HEALTH POLICY

Arthur Chesterfield-Evans

Just before the 2022 federal election, Mark Butler, now the Minister for Health in the Albanese government, spoke to the National Press Club, praising the courage of the Hawke government in creating Medicare in 1984. His speech also set modest priorities for a prospective Labor government, committing to (1) improve the digital health record and make the MyHealth record actually useful; (2) develop multidisciplinary care; (3) establish a new funding model for 'MyMedicare'; and (4) grow the medical workforce, with special mention of nurses and pharmacists (Butler 2022). Significantly, Butler did not commit afresh to Medicare as a universal health scheme *free at the point of delivery*, the key element of the original 1984 scheme that he praised. In an environment where, politically, it seems that taxes cannot be increased, perhaps this ideal may be an impossibility, but it is surely significant that it is no longer stated as an aspiration.

Currently, Medicare is quietly dying as the low rebates cause doctors to abandon it. Australia is moving to a US-type private system by default. This has resulted in large amounts of hand-wringing rhetoric, but so far little action. This short article comments on the changes initiated by the current Labor government during its first year and a half, contrasting these with the deep-seated problems needing to be addressed if better health outcomes are to be achieved.

Labor's reforms

The government has made some minor changes to Medicare which came in with great fanfare on November 1, 2023. There were new item numbers

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for new specialist technologies or treatments and an increased Medicare rebate for GPs, up to $41.40 for a standard visit for a RACGP member, which is 40.6% of the AMA fee. Doctors without the RACGP qualification still get $21, which is 20.6% of the $102 AMA fee.

When Medicare was born, the Medicare rebate was 85% of the AMA fee. The rebate has risen at half the inflation rate for 39 years, so doctors now feel ripped off every time they see a Medicare patient. Labor blames the disparity on the rebate freezes of the previous LNP Coalition governments, but its own record is poor. Successive governments of all types have deferred to the private health lobby and are starving Medicare, slowly defaulting towards a principally private system, as in the USA. This is a deeply-troubling prospect because the US health system has been recurrently criticised (Commonwealth Fund 2021) – and rightly so – because it makes access to health care dependent on ability to pay. Notably, however, it is the world's best system at turning sickness into money.

The other recent Labor 'reform' was to allow pharmacists to process prescribed medications to cover patients' requirements for 60 days, rather than 30 days, thereby halving the costs of prescribing and dispensing. While this may seem helpful, patients are often confused by complicated generic names and generic brands; and compliance or discontinuation of medicines is a largely unquantified problem. These are existing problems with the current arrangements for dispensing medications: the recent policy change, while well-intentioned, does not redress them. It transfers resources from professional staff to the pharmaceutical industry.

The 'Strengthening Medicare Taskforce' had good medical and allied health representatives and support. Its December 2022 report defined the problems but, trying to avoid controversy, positive suggestions were thin on the ground. A deeper analysis and more comprehensive approach to the redress of health issues is needed.

Basic problems in the health system

Diverse funding sources causes cost-shifting

Fundamentally, no-one is in overall control of the health system. It has a number of different funding sources: the Federal and State governments, the Private Health Insurance industry (PHI), Medicare and individuals

themselves. Workers Compensation (WC) and Compulsory Third Party (CTP) insurers also put in a bit. These arrangements lead to a situation where each funding entity attempts to shift costs without any real care for the overall cost of the system. Private entities such as pathology and radiology also have an interest in providing more services, whether they are needed or not.

The broad division of the health system is that public hospitals and emergency departments (EDs) are State-funded, and non-hospital services are Federally, PHI or self (patient) funded. There is some overlap, however, because the State's provision of some community-based services allows them to save on hospital-bed days; and private funds paid to State hospital in-patients are eagerly sought. The starvation of Medicare (which reduces the Federal government's spending) has resulted in more patients going to EDs at higher (State) cost, as well as increasing PHI and patient costs.

This cost-shifting has evident implications for the affordability of health care: notably, a recent study showed that Australia, when compared to 10 other countries, scored poorly on its measure of affordability (Commonwealth Fund 2021).

A new health paradigm is needed

Yet more fundamentally, there is a huge problem with the conceptual model of the health system. In common parlance, the 'health system' is the 'paying to treat illness' system. Paying doctors to see and treat patients is seen as the major cost and is the most politically fraught element in the system.

Historically, everyone was assumed to be healthy and had episodes of either infectious diseases or surgical problems. They went into a hospital for a brief period and either recovered or died. The legacy of this is that heroic interventions are over-resourced and the more cost-effective early interventions are under-resourced.

Infectious disease is now relatively uncommon, notwithstanding the recent and ongoing coronavirus concerns. Most disease is chronic; and the objective is to maintain health for as long as possible and to support those who need support in the community rather than in institutions. 'Health' must be re-defined as a state of physical and mental wellbeing; and maintaining it as 'demand management' for the treatment system.

Life-style diseases of diet, obesity, smoking, vaping, alcohol, drug-use and lack of exercise need attention. It might be commented that these habits are more determined by the political economy of the products than by any health considerations; and the government should intervene to re-balance this market failure.

Hierarchies, cartels and corporatisation

The medical system is hierarchical with specialists at the top and GPs at the bottom. The specialist colleges have produced less practitioners than would have been optimal. The starvation of General Practice has led to increasing specialist referrals for simple procedures. Most patients are happy to go along with this, though often much less happy about the rising costs. Practitioners tend to work down to their station rather than up to their capacity. GPs, if given the appropriate additional education and empowered to act, could do what quite a lot of specialists do now, while nurses could take the load from GPs; and, in terms of home support, a more comprehensive and flexible workforce needs to be developed.

Private medical insurance systems are a further source of problems. They have marketing, churn, profits, liability and fraud issues; and they make it necessary to account for every item of every procedure. While the corporations watch every cost, the regulator cannot. Corporations buy medical practices and take up to 55% of the gross revenue. Smaller radiology practices are being gobbled up as investments (Cranston 2020). If overheads are defined as the amount of money put in compared to the amount paid for treatments, Medicare costs about 5% and PHIs, as they are regulated in Australia, about 12%. In the USA, the private health funds take up to 35%, and Australia's CTP system got close to 50%. A universal health insurance system could avoid many of these costs and would be far superior from a social equity point of view.

Similar problems are evident in the provision of care for people with disabilities. Labor pioneered the NDIS when last in office a decade ago, and rightly claims this as evidence of its commitment to redress the previous neglect. However, the NDIS can be considered as a privatisation of the welfare system. It overlaps medical system functions and is poorly regulated. If its efficiency is judged by the percentage of money put in that is paid to the actual workers delivering the service, care is not very

efficient. There have also been significant criminal rip-offs (Galloway 2023).

Retirement care arrangements have major flaws too. Aged-care accommodation is largely driven by the real estate industry; and access to continuing care is an add-on of often dubious quality.

What should the government do?

The problems described above are diverse, deep-seated and not easily rectified. However, a government intent on staying in office for a series of terms could heed the call for some big thinking, drawing on the experience of health practitioners themselves. Here is a list of what might be done, becoming more medical and more politically difficult as it progresses:

- Keep people healthy with education, clean water, sanitation, housing, good food, regular exercise, high vaccination rates, road safety, universal swimming lessons, CPR and first aid training and the active discouragement of smoking, vaping, alcohol and drug use, junk food and gambling.
- Provide housing with graded community support options for those people with disadvantage or impairment. Create a registration and insurance system for home and community support services, so that individuals can buy standardised services from other individuals.
- Maintain fixed staff-patient ratios related to the disability classification of residents in institutional care.
- Make maximum use of community and school interventions and support services such as District and Community nurses and School nurses, mental health support networks, Aged Care Assessment Teams, Hospitals in the Home etc.
- Address health problems as early and as low down the support and treatment hierarchy as possible, by empowering those who provide the services.
- Create a meaningful regulatory, inspection and enforcement system for support services, both community and residential, and for workplaces and recreational facilities.
- Use the medical information system to research drug and treatment effectiveness.

- Support General Practitioners and try to increase their ability to solve problems without referral. Have GPs work in Health Centres with community support workers as far as possible; and improve communication with data collection a by-product of normal work, not an additional imposition.
- Have independent evaluation of the numbers needed in the specialties and pressure the colleges to provide these numbers. Use waiting times as an initial index.
- Initiate either university-based or college-based continuing medical or professional education, with mandatory refresher exams every decade.
- Have universal professional indemnity insurance, with doctors and other health professionals unable to be sued if they report all incidents of sub-optimal outcomes within 48 hours of becoming aware of them, and participate in regular quality control meetings.
- Publicise and promote organ donation, end of life plans, wills and enduring powers of attorney as sensible steps in life-management.
- Evaluate Intensive Care interventions in QALY (Quality-Adjusted Life Years) terms, researching their outcomes and comparing them to earlier intervention initiatives.
- Change the composition of the Pharmaceutical Benefits Advisory Committee so that it has no pharmaceutical industry representative on it; and remove ministerial discretion from its decisions. The previous system evaluated new drug listing approvals with a cost-benefit analysis (Doran *et al.* 2008), but the Howard reforms of 2007, following the Australia-US Free Trade Agreement and lobbying by Pfizer, put a drug industry representative on this committee, making its negotiations more transparent and thus more difficult for the PBS to negotiate prices (Access to Medicine Working Group 2007).
- Work towards replacing Workers Compensation and CTP insurance schemes with income guarantee schemes (this will only be possible when Medicare allows timely treatment).
- Create a credible and indexed scheme for paying medical professionals which does not have KPIs that distort performance.

- Make Medicare a universal taxpayer funded health system that is free at the point of delivery and stop subsidising PHI. It might be noted that the Government currently quotes Medicare and PHI costs together as a sum rather than itemising the two, which serves to disguise the subsidy to PHI (Parliament of Australia 2022).

Conclusion

The current federal Labor government has made statements about health policy reform and done minor tinkering during the first year and a half in office. Based on this start, it is doubtful that it will have the courage to make the necessary major changes, addressing the systemic problems. Fine rhetoric is unlikely to achieve much. That makes it doubly important to develop proposals for more fundamental reform. Written with this intention, the suggestions made in this article could be the basis for tackling the fundamental institutional and political economic issues problems associated with personal and societal ill-health.

Dr Arthur Chesterfield-Evans trained as a surgeon in Sydney and the UK and is a Fellow of the Royal College of Surgeons. He currently works as a GP with interests in workers' compensation and third-party injury. He has been a tobacco activist and an elected member of the upper house of the NSW Parliament. He has Master's degrees in Occupational Health and in Political Economy.

chesterfieldevans@gmail.com

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