

Carry on DOCTOR

Brian Howe's copayment scheme justifiably raised the hackles of Medicare's supporters. But the problems it tries to confront are real enough. Deirdre Wicks and Roy Green argue that defending the health status quo isn't enough. And they detect a hidden theme in Howe's reforms which could direct the scrutiny about overservicing back onto the major culprit—the medical profession. And Julie Power interviews Medicare architect John Deeble.

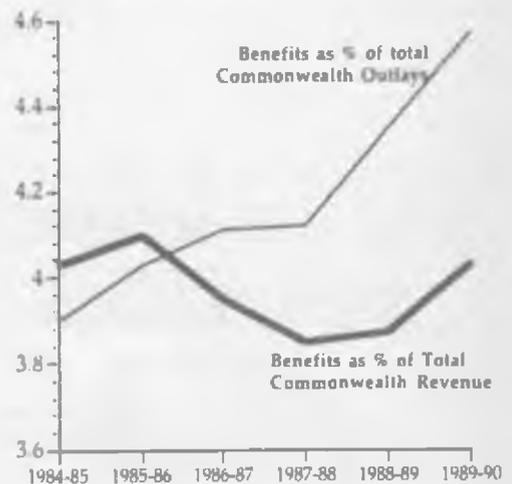
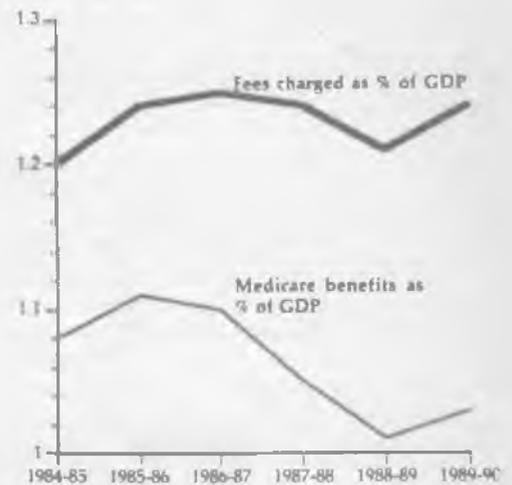
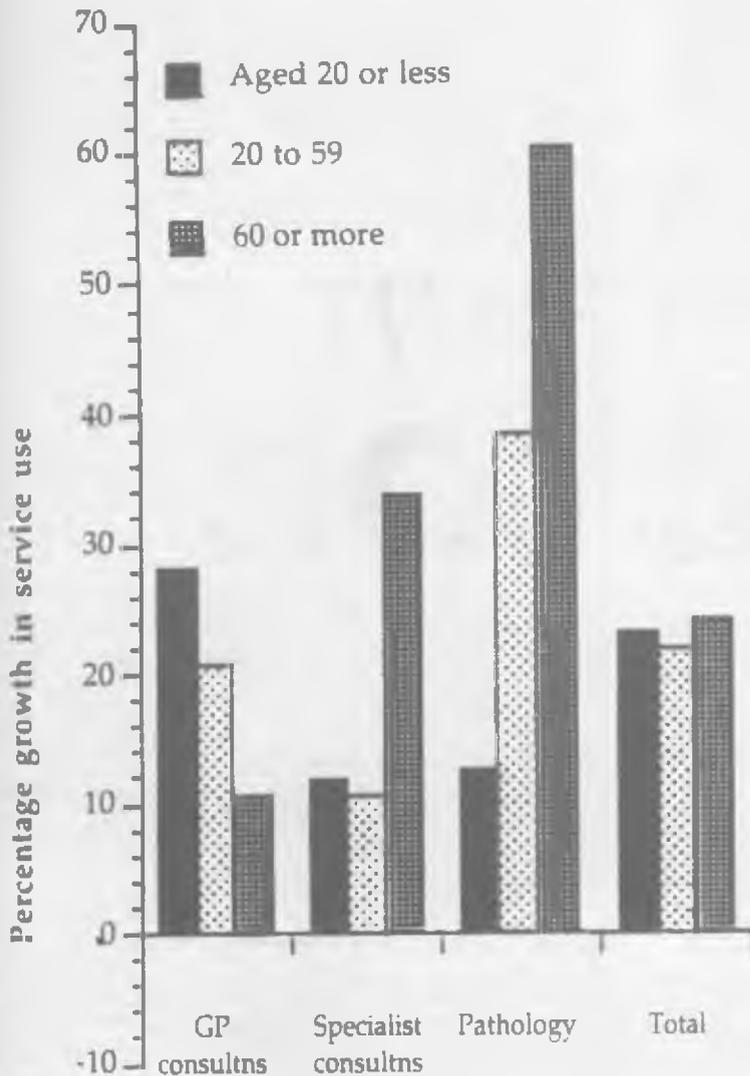
As it turns out, Health Minister Brian Howe may unwittingly have done the health care reform debate in Australia a favour with his decision to bulldoze a \$2.50 Medicare fee copayment through Labor's federal Caucus.

This is not to say that the idea of copayment has any merit. Virtually every health and consumer organisation in the country has shown why it doesn't. However, what the proposal will now do is sharpen the debate about the kind of health system Australia needs with the prospect of an ageing population and steadily rising health costs.

Of course, the immediate reaction to Howe's August Budget Paper, *Health Care in Australia*, was to defend the

basic principle of Medicare against an unprecedented and unexpected attack from the very government which introduced it. While this reaction was justified, we will argue here that defence of the status quo in itself, in the absence of fundamental reforms to the health care system, will prove to be self-defeating in the longer term. Ironically, the seeds of such reforms may be found, as we shall see, in the Budget package itself. These reforms, if developed in the right direction, would allow the government to replace Medicare fee for service arrangements altogether with a system which promotes not only fairer access and achievable cost control but also better health outcomes.

It is simply no solution to the problems identified by Howe to call for an increase in the Medicare levy, though this would at least be preferable to a flat charge which discriminates against low income families and the chronically



Source: National Health Strategic Inquiry

sick. Nor is it feasible to design a more 'equitable' system of copayments, which penalises fee-charging doctors as opposed to bulk-billing doctors—or, more accurately, which penalises their patients. In attempting to do so last month, the Caucus committee established to 'second guess' the Budget changes was on a hiding to nothing.

The danger of this limited approach is illustrated by the response in Britain to the Thatcher government's attacks on the National Health Service (NHS) in the early 1980s. Thatcher was able to capitalise on widespread disenchantment with the faceless, bureaucratic nature of the NHS, and its failure to cater for women and groups with special needs. For example, as one British commentator on the Left pointed out at the time, "The NHS has failed to meet women's needs in relation to contraception, abortion, pregnancy and childbirth" (C Thunhurst, *It Makes You Sick: The Politics of the NHS*, 1982).

In this context, the slogan 'Defend the NHS' fell flat not because it went too far for public opinion, but because it did not go far enough. While chronic underfunding of the health service by successive governments was seen as a key factor in queues for surgery and hospital beds, it did not explain or justify the inadequate nature of health care provision. Rather, this reflected the class character of British society, the power of the medical profession and the associated dominance of a medical 'cure-focused' perspective over more 'holistic', health-focused models.

Unfortunately, the analysis of these deeper forces shaping the health care system in Britain was conducted 'on the hop' by the opposition Labour Party, health unions and user groups, under pressure from a deliberate government strategy to wind back the NHS in favour of private hospitals and private health insurance. Ultimately, the slogan was changed to 'Defend and extend the NHS', but the

initiative once lost was not easily regained. Even the latest Labour Party policy document, *A Fresh Start for Health*, is open to the criticism that it "smacks of half measures", for its key proposal to finance hospitals according to their workload will simply "reinforce the power of the hospital doctors and undermine the ability of health authorities to shift resources into other fields of health care" (*Economist*, 28 September, 1991).

We shall return later to this analysis, which applies equally to the Australian health system. The clear lesson to be drawn from the British experience is that in defending Medicare, perhaps the most outstanding achievement of the Hawke Labor government, we cannot afford to ignore its defects. And it is the manifestation of those defects in rising costs which has provoked Howe into action.

Indeed, in the current debate, while the forward estimates are inevitable contentious, the economic background to Howe's Budget statement is not in dispute. It is a widely acclaimed feature of the success of Medicare that health spending as a proportion of Australia's GDP has remained relatively stable at around 8%, and is far from excessive by comparison with other OECD countries. However, this apparent success should not be allowed to breed com-

placency, for spending as a proportion of Budget outlays has blown out by 46% over the last six years.

The main cause of the increase is hospital grants to the states, but spending on medical services has also grown by over 30%. Nor is it difficult to identify the fastest growing expenditure items. The National Health Strategy Background Paper No. 2 (February 1991), *Medical Services through Medicare*, reveals that, while benefits for GP consultations remain the 'big ticket' items, the use per person of diagnostic services such as pathology grew at twice the rate of medical services generally.

The demographic picture is even more revealing. While people aged up to 59 increased their use of pathology services by around 25% over the last six years, those aged 60 and above increased their use of these services by no less than 60%. A similar picture emerges for other specialist and diagnostic services, and this highlights a further dimension of the health funding crisis. As the 'baby boomers' get older, unless health priorities change drastically, the growing demand for expensive, high-tech services will stretch the system to breaking point.

Obviously, something has to be done to control spiralling health costs, but what? As *Medical Services Through Medicare* points out, Australia has a unique problem in that its health care system is "open ended in two major aspects—utilisation and doctor fee charging". Most countries have closed off one or other of these openings. However, whereas costs have been relatively successfully controlled in the British NHS by supply side management, the US approach of managing demand through various insurance options has been a widely acknowledged failure in both economic and human terms.

Indeed, the recent illness and death of a prominent US Republican turned the public spotlight onto the fact that his own staff members could barely afford their gigantic medical premiums. It was reported that this "underscores a trend that is pushing health care rapidly to the top of the domestic political agenda and creating a consensus for change. The middle class, not merely the poor, are finding themselves disadvantaged by the current system". And, of course, "Few rules of politics are so consistent that when the middle class is hurting, change is inevitable" (*Australian Financial Review*, 28 June, 1991).

In Australia, growing service utilisation is directly correlated with the increasing number of doctors. Indeed, Howe's Budget Paper concludes that "the current and increasing supply of GPs is the single biggest factor affecting Commonwealth Medicare benefits outlays". In this context the market cannot operate to restrain fees; unit prices are insensitive to 'oversupply' because the floor price is determined by the Medicare benefit level. This has convinced Howe to accede to the AMA's self-serving policy of reducing the doctor intake, especially those from overseas.

Yet this policy, far from restraining fees, will almost certainly give doctors the opportunity to increase them, as

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Howe himself now seems to have conceded. *Medical Services Through Medicare* finds an inverse relationship between the growth in particular medical specialities and increases in over-schedule billing, or 'fee drift', over the last six years. For example, obstetricians, whose numbers have not measurably increased as a proportion of the population, have been able to increase average over-schedule billing by 16%, while GPs, whose numbers have grown by almost 16%, have not been able to increase over-schedule billing at all.

If Howe's supply side policy acts not so much to reduce health costs as shift them to patients, then it will be reinforced in this respect by the attempt to operate on the demand side through the introduction of 'consumer' copayments. This is a policy which is regurgitated each year in the lead-up to the Budget by officials in the Department of Finance, who know nothing about health economics and, comfortably domiciled in a Canberra garden suburb, care even less about the social impact of their mindless number-crunching.

Having been put back in their box on countless occasions by former Health Minister Neal Blewett, who understood the implications of copayments for Medicare, the Finance Department officials could not believe their luck when the 'social reformer' Howe was prepared to bite the bullet in return for his half-baked 'better cities' program. No doubt, they slept soundly on the assumption that they could dispose of this program later. By contrast, Howe's disbelieving officials must have been up all night shredding their criticisms of copayments and preparing to defend them in the face of all the evidence they were now told to forget.

And the evidence is overwhelming. The National Health Strategy Background Paper No. 5 (June 1991), *The Effects of Consumer Co-Payments in Medical Care*, shows that the fall in copayments since 1976 accounts for no more than 10% of the increase in service use over this period. Equally, the paper concludes, it would require an increase in copayments to 50% of medical bills to reduce service use by 7.6%. The proposed \$2.50 copayment for GP visits would thus have a negligible effect on service use, and could not, even taken together with a cut in doctor numbers, produce the estimated net saving by 1994/95 of \$605 million.

Nor let it be forgotten that this saving, should it be anything more than a chimera in the imaginings of the Finance Department number-crunchers, would not constitute a reduction in health costs, but merely in those costs borne by the Budget. In reality, the costs would be transferred to the patient, unless dissuaded from visiting the doctor. It would effectively signal the end of bulk-billing, as pressure grows to insure the 'gap', and open the door to the American model of health care. Patients would be paying the price of 'problems' outside their control - problems, moreover, which have nothing to do with market forces. Also paying would be those doctors who choose to bulk-bill, as opposed to those who do not. This is well understood by the Opposition Leader Dr John Hewson, who welcomed the government's decision on co-payments as

"the first tentative step to making health care more price sensitive".

The fact is that the health care system throughout the world, as Howe's Budget Paper itself recognises, "has characteristics that stop a pure market working". *Medical Services Through Medicare* puts it more bluntly: "Price is not a mechanism which equilibrates supply and demand, only a variable which, with service volumes, can be ordered so as to achieve the driving force behind the whole system, namely the doctors' target incomes". The basic problem, which the government has yet to confront, lies in the traditional prerogatives and power of the medical profession.

This is by no means a new problem in Australia. As long ago as 1868, Florence Nightingale wrote to the then NSW Colonial Secretary Sir Henry Parkes warning him that, "Your Medical Officers, Resident and other, have more power than almost anywhere else". What is extraordinary is that even today, thanks to a constitutional anomaly created by a previous Labor government, this vested interest is permitted both to set the health care agenda in Australia, and to make the community pay for it.

Buried deep in the Budget paper are Howe's proposed 'Future reforms to the funding of general practice'. These reforms are a start to tackling the problem of professional power, and to delivering substantial and realistic savings across the health portfolio. So deeply buried are they, however, that they have been largely ignored by the media—though not by the AMA which has already begun to organise a national campaign of opposition. They do so, of course, in the certain knowledge that the government's own constituency, and potential source of support for radical reforms, has been alienated by the proposal for copayments.

The Budget Paper proposes three main reforms. First, practice grants would provide "some remuneration to those general practices which choose to reduce their reliance on fee for service". This could be interpreted as the beginning of a move away from fee for service, with all its attendant problems of over-servicing and fee drift, towards some kind of salaried arrangement. Already, as part of the Caucus compromise, Howe has agreed to allocate \$12 million to practice grants in 1991/92, which is surprising given the absence of any developed policy criteria for these grants.

Second, practice budgets would be allocated to general practices to "cover the costs of diagnostic services and pharmaceuticals". This reform, which surfaced in NHS Issues Paper No. 1 (July 1991), *The Australian Health Jigsaw: Integration of Health Care Delivery*, as a proposal for budget-holders to purchase "packages of care". Although equally vague at this stage it might, together with practice grants, introduce a measure of financial accountability to the real consumer of medical services—the GP.

Third, accreditation of general practices would, according to the Budget Paper, provide a framework for addressing

"quality of care issues". In particular, it is suggested that links with academic departments of general practice in medical schools could result in improved continuing education and quality assurance programs. There are good grounds for questioning the suitability of the current level and type of undergraduate medical education and postgraduate hospital-based training for primary health care work in general practice. For example, *Medical Services Through Medicare* found that, while GP consultations account for 70% of services to young people under 20, they represent only about half the services to people over 60, who are more likely to be referred on for further tests or specialist consultations.

Consequently, an important aim of reform in this area is to 'upskill' GPs so that they are better able to deal with health and medical problems without further referral. Again, it will not be an easy task, for it means reversing the whole process of specialisation which has been a feature of the 20th century medical profession.

Before focussing on the inadequacies of these proposals, at least as they are presently formulated in the Budget Paper, it is worth speculating on where ultimately they might lead. The service model which could emerge from the reforms is a publicly funded, multidisciplinary practice, separating funder and provider, where the GP is, in the words of the Budget Paper, "the co-ordinator of a network of care". When the budget for diagnostic services and pharmaceuticals also includes, under the supervision of area health management, a component for hospital in-patient services, the model begins to look very much like a Health Maintenance Organisation (HMO). If, indeed, this is what Howe has in mind, he is on the right track.

Essentially, HMOs comprise a group of health and medical practitioners with a set budget and a population of enrolled members. They provide directly, or arrange provision of, a wide range of health and medical services, including hospital services. Because the budget is fixed, there is a built-in incentive to keep HMO members healthy and out of hospital. As a recent *Economist* survey of health care pointed out, HMOs "amputate the incentives to overtreat, overspend and overhospitalise. They put a premium on prevention and primary care, both neglected in traditional health care systems". They thus "add to the advantages of Britain's GP system a closer link between primary and secondary care and a smaller incentive to refer patients to specialists".

Even where hospitalisation is required, US studies show that the number of short-stay hospital bed-days per head of the HMO population is about half that of the population generally (H Luft, *Health Maintenance Organisations: Dimensions of Performance*, 1981). The portfolio savings implications for Australia should be obvious, especially since the public sector model which would presumably be favoured by Howe avoids the drawbacks of private sector HMOs in the US—not to mention the disastrous 'self-governing trusts' recently introduced by Britain's Conservative government as part of their 'internal market' reforms to the NHS.

Nevertheless, there are three fundamental inadequacies in Howe's approach to structural change. The first relates to the method by which he hopes to introduce his reforms, namely by "discussions with the medical profession". The experience of health care reform in Australia suggests that, despite the sympathetic views of a minority of GPs, the AMA, like the Soviet old guard, simply will not co-operate with any changes which appear to threaten their professional power. It seems that, while all reforming health ministers must learn for themselves this basic truth, few have been blinded to it as comprehensively as Brian Howe.

It may be said, by way of justification for Howe's tactics, that the position of the medical profession is made unassailable by the 'civil conscription' clause in the Constitution, which invites non-compliance with policies ranging from bulk-billing to filling in forms for notifiable diseases. Yet any government which is serious about controlling health costs, let alone introducing reform, will sooner or later have to challenge this clause in the High Court, whose approach to such issues has itself undergone considerable change in recent years. (Witness, for example, the Court's interpretation of the Constitution in relation to the environment, and even managerial prerogative.)

The origin of the clause was a referendum called by the Chifley government in 1946 to seek powers to make laws and regulations with respect to social welfare matters. After winning the referendum in the teeth of a vociferous campaign by the doctors against 'socialised medicine', then Attorney General H V Evatt, in a gesture as inexplicable as it was short-sighted, accepted an Opposition amendment to the new powers ruling out 'civil conscription'. The effect of this amendment, at least until now, has been to ensure that no major health reform could be introduced without the co-operation of the medical profession.

The question for the present government is whether the ground for a High Court challenge is better prepared by keeping the reform agenda under wraps, in the futile hope that the AMA may not notice it, or by opening it up for public education and debate. Although inevitably there is a risk that Howe might lose the High Court battle in the short term, the democratic process will at least give him a chance of winning the war, either through a further referendum or possibly just the threat of a referendum.

That the mere thought of this approach makes the government nervous ("Whatever you do, don't mention the Constitution") indicates how remote it has become from its pro-reform constituency. If the Labor leadership can rediscover and renew its confidence in the constituency responsible for its political agenda, that confidence will be repaid by a popular campaign with far greater impact than a tete-a-tete with Dr Bruce Shepherd. If it does not, a fundamental issue distinguishing Labor from the Opposition will have been thrown away.

The second, closely related, inadequacy in Howe's approach concerns the dominant status allotted to the medical profession within the reform package itself. Of course, doctors play an important part in the delivery of medical services, but so do nurses, physiotherapists, dieticians,

midwives and a whole spectrum of health workers, most of whom now receive their basic education in university at degree level.

Yet the medical profession enjoys a monopoly over health decisions and practice which is looking increasingly out of place in a society which values, on the one hand, choice for the consumers of health care and, on the other, opportunities for all health professionals to make full use of their skills. If the government is working towards a model of Commonwealth-funded HMOs, why should the co-ordinating professional be a doctor? Why not a nurse practitioner? And why should the "network of care" referred to in Howe's Budget Paper not include complementary therapies, such as chiropractic, naturopathy and acupuncture?

Here, the substance of health reform has been subordinated to the prospect of 'successful' negotiations with the AMA and the College of GPs, for, as every health worker knows, the dominance of the medical profession is the basic source of the continued dominance of the medical model, with its primary emphasis on treatment and cure. That is why it is crucial for a government committed to social justice, access and equity in health care to ensure that HMOs are explicitly funded and accredited according to their adherence to the 'New Public Health' principles established by the 1986 Ottawa Charter for Health Promotion.

The Charter identified five health promotion action areas; building healthy public policy, creating supportive environments, developing personal skills, strengthening community action and reorienting health services. No one would expect the Department of Finance to understand these principles, but they should be second nature to a health minister in a Labor government. The focus of the principles on long term health outcomes, if matched by the provision of appropriate services, would be a priceless legacy for future generations.

The third inadequacy in Howe's reform package is its timid approach to restructuring pathology and diagnostic services, which relies on the existing private infrastructure to restrain exploding costs. There is, of course, well documented evidence on the scope for abuse at the point of intersection with the users of these services, mainly the GPs. Even the Australian Association of Pathologists has been forced to admit that. "Unethical pathologists bribed GPs so that they could perform thousands of dollars of unnecessary tests on their patients" (*Sydney Morning Herald*, 30 August 1991).

Again, Howe's attempt to reduce the incentive for overservicing potentially disadvantages patients by restructuring benefits and, in a bizarre move akin to removing \$100 notes from circulation to discourage consumption, halves the number of collection centres. The package completely ignores the proposal in NHS Background Paper No. 6 (July 1991), *Directions for Pathology*, to reorganise pathology services in Australia by expanding public provision "particularly where the public sector has an advantage, such as

the provision of specialised testing in reference laboratories".

It is arguable that the establishment of a publicly-owned testing service—and indeed pharmaceutical industry—possibly in collaboration with the CSIRO, would not only reduce costs but would also permit closer surveillance of overservicing. Indeed, it is apparent from reforms already introduced by the government that the identification of doctors involved in overservicing, followed by counselling and education, has a dramatic effect on their behaviour. While the public sector may recently have fallen out of fashion, its superiority over the market in important areas of our national life cannot be dismissed.

In conclusion, we have identified the enormous potential of the government's proposed structural reforms to health care in Australia, but we have also pointed to serious inadequacies in the strategy for their implementation. If the government is to win back the trust of health activists and the electorate, it must begin to address these inade-

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quacies openly, and develop the potential within its reforms as part of a wider process of public discussion and debate.

Brian Howe is still relatively new to the Health portfolio, and has found himself on a steep learning curve. Like all avowed social reformers, he would like to secure his place in history, but has begun to realise that health care reform is a less straightforward area than most. Unfortunately, in his first attempt, he has been too clever by half. He wanted to win the support of the doctors by introducing copayments, while playing down future reforms to the health care system. Instead, he has united not only the doctors but also his potential base of support for reform against his whole Budget package.

Instead of being remembered by history as a champion of social reform, Howe is now in danger of being remembered as the ambitious cabinet minister who was able to secure influence and respectability for the Left in a Labor government, but only at a terrible price—the destruction of Medicare, and the best prospect of health care reform in a generation.

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