Seeking a Cure

In putting out an SOS for the Medicare Benefits Scheme, **Margaret Faux** says what we need is a thorough examination of the way it is used, along with a truly sustainable solution.

Almost 40 years after the introduction of Australia's tax-payer-funded universal healthcare system, Medicare is again in the spotlight. The Federal Government warns of the drastic measures that have to be taken if we are to retain Medicare, rightly seen by most Australians as a national treasure.

So far, these measures seem to include patient co-payments, allowing private-health funds to insure the gap, and capitation-styled payments for chronic disease, modelled on the UK's National Health Service (NHS).

Yet on its 65th birthday in 2013, the NHS, often championed as being one of the world's greatest healthcare systems, was facing its own financial woes. In an attempt to curb excessive expenditure, new legislation was introduced in 2012, which quickly came under attack by some, who saw it as the beginning of a slippery slope to the privatisation of the NHS – a public, capitation-styled, tax-payer-funded scheme, free at the point of use.

While holidaying in the UK over last Christmas and New Year, I received texts and emails from those back home with links to articles in the Australian press proposing a $6 patient co-payment for both GP and Accident and Emergency (A&E) attendances. My initial thought was: 'Same old, same old… Just collect more money from taxpayers and that will solve all our problems, even though historical evidence tells us that the contrary is true'.

One needs only to read the history of Malcolm Fraser's time in government to understand that tinkering around the edges of Medicare (then known as Medibank) by introducing co-payments and applying macroeconomic policies to health reform will not result in desired cost controls.

Between 1976 and 1981 we endured Medibank versions ii, iii and iv, before it was finally abolished altogether in April 1981, at which time we reverted to a completely private and voluntary healthcare system for the best part of three years.

THE HIGH PRICE OF HEALTH

We have strong historical evidence to suggest that introducing crude methods of cost containment, such as co-payments,

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will do nothing more than unfairly disadvantage those who can least afford to pay. And if private health funds are able to insure the gap, it is inevitable that gaps will continue to rise, which in turn will cause the health funds to increase premiums.

It's a headlong slide into a US-style of healthcare system, which has the highest per-capita expenditure of any OECD country on health – around 18% of GDP. Both Australia and the UK fare comparatively well, at approximately 9% of GDP.

Fortunately for Australians, it is currently not lawful for public hospitals to charge public patients any fee at all. And given the glacial speed at which legislative wheels turn, the public are probably safe from A&E charges for the time being. It is also not lawful for GPs (or any practitioner for that matter) to charge patients a gap of $6 or any other amount if they are bulk billing. So exactly how any proposed GP co-payment would be implemented is in itself an interesting question.

But there's no denying that spending on health is consuming more and more of both state and federal budgets. In 2009-2010, the cost of Medicare-funded reimbursements was $21.2 billion, representing 18.3% of total spending on health. And in the preceding decade the average increase was reported as being 3.9% per annum.

If this trend continues, we may see MBS claims alone rising to approximately $31 billion by 2020. It's a sizeable sum and most would probably agree that predictions like these will result in a healthcare system that we can't afford and that something must therefore be done. But what?

ON THE MONEY

Given there are essentially only four ways by which doctors are paid in the developed world, it is not surprising that governments are looking at all options, including capitation, to find solutions. For those needing a quick brush-up, here is a summary of the four options, including the well-documented advantages and disadvantages of each:

- **Salary:** The clear advantage here is of controlling costs, but this does not incentivise efficiency and can even reduce the amount of services delivered.
- **Fee-for-service:** This increases effort by providers and can therefore be useful in areas where there is an undersupply of needed services. However, it also introduces the temptation to over supply services beyond what is necessary.
- **Capitation:** Delivers very strong cost controls but is vulnerable to 'cream-skimming' behaviours, whereby providers will recruit less-sick patients who require less care and less effort on their part.
- **Performance-based payments:** Provide a good control of costs and can increase the delivery of targeted services but are vulnerable to another behaviour known as 'gaming', whereby providers may try and scam the system by over-reporting the services delivered.

Most countries have adopted more than one of these payment arrangements. In Australia, we currently work in a complex blended system that uses three out of the four options – capitation is not currently a major part of our health-funding landscape.

CAPITATION PROS & CONS

So, if co-payments are not the answer, is a form of capitation the way forward?

A constitutional guarantee currently prevents the adoption of a full capitation-style healthcare system in Australia. Section 51 (xxiiiA) of our constitution provides that doctors cannot be conscripted to serve the Federal Government.

It's the foundation of our Medicare scheme, which subsidises healthcare costs for patients as opposed to paying doctors. It also complicates any potential ability for the Federal Government to take over the running of public hospitals, something Kevin Rudd wanted to address by way of a referendum during his period in office, but it was not to be.

That aside, if you had been reading the headlines in the UK in early January, capitation probably would have been deleted from your list of possible solutions.

In a surreal moment, on what felt like the very next day after the $6 Medicare co-payment headline, headlines in the UK were identical, with one in particular reading: *GPs propose £10 fee for A&E to deter the worried well'*.

A study of 800 British GPs had apparently shown that one-third supported the proposal. Patients hit back swiftly and with brutal force, blaming GPs. One comment stated:

"If GPs hadn't dumped their responsibilities on A&E, the crisis wouldn't have happened. Presumably ambulance crews would have to stand by until a patient could find their purse".

The dumping referred to was a result of the Labour Government's widely criticised 2004 reforms, which allowed GPs to opt out of providing

after-hours care. Not surprisingly, they all did. This, in turn, put pressure on A&E departments, where patients who had failed to become ill during office hours went to seek medical assistance.

Since the 2004 changes, patients had also complained of being unable to get an appointment with their doctor for up to a week, and of having no choice but to attend A&E.

The A&E co-payment plan included a proposal to refund the payment if the attendance was necessary, begging the question: Who decides what's necessary? And then, of course, there was the administration of it all – who was going to collect the cash, swipe the credit cards, process the refunds and balance the books? And what if a credit card bounced – would the patient be turned away?

It was all sounding very familiar and seemed to just keep getting worse for those very same GPs who had voted in favour of the £10 co-payment, when it was found that they were earning up to £1500 per shift moonlighting in A&E departments on the weekend rather than opening their own practices.

"Family doctors are earning thousands of pounds working night and weekend shifts at stretched A&E units, it was reported. GPs are being paid up to £1500 a shift as they help crisis-hit casualty departments cope with soaring numbers of patients, the Daily Mail said. Four out of 10 accident and emergency departments are hiring family doctors, who are already paid an average of £104,000 a year."

Patients were understandably outraged at the prospect of being slugged £10 in this context. To them, still reeling in the wake of the Mid-Staffordshire enquiry, where 1200 unnecessary deaths occurred in one NHS trust, it represented yet another failure of both the system and the providers working within in it, who were seen as having abandoned their flocks in favour of self-interest and KPIs.

Presumably the Health and Social Care Act 2012 (the Act) was designed to remedy some of these long-standing problems crippling the NHS. Capitation operates simply thus: here's a bucket of money, here's your population, keep them healthy. The Act abolished the long-standing primary care trusts and strategic health authorities, who used to administer the bucket of money, and replaced them with various organisations, including Clinical Commissioning Groups (CCGs) and Commissioning Support Units (CSUs).

The CCGs comprised GPs, who were given the money and the responsibility of deciding how it should be spent and proceeding to procure and contract NHS services accordingly. These services could be from private providers, as the Act allowed competition from private companies who met certain NHS standards on price, quality and safety.

But being clinicians first and foremost, it was to be expected GPs would need to call on assistance and support from the CSUs from time to time, for advice on how to allocate the resources appropriately and responsibly. The CSUs had the finance and management expertise to provide this advice, or so the public were led to believe, until this appeared on 4 January 2014 in *The Times*:

"Health chiefs spent £10 million on advice for their own advisers as part of a £40 million management consultancy bill to implement the Government's NHS reforms.

Figures released to Parliament reveal how the hundreds of new bodies which took over running the health service in April immediately began spending millions on help from consultants. Singled out for criticism were the 18 Commissioning Support Units (CSUs), created to advise the GP-led groups now responsible for buying services for patients. These in-house consultancy units spent £10 million on external management consultants in the six months to September."

A representative of the patients association said:

"…[CSUs] are there to give advice and support, yet they are buying people in to give advice and support on how to give advice and support. This sort of expense is totally unjustified".

It was becoming a tragedy of Shakespearean proportions when it appeared that some of the advisers, who had been hired to advise the advisers on how to advise, were senior NHS executives who had recently received huge redundancy payouts of up to £600,000 from the NHS as part of the restructure, only to then jump right back on what was referred to as the NHS merry-go-round and be rehired as consultants a month later, to pocket more NHS funds.

COUNTING OUR FORTUNES

So, it may not be a bad thing that in Australia we are unable to have a full-blown capitation system, as it's clear that no system is without problems. Though it has been suggested a similar model on a smaller scale could perhaps be adopted for some chronic diseases. For example, a diabetic patient may be rebated a fixed amount per annum, which they would assign to the GP and which would cover all attendances related to that disease in that year. It's a sort of capitation-per-disease model and, provided there is no option for the doctor to revert to fee-for-service if the patient consumes more services than were anticipated, it may have some merit.

We can and should feel very fortunate that we have so much choice in Australia and can still be treated free of charge, confident that we will receive the highest standards of care. But it's time we all engaged in a new conversation about the cost of Medicare.

Most Australians are blissfully unaware that their levy goes nowhere near to covering the cost of Medicare, which includes the MBS, the PBS and grants made by the Federal Government to the states to run public hospitals. The total cost of these three funding streams is currently close to $40 billion per annum, of which the levy, estimated in 2012-2013 as approximately $10.5 billion, covers about a quarter. The remainder is paid from other taxes.

There is a public assumption that payment of tax, by way of the Medicare levy, provides an immutable right to a package deal of health services that is all-inclusive, with no hidden or additional costs anywhere.

I see this in my work daily, as patients call to query accounts they have received, sometimes angry but more often confused. It can be mind-boggling sometimes when a patient calls who was a private patient in a private hospital, having non-urgent elective surgery, and is outraged that they might have to pay an amount from their own pocket for some, but not all, of the services they received.

We speak with so many patients who firmly believe that by having *private health* insurance they will never have to pay another cent for their healthcare. Yet such cover is not possible under our current healthcare system and has never been, so what makes them think that in the first place? It makes one wonder what marketing tools and strategies the *private health* funds use to entice and induce new members.

On the other hand, there are times when patient frustration is completely understandable, such as when a public patient in a public hospital ended up with an account for a service they didn't recall receiving.

AVERTING ERRORS

The Australian public wears Medicare as a badge of honour, but it's true that most don't understand very much about how it works and are largely ignorant about the real costs of the services they receive. And let's face it, we are all guilty of thinking that it's not over servicing if it's "me or someone I love" who is the patient.

The Grattan Institute predicts health will consume an additional 2% of GDP in the next decade, not because of an ageing population as many believe but largely due to the use of expensive tests and treatments by doctors.

But doctors are also largely ignorant about how Medicare works and their individual responsibility for the *national health* budget.

It's always a privilege to assist doctors with their Medicare claiming and compliance obligations at all stages of their careers. It's work we take very seriously, as we are often the first point of contact for young clinicians and the advice we give may impact claiming decisions they make for the rest of their careers.

I can tell you that it is always a great relief when we receive the phone call before rather than after the mistake has been made. Take last week for example, when a fairly new client – a recently qualified specialist – called because one of his senior colleagues had assured him that he could claim Medicare benefits in a particular

circumstance, but it just didn't "feel right" and he wanted to check.

The situation involved him as a VMO on call, seeing a patient in a public emergency department (ED) who elects to be private and for whom he can do the quick (though expensive) procedure in ED, after which the patient can go home. It's a scenario that definitely cannot be claimed due to a particular clause in the National Health Reform Agreement preventing patients being classified as anything other than public while they are in a public ED, irrespective of any private election the patient might make.

Another pattern of incorrect claiming averted and unknown thousands of tax-payer dollars saved! But the point is that both potential patients and this provider would have been completely unaware that the private arrangements they may have innocently entered would be wrong. And you couldn't really blame them. I mean, who reads the National Health Reform Agreement and examines its interface with the MBS?

The problems we face go way beyond quick fixes. They lie at the very heart of an extremely complex system very few understand. And as custodians of public money, the Federal Government must do better than to impose stop-gap measures layered on top of an already labyrinthine system.

Deeper examination is required, at the service-delivery level, where entrenched attitudes and practical problems exist that have plagued the system for decades. For it is the doctor and patient who are the only two relevant transacting parties at the point of service where the money is spent, and both must be considered in any proposals for reform.

In the 2009 High Court judgement of *Wong v Commonwealth*, Justice Michael Kirby highlighted the importance of each individual transaction between doctors and their patients when he commented:

"…because of the very great aggregate sums of federal moneys involved and the multitude of very small payments for the provision of individual services arising in the case of particular recipients, a high degree of particularity in monitoring, supervising and checking such payments is inescapable… So long as there is any payment of moneys out of the Consolidated Revenue Fund."

A MATURE APPROACH

It is naive to think our problems will be solved by simply changing the dollar amount of the transaction by $6 if the two contracting parties are to remain largely unclear as to the rules determining whether they should be entering the agreement in the first place.

Simple measures that don't punish tax payers, such as introducing cognitive steps into the transaction, have been proven to reduce expenditure both by slowing the process down and costing little to implement.

Some may remember the changes made to pathology request forms way back in the Medibank years, when the cost of tests had soared due to the 'tick and flick' phenomenon. The request forms included a long list of tests the doctor could simply choose from by ticking boxes. When the list was removed in favour of a free text area, where the clinician had to write down the names of the tests he or she wished to order, costs plummeted quickly and dramatically.

Millions of interactions take place daily between doctors and their patients and, by and large, our system works well. Certainly as well, if not better, than the systems in comparable countries. But if we continue to pathologise Medicare itself, reacting to symptoms and failing to treat the underlying disease, it will continue to fester and any efforts to find a cure will be hampered.

A mature conversation is needed, examining the way we use Medicare and why. Only then will meaningful and sustainable solutions be found. Ⓟ