Australian Health Care Reform Alliance

POLICY POSITION PAPER 1
UNIVERSAL HEALTH CARE

UNIVERSAL HEALTH CARE/EQUITY

Key points

- **Universality is an important underlying principle for the Australian health system for ideological, practical and historical reasons.**
- **As a health funding system Medicare has a number of important strengths, but also some limitations.**
- **There are a number of groups in the community with unequal timely access to affordable health care in our current system.**
- **By making some changes to our current funding system and introducing a range of innovations, Medicare can support a genuinely universal health system.**

WHY IS UNIVERSAL HEALTH CARE/EQUITY IMPORTANT?

Universality in health care is one of AHCRA's key principles and strongly supported by all members.

Universal health care is based on a conception of equity that includes the following two principles:

1) equal access to equal care for equal need
2) equity of health outcomes = outcomes independent of social class, income, education, gender, culture, geographical location (a Social Determinants of Health perspective)

Universal health care is important for a number of reasons, including:

- Ideological factors: AHCRA believes in social justice and equity principles which cannot be met through non-universal health systems
- Practical factors: a universal health system is generally more efficient and productive than alternatives and delivers significant population health benefits
- Impact on vulnerable groups: without universal health care people on low incomes, people with chronic conditions and other vulnerable groups would be disadvantaged in getting timely access to affordable health care
- Historical factors: pre-Medicare there were 2 million uninsured people in Australia who were reliant on charity and public hospitals for their health care

MEDICARE – BENEFITS AND LIMITATIONS

Medicare, as Australia's universal health insurer, offers all Australians public health insurance funded through taxes and the Medicare levy, which are based on people's ability to pay (if imperfectly). Benefits are provided according to need and include public hospital treatment at no extra cost and subsidised general practice services (again at no extra cost if bulkbilled).

This system provides Australians with a number of benefits including:

- Major reductions in inequities of access
- An efficient payment system with low administrative costs
- A widely acknowledged and supported sense of security that health care is a key 'common' and available to all

However, as currently structured, Medicare also has some key limitations including:

- Some inequities due to doctor and government-imposed co-payments
- A lack of guiding mechanisms to ensure reasonable distribution of GPs throughout population – distribution is largely dependent on GP decisions
- An over-reliance on the fee-for-service system which does not meet the needs of many consumers, contributes to the mal-distribution of providers, and does not encourage more effective and cost-effective approaches to care
- Limitations on the ability of nurse practitioners and allied health professionals to function at full capacity due to limited access to Medicare rebates (again reducing cost-effectiveness)
- A lack of focus on preventive health (also partly due to fee-for-service payment system)
- The Federal/State/Local Government split in roles and responsibilities which results in inefficiencies and disconnected care and therefore inequities
- Minimal consumer/ citizen engagement
- No means of addressing the social determinants of health
- Only minimal provision of dental care

There have been a number of major policy directions since Medicare's introduction, including the following:

- Increased copayments for pharmaceuticals (Government)
- Increased copayments for GP and other services (Government and doctors)
- Support for expansion of private health insurance (PHI) and for-profit private health industry at expense of universal patient access
- Funding for defined services outside of the fee-for-service structure, i.e. chronic disease management
- Recognition of non-doctor health professionals and incorporation into funding structures

Some of these policy changes, such as support for chronic disease management, have had partial success in addressing Medicare's limitations. However, they have also resulted in a system that is convoluted with incentives, complex administrative arrangements and 'add on' payments, rather than being focussed on the provision of core, high quality and consumer-centred services.

Overall, these policy changes have not reduced the inequities within the current system, including for groups still experiencing reduced timely access to affordable care, nor in specific sectors of the health system (hospitals, allied health, dental and others). Particularly affected are groups such as:

- People who hold concession cards
- Pensioners
- People with chronic and complex conditions
- Low income workers
- People who are unemployed
- Refugees
- People living in rural and remote areas
- People from diverse cultural and linguistic backgrounds

- Indigenous Australians

CURRENT POLICY AGENDA

Recent policy changes by the Federal Government will impact on universal health care and equity of timely access to affordable health care. These include policies affecting Medicare rebates, such as the freeze on rebate levels.

These policy changes have been implemented without consultation across the health sector and without an evidence base. There has been only limited analysis of alternative strategies to reduce the demand for health care, such as reducing requirements for GP referrals for specialist visits, reducing the number of unnecessary diagnostic tests and reducing requirements for GP visits to satisfy other bureaucratic requirements such as sick leave certificates.

The increased role of private health insurance, including its expansion into primary care, such as in the Medibank trial in Queensland, will reduce equity of access by providing some people with higher levels of care and/or faster access and reduced costs.

Increasing the cost of primary health care will create cost barriers to accessing care for some of the most disadvantaged groups in the community. Evidence from international experience shows that the most cost-efficient health systems are those where the barriers to accessing primary health care are low.

Areas of inequity within our current system (identified above) are likely to increase if these are not explicitly addressed. The demand for preventable hospital emergency department services could increase, resulting in higher costs overall to the community.

Over time, these proposals are likely to lead to a two-tiered health system where health consumers' wealth will determine the level of care they receive. This will be the end of universal health care in Australia.

FUTURE AGENDA - WHERE WE WANT TO GO?

AHCRA's vision is for an equitable universal health system where all Australians receive equal timely access to affordable health care based on their level of need. We have outlined the following practical policy, legislative, structural and funding changes required to achieve this vision over the short, medium and longer term.

What can happen over the next 12 months:

- Acknowledge that timely access to affordable health care is a fundamental human right for every Australian irrespective of where they live.
- Quarantine GP services from the introduction of private health insurance
- Restore indexation to Medicare rebates
- Ensure access to all to emergency care without upfront costs
- Adequately resource Commonwealth and State/Territory partnership agreements on dental health to ensure universal access to basic and preventive dental care
- Restore the Federal/State hospitals funding agreement

Over the next 2-3 years:

- Promote measures to increase the efficiency of Medicare
    - Review Australia's medicine pricing systems against the world market price for pharmaceuticals[1]

[1] Stephen Duckett *Australia's Bad Drug Deal* The Grattan Institute 2013

    - Accelerate the reduction/removal of funding for low value MBS services (Elshaug[2])
    - Address hospital cost inefficiencies (Duckett[3])
    - Develop mechanisms to reduce futile care, especially at end of life
- Innovate more with GP/allied health funding, e.g. via block and/or capitation grants
- Explore options for the medical home and patient enrolment for primary healthcare services
- Develop alliances with industry around the value of a healthier workforce
- Develop a plan to address the social determinants of health
- Ongoing preventive health goals built into key performance indicators for Ministers, senior bureaucrats and Primary Health Network CEOs
- Ensure adequate reimbursement is provided for allied health and nurse practitioner services, including fee-for-service where appropriate
- Ensure adequate funding of Primary Healthcare Networks to enable them to effectively increase the equity and effectiveness of primary health care
- Fund a national health workforce database framework capable of collecting meaningful data, including data for future allied health professional workforce planning.
- Freeze the level of PHI rebate and reduce the threshold for the highest level of subsidy
- Increase funding for the employment of public (salaried) specialists
- As Primary Healthcare Networks mature, trial needs-based regional funding
- Explore the feasibility of single-funder or regional funding models (as above using Primary Healthcare Networks) and develop an implementation plan
- Instigate an ongoing consultation process with the community about their values and preferences for health issues

Over the next 3-5 years

- Trial (possibly in Tasmania) and then implement a single/regional funder for all health care, based on feasibility studies (above)
- Address the current inequities in health workforce distribution
- Implement outcomes-based funding for all forms of health care, where this is supported by evidence
- Create a national performance authority for primary care which includes all of primary health care and specifically GPs
- Abolish the private health insurance rebate
- Develop and implement ongoing consultation mechanisms for consumers and stakeholders to have input into health funding decisions
- Develop and implement funding mechanisms which support the role of nurse practitioners and allied health professionals in primary health care, without reducing equity.
- Implement ongoing consumer collaboration practices in all sectors of the health system
- Ensure the social determinants of health are addressed through all health policies and programs
- Introduce a focus on health issues in policies and programs across all sectors of government

[2] Adam G Elshaug, Amber M Watt, Linda Mundy and Cameron D Willis
Over 150 potentially low-value health care practices: an Australian study
Med J Aust 2012; 197 (10): 556-560
[3] Stephen Duckett *Public hospital efficiency gains could save $1 billion a year*
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CONTEXT AND CONTACT DETAILS

This paper is the first one in a series being developed by AHCRA focussing on the future of our health system. The other papers in the series include: Primary Health Care, Mental Health and Prevention and are available on the AHCRA website www.healthreform.org.au

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