Australian Nursing & Midwifery Federation

CATHOLIC HEALTH Australia

Consumers Health Forum of Australia

Mental Health Council of Australia

Public Health Association AUSTRALIA

Introduction

The introduction of Medicare in 1984 aimed to ensure that all Australians could access high-quality care when they need it, regardless of their financial means.

Under Medicare, Australians are entitled to free public hospital care as a public patient, as well as subsidies to assist the payment of GP and specialist services in the community and medical expenses when being treated as a private patient in a private or public hospital.

Increasingly, however, Medicare is failing to meet the needs of the most disadvantaged.

The Mend Medicare Coalition calls on each of the political parties to outline how their plans for this election will ensure Medicare is able to meet the needs of all Australians into the future.

Background

Australians generally enjoy good health by comparison with most other countries.

According to the OECD Better Life Index, Australia ranks fifth amongst advanced economies in both life expectancy and the health of its population. With an average life expectancy at birth of 82 years, Australians can expect to live for two years longer than the OECD average of 80[1].

These figures, however, mask the widening gaps in both health outcomes and ability to access health care that are being experienced by an increasing number of Australians. This includes people who find it hard to access necessary health services, as well as those whose circumstances and background make it more likely that they will disproportionately suffer from disease than those in society at large.

People who suffer a disproportionate share of poor health outcomes are not served well by the health system. These groups include:

- Indigenous Australians;
- people living in regional, rural, remote and outer metropolitan locations;
- those who are financially less well off;
- those with chronic conditions and illnesses;
- those experiencing mental health issues;
- those with dental health problems;
- those living with varying degrees of intellectual and physical disability and ill health, and their carers.

1 OECD Better Life Index accessed at: http://www.oecdbetterlifeindex.org/topics/health/ 30 July 2013

These difficulties in access show that Medicare is increasingly failing to meet its objectives[2], which are:

- to make health care affordable for all Australians;
- to give all Australians access to health care services with priority according to clinical need; and
- to provide a high quality of care.

At this election, the competing parties need to explain what they are going to do to make the health system work more effectively for all Australians.

2 Medicare Principles accessed at http://www.medicareaustralia.gov.au/provider/medicare/ 30 July 2013

What needs to be done?

The Mend Medicare Coalition calls on whichever party forms government after the election to establish a Parliamentary Inquiry to consider:

- Why is Medicare no longer providing universal access to health care?
- Who is missing out on essential health services?
- What are the consequences of poor access on health outcomes?
- Where is there financial waste in the health system that could be redirected to improved health care access?
- How can Medicare be remodelled to achieve its objectives?
- How can Australia give greater priority to prevention, integrated primary care, the social determinants of health and hospital avoidance?
- What funding models can best provide greater access, reduced out-of-pocket costs for consumers and better quality health care, particularly for those with complex and chronic care needs?

The Barriers

The barriers to accessing necessary health care include:

- out-of-pocket costs;
- lack of health care professionals or facilities where and when people need them; and
- rationing of those services that are available, which arises where demand for services exceeds those which are made available. Waiting lists are the most obvious example of the rationing of services.

COST BARRIERS

With 18.2 per cent of health expenditure sourced from their own pockets, Australians pay a higher proportion of health care from their own pockets than people in most other wealthy countries, including both the United States and Britain.

In 2010-11, every Australian paid, on average, more than $1075 out of their own pockets to access health care[3]. This figure includes children, meaning the average family is paying several thousand dollars out of their own pockets each year to access health care. After taking into account inflation, this amount has been relentlessly increasing by over 6 per cent a year for the last decade, with households being asked to pay an increasing share of total health costs.

Over one third of out-of-pocket expenditure is directed to medication expenditure (6.5 per cent for Pharmaceutical Benefits Scheme co-payments and 33 per cent for other medications)[4]. A further 20 per cent of out-of-pocket expenditure goes to payments for dental services and another 11 per cent for medical services[5].

Many families and individuals do not have the financial resources to pay these amounts and are missing out on necessary care. People in poorer health with multiple chronic conditions are hit particularly hard, as what may seem a modest co-payment to fill a single prescription or to visit a doctor once can soon mount up in order to access necessary ongoing care.

Recent data show that:

- The average out-of-pocket cost for a visit to non-bulk-billing doctors, including GPs and specialists, was $46.50 in 2012, up from about $30.00 five years previously.[6]
- GP bulk billing now sits at an average of 82.4 per cent nationally[7], but this belies large variations between regions. The recent report by the National Health Performance Authority showed that bulk billing rates varied from as low as 49 per cent in some Medicare Local districts to up to 95.8 per cent in others[8], and low bulk-billed areas are not always the least needy. Clearly, those who live in areas with low bulk billing will face higher out-of-pocket costs than those who live

3 Australian Institute of Health and Welfare (AIHW) 2012 Health Expenditure Australia 2010-11 (Health and welfare expenditure series no. 47.Cat.no.HWE 56).AIHW, Canberra p84

4 Ibid p34

5 Ibid

6 Based on figures from Department of Health and Ageing 2012 "Quarterly Medicare Statistics – March Quarter 2007 to December Quarter 2012", online at http://www.health.gov.au/internet/main/publishing.nsf/Content/Quarterly-Medicare-Statistics accessed 5 April 2013

7 Medicare Australia March Quarter online at: http://www.medicareaustralia.gov.au accessed 31 July 2013

8 National Health Performance Authority, Healthy Communities: Australians' experiences with access to health care in 2011-12, p19

in areas where there is closer to 100 per cent bulk billing.

- The Australian Bureau of Statistics reports that the proportion of people delaying a GP visit has risen from 6.4 to 8.7 per cent between 2009-10 to 2010-11 – a 36 per cent increase[9].
- The National Health Performance Authority reports that the proportion of people who delayed or did not see a GP in 2011-12 varied from 1 per cent to 13 per cent across Medicare Local boundaries[10].
- For specialists, the proportion of people who delayed or did not see a specialist ranged from 3 per cent to 14 per cent across Medicare Local boundaries[11].

A further indicator of inequitable access to specialist care can be seen in the variation of use of the Extended Medicare Safety Net.

Once out-of-hospital expenditure exceeds a certain threshold over a year – $610 for lower income families and $1,221 for those on higher incomes – Medicare then pays for 80 per cent of additional out-of-pocket expenses up to a certain level[12].

However, because accessing this safety net requires the ability to spend at least up to the threshold amount, this safety net has disproportionately advantaged those who live in wealthy electorates such as Wentworth in eastern Sydney, where $11 million in safety net benefits has been claimed over a 12-month period compared to only $460,000 in Braddon, in less well-off northwest Tasmania[13].

Access to the safety net will be further reduced as a result of decisions announced in this year's Federal Budget. Many people will be further disadvantaged in receiving assistance for high medical costs.

Dental costs

The critical area of oral health is one that has not been part of the Medicare scheme. This has resulted in many people not being able to see a dentist, particularly with over half of all dental providers working in the private sector.

According to recent research:

- 25 per cent of people reported delaying or not seeing a dentist due to cost[14]; those who did faced an average $203 out-of-pocket charge.[15]
- The National Health Performance Authority reported that the proportion of people who delayed or did not see a dentist varied between 11 per cent and 34 per cent across Medicare Local districts.[16]
- Many who delay seeing a dentist will eventually suffer unnecessary pain and complications – ultimately requiring expensive hospital treatment.

9 Australian Bureau of Statistics (ABS) 2012 *Patient Experiences in Australia: Summary of Findings, 2011-12* (Cat.No.4839.0), online at http://www.abs.gov.au/ausstats/abs@.nsf/mf/4839.0. Accessed for April 2013

10 National Health Performance Authority Op Cit p61

11 National Health Performance Authority Op Cit p17

12 Medicare Australia online at: http://www.humanservices.gov.au/customer/enablers/medicare/medicare-safety-net/medicare-safety-net-thresholds accessed on 31 July 2013

13 Department of Health and Ageing 2012 "Facts and Figures: Electorate Reports on Health Data", online at HTTP://www.health.gov.gov.au/Internet/main/publishing.NSF/content/electoratereport-index-2010 Accessed 4 April 2013

14 ABS Op Cit

15 AIHW Op Cit p34

16 Australian National Performance Authority Op Cit p17

Pharmaceutical medication

The National Health Performance Authority reported that the proportion of people who did not fill a pharmaceutical script because of the costs they will incur varied between 5 and 15 per cent across Medicare Local districts[17].

Private health insurance costs

With nearly 50 per cent of people feeling the need to take out private health insurance, a mid-level policy for a family costs around $3000 per annum.

Those who do use their private health insurance to be admitted to hospital as a private patient face an average out-of-pocket cost of $1,170 per year to cover the medical and other associated costs[18].

Use of hospital emergency departments

One of the more startling findings from the National Health Performance Authority's recent *Healthy Communities* report is the variation in the proportions of people between Medicare Local districts who present to hospital emergency departments each year. They vary from 8 per cent to 29 per cent[19]. However, according to the Authority, this variation does not appear to show any relation to the health status of the population. In other words, it must be concluded that significant numbers of people are resorting to using hospitals in order to gain access to basic health services.

According to the Authority, it is not possible, however, to report on the degree to which individuals in Medicare Local catchments are actually getting access to the care they need.

17 Ibid
18 AIHW Ibid
19 National Health Performance Authority Op Cit p55

Hospital waiting times

Given the access issues outlined above, it is not surprising that despite all the additional resources directed to hospitals over the last five years and the strong focus on meeting reduced waiting time targets, public hospital waiting times have in fact increased from 34 days to 36 days.

However, according to the COAG Reform Council, people who lived in the most disadvantaged 10 per cent of Australia in 2008-09 waited 38 days for elective surgery compared to only 27 days for those living in the most advantaged to least disadvantaged areas[20].

In 2010-11, the gap between the two had grown, so that people from the most disadvantaged areas waited 13 days longer. In 2008-09, of those people who had the longest waits, people in the most disadvantaged 10 per cent of Australia waited 231 days for elective surgery – 61 days longer than in the least disadvantaged areas, where wait times were 170 days. In 2010-11, the gap had grown to 94 days[21].

Recent figures also show that the rate of private patient use of public hospitals is rising much faster than either the growth in public patient numbers or the rise in private patients use of private hospitals.

20 Council of Australian Governments Reform Council, Healthcare 2011-12: Comparing outcomes by socio-economic status, Supplement to the report to The Council of Australian Governments, p6
21 Ibid

Why is Medicare failing?

The nature of illness and disease has changed significantly since Medicare was introduced nearly 30 years ago. Medicare has essentially provided a funding subsidy for one-off interactions with the health system such as a visit to the doctor or a short hospital stay.

While this model works well for people who have a single or short-term health condition that can be treated effectively over a short period of time, it is less suited to the increasing numbers of people who may have one or more chronic – and often complex – illnesses that require ongoing interactions with a range of health care providers in both the hospital and community environment.

For people with multiple chronic conditions who do need to use the health system on an ongoing basis or see a number of different health care providers, multiple out-of-pocket charges soon add up to become an insurmountable barrier to receiving the care they need.

For Indigenous people, those living in regional areas, those from lower socio-economic backgrounds, those with mental health conditions and those with poor oral health, it is arguable that the existing Medicare model has never totally been able to meet their health needs.

It is time to take stock of who is missing out under current arrangements and rethink how health services are delivered to make sure that those who are the most vulnerable and disadvantaged – and who need to access health care services the most – are best able to.

Importantly, Australia needs a system that places much greater emphasis on the social determinants of health, such as employment, housing and transport, to minimise ill health and reduce the inequities in health outcomes. We need to have better preventative strategies to help people live healthier lives and we need to provide more access to primary care to help people better manage their chronic conditions and reduce the need for more expensive hospital stays.

Australia also needs to consider funding frameworks that go beyond our current fee-for-service model, which is focussed on throughput, and instead focus on health outcomes and delivering services that meet the needs of consumers. A fee-for-service model can work effectively for individual visits to health professionals to manage straightforward health problems. However, for consumers with multiple chronic complex conditions requiring multidisciplinary care arrangements with the consumer at the centre, it is time to consider alternatives. These could include:

- Grant payments to a service based on the volume of patients enrolled with the service to support multidisciplinary clinical services and care coordination.
- Outcomes payments to reward effective treatment for a condition or good performance in outcomes for enrolled patients.
- Episodic or bundled payments, bundling together the cost of packages of primary health care for individuals over a course of care or a period of time, which would give primary health care services the freedom to take on a long-term, whole-person, population health perspective.
- Hybrid models that draw on the best features of both fee-for-service and episodic, outcome-based payments.

Members of the Mend Medicare Coalition

Australian Nursing & Midwifery Federation

www.anmf.org.au

CATHOLIC HEALTH Australia

www.cha.org.au

Consumers Health Forum of Australia

www.chf.org.au

Mental Health Council of Australia

www.mhca.org.au

Public Health Association AUSTRALIA

www.phaa.net.au

Recommendation

The Mend Medicare Coalition calls on whichever party forms government after the election to state how they intend to address the issues identified in this document and to establish a Parliamentary Inquiry to consider:

- Why is Medicare no longer providing universal access to health care?
- Who is missing out on essential health services?
- What are the consequences of poor access on health outcomes?
- Where is there financial waste in the health system that could be redirected to improved health care access?
- How can Medicare be remodelled to achieve its objectives?
- How can Australia give greater priority to prevention, integrated primary care, the social determinants of health and hospital avoidance?
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