Post-election policy pointers

Changes in health financing

The medical profession has an important role in the stewardship of the health system

In the past month, we have seen many opinions on what health financing changes have to be made to ensure we have a sustainable health care system. The most notable proposal has been the often-recycled idea of imposing a patient copayment for visits to general practitioners — a concept the Australian Medical Association does not support, for very good reasons.

When governments get nervous about spending in health, they have three options: reduce the price they pay; spend more wisely; or collect more revenue.

In terms of spending on medical services, medical practitioners have done their bit over the past decade on price. The proportion of health expenditure on medical services was 18.8% in the financial year 2001–02 compared with 18.1% in 2011–12.[1] Average annual growth in health expenditure on medical services in the decade to 2011–12 was 4%, compared with growth in expenditure on pharmaceuticals covered by the Pharmaceutical Benefits Scheme (PBS) of 6.0% and 9.3% for products at the pharmacy.[1] Further, growth in average health expenditure by individuals on medical services in the decade to 2011–12 was 4.0%, compared with 5.3% for PBS medicines and 7.5% for products at the pharmacy.[1] And the average growth in Medicare benefits paid per service in the decade to 2012–13 was 4.7%,[2] less than the real growth in total health spending of 5.4% in the decade to 2011–12.[1]

Today, 81% of GP consultations are bulk billed,[2] and 89% of privately insured inhospital medical services are charged according to the patient's private health insurer's schedule of medical benefits.[3] Patients had no out-of-pocket cost for their doctor's fee for 93.5 million GP consultations in 2012–13, and for more than 26 million inhospital services covered by private insurance.

The message from these figures is clear. The price of medical services is not where the problem lies, and it is not where the focus of the federal government should be.

The drivers of health cost lie in the volume of services — specifically, those related to the growth in non-communicable diseases — and the demand this places on the health system. In this area, the medical profession is critical to decision making about health financing.

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On the world stage, Australia's health system delivers an enviable service. If you become seriously unwell, you will receive world-class care in Australia. We need to ensure that when acute treatment is needed, people continue to get the care that is currently being delivered. However, we need to reshape the current system to meet the challenge being thrown up by an emerging set of problems. An ageing population with chronic and complex health needs changes the demand for health care.

While mortality from heart attacks decreased from 14 443 in 2001 to 9811 in 2011,[4] more Australians are now living with coronary heart disease and the disability that follows an attack. It is far cheaper if we can prevent people developing such disease in the first place.

Consequently, better support is needed for GPs to provide effective preventive care and improved disease management. Although this would require increased investment from Medicare, it would save the government money in the longer term.

For its part, the medical profession has two areas on which to focus: first, changing the way we provide health care, where we provide it and when we provide it for non-communicable diseases; and second, identifying cost-effective services. Both of these require wise spending.

In terms of our clinical practice, we must have a structured process for translating what we know into what we do. This requires much greater scrutiny of what we are doing, through participating in more research into and review of our own practice, so we avoid practices that don't provide real outcomes for patients.

The challenge for the medical profession is to accept that we do have a role in the stewardship of the health system. Otherwise, government will step in, and health care will be dictated by health financing experiments, rather than evidence-based and effective health care.

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1 Australian Institute of Health and Welfare. Health expenditure Australia 2011–12. Tables A9, A8, 3.11, 2.1. Canberra: AIHW, 2013. (AIHW Cat. No. HWE 59; Health and Welfare Expenditure Series No. 50.)
2 Australian Government Department of Health. Annual Medicare Statistics. Table 1.8. Benefit paid ($) for total Medicare (excluding broad type of service "dental benefits schedule"). https://www.health.gov.au/internet/main/publishing.nsf/Content/Annual-Medicare-Statistics (accessed Feb 2014).
3 Private Health Insurance Administration Council. Quarterly gap payment and medical benefits statistics. September 2013. http://phiac.gov.au/wp-content/uploads/2013/11/Gap-Sep13.pdf (accessed Mar 2014).
4 Organisation for Economic Co-operation and Development. OECD health data 2013 (online database). http://www.oecd.org/health/health-systems/oecdhealthdata.htm (accessed Jan 2014).