Australian Health Care Reform Alliance

SUBMISSION TO THE MEDICARE REVIEW TASKFORCE

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INTRODUCTION

AHCRA congratulates the Government on establishing this Review and welcomes the opportunity to provide comment on the MBS Review Taskforce's Consultation paper.

The Australian Health Care Reform Alliance (AHCRA) is a coalition of peak health groups working towards a better health system for Australia's future.

Australia's health system was designed more than a generation ago and it is important that it is reviewed against current community needs and taking into account the findings of recent research. While by international standards our health system delivers a high standard of care at a relatively low cost, there are a number of areas where it could be improved. Many Australians are either missing out on the care they need or not receiving the best possible care for their condition. There has always been a gap between the health of the best and worst off in our community, and between city and country, and this continues to undermine the fairness of our society.

We need to make major changes to our health system to make it better and fairer for all. With an ageing population and increasing demand for health care, we need to ensure that every dollar spent on health care delivers maximum value. We also need to make sure that our health system reflects the values of our community.

AHCRA believes that governments and providers need to find solutions to the key problems with our existing health system, including:

- poor access to care for many Australians
- a resistant biomedical health service culture changing too slowly to a universal person and health literacy centred model of service delivery
- consumer and provider frustration with problems in navigating an overly complex and siloed system
- mechanisms that add layers of administration and costs without adding value, such as private health insurance
- the health gap between Indigenous and non-Indigenous Australians
- increasing out-of-pocket costs for services
- a maldistribution (and in some areas a shortage) of doctors, nurses and other health professionals
- an insufficient focus on prevention and primary care
- creating payment systems that provide the right incentives, particularly in relation to multi-disciplinary models of care
- the inefficient allocation of resources caused by the current State/ Commonwealth funding structure.

The Taskforce should be cognizant of the following issues as it reviews the MBS

AHCRA's broad premise is that, although there are many dedicated and skillful health practitioners providing high quality, person-centred care, there are too many people who miss out on this standard of care. The Taskforce will be well aware of those sub-groups often missing out, including of course Aboriginal and Torres Strait Islander peoples, those with lower than average SES status, rural and remote Australians, and others. However even among the remainder of the population, our system does not guarantee good quality care for people with non-episodic conditions such as chronic diseases or mental illness.

Part of the cause of this patchy performance by the system is its emphasis on hospital care and insufficient focus on primary health care and prevention. Again the Taskforce would be well aware of the strong evidence about the value of preventive activities (and Australia has been singularly successful in tackling smoking and road accidents) and the better than average outcomes and cost-effectiveness of care in countries whose systems have a strong emphasis on primary health care. While this policy area is beyond the remit of the Taskforce, AHCRA believes it is very important to place this aspect of care within the broader policy context.

GENERAL ISSUES

KEY POINTS

In AHCRA's view, a review of the MBS should occur regularly through an ongoing systematic approach. AHCRA does not offer a clinical view on specific MBS items, but would like to make a number of points from a broader policy perspective.

The consultation paper notes that Medicare is a system for the payment of patient reimbursements not a remuneration system for doctors. Whilst AHCRA agrees strongly in principle with this, it is obvious that this is far from true in reality. Doctors have fought significant battles over the years with the Government about MBS rates and definitions, and Governments have focussed on consultation and negotiation with medical provider groups to resolve these disputes. A system which reflected the fundamental intent of Medicare would include a very significant role for consumer and community organisations in policy development as

well as consultation with consumers and the community in managing the MBS. AHCRA urges the Taskforce to recommend this change.

The number of MBS items is a reflection of the overly fragmented nature of the primary health care and specialist system. From a consumer perspective, this complexity has been strongly provider-driven and could be massively simplified. Many services in our society are paid for on a simple time-expended basis. Whilst AHCRA understands that some care requires specialist equipment or resources, it urges the Taskforce to concertina many of the items to recognize their holistic application in care. AHCRA recommends the application of a basic criterion 'is the care funded by this item number based only on clinician time'. If the answer is positive, then such items should be replaced with catch-all time-based consultation items, as occurs commonly in general practice. AHCRA suspects that this step would reduce the use of many more expensive items or of multiple items during a single consultation.

PRIMARY HEALTH CARE/GENERAL PRACTITIONER FUNDING

AHCRA shares the view of many health policy makers and clinical leaders that primary health care funding mechanisms are no longer fit-for-purpose. Primary health care is important because it is where the great majority of health issues are identified and can be addressed at an early stage. There is good evidence that a health system that is oriented towards primary health care is more cost-effective, results in better health outcomes and higher consumer satisfaction than one oriented towards hospital or specialist care. A health system focused on primary health care also tends to be more equitable in terms of both the allocation of health care resources and health outcomes for the population.

International comparisons have found that countries that orient their health system around primary care have lower infant mortality, lower suicide rates, higher average life expectancies and greater consumer satisfaction than those whose health system is oriented around specialist care. In contrast, Australia's health system often appears to be centered on hospitals rather than community-based primary health care.[1]

Australia's primary health care sector also does not provide consistently high quality, preventive and accessible care which engages all community members. Despite the strong commitment of most health care practitioners to their clients/consumers/patients, it is well-known that funding mechanisms shape care, not the other way around. Reliance on fee-for-service funding tends to fragment care; to reward quick turnover and short-term perspectives rather than longer-term views and a culture of person-centred care; to discourage optimal and innovative uses of the primary health care team; and to ignore the social context of many people's lives. The very different health needs of today's population requires a much more flexible funding framework that can foster ongoing multidisciplinary care in much more innovative and optimal ways. This is particularly important in the effective care of chronic and mental illnesses. The relative oversupply of private specialist doctors in Australia (compared with Canada for example) has the potential to drive unaccountable servicing without an adequate assessment of cost effectiveness.

The Primary Health Care Advisory Group is clearly examining other options to fee-for service in their parallel consultation, and we trust that the Taskforce will be highly cognisant of their recommendations, rather than undertaking the MBS Review in isolation. AHCRA supports a move away from fee-for-service as a funding mechanism for primary health care and recommends that the Taskforce work with consumers and other key stakeholders to develop more suitable funding options.

[1] See Contribution of Primary Care to Health Systems and Health, Barbara Starfield, Leiyu Shi, and James Macinko The Milbank Quarterly, Vol. 83, No. 3, 2005 (pp. 457–502) _c 2005 Milbank Memorial Fund. Published by Blackwell Publishing.

SPECIALIST CARE

There are a number of ways in which specialist medical care could be made more efficient and equitable and AHCRA believes there are several MBS items that could be more effectively provided by another health care professional. One example is the requirement for an annual referral from a GP for consumers already receiving ongoing care from a specialist. This practice is unnecessary and costly, as it means that specialists can charge an initial fee every time such a referral is received, regardless of the length of time they have been treating the consumer.

AHCRA urges the Review Taskforce to involve consumers in future efforts to evaluate and re-assess specialists' fees relative to those of generalists.

HEALTH TECHNOLOGY

Health technology offers the potential to increase the value of our health system through providing services more accessible and efficiently and/or achieving improved outcomes compared with traditional methods. However, not all health technologies are good value and it is important that our health care resources only go into those technologies that add value.

As health technology is a rapidly developing area, it is important that there is ongoing review of health technologies to ensure they continue to deliver good value. It is also important that assessments of health technologies are shared by all jurisdictions and sectors of the health system to ensure the findings can be used to inform all resource allocation decisions.

HEALTH WORKFORCE

The health workforce is the most important resource in the health system and it is vital for overall efficiency that it is used to deliver maximum value. A major barrier to this within our current health system are professional boundaries which are based on historical practices rather than clinical evidence or consumer preference and work against the delivery of person-centred care. This restricts what activities health professionals can undertake, often preventing the provision of services from lower cost providers. Addressing this issue will require ongoing research and consultation with stakeholders, including consumers, to break down established professional boundaries where this is indicated by research and supported by the community. Three targets for workforce reform within the hospital sector include:

1) expanding the use of nursing assistants and clarifying their role;
2) introducing new specialist nursing roles for endoscopies and anaesthesia; and
3) Expanding the use of allied health assistants.

Modelling has indicated that these changes would save Australia's public hospital system $430 million a year.[2]

Within the primary health care sector there is scope for an increased role for both practice nurses and nurse practitioners in order to reduce the pressure on medical practitioners and increase the overall efficiency of the sector. There is also the emerging Physician Assistant (PA) profession in Australia which needs to be considered in new applications to the MBS. Paramedics, which will become registered health practitioners in the near future[3], also offer a highly skilled health workforce that has been underutilised in

[2] Unlocking skills in hospitals: better jobs, more care Stephen Duckett and Peter Breadon The Grattan Institute
[3] COAG Communique http://bit.ly/1MgfRQL

the past for primary and community care roles and whose interventions need to be embraced within the MBS.

The Australian Society of Physician Assistants (ASPA) feels inclusion of PAs as practitioners accessing the MBS will assist Australian medical practices to reflect contemporary practices that are already utilizing or developing practice models incorporating PAs. PAs are being recognised and supported in Australia as medical care practitioners, working in collaborative inter-dependent relationships with medical practitioners.

The PA model supports and recognises doctors as key healthcare providers, through extension of and promotion of cost effective and efficient medical services. Access to MBS would enable PAs to practice at their full scope of practice and support innovation and flexibility in the provision of medical care.

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