the reforms. In doing so, the chapter demonstrates how powerful actors contributed to path dependency in Australia's healthcare financing system – limiting the scope for reform.

² DRGs use diagnosis and intervention codes with other routinely collected data to classify admitted acute care. DRGs are used to price admitted acute care in Australian public hospitals. Broadly speaking, this price is then used to determine funding for hospitals from the Commonwealth on an activity-based funding model (a fee-for-service model).

5.2 Environment

5.2.1 The role of PHIs in a mixed model

Private health insurance was the only insurer for the Australian population until 1984. The introduction of Australia's universal healthcare system (Medicare) created another insurer for people to choose from. Effectively, private health insurers competed with a public health insurer who provided insurance without premiums for membership. Many Australians opted to support or utilise Medicare only, and participation in private health insurance fell from around 59 per cent in February 1984 to 38.4 per cent in December 1993 (Australian Institute of Health and Welfare, 1994). At the time of this case, PHIs had been existing in a tense relationship with Medicare for around eight years, and as the proportion of people covered through private health insurance declined, the first calls to say the industry was in a 'death spiral' started in the early 1990s (Duckett & Nemet, 2019).

Expenditure in both the private and public healthcare systems was continuing to grow. The year-on-year increase in premiums was 1.9 per cent, and benefits paid (outlays) increased on the previous year by 2.1 per cent (Private Health Insurance Administration Council, 1994). The Australian Democrats (Democrats), a minor political party who held the balance of power in the Federal Parliament during this period, acknowledged the falling levels of private health insurance and concerns about viability, saying they were 'exaggerated, but legitimate, particularly in the current climate of cost-cutting, cost-shifting, privatisation and sell-offs' (Lees, 1994, p. 1).

The payment and access rules were developed to protect Medicare and limited the operations of insurers and their capacity to control expenditure. The combination of ever-increasing premiums, dropping membership and increasing outlays created an environment in which the private health insurance industry needed to make changes to the way health insurance operated in Australia for it to remain sustainable (Burns, et al., 1997, p. 205). It was argued that to remain sustainable, PHIs needed to transition from being passive payers in a mixed model to active managers in the health system. Actors in the private health insurance industry utilised the lack of sustainability as a catalyst to advocate for change to the relationship between insurers and providers, which would have resulted in increased vertical integration.

5.2.2 The problems created through the rules of the relationship with Medicare

There were varying opinions on why the private health insurance sector was in decline at that point in time. The relationship between PHIs and Medicare was not clearly articulated, and as a result, the rationale for having both private and public insurance providing an individual cover was not clear. Quantifying the benefits of private insurance became increasingly difficult. Consumers' primary

concern, it was argued, was that private health insurance did not provide value. What constitutes value varies from consumer to consumer, given their personal preferences and circumstances. Whatever *value* was, consumers were leaving PHIs. Interviewees all agreed that the concern around value was helping to drive reform. 'Every government since the 1984 has struggled with how . . . to make health insurance better value' (4case1). The Australian Health Insurance Association (known then as the VHI Association) researched consumer preferences and found that out-of-pocket expenses and premiums were the cause of attrition (1case1). Given the evidence suggesting that the out-of-pocket costs were creating a disincentive, there was a theory that containing these costs would provide the consumer with better value and thus stop the decline in coverage.

Altering the system to reduce out-of-pocket costs required changes to the payment and access rules. The payment and access rules in 1993 required insurers to pay 25 per cent of the scheduled fee, and they were not allowed to pay above that; however, doctors could charge above the scheduled fee. One of the reasons for that rule was that the Department of Health thought removing a cap on payments would lead to medical inflation, which would increase costs for consumers. There was also a growing concern that the insurers were passive payers rather than active managers in the system, and any increase in prices was passively passed onto consumers through inflated premiums. This concern was supported by one participant who noted that prior to these reforms, 'the associations set the price and the funds paid the price' (6case1). 'The medical associations would meet with the insurers one afternoon and they would say, "Here's our prices for next year," and the insurers would say, "Thanks very much," and that was about it' (6case1).

The impact of costs upon consumers was a key factor, with one interviewee stating that 'a lot of this, in a crude economic sense, is how do doctors set prices and how do you stop a situation if an insurer . . . pays a certain rebate, how do you stop doctors from seeing that as a floor price and squeezing whatever they can out of them[the insurers]' (2case1). Interviewees noted that the medical profession held what may be considered an oxymoronic view: 'there were a significant number [of doctors] who were also concerned about the gaps and didn't like to extract money from the patients but were happy for the insurers to pay' (1case1), even though these costs flowed through directly to consumers.

The then-government perceived the problem slightly differently, and in 1994, the government and bureaucracy believed that the private health insurance industry required greater competition to stem the flow of people out of the private system (Unknown, 1994). The Department of Health had commenced work to understand the differences in outcomes and fees between private hospitals and public hospitals and had begun to utilise DRGs as a classification system for this purpose. The

Department's research proved conclusively that no matter the reason for your admission and treatment, if you went to a private hospital, you stayed for three days longer (4case1). One interviewee felt that the Department of Health's main concern was to get DRGs included, and the contracting aspects to the reforms were peripheral (1case1).

Thus, the key stakeholders in the system perceived the problems facing private health insurance differently, and as a result, potential solutions to improve sustainability varied. The government wanted increased competition to stop the decline in private insurance membership and reduce resultant pressure on the public system, the industry wanted to directly contract to reduce outlays and mitigate the risk of out-of-pocket costs for consumers, and consumers wanted better value for their insurance dollar. Changing the power relationship between purchasers and providers was thought to be able to deliver the desired outcomes.

5.3 The proposal

This proposal had a long gestation. In 1993, reforms were aired by then–Health Minister Graham Richardson; however, it was in 1994 that the Federal Cabinet finally agreed to make changes to the regulations with a view to stabilising the price of private health insurance. The government had decided there was a need to restructure the health insurance system, and regulations that restrict efficiency and competition were to be removed (Senate Community Affairs Legislation Committee, 1994). 'The most significant change is the lifting of the requirement that funds deal equally with all doctors and hospitals. Instead, funds will be able to shop around, using the bargaining power of their vast memberships to negotiate a better deal on behalf of their members,' the then–Health Minister said in a press release in 1994. She continued, 'Funds will also be able to form agreements with doctors to enable them to offer private health insurance that covers the full cost of medical services, eliminating out of pocket expenses. Important safeguards in the system will, however, remain' (Press Statement by Dr Lawrence, 1994, p. 2).

The Health Legislation (Private Health Insurance) Reform Amendment Bill to implement these changes was introduced into the House of Representatives on 7 December 1994 by Minister Lawrence. The purpose of the bill according to the explanatory memorandum was to reform private health insurance arrangements in order to make insurance better value for money. The reforms were intended to provide members with a wider choice of health insurance products and allow consumers to purchase health cover, eliminating out-of-pocket costs through agreements made between health benefits organisations (funds) and hospitals and medical practitioners (Senate Community Affairs Legislation Committee, 1994).

The bill contained a series of measures to help define the costs of hospital services and assist patients in providing more information about the costs of care prior to the service being performed (Senate Community Affairs Legislation Committee, 1994). In particular, the amendments were to allow insurers to:

- . . . enter agreements with hospitals, providing for the amount to be paid to the hospital for an insured patient's episode of hospital treatment. These hospital purchaser-provider agreements may eliminate a privately insured patient's 'out of pocket expenses' owed to a hospital or day hospital facility, by providing for full payment by a health benefits organisation of the cost of an episode of hospital treatment; and
- . . . enter agreements with medical practitioners, providing for the amount to be paid to the medical practitioner for the provision of a professional service (in respect of which a Medicare benefit is payable) to an insured patient in a hospital. These 'medical purchaser-provider agreements may eliminate a privately insured patient's out of pocket expenses' owed to a medical practitioner, by providing for full payment by a health benefits organisation of the cost of an in-hospital professional service. This removes the legal prohibition on 'gap' insurance for any charges above the Medicare benefit, including charges above the schedule fee, for professional services provided to patients in hospitals.

(Department of the Parliamentary Library 1995, 1)

The bill was referred to the Federal Senate Community Affairs Legislation Committee on 2 February 1995 for review. The legislation received the Royal Assent on 29 May 1995. Prior to passing the bill, Parliament agreed to refer the resulting Act to the Senate Community Affairs Committee for a second review on 11 May 1995 (The Department of the Parliamentary Library, 1995).

5.3.1 Who instigated the reforms?

Much like the perceptions of what was driving the reforms, recollections of who instigated the reforms varied between participants. However, some themes emerged.

The discussion concerning the reform of the private health insurance system commenced in seriousness a year before the introduction of the bill when the former Minister for Health, the Honourable Graham Richardson, issued a discussion paper acknowledging the decline in the rate of private health insurance coverage and increased pressure on the public system in December 1993. The paper argued that the two plausible reasons for the decline in membership were out-of-pocket expenses and increasing insurance premiums (The Department of the Parliamentary Library, 1995).

A few participants noted the role of the Australian Health Insurance Association in instigating the reforms. The Australian Health Insurance Association lobbied the Executive in the Health Insurance Branch of the Department of Health about the need to do something about medical gaps (1case1). This position is supported by newspaper reports at the time noting the role of the CEO of the Australian Health Insurance Association as the architect of the reforms (Department of the Parliamentary Library, 1995; Jurman, 1995). One participant held that the government had set up the reforms to ensure the debate occurred between the providers and the insurers.

[The Health Minister] said there is going to be a fight with the doctors, but I am not going to fight with the doctors, [PHIs] are going to fight with the doctors. (1case1)

Some respondents noted that various entities had commenced considering methods to gain control of escalating costs. Some insurers had started to look at contracting models to try and gain control over price escalation, and they also started to engage clinical personnel to better understand the business (6case1).

Other participants argued that the Department of Health had re-characterised the reforms so as to create a system for PHIs to help themselves rather than the government propping up the sector (5case1). The change of Health Minister, when Graham Richardson resigned, to Dr Carmen Lawrence had provided an opportunity to change the narrative from 'the government must do something to help health insurance' to 'how can you make the insurance industry more efficient without [the government] giving them any more money' (5case1).

The interviewees and data from the document review indicate that representatives of the private health insurance industry were the catalyst for the reforms, and the Department of Health was successful in adjusting the package of reforms from being a handout to the private health insurance sector to changing regulations to provide the sector with more market power, prior to the final package going to government for decision.

Table 5-1 Scope of initial reform ideas and eventual outcomes at implementation

Initial breadth of reform	Government policy relating to payment and access rules (as introduced to Parliament)	Final law	Actual change to the healthcare system (implementation)
The initial policy ideas included: Amalgamating/rationalising private health insurance funds.	Allow registered health benefits organisations to enter agreements with funds	Agreements allowed	Few medical agreements had been signed when the Parliamentary Inquiry reviewing the implementation started to

Removing restrictive rules and allowing insurance funds to negotiate with hospitals and doctors to arrive at 'a better deal on behalf of their members' (Department of the Parliamentary Library 1995, 8). Introducing an all-inclusive billing scheme – single billing. Establishing a formal financial consent process which would require medical practitioners to advise their patients what the cost of a particular treatment was likely to be.	medical practitioners and hospitals. The agreement would allow the fund to pay medical benefits above the Medicare Benefits Schedule for that practitioner's services (Department of the Parliamentary Library, 1995).		take evidence on 24 July 1996. The Australian Medical Association stated that there were between 'zero and 100', and the Australian Doctors' Fund claimed that 'to our knowledge no doctors have signed contracts'. The Department of Health stated that it was 'unaware of any MPPAs' and knew of only one Practitioner Agreement (Senate Community Affairs Legislation Committee, Parliament of Australia, 1996).
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5.4 The network

5.4.1 Members of the network – the network map

This section presents the findings of the network analysis of actors and their ties in the policy network surrounding this case. A network map was created applying the network analysis methods described in Chapter 4, and measurements of the degree of network closure, heterogeneity, influence and power investigated. The analysis of the network sheds light on how these actors work together and form constituencies or subgroups whose aim is either to maintain or alter the payment and access rules. The network map illustrating the structure of the network is below (see Figure 5.1). Table 5.2 provides the measurements of the modelling in a numerical format.

The documents from the time of the case suggest that there were 21 nodes (actors) engaged in the policy debate, a small network of actors given the size of the proposed change and the length of debate (see Table 5.2). The first measure taken is the network diameter, which indicates how close or distant the actors are from each other. The diameter is the maximum number of actors that any actor can pass through to reach any other actor. For this case, the network diameter is 4.0. This lower score indicates that all of the actors are quite close to each other. Thus, actors likely had easy

access to each other, and information, resources and norms could flow around the network relatively quickly, giving key connector nodes increased power.

The modularity score describes the number of communities that have formed within the network and shows how strongly actors identify in a community. It demonstrates whether the network is wide and rambling or whether it has key actors or clusters of nodes. The score of 0.266 indicates that there are only two strong subgroups, and the map shows these two groups are connected tenuously by Senator Lees (the leader of the Democrats)³. There are two main actors in this case, the Australian Medical Association (AMA) and the Australian Health Insurance Association. Two large subgroups formed around these actors: the first centred around the Australian Health Insurance Association of seven actors, and the second around the AMA of 14, creating two competing power blocks.

Centrality measures show the importance of the various actors within the network, illuminating power and dependence. The AMA had a large community of advocates surrounding them, and this is reflected in the high betweenness centrality score of 132.47. The next most connected actor is the Australian Health Insurance Association, with a score of 68.57. Nodes with higher centrality scores are considered dominant in the network. Betweenness centrality measures how often a node (actor) appears on the shortest paths between nodes in the network; an actor with a high betweenness centrality ranking has greater capacity to exert power and influence over the information and norms being distributed around the network of other actors. The majority of other actors may have been brokers of information; however, the considerably lower betweenness centrality scores are a function of their place within the network (with respect to the distance from central decision-makers) and reflect that their linkages are to fewer disconnected actors in the network (which subsequently gives those actors a lower degree score). The lack of connections to high-ranking actors leads to a lower capacity to connect to other actors within the network for these lower-ranked actors.

Eigenvector centrality is a measure of the influence an actor has in a network; it measures the number and quality (connections to high-ranking actors) of connections of a particular node. In a highly connected network, such as in this case, the eigenvector centrality index should correlate closely with betweenness centrality; however, in this case, the Australian Health Insurance Association's connections are not considered to be as influential as those held by the top five medical provider groups (AMA, Council of Procedural Specialists, Australian Association of Surgeons,

³ The Democrats were a minor party in Australia who held the balance of power in the Senate from 1980 until 2004, thereby controlling or heavily influencing the passage of legislation.

Australian Doctors' Fund and Australian Society of Orthopaedic Surgeons). This result could be driven by the large group that formed around the AMA.

The average weighted degree is an average of the weighted degree of all the nodes. A node's weighted degree is based on the number of edges for a node but moderated by the weight of each edge. The higher the average weighted degree, the greater the connection within the network. For this case, the average weighted degree is 6.48, which correlates with the higher-than-expected clustering coefficient. The network is interconnected, and all nodes can reach each other without great amounts of effort.

The clustering coefficient indicates how closed the community is – the more closed a community is, the less opportunity it has to explore alternative opportunities and ideas (Garud and Karnøe, 2001). A coefficient of 0 means that no one is connected to any of the other nodes, and a score of 1 demonstrates that all the nodes in the network are fully connected. Given that there are two distinct subgroups, one would expect a coefficient lower than or around 0.5. However, in this case, a clustering coefficient of 0.69 was found, potentially driven by the large community formed around the AMA.

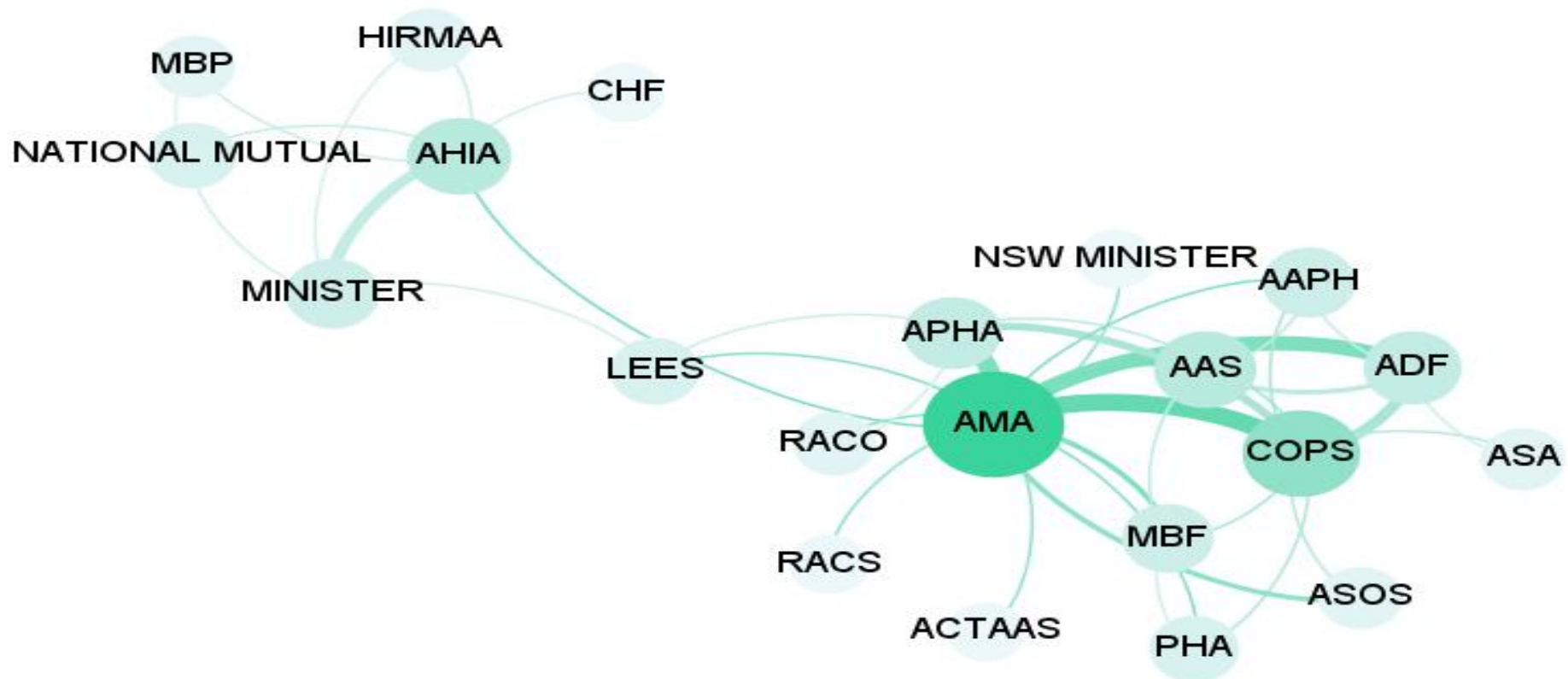
Table 5-2 Network measurements, Case 1

Name	Degree	Closeness centrality	Betweenness centrality	Eigenvector centrality
Australian Medical Association (AMA)	14	0.77	132.47	1
Council of Procedural Specialists	9	0.56	17.93	0.82
Australian Association of Surgeons	6	0.51	1.67	0.68
Australian Health Insurance Association	6	0.57	68.57	0.29
Australian Doctors' Fund	5	0.5	6.57	0.56
Australian Private Hospitals Association	5	0.51	4.37	0.53
Association for Advancement of Private Health	4	0.49	0	0.53
Medical Benefits Fund	4	0.49	0.33	0.5
Minister for Health	4	0.41	5.17	0.16
Leader of the Democrats (Senator Lees)	3	0.5	9.1	0.3
National Mutual Health Fund	3	0.39	0.83	0.11
Private Healthcare Australia	3	0.48	0	0.4
Australian Society of Orthopaedic Surgeons	2	0.47	0	0.32

Royal Australian College of Ophthalmologists	2	0.45	0	0.27
Australian Society of Anaesthetists	2	0.37	0	0.24
Health Insurance Restricted Membership Association of Australia	2	0.38	0	0.09
Medibank Private	2	0.38	0	0.08
Australian Capital Territory Association of Surgeons	1	0.44	0	0.17
NSW Minister for Health	1	0.44	0	0.17
Royal Australian College of Surgeons	1	0.44	0	0.17
Consumer Health Fund	1	0.37	0	0.06

Figure 5.1 provides a visual representation of the network developed from the document review (page 94).

Figure 5-1: Network Map – Case 1 – 1995



The colour and thickness of the ties in the network map represent the number of references (or any kind of connection) made to one node by another. The more references between the two nodes, the thicker and darker the tie. The colour and size of the nodes in the network map represents degree, i.e., the total number of times a node was connected to other nodes in the network. The larger and darker the node, the more times it is connected to other nodes.

The key to the map is on the following page.

Key to network map – case study 1: Medical Practitioner Contracting (1995)

<i>Acronym</i>	<i>Name</i>
AAPH	Assoc. for the Advancement of Private Health
AAS	Aust. Assoc. of Surgeons
ASOS	Aust. Society of Orthopaedic Surgeons
ACT AAS	ACT Aust. Assoc. of Surgeons
ADF	Aust. Doctor's Fund
AHIA	Aust. Health Insurance Association
AMA	Aust. Medical Assoc.
APHA	Aust. Private Hospitals Association
ASA	Aust. Society of Anaesthetists
CHF	Consumer Health Forum
COPS	Council of Procedural Specialists
HIRMAA	Health Insurance Restricted Members Association Australia
Lees	Democrats leader - Senator Lees
MBF	MBF
MBP	Medibank
MINISTER	Minister for Health (Federal)
National mutual	National Mutual
NSW Minister	Minister for Health (NSW)
PHA	Public Health Australia
RACO	Royal Aust College of Ophthalmologists
RACS	Royal Aust College of Surgeons

5.4.1.1 *Members of the network – post-interview*

Interviews were used to provide a deeper understanding of the relationships, resources available and used by the actors, their power, and the structure of the network. The interview process, as anticipated, provided a significantly greater depth of understanding of the operations of the network. In addition to the actors identified through the documents of the time, interviewees added seven players. Most interviewees noted the important role of the Department of Health (2case1), and the Treasury, which are not included in the visual map. Interviewees also added individuals that they felt would have contributed to the policy design or debate, including Mr John Deeble and Dr Dick Scotton (architects of Medicare and researchers in the health systems), Mr Neil Blewitt (previous Labor Health Minister), and Dr Bob Woods and Dr John Herron (both medical practitioners in the Liberal Coalition government in 1994). This increased the total number of actors in the case from 21 located from the document review to 28. Interviewees confirmed that the visual structure, depicting the centrality of the two main actors (AMA and Australian Health Insurance Association) and the structure of the nodes that were connected to them, was correct. No interviewees commented on the timeline document of key events in the case specifically (see Figure 5-2). Having discussed the measurements from the network model derived from the quantitative data, I turn now to discussing the operations of the network, utilising the network model measurements and the information from the interviewees.

5.4.2 Mobilisation

The following section discusses the operations of the network and the formation of brokers and alliances, key relationships and power blocks, drawing on the interviews. The interaction between decision-makers and vested interest groups is also explored with a view to determining who held power and control over the policy outcome.

Throughout this case, members of the network enacted specific strategies to reduce their dependence and pursue their interests, attempting to alter the allocation of economic resources that fell from the payment and access rules. The dearth of resources serves to motivate actors to attempt to deviate from the current regulatory path – changing the payment and access rules can serve to provide one actor more resources; however, any change is likely to come at the expense of another actor due to the dependencies of the three-players in the sector.

The analysis of the network's operations can reveal how organisations behave when acquiring or preserving the resources needed for their survival – in this case, by deploying a set of strategies and actions to advocate for the collective interests that they represent, with the intention of influencing the operation of the payment and access rules (Onyx, et al., 2008).

5.4.2.1 *Operations of the network*

5.4.2.1.1 Relationships

Strength, or power, can be derived through a node's position within the network. A node may have many relationships, key or important relationships, or both. Structural balance and structural equivalence are important relational mechanisms in network analysis (Hafner-Burton, et al., 2009). The theory of structural balance suggests that certain patterns of positive and negative ties will exist between the actors. Essentially, the friend of my friend is my friend, and the enemy of my enemy is also my friend (Wasserman & Faust, 2008). Structural equivalence, on the other hand, may foretell that nodes in similar structural places in relation to other nodes will behave in a similar manner.

Relationships develop over time. Back in 1993, the Australian Health Insurance Association had developed a good relationship with then–Minister for Health Graham Richardson and had convinced him that private health insurance was a valuable part of the health system. ‘He was sympathetic about doing something about it [the issues facing the industry]’ (1case1). Other respondents also noted the closeness of the relationship: ‘Graham Richardson was captured by the PHIs and the accepted health insurers’ narrative about [the] importance of private insurance and that it should be “saved” . . . this was unusual for a Labor Minister, as Labor had never been seen as an ally for the insurance industry’ (5case1).

The relationship between the Australian Health Insurance Association and the Minister was strong, and the network model shows that the Australian Health Insurance Association was supported by the majority of the insurance industry, securing its central position in the network. Interviewees noted the Australian Health Insurance Association's capacity to develop ideas and put them forward: ‘The [private health insurance] sector was definitely highly connected’ (7case1). This was potentially due to the strong leadership role, noted by all interviewees, of the key political operative and CEO of the Australian Health Insurance Association, Mr Russell Schneider AM.

The influence of one person's capabilities to advocate for change came through in the interview process and was summed up by one interviewee: ‘Mr Schneider was a good political operative and knew his way around Parliament House. . . . [The Australian Health Insurance Association] seem[ed] to be everywhere we went, he seemed to have been there a week before or a month before, putting [their] position first, so we were always fighting – we never could come in and put ours forward, we had to first of all debunk theirs – try and discredit [them]’ (7case1).

Whilst the network model indicates that links between the government and the powerful opposing subgroup were weak, implying a lower level of influence, the interviews revealed that they were much stronger ties. The AMA had strong relationships with a few players, who also had strong

relationships with each other. This is not surprising, as this reform directly affected specialists, and the vehement opposition was principally the procedural specialists – those doctors who use private hospitals (5case1). As the debate progressed, the subgroup that formed around the AMA acquired more and more members. As a result, in the end, this subgroup had 14 of the 22 members of the network. Such a large group allowed for the development of a campaign using significant resources. Interviewees concurred that for the AMA, it was a period of strength, strong membership growth and the development of a strong presence among the rest of the medical provider groups.

The medical profession as a whole deployed a substantial number of resources during their campaign. In particular, the AMA exerted considerable influence and used considerable resources in its attempts to alter the government's policy position. They wrote to every member of the Labor caucus to explain their concerns regarding the proposed preferred provider arrangements in 1994 (Boreham & Birnbauer, 1994). Interviewees remembered that they ran a major campaign about managed care. Papers were written and distributed 'to all GPs, all members, all surgeons' (2case1). 'The paper that was sent to all GPs quoted some of the more egregious pieces of the American contracts – and stated that unless you follow the AMA this is what you will be left doing' (2case1).

The opposition subgroup continued to strengthen and the AMA and the Council of Procedural Specialists (COPS) were joined by the Australian Society of Anaesthetists (ASA) in early January 1995, who claimed that the public was largely unaware of the implications of the government's moves and accused the government of intentionally glossing over the far-reaching nature of the changes. 'The proposed legislation will enable private health insurance companies to "play God"' (Australian Society of Anaesthetists, 1995, p. 1). In February, the rhetoric altered slightly, with groups warning that they would discriminate against retirees, war veterans and the mentally ill (Jurman, 1995). The AMA claimed the reform would result in a drastic decline in the quality of medical care because it gave the federal government power to control private health insurance premiums and reiterated its claim that the reforms would give the private insurance companies unprecedented power (Jurman, 1995).

The AMA, in April 1995, intensified their commentary effectively undermining the insurance industry, stating that the legislation would introduce a US-style managed care arrangement (Taylor, 1995). The AMA, COPS and Australian Doctors' Fund all congregated in meetings around Australia to discuss boycotting the contracts (Anon., 1995). Specialist doctors united and moved to boycott the healthcare contracts that would have delivered patients hundred-percent medical cover. Doctors planned meetings across the country, starting in Sydney, where 220 specialist doctors unanimously agreed to boycott contracts. The boycott would effectively undermine the reforms (Anon., 1995).

The boycotts were supported by the Australian Doctors' Fund, the COPS and the Royal Australian College of Surgeons in May of 1995 (Bachelard, 1995; Brough, 1995).

Continuing to expand the alliance, the Royal College of Ophthalmologists joined in September of 1995 and warned that the standard of patient care would be threatened. The campaign continued to grow with the Australian Society of Orthopaedic Surgeons, representing another 600 surgeons, recommending against signing of contracts with health funds in November 1995, arguing that Medibank Private was intent on introducing a US-style managed healthcare system to Australia (Anon., 1995). The expansion increased the power of the AMA's position, as one interviewee noted: 'the Ophthalmologists and the ASA had a lot more power on the ground with the patient. . . . It made the politics a bit easier' (2case1). The collection of actors around the AMA changed the structure of the network and the actors' positions and, through this, the AMA's role in the network. One participant observed that 'the AMA had previously often been driven to action by the satellite groups that represented specialised medical groups around them, but on this occasion, [they] were right in the centre, convening all the meetings and driving the policy' (7case1). This time, the satellite groups were supporting the AMA.

The medical practitioner subgroup organised their advocacy strategy in a collective, sharing information and developed shared messaging that was provided to the public. Full-page advertisements in major newspapers were commissioned which demonstrated the unity in messaging across the medical professional groups. Signatories of the advertisement included representatives of the Australian Doctors' Fund, the AMA and the World Medical Organisation, as well as a leading Melbourne surgeon (Boreham, 1996).

Whilst the majority of the media attention focussed on the debate between the doctors and the insurers, the reform package had the potential to impact the health system more broadly. Cutler (2017) describes healthcare as a three-player network: providers, consumers and insurers. However, the financing policy in Australia creates a distinguishing feature between hospitals and medical practitioners – and Cutler's 'providers' can be divided into these two groups. The reforms were capable of impacting providers differently by imposing different regulatory requirements upon medical providers and hospitals.

Interviewees remembered distinctly the moment that they understood the full breadth and scope of the proposed reforms. Many interviewees spoke about the annual conference of the Australian Private Hospitals Association at the Sofitel Hotel, where the policy reforms were announced by the then-Minister for Health (4case1). Although the proposed reforms could impact the two groups of providers differently, the private hospital industry and the medical profession both had vested

interests that could be reduced through the proposal, and which were immediately obvious. As one interviewee stated, 'I've never seen a room – electrified is not the right word – the room froze – holy hell, this is important' (2case1).

There are unique characteristics in the private hospital sector that suddenly came into play as the actors developed their strategic responses to the proposed changes. Firstly, for the private hospitals in Australia, the real customer is not the patient but the surgeon (2case1). It is the surgeon that admits the patient, using their admitting rights that have been developed through the relationship with the hospital. Surgeons drive hospital usage. Medical committees in hospitals are also very powerful in decision-making, and surgeons are the main participants (Lupton & McLean, 1998). Finally, some surgeons own private hospitals, thus increasing their control further. These characteristics combined give surgeons as a group significant influence over hospitals and patients.

The network surrounding the AMA grew to include the private hospital industry. Demonstrating the theory that actors will find common territory when facing a common enemy, close linkages developed between the AMA and the Australian Private Hospital Association which provided for more resources to be deployed to advocate against the proposal. This expanded the number of people in Parliament that could be reached. 'The hospital groups complained bitterly and talked to Dr John Herron, who was in the Liberal party in Queensland' (1case1). Dr Herron was a Fellow of the Royal Australasian College of Surgeons and a member of the Australian Medical Association. In 1994, he became Parliamentary Secretary to the Shadow Minister for Health and Chairman of the Senate Community Affairs References Committee – the same Committee that reviewed the bill that encapsulated the proposed reform. Interviewees noted that Dr Herron had a reasonably strong influence in the Liberal party and was opposed to the concept of medical contracting (1case1; 6case1).

Power and its inverse, dependence, are relational concepts. How an entity engages with other entities in its sector demonstrates its perception of how it can exercise influence. The behaviour of the medical profession and private hospitals suggested that they felt they were reasonably independent of the insurers. However, when the then-AMA president tested the level of independence by suggesting that 'the AMA might tell people to stop buying [private health insurance,] [t]he surgeons who were opposed to all of these funds suddenly realised that the funds were three-quarters of their income – [which] caused an enormous issue' (2case1). In reality, the providers needed the insurers, the insurers needed the government's support, and the government needed the public's support. These interdependent relationships complicated the capacity to introduce new ideas.

5.4.2.2 Where was the locus of power?

Institutions can be reinforced when they have distributional consequences which can strengthen the power of actors that benefit from maintaining the institution (Bennett & Elman, 2006). Power comes in many guises. For this research, I decided to analyse power in relation to the ability to maintain or change a policy position. Thus, the greater the capacity to vet, alter or prevent a policy change, the greater the power that actor or subgroup is considered to possess.

Power in the network can be derived from a node's position in the network. Theoretically, the more central a node is within a network, the more power it should have within that network. Actors who are central can disperse their view of the policy to a greater number of actors. The greater the centrality, the greater the influence on the agenda of more organisations. Central actors have the capacity to act as a gatekeeper controlling both resource usage and the narrative; they can also set the norms that others in the broader network must follow.

RDT suggests that when organisations are regulated by the state, the importance of the economic environment fades and the importance of the political environment increases (Pfeffer & Salancik, 1978, p. 203). RDT argues that an organisation's environment is not a given, it must be given meaning through a process called enactment. Through this process, actors must establish who is controlling the narrative and who the decision-makers are in order to determine options for changing levels of dependence.

One surprising finding is that there were multiple interpretations of the power structure in the political environment. Opinions differed between interviewees as to how much power various actors had over the design of the policy. The Australian Health Insurance Association had considerable influence over the inception of the reform, and all interviewees acknowledged the organisation's capacity to advocate for change. The Australian Health Insurance Association instigated the idea and were consulted at the very outset in June 1993. The Association developed many of the concepts in the reforms, with the media commenting that the then-director was one of the main architects of the reform (Jurman, 1995; Senate Community Affairs Legislation Committee 1994, p. 5). The influence of the CEO of the Australian Health Insurance Association was confirmed by interviewees: 'In terms of an effective lobbyist [he] was one of the most sophisticated lobbyists in Canberra – in a class of his own' (3case1; 5case1). Interviewees noted that the Australian Health Insurance Association had support from the representative bodies the Health Insurance Restricted Membership Association of Australia and the Australian Health Service Alliance and from insurers Medibank and National Mutual, who were the two big insurers. Newcastle Industry Benefits Group (NIB) entered the debate a little later (6case1).

The AMA had a controlling role, with many connections across and a strategic position within the network, which was not matched by any other actor. This position gave the AMA a considerable amount of power, allowing them to control resources, information flow, the nature of the public conversation, the campaign design and norms.

However, whilst some interviewees noted the central role of the AMA in vetting and altering the proposals, other interviewees did not agree, stating the AMA had less power than the network model might suggest. 'The AMA had a lot of sound and fury and nothing much changed, the Australian Private Hospital Association had a lot of sound and fury and got nowhere, Council of Procedural Specialists and the Australian Doctors' Fund – lots of movement and light but no change' (4case1). It was felt that '[t]he doctors were less powerful, partly because they were not prepared to negotiate' (5case1). Other interviewees argued that the doctors had considerable strength. 'The doctors have had historically a very good position: it defends one trench and when it can't defend it anymore it steps back and defends the next trench' (2case1). The AMA was attempting to maintain the status quo of the payment system, and the good position of medical practitioners in the system.

The medical groups complained throughout the process that they had not been consulted adequately. The claims that consultation was inadequate demonstrated the medical profession's belief that the proposed changes could be wound back further during the policy development process, and they subsequently turned to other avenues of advocacy. Complaining publicly, they stated that 'history shows if you do not bring the doctors with you. . . . You are doomed to failure' (Kingston, 1994, p. 10). The Senate Committee noted that a number of organisations complained throughout hearings that they had not been consulted at all or not sufficiently, or were refused access to the Health Minister (Senate Community Affairs Legislation Committee, 1994). Countering claims that government had not consulted adequately, the Minister for Health provided evidence to the Senate Committee stating that the consultations had been extensive and wide-ranging. The Minister publicly argued that there had been regular communication with interested groups since December 1993. There had been formal correspondence or meetings of departmental officials with interest groups: 23 sessions with the medical profession, 22 with the Australian Health Insurance Association and 21 with the Australian Private Hospital Association. In addition, the Minister had met with peak industry groups 18 times (Lawrence, 1995). The data showed the power of the AMA and its subgroup. The view that the medical profession had sizable access to the Minister was supported by the majority of interviewees, who agreed that both the Australian Health Insurance Association and the AMA always had good access to the Health Minister (3case1; 2case1).

The absence of consumers as influencers is noticeable in the debate. One consumer organisation advocating in the reform process was identified during the data collection for the network maps – the Consumer Health Forum. Interviewees concurred with the network map, stating that consumers were not powerful. In the end, the interviewees did not consider consumers' thoughts to be overly influential on the outcome. 'I don't recall them being influential in this case' (1case1). 'The Consumer Health Forum was known as left wing, but consumers generally we don't know' (2case1). Interestingly, while not influential, consumers were often quoted as the potential beneficiaries or losers of the reform depending upon the actor's perspective. The use of consumers to create legitimacy for the positions of actors is discussed below.

Overall, power ebbed and flowed as the reforms were created and debated; however, the majority of interviewees agreed that the Australian Health Insurance Association and the AMA were the most powerful actors, reinforcing the findings from the network mapping process.

5.4.2.2.1 Changing the proposal

The Democrats were a minor party that held the balance of power in the Parliament of Australia at the time. As a result, and whilst not in government per se, the Democrats were in a position of power, as the reforms required legislative change and the then-Labor government needed the Democrats to agree on changes to legislation in order to implement the reform. Senator Meg Lees was the leader of the Democrats and was very influential. The Department of Health needed to convince her that the proposed changes were sensible; if she disagreed with the Department's propositions, the reforms would have failed.

Interviewees noted that Senator Lees was very fair minded, listening to both the medical profession and the Department of Health (4case1). By December of 1994, adversaries to the reform had managed to convince the Democrats that there was potential for contracts to result in substandard care (Lees, 1994). The alliance had stalled the reforms and gained a more significant review of the measures, and in early February, the bill was sent to the Senate Committee. The Senate Committee reported to the Senate on 21 March 1995 (Senate Community Affairs Legislation Committee, 1994).

Despite the considerable amount of evidence presented at the Senate Committee's review of the bill, the opposing alliance exerted enough influence to convince Parliament that there were issues, and the passage of the bill through the Senate was protracted. The bill was extensively debated over four sitting days in the Senate Chamber. Fifty-three amendments were made to the bill; being such a significant change, it was argued they created a whole new bill (Bacherlard, 1995; Jurman, 1995). The reforms were so controversial that Parliament agreed that a further review of the resulting Act

should occur in 1996. This unusual second parliamentary review afforded the opposing subgroup another opportunity to have it overturned.

The opposition party was not a key player in the network due to the policy positions that it held and the presence of the Democrats. Dr Michael Woolridge was opposition Health Minister for the Liberal–National coalition, and he was supportive of the idea of contracting, which was a marked change from the party's previous position (1case1). One interviewee suspected that the then–opposition Health Minister was placed in a difficult position: 'it was in Wooldridge's interest to see the legislation go through, as he suspected he would be required to increase participation if the coalition won the upcoming election' (4case1). It was thought that opposition Minister (Wooldridge) saw the problem of private health insurance sustainability through the lens of managing it when they eventually got into government, and rather than having to introduce these measures and wear the political angst himself, he might prefer to be in a position where the funds had a bit more power in the relationship. Consequently, the Liberal–National coalition stated that whilst they would not support the bill in its current form, they did support the notion of contracts between funds and providers. In the end, despite publicly agreeing to the principle of contracting, the coalition agreed to make some minor amendments to the bill to appease the AMA during the passage of the legislation in May 1995 (1case1) (Commonwealth of Australia, 1995).

By January of 1996, the medical practitioners' subgroup had decided that it was possible to seek a reconsideration of the proposals in the upcoming election, demonstrating their continued belief that they could vet the proposal, even after passage of the legislation (Boreham, 1996).

The characteristics of the broader political environment came into play, whereby both major political parties decided that PHIs should be supported to remain sustainable in some manner, even if the exact method of support was not agreed. The documents and the interviewees' reports suggest that in this case, one subgroup of advocates held the power to create the momentum to develop policy changes; however, the minor Democrat party were the real power brokers in the network and held the capacity to influence the regulator and alter, vet or defeat the proposals. This didn't deter the opposing subgroup led by the AMA, who believed that they could still influence the policy and vet the proposal post-passage. Whilst the new legislation permitted contracting of medical practitioners by insurers, this did not translate to a change in the relationship between insurers and medical providers as providers refused to sign contracts. Thus the legislative change, being permissive rather than prescriptive, did not ensure a change to the operation of the system.

5.4.3 Regulatory policy – institutions

This chapter has so far demonstrated that a constituency of actors formed to debate the reforms and mobilise around the policy event – the first two indicators of path dependency according to Brady et al (2016). In order to understand why the eventual legislative reforms did not have an impact on the ground, this section analyses the third mechanism of path dependency – when *regulatory policies function as institutions* that can ensure subsequent policies and reforms are more efficient and thus more likely to be implemented (Brady, et al., 2016). As more eloquently phrased by Pierson (2004, p. 35), ‘Policies, grounded in law and backed by the coercive power of the state, signal to actors what has to be done, what cannot be done, and establish many of the rewards and penalties associated with particular activities.’ Path dependency theory suggests policy lockdown is occurring when these previous decisions influence the policy choices available today (Antonelli, 2009). The following section analyses the impact of industry adapting to the regulatory policy: whether the cost of the change is prohibitive (Sydow, et al., 2009), and the actual change that eventuated as a result of the reforms (Pierre, 2009).

5.4.3.1 Industry has adapted and doesn’t change – cost of change

A constant theme expressed by interviewees was that change will not happen just because it is allowed to occur. The new legislation allowed insurers to directly negotiate with hospitals and surgeons to cover the full cost of a treatment. Previously, insurers needed to deal equally with all medical providers (hospitals and surgeons). Interviewees noted that once the insurance industry had worked out how they could work within the rules, it was very hard to get them to change course. One interviewee noted that initially, ‘a lot of work was needed to convince insurers that the reforms should be advocated for, as a lot of the time they do not like doing new things – the bureaucracy of the corporation’ (1case1).

These observations indicate that the industry had already commenced operating with the limitations imposed under the previous regulatory framework, as confirmed by one interviewee who noted the expectation was that ‘these are the rules, and you guys need to work out what the rules allow and how to make a profit within that construct’ (1case1). Interestingly, another participant also observed that the system was hard to change because every insurer had established their business operations according to the rules (being a passive payer) with a view that their operating model was the most appropriate. Because of the varying ways private health insurers operate, potential changes impacted insurers differently. ‘[Changes] can therefore become [an] insurer A versus insurer B problem, with one insurer likely to be in a position to gain and another [to] lose. Any proposed change will therefore have an impact upon one of the funds that they do not like’ (6case1).

It was clear by 1995 that lockdown of the path had started, with the cost of changing from one way of operating to another being so significant that reform was effectively not going to be economical. The amount of change required for insurers to move from being passive payers for episodes of treatment to active managers of contracts was considerable. There is always a cost involved in changing the operations of a business, and a couple of interviewees pointed out that the amount of data capture and labour involved to manage medical contracting was considered to be substantial (1case1). The government was also bringing in a case mix protocol. A case mix protocol provides enormous data about hospital performance, and if it can be linked to a doctor, it can provide enormous detail about provider performance to support a shift into active management of healthcare provision. However, back in 1994, the information technology systems and associated infrastructure were relatively expensive, and the data analytics required to facilitate such a change didn't exist.

There was also a significant cost to medical practitioners who wished to contract with insurers in addition to the financial cost. Interviewees pointed out the social costs: 'Doctors were effectively bullied into not signing contracts; if a colleague found out that a person had signed a contract, they were effectively ostracised' (1case1). In addition to potential changes in relationships in the workplace, the reforms challenged the primacy of the doctor–patient relationship: 'There was an emotional response to this that came over the actual practicalities of what was being proposed and obviously such a policy [that was] against the medical culture, particularly with private practitioners who see themselves having the relationship with the patient' (3case1). 'When doctors are contracting with insurance companies, the nature of the doctor–patient relationship changes. There is a contractual relationship to look after the welfare of the insurance company as well as the patient' (2case1). In short, the major problem of the reforms was that doctors would also be working for private health insurance companies increasing their administrative and relationship burden (Jurman, 1994).

Lockdown of a policy path can occur when the cost of changing to a new way of operating is prohibitive. In this case, it was significantly expensive for insurers and medical providers to alter their operations to take advantage of the opportunities afforded under the new regime. The legislated changes were permissive, allowing both PHIs and practitioners to choose not to change their operations and, therefore, to choose not to contract with individual providers (doctors). Without any part of the industry willing to pay for the change, and the change potentially costing each of the industry sectors, medical provider contracting became less attractive.

5.4.3.2 Actual outcome

To measure whether the mobilisation of the network achieved actors' preferences in policy debates, a comparison between actors' opening negotiating positions and the final legislation can be performed. However, what is legislated is not necessarily what is implemented in practice, and given that the reforms were permissive, actual behavioural change is an important indicator of lockdown of the operation of the payment and access rules and demonstrates which of the two subgroups achieved their goals. As a result, the actual behavioural change, as much as this can be measured, is analysed in this research.

Table 5-3 Policy, law and implementation

Government policy (as introduced to Parliament)	Final law	Implementation and changes to operations (actual behavioural change)
Allow insurers to enter agreements with medical practitioners. The agreement would allow the fund to pay medical benefits over the Medicare Benefits Schedule (MBS) fees for that practitioner's services (Department of the Parliamentary Library, 1995).	Agreements allowed.	There was extremely limited uptake of medical agreements when the law was reviewed by Parliament in July 1996. The Department of Health stated that it knew of only one practitioner agreement. The private health insurance sector shifted and developed a totally new benefits schedule designed to address the issue of out-of-pocket costs – the no-gap/known-gap benefits schedule.

The original design of the reform imagined that PHIs would enter into individual contracts with hospitals and medical practitioners (specialists rather than general practitioners) to establish payment arrangements for the services provided to privately insured patients (Willcox, 2001). The eventual impact of the legislation on the two major provider groups, private hospitals and medical specialists, was markedly different, with medical practitioners fighting much harder to prevent change (Willcox, 2001).

By 24 July 1996, when the second Senate Committee established to review the Act commenced taking verbal evidence, few medical agreements had been signed. The Australian Medical Association (AMA) claimed that there were between 'zero and 100', with the Australian Doctors' Fund (ADF) stating that 'to our knowledge no doctors have signed contracts' (Senate Community Affairs Legislation Committee, Parliament of Australia, 1996, p. 7). The Department of Health stated that it was 'unaware of any MPPAs and knew of only one Practitioner Agreement' (Senate

Community Affairs Legislation Committee, Parliament of Australia, 1996, p. 7). Medibank Private, however, informed the Senate Committee that the fund had a small number of medical agreements, but conceded that this was less than 100. These contracts covered a number of specialties and were not restricted to any particular geographical areas: 'we have at least some agreements in all States. We also have one instance where all of the doctors in a particular hospital have signed agreements' (Senate Community Affairs Legislation Committee, Parliament of Australia, 1996, p. 8). Insurers were able to contract with most hospital providers in their geographic market. However, insurers had not negotiated strategically and were operating at an aggregate loss of \$44 million by 1995–96 (Willcox, 2001). At the end of the review, the Committee found that the legislation had not been successful and had not achieved many of its objectives, making 24 recommendations to improve the system.

The opposing subgroup was successful during the debate in gaining major changes (including the removal of single billing and establishing a formal financial consent process for the cost of treatment), which eventually reduced PHIs' capacity to solve the value proposition problem. The low uptake rates of contracts continued, and in May 1998, Department of Health data indicated that only two private health insurers had contracts with 200 medical practitioners in Australia (Department of Health and Family Services, 1998).

Medical practitioners were directing how care would be purchased and given the opposition to direct contracting, a common view amongst interviewees was that actors had sought out another method to use the opportunities that legislation afforded to improve value. Interviewees' recollections differed as to how the new method arose; however, at some point, it was identified that the legislation also allowed for the creation of an 'agreement' via the development of a new benefits schedule⁴ whereby patients would have upfront no or known gaps for patients (7case1). Who developed the idea and how it gained traction were remembered differently by the interviewees (4case1; 1case1). However, in the end, 'The Australian Health Insurance Association

⁴ The Medicare Benefits Schedule (MBS) is a schedule of fees for medical services set by the Australian government that states how much money a person will receive towards the cost of a service under Medicare. The MBS lists a wide range of consultations, procedures and tests.

No gap/known gap is a unique benefits model. **No gap** cover means the insurer will pay a certain amount more than the MBS fee for a service. If the doctor charges more than the MBS fee but less than or up to the no-gap fee set by the insurer, the patient will have no out-of-pocket costs. **Known gap** cover applies if the doctor charges more than the no-gap fee, but not more than an additional amount set by the insurer. This is the known gap limit.

If the doctor charges less than or up to the **known gap** limit, the patient must pay the difference between the doctor's fee and what the insurer agrees to pay under their benefits model. If the treatment costs more than the known gap limit, the insurer won't pay more than 25 per cent of the MBS fee. The patient must pay the entire gap out of pocket (Department of Health, 2021).

convinced the Department of Health to allow insurers to pay above the benefits schedule, provided that they had a no-gap/known-gap agreement with the doctor that the doctor would not charge above the scheduled fee' (1case1). Through this variation, doctors could participate in the scheme without signing a contract with the insurer (3case1), and the Department of Health continued to be able to limit its financial exposure. The no-gap/known-gap benefit schedule that allowed patients to understand their likely out-of-pocket expenses gained traction and remains today.

Therefore, whilst the outcome of increased active management by private health insurance through direct contracting with medical providers was not achieved, a different change to the operation of the healthcare system occurred through the creation of the no gap/known gap benefit schedule. The aim of reducing out-of-pocket costs for patients was considered by some interviewees to be met to a small degree. As one interviewee suggested, 'It didn't deal with the issue 100 per cent, but in sufficient percentages to make the product better' (7case1). This view was echoed by another informant, who stated it 'goes some way to reducing the likelihood that a patient will face high unexpected costs, but it didn't totally solve the problem' (3case1). Another interviewee was less convinced of the magnitude of the change: 'What difference this made to consumers, in terms of the premiums they paid – little to nothing' (4case1).

If the main objective of the reforms was to create a system whereby PHIs moved from a passive to an active role in the management of healthcare provision through individual contracts, then the reforms were not successful. If the main aim was to reduce consumer outlays and improve the perceived value of the product, interviewees suggested that this may have occurred to a limited extent. Whichever perspective of the problem is taken, greater integration was not achieved and fragmentation remained.

5.4.4 Normative expectations of the regulatory policy

The fourth mechanism for path dependency according to Brady et al. (2016) occurs when *social policies influence normative expectations* about social equality and the role of the state in the economy and society, and it provides the final indication of path dependency when combined with the previous three discussed in sections 5.4.1, 5.4.2 and 5.4.3 (Brady and Bostic, 2014; Brooks and Manza, 2007). In Australia, the federal government has the role of setting the regulations surrounding healthcare services through the Medicare system. Altering the incentives contained within the payment and access rules for providers is key to changing the market for healthcare provision; this also requires a change to the relationship between Medicare and PHIs.

Normative expectations set what is considered legitimate behaviour. This section shows how actors used legitimacy as an operational resource to stabilise or alter the institution, and the resulting

impact upon the roles of insurers and providers. It concludes that a positive and self-reinforcing feedback mechanism developed through the societal expectations of the mixed model of health insurance in Australia. Feedback (or relative benefits) in whatever form come from the environment. Feedback may come in the form of increased power and legitimacy strengthening the institution, or by the way of reinforced social expectations for both government and industry alike.

5.4.4.1 Legitimacy – and the role of consumers in the network

Legitimacy is an important source of institutional change (Thelen, 1999, pp. 392-399). Institutions that are based on power can be destabilised by a reduction in power, or a reduction in the legitimacy of the actors that maintain them. Legitimacy is a 'widespread view or notion that the actions of an organisation are desirable, right or appropriate within a set of socially constructed norms, principles, values and definitions' (Suchman, 1995, p. 571). In the business environment, reputation can be used as an indication of an organisation's observed level of legitimacy and societal acceptance (Fombrun, et al., 2015; Rao, 1994). Legitimacy can then become an operational resource that organisations extract, often competitively, from their environments and that they use to attain their strategic goals. Legitimacy can, theoretically, be extracted by actors forming alliances or coalitions with other groups in any combination of any nodes in a network, giving strength to one perspective over another.

When seeking to convince other parties of the need for reforms, actors quickly asserted that improving private health insurance for consumers was the main reason for the reforms. When announcing the package, the Minister detailed the numerous issues currently facing consumers: 'Consumers were powerless and unprotected against rapid rises in premiums and faced uncertainty as to how large their out-of-pocket expenses would be' (Lawrence, 1994, p. 1). The Minister pitched the reforms as consumers versus providers (medical practitioners and hospitals). To provide better value, the reforms would increase competition, allowing funds to bargain with doctors and shop around hospitals and doctors to negotiate a better offering on behalf of their members (Lawrence, 1994). Private health insurance funds would also be able to form agreements with doctors to enable them to offer private health insurance that covered the full cost of medical services and eliminated out-of-pocket expenses.

The complexity of insurance, healthcare and the reforms made it challenging to convince the public that they were desirable. One analyst of the reforms at the time argued that a major problem for consumers would be determining the value of the packages offered. Consumers were unlikely to be able to see the details of the contracts between private health insurers and hospitals. Consumers would also find it difficult to assess those contracts' impact upon the range of treatments that they

were covered for or the quality of the care likely to be provided by the hospital (Tonti-Filippini, 1995). Acknowledging these limitations, and to help explain the reforms, the insurance industry published a booklet explaining how they would operate (1case1). However, the complexity also allowed an alternate narrative about the aims of the reforms to rise to the fore. This was supported by one interviewee, who noted, 'Insurers had to be very careful about their messaging, whereas the AMA was able to be very clear – no one else between the doctor and the patient' (7case1). It was very easy for doctors to get a broad message going to the market day after day (7case1).

A common theme from the participants was that there was little informed public debate focussing on the needs of the consumer. Unfortunately, consumers then quickly became pawns rather than major or powerful contributors to the policy design and debate. Consumers of health insurance are not always patients and are not a homogenous group. Groups of consumers were targeted by actors to derive support for their positions. Retirees, for example, would be supported as well as those on diminished incomes, as these groups were likely to be beneficiaries as they were less likely to face large out-of-pocket costs under the new arrangements (Lavelle, 1994).

The medical practitioner groups also claimed that they spoke on behalf of the patients (7case1). Opponents of the reforms claimed that patients were selling out their rights by reducing their insurance (Bishop, 1994). A common view among interviewees was that the managed care campaign run by the AMA was very effective at convincing consumers that doctors held their best interest at heart. The medical profession identified that the public were concerned about a US-style system, and although the government stated that the changes bore no resemblance to managed care, comparisons with the US system continued (Boreham, 1996). A recurrent theme participants discussed was the very strong media campaign run by the AMA based upon the issues with US-style managed care (5case1). 'People knew what was happening in America, [from] their television etc., and they knew it wasn't good' (7case1). The media campaign and portrayal of managed care connected nicely within the familiar and popular theme of consumer mistrust of powerful, private corporate entities and their lawyers (Pendo, 2004). Interviewees remembered movies highlighting equity issues within the managed care system in the US and linked these to consumer sentiment. Whilst the movies remembered were released after the debate on this policy measure, the popular John Grisham novel *The Rainmaker* was published in 1995.

The inability to create positive stories undermined the efforts of the private health insurance industry, as noted by one interviewee: 'I would say health insurers historically have had trouble engaging the media . . . [they] generally are negative stories; it is hard to get positive stories in the media; if you are looking for positive spins, they would be coming from the hospitals and the AMA.'

[There is a] good guy, bad guy scenario' (6case1). The community trusted doctors, patients trusted doctors, and they could therefore monopolise the market of trust.

The length of the debate, tactics and capacity to draw linkages with an overseas healthcare system that was not socially acceptable reduced the legitimacy of the proponents of the reforms. The lack of favourable media coverage for the reforms compounded the messaging from the opponent alliance and arguably extracted legitimacy from insurers. As one interviewee brutally observed, 'They [insurers] did not enjoy the war, it destroyed their reputation, tarnished their reputation is a better description' (7case1). As a result, 'they were much more selective in the bits they picked off' (7case1).

5.4.4.2 Outcome – the role of the insurer did not change

This reform was an opportunity to alter the roles of insurers and providers within the healthcare system in Australia. It would change the role of PHIs to encourage active management of outlays and potentially improve care through contracting for service provision. The proposed reform would also alter the balance of power between insurers and providers and increase vertical integration through the provision of better information on provider performance. This was a large change to the legislation, which some interviewees argued would improve transparency and competition. However, the 1995 reforms were permissive: they did not require a change in the operations of either medical providers or private health insurers; rather both parts of the health system were allowed to continue to do previously prohibited activities (Duckett, 1996).

The opportunity to change the operation of the payment and access rules was not exercised by insurers, and direct contracting did not eventuate. Richard Scotton (who was an architect of the Medicare system, and who interviewees suggested had also advised the government on the design of the reforms) argued that the regulatory changes did not have the desired effect and that the insurers were encouraged to maintain a 'pass-through' attitude for fees charged by providers, rather than a strong cost management approach. Insurers had been inclined to accept benefit/fee levels and usage rates as outside of their control and set premiums to cover benefits payable plus management costs (Industry Commission, 1997). This view was reinforced by interviewees. 'And if the insurers had taken advantage of the opportunity they had been given – they could have made significant inroads into the costs. They were very reluctant to drive this' (4case1). The complex financial relationship within the current financial system was provided as an argument as to why the competition theory wasn't completely sound. For an insurer to save money, it is coming out of someone's pocket, and that entity will resist this loss of income (1case1). Even if the rules were

altered to reduce insurer outlays, it was argued that the providers (hospitals, doctors and prostheses suppliers) would find a way to maintain income.

It was not a binary outcome, and these reforms opened an opportunity for insurers, hospitals and medical providers to develop their negotiations strategies in a fairly protected environment (Willcox, 2005). One commentator argued that the reforms could thus be seen as a pilot or experiment for the funds to provide more comprehensive insurance cover (Willcox, 2005). However, post-implementation data showed that insurers remained in their role as passive payers, and instead of negotiating discounts, plans increased the average daily benefit paid to private hospitals in 1996 by 40 per cent, which compared unfavourably to the 5 per cent average annual increase for the previous five years (Willcox, 2001).

Not all participants were negative about the outcomes. One participant noted, 'It is certainly a more robust environment – more tension in funding – the doctors always want more money, and the funds want to pay less money, so it is an adversarial environment' (5case1). Another stated, 'In fairness, I think it has created a more competitive landscape for the parties; you would normally view that that should be a good thing for consumers' (6case1). Interviewees also noted that the reforms became a conversation around how doctors set prices and how you stop the rebates being paid by insurers, whether Medicare or PHIs, from becoming a floor price (2case1). Another mentioned that for patients, a very high percentage were now being paid under either a known- or a no-gap scheme, thus removing some of the issues around out-of-pocket expenses (3case1).

However, no one definitively argued that these reforms had an impact upon costs in the longer term. A common theme among interviewees was that this particular reform didn't solve the real problems in the system being a fee-for-service payment model. Interviewees concurred that doctors in Australia hold a fairly good position in the health system. As one interviewee pointed out, doctors 'have got more freedom than [in] any other country, UK, US' (7case1). The medical profession did not want to be forced into a major concession that changed the power dynamics – 'doctors were in the control seat with the patient. Doctors didn't want to let anyone in the middle of that relationship or directing what they should do' (7case1). The reforms were designed to give insurers the opportunity to enter the conversation with the patient about the provision of services.

Medical practitioners were able to effectively stymie the implementation without significant consequences, thus confirming the norm or expectation of their role as the main person with the relationship with patients.

5.4.4.3 Outcome – continued public support for the mixed model

Path dependency theory describes the role of positive, self-reinforcing feedback mechanisms – or ‘increasing returns’. ‘The relative benefits of the current activity compared with other possible options increase over time’ (Pierson, 2000, p. 252). Policy creates actors, but policy development is also reflective of actions that actors have taken. In this case, feedback for providers and insurers came from consumers – they both received feedback that the providers’ position of ‘no medical contracts’ resonated better with the public. Feedback also came from the environment by way of reinforced social expectations for the government and industry alike supporting the mixed model of insurance. Feedback needs to be analysed over time to ascertain if it is leading to lock-in; as such, the community’s feedback in this case creates a baseline and a starting point to reflect from.

Society’s expectation of keeping the mixed model limited the options available to the political parties. Ground-breaking changes to the mixed model of Medicare plus private health insurance were not envisaged by either major political party. At the commencement of the reforms, some researchers of Australia’s health system advised that there was an option of simply allowing the private system to die a natural death and move the funding into the public system instead of reforming the insurance system. This option was not considered by either of the major parties, as it was perceived to be a vote-loser (Jurman, 1995). When introducing the reforms, the then-government noted, ‘The private health industry is an important and successful part of our health system. Private health funds’ reserves are at a record high, as are the occupancy rates and profit levels of private hospitals’ (Lawrence, 1994, p. 2). Private health insurance would support the public hospital sector by providing hospital (secondary/tertiary level) services (Willcox, 1993, p. 326).

The payment and access rules that structure the mixed model complicated any potential reforms. Some interviewees noted that allowing vertical integration with providers might place a government in a difficult situation if it created a two-tiered system. If there were resulting shifts in access to Medicare (particularly bulk-billing), this would be blamed on the reform and the government. No government desires this level of political pain (4case1). Whatever solution the government decides to implement to ensure the ongoing viability of the private health insurance sector is informed by an understanding that there is a whole generation of people who grew up with Medicare as their insurer and have never considered paying for private health insurance. The inability to alter access to Medicare places the government in a difficult position. As one interviewee observed, ‘the government hasn’t done anything too major. Medicare has been pretty stable over a long, long time’ (7case1). The feedback provided to politicians was that Medicare as a system, as the principal or key policy path, should remain as-is. Fixing other parts of the healthcare system needed to be

orchestrated in a manner that didn't expose the government to the criticism that could result from a change to Medicare. This limited options for the development of an alternate path.

Not all respondents indicated that future reform was impossible, but they noted that it is likely to be very difficult. 'There has never been a moment when someone hasn't agitated for reform. Reform is touted all the time, but it is difficult to achieve' (6case1). The structure, size and influence of the players influence the strategic operations and provide incentives to actively engage at a political level. The outcomes of this reform 'both encouraged and discouraged' future efforts. On a more positive note, one interviewee said, 'I think the lessons were that if you can have a clear idea about what you want and you can articulate that to the Senate cross bench clearly enough, then you can get reform done' (4case1).

Some interviewees felt that the lack of success set back reform of a similar kind over the next decade. One interviewee noted that the next reform was to shovel money at the insurers, so the whole idea of trying to fix health insurance without a subsidy ended with the change in government in 1996 (5case1). This provided a win for medical practitioners, as this money flows through the insurers, thus increasing their benefits from the structure of the current system. Medical providers received increases in income for their efforts when the government changed its options to support PHIs. A few interviewees commented that the federal government doesn't seem to have the mind for major insurance reform; they have tried with various other things to improve broader imperfections in the health system (7case1) (6case1).

The general population's policy preferences influence social and regulatory policy and become self-reinforcing. The lack of government determination to mandate changing the roles of PHIs and providers and instead moving towards a policy of subsidising PHIs would appear to appeal to mass policy preferences of 'not changing the payment and access rules'. When combined with an unwillingness to make changes that might be perceived to undermine Medicare, the two positions reveal that private health insurance and Medicare must continue to operate together in a mixed model of insurance.

Path dependency theory describes the role of positive, self-reinforcing feedback mechanisms – or 'increasing returns'. Feedback was provided by the environment through the reinforcement of society's expectations that there will be a mixed model of insurance and that the payment and access rules should continue to prevent insurers from directly contracting medical practitioners (insurers are effectively not active managers in the system). The rules that establish the operation of Medicare and the relationship between it and private health insurance are the dominant policy path, and this case demonstrated how difficult it is to change the relationship between insurers and

Medicare, signalling that lockdown had commenced. The observations by all interviewees of the lack of appetite for future reform in this area supports the continuation of the mixed model of insurance.

5.5 Conclusion

The addition of Medicare in 1984 started a new financing policy for healthcare in Australia. The payment and access rules developed at that time to protect Medicare have limited insurers' operations and their control over expenditure. The combination of ever-increasing premiums, dropping membership and increasing outlays created an environment in which the private health insurance industry needed to make changes. PHIs needed to change their operations from being passive payers for procedures to active managers in the system through direct contracting of medical practitioners; however, this level of integration is through the operation of the payment and access rules.

The then-government had decided that there was a need to restructure the health insurance system, and regulations that restricted efficiency and competition were to be removed. Increased competition in theory should either drive prices down or, at a minimum, limit the inflation of premiums. In a rough economic sense, the question surrounded the incentives around price-setting by doctors and, as a subset of that question, how to stop doctors from seeing the insurer-paid rebate as the floor price and then acting to obtain more from the funds and patients. Increased competition would flow through to premiums for insurance, helping the sector remain viable. To increase competition, PHIs would be allowed to directly contract with medical providers, thus giving them power to actively manage care provision. This case had the potential to alter the relationship between medical practitioners and PHIs. It exposed an adversarial environment where providers want more money, and the insurers want to pay less money.

This research demonstrates how the network quickly formed two major subgroups: one with a view to keeping the current payment model, and another that desired a change to create a more integrated system. Power shifted during the course of policy development, commencing with the insurance industry, who had built sufficient momentum to gain the government's agreement to develop a policy issue and place it on the policymaking agenda. The majority of interviewees agreed that the Australian Health Insurance Association and the Australian Medical Association were the most powerful actors, reinforcing the findings from the network mapping process, and that power to control the outcome shifted from the first group to the second, as the policy debate increased in intensity, with the AMA prevailing.

The financing policy of the Australian healthcare system (and its fee-for-service model) created a large constituency that benefited from maintaining the status quo. The group coalesced, developing

alliances, sharing information and forming a formidable and powerful subgroup. That subgroup, whilst not able to totally prevent legislative change, was able to prevent actual behavioural change and direct contracting of medical practitioners by PHI— demonstrating their power to control how care is purchased.

Both proponents and opponents of the changes claimed to have the consumers' best interests at heart; however, consumers were not a large part of the policy design, and their voice was not considered to be influential. A common theme from the participants was that there was little informed public debate focussing on the needs of the consumer. Unfortunately, consumers then quickly became pawns rather than major or powerful contributors to the policy design and debate, and actors targeted segments of the consumer market with a view to bolster their position.

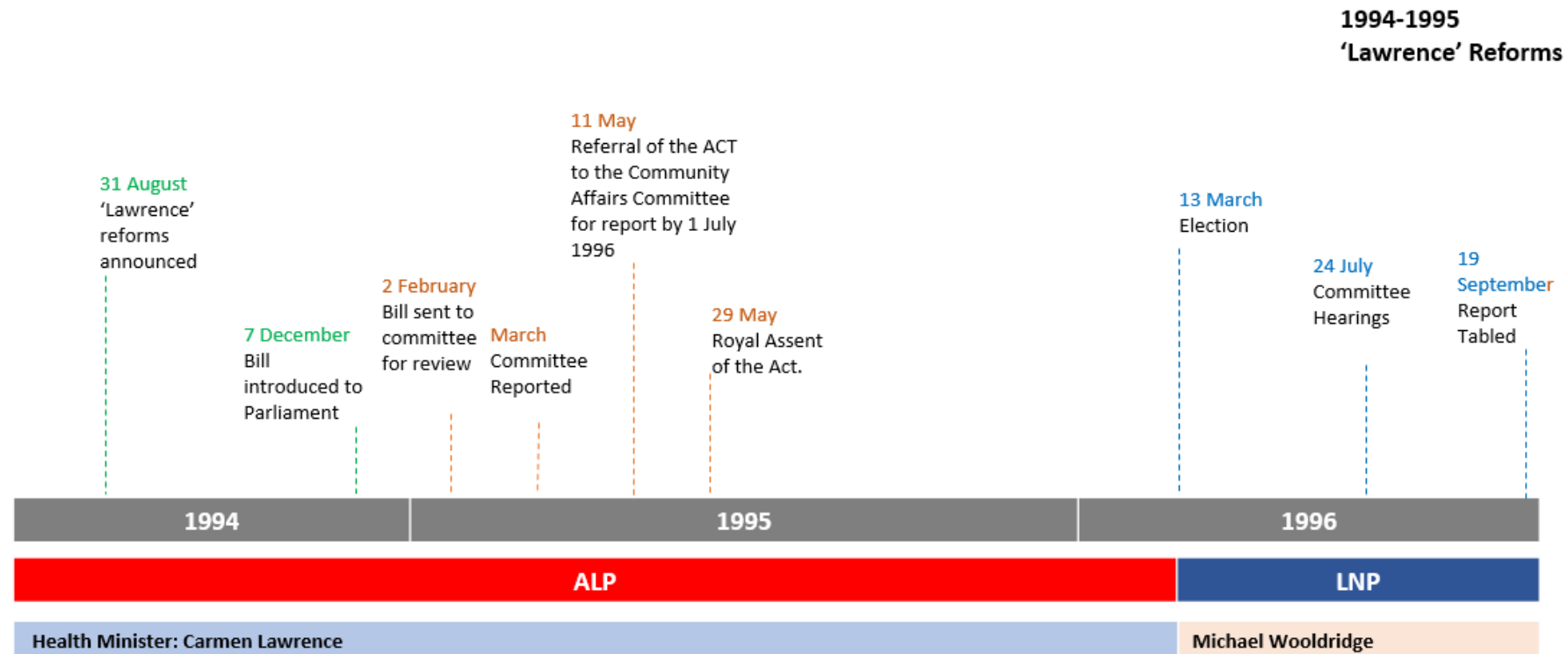
Lockdown of a policy path can occur when the cost of changing to a new way of operating is prohibitive. It was prohibitively expensive for insurers and medical providers to alter their operations and take advantage of the opportunities for better integration and active management provided under the new regime. The legislated changes were permissive, allowing both PHIs and practitioners to choose not to change their operations. Without anyone willing to pay for the change, contracting became less attractive. There were also costs for the then Labor government, with a significant public fight occurring during the lead-up to the next federal election.

In the end, the roles of the insurers and provider did not change. The desired outcome of increased integration or active management by private health insurance through direct contracting with medical providers was not achieved. Small changes to the payment and access rules occurred through the creation of benefit schedules for known- and no-gap schemes, and this may have had an impact of reducing out-of-pocket costs for patients. This new way of operating reflected that the mixed model of insurance creates an unusual set of co-dependent relationships: providers need the insurers, providers and insurers need the government, and all three need the public's support. The easiest path was for insurers to maintain a 'pass-through' attitude in relation to fees charged by healthcare providers rather than a strong bargaining approach, and the no-gap/known-gap benefits schedule allowed for the pass-through to continue.

The path dependency of regulatory policy constrains politicians from retrenching or removing programs and benefits. Major changes to the relationship between Medicare and private health insurance were not envisaged by either major political party. Feedback and increasing returns can be either positive or negative, and in this case, the constituency sent a message to political parties of both persuasions that attempting to change Medicare is dangerous and that retention of the mixed model is preferable. Medicare and PHIs must continue to operate together in an undefined manner.

The next chapter considers the next challenge to the payment and access rules, the 2007 Broader Health Cover (BHC) reforms and examines how the medical practitioner subgroup operated to limit the scope of reform. It provides the second of the three cases, which when combined enable an investigation over a span of over 20 years of how actors within the policy network have operated to constrain reform in Australia's healthcare financing system.

Figure 5-2 Timeline of events and environmental data



Industry size: 47 Funds
 Hospital Membership (proportion of Australian population with hospital cover): 37.2%
 PHI expenditure as a proportion of membership Income: 85.8%

Sustainability of the sector questioned prior to reforms - Yes
 Price increase of premiums: 1.9% per annum
 Benefits Paid: increase on previous year: 2.1%

Govt. Departments regulating the industry: PHIAC, Dept of Health.
 Cost of health system: \$38.5 BN in 1994
 Growth of cost of Health system 1994 to 1995: 5.4%

6 Case Study 2: Broader Health Cover (2007)

6.1 Introduction

This chapter reports the empirical findings of the second of three cases, which occurred 10 years after the first case. In this case, the then–federal government proposed a change to the payment and access rules that would allow private health insurers (PHIs) to provide cover for services outside the hospital walls. The initial conceptual changes included allowing PHIs to pay for general practice services, hospital substitute services, Chronic Disease Management Programs (CDMPs) and health and wellness programs. PHIs would be able to integrate care through contracts with teams of providers for patients with chronic conditions. Providers, insurers and consumers all had something to gain or lose depending upon the final package of reforms. A detailed description of the case is below.

The chapter proceeds as follows. Section 6.2 situates the case within the policy environment, detailing why the proposals were put forward and the interests of the key actors, drawing on documents and interviews. Section 6.3 traces the Bill through parliament, demonstrating a narrowing of ambition through the final legislation and implementation. The chapter presents the network analysis via a network map of actors within the network and their ties (section 6.4), and interviewee reflections on the network map. The chapter then details the operations of this actor network throughout the case drawing on interviews and document analysis, including the relationships between actors, who had power, the costs of change, claims to legitimacy, and how this ultimately influenced the outcomes of the reforms.

The chapter shows that two smaller opposing groups representing insurers on the one hand and medical providers on the other formed strong constituencies and the latter constrained the policy reforms. In this case, the proposal was significantly smaller in ambition than the previous case and subgroups representing consumers joined the network, but were ineffectual. Medical providers secured legislative protection of their clinical and billing freedom and excluded themselves from reforms to the payment model. The operation of the payment and access rules remained the same.

6.2 Environment

6.2.1 The Role of PHI in a mixed model

By the time the 2007 reforms were debated, the National Health Act had been in operation for 50 years, and Medicare had been a fundamental part of the setting for over two decades – both of these systems were well established.

The legislation was last subject to major change in 1995 (Case 1). This reform was intended to fix the industry's viability concerns by allowing PHIs to become more active managers in the system, reducing the possibility of out-of-pocket costs and reducing outlays – the combination of which created better 'value for money' for purchasers of the product. The 1995 reforms, whilst delivering known and no-gap contracts, did not fix the fundamental problem that the payment and access rules required PHIs to operate under a passive fee-for-service financing policy, reducing their ability to develop financial incentives to encourage medical providers to integrate care. PHIs remained passive payers, and calls for reform from the insurance industry, health analysts and academics began to gather momentum during the early 2000s (Productivity Commission and Melbourne Institute of Applied Economic and Social Research, 2002). During this time between the first and second cases, medical practice and the population's healthcare needs had altered dramatically, and a better understanding of the drivers of costs and the impact of fragmentation upon chronic conditions was forming (Metherill, 2006).

Questions surrounding the system's efficiency and the ability for the two insurers to co-exist in a mixed model led to the then–Health Minister, the Hon. Tony Abbott, sending the issue to the Parliament for its scrutiny, and on 16 March 2005, the House of Representatives Standing Committee on Health and Ageing established a review of 'How the Commonwealth Government can take a leading role in improving the efficient and effective delivery of highest-quality healthcare to all Australians' (House of Representatives Standing Committee on Health and Ageing, 2006, p. x). Part of the terms of reference were:

d) how best to ensure that a strong private health sector can be sustained into the future, based on positive relationships between private health funds, private and public hospitals, medical practitioners, other health professionals and agencies in various levels of government. (House of Representatives Standing Committee on Health and Ageing, 2006, p. xi)

The House of Representatives Committee heard evidence that 'there are opportunities for greater efficiency and effectiveness in healthcare in Australia, and quite significant opportunities to get better value for money' (Standing Committee on Health and Ageing, 2006, p. 26). Many of the models put forward involved changes to the structure of the funding model, which could lead to changes in healthcare provision. This included options that were currently used overseas for managing chronic conditions which brought primary and hospital care under the one insurer (Standing Committee on Health and Ageing, 2006). The alternatives were wide-ranging and included the creation of health savings accounts to address unexpected out-of-pocket costs (Standing

Committee on Health and Ageing, 2006) and removing private health insurance altogether. The private health insurance industry argued that the current suite of regulations prevented PHIs from providing some more appropriate care options for members (Metherill, 2006). Witnesses to the Committee hearings also mentioned that it was inappropriate for insurers to remain as benign bill payers, stating it was time to move on and embrace different incentives (Standing Committee on Health and Ageing, 2006). The Committee's recommendations focussed on the peripheral issues, such as who can advise members on transferring between funds and informed financial consent. The recommendations did not address payment models.

The cost of healthcare in Australia over the 10 years prior to the 2006 review had risen significantly, and Australia's healthcare costs were increasing faster than the OECD average (Standing Committee on Health and Ageing, 2006). Over the 2005–06 financial year, hospital and ancillary benefit outlays (private health insurance expenditure) grew by \$515 million or 6.2 per cent (Private Health Insurance Administration Council, 2006). Medical advances were adding to the cost of healthcare, with treatments that enabled people to live longer being very expensive. PHIs contended that increases in expenditure, due to such factors as new technologies and increased demand, were the main reason for the increase in premiums. In the decade to 2005, the cost of prostheses had gone up by about 538 per cent. During 2001–2006, the cost of medical practitioners had increased by about 124 per cent (Standing Committee on Community Affairs, 2007). The shift in expenditure due to the ageing of the insured population was contributing to increases. Benefits paid to persons aged over 65 amounted to 44 per cent of total benefit outlays, although this group only accounted for 13.1 per cent of the insured population (Department of Parliamentary Services, 2007). Health insurers noted that they regularly paid hospital bills of more than \$100,000 during the last months of a member's life (Australian Unity, 2007).

The long-term outlook of the private health insurance industry within the current setting was questioned by the Private Health Insurance Administration Council. In its 2005–06 report, the Private Health Insurance Administration Council contended that the industry continued to be 'heavily reliant' on non-premium sources of revenue for its surplus, claiming that 'the sustainability of this reliance is open to question because investment income, though important, cannot be expected to fund the benefits outlays growth anticipated by the industry' (Department of Parliamentary Services, 2007, p. 3). While members' average age continued to increase at a rate similar to that of the Australian population, this is a significant issue for private health insurers due to the increased usage of hospital services and associated benefit outlays for persons aged over 65 years (Department of Parliamentary Services, 2007).

Issues in the provision of healthcare were not limited to the private sector, as waiting lists for public hospital operations lengthened. Despite the then-federal government's claim that growth in private cover would reduce pressure from public hospitals, the proportion of public patients waiting for over 12 months for surgery in Australia rose from 4.4 per cent to 4.8 per cent (Metherill, 2006). The federal government's share of funding for public hospitals had declined to its lowest level in seven years (Metherill, 2006). In addition to the lower proportion of funding for public hospitals, the federal government had instigated a freeze on the indexation of the rebates paid to medical practitioners under the Medicare system in 2005–06 by using an indexation system (Wage Cost Index 5) that did not keep pace with CPI, thus increasing the amount of out-of-pockets paid by patients or limiting what medical practitioners could charge if they 'bulk-billed' and, through this, their income. By late 2006, the then-government were heading towards an election and had reduced funding for medical practitioners in both the public and private systems. As one informant noted, 'they were not eager to get into a fight with the medical practitioners on another front' (4case2).

6.2.2 Issues created by the mixed model

Similar to the 1995 case, opinions on the issues afflicting PHIs differed. Some argued that PHIs needed 'to address concerns about the participation rate, the value and attractiveness of the product and to explore opportunities to invigorate [private health insurance]' (Department of Parliamentary Services, 2007, p. 2). For others, the issue was that private health insurers could not apply mechanisms that could control the cost and utilisation of health services. For others, the ever-increasing premiums were leading to a downward spiral where low-risk members left as they perceived a lack of benefits, and the remaining members were an ever more expensive group of higher-risk people (House of Representatives Standing Committee on Health and Ageing, 2006).

Alterations in clinical practice during the previous 20 years had caused a mismatch between modern healthcare operations and the legislative framework that funded them. The new no-gap/known-gap benefits schedule model was well entrenched but was having little impact on insurers' financial viability. A desire to find a way that PHIs could cover services outside the hospital boundaries developed among day hospital groups, consumers and insurers. Research indicated that members wanted a broader range of services and treatments covered by private health insurance (particularly general practice services). The current set of payment and access rules prevented insurers from 'developing flexible healthcare products that better meet consumers' needs and expectations' (Department of Parliamentary Services, 2007, p. 3).

The Department of Health had commenced a process of rewriting the legislation in 2005, which all interviewees agreed was needed, as it was 'a mess' (2case2). There was therefore an opportunity to

shift PHIs' role. As one interviewee stated: 'It would be really nice if [the changes] could create some more explicit mechanism for health insurers to get out of the hospital and start doing some hospital prevention stuff, legitimately, under a hospital product rather than was occurring under an ancillary' (2case2). In theory, the reform beyond 'the hospital gate' would have the effect of allowing insurers to cover those services that people had traditionally accessed within the hospital, but which would be supplied in a less traditional setting, such as a clinic or even in the home (Gillard, 2006).

Multiple problems for the healthcare system remained because of the mixed model. In attempting to create better-value products, exclusions and co-payments became common, and consumers struggled to understand the products on offer due to substantive differences in their detail (Australian Competition and Consumer Commission, 2007). Co-payments and exclusions reduced premiums but led to increased out-of-pockets, which were compared to the 'free' public health system. The government's focus shifted to obtaining medical practitioners' agreement to ensure patients were always warned when they were expected to face out-of-pocket costs (Armitage, 2006). Finally, but most importantly, the system was still fragmented: healthcare provision had not changed to reflect the changes from episodic to chronic conditions. Barriers to coordinated care, such as multiple practitioners treating patients without understanding the full picture of the patient's treatment plan and medical record, remained.

6.3 The proposal

On 26 April 2006, the federal government foreshadowed a private health insurance reform package to be developed in consultation with the industry (Department of Parliamentary Services, 2007). Subsequently, the then-government conducted a period of consultation with the private health insurance sector before releasing an exposure draft of the Private Health Insurance Bill 2006 (20 October 2006) with a view to implementation in April 2007 (Department of Parliamentary Services, 2007). The bill provided a high-level framework and relied on subordinate rules 'to fill in the detail of the regulatory framework' (Department of Health and Ageing, 2007). These were released by the Department of Health on 1 February 2007, shortly before the anticipated commencement date in April.

The reforms covered many aspects, and the Department of Health argued that altering the guidelines would permit the private health sector to change in line with newer clinical models and meet consumer expectations by providing better integration and covering provision of services in the home that had previously been provided in a hospital setting (known as hospital substitute services) (Department of Health and Ageing, 2007). The reform process started with a conversation around a broad set of changes to funding models; however, during the course of the debate, these were

narrowed, and the final set of reforms in the bill was a much smaller subset of the group at commencement (Breusch, 2007). The final Broader Health Cover (BHC) proposal was designed to allow PHIs to broaden their suite of products so they could cover hospital substitute services, Chronic Disease Management Programs (CDMPs) and health and wellness programs (Department of Parliamentary Services, 2007). The component that had the capability to increase integration was the CDMPs, with a view to:

- reduce complications for a person with a chronic condition
 - delay or prevent the onset of chronic conditions
 - constructing a written plan that includes
 - the allied health service or other good that is to be provided
 - the frequency and period of the treatments
 - a date for a review of the plan
 - Consent to provide program services is given by the patient before services are provided.
- Coordination must be by a person who will:
- ensure the services are provided in line with the plan
 - monitor the patient's adherence to the plan. (Ginanne, 2007)

At the time, both insurers and the government claimed that BHC would improve the industry's sustainability, as insurers would receive fewer and less expensive hospital claims, and members would benefit because lower claims would reduce pressures on premium increases (Wilson, 2014).

Table 6-1 Scope of initial reform ideas and outcomes at implementation

Initial breadth of reform	Government policy relating the payment and access rules (as introduced to Parliament)	Final law	Actual change to the healthcare system (implementation)
The scope of the reforms was developed through a series of consultations, resulting in a broad range of ideas that included: A capitation model for fee payment.⁵	Broader Health Cover: expands the range of services that can be covered by private health insurance to include out-of-hospital services that substitute for or prevent hospital care (Department of Parliamentary Services, 2007).	Private health insurance broadened to include services that form part of an episode of hospital care and substitute for or prevent hospitalisation – no limits on location made (Australian Government, 2006).	Uptake of BHC services following the 2007 reforms initially was low. In 2007–08, nine of the 39 PHIs offered CDMPs to their members (Private Health Insurance Administration Council, 2007). By 2008–09, this

⁵ The capitation model provides a fixed amount of money per patient, paid in advance to the medical practitioner for the delivery of healthcare services. It is often a contract for servicing a population group.

PHIs would be able to pay for nursing and general practitioner services under BHC. Insurers determine the location and mode of healthcare (in/out of hospital).	BHC to include rules to allow for the development of CDMPs requiring two allied health professionals to be a part of the planning team. No payments from PHIs for general practitioners.	Medical practitioners determine where services are performed – clinical autonomy. General practitioners not required as a part of a CDMP. Only one allied health professional required for CDMP.	number had grown to 14, and to 30 by 2010–11.
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6.3.1 Who instigated the reforms?

In a similar manner to the 1995 case, the perceptions of who was driving the reforms and what the reforms were designed to achieve changed from interviewee to interviewee. In reality, there were a few groups from different parts of the network who were interested in the possibility of better integration by altering the role of PHIs, and these people happened to come together at one time.

One interviewee suggested that the Australian Health Insurance Association opened up the Department of Health's thinking on allowing PHIs to pay general practitioners for services outside of hospitals (1case2). The industry view was that insurers ought to be able to pay for any doctor's service, as long as the doctors involved did not claim from Medicare also (Senate Committee on Health and Ageing, 2006). This would ensure health insurers could create the best programs under 'Broader Health Cover (the most appropriate care that reflects contemporary clinical practice) in the interests of better health outcomes for the privately insured community' (Department of Health and Ageing, 2007, p. 2).

There were some suggestions that the reforms really started with a need to review and modernise the legislation, as it had become inoperable. As a second-order issue, it would be ideal to allow PHIs to cover services outside the hospital. Care in out-of-hospital settings should be cheaper and better for the patient; however, the payment and access rules at the time meant that private health insurance benefits could not be used for treatments provided in a non-hospital setting. One participant noted that Department of Health officials had seen wastage created due to requirements to provide care in hospital, and this had influenced their thinking. Healthcare in the Home programs had commenced in state-run hospitals, but for privately funded patients, the same models were difficult if not impossible to develop in the private hospital system (5case2).

The Australian Health Insurance Association's observations regarding the barriers to out-of-hospital care were reinforced by the Australian Day Surgery Association, who explained to officials and the

public that there was no way of being reimbursed adequately for services unless they invested in hospital-level accreditation, which was not economical for the type of procedures being performed in their smaller rooms. The Association issued a public booklet for the community on day surgery and how to encourage day surgery through the provision for payment of benefits for services provided in a non-hospital setting.

The differing accounts on how the reforms were instigated indicate that whilst it is possible for reforms to be generated from many areas of the industry, a collection of entities (private health insurers led by the Australian Health Insurance Association, the consumer groups Choice and the Consumer Health Fund, and the Australian Day Hospital Association) had strengthened the call for reforms, creating a tenuous initial grouping of actors around a problem.

6.4 The network

6.4.1 Members of the network – the network map

As outlined in the methods chapter, a document review was used to create an actor map using Gephi software that provided a visual of the actor network for this case, which is in Figure 6.1 below. The following section examines the characteristics of the actor network, including the level of closure, positions of power within the structure and positions of influence.

In this case, we saw the establishment of many smaller subgroups around the policy debate. The network diameter is five – which is larger than the diameter in the 1995 case, indicating a more dispersed set of actors. Whilst a larger diameter number normally indicates that there is greater scope for influence of ideas among the network (Crouch & Farrell, 2004; Garud & Karnøe, 2001), the network diameter should be analysed within the actual layout of the network, and in this case, there are six nodes (groups or actors) that are not connected to the main network who broke into two small and isolated subgroups.

From the document analysis, there were 23 organisations (nodes) interested in the proposed changes – a slightly larger group than the 1995 case. The actors formed into four subgroups. The first, with six actors, consists mainly of private health insurers and shows many linkages between the Australian Health Insurance Association, insurers, the Department of Health and the Australian Private Hospitals Association – nodes in this group are often connected with more than one other node. The second subgroup shows strong linkages around the AMA. It has nine actors and is more of a hub-and-spoke group, with less apparent interaction between the nodes than the first group. The third and fourth groups consist of three actors each, are completely closed, and are not connected to the two main groups. Thus, theoretically, actors in these two last groups lost an opportunity to develop a stronger advocacy platform. One of these last groups consists of entities who are focussed

on specific consumer needs – namely, Motor Neurone Disease, Palliative Care and Multiple Sclerosis. The lack of connection with consumer groups by either of the two main subgroups contradicts their claims that they represent the patient constituency and should, theoretically, reduce their legitimacy and power. Connecting with consumer groups would have also expanded the network of either of the subgroups and the information that actors in the network could have accessed. But since the consumer groups are not connected to either of the larger subgroups or the government, there appears to be very little capacity, if any, for them to influence the power brokers and bring in new ideas. The two subgroups are very small, and if we remove these nodes from our analysis, we see the strengthening of the larger subgroups and an increase in power of the central players in each of those groups.

The modularity score describes the number of communities that have formed. The score of 0.387 indicates that there were a few groups with fewer connections between them, and unlike the 1995 case, the network is not highly connected around the two main nodes. It is broader and more disparate than the previous network; groups appear to form around aspects of the reform but do not share as many common goals, again limiting their ability to influence decision makers. The Gephi analysis shows a medium weighted degree of 3.48. This shows that there were fewer interactions or less sharing of information. Norms would flow around this network less quickly than in the 1995 case, theoretically giving key connector nodes a lesser role and therefore less power than in the previous debate.

The clustering coefficient indicates how closed or open a community is. In this case, the average coefficient is 0.77, which demonstrates that more than 75 per cent of the community was connected to another member of the community. A high level of connection among nodes appears to be available, but when combined with the weighted degree of only 3.48, the connections do not appear to indicate high levels of sharing of information, norms, policies and other resources. This lack of sharing is influenced by the six nodes that are not connected. The sparsely connected nature of the network required a greater investment to contain the norms and disseminate messages than the previous case, drawing more heavily upon resources in proportion to the size of the two reforms.

The network map shows a relationship between the AMA and two of the eight organisations that represent consumer groups. This relationship arguably strengthened the AMA's position in the network, providing the AMA with another way to influence the Department of Health, which was noted by interviewees to be very influential in the design of the proposals. Over the course of the debate, informants reported that more actors had joined the AMA. Representing the hospital system, Catholic Health Australia joined the AMA. The opposing subgroup was also joined by the

Australian Private Hospitals Association, whose position commenced with supporting reforms for greater integration for chronic condition management and options for hospital substitute services but changed allegiances, citing concerns regarding quality of care and overprescribed regulations limiting the programs that could be covered under the chronic condition management arm of the reforms. This grew the subgroup to nine entities that covered three of the four main stakeholder groups in healthcare: consumers, hospitals and medical practitioners.

The documents indicated other groups that represented the medical profession, particularly those that represented surgeons, did not engage in the public debate, unlike the 1995 case. Non-participation is likely to be due to either a lack of interest or an understanding that the AMA had cemented its role as a key and effective advocator within the health sector for the medical profession.

The second main subgroup formed around the Australian Health Insurance Association and was made up mostly of insurers. There were close linkages to the Department of Health for a few of these insurers, and many were also linked to the Australian Private Hospital Association and the AMA. This may reflect that some insurers were wary of choosing a side or wanted to have a relationship with both sides of the debate to improve their position within the industry.

Fitting with the loosely connected structure of the network, there are three key actors – the AMA, Australian Health Insurance Association and Australian Private Hospital Association – that had higher levels of closeness centrality; however, the Australian Private Hospital Association had a lower level of betweenness centrality. The AMA and the Australian Health Insurance Association were the actors who were best placed in the structure of the network to spread key messages and were able to influence the entire network more rapidly than other actors. The two groups of three actors who were not linked to the rest of the network distort the results, and a page rank test was run to uncover nodes whose influence extended beyond their direct linkages and into the broader network. A page rank test allocates a node with a score based on the links made to that actor from other actors (Page, et al., 1998). The AMA had the highest page rank index of 0.11, followed closely by the Australian Health Insurance Association with a rank index of 0.10. The Australian Private Hospital Association was ranked 0.08 and the Consumer Health Forum was ranked 0.07. All other nodes had a rank of less than 0.05. There are low levels of betweenness centrality for many of the nodes, indicating that only five nodes appear highly connected – betweenness centrality shows which nodes are the ‘bridges’ between nodes in a network. The network did not appear to rely greatly on bridges or connecting nodes.

Eigenvector centrality measures the influence a node has in a network, it measures the number and quality (connections to high-scoring nodes) of connections of a particular node (Zaki & Meira, 2014). In a network such as in this case, where there are a few highly connected nodes and quite a few nodes that are not connected to the main actors, we would expect to see a large variance between the eigenvector centrality of actors: the AMA, Australian Health Insurance Association and Australian Private Hospital Association had high Eigenvector indices, which also correlated closely with their high degree and page rank scores. In closed networks, the eigenvector centrality index should correlate closely with betweenness centrality, and we see this pattern emerging in this network. Thus, whilst the network is not completely connected, the maps indicate that power was held by these three nodes, despite the lower betweenness centrality ranking of the Australian Private Hospital Association.

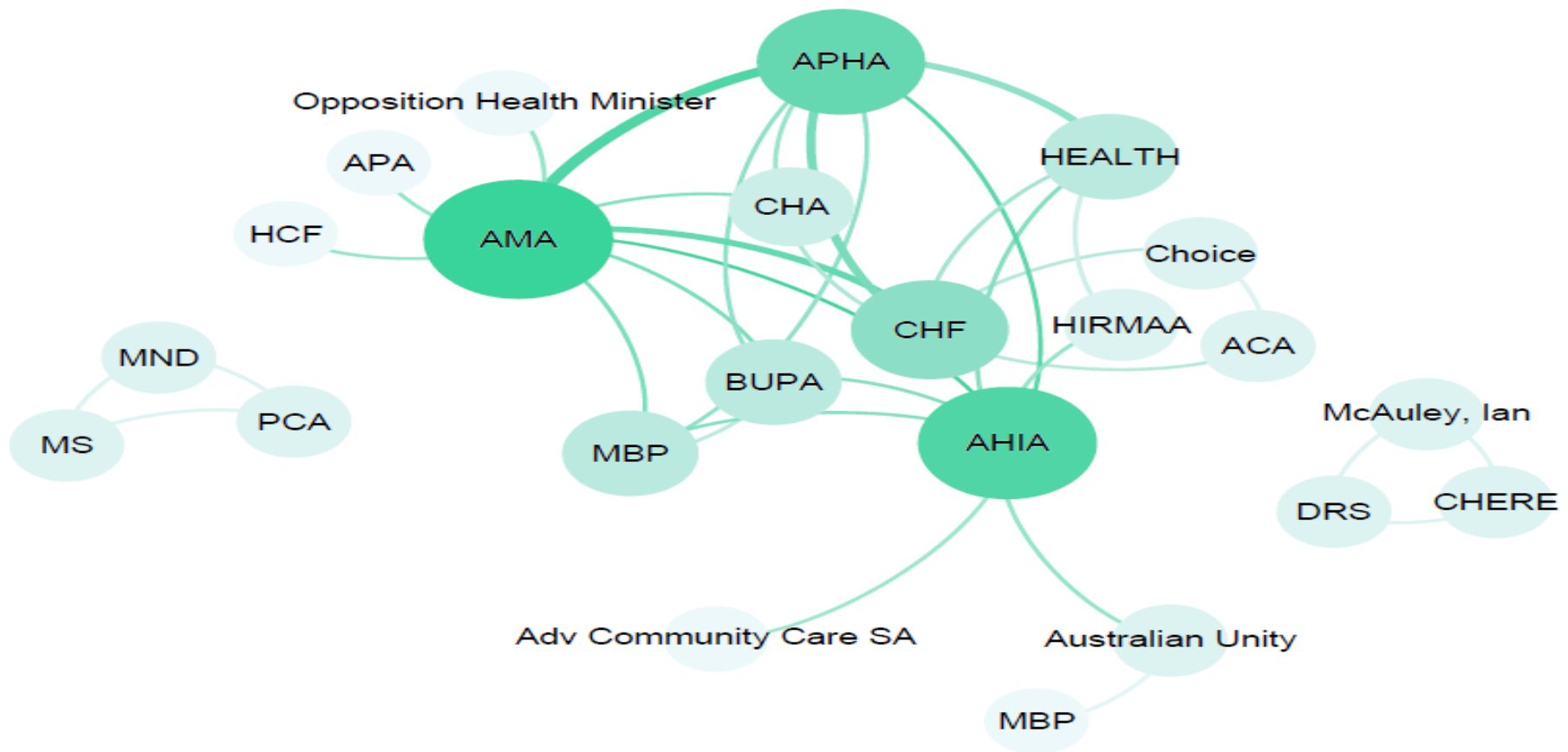
Table 6-2 Network measurements, Case 2

Actor	Degree	Closeness centrality	Betweenness centrality	Eigenvector centrality	Page ranks
Australian Medical Association	9	0.67	52.25	1	0.11
Australian Health Insurance Association	8	0.62	50.33	0.91	0.1
Australian Private Hospital Association	7	0.62	13.33	1	0.08
Consumer Health Forum	6	0.53	30.08	0.68	0.07
Department of Health and Ageing	4	0.50	8.00	0.56	0.05
BUPA HI Pty Ltd	4	0.52	0.00	0.7	0.05
Medical Benefits Fund	4	0.52	0.00	0.7	0.05
Catholic Health Australia	3	0.47	0.00	0.52	0.04
Choice	2	0.36	0.00	0.17	0.03
Australian Consumers Association	2	0.36	0.00	0.17	0.03
Australian Unity	2	0.41	15.00	0.19	0.03
Health Insurance Restricted Members Association Australia	2	0.43	0.00	0.29	0.03

Centre for Health Economics Research Evaluation	2	1.00	0.00	0.02	0.04
Doctors Reform Society	2	1.00	0.00	0.02	0.04
Ian McAuley (individual)	2	1.00	0.00	0.02	0.04
Multiple Sclerosis	2	1.00	0.00	0.02	0.04
Motor Neurone Disease	2	1.00	0.00	0.02	0.04
Palliative Care Australia	2	1.00	0.00	0.02	0.04
Advanced Community Care South Australia	1	0.39	0.00	0.18	0.02
Medibank Private	1	0.30	0.00	0.04	0.02
The Hospitals Contribution Fund of Australia Limited (HCF)	1	0.41	0.00	0.2	0.02
Opposition Health Minister	1	0.41	0.00	0.2	0.02
Australian Physiotherapists Association	1	0.41	0.00	0.2	0.02

Figure 6.1 provides a visual representation of the network developed from the document review (page 134).

Figure 6-1 Network Map – Case 2 – 2007



The colour and thickness of the ties in the network map represent the number of references (or any kind of connection) made to one node by another. The more references between the two nodes, the thicker and darker the tie. The colour and size of the nodes in the network map represents degree, i.e., the total number of times a node was connected to other nodes in the network. The larger and darker the node, the more times it connected to other nodes.

The key to the map is on the following page.

Key to the network map – case study 2: Broader Health Cover (2007)

<i>Acronym</i>	<i>Name</i>
ACA	Aust. Consumers Assoc.
ADVANCE	Advanced Community Care SA
AHIA	Aust. Health Insurance Association
APA	Australian Physiotherapists Assoc.
AMA	Aust. Medical Assoc.
APHA	Aust. Private Hospitals Association
Aust. Unity	Australian Unity
ASA	Aust. Society of Anaesthetists
BUPA	Bupa
CHA	Catholic Health Aust.
CHERE	Centre for Health Economics Research and Evaluation
CHF	Consumer Health Forum
CHOICE	Choice Consumer Advisory Group
HEALTH	Dept of Health (Fed)
DRS	Doctors Reform Society
HCF	HCF
HIRMAA	Health Insurance Restricted Members Association Australia
MBF	MBF
McAuley, Ian	Ian McAuley
MBP	Medibank
MINISTER	Minister for Health (Fed)
MND	Motor Neurone Disease
MS	Multiple Sclerosis
Opp. Health Minister	Opposition Health Minister
PCA	Palliative Care Aust.

6.4.2 Members of the network – post-interview

Semi-structured interviews were conducted to verify and interrogate the results of the network analysis. Most participants felt that the network map exhibited at the interview represented their memory of who was involved and how they were connected. However, there were a few entities and relationships that were not captured. Interviewees observed that the Australian Health Insurance Association was the peak body for 23 private health insurance funds (Australian Health Insurance Association, 2007); the Private Health Insurance Administration Council was part of the environment and would have contributed to the debate on the proposed reforms, and the Australian Day Surgery Association was involved in the reforms and has since changed its name to Day Hospital Australia. As per the first case, interviewees noted that the Treasury and the Department of Finance would have been involved as a part of the machinery of government. No interviewees commented specifically on the timeline of the case that was developed from the document review (see Figure 6.2, below).

This information increased the number of actors in the network from 23 to 27.

6.4.3 Mobilisation

Members of the network enacted specific strategies to enhance their autonomy and pursue their interests. The analysis of these strategies within the network allows us to understand how these organisations, which obtain resources through programs of government, behaved when acquiring or preserving the resources needed for their survival.

Whilst the majority of respondents felt that the reforms were technical in nature, the documents from the time indicate that the actors in the network invested significantly in influencing the reforms' design. One interviewee agreed with this sentiment: 'The actual reform measures got caught up in the big picture politics of health, and it became a fight . . . over who controls the health dollars, the AMA versus the health funds' (3case2).

The following segment reports the key findings of the interviews on the operations of the actor network in this case and the formation of brokers and alliances, key relationships and power blocks. The interaction of decision-makers and vested interest groups is also examined, with a view to establishing who was powerful and who successfully influenced the policy outcome.

6.4.3.1 *Operations of the network*

6.4.3.1.1 Relationships

The building of relationships occurred slowly during the long consultation process and development of the bill that was eventually passed through Parliament. The reforms were considerably less

ambitious than originally proposed. Some interviewees felt that some of the constituencies probably had far less to lose from this reform than in the previous case. Informants indicated that there was considerably greater sharing of information during this case. The AMA was reported to have talked to the insurers a lot and also to private hospitals. As a result, one informant noted that the level of lobbying was remembered as being far less intense in this case than other reforms (1case2).

Other participants remembered the scope of potential changes very differently. In their account of the events surrounding the time, one interviewee recalled a public meeting around funding of general practice services, 'I think it went from "Let's look at new models of care" to "Oh my God, you are in a really scary space, let's stop and think about this"' (6case3). The AMA also felt the scope was potentially broad, publicly voicing its concerns in September – before the exposure draft of the bill was publicly released on 20 October 2006 – that these reforms might increase vertical integration, 'resulting in health insurers gaining additional market power that could restrict choice and the capacity of medical practitioners to provide clinically appropriate care to their patients. Health insurers should not be healthcare providers and vice versa' (Australian Medical Association, 2006, p. 3). It was clear that the reforms of 1995 had left a mark – the AMA had advocated for years to remove the 'Lawrence style' contracts – because they were considered to be or have the flavour of managed care (Standing Committee on Community Affairs, 2007). Any movement to vertically integrate the provision of services was seen as having the potential to allow managed care to be introduced.

Similar to the previous case, alliances developed to debate aspects of the reform. The AMA worked with the Consumer Health Forum (5case2). Catholic Health Australia and the Australian Private Hospital Association worked closely together from the hospital side, and Catholic Health Australia worked well with the Department and, according to one interviewee, the big insurers (4case2). Whilst the impact from the proposed reforms was not as significant as in the first case, the hospital sector again joined with the AMA and the Consumer Health Forum, primarily because they realised that there could be reductions to the length of stay, admission numbers, and general admission and discharge processes as a result of Hospital in the Home (2Case3). The creation of a grouping by the AMA and the Consumer Health Forum provided a strong subgroup of actors in the network structure, building a strong centralised position from which to critique and adjust the reforms, which was supported by informants (3case2; 5case2; 7case2).

The private health insurance sector, on the other hand, drew upon previous relationships and continued to build upon their influence in Parliament. The Australian Health Insurance Association started to receive greater public support from some of its members – Medibank Private had direct

linkages to the government and had called for an expansion of the range of out-of-hospital treatments that could be covered by private health insurance under proposed reforms. In providing evidence to the Senate Committee, Australian Health Management also sought an expansion of the scope of the regulatory approach for BHC. Australian Unity supported the philosophy and intention of the reforms embodied in the bill, claiming that greater competition led to improved services for customers and clearer and simpler regulation for health insurers and service providers (Australian Unity, 2007).

There appeared to be communication between some of the nodes in the network, and interviewees felt there was considerable information sharing between the major subgroups. However, once the two smaller and completely disconnected groups of six nodes are removed, there is a much smaller pool of advocates from which to form alliances. Once the AMA had consumers and the private hospital groups in their alliance, they had formed a larger alliance where resources could be shared and norms established, allowing for the development of a strategy involving these entities. The AMA had established itself in a prominent position in the major subgroup. The next section explores whether greater strength and power was derived from this position.

6.4.3.2 Where was the locus of power?

Institutions can be strengthened when they have distributional consequences that improve the power of actors interested in maintaining the institution (Bennett and Elman, 2006). Interviewees were asked which actors they thought were powerful using the criteria of the ability to vet, alter or prevent a policy change. The greater the ability, the greater the power that actor or subgroup within the network possessed.

The power held by the bureaucracy was noted by most interviewees. A few interviewees remarked that the Department of Health was a powerful figure in this debate (4case2; 1case2). Similar to the previous case, it is not just the power or position of the organisational actor, but who at an individual level is actually in a decision-making position. One interview said that a lot of changes have been very dependent upon who has been in charge of the PHI Branch in the Department of Health, and if they were supportive of private health insurance (and provided that there were not totally ideologically opposed views from the Secretary), that was when things started to happen (1case2).

Observing the role of the Department in supporting change, the private health insurance industry peak body (Australian Health Insurance Association) and its members were in constant communication with the Department of Health, exerting influence and 'ensur[ing] that the legislative change best reflects their view of the Minister's intention' (Australian Health Insurance Association, 2007, p. 1). The Health Insurance Restricted Members Association Australia (peak industry body

representing all 13 restricted membership health benefit organisations and two open funds) were publicly grateful for the time and effort the Department of Health devoted to industry consultation (Health Insurance Restricted Membership Association of Australia, 2007).

Despite agreement on the need for change, the industry's opinions on how the BHC provisions should operate differed from group to group, which provided a muddled message to the Department of Health and reduced the impact of the industry's advocacy message, according to the documents of the time. Specifically, the Australian Health Insurance Association advised that the framework set out by the Department of Health in February 2007 was too restrictive with the definitions of CDMs. They proposed that a more practical method would be to increase 'the opportunity to develop more appropriate chronic disease programs in the private sector', rather than be wedded to a model that replicated the models being used in the public system (Australian Health Insurance Association, 2007, p. 5). The Australian Health Management Group noted that they were very happy with the rules that underpinned the BHC program as set out by the Department on 1 February 2007. 'I must admit that I am delighted. We have been in consultation with the Department over a long period of time and they have visited our facilities so that they could see how we deliver these programs. The rules that we received last night do exactly what our submission says they should do' (Mr Daniel Hook in Standing Committee on Health and Ageing, 2006, p. CA36). Australian Unity went further in placating the medical practitioners, noting the reforms were consistent with their view that private health insurers should be more than 'bill payers'; they also noted that 'it [was] essential that treatment continue to be clinician-led [and they were] . . . not proposing a form of managed care' (Australian Unity, 2007, p. 5–6).

Despite many actors claiming high levels of engagement with key players in the policy design process, the interviewees, on the whole, reported that the Australian Health Insurance Association and AMA were the power players in this case and were also in the most disagreement (6case2; 4case2). These were the entities that were well connected – not just with Ministers but with opposition parties and Senate backbenchers. They walked the corridors of Parliament House (3case2).

Although the power of the AMA was acknowledged, one interviewee argued this does not necessarily mean the government did everything the AMA wanted. It was more that the government was very unlikely to get into a public stoush with them, and, if they were going to get into a public stoush with the AMA, it would be over something the government really, really wanted (3case2).

there is definitely a public perception it was suggested that no one has any objections to health insurance funds, and I think politicians – most politicians would be quite happy to have a countervailing force against the doctors, but they are also pretty spooked by the

memory of the doctors' strike – what doctors can do – it is one of those political orthodoxies that doesn't get challenged – that you can't take on the doctors. (3case2)

The AMA exerted influence by dominating the media (6case2). They also developed strategic relationships with representatives of the private hospitals, who risked losing income, and consumers. Consumer representative organisations (Consumer Health Forum and Choice) became concerned about a two-tiered health system developing and opposed moves that might contribute to one group in society gaining better access to healthcare than another. In addition, there were concerns that by providing these services in the private system, they would be reduced in the public system. Participants discussed the influence of consumer organisations. One interviewee felt that the 'Consumer Health Forum, Choice and the consumer groups had a much smaller role I don't know whether it made any difference whether they joined in the debate or not. . . . But I think, especially, in that era, maybe not so much now, but back then, the AMA was really influential' (3case2). The ability to form an alliance between medical practitioners and consumers, however, proved powerful. The alliance 'between these very two different polarised parts of the health system really marginalised the health funds' (3case2). As one commentator noted, 'And then the government, well, they might take on one side or the other, not that they ever want to take on the AMA, but they are not going to go take on both sides of the ideological spectrum just for the sake of health funds' (3case2). By the time the debate had reached Parliament, the Australian Private Hospitals Association had been convinced of the potential for loss, sided with the AMA and advised Ministers that they were not fully supportive of the measures (Australian Private Hospital Association, 2007). At this point, the opposing subgroup included three of the four main segments of the health sector, similar to the previous case.

Consumers as a group were not considered by informants to be powerful in their own right. The absence of consumers as influencers is again noticeable in the debate. There were two general consumer organisations and six smaller groups advocating in the reform process identified during the data collection for the network maps. Notably, the three groups that formed one of the disconnected subgroups all represented patients: Palliative Care Australia, Multiple Sclerosis Australia and Motor Neurone Disease Australia; however, interviewees considered their influence on the outcome to be low (2case2; 4case2; 1case2). The relationship between the Consumer Health Forum and the AMA increased the AMA's influence by increasing the constituency the AMA was perceived to represent, thereby increasing the AMA's centralisation in the network structure and legitimacy (Ingold, 2011; Laumann et al., 1985; Skocpol, 1992; Ward et al., 2011). The consumer organisation Choice appeared to remove themselves from the debate after the Committee inquiry.

Once again, a subgroup of actors formed an alliance over time to vet the proposal with the desired outcome of limiting the scope of changes to the payment and access rules. At the end of the debate around the proposal, the bill had been altered to concede changes to both the insurer and opposing subgroups. However, prior to the construction of the bill, considerable redactions were made to the scope of the proposal to remove alternate payment models and the capacity for PHIs to pay for nursing and general practitioner services. Power was held by the larger group, with the AMA at the centre assuming a guiding, if not commanding, position. The use of resources to construct alliances proved productive.

6.4.3.2.1 Changing the proposal

In this case, the actors spent more effort vetting and changing the proposals than providing alternative ideas to solve a problem. The actors' actions may have also reflected their perceptions of the impact of the reforms, and a recurrent theme among participants was a sense that this reform was minor in nature compared with other attempts to achieve greater integration: 'It really was so non-controversial' (2case2).

The responses from some of the interviewees in their assessment of how uncontroversial the reforms were conflicted slightly with the documents of the time. The documents show the initial broad scope of the proposals during the commencement of the development of the reform agenda but a smaller and less controversial group of changes eventuating. Payments for medical and nursing services, which the Department of Health initially proposed should be included in the scheme, were excluded from the draft regulations that were issued in December 2006. The exclusion of the more controversial ideas (such as insurers directly contracting general practice or capitation payments – which would have raised the ire of the AMA) had been removed early in the development of the policy and before the bill was constructed to enact the reforms. Whilst no informants stated why these ideas were removed from discussion, two informants noted that these were radical or controversial and assumed that the government of the time had no appetite to progress them (7case2; 6case2). The government proposed more than 100 technical amendments to the bill as it moved through Parliament, suggesting that a reasonable level of negotiation between the then-government and actors did occur, and quite late in the process (Crawshaw, 2007).

Both alliances had good representation with the Health Minister's offices. Minister Patterson was the Health Minister prior to Minister Abbott. Whilst informants said she had a good relationship with medical practitioners, she had a difficult mandate because of the Medicare freeze, which froze the incomes of medical practitioners. The change of Minister to Minister Abbott, as a result of a reshuffle of responsibilities for Ministers in the Liberal Party, brought about a change in the relationship, with

one respondent mentioning that when Minister Abbott came in, his job was to keep the medical practitioners happy (4case2). Several changes to the bill were made following consultation with the health sector in relation to the exposure draft (4case2; Department of Parliamentary Services, 2007).

For the AMA, a major issue was any suggestion that health insurers might decide where patients were treated. Concerned about ideas from some areas that health insurers should have improved powers to choose to provide out-of-hospital care, the AMA argued there should be no opportunity for insurers to develop products that determined treatment options or locations (Australian Medical Association, 2006). Two interviewees specifically remembered the AMA raising the threat of managed care (3case2; 6case2). If the government gave health insurers power to make these essentially clinical decisions, the AMA argued it would send Australia towards a US-style managed care system, which it argued is a lower standard of care, however not necessarily less expensive. 'If the funds want to take clinical decisions, then they must be made fully responsible for outcomes' (Australian Medical Association, 2006, p. 3).

At the Committee hearing, the AMA voiced concerns that there was an imbalance in the power to negotiate between the health insurers and a sole medical practitioner. 'We would like to see a more equal economic balance of power through the legislation because this is about patients – patients' benefits and the quality of care that the patients are going to receive' (Dr Wainwright in Standing Committee on Community Affairs, 2007, p. CA27). The AMA was concerned by the perceived move of others into the management of the system. 'We are very wary of the initiatives which might unintentionally subvert the critical role of general practitioners, and indeed any other treating practitioner in the health system' (AMA in the Standing Committee on Community Affairs, 2007, p. 9). The AMA continued its pursuit of convincing Parliament that changes would lead to managed care and argued at the hearings that some of the programs envisaged under the BHC scheme were the first step towards managed care as far as the health fund stepping between the patient and their treating doctor. 'We are very concerned that this legislation may open the door for managed care' (Dr Wainwright in Standing Committee on Community Affairs, 2007, p. CA28).

The AMA argued for the power for insurers to veto proposed programs under the BHC scheme. 'They say the general products will be better, but we [the AMA] would like to overview those products before they are marketed because they may well not provide best care for the patients' (Dr Wainwright in Standing Committee on Community Affairs, 2007, p. CA31). Whilst the AMA did not obtain this change, they were able to gain the insertion of a clause into the bill specifying that the Hospital in the Home 'agreement must not limit the medical practitioner's professional freedom,

within the scope of accepted clinical practice, to identify and provide appropriate treatments' (Dr Wainwright in McCredie, 2007).

Catholic Health Australia supported the same position as the AMA and stated in the media, 'there is every likelihood that players in the system will abuse the opportunity of the power shift that occurs, and that's what you've seen in the US, where a style of managed care has been brought in' (Sullivan in Breusch, 2007, p. 44). Catholic Health Australia believed that this proposal was a form of managed care, as the health insurer would have a larger role in determining what it should pay for and where it paid out its benefits.

The Consumer Health Forum was cautious in its consideration of the proposals, noting the benefits of moving to a more attractive and modern system that reflected optimal care delivery, but was concerned by the potential for services to be limited by insurers (Consumer Health Forum, 2007).

The Australian Health Insurance Association had at an earlier time secured the inclusion of payment for general practice as a part of the design; however, the AMA challenged this. The Australian Health Insurance Association informed the Senate Committee that the industry position is that private health insurers should be able to pay for any medical practitioner's service, as long as the medical practitioner does not also claim from Medicare for that service. The Australian Health Insurance Association contended that 'this would ensure health insurers can develop the best forms of Broader Health Cover . . . in the best interest of better health outcomes for the privately insured community (Australian Health Insurance Association, 2007, p. 4).

The Australian Health Management Group argued that enrolment and access requirements for CDMPs should concede there is a different relationship between a health fund and its members and a general practitioner and a patient. 'Health funds need to be able to leverage their unique relationship and identify and refer members to different levels of intervention separate to the traditional medical-centric model of care' (Australian Health Management Group Pty Ltd, 2007, p. 3). However, Insurers successfully advocated for a change in the rules regarding the CDMP provisions. The initial rules required that chronic condition treatments must be provided by at least two allied health workers, such as dietitians, physiotherapists and podiatrists – this was later removed (Breusch, 2007; Department of Parliamentary Services, 2007). In the end, insurer's capacity to make payments to general practitioners remained outside the scope of these reforms.

As a final attempt to exert influence over the health system, and after the passage of the Act, the subgroup around the AMA created an opportunity to influence the operations of the products proposed by PHIs. The subgroup consisted of a panel of experts – representing hospitals, medical

practitioners and consumers – bringing together key actors in the system: the AMA, the Australian Private Hospital Association, Catholic Health Australia and the Consumer Health Forum (AMA, 2007). This panel set themselves up to advise the government on Broader Health Cover products. Demonstrating that the subgroup thought they were very influential, they announced their role but curiously had no gravitas nor role within the government. They were not endorsed by the government or established by the Department of Health. This group had tried to create another barrier to implementation.

The changes to the bill and removal of ideas at earlier stages of the policy design process showed that the AMA and their alliance held a considerable amount of power in vetting and reducing the scope of the proposal during its development. In a similar manner to the previous case, one subgroup of advocates held the power to create the changes, and the opposing subgroup mobilised the network to create a formidable alliance that represented three of the four parts of the system: hospitals, medical providers and consumers. The power to develop and alter the proposal lay outside of government and shifted to the AMA from the Australian Health Insurance Association over the course of the policy event.

6.4.4 Regulatory policy – institutions

This chapter has so far shown that a constituency of actors formed to debate the reforms and mobilise around the policy event – the first two indicators of path dependency according to Brady et al (2016). In order to understand why the eventual legislative reforms did not have an impact on the ground, this section analyses the third mechanism of path dependency – when *regulatory policies function as institutions* that can ensure subsequent policies and reforms are more efficient and thus more likely to be implemented (Brady, et al., 2016; Pierson, 2004).

6.4.4.1 Industry has adapted and doesn't change – cost of change

Informants raised that the Australian Health Insurance Association had seen the need to pay benefits outside the hospital since around 1990, but once again there were some problems convincing the industry itself that it was a good idea as there were some components that were going to be hard to implement. But gradually, the industry became locked into the idea of being able to pay general practitioners outside hospital (1case2). While bill paying is an essential part of the private health insurance business, some industry members believed that they could and should make a much broader contribution (Australian Unity, 2007). Among other things, insurers argued that they should have a role in helping coordinate members' healthcare. Proposed changes included that consumers should be able to obtain information about performance of hospitals and clinicians, a pay-for-performance model for medical practitioners, that consumers should be able to obtain information

about the billing practices of medical specialists from health insurers, and that private health insurance brokers should be required to disclose commissions received (Australian Unity, 2007).

Despite convincing the Department of Health of the potential benefits of the reforms, adopting them would prove difficult for the private health insurance industry. A common theme among participants was that PHIs kept arguing about how restrictive the payment and access rules were and how the rules prevented sensible things that would be beneficial. However, as one interviewee noted, ‘once given a mechanism to address integration, it could be argued that they have done “stuff all”’⁶ (2case2). This disbelief in the insurance industry’s ability to reform was echoed by the AMA: ‘Although one hopes that the laws of competition would ensure that much of this new freedom is passed on to members by way of lower premiums and better products, it has not been an industry noted for its willingness to engage in real competition’ (Dr Wainwright in Standing Committee on Community Affairs, 2007, p. CA26).

As a payer of benefits, it would appear the private health insurance industry had built its operating systems around certain methods of processing and auditing claims. One participant observed that some insurers were opposed to paying for anything that didn’t happen in a hospital, with the implications that changing the role of the payer would be difficult. ‘If something happens in a hospital, they know it’s really happened’ (2case2). Indicating that the ability to support change in operations is limited, it was noted, ‘The fact they are not doing it, as I said it is due to the innate conservatism – and I don’t know what you do about that’ (2case2).

6.4.4.2 Cost of change

Noting the apparent reluctance to change, further consideration is now given as to why has occurred, in particular, whether the costs of a change were perceived to be greater than the benefits.

At the time of the Senate Committee inquiry, BUPA Australia noted that there is a requirement for detailed Private Health Insurance Administration Council reporting for CDMPs, which is a significant administrative cost: it includes the planning and coordination of a large range of allied health services. Australian Health Management noted that the proposed model, similar to the multidisciplinary patient care teams in the public sector, would be costly and difficult to implement (Australian Health Management Group Pty Ltd, 2007). PHI information systems were designed to process payments (benefits and premiums) but not to manage healthcare services. Further research showed that the PHI systems did not have access to the patient data needed to be able to develop effective programs to reduce chronic conditions, ‘including identifying target groups, evaluating

⁶ A colloquial term for not much, if anything at all.

service outcomes and collaborating with other healthcare providers' (Khoo et al., 2019, p. 572). To develop effective programs, PHIs therefore relied on medical providers and patients to both share data with them about their chronic conditions and management thereof – considerably increasing the cost of data collection (Khoo et al., 2019). Adding to the cost of a program for a fund was the rule that only some CDMP benefits were eligible for inclusion in risk equalisation, and other parts of the CDMP could not be put into the risk insurance pool; thus, the full cost of the program could not be recouped in the same way as general benefits for the same population (Ginanne, 2007). A couple of interviewees provided a possible explanation for the level of administrative overhead, observing that the Department of Health or Treasury were worried that the scheme might blow out in costs, and that is why it became bureaucratic, and many approval processes were inserted to ensure there would not be a cost blow-out (5case2).

Finally, due to the portability rules that allow member to transfer between funds and maintain coverage, benefits may not accrue to the fund that provided the initial preventative health program. Thus, when combined, the cost of changes was prohibitive when compared with the potential return on the investment (Khoo et al., 2019).

From the federal government's perspective, this reform wasn't going to reduce budgetary outlays. As a result, the value proposition for the government started to decline quickly. Potentially, some people would get better service from their health funds; however, it was doubted that that the benefit would translate into more support for the government (3case2) 'There were also potential costs for the government in that change brings risks that may be difficult to prove or disprove. Hypothetically, the government could fairly or unfairly be criticised if someone was discharged early from hospital and died, which might not be anything to do with the discharge, but the Minister would need to be able to defend the policy' (3case2).

Finally, there were no savings anticipated by the hospital groups either. One informant observed that some private hospitals created packages or proposed services that health insurers could pay for. However, there was very little appetite amongst the insurers. The savings were not enough to make the project worthwhile. 'Hospitals drew the conclusion that insurers were only interested if you could move a service from a very expensive setting to a less expensive setting – e.g., a rehabilitation program – if you could put that in the home with a physio, all of the savings would go to the health funds' (4case2). Therefore, there were limited incentives for hospitals to engage in developing programs. In addition, hospitals would need to change some of their processes to manage

interactions between PHIs and outpatients. The flow of patients and records would change considerably. Finally, hospitals would potentially lose patient days and therefore could potentially lose profits.

The cost of developing, advertising, and implementing new programs needed to be recoupable by the entity developing them. For the insurers, the issues around an inability to directly capture benefits from the program, the costs of developing programs and the need to capture data from both providers and patients provided a significant barrier. In this case, it was prohibitively expensive for insurers and medical providers to alter their operations to take advantage of the opportunities afforded under the new regime. In a similar manner to the previous case, costs were also likely to be borne by other segments in the system: private hospitals would potentially lose patients, and the government faced potential political costs in the form of criticism that their policy caused adverse outcomes and also were unable to save on expenditure in the system. Lockdown of a policy path occurs when other options cease to be feasible. In this case, the cost of changing to a new way of operating meant that shifting to the new model was not feasible.

6.4.4.3 *Actual outcome*

In a similar manner to the previous case, these reforms are permissive. As a result, the actual behavioural change, as much as this can be measured, is analysed to establish which actors in the debate achieved their strategic preferences.

Table 6-3 Policy, law and implementation

Government policy (as introduced to Parliament)	Final law	Implementation and changes to operations (actual behavioural change)
Broader health cover: expanded the range of services that can be covered by private health insurance to include out-of-hospital services that substitute for or prevent hospital care (Department of Parliamentary Services, 2007). BHC included rules to allow for the development of CDMPs.	Private health insurance cover broadened to include services that form part of an episode of hospital care and substitute for or prevent hospitalisation – no limits on location made (Australian Government, 2006). Medical practitioners' clinical autonomy strengthened through insertion of a specific clause in the legislation.	There was not great uptake of opportunities to actively manage care provision by insurers. The uptake of CDMPs following the 2007 reforms initially was low. The number and scope of plans and programs have increased over time from 9,901 individual CDMPs prepared in 2007–08 to 67,097 in 2011–12; however,

	General practitioners cannot be paid by insurers.	the lack of integration with general practitioners is problematic (Department of Parliamentary Services, 2013).
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The uptake of the opportunities provided by the BHC reforms was slow. In 2007–08, nine of the 39 private health insurers offered CDMPs to their members, and approximately 9,901 individual CDMPs had been developed by insurers. The first number grew to 14 in 2008–09 and to 30 in 2009–10 (Department of Parliamentary Services, 2013). By 2011–12, the number of members with a CDMP had increased to 67,097 out of 12.6 million members. Benefits paid for CDMPs to members also climbed from approximately \$4.4 million in 2007–08 to about \$59 million in 2011–2012 (Department of Parliamentary Services, 2013).

The new arrangements appeared to replicate the Medicare Benefits Schedule (MBS) enhanced care planning items that were developed to support general practitioners to provide coordinated care services to patients with chronic conditions (Australian Competition and Consumer Commission, 2007). However, insurers faced a key limitation in that they were not able to pay for items that were covered by the MBS. This meant that their chronic condition management programs must focus on offering alternate models of healthcare (e.g., telephone coaching, care co-ordination and provision of health information) with the intention of complementing, rather than competing with, existing clinical care provided by general practitioners and other health professionals under the MBS (Australian Competition and Consumer Commission, 2007).

Despite legislation allowing private health insurers to pay benefits for CDMP services operating for over 10 years, it has been argued that ‘insurers are still in an early stage of implementation and evaluation of chronic disease management activities’ (Khoo et al., 2019, p. 572).

The provisions also allowed for hospital substitute treatment services under the Better Health Care reforms. The number of members that held cover for hospital-substitute treatment services increased from 2.1 million in June 2007 to more than 6.9 million in December 2012, considerably more than the program designed to help people with chronic conditions. The number of hospital-substitute treatments also jumped from 13,720 to 91,325 during the same period (Department of Parliamentary Services, 2013).

The steady increase in people using CDMPs or hospital substitute treatments demonstrated that PHIs were not totally averse to implementing programs, but the change was slow. Whilst various pieces of research have evaluated the programs PHIs offered for chronic condition management, there are

concerns that the incentives to create these CDMPs were undermined by the large administrative cost and PHIs' inability to capture anticipated savings in the long run. The return on investment was not sufficient. Despite the use of these plans, the most telling measure is that the health system remains fragmented.

6.4.5 Normative expectations of the regulatory policy

Similar to the previous case, this section investigates how organisations utilised legitimacy as an operational resource to stabilise or alter the payment and access rules. It then analyses the resultant shift in the role of insurers in the health system through this reform. The last section discusses the presence of a positive and self-reinforcing feedback mechanism, and how actors prevented changes to the payment and access rules and the likelihood of future reforms.

6.4.5.1 *Legitimacy – and the role of consumers in the network*

Mechanisms involving power and legitimacy can become important sources of institutional creation and change (Thelen, 1999, p. 392–99). Legitimacy was a resource in a political environment, employed in pursuit of a group of actors' goals. Whilst theoretically, whoever is viewed to have the more legitimate policy or position is more likely to be supported by the government, as legitimacy is a generalised assumptions or perception that an entity's behaviours are acceptable, this did not occur in this case (Doyle et al., 2016; Suchman, 1995).

Improving value for consumers remained a problem for the private health insurance industry, and improving value was also an ambiguous target. Research conducted before these reforms commenced consistently indicated that out-of-pocket costs and the growth of premiums remained key problems for consumers (Australian Government, 2006). Responding to this information, the debate quickly centred around containing costs and improving patient care as the means to improve value.

PHIs argued that the Better Health Cover programs would provide cost containment. At the Senate Committee Hearings into the bill to give effect to the scheme, the Australian Health Insurance Association argued that costs would be lowered but the outcomes would be better (Senate Committee on Health and Ageing, 2006). In their accounts of the events, a couple of interviewees noted that, hypothetically, these cost containments should have accrued through funding programs that would lead to fewer hospital admissions in 10 years' time (5case2; 4case2).

The insurance industry's claims that the proposal would help contain increases in premiums were supported by the Australian government. The Department of Health told the Senate Committee that modelling revealed no adverse impacts on members' premiums in 2006 (Gillard, 2006). Curiously, the

AMA claimed that insurers had overstated their ability to contain health system expenditure, in particular, their ability to reduce the amount of acute hospital care from the introduction of Broader Health Cover, effectively acknowledging that one of the drivers of increased costs is outlays for medical practitioners (Standing Committee on Community Affairs, 2007). Others agreed and argued that whether the provisions were inflationary depended on what services were covered. If those services were in scarce supply, then it was almost inevitable there would be an inflationary aspect (Department of Health and Ageing, 2007). Australian Health Management argued that the drivers of real healthcare cost in Australia are new technology and an ageing population, and neither of those two factors was going to change because of this legislation (Standing Committee on Community Affairs, 2007).

A common view among interviewees was that there was some (community) expectation that this reform might have had an impact on premiums and out-of-pocket costs (4case2). However, it was unsurprising that larger out-of-pocket costs for non-admitted services remained a problem for people with insurance (2case2).

In addition to reducing expenditure, the value proposition included improved patient care, and the two subgroups also debated whether the reforms would provide better care for patients. The insurers were interested in understanding their members' health needs better, allowing them to tailor arrangements for members. They envisaged the BHC reforms as improving their capacity to prevent illness and create better outcomes for patients. Everyone understands that if one is able to prevent an illness or an episode of care, that is clearly to the benefit of the consumer (Senate Committee on Health and Ageing, 2006).

Consumer organisations initially welcomed the preventative health measures under the proposed BHC reforms. Insurers had convinced the community that the reforms would deliver improved health outcomes and thus improve the value of health insurance (Armitage, 2006). The consumer expects to receive the most appropriate healthcare in the most appropriate setting. 'It is common sense that expanding the opportunity for an efficient private health insurance industry to cover the full range of modern treatments will result in improvements in clinical outcomes' (Armitage, 2006, p 1).

Consumer organisation Choice noted that public health specialists around the world had been calling for incentives for coordinating care for years (Korczak, 2006). The Consumer Health Forum's Mitch Messer said the changes 'will provide a better service' (Metherill, 2006, p. 2). 'Insured patients, particularly those with chronic illness, will get more' (Metherill, 2006, p. 2). Patient groups were particularly welcoming, with MS Australia, MND and Palliative Care Australia all making submissions

to the Senate Committee inquiry and presenting evidence supporting the need to expand the private health insurance offering as presented in the bill (Standing Committee on Community Affairs, 2007).

However, as discussed previously, consumers of healthcare are a broad group of people, and the debate eventually turned to examine the balance between PHIs and Medicare, with commentators remarking that the benefits of the BHC reforms would be beyond the reach of the 57 per cent of taxpayers who were uninsured, who contributed to the \$3-billion-a-year health insurance rebate (Metherill, 2006). Critics claimed that this would create a two-tiered system in which a new range of medical services would only be available for one cohort (Department of Parliamentary Services, 2007). Consumer groups began to qualify their support for the reforms; the Australian Consumers Association had welcomed the preventive direction of the changes but warned that the majority of Australians would get left behind (Metherill, 2006). Interviewees remembered consumer groups being concerned about equity if only health fund members could access these programs. There was a concern that by allowing programs under BHC, the government would absolve itself from implementing chronic condition management programs or reduce funding services in the public system (3case2). Caveats were subsequently attached to consumer support:

While Choice supports consumers' right to choose between the private and the public sector, Australia prides itself on being an egalitarian nation. The idea of a fair go still forms the foundation of our society. Yet here we have a situation where all taxpayers are funding a system which mainly benefits those on higher incomes who can afford to pay for better services. (Korczak, 2006, p. 31)

Once again, when discussing the desired outcomes of the reform, all the actors argued that the main benefits or disbenefits accrued to consumers. Actors also argued over whose policy represented the consumers' or patients' best interest. A common view amongst interviewees was that consumers are a very broad grouping, and this led to consumers differing in their position on whether the reforms were important. Whilst the majority of interviewees felt that the reforms were not very important to consumers, a couple of interviewees argued that there were engaged consumers, but that consumers were more interested in varying outcomes which diminished their collective position (4case2; 6case2). The inability to develop and prosecute a cohesive narrative for change allowed the debate around the policy to occur on multiple levels, and it became difficult for any actor to prove that their policy position was in the consumers' best interest. Similar to the 1995 case, consumers quickly became pawns rather than major or powerful contributors.

The AMA brought the spectre of managed care into the discussions around patient management, having found it to be a successful strategy in 1995. In the Committee hearings, the AMA argued that

the BHC provisions could allow insurers to make decisions regarding admissions. According to the AMA, 'the health funds should not be able to interfere in decisions about admission of patients and should not have rules whereby, if you fail the smoking treatment program and continue to smoke, you are not allowed to access surgery for your lung cancer' (Standing Committee on Community Affairs, 2007, p. CA29). The AMA argued that there needed to be 'provisions which required the continuing involvement and agreement of the patient's usual treating medical practitioner, particularly the patient's general practitioner for chronic disease management plans, and, if relevant, their treating specialist or psychiatrist' (Australian Medical Association, 2007). Some interviewees saw the AMA's position as opposing any role for PHIs and suggested that the AMA would have seen chronic condition management plans as a 'thin edge of the wedge' to gain some influence over management plans that were currently controlled by general practice (5case2). The Consumer Health Forum said that consumers were 'not keen to see a managed care type of arrangement. They were also concerned that the cost of funds offering all sorts of health promotional activities needed to be taken into account, given that health cover needed be provided for all sorts of ongoing health conditions as well, and it was important to get that balance right' (Consumer Health Forum in Standing Committee on Community Affairs, 2007, p. CA7-8).

Interviewees commented that the BHC programs commenced a discussion about who had the right to know about a person's medical history. To give effect to chronic condition programs, insurers needed information about people prior to an admission to hospital, which at that time was when they were finding out about a patient's health concerns. As one interviewee pointed out, 'consumers may not wish for insurers to have access to that information – or to some part of it. The insurers may want to know more about you, but the consumer may think that "you only want information to differentiate my premiums or to identify whether I have a tumour" whereas the insurer wants to develop chronic disease plans. There is a big divide on the trust scale about the use of data' (6case2). The lack of trust in insurers to hold complete sets of medical data demonstrates that consumers do not see the role of insurers as active managers in the health system as being legitimate.

Correctly anticipating criticism around the attempt to alter the role of insurers, the Australian Health Insurance Association engaged the media and asked the community to look beyond the rhetoric and myths by placing myth-busting articles in newspapers (Armitage, 2006). One participant discussed whether this was an achievable goal: 'I think the health insurers, even though they were influential, were still a bit distrusted in a way the doctors aren't. Doctors are always seen as having a more ethical role than health insurers' (3case2). The lack of trust by consumers challenges the industry and thwarts its attempts to position itself for a greater management role in the health system. Although government regulation has supported PHI funds having a role in CDM since 2007, research in 2019

suggested the public still has questions of legitimacy related to the role of PHIs (Armitage, 2006; Khoo et al., 2019).

Legitimacy is a source of institutional change (Thelen 1999). The federal government saw the proposed changes to the payment and access rules to allow for greater integration as potentially prudent and supported them. However, in the end, consumer groups had shifted in their view of the BHC proposal, moving from initially supporting to questioning and then injecting insurmountable barriers. The retention of the status quo indicates that shifts in insurers' roles in paying for medical services were not considered to be appropriate (legitimate), and only very limited changes that might impact Medicare were tolerated. Despite the limited scope of the proposed changes, the community provided their elected representatives with a message that they were not ready for a change to the mixed model of insurance.

6.4.5.2 Outcome – the role of the insurers did not change

The private health insurance industry had identified that they needed to create a role for themselves as active managers in the system rather than passive payers. This reform was described as an opportunity to alter the roles of insurers and providers within the healthcare system in Australia. If successful, the reform would have shifted the role of private health insurers from being passive payers of hospital costs to active managers that would design and implement programs to manage chronic conditions more effectively, preventing hospitalisations and developing programs to provide care outside the hospital walls.

Once again, the medical profession did not want the respective roles of the insurance industry and the medical professionals to change and prevented direct contracting. Concerned about the potential to change the power balance between medical professionals and insurers, the AMA vigorously opposed any measures which, 'either surreptitiously or inadvertently, increase the power of private health insurance vis-à-vis providers' (Australian Medical Association 2006).

By the time the bill went to the Senate Committee, the then-federal coalition government was unambiguous in its assertion that the BHC proposal would not change the power balance. In its submission to the Committee, the Department of Health argued that a balance was being maintained in the system. '[T]he existing restriction on insurers paying benefits for out-of-hospital general practice and specialist consultations that attract a Medicare rebate will continue. . . . Broader Health Cover will not extend to the costs of accommodation in residential aged care services' (Department of Health and Ageing, 2007, p. 8). Later on in the submission, the Department of Health emphasised, 'It is important to note that broader health cover arrangements will not limit the clinical

freedom of medical practitioners and the legislation includes an explicit safeguard' (Department of Health and Ageing, 2007, p. 8).

Interviewees held differing views on the reform's impact on the roles of insurers. One participant, when reflecting upon the balance in the system, noted that 'there is the case for whole-of-system reform, so I think this one was very contained and very incremental – nothing was stifled, this was just a very small effort to improve some aspects of a part of the health system' (2case2). Another informant remarked that the reforms were 'A lot of effort because they were very technical, and the consultation period extended . . . and consumed a lot of resources. Expectations were created, and they were not met' (4case2). There was a sense that this was not a successful attempt at reform among some interviewees. 'I don't really know where it has gone, but I don't think it has led to any systemic changes where – I guess that it is [the] aim of it' (3case2). Meanwhile, another person felt the reforms were successful and had moved private health insurer's operations along the continuum from passive payers closer to more active managers. 'Reform was successful, it continued to push the boundaries of where the relationship sat' (6case2).

Despite the picture of little to no change, there was a small shift in the role of PHIs. Whilst the changes may have been permissive in nature, the capacity to care for people out of hospital and to provide management programs for chronic conditions allowed PHIs to engage in different models of healthcare for members. However, and signalling a contrary outcome to the movement above, it is also notable that there was a specific requirement by government to keep the balance within the system, support the continuation of the mixed model of insurance, and effectively retain the current balance of power between insurers and medical providers within the system.

6.4.5.3 Outcome – public support for the mixed model

At one point in the proposals' development, significant changes were proposed to the payment and access rules by moving from the fee-for-service model to a capitation payment method and allowing insurers to contract for primary healthcare. However, by the end of the debate, there was little indication that there would be a significant change from the current operations of the mixed model. The Department of Health characterised the relationship between Medicare and PHIs: 'A strong and vibrant private health sector complements and balances the delivery of health services through the public system, which in turn is underwritten by the universal access provided by Medicare. The Australian government has a strong ongoing commitment to Medicare, and the proposed legislation does not in any way weaken this commitment' (Department of Health and Ageing, 2007, p. 2). Further, 'The Government's strong commitment to 'choice' in healthcare ensures a viable and

sustainable private health sector and, in turn, improves the capacity of the public hospital system' (Roxon, 2007, p. 6).

The policy debate around improving the efficiency of the mixed model of insurance brought out disparate opinions on what the relationship between the insurance industry and Medicare should look like. The interviewees remembered the relationship and ensuing tension brought about through the mixed model. 'The essence comes down to your view about Medicare and private health insurance – is insurance a significant part, is it complimentary, how far can private health insurance intrude into the Medicare market without compromising Medicare?' (6case2). 'That intrusion, movement into the medical space, is where the funds would argue PHIs are working in the patient's best interest, the other side will say PHIs are compromising universal healthcare' (6case2).

Some commentators took a different view of the relationship and contended that private insurance undermined Medicare's role and its ability through its purchasing power to control and manage costs in the system. It was argued that insurers were price takers. 'They do not use and do not have very much power to influence outcomes in the market. Being passive price takers, they are undermining Medicare's ability to set prices and standards in the community' (Menadue in House of Representatives Standing Committee on Health and Ageing, 2006, p. H34).

Altering the legislation to allow PHIs to pay for general practice services was also seen as a challenge to Medicare. For one interviewee, the attempt to include general practice in chronic condition plans managed by PHIs was a deliberate undermining of Medicare in an otherwise technocratic reform (5case2). Interviewees agreed that the legislative changes to allow for insurance to pay for items currently covered by Medicare would not be supported by Parliament. The Labor Party, who were at the time in the opposition, and the Greens (a minor political party with seats in Parliament) would see 'allowing PHIs to pay for general practice as the death knell of Medicare, it's a whole other iconic status' (1case2). 'It was interpreted as if you paid general practitioners a higher benefit for private patients, they may discriminate against public or bulk-billed patients. Moreover, it would reduce the competition that encourages bulk-billing (payment in full for a service)' (1case2). 'So, when there is not much of an upside, and a few possible downsides, why would a government support it?' (3case2).

Multiple barriers to reform were discussed by interviewees, and they held a variety of perspectives on whether significant reform could be achieved. Some interviewees felt that the federal government was not keen on reform – 'if you want to have proper hospital avoidance, you need general practitioners to change behaviour. General practitioners are so attached to fee-for-service, you can't prise them off' (3case2). 'Hypothetically, an insurer could contract with Dr X and pay Dr X in

return for them seeing all their members who have got diabetes and chronic obstructive airways and not bill Medicare. The fact that we haven't seen this behaviour indicates that the operation of the payment and access rules under Medicare is preventing the option from being economically viable' (2case2).

Interviewees also noted that from the government's perspective, it is very difficult to obtain agreement for reform. There are intractable differences established through the three-player model. In this case, it was argued that the insurers wanted to move risk onto the medical practitioners and medical practitioners wanted to move risk onto the insurers. 'It came down to the fundamental problem that pervades health systems around the world: that there are payers and providers, and the payers have the money, and the providers want the money' (1case2). The perception of this intractable issue led to one interviewee noting, 'I think a lot of people walked away from these reforms very cynical that health funds are always out to save money and health funds thinking that providers are always in it to get more money' (4case2). Interestingly, one informant observed that 'how we shift money to the best location hasn't been able to be solved anywhere' (3case2).

The policy preferences of the general population influence regulatory policy. In another sign that lockdown was strengthening, one interviewee mentioned that parts of the private health insurance industry had lost their appetite for reform in this space (1case2). Actors shifted as the feedback loop cemented in the policy settings. Participants noted that during this period, they saw a decided shift in policy from improving PHIs' ability to actively manage healthcare provision towards a system of financially supporting the industry through carrots and sticks. Government support, particularly through the private health insurance rebate and the Medicare levy surcharge, had helped to improve the long-term sustainability of the industry (Australian Government, 2006; Australian Unity, 2007). In the end, instead of managing outlays, the industry was propped up to improve its viability.

The rules that establish the operation of Medicare and the relationship between the public sector and PHIs are the dominant policy path, and whilst a change to the payment and access rules was obtained in this case, it resulted in little to no change in behaviour for medical practitioners. A greater indication of the lockdown of the payment and access rules was the significant shift in policy from helping PHIs to become active managers in the system to propping up the system through financial levers. These outcomes demonstrate that it is difficult to change the relationship between insurers and Medicare and signals that lockdown of the mixed model of insurance continued to develop during this case.

6.5 Conclusion

When the 2006 reforms commenced, the National Health Act had been in operation for 50 years, and Medicare had been a fundamental part of the settings for over two decades – both of these systems were well established. The continuation of ever-increasing premiums, dropping membership and increasing outlays had once again created an environment in which the private health insurance industry needed changes in the operation of the payment and access rules to improve its viability. Moreover, the health system remained fragmented, and Parliamentary reviews had identified that alternative models of structuring the system would provide significant opportunities for greater efficiencies and effectiveness. To improve the operation of the system as a part of an overall review of the legislation, the then-government embarked on reforms to allow PHIs to contract for treatments or services performed outside the hospital setting and for a team, that included medical practitioners, to treat patients under a chronic disease management plan. The scale of change and amount of potential integration started similarly to the first case, by opening up the conversation around the role of providers and clinicians in the system, but it quickly whittled away to minor reforms, removing medical practitioners from chronic disease management plans, due to the actions of the medical provider subgroup.

There was a larger and dispersed network of actors debating this proposal; however, this included six actors who sat on the periphery and did not appear to be influential. The network formed around two major subgroups: one with a view to retaining the operation of the current payment and access rules (led by the AMA) and one that desired a change the payment model to a more integrated system (led by the Australian Health Insurance Association) - power, again, rested between the two leaders.

One subgroup of advocates held the power to create the changes, and the opposing subgroup mobilised around the AMA and created a powerful alliance that represented three of the four parts of the system: hospitals, medical providers and consumers. This relationship strengthened the AMA's position in the network, providing it with more avenues to influence the Department of Health, which interviewees noted was very influential in the design of the proposals. Both subgroups claimed to have the consumers' best interests at heart; however, consumers were not a large part of the policy design, and interviewees did not consider their voice to be influential.

The change in the network's structure did not result in a different outcome. The AMA appeared to be the main body advocating for the medical profession and shifted to a position of power within the structure of the network. The documents showed that other groups that represented the medical profession did not engage in the debate, unlike the 1995 case. Non-participation was likely either

due to a lack of interest or because the AMA had claimed a role as a key advocator within the health sector for the medical profession. The power to vet proposals was, again, being held externally to Parliament by the AMA. The opposing subgroup, whilst not able to totally prevent legislative change, significantly slowed the amount of actual change by inserting administrative roadblocks, and keeping control over how payments were made to medical practitioners by preventing direct contracting by PHI.

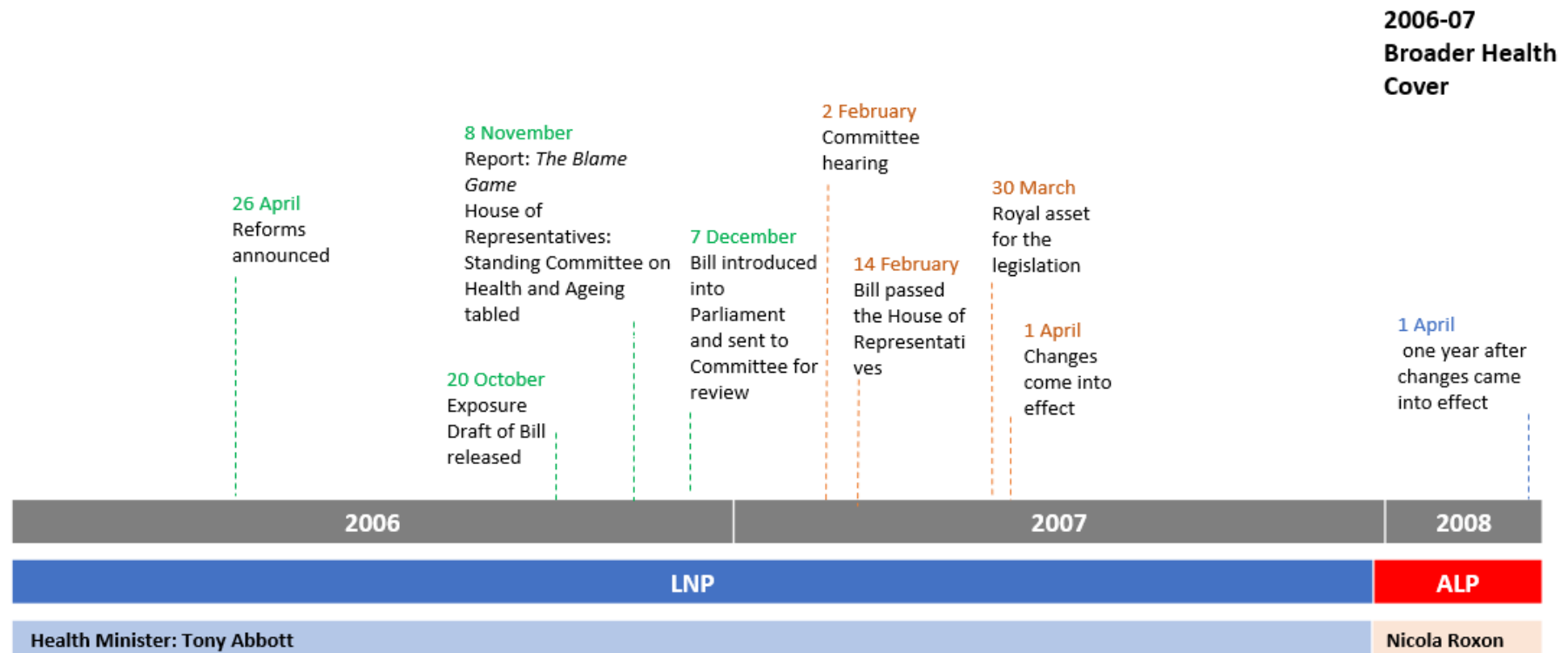
What commenced as an opportunity for significant reform of the financing policy in Australia by bringing in a capitation system was quickly truncated and became a debate around making much smaller changes to the system. The federal government saw the proposed changes to the payment and access rules to allow direct contracting as legitimate or desirable and supported them. However, the proponents of the reforms were unable to obtain sufficient consumer support for the idea, and the absence of a strong consumer position allowed the AMA to develop a narrative that the opposing position represented the consumers as well.

Despite a small change in the rules, and in a similar manner to the previous case, the costs of changing operations were prohibitive and demonstrated characteristics of lockdown of the system. For the insurers, there were no guarantees that the return on investment would cover the cost of developing programs. The need to capture data from both providers and patients created a significant barrier. Similar to the previous case, costs would have been borne by other parts of the system: hospitals would potentially lose patients, and the government faced potential criticism that their policy caused adverse outcomes without being able to save on expenditure in the system. Finally, medical practitioners felt they would lose some control over clinical decision-making.

The rules that establish the operation of Medicare and the relationship between medical practitioners and PHIs form the dominant path along which the payment and access rules originate. Whilst a small change to the payment and access rules was obtained, medical practitioners ensured they were excluded from requirements to integrate and significant behavioural changes did not follow. Elected officials received the message from their constituencies that there should be no changes to Medicare, leading to a specific aim to keep the 'balance within the system', thus removing options to change the relationship between insurers and medical practitioners. Medicare and PHIs must continue to operate together in an undefined manner. Building upon the previous case, the barriers and an acknowledgment of a lack of capacity to change suggest that the lockdown of the payment and access rules that structure the mixed model of insurance in Australia continued. The next chapter presents the findings of the next and final policy event that aimed to change the payment and access rules, Medibank Private's GP Access program 2013. It provides the third and last

of the cases, which, when combined with the previous two cases, trace a span of 20 years demonstrating the influence of policy actors on constraining reform in Australia's healthcare financing policy.

Figure 6-2 Timeline of key events and environmental data



Industry size: 37 Funds
Hospital Membership (proportion of Australian population with hospital cover): : 43.2%
PHI expenditure as a proportion of membership Income: 85.3%

Sustainability of the sector questioned prior to reforms: Yes
Price increase of premiums: 5.7% per annum
Benefits Paid: increase on previous year: 6.2%

Govt. Departments regulating the industry: PHIAC, Dept of Health, ACCC, PHIO
Cost of health system: \$94.0 BN
Growth of cost of Health system: up by 4.8% in real terms on 2005-06

7 Case Study 3: Medibank Private's GP Access Program (2013)

7.1 Introduction

This chapter outlines the findings from the last of three case studies. In this case, in 2013, the then–federal coalition government allowed the private health insurer Medibank Private to operate a pilot program where it directly contracted with general practitioners. This was a quick but significant attempt at vertically integrating healthcare through the insurer. After advocacy by medical practitioner groups in response to the program, a Member of Parliament – Senator Richard Di Natale, a former general practitioner and Greens⁷ federal spokesperson on health – proposed a legislative change to shore up the payment and access rules and place a firm barrier to prohibit this type of contracting between funds and general practice. General practitioners, insurers and consumers all had something to gain or lose depending upon the outcome of the debate on the pilot program and subsequent bill. A detailed description of the case is below.

The chapter follows the same structure as Chapters 5 and 6. It begins by detailing the origins of this reform and the views of key actors in Section 7.2. It then details the proposal – Medibank's pilot program, and the subsequent prevention of reform during the parliamentary debate and implementation (section 7.3). The findings of the network analysis via a network map of key actors and their ties are then presented, with interviewee reflections on the map (section 7.4). The chapter then details the operations of this actor network throughout the case drawing on interviews and document analysis, including the relationships between actors, who had power, the costs of change, claims to legitimacy, and how this ultimately influenced the outcomes of the reforms.

The chapter demonstrates that once again, power rested between opposing parties. One centred around the Australian Medical Association and the other moved from the insurance advocacy body to Medibank Private. The debate was short lived and ferocious. This chapter shows how the AMA used its power developed through positioning itself as the central actor in the medical provider subgroup to lessen the ambitions of reformers and propose changes that would have inserted greater barriers to coordination. Finally, I demonstrate that governments appear to have lost their appetite for the type of systemic reform needed to incentivise coordination of care.

⁷ The Australian Greens are a small political party founded in 1992 organised around green politics.

7.2 Environment

7.2.1 The role of PHIs in a mixed model

Reforms to the National Health Act over the past two decades had not provided sufficient incentives for PHIs to move into active management of patients. Whilst small changes at the periphery had occurred, the reforms from 2007 had not fixed the fundamental lack of integration in the health system that was a barrier to effectively managing chronic conditions. Australia's health services were still being provided episodically, when someone became unwell. Calls to move to a system of coordinated care, involving a blend of hospital and community support, continued as it became more obvious that the health system needed to adjust to better support the growing proportion of Australians with a chronic condition (Leeder, 2014).

In the lead-up to this case, there had been a considerable decline in the level of private health insurance cover. Consumers remained concerned about the cost of private health insurance premiums, which were paid by individuals and had been growing faster than the consumer price index (CPI) for more than a decade (Senate Community Affairs Legislation Committee 2014). Arguments that private health insurance was becoming unaffordable had begun to gain traction in the community again (Donato and Onur, 2018; Private Healthcare Australia, 2016; Silvester, et al., 2018). There were limited options for PHIs to control ever-increasing outlays, and the private health insurance industry saw controlling the demand for healthcare provision by controlling upstream providers (general practitioners) as critical to its ongoing viability.

One of the challenging aspects for policymakers was the Australian public's continuing desire to minimise outlays for PHIs. Containing costs was particularly difficult as demand for health services had 'increased on average 2.5% over the ten years to 2014–15 and health expenditure has grown on average by 4.5% over the same period. Average health expenditure per person by all sources in 2014–15 was \$6,846' (Australian Institute of Health and Welfare, 2016, p. 1). About 5 per cent of the growth in per capita health expenditure (as a percentage of GDP) was due to age, dropping from 9.7 per cent in 2013–14 (Australian Institute of Health and Welfare, 2016, p. 2; Reynolds, 2017), the rest related to increased demand for improved technology and service provision.

During this period, there was a considerable amount of movement in the structure of the industry and policy uncertainty at both macro and micro levels. The new coalition Health Minister Peter Dutton, on 13 December 2013, had instigated a review of the Medicare Locals - a wraparound program designed to

improve coordination and integration of primary health care in local communities, address service gaps, and make it easier for patients to navigate their local health care system through engaging the primary health care sector, the Aboriginal Community Controlled Health Service sector, and Local Hospital Networks. (Horvath, 2014). Interviewees noted that they felt that there was an anti–Medicare Locals sentiment in the government (2Case3; 4case3). The government eventually recommended a transition from Medicare Locals to Primary Health Networks (PHNs), creating a new meso-level influencer for primary care during the time of the case. PHNs were supposed to partially address the problem of fragmented care. There was some uncertainty in the industry about what the new PHN contracts might look like, what their role would be and how much influence they would have on healthcare provision. Medibank Private considered tendering for the operation of some of these primary health organisations (Senate Community Affairs Legislation Committee, 2014).

There was also a considerable amount of corporatisation of general practice occurring at the time. One interviewee observed that Primary Health Care (a corporation) had a growth model that was trying to develop business by acquiring general practice surgeries, which were mostly retiring doctors (2Case3). Another large corporation, Sonic Healthcare, through its 100 per cent owned subsidiary IPN, acquired the Australian Locum Medical Service group (Sonic Health, n.d.). This appeared to be a response to the acquisition strategy employed by Primary Health Care (2Case3).

Politically, the then–federal government were busily trying to undo lots of the previous Labor government’s health reforms, and interviewees all recalled that the government had raised the ire of a lot of health organisations by removing the National Preventative Health Agency and Workforce Australia and instigating the review of Medicare Locals (4case3). This reform commenced early in the coalition government’s first term, and political relations between the health sector and the government had begun to quickly deteriorate. Every interviewee also remembered the infamous 2014 Abbott budget had just been handed down,⁸ and the Prime Minister had managed to really upset everybody in healthcare, particularly the doctors.

⁸ The budget included:

- a new \$7 fee for patients seeing GPs on Medicare.
- raising the cost of medicines of pharmaceutical benefits schemes to include a \$5 fee.
- rescinding a commitment to increase public hospital funding.
- abolishing two statutory agencies: Health Workforce Australia and the National Preventative Health Agency.

7.2.2 The problems created by the rules of the relationship with Medicare

Leading up to this reform, the private health insurance industry continued to be challenged by the need to raise premiums to cover ever-increasing outlays. To contain costs, insurers needed to reduce the cost of services or the services provided. Medibank, along with other insurers and health system analysts, had identified that reducing hospital usage through programs to help people manage their chronic conditions was a good way to limit expenditure growth and provide better services for members (Department of Health 2014; HIRMAA, 2017; Senate Community Affairs Legislation Committee, 2014); however, the provisions under the 2007 Better Health Cover reforms were insufficient.

All funds had suffered reductions in the pool of healthy young members as a proportion of older people (Private Health Insurance Administrative Council, 2014). Driving part of the sustainability problem for PHIs was that the younger and healthier population were leaving insurance or purchasing cheaper products. This cohort is needed to cross-subsidise the older and less healthy policyholders. Without subsidisation from the cheaper cohort, the remaining cohort must carry an increasing share of the costs through ever-increasing premiums. By 2013, the death spiral, where young people who used less healthcare or people who perceived their risk as low dropped out and the 'risk pool' of the insured population worsened, was a decided feature of the system (Deloitte Access Economics, 2012; Keane, 2020; Private Health Insurance Administration Council, 2014).

Medibank Private was the implementer of the program that forms the case study. The insurer was created by the Whitlam government in 1975 by the then–Health Insurance Commission as an Australian government business enterprise. A scoping study into the sale of Medibank was announced by the government in October 2013 (Medibank, 2013), and the move to privatisation was announced on 26 March 2014. Medibank was fully privatised in November 2014 by the then–federal government (Medibank Private, 2017). In 2014, Medibank, and its fully owned subsidiary Australian Health Management, provided cover for approximately 3.8 million people across Australia (which is approximately 25 per cent of the privately insured population) (Medibank Private, 2014). At the time of the case, Medibank Private was the largest private health insurance fund in Australia.

In its 2013 Annual Report, Medibank noted that deteriorating consumer confidence had placed stress on the private health insurance industry and was negatively impacting the growth outlook for the industry. Medibank's membership growth had been in line with the remainder of the market, which resulted in a market share loss (Medibank Private, 2013). To address this issue, Medibank decided to invest a greater

amount in the health delivery arena, with a focus on improving their central insurance offering (Medibank Private, 2013). Medibank decided that to improve value and retain customers, it would return to basics and focus on customer needs and affordable health insurance (Medibank Private, 2013).

In 2013, Medibank noted that procedures that occurred in a hospital setting – overnight or day admissions – constituted a considerable portion of what they paid out on behalf for their members annually, and although the number of people with membership had slowly increased, it was far surpassed by the increase in the utilisation of services (Medibank Private, 2014). Member hospital admissions for Medibank grew to 1.1 million in 2013. Medibank noted that 2.2 per cent of its customers accounted for 40 per cent of hospital bed days and consumed one-third of hospital and medical expenditure, and that 70 per cent of these patients had an underlying chronic condition (Patton, 2016).

Developing programs to manage long-term conditions requires a long-term relationship and oversight of a patient, allowing for early and ongoing intervention. On the whole, consumers tend to stay with their insurer for long periods of time, with an average of only 5 per cent of members switching between funds per annum. This is quite low when compared to the current switching rate of bank transaction accounts of approximately 8–10 per cent (Deloitte Access Economics, 2012). The following Table shows the stability of the Medibank population.

Table 7-1 Proportion of customers that switch funds

Timeframe	Proportion of consumers who have switched funds
Within the last 3 years	15%
4–10 years ago	11%
Over 10 years ago	16%
Total proportion of people who have switched funds	42%

Source: Medibank and AHM Segmentation Report – July 2012 (Deloitte Access Economics, 2012)

Multiple problems for the healthcare system remained because of the mixed model. Insurers had started to look for new ways to improve the system's efficiency to reduce costs. Despite changes in 2007, the system was still fragmented; healthcare provision had not changed to reflect the changes from episodic to chronic conditions. Barriers to coordinated care remained.

7.2.3 Options to fix the problem

Insurers contended that it would be beneficial to be able to identify members with chronic conditions earlier in the development of the disease. There 'are practical limitations on our ability to provide support to members who are likely to develop or are recently diagnosed with chronic disease. Consequently, any programs to address early chronic disease prevention and/or management are limited due to member identification and targeting issues' (Medibank Private, 2015).

By 2013, the focus had turned to engaging with general practice. Primary care was delivered by general practitioners across Australia and formed an important function within Australia's healthcare system. General practitioners are the first point of contact for most Australians when seeking healthcare services. They held the gatekeeper function in the system and were therefore capable of changing the system to managing chronic conditions. Medibank was not the only insurer seeking improvements in the payment models. One interviewee mentioned that at the time, there were many conversations about the competitive landscape. Whoever could find the right funding or relationship model to manage growth in expenditure due to chronic conditions would improve their competitive position. 'I think everyone was trying to come up with a strategy to engage specialists' (6case3).

7.3 The proposal

In November 2013, Medibank commenced contributing to payments for general practitioner services. Medibank trialled a service in the state of Queensland designed to incentivise their members to access primary care services (Commonwealth Ombudsman, 2018). The trial provided Medibank members some certainty over the price and availability of a doctor, with Medibank effectively contracting subsidised general practitioner services by contributing to the administrative costs of the practice. This allowed for some end-to-end oversight over Medibank members for the insurer.

Medibank built the program around three key elements:

- Same-day appointments – members were guaranteed a same-day appointment if they made the appointment before 10 am on weekdays.
- Fee-free consultations – members who presented to a participating clinic or who used the after-hours general practitioner received the consultation fee-free.
- After-hours general practitioner home visits – members in metro areas were able to obtain an after-hours home visit within three hours (Medibank Private, 2014).

The GP Access program started as a pilot in Brisbane in November 2013, and in March 2014, it was extended to clinics out of the Brisbane area. The pilot was available to Medibank members at six larger Brisbane clinics operated by IPN Medical Centres Pty Ltd (IPN) (a large corporate provider operating a network of over 70 general practices), where patients would often pay an out-of-pocket fee. Members were guaranteed an appointment within 24 hours or, if they lived in the catchment area, an after-hours home visit. Medibank conducted an evaluation of the program, which was not public; however, they argued that the program increased the reliability of the services for patients in a period when up to 20.8 per cent of Australians reported waiting longer than they felt was acceptable to see a GP, and that early results were promising (Australian Bureau of Statistics, 2017; Harrison, 2015; Parnell, 2014; Rollings, 2015). The benefits were clearly targeted towards providing members some certainty over the price and availability of a doctor.

Medibank Private expanded the pilot in 2014. Twenty-six medical centres and 145 general practitioners participated in the program, which provided over 20,000 consultations (Medibank Private, 2014; Parnell, 2014). Approximately 13,000 members used the service and indicated that they were pleased with it (Harrison, 2015). Most of the partaking medical centres were part of the IPN Medical Centres Pty Ltd (IPN) group, and two non-IPN clinics joined the pilot in 2014 (Medibank Private, 2014).

Medibank's strategy was to engage general practice as the gatekeepers in the health system. They observed that the

immediate goal of the GP Access program is to encourage and support Medibank members to access a General Practitioner. If this can be achieved it should improve individual health and may reduce the need for hospital admissions and associated costs, thus easing pressure on premiums and helping to maintain private health insurance affordability. (Medibank Private, 2014, p. 5)

In short, Medibank believed that the GP Access program would ultimately lead to smaller growth in premiums than otherwise would have occurred (Uhlmann, 2014).

7.3.1 Who instigated the reforms?

Medibank Private had advocated for several months for a change to the payment and access rules to allow private health insurers to pay gap fees for general practice visits. The then-Federal Health Minister Peter Dutton indicated support in early 2014, declaring he would not rule out any changes to the legislation (Harrison, 2014). Allowing for insurers to pay for gap fees for general practice visits was

broader than the pilot program in that it would have allowed for benefits to be used to pay for services, rather than using funds to pay for an administrative component of the general practice's operations.

Other health insurers in the network had identified that the fragmentation in the system was prohibiting them from becoming more efficient and providing better value. Various insurers had created programs to involve themselves with primary healthcare with a view to reduce outlays and premium increases. These various smaller projects were implemented in lieu of a major change to the payment and access rules:

- HCF provided after-hours home general practice services for their members;
- BUPA provided discounts for their members in Healthscope's national network of medical centres, pathology services and skin clinics;
- Linking general practices services to aged care facilities: the BUPA conglomerate owned general practices that were co-located with aged care facilities; members and non-members could use these services;
- Connections with Primary Health Networks and state governments to deliver services to members and non-members: Medibank Private had an agreement with the Victorian government (a state in Australia) to test an integrated model of care for people with chronic conditions; and
- The establishment of 'preferred provider' contracts between funds and allied health for benefit of members (Doggett, 2015; Duckett, 2015; Rolfe, et al., 1973).

Unlike the previous case, where there was a convergence of actors looking to reform the system, Medibank's pilot was important only to Medibank, rather than the industry as a whole.

Medical provider groups, especially the AMA and the Royal Australian College of General Practitioners, opposed this practice, and unlike previous cases where the government instigated legislative reform, providers sought legislative change to prevent these types of payments. This pilot became the focal point of a campaign to shore up the payment and access rules to place a firm barrier to prevent vertical integration between funds and general practice.

Table 7-2 Scope of initial reform, outcomes at implementation

Initial breadth of reform	Government policy relating to payment and access rules	Final law	Actual change to the healthcare system (implementation)
Medibank piloted contracting subsidised general practice services (fee-free) by contributing to administrative costs of a general practice. Medibank did not make payments to general practitioners for services directly.	Insurers could enter into agreements with providers of primary care using their management income – aimed at encouraging members to access primary care services.	No change made. The existing law allowed arrangements between insurers and providers to provide preventative or intermediary care using management income rather than insurance income.	The arrangements were ceased by the insurer in July 2015 despite being legal. The operations of the healthcare system reverted to their state before the pilot.

7.4 The network

7.4.1 Members of the network – network map

The network model developed from the documents of the time indicates a shift in the actors that entered the debate from the previous two cases. There were 19 organisations (nodes) who publicly debated the policy. Of particular note was the change, in comparison to the previous cases, in who the entities engaged with at a political level in the public sphere. In this case, the Prime Minister of Australia is brought into the network, and whilst the Prime Minister would have been involved at some stage in each of the other cases, it certainly was not as public as in this case. Also notable is the change in the groups representing the medical provider profession, with the addition of the Royal Australian College of General Practice. The Royal Australian College of General Practice engaged in this debate primarily because the proposal directly impacted general practice. General practice was undergoing significant change, with proposals to change training provision for general practitioners, the review of Medicare Locals and creation of Primary Health Networks, and significant corporatisation encouraging the Royal Australian College of General Practice to engage more publicly in policy at a national level (3case3).

Similar to the second case, the actors formed into two main subgroups with two smaller groups on the periphery. This created a bit of an eclectic pattern with two hubs and spokes. Unlike the other cases, the documents indicated that there was very limited interaction between the two groups. The first subgroup centred around the AMA and consisted of six actors, and the second group centred around Medibank with eight actors. Of note is that Private Healthcare Australia (previously called the Australian Health

Insurance Association) is not the centre of the second group in this case, perhaps reflecting the relative strength of Private Healthcare Australia and Medibank Private on this particular issue. The map shows close linkages between Medibank Private, the Department of Health and the Minister for Health. The modularity score is 0.56, indicating that there are more communities in this particular network and that no one or two actors are controlling the information/resources flow. The smaller subgroups were both connected to the group with the AMA, which increased its reach and span of control.

The network diameter is six – six being the maximum number of actors that any actor can pass through to reach another actor. This score is higher than in the other cases and shows that the network is made up of many actors who are not highly linked. As a result, information would likely flow slower between the actors in this network than in the other cases. The density of the network, which describes the portion of the potential connections in a network that are actual connections, is 1.35, similar to the 2006–07 case and lower than the 1995 case; again, this points to a network with a lower level of connections.

The clustering coefficient indicates how closed the network is. A coefficient of 1 indicates that all of the actors in the network are connected, and a score of 0 indicates that no one is connected. The clustering coefficient of 0.52 is the lowest of the three cases and indicates that many nodes are not highly connected with each other. The weighted degree is 3.37, confirming a low level of interaction between nodes.

There are three key actors, Medibank Private, the AMA and Senator Di Natale, who have a higher level of degree – the number of nodes connected to that particular actor. The AMA and Senator Di Natale have a high level of betweenness centrality, which measures how often that actor appears on the shortest path between actors in the network. This high score indicates that these two actors are better placed to influence the flow of information around a network, as they are the ‘bridges between other actors’.

Eigenvector centrality measures the influence an actor has in a network; it quantifies the number and quality (interaction with high-scoring nodes) of connections of a particular node and therefore the influence an actor has within the network. Medibank has the highest score, which is consistent with its relationships with influential actors such as the Department of Health and the Minister for Health. Medibank is followed by Private Healthcare Australia (PHA) and then BUPA. Interestingly, the AMA ranks seventh with a score of 0.50.

The two smaller groups (one of two and one of three actors) distort the results, so a page rank test was run to uncover nodes whose influence may be stronger than indicated by their direct connections alone and extend into the wider network (Page, et al., 1998). A page rank test assigns nodes a score based on their connections with other nodes. Medibank Private had the highest page rank of 0.13, followed closely by the AMA and Senator Di Natale, who both had a page rank of 0.11. Whilst Services for Australian Rural and Remote Allied Health (SARRAH) had a medium betweenness centrality score, its influence was reduced, with a page rank of 0.05. Senator Di Natale and the AMA were part of one subgroup, thereby increasing their relative power; the next most powerful actor is Medibank Private.

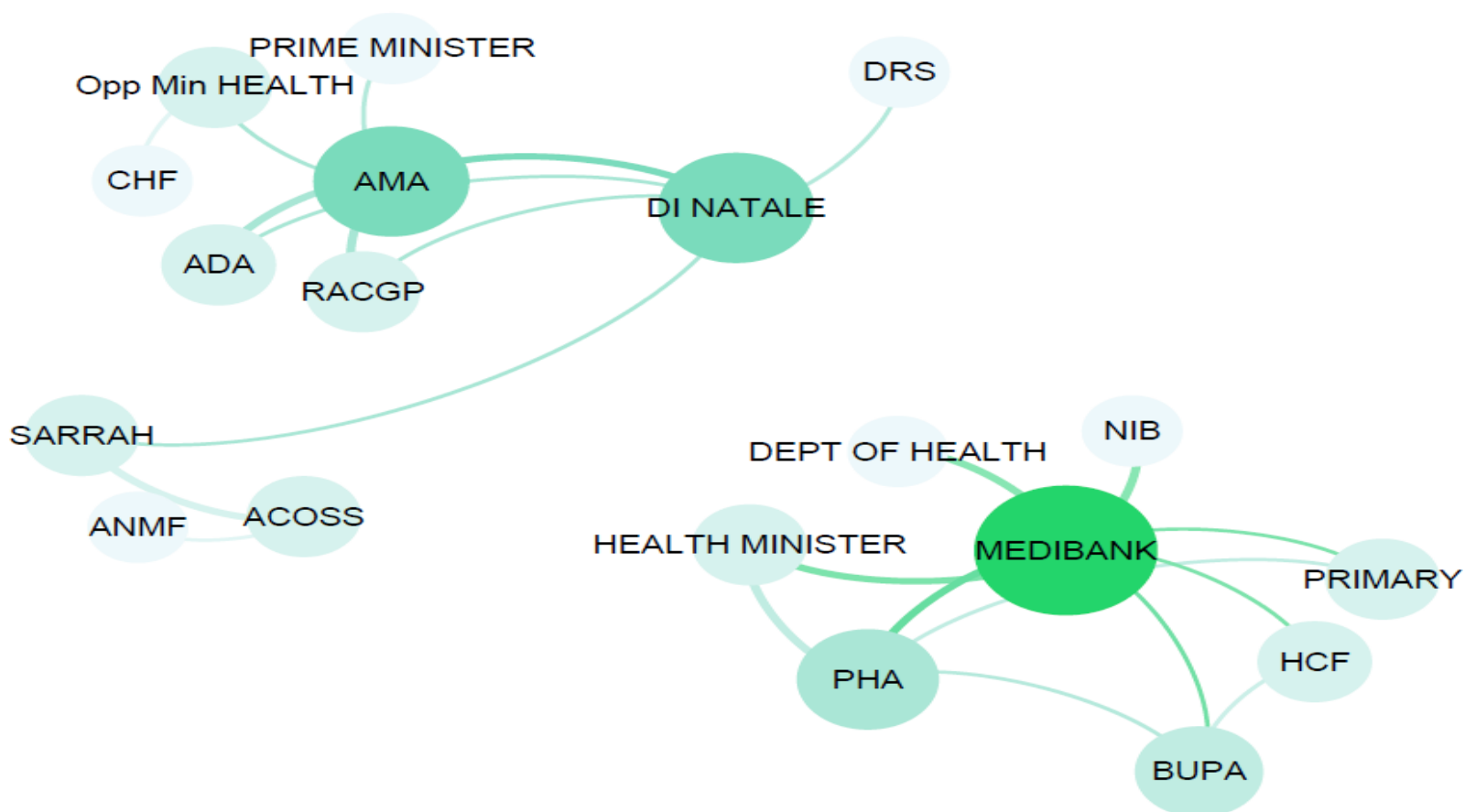
Table 7-3 Network measurements, Case 3

Actor	Degree	Closeness centrality	Betweenness centrality	Page ranks	Eigenvector centrality
Medibank Private	7	1.00	15	0.13	1.00
Australian Medical Association	5	0.56	23.5	0.11	0.50
Senator Di Natale	5	0.59	27.5	0.11	0.50
Private Healthcare Australia	4	0.70	1.5	0.07	0.76
BUPA HI Pty Ltd	3	0.64	0.5	0.06	0.64
Royal Australian College of General Practice	2	0.45	0	0.06	0.33
Federal Health Minister	2	0.58	0	0.05	0.51
Australian Council of Social Services	2	0.34	9	0.05	0.09
Australian Dental Association	2	0.45	0	0.04	0.33
Primary Health Care	2	0.58	0	0.04	0.51
Opposition Health Minister	2	0.40	9	0.04	0.19
The Hospitals Contribution Fund of Australia Limited (HCF)	2	0.58	0	0.04	0.47

Services for Australian Rural and Remote Allied Health	2	0.45	16	0.04	0.20
Newcastle Industry Benefits Group (NIB)	1	0.54	0	0.03	0.29
Consumer Health Forum	1	0.29	0	0.03	0.07
Department of Health	1	0.54	0	0.03	0.29
Doctors Reform Society	1	0.38	0	0.03	0.16
Prime Minister of Australia	1	0.37	0	0.02	0.16
Australian Nursing and Midwifery Federation	1	0.26	0	0.02	0.04

Figure 7.1 provides a visual representation of the network developed from the document review (page 174).

.Figure 7-1 Network Map – Case 3 – 2013



The colour and thickness of the ties in the network map represent the number of references (or any kind of connection) made to one node by another. The more references between the two nodes, the thicker and darker the tie. The colour and size of the nodes in the network map represents degree, i.e., the total number of times a node was connected to other nodes in the network. The larger and darker the node, the more times it connected to other nodes.

The key to the network map is on the following page.

Key to the network map – case study 3: Medibank Private’s GP Access Program (2013)

<i>Acronym</i>	<i>Name</i>
ACOSS	Australian Council of Social Services
ADA	Australian Dental Association
AMA	Australian Medical Association
ANMF	Australian Nursing and Midwifery Association
ASA	Australian Society of Anaesthetists
BUPA	Bupa
CHF	Consumer Health Forum
Dept of Health	Department of Health (Federal)
Di Natale	Senator Di Natale
DRS	Doctors Reform Society
HCF	HCF
Health Minister	Minister for Health (Fed)
Medibank	Medibank
NIB	NIB
Opp Min Health	Opposition Minister for Health
PHA	Private Healthcare Australia
Primary	Primary Health Care
Prime Minister	Prime Minister of Australia
RACGP	Royal Australian Council of General Practice
SARRAH	Services for Australian Rural and Remote Allied Health

7.4.1.1 Members of the network – post-interview

Key informants on the whole felt that the network map derived from the documents of the time represented who was involved and how they were linked at the time of the case. There were a few entities that the documents didn't capture. One interviewee suggested that a potentially influential group of actors missing from the maps were the primary health networks. Medibank and some PHNs had a close relationship through the design of a program of care packages, Carefirst and Carepoint, which were about care planning. Other insurers also had close relationships with some Medicare locals (the predecessor of the PHNs) (2Case3). PHNs commenced operations formally on 1 July 2015; it is therefore considered that their influence on the actors' actions in this case would have been limited (Booth, et al., 2016).

Similar to the other cases, interviewees noted that the Treasury and the Department of Finance would have been in the background because of the impact of any reforms to private health insurance on premiums and through the Australian government's budget outlays through the private health insurance rebate (4case3). The information garnered during the interviews added three additional actors to the network, bringing the total number of actors to 22. No interviewees commented on the timeline document specifically (Figure 7.2, below).

7.4.1.2 Mobilisation

Existing research suggests that members of a network will engage in specific tactics and pursue their interests in order to reduce their dependency or secure their position (Becker, 1983; Lewis, 2006). Like chapters five and six, the following analysis of the network's operations shows how these organisations behaved when acquiring or preserving the resources needed for their survival. The interviews shed more light on the mobilisation of actors.

7.4.2 Operations of the network

7.4.2.1 Relationships

The pilot program operated by Medibank Private required a change in operations by medical practitioners and customers using the program and increased integration between insurers and general practice. The program challenged the commonly understood interpretation of the law that prohibited payment by PHIs for general practice.

The trial was the subject of fierce controversy from the time it launched in October 2013, and actors in the health system quickly formed alliances, establishing strong ties among members of each of the two opposing subgroups. Strength, or power, can be derived through a node's position within the network (Cullerton et al., 2016; Hansen et al., 2010; Knoke, 2016). The strength of opposition was beautifully captured by one interviewee: 'In this case the AMA went ballistic' (3case3).

Actors in the health system who did not support the pilot engaged in numerous strategies to undermine the GP Access program. One informant explained that it is important to understand how an organisation uses its resources to develop its position and build a large coalition of willing advocates (2Case3). The AMA developed internal policy through a traditional governance structure including input from the state and specialist member subgroups of the AMA's Federal Council. The sheer number of members in the development of the AMA's position added to the depth of policy analysis and breadth of support for the position once it had been agreed upon (2Case3).

In addition to the broad coalition detailed above, the secretariat at the AMA would have developed key relationships with other organisations. The strength of the organisation is in the secretariat, and the larger the secretariat, the more the organisation can afford to deploy those resources to enact its strategies. The ability to draw upon corporate memory for policy development and corporate relationships was noted by interviewees; one in particular stated:

the secretariats of the organisations would have known each other better than the heads of the organisation, and the secretariat would have shared information, and that would have had some influence on policy. (2Case3)

The AMA was also able to draw upon significant corporate memory:

At that time the AMA's federal secretariat had very strong people who had been around for more than 10 years, and so they had a very good understanding – strongly influenced by Cases 1 and 2 – because the secretariat at that time would have been made up or of those who had grown up in the organisation. (2Case3)

The AMA also used their well-developed relationship with the media, providing interviews with the Australian Broadcasting Corporation and articles to the *Medical Journal of Australia* and *Australian Medicine* upon receipt of Departmental advice that the arrangements were legal. They questioned the government's 'hands-off' attitude to the trial (Rollins, 2014). Finally, they brought in the managed care

argument, claiming that the medical profession believed that letting private health insurers cover primary healthcare services would reduce their clinical autonomy (Morton, 2014).

There is a close link between the AMA and the Royal Australian College of General Practitioners according to the network map. Continuing to be incensed about the trials, in 2014, the Royal Australian College of General Practitioners invested in the development of a position statement about private health insurance in general practice, which aligned with the AMA policy.

The main concerns with the involvement of private health insurers in general practice revolve around the capacity for private health insurers to support continuity of quality healthcare, delivered by highly trained, autonomous GPs and general practice teams who have an ongoing relationship with their patients. The spectre of managed care models, where care may be rationed to reduce costs, concern GPs who adopt a holistic, patient centred approach. (Royal Australian College of General Practitioners, 2014)

The Royal Australian College of General Practitioners also joined the media conversation, whereas it had remained quiet in previous cases, warning the GP Access pilot would encourage private health insurance members to change general practitioners, undermining the principle of continuity of care, and that health economists forecast private insurers paying for primary care services would cause fee inflation (Harrison, 2015).

The AMA developed a formidable alliance of many actors across the system. Various organisations joined and argued against Medibank's program, albeit for different reasons. Consumer advocates felt that the pilot 'eroded universal healthcare because people with private cover would get a better standard of care than those without insurance' (Pha, 2014, p. 1). The Consumer Health Forum was concerned that the trial provided general practitioners with the ability to discriminate between two classes of patients: the insured and uninsured (Consumers Health Forum, 2014). The Australian Dental Association (ADA) worked alongside the AMA, hoping to obtain limitations from government on the preferred provider contracts being used by PHIs in the ancillary sector, and one interviewee noted that this was a particularly smart relationship move by the ADA, as people don't think that doctors are as bad as dentists (3case3).

If the trial had been successful, it would have put Medibank at a competitive advantage to other insurers. As such, Medibank did not receive unconditional support from its peers. Stakeholders appealed to multiple government regulators in an effort to cease the trial. The Health Insurance Restricted

Members Association Australia, representing 22 insurance funds, wrote to the Australian Competition and Consumer Commission, concerned that the exclusivity of the association between Australia's largest private health insurer and Australia's largest general practice network (IPN) would be anti-competitive and arguing that it could be a potential misuse of market power (HIRMAA, 2015). The Health Insurance Restricted Members Association of Australia and the AMA also contacted the Department of Health, questioning the legality of the arrangement (Australian Medical Association, 2014).

The opposing subgroup also drew upon political advocacy channels to promote their view. The AMA developed a very strong relationship with Senator Di Natale of the Australian Greens (political party). Senator Di Natale had close and strong linkages with many other actors according to the documents of the time. The AMA also liaised with the Prime Minister, the Hon Tony Abbott. This was the first of the cases where the Prime Minister became publicly involved in the debate, being quoted as supporting reform in payments and that he would not be 'ruling out lifting the ban on Private Health Insurers paying for GP services' (Harrison, 2014).

Once the AMA had consumers, senators, the opposition and allied health in their subgroup, they had formed a large alliance where resources could be shared and ideas promulgated, allowing for the development of a strategy involving these entities. Once again, the AMA had established itself in a prominent position in a strong and sizeable subgroup. Network theory suggests that greater strength and power can be derived from such a centralised position (Freeman, 1979; Laumann, et al. 1985; Ward et al., 2011).

7.4.2.2 Where was the locus of power?

Changing institutions that have distributional consequences requires the capacity to influence legislators as decision-makers. Thus, the greater the capacity to vet, alter or prevent a policy change, the greater the power that actor or subgroup possessed. Remarkably, in this case, no alternatives were proposed to resolve problems. A common theme observed by participants was that the debate was particularly fierce, or as one participant remarked, 'No debates were stifled, it was pretty bloody and out there' (4case3).

The powerful relationships were between individuals rather than entities in this case. Some individuals within the private health insurance industry had developed powerful connections with the federal government (Heath, 2014). George Savvides, CEO of Medibank, was a strong personality and had strong relationships with the government according to most interviewees. He was an advocate of integrated

care and was reported to have carried a fair bit of sway with the then–Health Minister, the Hon Peter Dutton, and the Prime Minister, the Hon Tony Abbott. Participants mentioned that it was reasonable to assume that some of these relationships would have formed when Prime Minister Abbott was Health Minister (between 2003 and 2007). One participant also raised the role of other insurer CEOs; Newcastle Industry Benefits (NIB) group’s CEO Mark Fitzgibbon almost became a public spokesperson. As one informant reflected, ‘NIB probably became more publicly savvy because of their demutualisation and public listing, they were always in the news as a listed company and Mark’s media presence’ (6case3).

The relationship between advocates and decision-makers can be collaborative or combative. As one interviewee pointed out, there was a very different flavour in the interactions and relationships between health ministers and government and the AMA according to who was the president of the AMA at the time. Some presidents of the AMA have had a much stronger relationship with the Health Minister than others. Dr Steve Hambleton (president of the AMA from 2011–14) was reported to have had a very conciliatory personality and a very close relationship with the government at that time (2Case3). The president of the AMA changed in May 2014, and the new president, Professor Brian Owler, was quick to raise fears that shifts by private health insurers into primary care would interfere negatively with the doctor–patient relationship (Doggett, 2015). One interviewee noted that Prof. Brian Owler had a much more robust and antagonistic relationship with the Minister for Health and was a very public figure – giving him a close and powerful relationship with the media.

Despite what appeared to be a less influential relationship with decision-makers, the opposing subgroup’s efforts gained political traction in early January 2014. The media campaign opposing the program was noticed by the pilot program participants. IPN, the provider of the general practice services, put out a statement to clarify the respective roles of Medibank and GPs stating that

IPN welcomes the interest of Medibank in supporting the general practice industry. General practice is the backbone of Australia’s health system and the best resource available to efficiently and effectively meet the increasing healthcare needs of the community. We believe that as long as the clinical independence of practitioners is maintained, having other healthcare organisations work with IPN should be welcomed. (IPN, 2014, p. 1)

The opposing alliance moved its attention to advocating in Parliament House. This investment was rewarded when they gained the support of Australian Greens Senator, and former general practitioner, Richard Di Natale. On 27 March 2014, Senator Di Natale introduced a bill into Parliament to alter the

legislation to clarify that private health insurers could not make arrangements that delivered preferential treatment (Di Natale in Senate Hansard, 2014). The investment by Senator Di Natale was considerable – there are very few opportunities and resources available for smaller parties to draft bills. This bill was sent to the Senate Standing Committee on Community Affairs on 17 June 2014 for review.

The bill served to coalesce the insurance industry. Insurers formed a stronger alliance and continued their claims that reform of the payment model was needed through such arrangements. BUPA, Australia's second-largest insurer, argued that '[i]t is well accepted that the private sector is often better placed to drive innovation with access to capital, higher appetite for risk and higher levels of flexibility. Furthermore, innovative programs developed and tested by the private sector can then be taken up by the public system' (BUPA Australia in Senate Standing Committee on Community Affairs, 2014, p. 9.).

Despite the insurance industry's reaction, interviewees did not feel that the Greens held a considerable amount of power, but that they certainly held less power than the Democrats had held in the first case. One interviewee noted that '[i]n different times the Greens have been more influential depending upon who is leading the party' (6case3). Another interviewee explained that although the 'Senator's bill had resulted in a committee considering the issues, a lot of committees are not very influential. They make a lot of noise, and opposition parties and independent parties can grandstand, but if the government wants to do something they will ignore the reports' (3case3). Yet another interviewee noted committees' lack of power: 'I mean the three people who read them [the reports] – it's not going to make any difference' (4case3). The Committee in its report found 'that it is important for private health funds to be able to trial and develop new models of service delivery or healthcare' and that 'the Bill, which would prohibit such projects, is not in the best interests of Australian healthcare consumers' (Senate Standing Committee on Community Affairs, 2014, p. 11). Interestingly, it would appear that a parliamentary review of a policy had lost its capacity to influence the policy outcomes somewhere between the second and third cases, as whilst the program remained supported by the law, it ceased in 2005.

Whilst the bill did not change the regulator's position, it did garner significant media attention. The AMA's position was supported by other representatives of the medical profession. However, some interviewees indicated that the RACGP and the Doctors Reform Society were not as influential as the AMA (3case3; 6case3). Overall, a general sentiment emerged from the interviewees that the AMA's opposition would have been the deciding factor (3case3).

To conclude, in this case, changes to the payment and access rules were not envisaged by either side of politics; the debate was fought by the industry players with a view to either maintaining the status quo of the payment and access rules or seeking to change them. Once again, a subgroup of actors formed an alliance to limit the changes to the operation of the payment and access rules by censoring Medibank Private's program. Unlike the other cases, this power extended beyond minimizing the scope of changes to vetting the pilot program completely. This power was held by the group with the AMA at the centre, assuming a guiding, if not commanding, position. This subgroup's use of resources to construct alliances proved productive.

7.4.3 Regulatory policy – institutions

This section analyses whether the previously established rules around payment and access in the healthcare system restricted the policy options available for reformers and then considers whether the cost of the proposed change created a lockdown mechanism (Pierre, 2009). This section finishes with an examination of the change implemented as a test of the strength of the operation of the payment and access rules (Edwards, 2020; Tuohy, 2018).

7.4.3.1 *Industry has adapted and doesn't change*

The regulations that established the payment and access rules did not prevent private health insurers from paying for general practitioners' management expenses. The Department of Health provided evidence to the Senate Committee that the arrangement was not illegal and could benefit patients. In the hearings, it explained that 'the arrangement between Medibank and its [external provider, Independent Practitioner Network (IPN),] is not health insurance business, but a management expense. This arrangement does not appear to contravene Commonwealth legislation and is beyond the scope of the Act and any amendment that the bill attempts to effect' (Senate Standing Committee on Community Affairs, 2014 p.8). The government also supported shifts towards vertical integration, stating that 'any regulation which may discourage [funds] from arranging preventative or intermediary care for their members would not be a desirable outcome' (Senate Standing Committee on Community Affairs, 2014 p.6).

Changing the payment and access rules was going to be difficult, as medical practitioners had adapted to the Medicare fee-for-service model:

most GPs have never worked in a non-Medicare environment. In fact, there are probably very few who graduated before Medicare was introduced (1983), so they are accustomed now to

doing their work, and government itself has now become a bigger competitor with the PHI[s] for disease management programs because they are now allowing GPs to be paid Medicare benefits if a general practitioner refers [a person] to a disease management program. (1case3)

The creation of the MBS chronic disease management programs further perpetuated the MBS and its fee-for-service model as the payment model for remunerating medical practitioner services.

Unlike the previous cases, data on the amount of actual or perceived change required was extremely limited. Interestingly, interviewees had mixed views on who needed to adapt and who had the most to gain or lose. Some interviewees felt that the implications for general practitioners were minor; however, others considered that the change in operations for practices was significant. The Medibank Private program required a change to the general practitioners' usual processes, as a general practice would not normally identify if a person was a member of a fund at the point of making an appointment, nor need to balance bookings to ensure that an appointment could be made within 24 hours.

The focus of the resistance was about who would direct care, and thus a major potential change would be a reduction in the amount of autonomy held by practitioners (Doggett, 2015). From the perspective of the medical practitioner, 'There is an innate suspicion of health funds extending their tentacles, and from a GP perspective, they were torn between taking the money and the spectre of ending up being captured and controlled by PHIs. It wasn't an easy debate within the GP community' (4case3). General practitioners did not want changes to the amount of autonomy they had acquired under Medicare. As one interviewee mentioned,

It is actually about autonomy and it's about maintaining doctor autonomy. That autonomy includes autonomy to set fees and autonomy of practice, and that there was a very real concern that Medibank would try to control practice, whether it be overt or covert, through this system. (2Case3)

Another interviewee concurred: 'The AMA didn't support any third party getting involved with what they can charge – even if the individual general practitioners would [have been] quite happy' (3case3).

Other interviewees felt that the group who faced the largest potential changes were the private specialists who rely on GPs for referrals. Changes to improve preventative health would inevitably require a reduction in referrals for tertiary-level services in order for insurers to reduce outlays.

Somewhat controversially, a couple of interviewees felt that it was entirely possible that the general practitioners looked like their needs were sold out by the private specialists (1case3; 2Case3; 3case3).

The fee-for-service model under Medicare ensures autonomy of practice. Changes to the model would require a fundamental shift in the operations of general practice, who have been working within the Medicare model since 1984. There was limited incentive to give up autonomy of practice and billing.

7.4.3.2 Cost of change

The federal government has been generally supportive of a larger role for private health insurance within primary care, with former Health Minister Peter Dutton showing public support for changes (Doggett, 2015). A recurrent theme in the interviews was that it would have been a big political problem for the government, as they were already fighting with the doctors regarding the freezing of the level of the MBS rebate and also the proposed co-payments, and the Minister was 'really on the nose with everyone' (3case3). The majority of participants agreed that the government's appetite for any kind of controversy was pretty low. This was reinforced by one interviewee who said, 'I can imagine the Prime Minister's Office would have said that the Health Minister's job is to shut down any concerns and make friends with everyone – not be a political liability' (3case3). Once again, the actors had created an alliance of medical practitioners and consumers who voiced threats of a two-tiered general practice system – 'Governments in Australia are afraid of a two-tiered GP system, as they are viewed by the community to undermine Medicare' (5case3).

One informant felt that 'this [policy proposal by Medibank] is a bit more of an interesting one, because there would be more of a value proposition for the government as you could potentially increase the value of private health insurance without them having to chip in any money' (3case3). However, another informant thought that the issues that arise from cost-shifting between the state governments funding hospitals and federal government funding primary care meant the more the government funds primary care, the more states save money. 'Federal governments are also suspicious of doing anything that may make them unpopular, particularly if another level of government gets the benefit. That feeling at government at the highest levels cannot be underestimated' (4case3). Whilst this is perhaps not the most logical of arguments, it shows the depth of concerns around the issues of cost-shifting and how this impacts the design of healthcare program. 'Why should the government upset the medical profession if someone else is going to get the benefit years down the track?' (4case3).

Details on the whether the actual costs of change for practitioners were feasible were unavailable for the public debate (Heath, 2014). One interviewee noted that it was possibly impractical for general practitioners to make this change for a small portion of their patients, suggesting that the pilot 'ultimately fell apart because the doctors who were in the program saw no point in being a part of it for 10% of their patients and therefore were open to contracting with other insurers. The moment that happened, the competitive advantage Medibank may have achieved would have been removed' (1case3).

The interviewees presented a number of ideas as to why Medibank ceased the pilot. Interviewees agreed that it was interesting that Medibank closed the program in 2015. Interviewees varied on their reasoning, some believing that Medibank were not convinced that it would make the difference that they thought it might, and other interviewees added that the political perception could have been that the heat would continue to escalate and that the project was not worth it. One person thought that perhaps the time wasn't right (6case3). Another interviewee mused that they didn't know why Medibank walked away but assumed 'there was no value in it, there was no value in what they tried to do the way they tried to do it' (5case3).

The relationship between Medicare and PHIs was brought into the reasons for the closure of the program, with one participant reasoning that there would need to be some 'Medicare reform to make a project like the Medibank pilot meaningful; otherwise you are not gaining from substituting costs, you are just adding to the health budget' (6case3). Finally, another interviewee observed that if an insurer implements payment and performance oversight of the patient's journey, the benefits need to accrue to that insurer. 'Asymmetry of benefits accrual – benefits do not accrue to those that provide the service – is the problem, is very real. If an entity is operating a program that should control costs – it needs to see linear benefits accruing, not asymmetric, otherwise there is no point for them to fund the program' (2Case3). In short, Medibank was not assured that they would recoup their investment through reduced hospitalisations.

Lastly, one interviewee observed that the more you find a way to extend the services that PHIs cover, the more they need to pay out in benefits. Moreover, it is not just the increased benefits that cost the fund, but the initial work to develop the program and its ongoing management (6case3). Thus, without being able to capture savings, there would have eventually been a cost to consumers through higher

premiums, which would be counter to consumers' desires for lower premium increases and potentially damaging for PHIs, who had claimed that these types of programs would have led to savings.

Lockdown of a policy path can occur when the cost of changing to a new way of operating is prohibitive. Costs accrued to almost all industry players. For the government, the costs of supporting the program were mounting. Its support did not waiver, nor did it strengthen. For general practice, costs were in changing operations. In this case, it is not entirely clear why Medibank closed its pilot, but the cost appeared to be political and financial.

7.4.3.3 Actual outcome

To measure whether the mobilisation of the network achieved actors' preferences, actors' opening negotiating positions can be compared to the final legislation (Edwards, 2020). In addition, measuring the outcome at implementation (whether there was a change in the way the system functioned) provides further evidence of the strength of the institution (Tuohy, 2018).

Unlike previous cases, the bill before Parliament was designed to prevent integration between private health insurers and practitioners. It was introduced into the Parliament as a private Senator's bill on 27 March 2014 and sent to Senate Committee for review and remained in Parliament for the majority of 2014. The Committee reported on 4 September 2014 (Senate Standing Committee on Community Affairs, 2014). The bill had the support of the AMA and consumers. However, the majority of the government Committee did not support the bill and sided with the insurer subgroup. Labor Senators did not agree with the Committee's findings and felt that the intent of the bill was worthy, but due to potential unintended consequences, the bill could not be supported in its current format. They recorded concerns that the GP Access program could lead to an inequitable health system. The Greens Senators were stronger in their disagreement and lodged a dissenting report (Senate Standing Committee on Community Affairs, 2014). The bill did not pass through the Parliament of Australia and lapsed when Parliament was prorogued. As a result, integration using a payment model such as the pilot program operated by Medibank remained permitted by the regulator.

The pilot started in Brisbane with six clinics and had expanded to 26 medical centres and 145 general practitioners as of 1 August 2014 (Harrison, 2015). Despite its legality and policy support from the government of the day, on 22 May 2015, six months after it was publicly floated, Medibank publicised that it had 'redefined its involvement in primary care' and would cease the trial of its GP Access program on 31 July 2015 (Rollings, 2015). Medibank's evaluation of the trial was never published.

7.4.4 Normative expectations of the regulatory policy

Similar to the previous case, this section investigates how actors used legitimacy as an operational resource in this case to either stabilise or alter the institution (Brady & Bostic, 2014; Brady, et al., 2016; Brooks & Manza, 2007; Skocpol, 1992). It then discusses the inability to shift the insurers' role in the health system through this reform. It concludes by examining whether society (the general public) has communicated to governments that the mixed model of insurance is the preferred financing policy, locking down that policy path and preventing future reform.

7.4.4.1 *Legitimacy and the role of consumers in the network*

As interrogated in the previous two cases, legitimacy is a significant source of institutional change, as institutions based on power, for example, can be destabilised by a reduction in power through changes in legitimacy (Thelen, 1999, pp. 392-399). Legitimacy is an important concept for understanding organisations and their relationships with their social environment, as whoever's position is seen to have more legitimacy is, theoretically, more likely to be supported by the government, which is particularly important in a highly regulated industry (Parsons, 1960).

Once again, the arguments centred around whether allowing PHIs to fund general practice would be beneficial consumers and were a key point of disagreement between the opposing subgroups. Two main issues arose: the first was the creation of a two-tiered system of primary care. Consumer advocates were fixated on the potential creation of a two-tiered health system, where those who could afford private health cover would obtain a better standard of care from general practitioners charging higher fees (covered by private health insurance), leaving people without health insurance to rely on a declining number of bulk-billing general practitioners, who would need to increase the speed of service through their practices in order to remain viable (Harrison, 2014). When talking about the program, the Consumers Health Forum spokesman Mark Metherell said such a change would 'erode the notion of universal access that Medicare is supposed to provide' (Harrison, 2014, p. 9).

The second issue was that adding another funding source might allow general practitioners to inflate prices. Jeff Richardson, from the Centre for Health Economics at Monash University, argued that if insurers were permitted to cover general practitioner fees, it would incentivise fee inflation. 'One of the reasons we've managed to keep GP fees very low is that bulk billing has been a very effective technique for competition to prevent [doctors] from raising fees. If we let the private sector in we're really taking the lid off the can' (Harrison, 2014, p. 8).

A common theme among interviewees was the effective use of the media to improve legitimacy for ‘the medical practitioners’ argument’. One interviewee noted that it often comes down to who can sell a better story (2Case3). ‘It’s easy to run scare campaigns around who is going to be pulling the strings, to suggest that the health funds might be shadowy figures in the background influencing what the doctors can and can’t do. There was a view that people are quite vulnerable to that’ (3case3). The majority of interviewees acknowledged active targeting to reduce the opposing subgroup’s legitimacy – ‘with the media, it is good guys and bad guys – can the AMA paint the insurer as the villain? It is easy to get good press coverage on that’ (2Case3). One interviewee summed up the relationships with the relative levels of legitimacy succinctly: ‘I think that the private health insurers didn’t have the moral weight to take on the doctors even though they have control over a lot of the money and have the capacity to help solve a lot of the problems in the health sector; they just don’t have the public support’ (3case3).

An interesting observation by one participant was that there is no committed private health insurance consumer group, no one to articulate the needs of consumers, as opposed to the organisations in this space (1case1).

At the beginning of the debate, there was disunity among the insurers in the private health insurance industry, with some insurers holding different positions on the pilot program. Medibank Private, understandably, was the most vocal of the insurers agitating for reform (Heath, 2014). BUPA in January of 2014 stated that they did not support Medibank’s Program (Heath & Gardner, 2014). The Health Insurance Restricted Members Association Australia voiced concerns with the Department of Health, the Australian Competition and Consumer Commission and the Parliamentary Committee. Whether the lack of support was due to the nature of the reform or to prevent a competitive advantage for Medibank is uncertain; however, one interviewee noted that there was a lot of angst about the pilot program within the industry at the time. Whilst insurers were not absolute in their support for Medibank’s pilot, they did align quickly against the bill which would have prevented integration, suggesting it was more an issue of competitive advantage rather than the policy intent that was the original concern.

Private health insurers were disappointed with the outcome and the public’s perception of them. One participant thought that ‘the availability for the member to go and see their general practitioner and not face an out-of-pocket cost and then programs for prevention and health enhancement developed for them made a lot of sense’ (4case3). Another interviewee explained that the programs are ‘about understanding the customer and developing services, it is not about being mean and nasty’ (6case3).

When Medibank announced that the trial was ceasing, they noted that the consumers had accepted the opponent's proposition of inequity. 'Disappointingly, it was clear from the feedback that this pilot was perceived as a first step towards the creation of a two-tier or exclusive health system. Medibank is a strong supporter of universal healthcare, and we would certainly hate people to think that we were trying to do anything like this,' Dr Wilson said. 'Further, [members] didn't feel it added additional value to their private health insurance' (Harrison, 2015, p. online). Thus, the subgroup around the AMA had managed to convince Medibank's members that the AMA's position was more legitimate.

The GP Access program had the support of Medibank, the private health insurance industry, the largest corporate supplier of general practitioner services in Australia (Independent Practitioner Network), government regulators (Australian Competition and Consumer Commission and Department of Health) and the government of the day. Interestingly, for an industry that is highly regulated, the government's support did not correlate to higher levels of legitimacy for PHIs. The brutality of the debate, tactics, and capacity to draw linkages with an overseas healthcare system that was not socially acceptable reduced the pilot program's legitimacy. The lack of favourable media coverage for the reforms compounded the messaging from the opponent alliance and arguably extracted legitimacy from insurers.

7.4.4.2 Outcomes – the role of insurers in the health system

The operation of the payment and access rules did not change as a result of the pilot program, and thus the roles of the insurers in the health system remained the same. This reform provided another opportunity to alter the roles of insurers and medical providers within the healthcare system in Australia and allow direct contracting of medical providers. If the pilot had continued, it would have allowed for greater integration between PHIs and general practice in Australia. The program, it was argued, would have allowed PHIs to move from being passive payers of hospital costs to active managers by identifying and offering members chronic condition management programs earlier in their disease progression, thus either delaying or preventing hospitalisations.

Medibank understood that to effect change, they needed to influence the gatekeepers of the system: 'This is a toe in the water for us but it's a recognition of the important role of GPs as gatekeepers for the rest of the health system, and also a recognition that our members want more from us' (Savvides in Parnell, 2014). Other insurers were also quick to also acknowledge the role of general practitioners as gatekeepers in the system (Heath & Gardner, 2014; Parnell, 2014).

Everyone had identified the need to influence the how general practice operates, integrating it better with the rest of the health system due to its role as a gatekeeper with the power to prescribe the course of treatment for their patients. Interviewees pointed out that there was a very real concern that Medibank would try to control practice, whether it be overtly or covertly, through this system by adjusting treatment patterns and reducing referrals to specialists (2Case3). The AMA's concerns centred around giving PHIs a much greater power in the health system (Heath, 2014), potentially driven by members who were specialists rather than the general practitioners. A common theme among interviewees was that procedural specialists, as a rule, are much more wary of managed care as they have much more to lose due to their financial connection with PHIs, whereas general practitioners have a very limited relationship with PHIs as a general rule.

Changes in insurers' roles were supported by both major parties; however, this was within the confines of the continuation of the mixed model of insurance. The federal opposition (ALP) were open to PHIs moving into the prevention and integrated care management space. In January of 2014, in a speech given to the Australian Healthcare and Hospitals Association Medicare roundtable, the Opposition Health Minister – Catherine King – stated, 'I am interested from a policy perspective in good models of care. I am interested in how there can be a stronger role for prevention and more integrated case management, better consumer health literacy, more consumer engagement. There are very good examples across the country, including some of the work private health insurers are doing with their captured population of patients' (King, 2014). They also held the position that governments have a duty to safeguard the private health insurance industry and ensure that insurance is reasonably affordable and is good value (King, 2014): 'It's important to acknowledge that the private health insurance industry does play an important role in healthcare in Australia'. However, and perhaps seizing upon a political opportunity, the ALP's opposition to the pilot program grew over the next 18 months, limiting the potential scope of PHIs in the management of the health system. Whilst acknowledging good examples of PHIs' work in primary care, they announced that their concern with the Medibank GP Access Program was that it would restrict access or come at the expense of those Australians who choose not to purchase, or cannot afford, private health insurance (King, 2014).

Despite having the support of the government of the day, no changes to the regulations that govern payment and access were made, and the pilot ceased. This is unlike the first two cases, where changes in rules were secured that could improve integration (even if they did not subsequently amount to changes in behaviour). The roles within the healthcare system and the balance of power between the funds and

the medical profession did not change at the end of the debate. General practitioners retained the same clinical autonomy, allowing referrals to continue unabated, and PHIs remained passive payers, unable to contract medical practitioners.

7.4.4.3 Outcomes – public support for the mixed model

It has been argued that community support for a particular social policy can constrain politicians and lead to path dependency (Brady & Bostic, 2014). At the commencement of the debate, healthcare analysts noted that the moves by Medibank Private to acquire and vertically integrate primary care services opened up an opportunity to examine new models of financing primary care (Fitzgerald, 2015). However, by the end of the debate, reform appeared to be more difficult. As one interviewee said, ‘I do not recall any noticeable relationship changes as a result of this. If the discussion had gone a different way, they could have brought forward the health reform discussion by about 5 years’ (2Case3).

In this case, at the commencement of the pilot program, changes to the relationship between Medicare and PHIs were envisaged by both major political parties, and both parties were open to the idea of PHIs engaging with general practice, but that support did not extend as far as creating a regulatory change. The operation of the legislation is important here: whilst it allowed for PHIs to fund certain areas of general practice (administration) from certain parts of PHI income, the inability to contract for the provision of services under the fee-for-service model remained. The support from the then-federal government did not extend to amending the legislation to increase integration.

The opposition party’s support for change to improve integration in the healthcare system was also qualified, and in a media article, Opposition Health Minister Catherine King was quoted as not supporting the Medibank program (Heath & Gardner, 2014). One interview captured this position: ‘The ALP were always a bit more cautious as private health insurance is not in their DNA, but at the same time they know that a large proportion of the population have got it, including a lot of people who would normally be a bit poorer’ (4case3). Consumers were generally very Medicare-focused. Unless consumer groups saw a policy proposal as threatening Medicare, organised consumers tended not to take a strong line (1case3). The AMA used the public sentiment and ran a line in the media stating that the pilot program breached the ‘spirit of the law’ which prohibits private insurers paying for services covered by Medicare, such as general practice visits (Australian Medical Association 2014; Harrison 2015).

Thus, we see a continuation of the community’s message to maintain a system wherein PHIs and Medicare operate together in a mixed model. The majority of the interviewees commented on the

tension inherent in the system – this ‘goes to one of the broad discussions that Australia has never resolved, which is the role of private health in the Australian system’ (4Case3). As one interviewee commented, ‘it is a political question about who plays where’ (6case3). Confirming the closure of opportunities to change the relationship, one stated, ‘There is a dominant public system, but whether there is a role for private health and what that should be wasn’t resolved during the 2010 Roxon reforms and is one of those things that you almost don’t talk about (4case3).’ Public opinion on the insurers’ role in the healthcare system and social expectations of how the system should provide healthcare appear to have limited parliamentarians’ ambition to reform the healthcare system, and instead, elected officials choose to tread a fine line of ‘no observable change’ for the role of PHIs.

One interviewee commented that the government itself has now become a bigger competitor with insurers for chronic condition management programs because general practitioners are now paid Medicare benefits if they refer a patient to a chronic condition management program for five services. One interviewee suggested that this is similar to what a patient would obtain from their health insurance program. ‘The funds are now in direct competition with the government in that area’ (1case3). This shift in government policy to pay for chronic condition management under the Medicare Benefits Schedule further cements its fee-for-service model and missed an opportunity to introduce direct contracting of medical practitioners in Australia.

Not all interviewees felt that future reform was impossible. One indicated, ‘health reform is one of those hard issues – you have very powerful interest groups and money always plays a role, even though [it’s] not just money but culture, and particularly when you are talking about the private health insurance sector, you’ve got the doctors who support [private health insurance] on one hand as it provides an income, but at the same time they won’t have a relationship with health funds’ (4case3).

The importance of the role of the network in any reform process was noted by Interviewees. Clearly put, ‘I think if it is reform that you don’t have the AMA behind, the takeaway message is, “If you don’t have the backing of the AMA, it is very unlikely to get up,” or, “If you don’t have the AMA, you need everybody else”’ (3case3). To gain the support of ‘everyone else’, multiple interviewees noted the need for a clear value proposition for consumers that you can sell in the media (3case3). Clarity, though, can be difficult to achieve when the policy settings themselves lead to mixed messages due to the relationship between PHIs and Medicare and the complexity in the system from the mixed model of insurance.

At the conclusion of the case, the payment and access rules remained unchanged. No vertical integration was achieved, and the debate exhibited that there is little political will to reform the system going forward. The observations by all interviewees of the lack of appetite for future reform in this area supports the argument that the continuation of the mixed model is the socially desirable course of action and actions by industry that undermine the current system will not be considered legitimate. The Medicare system and its fee-for-service payment model has created a self-reinforcing mechanism, influencing what actors believe are possible alternative options for PHIs to remain viable. These options do not include structural change that would allow PHIs to directly contract medical practitioners and become active managers in the system. The payment and access rules established under Medicare and the relationship between it and PHIs are the dominant path, and this case demonstrated how difficult it is to change the relationship between insurers and Medicare.

7.5 Conclusion

Reforms to the National Health Act over the past two decades had not provided sufficient incentives for PHIs to move into active management of patients. Developing programs to help manage chronic conditions requires a long-term relationship and oversight of a patient, allowing for early and ongoing intervention. Medibank, along with other insurers and health system analysts, had identified that reducing hospital usage through programs to help people manage their chronic conditions was a good way to contain expenditure growth. Insurers identified that it would be beneficial to be able to identify members with chronic conditions earlier in the development of the disease, rather than at the stage where the person needed tertiary-level care. Relations between the health sector and the then-government had begun to deteriorate, and the tension grew after the 2014 Budget. It was at this time that Medibank decided to pilot a program to encourage and support Medibank members to access a general practitioner by contributing to the costs of the general practice's operations, increasing integration between insurers and general practice.

A smaller group of actors debated this reform. Once again, power rested between opposing parties. One centred around the AMA and the other around Medibank Private (rather than the PHA). The debate was fiercely fought, and there was less interaction between the opposing groups than in previous cases. The AMA developed a formidable alliance of many actors across the system. Once again, the AMA had consumers, senators, the opposition and allied health in their subgroup; they had formed a large alliance where resources could be shared and ideas promulgated, allowing for the development of a strategy

involving these entities. Consumer organisations joined and argued against Medibank's program, albeit for different reasons. Both subgroups claimed to have the consumers' best interests at heart; however, consumers were not a large part of the policy debate, and interviewees did not consider their voice to be influential.

The powerful relationships were between individuals rather than entities in this case. Some individuals within the private health insurance industry had developed powerful connections with the government. Overall, interviewees indicated that the AMA's opposition was the deciding factor. The power to vet proposals was, again, being held external to Parliament by the group that contained the AMA.

The costs of changing to the model in the pilot program were not explored in detail in the public debates. The debate quickly moved to the threat of a two-tiered system of primary care where patients with insurance might get better care than those who relied on Medicare alone. Costs accrued to almost all industry players. For the government, the political costs of supporting the program came from the public perception that it could undermine Medicare. For general practice, costs were in changing operations for a small proportion of their client base. Whilst it is not entirely clear why Medibank closed its pilot, the costs appeared to be both political and financial.

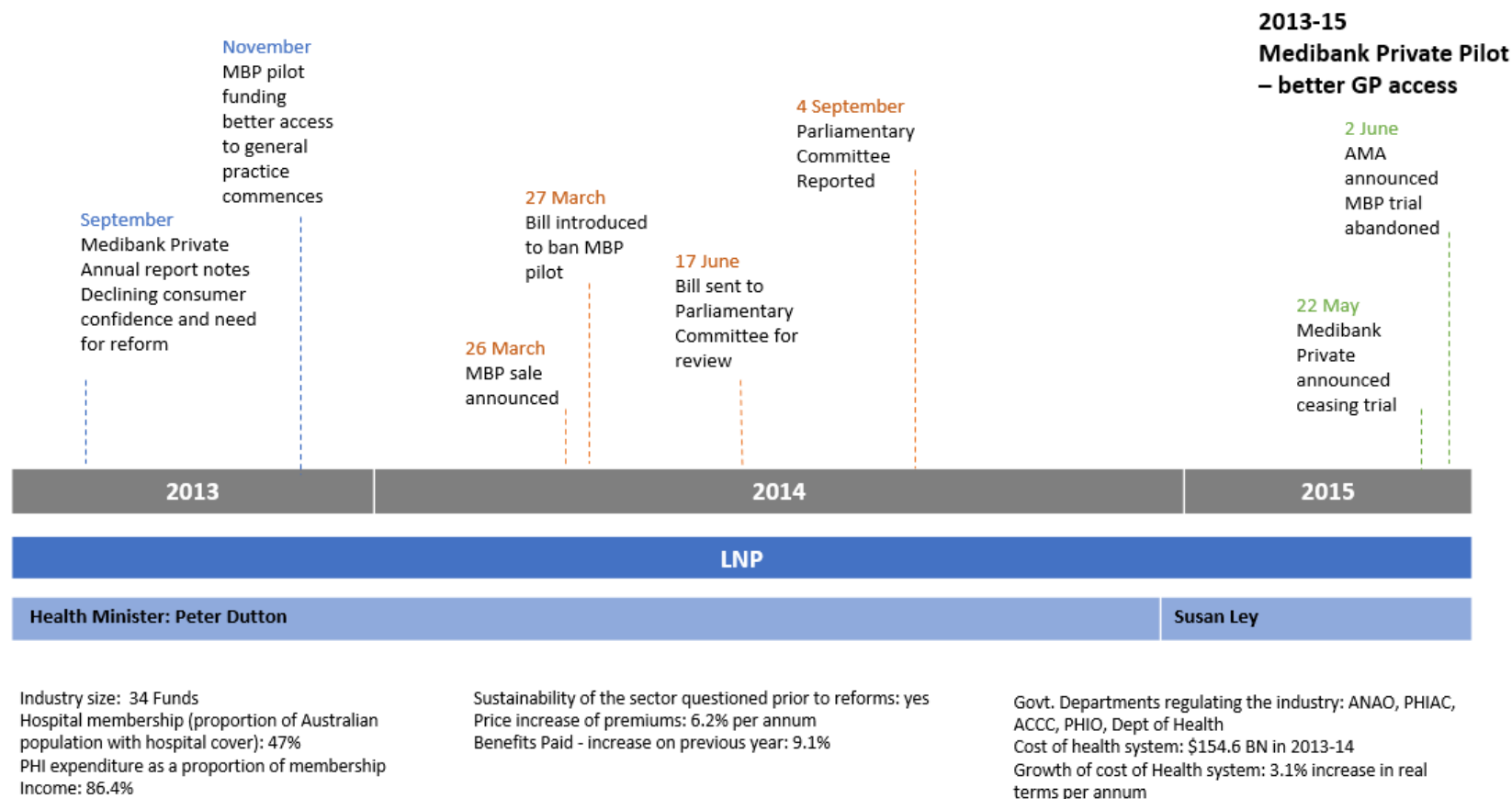
Future change requires the support of the largest subgroup within the network, in other words, the group that forms around the AMA, or everyone but the AMA. To gain the support of 'everyone else', multiple interviewees noted the need for a clear value proposition for consumers that you can sell in the media. Clarity, though, can be difficult to achieve when the policy settings themselves lead to mixed messages as to the relationship between PHIs and Medicare. The brutality of the debate, tactics and capacity to draw linkages with an overseas healthcare system that was not socially acceptable all reduced the legitimacy of the pilot program. The lack of favourable media coverage for the reforms compounded the messaging from the opponent alliance and arguably extracted legitimacy from insurers.

Despite having the support of the government of the day, no changes to the regulations that govern payment and access were made, and the pilot ceased. This is unlike the first two cases, where changes in rules were secured that permitted for changes in behaviour that, if implemented fully, would have changed the operations of the system and potentially improved integration. The roles within the healthcare system and the balance of power between the funds and the medical profession did not change at the end of the debate. General practitioners retained the same clinical autonomy, allowing

referrals to continue unabated, and PHIs remained passive payers. In short, society does not want changes to the mixed model of insurance if the changes would impact upon Medicare, and have limited government appetite for reform.

This chapter considered the actions of the network during a policy debate. Similar to the previous chapters, it dissected a case that occurred in a discrete period of time, analysing the operations of the actors in relation to the specific environment and changes proposed by the reform. Although the structure of the network altered slightly from the previous two cases, it found that a subgroup of actors had formed and was able to ensure that the payment and access rules did not change. Lockdown of the payment and access rules can only be determined over time and in retrospect. The next chapter considers the trends across the cases and the operation of the network, the use of power and the impact of the structural change with a view to explaining how lockdown has occurred.

Figure 7-2 Timeline of key events and environmental data



8 How the network shaped policy over time

8.1 Introduction

‘ . . . The Doctors have had historically a very good position. . . you defend one trench and when you can’t defend it anymore you step back and defend the next trench (2case1).

This chapter discusses key findings from the research across the three case studies. It begins by demonstrating a narrowing of the proposed policy reforms in the case studies over time, both in the scope of reform and in implementation (section 8.2). It then explores how power operated within the network across this period of 20 years (8.3), and explores the role of legitimacy over time (8.4). The chapter documents the centralisation of power by medical providers and the disempowerment of consumers. Furthermore, it shows how the institution of the payment and access rules were maintained, constraining attempts at reforms over the decades (8.5). Finally, by examining feedback-loops across the cases, the chapter concludes that public support for the mixed model of insurance is entrenched in Australian society.

The cases were explored in detail in chapters five, six and seven. In each case, there was an attempt to increase the level of integration between private health insurers and medical practitioners by allowing PHIs to contract medical practitioners (thus reducing practitioners’ autonomy) and increasing the amount of active management insurers could have in the system. In each case, actors in the network formed alliances and debated the policy event in the public arena. Improving healthcare for consumers was always given as a reason for the proposal by private health insurers, although containing costs was also always part of the reasoning. In addition, insurers and the government of the time argued that the changes would increase value for money for consumers who held private health insurance.

As time progressed, a more nuanced understanding of the impact of the operation of the payment and access rules on the provision of healthcare emerged after the 1995 reforms. The focus moved to the part of the system that could influence downstream costs or drive efficiencies, the general practitioner, when analysts and insurers identified the need to integrate the healthcare system by coordinating care at the primary level. Driven initially by the need to contain costs at the tertiary level, thinking on management of demand shifted to a focus on the increasing prevalence of chronic conditions, which led to calls by insurers, health researchers and academics for greater integration to be driven through all insurers (Productivity Commission and Melbourne Institute of Applied Economic and Social Research, 2002; Vaithianathan, 2004).

8.2 Cases

To position the reader, the key features of each of the three cases – the proposal, the opposing subgroup’s position, the change permitted (final law) and the change that occurred in the system (change to operations) – are outlined in Tables 8.1, 8.2 and 8.3 below. Each case shows a narrowing of what was possible for potential reforms to the healthcare financing rules, and a lack of implementation of permitted integration.

Table 8-1 Key features of Case 1 – Medical Practitioner Contracting 1995

Proposed integration	Opposing subgroup’s preference	Final law	Implementation
Allow registered health benefits organisations to enter agreements with medical practitioners. The agreement would allow the fund to pay medical benefits in excess of the Medicare Benefits Schedule (MBS) fees for that practitioner's services.	No agreements between insurers and medical practitioners.	Agreements between insurers and medical practitioners were allowed.	There was extremely limited uptake of medical agreements when the law was reviewed by Parliament in July 1996. The Department of Health stated that it knew of only one practitioner agreement. The sector shifted and developed a new benefits schedule to address the issue of out-of-pocket costs – the no-gap/known-gap benefits schedule.

Table 8-2 Key features of Case 2 – Broader Health Care 2007

Proposed integration	Opposing subgroup’s preference	Final law	Implementation
Broader health cover: expanded the range of services that can	Remove the potential for insurers to determine the	Private health insurance broadened to cover services that form part of an	Uptake of BHC services following the 2007 reforms initially was low.

be covered by private health insurance to include out-of-hospital services that substitute for or prevent hospital care. BHC to include rules to allow for the development of CDMPs, which required two allied health professionals to be a part of the planning team. No payments for general practitioners. Insurers to determine the location and mode of healthcare (in/out of hospital).	location and mode of healthcare (in/out of hospital) and thereby interfering in healthcare providers' decision-making. Prevent insurers from developing products that <i>determine</i> treatment options or locations. Require the continuing involvement and agreement of the patient's usual treating medical practitioner for CDMPs.	episode of hospital care and substitute for or prevent hospitalisation – no limits on location made. Medical practitioners determine where services are performed – clinical autonomy. General practitioners not required as part of a CDMP. Only one allied health professional required for a CDMP.	In 2007–08, nine of the 39 registered health insurers offered CDMPs to their members. By 2008–09, this number had grown to 14.
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Table 8-3 Key features of Case 3 – Medibank Private GP Access Pilot Program 2013

Proposed integration	Opposing subgroup's preference	Final law	Implementation
Medibank piloted contracting subsidised general practice services (fee-free) by contributing to the administrative costs of a general practice. Medibank did not make payments to general practitioners for services directly.	Ban private health insurers from making arrangements to help deliver or directly pay for general practice treatments.	The law allows arrangements between insurers and providers to provide preventative or intermediary care using management income rather than insurance income.	The insurer ceased the arrangements 20 months after they commenced despite being legal.

8.3 Exercising power – within the network

Institutions can be path-dependent (Kay, 2005) and can be reinforced when they have distributional consequences that improve the power of actors who have an interest in maintaining the institution (Hall & Taylor, 1996). The institution in this study was the payment and access rules, which allocate funds and income and reflect vested interests (Bennett & Elman, 2006).

Previous studies have found that network centrality does not always correlate with power and influence (Bonacich 1987; Brockhaus, et al., 2014; Flandes, 2013). To strengthen the validity of the quantitative results of this research, I decided to also analyse power by assessing an actor's ability to achieve their policy goals and whether this altered over time or remained with one group or actor. Thus, the greater the capacity to vet, alter or prevent a policy change (including at implementation of the policy), the greater the power that actor or subgroup was considered to possess.

Curiously, the documents indicate that links between the regulator (government) and the most powerful opposing actors were weak. According to the network maps developed through the documents, there was not a strong link between the government regulator and the strongest subgroup within the network in any of the cases. The government's position was always legislated, although the scope of the potential change was reduced during the process of policy development and passage through Parliament. However, it was at the point of implementation where the actual change was prevented demonstrating the true locus of power in the network fell outside of government. At the end of each policy event, the government's regulatory framework permitted a greater level of contracting by PHI of medical practitioners than was implemented. The insurance industry never exploited the full potential of the capacity to integrate permitted by the legislation.

In the first case, the medical practitioners' refusal to alter their behaviour and integrate with payers was so significant that a new strategy was designed. In the second case, a larger amount of integration occurred over time, but to quote one interviewee, the level of change was 'stuff all' (2case2). Finally, no real change occurred as a result of the third attempt to integrate, and the pilot scheme was abandoned.

These cases demonstrate that change was prevented and the power to create policy or vet proposals or their implementation was being held external to the government. In each case, the research indicated that the capacity to vet proposals effectively sat with the subgroup

that contained the medical practitioners. Despite numerous attempts, integration between insurers and medical practitioners never occurred, and private health insurers remained unwilling to directly contract medical providers.

8.3.1 The locus of power and the operations of the network

One surprising finding was that interviewees provided multiple interpretations of the power structure in the political environment. The regulation of the health system is distributed among a network of private organisations and individuals (who have grouped together as various industry bodies). This transformation has had consequences for where the power to regulate the health system is located, and how it is exercised. The topography of the network can shape power relations, generating differences in who can gather and disseminate information and resources; powerful actors can then strategically use these structures to leverage their position to achieve their goals (Farrell & Newman, 2019). Moreover, Farrell and Newman (2019) argued that network topography can generate enduring power imbalances between nodes.

There is a strong set of interactions between the instigator of the reform and the Federal Minister for Health in each of the cases, and interviewees from the first two cases noted the importance of support by the Department of Health for your proposal. However, whilst the agreement of the Department of Health and the agreement of government was needed to instigate a reform process, it was not sufficient to ensure a proposal survived the policy debate without a significant reduction in the scope of reform, nor would it guarantee the reform would be implemented.

Increasing levels of political support were obtained by the instigators for the reforms. The first two cases began with the Minister for Health's agreement, while the last case received the Prime Minister's endorsement. Despite the increased status of the person providing political support, obtaining agreement for their position from more powerful people in government did not translate to organisations obtaining their strategic goals. Furthermore the proposals proved easier to vet over time – the capacity to prevent integration in the implementation state (even when supported by the Prime Minister) demonstrated the locus of power was external to the government of the day. This showed that the instigators of reforms needed further support from one or more actors within the network in order to gain systemic change.

Power appeared to increase to medical providers across the cases, with the opponent subgroup effectively preventing integration in its entirety in the last case. In the first two

cases, the opponent subgroup influenced the design of the policy to reduce the scope of the potential level of integration that could be achieved. Moreover, the opponent group's resolve appeared to strengthen across the cases, where they not only prevented implementation of integration but created a scenario where each reform was progressively smaller in the scope of desired change to the health system – perhaps reflecting a declining appetite by government for reforms.

Power accrued to the Australian Medical Association as it cemented its position within the opposing subgroup over time. This was summarised neatly by one interviewee who said to effect change, '[y]ou need the government to have an appetite or a political climate when they can take on the AMA' (3case3). This research found a more complex picture of power and demonstrated that the AMA did not hold power solely. Power was not held by any single actor but developed through alliances within the network. Using its resources, the AMA developed strategic alliances with major part of the healthcare system. These included hospital representatives in Cases 1 and 2, and in the two latter cases, consumer health representatives. It became very difficult for the instigators to build a powerful grouping to convince legislators that the proposed reforms had the backing of a large constituency. Without a constituency, legislators are less likely to support reforms, and they would have seen that the reforms in each of the cases would have been difficult to promote to the community (Arts, 2003; Korpi & Palme, 1998).

In summary, across the cases, the AMA continued as the key central actor of one of the opposing subgroups. In the first two cases, there was an indication of the commencement of a phenomenon where network power distribution over the longer run continued to reconfigure until, in the third case, where it is argued that it has become asymmetric. The operations of the network and the structure of the network turned into a symbiotic relationship where power was able to build upon itself.

8.4 Legitimacy

As outlined in chapter three of this thesis, legitimacy is an important source of institutional change (Thelen, 1999, pp. 392-399). Legitimacy became an operational resource that organisations extracted from the environment and used as a resource to achieve their goals during the policy debates (Cashore, 2017; Taylor, et al., 2018). Institutions that are based on power, for example, can be destabilised by a reduction in power, a reduction of these institutions' functionality in the context of other changing institutions, or a reduction in the legitimacy of the actors that maintain them (Bennett & Elman, 2006; Thelen, 1999).

Legitimacy is a generalized 'perception or assumption that the actions of an entity are desirable, proper or appropriate within some socially constructed system of norms, values, beliefs, and definitions' (Suchman, 1995, p. 594).

In the debate between insurers and medical practitioners, both sides argued that their proposal was more socially desirable than the alternative and claimed to represent consumers. Legitimacy was certainly a resource that both sides aimed to utilise to achieve their goals, and actors targeted groups of consumers to bolster their claims and derive support for their positions. In all cases, the argument centred around whether it was better for consumers if medical practitioners retained their current clinical freedoms, or whether consumers would be better off with a restructuring of the payment and access rules to incentivise increased integration. Finding the right balance between these competing needs and translating them to the needs of all Australians is complex, and a common theme from the participants was that there was little informed public debate focussing on the needs of the consumer.

Legitimacy is derived from the acceptance that your actions are desirable, and therefore, legitimacy is socially conferred by the community (Deephouse, et al., 2016; Suchman, 1995). An organisation is therefore 'more legitimate' when it enjoys public approval. In order to extract legitimacy, or claim your policy is 'more legitimate' than the alternative, a good understanding of the issues of the constituency is needed (Doberstein, 2013; Rindova et al., 2006). Support is then derived from the perceived benefits that constituencies believe they will obtain.

Consumers were clear that they wanted improved value, but this is a broad concept and can mean many things. In each of the cases, research showed that out-of-pocket costs and the growth of premiums were key problems for consumers. Insurers contended that each of the proposed reforms would provide better value for consumers, generally through lower premiums or out-of-pocket expenses. However, Australians provide their elected representatives with mixed signals (Fiebig, et al., 2006). They want increased health services, lower costs, affordable private health insurance for when they wish to be treated privately, and the ability to choose the public system when it is advantageous for them (David, 2017; King, 2018). These mutually exclusive desires are, obviously, problematic for insurers (both public and private). Adding to the complexity of the equation is an inexhaustible demand for healthcare, which clashes with insurers' desire or need to contain expenditure.

The mixed signals provided by the community allowed both subgroups debating the reforms to argue that they represented consumers. In the first case, the proponents argued that the reforms would increase competition, allowing funds to shop around hospitals and doctors and negotiate better deals on behalf of their members (Lawrence, 1994). This was a broad-ranging reform that had the potential to benefit all consumers who held private health insurance through lower premiums. The opponent subgroup ran a campaign focussing on the primacy of the relationship of a patient and their doctor – that this should not be interfered with by insurers. A common view among interviewees was that the managed care campaign run by the AMA was very effective at convincing consumers that doctors held their best interest at heart. The community trusted doctors, patients trusted doctors, and doctors used this trust to extract legitimacy for their campaign.

As the proposals started to narrow in scope, the constituencies that could potentially benefit also narrowed, and the narrative changed from increasing system benefits for all users of healthcare to improving the benefits for a smaller and smaller number of consumers. The debates then became an ‘us v them’ problem. During the second case, actors continued to argue over whose policy represented the consumers’ or patients’ best interest. Whilst the majority of interviewees felt that the reforms were not very important to consumers (2case2), a couple of interviewees argued that there were consumers engaged, but that consumers were interested in different outcomes, which diminished their capacity to present to government a collective position or request for action. Consumers of health insurance are not always patients and are not a homogenous group. This allowed the debate around the legitimacy of the proposal to occur on multiple levels, and it became difficult for consumer groups to develop a narrative to prosecute. Adding to the perspective of multiple messages from consumers in the second case, consumer groups Choice and the Consumer Health Forum initially supported the proposal, seeking better levels of integration and citing international experience. However, their support waned, and they became concerned about a two-tiered health system developing, and eventually opposed proposals that they felt might contribute to one group in society gaining better access to healthcare.

The spectre of a two-tiered system undermining the universality of Medicare was front and centre in the third case. Organisations representing consumers moved very quickly to consider how such a change would impact those with and those without private health insurance and did not support the integration pilot. Despite constant complaints about out-of-pocket costs, the option of creating a system where members could visit their general practitioner and not face an out-of-pocket cost did not sway the consumer groups the

Australian Council of Social Services or the Consumer Health Forum, who aligned with the medical practitioner group. This is despite little observed public interaction between consumer bodies and the AMA in the model.

One interesting finding is that the government's support did not drive higher levels of legitimacy for any of the reforms proposed by the private health insurance industry, and the industry's legitimacy to propose changes to the payment and access rules dwindled until it was clear by the third case that it had reached an all-time low. The opponent group's messaging drawing linkages with an overseas healthcare system that was not socially acceptable in Australia was a successful tactic to reduce the legitimacy of all of the proposals. Legitimacy can be mined by actors as a resource to use to achieve their goals, and the AMA was able to develop and implement campaigns that questioned the motives of insurers, increasing the AMA's control of the system – 'history shows if you do not bring the doctors with you. . . . You are doomed to failure' (Kingston, 1994, p. 10). Interviewees noted the lack of favourable media coverage for all the reforms, which provides further evidence that the insurers did not have sufficient legitimacy from the community to advocate for changes to the system and see them through to implementation (7case1; 4case3; 6case3). The media's tone compounded the messaging from the opponent alliance, claiming the pilot would lead to a 'two tiered system' (Swan & Hunter, 2014, p. 3) and that 'Private Insurance for GPs poses a risk to Medicare' (Harrison, 2014, p. 8) arguably extracting legitimacy from insurers.

8.4.1 Consumer disempowerment

Unfortunately, in each of the cases, consumers quickly became pawns rather than major or powerful contributors. What this study showed was that despite supposedly being the group who would determine legitimacy, consumers were not in control of the conversation or central players in any of the networks. In the first case, the only consumer group included was the least connected to the network. The Consumer Health Forum had a closeness centrality of 0.37 and a betweenness centrality of 0. In the second case, this was increased, as the government paid for the Consumer Health Forum to consult on the changes, leading to a closeness centrality of 0.53 and a betweenness centrality of 30.08. The addition of another consumer group (Choice) into the second case increased their voice; however, Choice had a betweenness centrality index of 0, indicating it was not connected to more than one group. In the third case, there were two groups, the Australian Council of Social Services and the Consumer Health Forum. ACOSS had a closeness centrality score of 0.34 and a betweenness score of 9, mostly due to a strong linkage with the organisation Services for

Australian Rural and Remote Allied Health. The Consumer Health Forum's index of 0.29 for closeness centrality and 0 for betweenness centrality, dropping from the first and second cases, show it was on the outer edge of the subgroup rather than controlling the network.

These lower scores potentially reflect the resources available for consumers' groups, or the fact that these groups may spend more time advocating in meetings rather than publicising their alignment with others in the system. Finally, it could also reflect the tension in the healthcare system that falls from a mixed model. Without a defined role for PHIs in the system, developing a clear narrative for change becomes more difficult (Dobrosak and Dugdale, 2021; Harley et al., 2011). It has been noted that consumer representative groups are funded by the government and that this creates a problem where the groups cannot be seen to be overly critical of the government's ideas (McAuley, in Senate Committee on Community Affairs, 2007, p.CA6).

The cases demonstrated that there was a need to have a clear picture of the reforms prior to their introduction to Parliament to be able to describe the outcomes to the constituency. When numerous parts of the health system were in agreement that reform was needed to fix a particular problem, the reform was much more likely to achieve some of the intended goals. When one actor went out on their own, as in the last case, the reform did not succeed.

8.5 Change over time

Path dependency theory suggests policy lockdown is occurring when previous decisions influence the policy choices available today (Antonelli, 2009). Alternatively worded, path dependency can develop when the costs of change are prohibitive. This research interrogated the level of inertia and the strength of the operation of the payment and access rules and found that the costs of change outweighed the perceived benefits and limited the possible change put forward. The actual change that occurred to the healthcare system was examined to verify these results.

8.5.1 The strength of the institution

A continuous theme stated by interviewees was that change will not happen just because it is allowed to occur. Interviewees noted that once the insurance industry had worked out how they could work within the rules and invested in business models to support this way of working, it was very hard to convince them to change their operations. The level of change required for insurers to move from being passive payers for an episode of treatment to active managers of contracts was considerable. The lack of information technology systems at the

time made the potential transition costly, and without a way of quickly entering a significant number of contracts, it was difficult for insurers to recoup the upfront costs of change in a suitable period. The changes to payment systems were also going to be sizeable. The cost of changing from operating one way to another was so significant that reform was effectively not going to be economical. The costs of change also fell to other parties in the system; medical providers would have lost clinical autonomy and their flexibility in setting prices; hospitals would have lost autonomy in billing. Finally, the government lost some political capital.

The opposing organisations were able to insert additional barriers to change during the implementation of the program, as this was where they were able to effectively vet it. In the end, very few contracts to alter the payment arrangements were agreed as per the initial intent of the legislation. In fact, the low uptake continued for a few years until another variation of the payment model was developed. Practitioners had prevented direct contracting.

The institution that is the operation of the payment and access rules remained unchanged during Case 2, despite legislative changes that allowed PHIs to provide care to people out of hospital and management programs for chronic conditions, as these changes did not allow insurers to contract medical practitioners. The end result was a program that insurers were slow to take up (Biggs, 2013) primarily, it has been argued, due to the limitations of the arrangements reducing the potential return on investment for PHIs (Khoo, et al., 2019). The potential benefits from the chronic care programs may accrue far into the future and potentially to another an entity that did not fund the program (e.g., a reduction in public hospital usage for cancer treatment from private health insurer A's quit smoking program provides a saving for the government that funds the hospital, not private health insurer A). In a similar manner to the previous case, costs were also likely to be borne by other sectors in the system: hospitals would potentially lose patients, and the government faced criticism that their policy might cause adverse outcomes without the benefit of saving on expenditure in the system.

Once again, medical practitioners were able to limit the scope of the changes, effectively ensuring that their role as gatekeepers and their clinical freedom were not changed.

Unlike the first two cases, where a small amount of change in the system was achieved, in the third case, no regulatory or operational change resulted. Medibank Private's pilot program of paying for additional services through a contribution to general practice

management fees ceased in 20 months. At the commencement of the reforms, both major political parties were open to the idea of insurers engaging with general practice. However, that support did not extend as far as amending the regulatory framework to support integration. Once again, costs accrued to almost all parts of the system. For the government, the political costs of supporting the program escalated the longer the program was in operation. For general practice, costs resulted from changing operations, and from the documents of the time and interviewees, the costs for Medibank were both political and financial. After a short but strong public campaign, Medibank Private cited that their members had agreed with the opponents' position that this type of vertical integration would create a two-tiered health system. Thus, the opponents were not only rewarded for their efforts by the cessation of the pilot program, but they received confirmation that their messaging about the barriers that stopped PHI from directly contracting medical practitioners resonated with the public.

In Cases 1 and 3, at the end of the debate, the legislative framework permitted greater integration between insurers and medical providers. In both cases, however, the costs appeared to financially outweigh potential benefits. In Case 2, greater integration with allied health professionals was permitted, and whilst very few programs increasing integration were implemented initially due to high costs, the number of programs has slowly increased (Khoo, et al., 2019). However, the programs permitted under the changes in Case 2 have limited ability to integrate the whole health system, as medical practitioners cannot be included in the programs (National Commission of Audit, 2014; Productivity Commission, 2017).

The current system has placed barriers to integration, requiring an upfront investment that insurers could not be assured they would recoup or profit from. There were political costs for governments that became starker as time progressed. The payment and access rules restrict the options available for insurers to integrate with medical practitioners, and the industry appears to have adapted to the rules given the small amount of actual change that has occurred. Over the 20 years under review, the system withstood three strong challenges, with minimal integration occurring. The cost of changing to a new way of operating – which were both monetary and non-monetary and accrued to insurers, medical practitioners and governments – was prohibitive.

8.5.2 Roles of the insurer and medical practitioner

Interviewees concurred that medical practitioners in Australia hold a fairly good position in the health system when compared with other countries. As one interviewee pointed out, doctors 'have got more freedom than [in] any other country, UK, US' (7case1). General practitioners in Australia control the treatment pathway directing healthcare, and without a referral, a patient may not be able to access tertiary-level services, or their out-of-pocket costs may increase substantially. To increase integration between insurers and practitioners, the roles of insurers and practitioners need to change. In all three cases, the reform proposed an opportunity to alter the roles of insurers and allow PHIs to move from being passive payers of costs to active managers within the healthcare system. Medical practitioners opposed this change in role and wanted their clinical autonomy to stay the same. A shift towards active management by insurers cannot occur without a shift in medical practitioners' freedoms and the actors formed subgroups along these opposing positions.

In each of the cases, there was a proposal to shift the nature of the relationship to allow the insurer to have an active role in the system, which would have altered the doctor–patient relationship. These changes would mean that there was a contractual relationship to look after the welfare of the insurance company as well as the patient, which would change the factors considered when making decisions about treatment. The impact of the cost of the treatment upon the insurer is not a fundamental part of decision-making process at present.

In the first reform, the majority of interviewees noted that the potential scope of the changes was the most significant. Direct contracting of doctors would allow insurers to enter agreements with medical practitioners providing for the amount to be paid to the medical practitioner for the provision of a professional service (in respect of which a Medicare benefit is payable) to an insured patient in a hospital. The opposing subgroup quickly argued that this would extend the role of the insurer significantly, allowing the insurer to determine the scope of treatment and even whether the treatment should occur, reducing medical practitioners' clinical freedom. As one interviewee noted, 'They [the doctors] didn't want to let anyone in the middle of that relationship or directing what they should do. The reforms seemed to give insurers the opportunity to do that' (7case1). In the end, there was no change to the way medical practitioners were paid, and contracting between PHIs and medical practitioners was prevented. After a while, a different solution was proposed that allowed doctors to agree to a fee schedule for a proportion of patients instead of a contract and insurers remained passive payers.

In the second reform, potential changes to increase integration through different models of healthcare were explored. It was clear that the Department of Health was interested in a model of funding that would change how medical practitioners were paid and would be more sustainable in the long run; however, this was not the model preferred by the medical practitioner subgroup, who wished to retain a fee-for-service payment model. The initial policy discussions also included a method to allow insurers to pay for general practice and nurses; however, this idea was removed very early in the development of the reforms. In the end, a small change was made to allow more integration, and the Department of Health argued that a balance was being maintained in the system. The resulting Broader Health cover arrangements did not limit medical practitioners' clinical freedom. The legislation included a specific safeguard to this effect – locking in this requirement explicitly and strengthening this part of the regulatory framework, enshrining the role of medical practitioners and, through this, insurers.

In the last reform, minimal changes to the levels of integration were envisaged. One insurers (Medibank) attempted greater integration with general practice and by funding services and offering their members access to PHI-funded chronic care schemes. The program, it was argued by Medibank, would have allowed PHIs to move from being passive payers of hospital costs to active managers by identifying and offering members chronic condition management programs earlier in their disease progression (Medibank, 2014). Changes to the regulatory framework were not secured, and an opportunity to integrate to a greater level was defeated. In the end, general practitioners flexed their power and retained the same clinical autonomy, allowing referrals to continue unabated, and PHIs, unable to directly contract providers, remained passive payers. The result effectively prevented options to change the payment and access rules in the future.

8.5.3 Public support for the mixed model

Brooks and Manza argued that the path dependency of regulatory policy *constrains politicians from retrenching or removing rules* that benefit certain groups (2007). One of the key notions in path dependency is the concept of increasing returns (Antonelli, 2009; David, 2004). This describes a self-reinforcing process with a spiral form of dynamics that can eventually lead to a 'lockdown' or 'inflexibility' (Bennett & Elman, 2006; Djelic & Quack, 2007). Positive or negative self-reinforcing feedback mechanisms can come from the environment by way of reinforced social expectations for both governments and industry alike (Brady & Bostic, 2014; Pierson 2004). When a lockdown occurs, other alternatives cease to be feasible (Pierre, 2009).

In each of the three cases, a change in the operation of the payment and access rules would have allowed PHIs to directly contract (vertically integrate) with medical providers and move to a more active manager of healthcare. The universal healthcare system in Australia, Medicare, sets the medical practitioners are paid under its payment and access rules. These rules provide for a payment model that is predominantly fee-for-service, thus disincentivising the level of integration required to manage a community where chronic conditions are becoming more prevalent. In Australia, the policies around private health insurance are nested within the fee-for-service framework under Medicare (Kay, 2007). It is the dependent relationship that private health insurance has with Medicare which needs to change for PHIs to become active managers in the health system, more efficient and more viable.

The relationship and tension brought about through the mixed model of insurance were remembered by interviewees. The majority of the interviewees commented on the tension inherent in the system; as one stated, this 'goes to one of the broad discussions that Australia has never resolved, which is the role of private health in the Australian system' (6case2). One stated, 'There is a dominant public system, but whether there is a role for private health and what that should be wasn't resolved during the 2010 Roxon reforms and is one of those things that you almost don't talk about' (4case3). 'The essence comes down to how to view Medicare and PHIs – is insurance a significant part of the system, is it complimentary, how far can PHIs intrude into the Medicare market without compromising Medicare[?]' (6case2). Changing the payment and access rules would alter the roles of both insurers in the mixed model, reducing the freedom of billing that comes from no contracts for medical practitioners.

At the commencement of the 1995 reforms, some researchers into the health system in Australia advised that there was an option of simply allowing the private system to die a natural death and move the funding into the public system instead of reforming the insurance system. This option was not considered by either of the major parties, as it was perceived to be a vote-loser (Jurman, 1995). Closing down the option to move from a mixed model of insurance, the then-government, when introducing the reforms, noted, 'the private health industry is an important and successful part of our health system' (Lawrence, 1994, p. 3).

In Case 2, whilst large shifts were considered in the early stages of policy development, such as capitation payments, these ideas were quickly removed. The relationship in the mixed model was summed up by the Department of Health as 'a strong and vibrant private health

sector complements and balances the delivery of health services through the public system, which in turn is underwritten by the universal access provided by Medicare', further noting that 'the Australian Government has a strong ongoing commitment to Medicare, and the proposed legislation does not in any way weaken this commitment' (Department of Health and Ageing, 2007, p. 2).

By the time the third case concluded, there was limited political interest in changing the relationship between PHIs and Medicare. Both political parties supported better integration as a concept but were unclear on what this meant and what it might look like. Contrasting the two previous cases, where the opposing subgroup successfully prevented implementation, the strategy in Case 3 boldly sought to propose greater regulation to prevent a change in the way they are paid by introducing a Bill to Parliament. This attempt to strengthen the barrier to direct contracting of medical practitioners failed too, and the operation of the payment and access rules remained stagnant.

Adding to the evidence that lockdown is occurring in Australia's healthcare system, many interviewees commented that the federal government 'doesn't seem to have the mind for major insurance reform; rather, they have tried with various other things to improve broader imperfections in the health system' (7case1; 2Case3; 4case3). Interviewees also noted that from the government's perspective, it is very difficult to obtain agreement for reform (3case3; 4case3). 'How we shift money to the best location hasn't been able to be solved anywhere' (3case2). Medicare is synonymous with healthcare within the community, and any changes need to have a clearly defined case. In the first two cases, the failure to alter the operations of the health system led to the introduction of incentives and penalties to encourage the uptake of insurance to prop up the industry and reduce viability issues. In the final case, tweaking of existing incentives followed. The incentives are significant, with the major one, the private health insurance rebate, forming 7 per cent of the federal government's total Health Budget for 2023–24 (The Treasury, 2023).

Bolstering the argument of lockdown is the community's expectation that PHIs and Medicare must operate together in a mixed model. Both major parties see a role for private health insurance as an essential part of a balanced system comprising both public and private healthcare (Plibersek, 2012, p. 263). Politicians are aware of the status of the system, so much so that Labor named its primary care organisations 'Medicare Locals', despite the fact they have nothing to do with Medicare (Doggett, 2013).

The inability to make changes to the actual operation of the system through changes to the payment and access rules provided a feedback loop, whereby in each attempt the amount of integration achieved lessened until, in the final attempt, no integration was achieved. This feedback over multiple attempts over multiple decades indicates that there is unlikely to be a change in the relationship with the dominant path of universal healthcare (Medicare) and that lockdown of that path has occurred. Alternatively put, lockdown can be demonstrated through the presence of self-reinforcing mechanisms, or the increase of a certain variable leading to a further increase of this very variable (Fouda & Paolucci, 2017). Over the course of the cases, barriers to reforms to incentivise integration grew until no change was achieved. Cementing the notion that alternative options had ceased to be politically acceptable was the public acknowledgment by Opposition ALP Health Minister Catherine King that 'Australians value Medicare highly and changes to the payment model are politically difficult' (King, 2014, p. 2).

The mixed model of insurance, without a sustainable management role for private health insurance in the Australian health system, appears to be the policy framework that has been locked in across the three cases. This preference, combined with the limited options politically available and a powerful constituency with an interest in maintaining the current payment and access rules, has constrained politicians from changing the financial benefits allocated under the program. The reforms could not be implemented in a viable manner.

The acknowledgement by Australia's two major political parties that it is difficult to pursue a policy agenda of changing the roles of PHIs and providers leads instead to moving towards a policy of subsidising PHIs to appeal to mass policy preferences. Combined with an unwillingness to make changes that might be perceived to undermine Medicare, the two political parties appear to acknowledge societal expectations of a health system wherein PHIs and Medicare must continue to operate together in an unsustainable model.

8.6 Conclusion

In each of the cases, the actor network formed two major subgroups: one with a view to keeping the current payment and access rules and one that desired a change to a more integrated system. Although the structure of the actor network changed in each of the cases, this did not appear to have a material impact on the outcome of the reform. It has been argued that lockdown of a path can be broken if the network is expanded to include new participants and ideas (Crouch & Farrell, 2004; Garud & Karnøe, 2001). However, there was a reduction over time in the number of potential actors who were involved, and this trend may

stifle future efforts to obtain new ideas. This is of concern for future policy development in this area.

Building upon network theory, gaining a broader perspective from a less dense network is more likely if new actors enter the network and can bring an alternate view (Garud and Karnøe, 2001). Therefore, accessing diverse forms of knowledge depends on how broad the group of organisations are and their respective agendas. Across the cases, we saw that creating coalitions within the network with likeminded people only served to build the power of the central actors.

The system created a large constituency that benefited from maintaining the status quo; this group developed alliances, shared information and formed a formidable and powerful subgroup to advocate against each reform. As the proposals started to narrow in scope, the constituencies that could potentially benefit also narrowed, reducing the number of people who could benefit without a proportional reduction in the potential 'losers'. Thus, the constituency that benefited from maintaining the operation of the payment and access rules grew in comparative size, increasing its power.

Across the cases, the AMA continued as the key central actor of one of the two subgroups. Over the course of the cases, there was an indication of a phenomenon where network power distribution over the longer run continued to reconfigure until it became asymmetric. The operations and structure of the network then exhibited a symbiotic relationship where power was able to build upon itself. The role of the insurer and provider did not change materially throughout the cases. In each instance, there was an opportunity through changing the payment and access rules to incentivise coordination by allowing the insurer to directly contract medical providers and actively manage healthcare provision. Lockdown of a policy path occurs when the industry has adapted and the costs of changing to a new way of operating are prohibitive. In these three cases, we saw that the potential return on investment was not sufficient for insurers and medical providers to alter their operations and take advantage of the opportunities for better integration. Without it appearing to be viable or prudent for any part of the industry to pay for the change, the change became less attractive for government. Costs also accrued to the governments of the day (both Labor and coalition) as they bore political pain from each of these reforms.

However, in the end, medical practitioners retained the same level of clinical autonomy, allowing referrals and treatments to continue unabated, and PHIs remained passive payers.

Governments of both persuasions appear to be constrained from reforms that might be perceived to reduce benefits to any part of the system. From the government's perspective, it is very difficult to obtain agreement for reform. The feedback from the constituency provided to political parties has been that attempting to change Medicare is dangerous and the mixed model, as it currently operates, is preferable.

Major changes to the relationship between Medicare and PHIs were not envisaged by either major political party after the 1995 case. There is a dominant public system, but whether there is a role for private health and what that should be were not resolved over the time of these cases and have not been considered in depth since. There has been a decided shift in policy from improving the effectiveness of private healthcare provision towards a system of financially supporting the industry through carrots and sticks – thereby propping up the system rather than encouraging PHIs to become more effective by becoming active managers within the system. Medicare and PHIs have to operate together in an undefined manner.

This research shows how segments of an industry may arrive at a lockdown that confronts them to break out from a dominant and seemingly irreversible path; it also shows that the powerful actors in the network can manage the network's operations to support their strategic interests, thus ensuring the institution's continuation. The next chapter situates these research findings, drawing on the combined application of network, RDT and path dependence theory. The thesis concludes that lockdown of the operation of the payment and access rules has occurred along with the unique Australian mixed model of insurance. It finishes by discussing the role of private health insurance in Australia and the implications of its dependent relationship with Medicare on its role in the healthcare system. The next chapter also notes areas where further research is warranted.

9 Stickiness and Stuck

9.1 Introduction

This research began with an interest in changing financing policy for healthcare in Australia. I started with questions around ‘Who is responsible for regulating the amount of vertical integration occurring in Australia? What do all the stakeholders think is the ideal amount of integration? What roles are the various stakeholders playing in this space? What is the ideal amount of vertical integration for society, or perhaps, can the right amount be calculated?’ A kind friend pointed out that these questions were much larger than could be researched by one person completing a doctorate.

I narrowed the question significantly to understand how a network of actors have operated to prevent a change to the payment and access rules in Australia to prevent direct contracting, and further refined it to:

1. What role have collectives of organisations (actor networks) played in enabling or constraining policy change in Australia’s healthcare financing policy?
2. Is there a relationship between any change in the structure of the actor network (i.e. who has power and what relationships exist between actors) and success in attempts to alter the operation of the payment and access rules that set how insurers can pay medical providers?
3. What does this tell us about the role of private health insurance in health financing in Australia?

This research is not about private health insurance. It is fundamentally about how actors in Australia’s healthcare system have sought to influence the payment and access rules governing the system. This question is important to both the public and private systems, as the current rules are a barrier to integrated care and patients in both systems deserve joined-up coordinated care.

Over the past three decades, networks have become a prominent feature of international public policy (Bevir & Waring, 2018). This research explored in depth how different actors worked together, what resources they used, and how the coalitions or subgroups achieved their strategic aim of preventing integration between private health insurers and medical practitioners. This chapter brings the threads together, first explaining why this study is significant and highlighting its contribution to the field (section 9.1). It then reflects on the findings and limitations of the network approach used in the thesis and the additions of path dependency and resource dependency theory in the analysis (9.2). The chapter then explores the role of consumers in the reforms over time, and reflects on opportunities to strengthen consumer engagement (9.3). Finally, the chapter reflects on the role of

private health insurance in Australia and the need for reforms that offer better coordinated care for people with chronic conditions, and a more efficient health system (9.4 and 9.5).

9.1.1 Why care – why explore barriers to changing the financing policy?

The issue of a potential gap between the demand for healthcare and the system's ability to deliver services in Australia remains an issue for the bureaucracy and politicians alike (National Commission of Audit, 2014).

It has been argued that there are alternatives that governments, policymakers and the industry can utilise to create a health system more appropriate to the changing health needs of the community (North, et al., 2015). Many options have been considered to manage costs; some have focussed on further rationing of healthcare funds to contain supply through to the application of co-payments to dampen demand, whilst others have considered how to re-allocate resources by redesigning programs to better manage chronic conditions (National Commission of Audit, 2014).

Structural arrangements are primarily about the relationship between provider organisations and insurers. A poignant question for operators of service providers and operators of health systems is the extent to which organisations should be separate entities, or whether they should form networks of different levels of complexity and integration. The structure of such systems will determine the method of access for a treatment, for example by instigating gatekeepers for secondary-level services. Research by Shortell suggests that changes to the payment model can lead to structural changes in healthcare delivery (Shortell S. , 1988).

Under the current structure established by Medicare, demand for services is controlled by general practice, as they determine the treatment pathway (who is referred to where and for what service). Practitioners have always argued for clinical autonomy: the right to refer and treat as clinically determined by the practitioner. This is now enshrined in legislation. An insurer's business is reliant on the behaviour of general practitioners, as they influence decisions around patients' long-term health needs and therefore claims on insurance funds. Insurers must pay for treatments covered by an insurance policy, which removes a price signal for practitioners when determining treatment options (OECD, 2019).

The resource that determines who controls the treatment pathway is the payment system and access rules. The payment and access rules prevent PHIs from paying benefits to directly contract general practice. The rules do not prevent private health insurers from using their non-premium-based income to operate or own general practices, and this gives insurers some scope to vertically integrate

and provide support for patients with chronic conditions. Changes to these rules could allow insurers to move to a more active role where they could influence who received what treatment (access).

To incentivise increased integration, insurers have advocated for more control over provider behaviour by influencing primary-level gateway services. This, they argue, would remove low-value care and reduce patients' out-of-pocket expenses (Australian Health Reform Alliance, 2017).

Moreover, it would help manage the significant change to the demands on the healthcare system for the more than 11 million Australians who have at least one chronic condition, and the one-quarter of the population who have two or more of them (McKinsey & Company, 2010). The current fee-for-service system that was designed for episodic conditions does not incentivise the coordination or integration of healthcare needed by people with multiple chronic conditions and is no longer appropriate (Senate Committee on Health and Ageing, 2006).

It remains important for Australia to consider how to best reform the healthcare system – not only to make it more efficient, but to improve the outcomes of Australian citizens. The current system places a barrier to the integration of care through the operation of the payment and access rules which prevents direct contracting of primary care providers by insurers (public or private), with the resulting fragmentation of care disadvantaging those who are least able to advocate for joined-up care. Despite the inefficiency and inequity of the current system, there does not appear a willingness to alter the system one way or another.

9.1.1.1 Reform is possible

Reform in healthcare financing policy is possible by allowing direct contracting of medical practitioners. It has been observed from overseas examples that there are many types of restructuring that can be achieved. In some cases, these are large-scale reforms that impact the whole of the country's population, for example, in Germany, the Netherlands and New Zealand. This has included amending the policy settings to encourage coordinated approaches for care in conjunction with financial incentives (Germany) or payment model changes (the Netherlands) (Vrijhoef, 2012). Other reforms have had smaller populations but also managed to achieve greater coordination, such as Kaiser Permanente in the United States of America. All of these models show the potential for better care that Australia could achieve.

9.1.2 Contribution

It is hoped that this research will be useful to policymakers and practitioners in a number of ways. The prevalence of chronic conditions is continuing to grow in Australia (Dennis, et al., 2008; Harrison, et al., 2016). Moreover, it is unknown what the impact of COVID-19 will be upon future generations, as the prevalence of long COVID is unclear, its incidence is unknown, and the severity of disease is

unknown. What is known is that there will be increased demand upon healthcare services into the future, and the people who have contracted long COVID will need to compete with those who have other chronic conditions for limited resources (National COVID-19 Health and Research Advisory Committee, 2022).

Second, there is no argument that the health system cannot function more effectively, nor is there debate about whether the system can become more patient-focussed, but what this looks like in practicality and how to obtain changes to the healthcare system to increase integration remain debated topics (Blecher, et al., 2020). There is a need to refocus the health system from one that is currently dominated by the treatment of acute disease to a system that prioritises prevention and managing chronic conditions, delaying disease progression, avoiding hospitalisations and improving patients' quality of life (Primary Health Care Advisory Group, 2015). Previous research suggests that incentives through the payment and access system can be used to modify behaviour and develop models of care that reduce fragmentation, reduce waste and duplication, emphasise prevention and slow the progression of chronic conditions (Institute of Medicine (US) Committee on Quality of Health Care in America, 2001; Mollica and Gillespie, 2003; Song, 2014).

I could not have known when I commenced this research how different society would be at the end. The COVID-19 response has required significant funds from the government and has left the Australian people with a sizable national debt and a potential recession (Jomo & Chowdhury, 2020). Gaining better value for money from the health system, one of the largest federal government expenses, would appear to be a prudent part of managing the federal budget going forward. Therefore, understanding how to change the healthcare system is not only beneficial for private health insurers but for the system as a whole. Medicare is here to stay. Given that it appears to be an enduring system, gaining the best health outcomes for the taxpayers who pay for it should be a reasonable goal in itself. More importantly, though, providing the best care for people with chronic conditions is a goal worth achieving.

This research commenced with an aim to review the operations of a network when actors debated a policy proposal. In the beginning, I had assumed that only a few actors were a part of the debate. In hindsight, this was particularly naïve. Consistent with Sabatier's (2007) description of a policy network, the enduring nature of the fundamental structure of the policy network became evident across the cases; however, the structure transformed as a policy event began to become more defined. The network appeared to hum along under the surface using minimal amounts of resources, and then actors ramped up their efforts when a policy event demanded action.

As it transpired, I had started this research at the end, when the opposing team appeared to have won, and insurers started to consider alternative options for improving their viability. But the end is not the best place to start to understand why something cannot be changed, where the barriers and blockages lie in improving the healthcare system. To understand the policy path, and how we got here, one must go back to the past. To do this, I added path dependency theory, as it provides a framework to answer the question: What makes some policies persevere over time? Combined in an theoretical framework with network and resource dependency theories, I consider the role of actors in creating barriers to reform.

9.2 Power

9.2.1 The Structure of the network and power

As has been discussed in this thesis, power is a relational concept; it can be wielded by markets, communities and associations. Power can flow through networks (Foucault 1980) or be put into action by actors in networks (Latour 1986). When a policy issue enters the policymaking agenda, advocacy organisations are incentivised to increase their efforts to influence policy decisions (Leech, et al. 2005). Given the aim to influence policy decisions, power can be defined as achieving collectively binding decisions, regardless of whether the source of power is located within the government or not.

Actors in policy spheres do not operate in isolation and often seek to develop policy coalitions (Sabatier, 2007). This phenomenon can be studied from the strategic or institutional perspective. Researching policy coalitions from the perspective of the nodes' strategic conduct is akin to a policy network approach (Arts & van Tattelhoeve, 2004). Working with others is considered to be a strategic choice by actors applying a resource to achieve their goals (Leifeld & Schneider, 2012).

Throughout the cases, we saw one actor deploy this strategy with remarkable effect by developing a strategic set of relationships that often included consumer groups. Whether alternative outcomes might have been achieved if the private health insurance sector had developed stronger relationships with consumers remains a question. Path dependency and path-breaking theory suggest that actors can obtain diverse amounts of knowledge through their linkages with actors that are members of other networks (Crouch & Farrell, 2004; Steel & Weber, 2001). However, the findings of this research showed that the converse is also true. The practice of expanding the network to grow the subgroup did not result in a diverse field of ideas but resulted in a more diverse group of constituents supporting the central actor's position, strengthening the claims of the central actor and therefore their power. This network analysis showed that in a political arena, an actor can draw upon other actors in diverse fields to bolster their position to lock down a policy. Over time, the cases

showed an increase in the status of the government officials publicly supporting the reform, from the Health Minister to the Prime Minister. This was to no effect, as the cases also proved easier to vet over time – again showing the locus of power was external to the government of the day.

Power can be regarded as the ability to mobilise resources in order to achieve outcomes; it can also be a structural phenomenon of a political system (Scott, 2017). Interestingly, this research found that across all the cases, power did not rest with the consumers or their representative groups. The consumers' inability to determine a clear advocacy position or a clear ask of government meant that other players would speak on their behalf. Power is about autonomy and its inverse dependency, and it would appear that consumers as a group were highly dependent upon others to be their voice in these debates.

Policy feedback is a circular process by which actors influence policy outcomes and policy influences actors' behaviour (Bennett & Elman, 2006; Pierson, 1993). Over the course of the cases, actors tested potential changes to the payment and access rules and learned that society expected that the complementary policies of medical practitioner clinical autonomy and preventing PHIs from managing the treatment pathway were to be maintained. Path lockdown can be found when there are increasing returns, which then leads to a distribution of gains question: 'Returns for whom?' (Bennett and Elman, 2006). Each successive attempt at reform was smaller in the size of the attempted change, and the amount of change implemented also diminished between Case 1 and Case 2, with Case 3 failing to make any change to the system. Demonstrating lockdown, the group supporting lockdown of the payment and access rules required fewer and fewer resources to successfully deflect attempts to reform the system. Each attempt resulted in a strengthened policy position for the opposing group and locked down clinical autonomy, effectively locking out vertical integration. A reduction of potential actors who could contribute alternate ideas also occurred over time, perhaps reflecting their assessment of the value of investing in the debates, and this trend may stifle future efforts to obtain ideas, as actors will only invest in idea generation when there is a perceived chance of these ideas gaining traction.

Network analysis as a theory has been criticised for being too unstructured or fragmented (Dowding, 1995). One of the more interesting, but perhaps not surprising, findings in this research is the value of establishing a good methodological framework for conducting network analysis. There is an inherent tension between conducting exacting in-depth case analysis and the need to review a few cases in order to explore the impact of networks over time. In a resource-limited piece of research, endless interviewing of all identified nodes could not occur, and the identification of key actors who could be interviewed became critical. The document review process identified key actors; however,

the interview process identified other actors who were described as playing a critical role but did not have a public presence. Inserting these actors after the construction of the network models from the documents proved difficult, and they were included in the results through the process of merging the qualitative data with the results of the quantitative network models. Following Wishaar et al.'s (2015) approach, the network models focussed on the organisations that represented larger constituencies; and then drew upon interviews to add depth to the findings. Key actors were highlighted who were significant to the reforms by either establishing the potential change, garnering support or blocking that change (Wishaar et al., 2015).

The use of people and relationships in a network was highlighted by the 1995 case, which showed that the AMA's influence reached far and wide. This capacity to draw upon a wide-ranging and covertly powerful network allowed the AMA to establish itself as a key representative of the medical practitioners. Feedback (or relative benefits) comes from the environment; it may come in the form of increased profits solidifying a company's decision or increased power and legitimacy strengthening the institution (Pierson, 2004). Across the cases, we saw the AMA increase its power as an advocate and cement itself as the key advocate for the medical profession. 'History shows if you do not bring the doctors with you. . . . You are doomed to failure' (Kingston, 1994, p. 10).

It would be fair to say that network analysis methods have some flaws. Most importantly, it is impossible to completely rule out that there was an exogenous event that influenced the course of these cases. Whilst all efforts were made to understand the environment in which the network operated by reviewing the literature of the time and interviewing a broad range of actors, the network analysis must be read with its limitations in mind. Having said that, the network analysis has brought to light the relationships in the advocacy space around healthcare provision. Most importantly, I believe it illustrated that the AMA, despite its reputation of being a lone and powerful advocate, derived its power in these big debates by using its resources to expand its network and, through this, effectively expanding the constituency it represented. The operations and structure of the network turned into a symbiotic relationship where power was able to build upon itself, and during the last reform, we saw actors quickly partner with the stronger group (Farrell & Newman, 2019).

The network analysis also showed who had resources and who did not. It allowed for a visual representation of the relationships and the importance of key actors. Most importantly, the cases showed that, contrary to what network theory would predict (Laumann, et al., 1985; Yan & Ying, 2009), a reduction in centrality does not necessarily lead to a reduction in power.

Finally, the network analysis, through both the documents and the interviews, highlighted an unexpected finding of the role of the consumers in the reforms. It showed time and again that consumer organisations were on the periphery. The conversation was about the consumer, not with the consumer. Theoretically, legitimacy and power should come from representing the consumer, yet this network analysis showed that legitimacy actually was derived from controlling the narrative. Interviewees noted that the private health insurance sector had difficulties engaging with media, and this made it very difficult for insurers to justify what they wanted to achieve and why.

Interviewees noted that in each of the cases, a clear understanding of the potential benefits of change was outweighed by the fear of change. What became apparent from the cases is that to be successful, any reforms that propose to change the current financing policy will need a strong coalition to be established to counter the strength of the coalition that will form to oppose the change. This coalition will need to have the agreement of consumers or be led by a consumer body that is adequately and independently funded. Consumers should have a say in how their healthcare system is designed. However, at this point in time, there appears to be an inequality in who represents the consumer's voice in the system.

9.2.2 Power and path dependency

This study considered the perseverance of the operation of the payment and access rules, more specifically the inability for private health insurers to directly contract medical providers, despite many attempts to change. Path dependence was brought in due to its ability to explain institutional perseverance (Garud et al., 2010; Vergne & Durand, 2010). The path dependence mechanisms have shown that powerful actors have removed policy and implementation options, resulting in a way of operating that cannot be changed. Garud and Karnøe, (2001) posit that path-dependent processes can change when actors mindfully deviate; however, to 'deviate', actors need to work with others in the system, and this leads to the need to recognise the impact of power, particularly in the field of policy and politics (Kay, 2005).

Path dependence started as an economic theory and was readily applied to the fields of political science (Bennett & Elman, 2006). Politics differs from economics – there is value in collective action (Pierson, 2000). The goods that may be produced may be public goods, and obtaining an outcome requires coordination. Social policies have an added variable in that there are many constituents that may benefit a small amount from a change over an indeterminate time in the future, and this needs to be balanced against the voice of a small group who may be disadvantaged to a large extent by that same change. Political decision-makers operate in a different environment to business operators. They need to decide who the winners are and what price the losers must pay. Moreover, politicians

need to ensure that they are on the winning side, as losing can lead to significant consequences. Also, unlike in business, changing strategy midway can be disastrous. Through this research, it has been shown that political masters can avoid choosing a side. Most disturbingly, it was not clear that the constituency that is the general public was actually a primary consideration – this is explored in detail below.

It was the power of one group to prevent another group from doing something that was permitted under the law that first piqued my interest. Policymaking, it has been noted, has changed in some Western countries over the last few decades. This is because of shifting power relations between governments and private actors. The state was the major actor in politics up to the 1970s; however, since then, society's stakeholders have strengthened their influence. Scott (2000) argued that the resources relevant to holding regulatory power are dispersed, and capacities derived from owning or controlling key resources are not necessarily exercised hierarchically within the regulatory space. Deregulation and the location of regulatory authority in private bodies reflect a style of government that is less intrusive and shift its role to directly providing fewer services but maintaining broad oversight and legal frameworks (Power, 1994, p. 12).

9.2.3 Three players – in theory only?

Cutler (2017) discusses the three-player market in healthcare necessitating three transactions to take place to procure the good. This research explored the network at an organisational level, primarily as the actors within the network have all formed member bodies, collectives or other representative bodies that, generally, operate as a block or singular entity when debating policy.

Theories of transitivity or structural balance suggest that particular patterns of positive (support) and negative (animosity) ties can occur between actors in a network (Hafner-Burton et al., 2009; Wasserman and Faust, 2008). Basically, the friend of my friend is my friend, and the enemy of my enemy is also my friend (Hafner-Burton, Kahler & Montgomery, 2009, p. 567). In network theory, structural equivalence predicts that actors in similar structural positions in relation to other nodes will behave in a similar manner. There is a greater likelihood of actors forming ties if they are not in competition for resources (Cao, 2009; McPherson et al., 2001; Silverman 2000).

Any reforms to the healthcare market therefore will impact three distinct, but co-dependent, stakeholder groups. These interconnections make determining new courses of action difficult. A three-player market suggests that in a trilateral dependent relationship, each of these groups needs each other, and therefore power should be relatively equally distributed. However, because of the mixed model of insurance that effectively insists on double-insuring a proportion of the population,

consumers don't really 'need' PHIs. Thus, the presence of Medicare reduces the power of the insurance industry.

It is interesting that in each of the networks that debated the reforms, the industry groups representing Cutler's (2017) three players divided into two camps during the policy event. Intuitively, if one subgroup has two out of the three players, they will be the stronger subgroup or coalition. Customers who hold private insurance basically have insurance through two systems, and there are therefore two insurers for the vast majority of hospital services utilised by patients – perhaps dividing consumer loyalty. The research indicated that it was difficult for PHIs to build a narrative that they represented healthcare consumers; this may have occurred as consumers in Australia also have a relationship with Medicare, the other funding source. The interaction of the two funding sources and the interdependencies that fall from the relationship of PHIs and Medicare mean that changes to one impact the other. It became difficult for PHIs to convince consumers to side with their policy, potentially due to this complexity, and interviewees noted a lack of 'informed debate' (3case1; 4case2; 2Case3). Without being able to demonstrate that they had a large constituency with an interest in improving benefits, PHIs were unable to influence politicians and their decision-making to obtain favourable outcomes when a disbenefit was perceived to accrue to consumers (Brooks & Manza, 2007; Korpi & Palme, 1998).

One of the more interesting aspects of the Australian political landscape is the absence of a consumer group that represents consumers who are privately insured. It is clear from the outcomes of these cases that there is a significant proportion of the Australian public who value private health insurance, but that group has not coalesced. Despite the lack of a group representing these private health insurance consumers, there is a political reticence to allow the industry to collapse, and successive governments have propped up the industry through significant financial support. Further research should be completed to see if strengthening consumer groups would allow the proposals around changing the operation of the payment and access rules to be debated with more rigour.

9.3 Consumers and reform

This section reflects on the findings of the research for engaging consumers in future reform.

Consumers buy insurance directly and, as a result, notice every increase in premiums. Insurance, it is claimed, is becoming less and less affordable (Private Healthcare Australia, 2016). In response to premiums increasing beyond inflation for the past decade, Australians have progressively purchased cheaper products that provide less cover due to exclusions and co-payments (limited benefits) (Australian Prudential Regulation Authority, 2018; Silverster et al., 2018). Increasing premiums to cover increasing demands for healthcare have created what is known as a 'death spiral' where

people adversely select out of private health insurance, leaving an ever more expensive group of members.

Consumer dissatisfaction with the system was part of the genesis of each of the reforms; however, consumers' inability to develop a clear narrative and argue a position revealed two problems. Firstly, the resources for advocacy were unequally distributed. The bodies that advocate for consumers are often poorly funded and under-resourced when compared to industry bodies. Compounding the lack of resources, consumer groups may rely on government funding, and this will limit how critical of any government policy they can be.

The second problem is that consumers are not a homogenous group. The mixed model of insurance in Australia effectively ensures that one group of consumers' interests are at odds with the others'. The regulation to prevent private health insurers from paying medical practitioners directly was supported, as there were concerns that allowing private health insurers to provide benefits for general practice could create a 'two-tiered' health system, where privately insured patients had better access to general practitioners while waiting times for public patients increased (Productivity Commission, 2015, p. 65). There remain concerns that improving access to primary care for private health insurance members would decrease the pro-poor and progressive nature of the Australian primary healthcare system (Van Doorslaer et al., 2008, p. 107). In particular, those with private health insurance might enjoy privileged access to services and create over-servicing, as the price signal normally applied to this segment of people in the market would be removed. Publicly insured people might be forced to the end of the queue, but only if private health insurers were prepared to pay more per episode of care than the current bulk-billing benefit. There is also a risk that general practitioners would increase fees or reduce the proportion of services that were bulk-billed (free for patients) if these were mostly covered by insurers (Productivity Commission, 2015, p. 65).

There is a lack of trust by consumers of large financial institutions in Australia, and the private health insurance industry is no exception. Consumers would like better value, but this requires insurers to understand the customer and develop services. Insurers have a difficult task ahead of them to convince consumers that they should be able to access or hold significant amounts of data that would enable them to help develop more detailed coordinated healthcare programs and actively manage a person's healthcare. Consumers, particularly after the recent Medibank data breaches, are even less likely to agree to hand over further data now. There is an inherent distrust among the public of handing over health data, particularly to insurers (3case2).

Adding to the issues caused by a lack of homogeneity are a group of people who do not engage in the health system until they need it. One interviewee remarked that they

didn't think there are 'consumers' as such. . . . There are 25 million of us, and half have [private health insurance], 43 per cent have hospital [cover], only 4 or 5 per cent use it, so the great mass of Australians couldn't [care] about this [issue]. Only half of us have insurance, of that, 45 per cent have the cheapest possible insurance they possibly can, the other 45 per cent have the insurance they want – so you are talking 45 per cent of 45 per cent (or 20 per cent of the population). A third of them are probably children, so you are talking 14 per cent have health insurance that know about, and care about and might use [it]. (5case3).

Finally, there are concerns that allowing PHIs into the primary care market would reduce clinical autonomy and that insurers would interfere with the doctor–patient relationship by attempting to control which medical services a patient can receive (Doggett, 2015; Productivity Commission, 2015).

9.3.1 How to engage consumers

Interviewees noted that it is very difficult to have an informed conversation around healthcare and future expectations of the system. The health system is a highly technical set of rules, and if you change one aspect, there are bound to be unanticipated follow-on effects. Perhaps due to this complexity, a plethora of consumer groups have emerged, each one putting forward a list of individual demands and competing for scarce resources. Consumers may need to be supported to find a voice to have these conversations: one method that may be useful to move the conversation forward is a process called constructive conversations.

Deliberative processes are built upon the premise that a properly informed section of the population can deliberate effectively with a view to making a contribution to policymaking that accurately reflects broader community beliefs (Degeling, et al., 2015). Research has found that if used productively to test stakeholder group or broader community views on health policy parameters, deliberative methods can strengthen and legitimate policy directions (Carman, et al., 2015; Davies et al., 2006; Russell & Greenhalgh, 2009). It has been argued that deliberative approaches may provide increased transparency when discussing the multifaceted, ethical aspects of resource allocation and policymaking and could therefore be more appropriate for conversations around how to alter the payment and access rules (Hodgetts, et al. 2014). Unfortunately, the findings from this research indicate that there does not appear to be much appetite from government of either persuasion to commence a conversation around reforming the payment and access rules.

9.4 PHIs in the mixed model

Some theorists argue 'that policy networks, as a result of previous political decisions, produce certain interactive routines, modes of interest intermediation and decision making' (Dohler, 1991, p. 238).

This ‘sedimentation’ of prior policies, which are likely to benefit particular actors, is a process that closely mimics the concept of ‘lock-in’ (Arthur, 1989; Knoke, 2016) used by economists to explain the persistence of certain technologies, notwithstanding the availability of other options in the environment. The policy framework surrounding Australia’s current mixed model of insurance is vague and ranges from supporting people who choose to contribute to their healthcare, to supporting the insurance sector, through to reducing the burden on public hospitals (Biggs, 2013; Harris, 2013; Private Healthcare Australia, 2017). Perhaps it is best described by Kay (2007, p. 584) as ‘universal health cover plus choice’.

Private health insurance in Australia has grown as a uniquely complementary and supplementary system to the universal health cover provided under Medicare, duplicating the Medicare system for in-hospital services (Colombo & Tapay, 2003). Under the original design features of Medicare, private health insurance would ideally support the public hospital sector by providing hospital (secondary/tertiary-level) services.

Private health insurance in Australia has a curious relationship with Medicare. Private health insurance is presented as an alternative to Medicare, but it generally does not dissuade public hospital usage. This may be because insurers want members but would prefer them to use the public system, thus not drawing down benefits. All in all, successive governments have decided that maintaining ‘a balance’ is important. One of the designers of the Medicare system said:

I think one of the big mistakes, which I have regretted for many years, is that Medicare is viewed as the public hospitals and the medical benefits system, or the medical benefits schedule. But Medicare is a system – it is not just that bit – and it includes the private hospitals and private insurance. [Private Health Insurance] should be regarded as part of the system. It should be made to integrate with the system and be designed to integrate with the system. (Prof. J Deeble in Senate Standing Committee on Health and Ageing, 2006, p. HA46)

In the absence of changes to the regulation of PHIs or additional government funds, PHIs will become unviable. The number of Australians with private health insurance hit an 11-year low in 2018, despite a 1.6 per cent uptick in private hospital visits in the December 2018 quarter (Australian Prudential Regulation Authority, 2018). The consumer value proposition for private health insurance remains difficult to define. Greater flexibility and choice appear to be the main benefits espoused by the industry. However, the current method of reducing outlays, for example, preferred provider arrangements for ancillary services (encouraging the patient to use a practitioner of the fund’s choosing rather than their own practitioner) would appear to be removing choice. Controlling the demand for healthcare provision in the tertiary sector is critical to the insurance sector’s ongoing

viability, and this too contradicts the value proposition, which is basically the provision of faster access to hospital care for members when they need it.

In each of the reforms, insurers advocated for more control over provider behaviour by incentivising integration with a view to dampening demand for tertiary-level services, removing low-value care and reducing patient out-of-pocket expenses. Across the course of the cases, the understanding of the operations of the payment and access rules upon the structure of the health system matured, and the insurers' attention turned to general practice. General practitioners are important as they influence decisions around patients' long-term health needs, treatment options and, through this, claims on insurance funds. The operation of the payment and access rules prevent private health insurance benefits from being paid directly for general practice treatment items. Changes to the rules would have allowed insurers to move to an active role where they could directly contract medical practitioners and influence who received what treatment (access).

In each of the reforms, medical practitioners argued stridently for clinical autonomy: the right to refer and treat as clinically determined by that practitioner. Across the course of the cases, this right became more stable and clearer and was enshrined in legislation. This right prevents insurers from influencing practitioner behaviour using financial incentives. Clinical autonomy effectively does not allow private health insurers to move to a position of managing healthcare. Access to tertiary services remains controlled by general practice.

To fix the private health insurance sector's viability issues, consecutive Australian governments have introduced many measures to encourage people to take up private insurance. Private health insurance as an industry in Australia enjoys significant protection from the Australian government. In the late 1990s, they introduced a Private Health Insurance Incentive Scheme. In 1997, the Medicare Levy Surcharge was introduced as a supplementary tax on high-income earners who were not covered by a hospital policy (Australian Institute of Health and Welfare, 2017). A 30 per cent rebate on premiums was introduced in 1999, shortly followed by the Lifetime Health Cover loading in 2000. This last policy allowed insurers to charge an additional 2 per cent of the premium for each year the person was not covered by a private hospital policy after the age of 30 (Department of Health, 2017).

The initiatives to reverse declining membership in the late 1990s and early 2000s mean that people are becoming members for reasons that are not connected to either their health or insurance, and as a result, they may have perverse incentives to use more services than might be necessary (Fiebig, et al., 2006). Thus, the protections afforded to the industry may also increase demand for care.

It is argued here that the insurance industry had developed another policy path, moving away from finding more efficient ways to operate at a system level and becoming attached to government for regulatory and financial support. It has been argued elsewhere that government financial support for the PHIs is not efficient, in that the cost to government for each additional patient treated in the private sector is greater than the price paid to treat an additional patient in the public sector (Duckett, 2005). However, despite many calls for changes to the private health insurance rebate, governments have been loath to reduce the amount of support for the private health insurance sector (Australian Health Reform Alliance 2017; Duckett 2019). Governments appear to have accepted that they need to contribute significant funds to both the public and private insurers rather than reform the system.

9.4.1 No change to the payment and access rules

The impact is not just on the private health insurance industry. The inability to alter the payment and access rules also presents challenges to Medicare. In Australia, it is through the purchasing role that the Commonwealth and state governments seek to influence the supply, distribution (regional or urban) and quality of healthcare services (Productivity Commission, 2014, p. 11.4). The Commonwealth lacks the direct power to regulate the delivery of health services and instead must rely on incentives (financial or other resources) to influence behaviour (*The General Practitioners Society in Australia v Commonwealth* 1980).

Previous attempts to coordinate care through general practice incentives for coordinated care plans and Medicare Locals did not achieve the desired outcomes. General practice incentives were rorted in some cases and not sufficient in others, and in the case of Medicare Locals, the integrating agency did not have the ability to influence practitioner behaviour to a sufficient degree to deliver noticeable change. Medicare Locals were replaced with Primary Health Networks (PHNs), which have been established with a view to ‘increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improving coordination of care to ensure patients receive the right care in the right place at the right time’ (Russell, 2018, p. 2). At this point in time, it is too early to determine the impact of the PHN program. However, questions about the program’s ability to deliver change are arising (Russell, 2018).

The National Health and Hospitals Reform Commission review of the Australian health system (2009) concluded that healthcare provision cannot be improved without reform to the structural configuration of the Australian health system (National Health and Hospitals Reform Commission, 2009). Major reforms to social systems typically start with good intentions and can be derailed by political processes. To avoid political issues, reforms in social policy spaces are often required to be

delivered with 'no losers'. Developing models to provide financial assistance to support industries' change operations is fraught with danger. If there are insufficient funds, the industry will complain; if there is over-subsidisation, the community will feel that taxpayers' funds have not been used prudently. Moreover, it is very difficult to remove a stream or source of government funding once it has commenced. Given these barriers, how does a government fund change its operations without this expense becoming an ongoing funding requirement?

In the three-player model, for one group to benefit, another group is required to change their way of working. For each of the three cases, to effect change, there would have been costs accruing to medical practitioners and insurers to implement the reforms. There was no guarantee of recouping these costs, and the perceived return on investment was insufficient to incentivise either group to change. Changing businesses' operating models costs money, and previously, governments have needed to provide incentives to help industry adjust (see ePIP program, Health Workforce Incentives, Health Care Homes) (Department of Health, 2022; Department of Health, 2022a). There needs to be a clear value proposition for each of the three groups: providers, insurers and consumers.

9.4.2 PHIs' changing strategy

The major political parties' acknowledgement that it is difficult to pursue a policy agenda of changing the payment and access rules has led, instead, to a policy where the government subsidises PHIs. This appears to appeal to mass policy preferences. Combined with an unwillingness to make changes that might be perceived to undermine Medicare, the two policy paths – (a) retention of the payment and access rules preventing PHIs from directly contracting medical practitioners and (b) a suite of carrots and sticks to effectively prop up the private health insurance industry – appear to represent societal expectations of a health system wherein PHIs and Medicare must operate together in an inefficient manner. It could be argued that that two policies to fund healthcare in Australia that do not provide efficient outcomes are now locked in.

Consistent with RDT, the continued presence of viability issues has led PHIs to consider alternative options to ensure sustainability. The subsequent corporatisation and consolidation of health practices has led to a higher concentration of ownership and a move into some primary healthcare provision such as dental, optical and general and preventative practice by the private health insurers. These, the Department of Health stated in a submission to the Australian Competition and Consumer Commission in its annual review of anti-competitive behaviour by insurance firms, 'are commercial decisions between providers and insurers' (Department of Health and Ageing, 2011, p. 6).

It is interesting looking now, after the timeframe of this research, at some of the very recent vertical integration that is happening in this industry, which provides PHIs with greater control over medical

practitioner behaviour than what was proposed under any of the reforms considered in this research. In the primary care sector, BUPA and Medibank Private now own primary healthcare services, and recently NIB and a US managed care corporation came together to operate a new health services buying group (from September 2021). Interviewees noted that if left uncontrolled, ownership changes are more concerning than individual doctors contracting with the private health insurers (2case3; 3case3).

Significant investments into ownership of health services are also occurring in the tertiary healthcare space. More recently, BUPA commenced an initiative with Cabrini Health – a not-for-profit, private operation in Melbourne, Victoria. This partnership will see BUPA contribute funds towards innovative alternative models of care, focusing on care in the home and guaranteeing services for their customers without out-of-pocket costs from Cabrini or its contracted providers (Libatique, 2022). Australian Unity's Healthcare Property Trust has also recently announced investments in Australia's health infrastructure. According to the *Australian Financial Review*, Australian Unity will fund new projects totalling \$250 million, a subset of a \$1.2 billion development pipeline, which is estimated to increase the value of assets under management by over 30 per cent (Libatique, 2022).

In the hospital sector, the growth of for-profit service delivery has become increasingly evident. There is a significant modernisation of the hospital sector in Australia with the co-location of public and private hospitals. For the state governments that operate the public hospital system, co-location appears to be popular, and corporate providers have been quick to invest in this new arrangement. It is claimed that greater focus is needed by health geographers on these changes in service delivery systems and resultant changes to access to health services (Brown & Barnett, 2004). With few exceptions, the documentation and analysis of corporatisation of hospital service provision has been slow, and it is unknown how these changes are reorganising 'healthcare places' (Brown & Barnett, 2004).

The Increasing number of ventures in both the tertiary and primary spaces could total to a sizeable amount of vertical integration. The responsibilities for regulating the system's structure are unclear, and the regulatory environment is complex. There are five government agencies with a role in regulating the private health insurance. The Department of Health is the main policy agency responsible for the health system, including private health insurance; APRA sets prudential standards, including risk management, capital and financial statements, and supervises industry compliance; ASIC is Australia's corporate regulator, which enforces company and financial services laws to protect consumers, creditors and investors; the Commonwealth Ombudsman (Private Health Insurance) protects the interests of private health insurance consumers; and the Australian

Competition and Consumer Commission promotes competition and protects consumer rights and fair trading for the benefit of all Australians (Australian Competition and Consumer Commission, 2018; Australian Prudential Regulation Authority, 2018; Australian Securities and Investment Commission, 2018; Commonwealth Ombudsman, 2018).

It is not clear whether any of the regulators involved in the market are making an active decision on how much integration is appropriate for the health system as a whole, and how to drive or regulate to achieve that aim. Potential changes to the market structure through vertical integration impact all of these regulators in different ways. Responsibilities between these agencies are blurred and overlaps or gaps in regulatory activity are likely, making the development of a coherent policy in this space difficult. Given the impact of the financial structure on the delivery of services, a clearer policy position on the amount of vertical integration that is desirable or permissible and more transparent oversight of the changing structure of the health system is warranted. Without a defined policy goal, greater access inequities could follow as people in inner metropolitan areas are afforded different levels of integrated care compared to rural and remote populations.

9.5 Is health financing policy sticky or stuck?

9.5.1 Institutional lockdown

The issue of the mixed model of insurance in Australia and its impact upon the delivery of healthcare has become one of the more intriguing social policy conundrums in a system which is based on social health insurance. Institutions tend to involve incrementally rather than radically (Djelic & Quack, 2007). They evolve over time; yesterday's rules of the game are regularly only slightly changed to how things are operating at the moment (Vergne & Durand, 2010). Researchers argue institutions are carriers of history maintaining norms and patterns throughout time (David, 2004; Sydow et al., 2015).

Deeg (2001) argues that increasing returns leading to lockdown of a policy path can be cultivated by actors, which I would argue complements the theories of Crouch and Farrell (2004), who argue that shifts into new ways of doing things can occur due to the agency of actors. Across the three cases, we saw multiple attempts to change the way health practitioners are paid by insurers. In each case, the policy, which would have given insurers greater management and control over payment and access, and through this, the management of the treatment pathway, was prohibited at the implementation phase.

9.5.1.1 *A policy is always a function of another policy*

The relationship between private health insurers and medical professionals is shaped by the payment model in Australia, which is derived from the regulation that implements Medicare. Within the

Australian broader healthcare system, it is clear that small changes have been allowed to occur (Productivity Commission, 2017), but have they been significant enough? If we define the institution as the fee-for-service model, we can argue that medical practitioners have successfully maintained this as the primary payment model in Australia, accounting for the vast majority of income for providers. If we define the path as limiting direct contracting of medical provider services by insurers, we can also argue that this has been prevented by the actors in the policy network. Changes to major institutions can occur at the periphery whilst also maintaining the major institution (North, 1990; Thelen, 1999). Interestingly, a system may develop a new parallel path to accompany the main institution to allow it to continue unchanged (Kay, 2007).

9.5.2 Policy networks and the stickiness of health financing

At the conclusion of this research, it would appear that the first case was the most important policy event since the introduction of Medicare in Australia for the shaping of the network structure. This was the policy event in which the government tested the concept of PHIs establishing themselves as active managers in the healthcare system. All of the interviewees referred to this debate. It remains renowned within the health profession. Interviewees spoke passionately about their roles within this debate, or the impact of the outcome of this case upon their work in health policy. Interestingly, many of the interviewees would not have participated directly in this first case, and a few of the interviewees would have been too young to really have understood what was happening when it was occurring in 1995.

When I commenced the research on the first case, I was concerned that interviewees would not remember what had occurred and how. However, the fact that people remembered this case so well verifies the claim that this case was important. Many of the interviewees gave significant amounts of time and detailed recollections, providing an insight into the environment and the importance of the reforms being debated (Gulati, 1998; Sandstrom & Lundmark, 2016). There were lengthy descriptions as to the machinations employed by key leaders of both of the subgroups. Moreover, interviewees conveyed a significant amount of respect for all of the individuals who held key positions. The influence of key personnel was mentioned a lot. Their wisdom, insights, knowledge and political nous were recognised by interviewees. The 1995 Lawrence reforms were pivotal in establishing advocacy positions of the two sides and the development of the strong subgroups should be examined in further research.

If, as suggested by the findings of this research, we accept that the network of actors have prevented changes to the operation of the payment and access rules in Australia, and the rules are exhibiting path-dependent lockdown, the problem for policymakers is how to best improve the system and

manage this constraint. Firstly, future policy options need to openly acknowledge the concept that 'history matters' and that due to the mechanisms that support path dependence, the health system is already locked into a particular way of operating built upon Medicare and its fee-for-service model. Practitioners benefit from the continuation of the fee-for-service model and the capacity to bill without a limit; the benefits to consumers come from retaining the capacity to continue to use a preferential health system without a price signal. Secondly, there is a secondary and parallel path to Medicare policy, where the private health insurance sector is propped up by the federal government. Policy options and decisions can then be developed on the basis of pursuing ways to make the system more efficient, rather than a static conceptualisation of 'making PHIs more attractive through carrots and sticks'.

Health reformers everywhere should be mindful that a change in one part of the system, no matter how small, may produce unexpected outcomes, and that a lack of enough change in one area may prove to be the recipe for incrementalism, paralysis or a major divergence in behaviour that is significantly more difficult to manage from a governmental systemic perspective. Finally, it is hoped that a focus on networks and their operations in the health financing policy arena will encourage the adoption of a network lens in everyday policy thinking, which it is argued here is critical for managing policy processes in highly fractious policymaking environments.

10 Conclusions

This thesis drew on a theoretical framework that combined network, resource dependency and path dependency theories to explore the role of actor networks in attempting to change (or retain) the payment and access rules in the Australian healthcare system. This unique use of these theories, combined with tested network analysis methods, makes an important contribution to our understanding of how to effect change to the operation of the payment and access rules in Australia. International reforms (see New Zealand and the Netherlands as examples) have shown it is possible to restructure health systems to provide greater integration (Gauld, 2014; Hall, 2010, p. 66; Jackson & Gauld, 2018; Kroneman, et al., 2016; Ministry of Health, 2016).

The research showed that actors within the network actively worked in coalitions to either alter the payment and access rules or cement them (pro-change or change preventers). Consistent with Crouch and Farrell's (2004) path-breaking theory, actors commenced developing policy alternatives on numerous occasions with a belief that they could alter the payment and access rules to allow direct contracting, even though the rules were beginning to show path-dependent characteristics. The research also confirmed that institutions can be reinforced when they have distributional consequences that increase the power of actors interested in retaining the institution (Hall & Taylor, 1996).

At its broadest, two main roles were established in the network: those who attempt change, and those who prevent it. Both coalitions demonstrated the use of power; however, the change prevention coalition's (greater) power to control the system prevented changes to the healthcare system that would have increased integration (direct contracting) between insurers and medical providers in each of the cases. The change-resistant coalition centred on the Australian Medical Association (AMA) who, through its use of resources in the network, contributed to the production of path-dependent mechanisms and the eventual lock-in of the payment and access rules (Brady, et al., 2016).

Firstly, the AMA showed its capacity to develop a *large coalition that represented a large constituency*. Over the cases, the AMA strengthened its position by becoming the central advocacy body for the medical profession and claimed it represented consumers' interests (generally by partnering with consumer organisations). Secondly, the change prevention coalition *mobilised a large alliance that had a vested interest* in the benefits from the operation of the current payment and access rules. Medical providers wanted to retain clinical and billing autonomy, and consumers wanted to retain the benefits of the Medicare system (bulk-billing without caps on usage in primary care and free hospital care).

Path dependency is said to occur when *regulatory policies function as institutions* and the cost of changing to a new way of operating becomes prohibitive; moreover, the industry may have adapted their operations to the current set of rules. Implementing a change to the payment and access rules presented different potential costs for medical providers, insurers and the government, and in each case, it was found that the costs of change borne by the groups would have outweighed the benefits. The change prevention coalition used their resources to deploy strategies to ensure that implementation of any integration had additional costs for insurers and government. The costs for insurers ranged from medical providers refusing to contract with them through to claims that they were bringing in managed care and thus reducing their legitimacy to operate. For governments, none of the reforms were likely to reduce budgetary outlays, and there was a risk that the government would be unfairly criticised for an adverse outcome for a patient (whether provable or not). Finally, and not insubstantially, in each case there was a varying amount of political capital used during the policy event. This leads to the fourth mechanism of path dependency when *social policies influence normative expectations*. In the first case, the medical profession used the spectre of managed care against the government of the day and the insurers, and this rhetoric was brought out in each case when needed. It became clear by the conclusion of the third case that the community did not want changes to the system that might impact Medicare and its fee-for-service model. Without being able to incentivise integration through the payment and access rules, other changes occurred. PHIs increased integration by investing directly and owning hospitals to obtain medical provider services, and the federal government has successively scaled up its own coordinated planning programs. Unfortunately, these two investments are not necessarily aligned and may yet increase fragmentation in the system.

The data from this research indicates that governments of both persuasions appear to be constrained from reforms that may be perceived by the public to reduce benefits to any part of the system and have therefore lost interest in major reforms in this space. The findings are consistent with Brady et al.'s (2016) fifth mechanism of path dependence of regulatory policies. Society appears to demand from its politicians a health system wherein PHIs and Medicare must operate together in an inefficient manner. This contributes to our understanding of the role of PHIs in Australia, which is the third research question, as this research suggests the relationship between Medicare and PHIs is not likely to change soon and, therefore, the ill-defined role of PHIs is unlikely to change either.

For policymakers, the cases demonstrated that there is a need to have a clear picture of the reforms prior to their introduction to Parliament to be able to describe the outcomes and benefits to the constituency. Given the unusual three-player market structure in healthcare (where medical

providers, consumers and insurers are all needed to procure a good), policy changes will need the explicit agreement of at least two of the three players to be successful.

Moving to the question of the impact of the network's structure on policy outcomes, the data showed that although the structure of the actor network changed in each of the cases, it did not appear to have a material impact on the outcome of the reform. Whilst changes in the network's structure brought in new actors across the cases, these actors did not appear to bring in new ideas to alter the path. The findings show how strong actors went about deploying strategies to change the structure of the network to reconfigure power distribution until it became asymmetric, and the network entered a symbiotic relationship where power built upon itself (Farrell & Newman, 2019). The change-resistant coalition's resolve appeared to strengthen across the cases, and they not only prevented implementation of integration but created a situation where each successive policy event was smaller in its desired change to the health system. By the time of the last case, the prevention coalition were sufficiently emboldened to propose measures to increase legislative barriers to integration. These findings add to the literature (see Lewis, 2006; Willis, 2006) that indicates medical dominance in policy design in Australia.

The use of network, resource dependency and path dependency theory allowed for an understanding of how the environment impacted the operations of the network. Interviewees provided multiple interpretations of the power structure in the political environment, and this flowed through to the network structure. Contrary to what network theory would predict (Laumann, et al., 1985), the reduction in the centrality index for the main actor in the coalitions across the cases did not appear to reduce their power in the network.

Finally, the network analysis derived from the document review and the interviews highlighted an unexpected finding of the role of the consumers in the reforms. It showed time and again that consumer organisations were on the periphery of the network during the policy event. The conversation was about the consumer, not with the consumer. Theoretically, legitimacy and power should come from representing the consumer, yet this network analysis showed that legitimacy actually was derived from controlling the narrative.

For policymakers, developing a strong and independent consumer representative body is important for obtaining information about consumer needs during reform processes and for consumers, with their multiple needs, to be a part of the conversation rather than the subject of the conversation. Consultations should be structured to garner and bring together divergent views and methods, such as deliberative processes could be deployed to ensure in consumer voices are strengthened in these types of debates.

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12 Appendices

Appendix 12-A Interview Schedule

Interview schedule

“The map before you is a pictorial representation of all of the actors (organisations) who engaged in debate around the (insert case name here).

The map has been derived through reviewing, publicly available documents from the Federal Parliament, journal articles and media from the time of the announcement of the policy change through to implementation. The more times an actor is mentioned by their peers, the greater the level of influence the actor is purported to have. The level of importance of an organisation is derived from the number of positive endorsements that organisation’s positions by other groups. The closer (E.g., frequency of contacts) the actor is to decision makers also increases their importance. The direction of the arrows indicates the flow of information if this can be ascertained.

I would like to understand how accurately you feel this map represents the interactions between actors as you remember or understand them to have occurred. The following questions acted as prompts. A timeline depicting the events surrounding the case is attached.

Questions:	
Follow up questions (if required) shown as dot points under each main question.	
Environment and actors in the network	
Theory	Questions
Biographical Characteristics tells us who is in the network and provides some environmental context	1. Please could you tell me about your background, and your role at the time? 2. Who was part of the network debating this policy? Are there any key players missing from the model? Did anyone join the network or leave during the debate? 3. Who instigated the reform agenda? 4. What was happening in the broader political context that brought this issue forward for debate? (What was the rationale for the reform?) ○ Health system issues ○ Political system issues ○ Changes in power among the players ○ Changes in coalitions of players?

Power in the network	
Role of organisations within the network. Describes the structure of the network, who is central, who is closely linked to the regulator, who is not linked. Who has power to control the norms of the network and issues under consideration?	5. Who were the most powerful actors in the debate: they should have demonstrated the capacity to either: 1 Shape ideas around the policy 2 Initiate policy proposals 3 Substantially change or veto the proposal 4 Substantially affect implementation of the proposal 6. Did any actors have greater access to decision makers? 7. Were there any important debates stifled, and by who and why? 8. Were there any organisations that you thought might engage in the debate, but didn't? Why? 9. Why, in your opinion, were these actors powerful? 10. (Is it relevant to ask about what were the values, perspectives or interests that informed the rationale for the reform – or is that already known from documents?)
Use of resources by actors	
Resources used to control the policy debate. Tells us who used what resources and who with – elaborates on the structure of the network (nodes and ties).	11. Which organisations did the more powerful actors work? ○ how did they interact with other organisations? ○ What resources do you think they shared? 12. At an organisational level, who did your organisation work with? Who was important to your organisation in this process? Why? 13. How did you interact with other actors in terms of their sharing of information, developing policy positions, media resources, campaigns? 14. Were there any other resources shared (ideas, money, expertise, gravitas)?
Importance of the policy change	
Role of the resource (issue being debated) to Actors. Shows shared interest; movements in alliances (if any);	15. Were certain actors more able to dominate the policy debate in the media? 16. Do you think there was agreement among subgroups of actors as to the importance of the issues, (follow up, if so, which ones? And who was in clear disagreement?)

attempts to create or change legitimacy.	17. How important were the issues to consumers, providers and insurers? 18. Who did the government side with, who did the public side with? 19. And, if you can remember, what was the general public's sentiments of the key actors and how did that vary by actors' positions on the reform? ○ Whose arguments resonated better with the public? 20. Do you think the attempt at reform was successful, why? 21. Do you think the outcome encouraged or discouraged future attempts at reform?
Summary questions	
To close the interview and capture anything that the interviewee may wish to share about the case	22. Is there anything else you think might be of interest to me, that we haven't discussed? 23. Can you recommend anyone else to interview who might provide a view on this case? (perhaps that was actively involved in the process to develop this solution, decision making about it or its implementation?)
Additional questions for interviewees who can speak about all cases.	1. Were there any noticeable attempts to change the relationships (alliances) between the three debates? 2. Were there any noticeable attempts to change the framing of the problem?

Gephi measurements used

- **Average Degree:** The average degree for a graph is the measure of how many edges there are in the graph compared to its number of nodes. 'To find out the average degree for a graph, Gephi computes the sum of the degrees of individual nodes in the graph and divides that by the number of nodes present in it' (Khokhar, 2015, online).
- **Diameter:** The diameter of a network gives the maximum number of steps that must be made to travel from one node in the graph to the other. 'To find the diameter, all the shortest paths between every pair of nodes in the graph are computed and then the length of the longest of them gives us the diameter of the network. If the network is disconnected—that is, if the network has multiple components that do not share an edge between them—then the diameter of such a network is infinite. The diameter is the maximum distance between all pairs of nodes' (Khokhar, 2015, online).
- **Modularity:** The modularity of a graph is a measure of the strength of the network and describes how easily the graph could be disintegrated into communities, modules, or clusters (Khokhar, 2015, online). These are referred to as subgroups. In Gephi, modularity measures how well a network decomposes into subgroups.
- **Betweenness centrality:** measures the amount of connection between the different actors and if the form of linkages differs and well as the level of homophily of the network (Robins, 2015).
- **Closeness centrality:** the average length of the shortest path between the node and all other nodes in the graph
- **Eigenvector Centrality:** measures each nodes 'degree' score – which is simply a count of the number of links that node has to other nodes in the network. However, Eigenvector Centrality adds in the first-degree connections to count how many links the first-degree connections have, and so on through the network, thus it creates a complex picture than degree centrality.
- **Page Rank:** The Page Rank for a node is based on the links made to that node from other nodes. Page Ranks work better in directed networks but was applied by treating the undirected graph as a directed graph, that is, it made each edge bidirectional.

List of documents for the network maps

	Name of Article	Date
Case 1	Health Reforms Get Cabinet Approval	1/09/1994
	Surgeons Say Health Plan will not work	2/09/1994
	Health Cover Change Muted	31/10/1994
	Lawrence Ditches Proposals to Open up Health Funds	9/11/1994
	Doctors Told to Resist Contracts	8/12/1994
	Reforms to Raise Costs	10/12/1994
	Setback for Health Shakeup	3/01/1995
	Health Insurance Reform Date Doubt	4/01/1995
	Health Reforms Attached Widely	14/02/1995
	AMA Attacks Health Plan	17/02/1995
	Senate Hansard No. 170, Thursday, 30 March 1995	30/03/1995
	Insurers Cast Doubt on Health Reforms	15/04/1995
	Health Funds: Why Members Will Gain	19/04/1995
	Doctors Urged to Boycott Bill	1/05/1995
	AMA Threat Fails to Sway Lawrence	2/05/1995
	Relief for Private-Fund Members	12/05/1995
	More Drop Out fo Private Insurance	20/05/1995
	AMA Pushes for Doctors to Block Reforms	14/09/1995
	Curing the Ills of Private Health	30/09/1995
	AMA, Medibank in Contract Row	26/11/1995
	Health Insurance Clash Looms	27/11/1995
	Lawrence Hits at Rebel Doctors Campaign	16/01/1996
	Canberra to Push for GP Contracts	8/05/1996
	100 per cent Oover	26/06/1996
	Hansard Senate Community Affairs Legislation Committee, 24 July 1996, Review of Health Legislation (Private Health Insurance Reform) Amendment Act 1995	24/07/1996
	Senate Community Affairs Legislation Committee - Report The Review of the Health Legislation (Private Health Insurance Reform) Amendment Act 1995	19/09/1996
Case 2	Coming Home Now: Door Opens to Private Health Care	28/10/2006
	Reality Debunks Myths About Private Health Insurance	9/12/2006
	Health Fund Seeks Wider Reach for Treatments	12/01/2007
	Moving Out of the Hospital	20/01/2007
	AHIA Submission to the Senate Community Affairs Committee	25/01/2007
	Bills Digest: Private Health Insurance Bill 2006 no. 81,	8/02/2007

	Senate Standing Committee on Community Affairs: Report Private Health Insurance Bill 2006	28/02/2007
	Press Release: Industry and Consumer Panel to Advice Government on Broader Health Cover (BCH) Products	30/04/2007
Case 3	Fund to Pick up GP Costs in Trial	10/01/2014
	Plan for Insurers to Pay Costs of GP Visits	11/04/2014
	Divided System Concerns Over Primary Care Changes	26/03/2014
	Two-Tier GP Visit Warning	8/06/2014
	Stage Set for US-Style Health System: AMA	27/07/2014
	Health Insurers Push into GP Clinics	27/07/2014
	GP Clinic Scheme Under Fire	21/08/2014
	Senate Community Affairs Legislation Committee: Report Private Health Insurance Amendment (GP Services) Bill 2004	4/09/2014
	Medibank Dumps GP Access Trial	25/05/2015