MEDICARE AND THE NEW AUSTRALIAN HEALTH CARE AGREEMENTS: WHAT CAN AUSTRALIANS EXPECT OVER THE NEXT FIVE YEARS'

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ABSTRACT

Australia has operated a universal health insurance system known as Medicare since February 1984. It is based on the principles of universality, equity, simplicity and ease of access. All Australians are insured for medical services under this system. Medicare is administered via a health care financing Agreement between the Commonwealth and the six States and two Territories known (until recently) as the Medicare Agreements. It is supported by several pieces of legislation at both levels of government which regulate and protect the integrity of the system overall. Medicare is perceived by many as a complicated, confusing and disintegrated system and yet, despite this it is popular among Australians and as such, it has been retained through two changes of government since 1984. The Australian Health Care Agreements (AHCA) replaced the existing Medicare Agreements in July 1998. In developing the policy for negotiating these new Agreements, it was important to closely examine the existing Agreements in terms of where the benefits were and where change was required. In particular what were the areas of difficulty that existed with the existing Agreements that had to be changed in order for the Medicare system to be able to continue to provide health services into the twenty first century. In developing the policy to support the negotiation process for replacing the Medicare Agreements the impact of the current Agreements was required. The 1993-98 arrangements promoted cost shifting games due to barriers within the system which prevented exploration of ways to improve the effectiveness of health care in Australia. This paper explores the structure and function of Medicare, its problems and where reform will most likely occur under the new arrangements.

Keywords: Medicare Agreements, Australian Health Care Agreements, Funding, Universal Health Insurance System, Equity, Access, Health Care Reform, Measure and Share Models
INTRODUCTION

The Australian health care system provides universal access to quality health and hospital care through Commonwealth and State/Territory Medicare funding. The Commonwealth Government has responsibility for Medicare funding (derived from income taxes) and States and Territories for the delivery. There is also substantial private funding through the private health insurance system, which is supported and regulated by the Commonwealth.

Prior to 1975 the Australian health care system resembled a complex system of government subsidised, voluntary public and private health insurance schemes which offered private hospital cover or doctor of choice in public hospitals. In 1975 Medibank was introduced which operated as a non-contributory health insurance scheme. The most important issue was that Medibank offered universality and while several amendments occurred to the scheme over the next nine years, including a return to a ‘voluntary system’ the catalyst for full implementation of Medicare in 1984 was a change in government which again offered the universality of health cover.

Overall Medicare is estimated to be Australia’s third largest employer, accounting for approximately 8.5% of gross domestic product (GDP) and costing approximately $30 billion to operate. It is paid for in the ratio of two to one from public and private sources.

This paper explains the administration and operation of Medicare and the development of the new health financing agreement (known as the Australian Health Care Agreement) to continue Medicare provision in Australia. There is then a discussion of what Australians might expect to see change over the next five years of this new agreement.

AN OVERVIEW OF THE FUNDAMENTALS OF MEDICARE

Medicare is a universal health insurance system based on principles of universality, equity, simplicity and ease of access. Under this system all Australians are insured for medical services and are entitled to access public hospital services.
Medicare is in itself the principal instrument of a national commitment to equity in health care for Australians. Equity in this sense is defined as equal access to equal care for equal need. Indeed it is considered the most important principle yet the most difficult to ensure. Medicare also ensures that eligible persons receive public hospital services free of charge as public patients, and that access to these services is on the basis of clinical need, regardless of geographic location.\(^3\)

**THE LEGAL FRAMEWORK GOVERNING MEDICARE**

There are several important pieces of legislation that relate to the administration of Medicare and are designed with the intention to protect the integrity of the Australian health care system. The Commonwealth Minister for Health and Aged Care administers Commonwealth Acts that are relevant to the delivery of health services in Australia, such as the National Food Authority Act (1991).\(^4\)

The two most relevant Acts for the purpose of arranging and administering health services in Australia are the National Health Act (1953) and the Health Insurance Act (1973). Both these Acts were amended in 1983 to establish a national health insurance scheme (Medicare) and to introduce a standard and universal level of medical benefits.\(^5\)

The National Health Act (1953) is the only Commonwealth Act with the authority for the provision of Commonwealth pharmaceutical benefits and the supply of aids and appliances (such as hearing aids). It also is the authority for the payment of benefits in respect of nursing home care and oversights the registered health benefits organisations which administer payments in relation to the private health insurance industry. When the Health Legislation Amendment Act received Royal Assent on 1 October 1983 it allowed for the Commonwealth to enter into Agreements with the States and Territories in relation to the provision of hospital and community health services to eligible persons from February 1984. The importance of this Act was that it defined the parameters within which health care could be delivered and financed and who was eligible to receive it. Prior to this the level of service provision was dependent upon showing evidence of enrolment in a contributory (or otherwise) health fund and it was merely implied that all citizens were eligible.

Payment for medical benefits and hospital services is authorised by the Health Insurance Act which includes coverage for other items such as optometrical, dental and pathology services for all Australian residents. Importantly, this Act provides for the Commonwealth and State Governments to enter into political agreements to facilitate the provision of public hospital services without charge to all Australian residents. All States and Territories have their own health services legislation which
is administered by the State/Territory Minister for Health and depending on the State/Territory, also make provisions for the management of health professionals.

The regulation of Medicare is via the statutory authority known as the Health Insurance Commission (HIC) and the Commonwealth Department of Health and Aged Care. Since the Commonwealth is responsible for paying for the majority of health and hospital services in Australia the onus on the HIC is to act as a "watch-dog" for the government to prevent fraud and over servicing. Therefore, the HIC has a role in monitoring activity and reporting on change over time. Since the States and Territories are required to structure their respective systems to deliver health and hospital services they have input into the ongoing management of the public system through structures such as the Australian Health Ministers Conference and Australian Health Ministers’ Advisory Council (AHMC and AHMAC).

THE COST OF MEDICARE SERVICES

Although the Australian public contribute 1.4 percent of their taxable income towards the total cost of Medicare, this only meets one tenth of the total operating cost. The remainder comes from Commonwealth general revenue sources. A large part of the cost of operating Medicare is complicated by Commonwealth/State responsibilities governing the financing and delivery of health and hospital services in Australia. On the basis of international statistics for the early 1990s, the Commonwealth Government collected close to three quarters of all government revenue. However, about one quarter of its tax revenue is distributed to the States/Territories and local government. The balance between expenditures and revenue at the central level in other OECD countries and the United States and Canada is much closer than in Australia. This means that there is an imbalance between the revenue raising and expenditure responsibilities at the Commonwealth and the State levels leading to a much greater financial dependency of the States on the Commonwealth.

While the Commonwealth has no direct responsibility for providing public health or hospital services it tries to ensure that States and Territories deliver them in a way that is consistent with national policy directions. It can usually be linked to a particular national policy such as the National Health Priority Areas (heart disease, cancer, diabetes and so forth) and require the States to conform with the Medicare Principles and commitments governing the administration, financing and delivery of health care services in Australia. This has the effect of constraining the States from raising user charges for public hospital services and depending on the type of payment arrangement there can be reduced flexibility in the State/Territory’s ability to manage its responsibilities. On top of this States and Territories have a narrow revenue base from which to finance health services and to accommodate for growth in demand for public hospital services which were previously paid for by private sources.
In broad statistical terms Commonwealth expenditure on Medicare benefits in 1997-98 was $6.33 billion compared to $5.7 billion in 1994-95. As a percentage however, this figure represents a growth in Medicare expenditure of 1.5% in real terms over three years and has been held back in part by the continuing negative real growth in the number of self referrals (or services provided by general practitioners). It is from MBS services that many other MBS services are derived, such as diagnostic services and pathology which are service items payable under Medicare. Broadly the distribution of services provided under Medicare in 1997-98 were in General Practitioner services (51%), pathology (26%), specialist consultations (9%) and diagnostic imaging (5%). There was a rise in the volume of services provided under Medicare by 2.5% from the corresponding period in 1997.

For every person in Australia the average expenditure on Medicare services was $330 or eight services per person. The average patient contribution on top of the rebate received through Medicare was $16.10 in 1997-98.

Charging for Medicare services is assisted by the annually produced Medicare Benefits Schedule (MBS). This book contains a listing of all the types of services and procedures that may be provided under Medicare. A medical practitioner can raise a fee directly or indirectly using the MBS as a guide or can charge using another schedule of fees such as that produced by the Australian Medical Association (the AMA). By directly charging a patient the practitioner receives payment at the time of service and can accept the Medicare rebate as full payment (termed bulk-billing) or can charge more than the Medicare schedule fee, thereby requiring the difference to be paid for by the patient. Although a practitioner is free to charge any price over this listing of fees, the schedule is generally what is used for charging purposes. The Commonwealth also manages a Schedule of Pharmaceutical Benefits known as the PBS. It includes only medicines that are clinically necessary and cost-effective. A practitioner can prescribe drugs that are listed on this schedule or can prescribe alternative forms of drugs not listed on the PBS. However in order to claim a rebate the drug must be listed on the PBS.

PBS prescription costs are met partly by patient co-payments, while the Commonwealth Government meets the remainder of the cost. In 1997-98 there were 124 million prescriptions filled at a total cost of $2.7 billion. The Commonwealth Government contribution was 82 percent. As a percentage of GDP, pharmaceutical expenditure in 1997-98 represented 0.51%. A patient co-payment of $20 per prescription is required with a safety-net system in place to limit total per capita expenditure on pharmaceuticals up to $612, after which the safety-net applies and no further out-of-pocket expense is required. In addition to the drugs available under the PBS the States and Territories provide and fund drugs for inpatient use and outpatient use. Many of these drugs will be listed on the PBS and hospitals have the ability to provide these drugs as well as generic type drugs supplied under government contracts.
The type and range of drugs used by hospitals will be different to the range required for community based use and the cost differential is higher for hospitals as a result. There are high cost drugs not funded by the Commonwealth (and therefore not attracting a subsidy) which hospitals will provide because of the nature of a particular disease which warrants hospitalisation. There are high cost drugs funded by the Commonwealth under Section 100 of the Health Insurance Act which attract a subsidy and have strict criteria associated with their use. In terms of access and equity provisions, the Commonwealth regulates the number of pharmacies approved for urban, rural and remote areas with roughly one pharmacy per five thousand people. There is a difference between the services provided for rural and remote people compared to urban people in Australia, and the most difference occurs in the Northern Territory where there are eighteen pharmacies in the urban sector to ten in the rural sector. This is because community health services are used more than community pharmacies and these centres are able to dispense drugs.

The MBS and PBS expenditure information does not reflect expenditure on those services rendered free of charge in public hospitals or relating to compensation cases, health screening services or program grants. In 1997-98 States and Territories received $5 billion to finance the public hospital system including community based and outpatient care. In the five years to the end of that financial year growth in Medicare funding by the States on State total health expenditure was stronger than such funding by the Commonwealth.

DEVELOPING POLICY FOR THE REFORM OF MEDICARE

One of the features of the Australian health care system is that it is pluralist, and therefore it is diverse. Diversity influences the managerial aspect of health care by dictating the type of structure required to deliver services. This is shown in how the Australian health care system is organised differently around the six States and two Territories. There is a purchaser/provider arrangement in the Australian Capital Territory which is an output based funding system; a modified purchaser/provider model in Western Australia, and a population based model in New South Wales where allocations are paid to health services according to the age and illness experience of the population. The differences are only in relation to the nature of the structures because the States and Territories are bound by the Medicare principles and commitments.

The theory of a universal health system is well supported, but the management and delivery arrangements in Australia are far from perfect. There has been widespread criticism of it being a complicated system from an administrative perspective and a confusing mixture of Commonwealth and State responsibility in terms of
management. Waiting lists are a growing cause for concern nationally and there are inequities apparent in rural and remote regions.

Despite these concerns and criticisms there is bipartisan Commonwealth support for Medicare’s continuation. Indeed Australia’s compulsory voting system has proven to be the force behind its retention with health care a major electoral issue, as it appears to be in any country. Over the past five years the Health Insurance Commission has conducted on behalf of the Commonwealth, a series of customer satisfaction surveys designed to test the level of support Australians have for the Medicare system. Between the period 1993 and 1998 the level of support for the Medicare program and its administration overall ranged from 85% to 93% in 1996. It stands at 88% in 1998.11

So Australians want to retain Medicare despite its complicated structure for administration. One reason for its popularity may be the durability that comes from a lack of change to the basic tenets of the system since its inception in 1984. Another reason may be the Australian sense of egalitarianism where support for Medicare exists because it is ‘free’ and everyone can enjoy its benefits. Medicare is free only for those persons who do not pay taxes (such as the unemployed or pensioners) since the levy merely acts as a contribution to the overall cost of financing the system. The Australian population likes to believe that it is free, that it will treat anyone at any time and for any illness. It is more like a comforting thought than an insurance plan. Over the past few years however, Medicare has struggled to keep pace with the changes in technology, utilisation and cost due to inequities in financing and management, and a growth of the population overall, a large component of which is ageing.

THE REFORM PROCESS

In order to effectively progress negotiations with the Commonwealth for the new five year health financing agreement, each State and Territory conducted an analysis of the existing Medicare Agreement to evaluate its impact. The main purpose for undertaking such an exercise was to establish how effective Medicare funding had been in compensating States and Territories for the costs of health care provision, where the major difficulties were and what could be improved in a new agreement. The principal factors influencing the capacity of any State or Territory’s health systems to function are:

- changes in the composition and size of the population utilising health care services;
- changes in demand for types of health care services;
- changes in health care technology and clinical practice;
fluctuations in levels of private health insurance membership and in particular the utilisation of that insurance;

efficiency in health care services supply;

changes in the cost of goods and services utilised in the provision of health care services, and

utilisation drift, including trends in settings of care and private patient treatment\textsuperscript{12}.

None of these factors operates in isolation of the other as an inter-dependent relationship exists where the impact of a change in one factor directly influences the nature of another. This is easily explained by examining the changes in medical work practices having arisen directly as a result of improvements in medical technology and support systems such as Magnetic Resonance Imaging (MRI) and Computerised Axial Tomography (CAT) scans which assist in the diagnosis and management of illness. Any change in diagnosis and treatment patterns will influence the demand for health care services and level of efficiency in supply.

In evaluating the existing agreements States and Territories acknowledged that one of the major problems with the 1993-98 Medicare Agreements was that it was structured in such a way that States and Territories lost opportunities to undergo structural reform because of the significant time lags that were apparent in the process of adjusting the quantum of funds for movements in the national population. It is widely recognised that it is difficult to transform sudden unexpected injections of funding into expanded service provision if it has not been planned for. In addition to this more emphasis was given to population related funding adjustments on the basis of increased performance. If a particular State or Territory met targets but not at the performance level then the total quantum of funds received would be less than another State or Territory which targeted specific areas for service delivery.

Overall the consensus was that the Australian health care system had been structured so barriers and boundaries existed that not only prevent appropriate care being provided but encouraged cost shifting games to be played out between the Commonwealth and various States and Territories. Cost shifting is defined as the inappropriate shifting of costs of health service provision to another level of Government or to the individual\textsuperscript{13}.

In 1995 in an effort to reduce cost shifting the Commonwealth imposed financial penalties on several States for what were perceived to be cost shifting activities. The result was that apart from reducing the level of co-operation by States and Territories for activities which may have resulted in mutually beneficial efficiency gains, it had no real effect on the management of the Australian health care system.
In developing the new Australian Health Care Agreement, States and Territories recognised that the Agreements are primarily political in nature rather than legal, and exist so that both levels of Government can achieve one of the core principles of the Australian health care system: choice of free hospital care for all Australians. Indeed, as important as they are for allocating funding across the various jurisdictions, States and Territories use whatever agreements are in place at the time to achieve a much broader range of health policy objectives that are in the national interest than merely service delivery. This has in fact been happening since the Commonwealth first allocated funding to States and Territories for health and hospital care in 1949-50.

The proposal in 1997 for a new Australian Health Care Agreement contained a shared vision endorsing a set of building blocks for the Agreements including the ‘measure and share’ arrangements, an integrated information system, an output and outcome focus and risk management arrangements. Five main elements proposed for the Agreements were an Admitted Patient Component; Non-admitted Patient Component; Mental Health; Palliative Care; Quality Issues and system restructuring arrangements. The proposal was designed with a funding model to accompany the policy so that for the first time, negotiations would be able to centre on policy as well as funding matters. It also allowed for full cost supplementation to the Department of Veterans’ Affairs (DVA) to enable it to enter into full cost charging arrangements for the treatment of veterans without any adjustment to the Commonwealth offer in regard to Health Care Agreements.

The details of the proposal were discussed and negotiated at a political level and at a Departmental or bureaucratic level. The general dissatisfaction was due to inadequate funding proposed from the Commonwealth to fund health and hospital services. The level of funding is a significant matter largely due to the vertical fiscal imbalance that exists in the Commonwealth/State relations and the lack of a broad revenue base from which States/Territories can draw from to finance additional costs. The continued and sustained growth in total separations when taken with a very significant decline in private patients has been a major factor in increasing the cost structures in public hospitals. The rate of Australians holding private health insurance has declined to approximately 26% with utilisation rates lower than that and variable across States and Territories depending on the nature of the private hospital industry operating. At the same time the Health Care (Amendment) Bill introduced to Parliament in April 1998 became subject to a Senate Public Inquiry on 5 May 1998. The Commonwealth allowed this legislation to lapse. A Bill titled Health Care (Appropriation) Bill 1998 was passed on 29 June 1998 which had the effect of appropriating funding to States and Territories over the five years of the Agreement. The Agreements were finally signed in August 1998 after over two years of negotiation. Some time lags were experienced arising from State and Federal elections.
A PLAN FOR REFORM. WHICH FIRST AND WHEN?

The major changes that are indicated in the signed Agreements relate to a change in the means by which health services are delivered and paid for so that there are structural changes anticipated and managerial changes flowing from that. Despite the major emphasis on reform, structural changes will be implemented moderately in the first two years of the Agreements. This is because under the previous Agreements there was no sharing of risk between the parties with States taking the responsibility for any increases in demand due to utilisation drift. The new Agreements seek to share the risk but in order to do this some models of care need to be tested and evaluated before reform can occur. There can be an expected emphasis on service delivery reform in the form of co-ordinated care trials which are considered the precursors to models of integrated care and an ongoing exploration of additional initiatives under a measure and share model.

A measure and share model is a funded program which is based on accepted evidence that the changed method of delivery or finance leads to improved patient outcomes and/or more cost effective care and that care can be measurable. The whole idea behind the concept of a measure and share approach is that it may result in the cashing out of State or Territory funded programs and/or Commonwealth funded programs, including the Medicare Benefits Schedule and the Pharmaceutical Benefits Scheme but only if one or the other source of funding is found to be the more appropriate means for financing care. This is currently being explored in the development of models of inpatient and outpatient care in certain States.

There will be greater involvement by both levels of Government in partnership with clinicians and consumers, to explore ways to improve health care safety and quality. Health system improvement will occur in two distinct ways by funding, and by changing the boundaries within which health care is managed. Through the establishment of a National Health Development Fund both parties expect to pursue projects and programs which improve patient outcomes and improve the efficiency and effectiveness, or reduce the demand for, the delivery of public hospital services. This will also help the system move to improve integration of care between public hospital services and broader health and community care services. By giving priority to making an investment in information technology and information management across the health system the changes will be able to be monitored and evaluated better which can only lead to improved patient outcomes and system efficiency overall.

What is important however, is that all the initiatives will seek to be managed on a collaborative basis with other jurisdictions where possible so that there is integration in ideas as well as outputs.
CONCLUSIONS

Since 1984 Medicare has been the centre of attention for Australians when they speak of health care. This is because it has generally been able to provide effective care for those who need it irrespective of their capacity to pay. The negotiations for the new Australian Health Care Agreements were focussed on ensuring the system was reoriented to providing services where they were best received and funding it appropriately. The end result is a continuation in the traditional expectation of free care but a more realistic approach to where the care is best provided and how it is to be paid for. The new Agreements show a willingness on both sides to focus on models testing appropriateness of care, setting and financing to preserve the values of Medicare as opposed to continuing activities which were designed to exercise which party had the most power to control the care.

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