AUSTRALIAN MEDICAL ASSOCIATION

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Major Health Issues in Australia

Almost immediately following my election as President of the Australian Medical Association, Australia was engaged in a national election campaign, culminating in the election itself on 2 July 2016. The AMA and health issues were particularly influential in the election result, which saw the Government returned with a wafer thin majority in the House of Representatives and increased representation of minor parties and independents in the upper house.

The big issues that concerned the AMA and other health groups included cuts or an long-term indexation freeze on the government funded medical benefits schedule, public hospital funding, and cuts to bulk billing incentives for pathology and diagnostic imaging services. These were issues that mattered to voters. The take-home message for the Government was clear – Health matters. This has been clearly acknowledged since the election.

Health Expenditure

The Government has consistently argued that health spending in Australia is out of control. Backed by national and international data, the AMA has equally consistently argued that we do not have a health spending crisis, and has called for better targeted funding of the things that work in health – prevention, general practice, finding the balance between public and private medical care. The AMA strategy is about investing in the parts of the health system that will deliver better health outcomes – and importantly, savings – over time.

Total health expenditure in Australia has seen two years of modest, sustainable growth, with expenditure in 2013-14 representing 3.1% growth on 2012–13, which was only a 1.1% increase on 2011-12. For these two years growth has been well below the long-term average annual growth of 5 per cent over the last decade.

The Australian Government's share of total health spending fell from 44.2% in 2008–09 to 41.2% in 2013–14. Health expenditure represented 9.8% of Australia's GDP in 2013-14, with the 10-year average for Australia being 9.12%. On the OECD scale, Australia is below the OECD average and lower than 18 other OECD countries. Australia achieves better health outcomes for its significantly lower proportional spend than the USA (16.4%) and many other countries including the Netherlands, Switzerland, Sweden, Germany, France (all around 11%).

Public Hospital Funding

The AMA's Public Hospital Report Card (January 2016) documented that, against key measures, the performance of our public hospitals is static, or even declining. States and territories are failing to meet national targets for treatment and waiting times in EDs and elective surgery. This is the direct consequence of reduced growth in the Commonwealth's funding of public hospitals.

Following release of the report card and sustained pressure on public hospital funding from states and territories and the AMA, on 1 April 2016 the Commonwealth reached agreement with the states and territories for new hospital funding arrangements, resolving the impasse created by funding reductions in the Commonwealth's 2014-15 Budget.

This agreement involves an additional $2.9 billion funding over three years which is welcome but inadequate. It represents a short term fix for the needs of public hospitals, with a further three years to wait before a long term solution to the ongoing need for sufficient and certain public hospital funding. The AMA continues to advocate that the public hospital system needs a guarantee of adequate funding over the long-term.

The agreement also includes new initiatives, including to consider how hospital pricing could reflect safety and quality, and how to reduce avoidable hospital readmissions. The AMA will take an active role in any consultation opportunities in the development of these initiatives, and has already expressed its view that these reforms should not be funded at the cost of funding public hospital services themselves.

Private Health Insurance

The AMA supports a system where the public and private systems work side by side to provide universal access for patients to health care. The public system relies on a complementary, strong and innovative private system. The balance between these two is one of the reasons we have such a successful health care system. Unlike the US system, we have a community rated health insurance system which has ensured that we have been able to continue to insure patients with chronic conditions and where patients cannot be refused private health insurance or have their policy withdrawn when they become ill or too expensive. The cost is shared.

However, there is work to do to improve the value of Private Health Insurance for consumers. Two-thirds of respondents to a Government survey on PHI in 2015 said they were not getting value for money from their plans.

The Government plans to reform the provision of private health insurance policies whilst maintaining the community rating system. It will develop gold, silver and bronze health policy categories, standardising terms and mandating minimum levels of cover. We hope this will elicit greater consumer engagement with the private health insurance market. The AMA is also pleased that the Government has announced it will be removing 'junk' policies from the market. Policies with a primary purpose ofavoiding financial penalties for not having insurance are detrimental to the health system.

Managed Care

The AMA continues to be concerned about the behaviour by the larger insurers.

The big insurers are using aggressive tactics to reduce their benefit outlays (and increase their profits for their shareholders). There appears to be a concerted effort on behalf of some of the large insurers to undermine and control the medical profession. The stage is being set for an American style managed care system.

Some private health insurers are refusing to pay for so called ‘preventable’ adverse events and have successfully negotiated contracts with the majority of hospitals with new clauses for non-payment for hospital acquired complications and readmissions within 28 days. This effectively adds more exclusions to existing policies and will have a detrimental impact on doctors’ ability to care for their privately insured patients.

Other insurers are requiring ‘pre-approvals’ for surgery, effectively questioning the doctor’s advice to the patient. These behaviours mean that the patient may not be able to receive the care they need at the time they need, undermining the value of the product purchased by a consumer.

The AMA is glad to see the Australian Consumer and Competition watchdog challenging these behaviours. A change in the regulatory landscape is needed to en-

sure that consumers get what they have paid for.

General Practice under Pressure

The strength of the Australian health system is its reliance on general practice and the pivotal role of the general practitioner, who is a highly trained medical specialist. GPs are the first point of contact when most Australians feel unwell and the manage 90% of the problems they encounter.

General practice is under sustained pressure and it has been for many years. Because of an ageing population and the growing burden of chronic and complex disease, GPs are seeing more patients than ever before – with over 139 million Medicare funded services delivered in 2014/15. This compares to around 98 million Medicare funded services in 2004/05.

In 2014–15, GPs managed 155 problems per 100 encounters, significantly more than a decade earlier when it was 146 per 100. Over the last decade, GPs have

- Managed 68 million extra problems of which 24 million were for chronic conditions such as diabetes and depression – up by 48%;
- Delivered 35 million extra GP-patient encounters – up by 36%, with 17 million of these with patients aged 65 and over - up by 67%;
- Delivered 10 million extra hours of GP clinical time – up by 43%; and
- Deliver 10 million extra procedural treatments – up by 66%.

Data from Bettering the Evaluation and Care of Health highlights that if GP services were performed in other areas of the health system they would cost considerably more than when provided in General Practice. For example, GP services provided in a hospital emergency department would cost between $396 and $599 each, compared to the average cost of a GP visit of around $50.

General practice is keeping the nation healthy and is very good value for money. Medicare spending on GP services only represents about 6 per cent of the total government health expenditure. Successive Governments have praised GPs and the role they play in the health care system, yet at the same time they have cut funding for GP services to the bone.

We have seen both major parties implement a freeze on Medicare rebates and GPs have also been hit by cuts in areas such as the Practice Incentive Payments program and mental health funding. The actions of Government fail to match the rhetoric and see GPs caught in a terrible squeeze. They are caring for increasingly sick patients while Government tightens the financial screws under the guise of fiscal repair.

GPs are now at breaking point. Unless there is a substantial investment of funding into general practice, there is no doubt that the quality of care will start to suffer and patients will face growing out of pocket costs.

Many patients who are treated at no cost currently by GPs (bulk billed) could face out of pocket costs well in excess of $20. The fees GPs will have to charge will need to cover the loss of Medicare indexation, the loss of bulk billing incentives for eligible patients as well as cover the administration costs of collecting money from patients.

Health Care Homes

The Commonwealth Government released the report of the Primary Health Care Advisory Group (PHCAG) in April as well as its response. At the centre of the Government's response is the proposal for a trial of the health care home concept, linked to the voluntary registration of patients with complex and chronic disease. Importantly, the health care home is built around general practice.

The proposal for the Health Care Home appears to be the Government's major health priority, with the Prime Minister taking a personal interest and little other health policy on its agenda – other than cuts to funding programs.

The inaugural meeting of the Health Care Homes Implementation Advisory Group (HCHIAG) was on 22 July, with AMA Vice President, Dr Tony Bartone, representing the AMA. A number of working groups sit beneath the HCHIAG, with the AMA being represented on the payment mechanism working group and the patient identification working group.

Overall, the initiative is in very early days in terms of progress and the lack of new funding to support the trial remains a critical issue in so far as GPs will be asked to do more work with no extra funding support. The Medicare rebate freeze is also likely to undermine the trial to the extent that it has left GPs with very little goodwill towards the Government and unwilling to engage.

National Training Survey

The AMA has been pursuing a proposal to implement a national medical training survey for some years, similar to one run by the General Medical Council in the United Kingdom. This proposal became one of the recommendations of the Report of the Council of Australian Governments Health Council National Review of Medical Intern Training that was delivered last year.

While the recommendations of the above Report continue to work their way very slowly through the bureaucracy, the concept of the NTS has gained some momentum and there now appears to be broad stakeholder support for the concept, including among state/territory health departments, colleges, training providers, medical schools etc.

Higher Education Submission

The AMA made a response to the latest potential overhaul of higher education that the Commonwealth Government outlined in a discussion paper it released in May. While the Government has abandoned deregulation of university fees, the potential for this to happen in medicine is still on the table with the discussion paper outlining an option to allow universities to charge deregulated fees on a limited number of prestige "flagship" courses.

The discussion paper also keeps on the table the proposals to cut government contributions to university course funding by 20% and reducing per student government grants. The AMA submission reiterates our opposition to fee deregulation as well as proposed funding cuts, highlighting in relation to the latter that funding for undergraduate medical education in Australia is modest in comparison to comparable countries.

Doctors' Health

The AMA continues to progress the development of a national health program for doctors and medical students in Australia, with funding to support this provided by the Medical Board of Australia. The AMA's subsidiary company, Doctors Health Services Pty Ltd (DrHS), is overseeing the move to fund and coordinate nationally consistent services in every State and Territory. DrHS has finalised funding arrangements covering NSW, ACT, SA, NT (commenced 1 May 2016), Queensland (commenced 1 June 2016), Victoria and Tasmania (commenced 1 July 2016).