Post-election policy pointers

Is it time for Medi-change?

As Medicare turns 30, it is timely to reflect on how well it is delivering on its original principles and what needs to change

Vlado Perkovic
MB BS, PhD
Executive Director[1]

Fiona Turnbull
MB ChB, MPH(Hons), PhD
Head of Strategic Initiatives, Office of the Chief Scientist[1]

Andrew Wilson
PhD, FRACP, FAFPHM
Director[2]

1 George Institute for Global Health, University of Sydney, Sydney, NSW.

2 Menzies Centre for Health Policy, University of Sydney, Sydney, NSW.

vperkovic@george.org.au

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Australians are justifiably proud of their health care system. For 30 years, its main pillar has been Medicare, providing free access to public hospitals and subsidised primary and specialist care. In that time, the range of health care interventions available, the way care is delivered and the range of providers have changed dramatically. Moreover, the success of Medicare in supporting access to care has escalated community expectations. It is timely to consider how well our health system is achieving the original principles of Medicare, and the future of Australian publicly funded health care.

Medicare's delivery of its original principles

In September 1983, then health minister Neal Blewett described four attributes underpinning the new Medicare scheme:[1]

- Simplicity: "the simpler we make a health scheme the more chance it has of delivering the services to those who need them most"
- Affordability: "everyone will contribute towards the nation's health costs according to his or her ability to pay"
- Universality: "Medicare will provide the same entitlement to basic medical benefits, and treatment in a public hospital to every Australian resident regardless of income"
- Efficiency: "having the maximum number of health dollars spent on delivering health services rather than administering them"

A fifth attribute, access, was added in 1992.

Simplicity

Health care is becoming increasingly complex, responding to the modern epidemic of chronic disease and changes in reimbursement structures. Medicare now caps annual costs in allied health and dentistry for people with chronic disease, and psychologist and social worker costs for people with mental illness. It funds assessments for target groups such as Aboriginal and Torres Strait Islander people, children and nursing home residents. An increasing range of specialist services are provided under the Medicare Benefits Schedule (MBS). Because Medicare is still fee-for-service-based, there are over 5000 MBS items.

Some services attract a gap payment for people with private health insurance (PHI). However, all patients will face growing copayments for most services with the 2014–15 federal Budget announcements.[2] The 2014–15 Budget also proposes rationalising the current two Medicare Safety Net arrangements, which provide some relief for heavy users, but it remains confusing and further complicated by caps on particular medical fees.

Additionally, 47% of Australians have some PHI coverage, with most entitled to a subsidy[3] supporting private hospital care and other services, while retaining public hospital rights. Different PHI products offer variable entitlements and deductibles and often still require substantial copayments.

Positively, information systems are being used to simplify reimbursement procedures for both patients and providers, albeit with patchy uptake, and the system remains complex to understand and navigate.

Affordability

This principle originally described equity in health care costs to individuals, but current discourse has moved towards affordability for government. Free public hospital and community care is available to all Australians, although with significant variability in practice. Means-tested contributions are required for some services.

The proposed $7 mandatory copayment for general practitioner visits and pathology and radiology services ignores the fact that many patients are already paying substantial copayments for other services. Many visits combine these services, so the copayment may actually be $14 or $21. Less than a third (28.7%) of specialist services are bulk billed.[4]

The 2014–15 Budget increases both copayments for pharmaceuticals and the thresholds for the safety net. Additionally, a growing number of drugs and devices are not government-funded, increasing out-of-pocket costs. Many patients, especially those least able to pay, report deferring visits or treatment because of this.[5] For a growing number, this is causing economic hardship.[6]

Australians may feel that the modest Medicare levy suggests good value for money. The true cost of health care delivery is of course much higher — the Medicare levy covers less than 20% of government health care expenditure ($9.7 billion of $61.0 billion in 2012–13). Greater transparency may improve accountability.

Universality and access

Australia's health care expectations are underpinned by a strong sense of equity. Universality is recognised as a key principle of an effective health care system[7] but is open to practical interpretation. Access to specialist care is highly variable in terms of out-of-pocket cost and availability in the public sector. Some services (eg, most cosmetic surgery) are not provided in public hospitals, and others (eg, bariatric surgery) have such long

waiting lists or limited access that they are effectively unavailable in the public sector.

There are also significant inequities for different community segments. Access is reduced in regional and remote Australia and disadvantaged areas of our cities, for reasons including availability, transport and ability to pay.

Many specialist services are increasingly difficult to access, with long waiting lists. Despite public hospitals moving towards models of MBS-billed specialist clinics, they are not keeping up with demand. Specialists' concerns about the impact on private income may be a factor.

As demand for medical services appears limitless, and the range of interventions grows, there is a need to discuss what "universality" means today.

Efficiency

The initial aim of this principle was to minimise the costs of administering Medicare, which has been achieved for the MBS and Pharmaceutical Benefits Scheme. However, there are concerns about the efficiency of funding arrangements for public hospitals.[8] Funding is split between the federal government (about 40%) and state and territory governments (55%), with a small proportion from other sources. The states are most vulnerable to the increased cost of health care, due to limited ability to increase revenue and disproportionate growth in health care budgets. The sustainability of funding for public hospitals will be further threatened by the Budget decision to not proportionally fund growth in activity at the efficient price but by the lesser amount of consumer price indexation plus population growth.

But efficiency needs to be seen more broadly. While 65% of health care services (including GPs) are provided in private settings, 65% of costs are publicly subsidised. Health care is growing fastest in the private sector, and the PHI rebate is one of the fastest growing budget components. We therefore need to examine the efficiency of the system as a whole. For example, inappropriate and ineffective care, such as imaging for uncomplicated back pain, is inefficient wherever it is provided.[9] A fee-for-service-based system promotes increased numbers of short visits, suboptimal quality of care and excessive use of pathology and radiology services.[10]

Another challenge is Medicare's focus on medical services. Many allied health practitioners (eg, physiotherapists) now provide services without referral. Current policy has not adequately considered all contributors, settings and health care providers. If alternative models of care, such as allied health or nurse-led services, were as effective as existing services, but cheaper, an efficient system would fund these services.

Creating a better system

Modernising Medicare, while adhering to its founding principles, will require purposive and intelligent redesign that considers the drivers of both demand and service availability. The large increase in doctor numbers will generate increased costs if provider-driven demand remains fundamental in the system. Novel funding approaches incorporating primary and specialist care, pathology, radiology, allied health and other services are required. Changes should encourage necessary and high-quality care and discourage low-value services. They should encourage service provision to regions with inadequate services, including using funding as a lever. A long transition period is needed, highlighting the need for appropriate, early change.

> "Modernising Medicare ... will require purposive and intelligent redesign that considers the drivers of both demand and service availability"

There are multiple ways that the true efficiency of the system could be improved. Key to this is good research to understand effectiveness and cost-effectiveness, as there are still many interventions of unknown value.

The changes proposed in the 2014–15 federal Budget, on top of piecemeal changes during the past 30 years, have substantially affected the arrangements to deliver on the original Medicare principles. There is a need for urgent and major reform. We must consider the whole health care system and recognise the strengths of what we have, but also be prepared to change to reflect contemporary practice. Defining a solution will first require a clear definition of our ultimate goal, beginning with a frank discourse. The medical profession has an important leadership role in this public discussion and in designing and implementing subsequent changes; but the time to act is now.

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