HEALTH REFORM SUMMARY - MARCH 2016

The following is a summary of key health reform options being considered by the Federal Government. This document is current as of March 2016 and will be updated in the lead-up to the federal election, in response to government announcements and other developments in these areas.

These options are being considered in the broader political and policy making context of government, including two major processes:

- the review of federalism currently underway and the release of the Reform of Federation White Paper in 2016; and
- the next federal election (likely to take place in late 2016).

These two processes will influence both the policy options being considered by Government and the negotiation and implementation process.

PRIVATE HEALTH INSURANCE

The ISSUE
Despite rising numbers of people with private health insurance, there is widespread stakeholder dissatisfaction with private health insurance.

In particular, consumers are dissatisfied with rising premiums, high gap payments and confusing products.

Premiums are rising due to both the growth consumer demand and increased health care costs. Private insurers have little or no capacity to influence either of these factors and have argued for more control over provider behaviour, in order to reduce inflated costs and low value care.

Health funds have restricted premium growth by reducing coverage through increasing excesses and introducing products with greater numbers of exclusions. This reduces the overall value of private health insurance, undermines its stated role in shifting demand from the public system and is not a sustainable way of managing the increased costs of private health care.

PHI health fund membership numbers are currently kept artificially high due incentives (a 30% rebate) to join a private health fund and penalties (tax increases) for the uninsured (above a defined income level).
The rebate costs the Government around $8.5 billion a year and is one of the fastest growing areas of government health expenditure. Many economists, including those from within Government, believe that this is an inefficient use of resources.

THE PROCESS
To address these issues, in late 2015 the Government initiated a comprehensive consultation process on private health insurance (PHI). The Minister for Health Sussan Ley stated that through this process she wants to develop options to:

- enhance the value of private health insurance to consumers;
- encourage increased efficiency of private health insurance;
- increase the effectiveness of Government incentives for private health; and
- improve the sustainability of the private health sector.

The Minister also said that the consultations will consider potential future roles for PHI within the context of broader changes being considered by the Government. These include the White Paper on the Reform of the Federation, and the Government’s reviews of primary health care and the Medicare Benefits Schedule.

The consultations began in November 2015 and included the following activities:

- online consumer survey; and
- roundtable discussions, hosted by the Department of Health, with industry representatives, academics, consumers and health providers (commencing 16 November 2015).

The Government also invited submissions from interested parties.

The Government has stated that it will report on the outcomes of this consultation process in ‘early 2016.’

LIKELY OPTIONS
One option being canvassed in the consultation process, which reportedly has the support of key bureaucrats, is to abolish PHI subsidies entirely and instead direct government subsidies directly to private hospitals (similar to the old ‘bed day subsidy’ but including medical as well as hospital costs).

Part of the support for this position is due to the efficiency gains that activity-based funding brought to public hospitals. Key figures in the Commonwealth bureaucracy believe that similar gains can be made in the private sector.

This could be achieved via a Hospital Benefits Schedule which would prescribe a schedule fee for private hospital care, based on existing Commonwealth payments for public hospital services under activity-based funding. The same schedule may later be used for public hospitals, replacing grants to the states.
However, current estimates are that this option would result in a net cost to the Commonwealth making it politically unpalatable in the current environment.

There are also a number of unknown factors, such as whether the proposed payments be directed to doctors or to hospitals and whether they would cover diagnostics as well as procedural services. These issues are currently being explored and will need to be resolved if a concrete proposal is to be put forward.

The Government has also been considering a cut to all benefits on the Prostheses List (reportedly around 45%), along with other changes such as removing low value items and including clinically effective non-implantable devices.

This has been supported by the private health insurance sector which has run a political and media campaign arguing that devices are over-priced in the private health sector (based on a comparison with public sector prices). This argument is based on a number of examples in some clinical areas (in particular cardio) where there is a large price discrepancy between the public and private sectors. The private health insurance sector has claimed that a 45% reduction in prostheses prices is reasonable and that this would result in $800m in potential savings per annum and put downward pressure on premiums.

This proposal has been vigorously opposed by industry and hospital groups and the Minister has postponed any decision on funding levels until a stakeholder taskforce has developed alternative options for her consideration.

The Consumers Health Forum (CHF) has called for an overall simplification of PHI and has specifically recommended:

- The creation of a suite of nationally standardised (or default), basic private health insurance packages for Hospital Cover (myCover). The features of these packages should be developed jointly with consumers, health insurers, doctors and private hospitals and would offer a range of services to fit different stages of the life course;
- Making the Rebate available only for myCover packages, and reinvesting savings back into the public system; and
- Limiting the Rebate on general cover to interventions that have a sound evidence base.

If the Government is unwilling to pursue major reforms of this nature, its only option is to attempt to stabilise PHI prices (at least until the next federal election) and win the public relations war by advocating for consumers and shifting blame for increased costs to the funds (for example through publicly calling for them to minimise premium increases.)

PUBLIC HOSPITALS

The ISSUE
Public hospital funding has been an ongoing issue of contention between Federal and State/Territory Governments and is often identified as the site of cost-shifting and inefficiency in health funding.

These issues looked to be resolved – at least to some extent – when in 2011 the National Health Reform Agreement was reached between former Prime Minister Julia Gillard and State/Territory governments.

This agreement gave the Commonwealth a share of the growth in cost of hospital funding (previously borne solely by the States/Territories) and based funding levels on a “national efficient price” of care determined by an independent body. It also ensured the Commonwealth had a vested interest in keeping people out of hospital through effective primary and aged care systems.

However, the 2013/14 Federal Budget reneged on this agreement and announced that from July 2017, the Commonwealth’s contribution will no longer use this funding model. From this date, the Commonwealth contribution will be linked to movements in the consumer price index (CPI) and population growth—essentially a return to the earlier funding model.

The Budget also stated that from 2014–15, the Commonwealth will cease the funding guarantees made previously, meaning that payments of up to $574 million which were due to commence from July 2014, will not proceed.

Other funding cuts in that Budget included the $5 billion Health and Hospitals Fund (HHF), established under the Nation-building Funds Act 2008 and the National Partnership Agreement on Preventive Health.

When making these changes, the Commonwealth government indicated that the changes were a ‘platform’ for moving towards longer term health funding arrangements. However, the Commonwealth has not articulated any concrete options for reform. Instead it has supported a joint approach to developing future funding options via COAG and has initiated a broader review of Commonwealth-State relations and responsibilities via the Reform of Federation White Paper.

**THE PROCESS**

Hospital funding issues have been on the COAG agenda since the 2013/14 Budget. At its most recent meeting in December 2015 COAG members agreed to progress ‘a long term vision for health reform to support the health of all Australians and achieve long term sustainability of the Australian health system – based on the Medicare principles.’

The next stage of work will be discussed at the first meeting in 2016 and will include developing:

- design principles and key features of a fair, adequate and efficient hospital funding scheme;
• timeframes for potential implementation, and terms of any transition funding if the new scheme cannot be in place by 1 July 2017;

• a new approach to integrated community and primary care, with particular focus on a chronic care model for patients at risk of, or with complex and chronic disease, and timeframes for potential implementation;

These issues will be progressed by COAG Health Council (CHC) advised by the Australian Health Ministers Advisory Council which will report to COAG on options for reform. At the most recent CHC meeting, Queensland representatives presented a paper to ministers on health reform noting the current challenges facing the health system and the potential financial and service delivery impacts of declining National Partnership Payments and the move to an indexation formula based on growth in population and the CPI from 2017–18.

Ministers noted the range of initiatives currently underway and in recognition of COAG Health Council’s critical role Ministers agreed that AHMAC discuss the current range of national health reform initiatives and provide an update at the first CHC meeting in 2016 including potential opportunities for a nationally coordinated approach to an improved health care system in Australia.

In addition to formal COAG and CHC processes, informal pressure is being exerted by State/Territory governments via the media for the Commonwealth to resolve the public hospital funding shortfall. Since the 2013/14 Budget announcement the States and Territories have been calling for a re-instatement of the agreed funding to public hospitals. However, the Commonwealth has resisted these calls and this has led to a return to the ‘blame game’ between different jurisdictions, with states attempting to shift responsibility for public hospital problems to the Commonwealth.

This year the pressure is likely to increase on the Commonwealth as the States/Territories are likely to start reducing funding levels from 2016, anticipating the cuts due to start in 2017.

**LIKELY OPTIONS**

Options for reforming public hospital funding canvassed in the Federation White Paper and likely to be considered by COAG are the following (not all mutually exclusive):

1. States fully responsible for public hospitals
2. Commonwealth Hospital Benefit
3. Individualised care packages for chronic and complex conditions
4. Regional Purchasing Agencies for all health care
5. Commonwealth single funder + purchasing agency

These options will be explored in more detail in 2016 by COAG and its advisory bodies as well as by the bureaucracies at both a federal and state/territory level.

While formal and informal options for increasing public hospital funding at the Commonwealth level are being pursued, the states/territories have also been considering options to increase
their revenue by increasing or broadening the GST and introducing a state income tax. Increasing the efficiency of public hospital care is also on the agenda but the resulting savings are unlikely to be enough to meet future growth in demand.

The pressure to address this issue increased recently when the AMA released its Public Hospital Report Card which found that bed numbers were decreasing and public hospital performance had dropped over the past two years.

Hospitals will also be under pressure to lift quality and will face more stringent “quality standards” with tougher monitoring covering a broader scope of issues, including access and timeliness.

MEDICARE
The issue:
Medicare is a fee-for-service based funding system which was designed over 30 years ago and no longer meets the community’s needs, in particular in relation to coordinated and multidisciplinary care for people with chronic conditions.

The current value attached to many Medicare item numbers does not reflect modern clinical practice, in particular many items have been shown by research to be either over-priced or no longer needed.

THE PROCESS:
On 22 April 2015, the Minister of Health and Sport Sussan Ley announced a programme of work to deliver a Healthier Medicare and announced that a Medicare Benefits Schedule (MBS) Review Taskforce (Taskforce) would be established.

Membership of the Taskforce includes doctors with expertise in general practice, surgery, pathology, radiology, public health and medical administration, who work across both the public and private health sectors, as well as consumer representation and academic expertise in health technology assessment. It is chaired by Professor Bruce Robinson.

The Taskforce is considering how the more than 5,700 items on the MBS can be aligned with contemporary clinical evidence and practice and improve health outcomes for patients. There are no explicit savings targets attached to the Review and recommendations will be made directly to the Minister.

The Medicare Benefits Schedule Review Taskforce developed two Consultation Papers which were released in September 2015. Stakeholder consultation forums were held in late 2015 and more forums will be held in 2016.

The forums addressed a range of issues including:

- Background to the MBS Review
- Overview of approach and status
Insights from the pilot reviews
Discussion and feedback on focus to date
Which cross-committee issues should the Review consider?
Which issues with specific items should the Clinical Committees examine?

Six initial Clinical Committees have been (or are in the process of being) established. These include:

- Ear, Nose and Throat Surgery - Chair: Mr Patrick Guiney
- Obstetrics Clinical Committee - Chair: Professor Michael Permezel
- Thoracic Medicine Clinical Committee - Chair: Professor Christine Jenkins
- Gastroenterology - Chair: Associate Professor Anne Duggan
- Diagnostic Imaging – Chair: TBA
- Pathology – Chair: TBA

These Clinical Committees will review priority items and test the underlying methodology ahead of the full roll out of the Review in 2016. Following this, the other Clinical Committees will be established and operate throughout 2016.

The Taskforce was expected to deliver an interim report on the Review to the Minister in December 2015.

Stakeholder consultations and the bulk of the Review will be conducted during 2016 with a second report providing recommendations to Government expected in December 2016.

**LIKELY OPTIONS:**
The MBS Review Taskforce was asked to provide by the end of 2015 a list to the Minister of ‘low hanging fruit’, i.e. MBS items which could have their funding reduced or removed without causing major conflict with stakeholder groups. The Minister is reportedly currently considering how to implement the recommended changes to the MBS schedule.

Developing options for reducing funding across the MBS will be more difficult and require ongoing negotiation with clinicians and other stakeholders. The potential for some providers and clinical areas to lose funding may reduce support for this process once the recommendations are made.

Also being considered are the establishment of ongoing review processes to ensure that all MBS items are regularly reviewed in line with changing clinical practices and technological development.

**PRIMARY HEALTH CARE REFORM**

**The ISSUE**
Research shows that a well-functioning primary health care system keeps people healthier and reduces overall health care costs. However, the Australian primary health care system is not
optimally designed to promote the type of comprehensive and preventive care that addresses the needs of the current Australian community. In particular, a fee-for-service based system is not well equipped to support comprehensive, ongoing and collaborative care for people with chronic conditions.

While the problems with primary health care pre-date the current government, more recent cuts to primary health care funding have exacerbated the situation. These cuts include a four-year freeze of GP Medicare rebates (introduced in 2014/15). The cut has not been reversed and modelling shows that by 2017-08 a GP seeing a non-concession patient will get a rebate that is 7% lower than today. GPs are likely to pass some of these losses on to patients through higher fees. This would increase out-of-pocket costs and could stop some people getting care.

Cuts have also been made in other areas of primary health care including to national partnership on preventive health and primary health care translational research organisations. Some of the functions of these bodies have been taken on by the Department of Health.

**THE PROCESS:**

In 2015 the Government established the **Primary Health Care Advisory Group** to develop options for reform of primary health care. The Minister for Health stated that the role of the Group was to examine opportunities for the reform of primary health care in improving the management of people with complex and chronic disease.

The Group was directed to review national and international primary health care literature and experiences, including those relating to innovative service models. It also undertook a national consultation activity with the public, stakeholders and health professionals to inform consideration of reform of primary health care.

Membership of the Group included individuals with a wide range of experience and expertise in primary health care services, including allied health, pharmacy and GPs and representative consumer groups. The Chair of the Group was Dr Steve Hambleton, the past president of the AMA and a practising GP.

The Group developed a discussion paper and consumer document and a comprehensive consultation process was undertaken on these papers in August 2015.

The national consultation process included public information briefings in major centres across Australia as well as targeted sector and stakeholder meetings. An online survey was also conducted to obtain input into the review process.

The consultations suggested that the following issues were among the most important for people with complex and chronic conditions:

- access to health services, especially low cost services;
- prevention measures and health education;
the coordination of care across different health care services, involving multidisciplinary team care and effective communication and collaboration between different health care providers; and

knowledge and understanding of complex and chronic conditions, and the associated care requirements for people with them.

The Advisory Group combined both international and domestic evidence with the findings of its own public consultation process to develop its final report to Government in December 2015. Consistent with the consultation discussion paper, the report outlines reform options structured around four reform themes:

- Effective and appropriate patient care
- System integration and improvement
- Payment mechanisms
- Achieving outcomes

The theme of better use of technology is embedded throughout the report in recognition of its important role as an enabler and vehicle for implementation across all aspects of the reforms recommended. The Government is currently considering the report and will respond to its recommendations sometime in 2016.

**LIKELY OPTIONS**
Options likely to be considered by the Government for primary care reform include those for supporting care for people with chronic conditions. This was an issue that was highlighted by stakeholders in the consultation process and it aligns with parallel consideration of options for individualised care packages for people with chronic health conditions through the Reform of the Federation discussion by COAG.

Other options reportedly on the table include a shift in the balance of payments to practices, with less emphasis on payment for attendances (fee-for-service) and more emphasis on payment for care over the episode of illness or year (capitation payments).

There may be other changes in payment structures, in particular to focus on reducing incentives for ‘six-minute medicine’, such as a minimum consultation time imposed on the standard (level B) fee.

A further issue to be addressed is the shift toward practices owned by corporate chains that profit from referrals to and provision of diagnostic services, such as blood tests and X-rays.

**MENTAL HEALTH REVIEW**

The issue:
The Commonwealth and the States and Territories both have roles in policy, funding, and regulation in mental health. These roles have evolved in piecemeal fashion and have usually not been defined with respect to an overarching vision shared across governments and portfolios. As a result, the system is fragmented, inefficient and difficult for consumers to navigate.

The Commonwealth and the States and Territories both bear the risk of avoidable costs arising from poor coordination of mental health services. Cross-portfolio interactions are particularly complex when applied to mental health. Downstream costs from State/Territory system failures are borne in other areas such as disability, income support and employment services – at the Commonwealth’s expense. But when problems arise through Commonwealth-run systems, people with mental illness are more likely to require expensive treatment in a public hospital, interact with the justice system, or become homeless – at the cost of the States and Territories.

Therefore, while all levels of government have an interest in improving mental health care, no level of government ‘owns’ mental health, which in turn has made it difficult to ensure accountability for mental health outcomes. The task of defining roles and responsibilities is therefore particularly important, as is governance in order to improve service coordination within and across systems, address service gaps, reduce inefficiencies, and ultimately improve outcomes.

THE PROCESS:
The Commonwealth Government established the National Mental Health Commission to conduct a national review of mental health programmes and services. The focus of the review was on assessing the efficiency and effectiveness of programmes and services in supporting individuals experiencing mental ill-health and their families and other support people to lead a contributing life and to engage productively in the community.

This included programmes and services which have as a main objective:

- The prevention, early detection and treatment of mental illness;
- The prevention of suicide;
- Mental health research, workforce development and training; and/or
- The reduction of the burden of disease caused by mental illness.

The final report of the Review Contributing Lives, Thriving Communities was provided to the Commonwealth Government in December 2014.

The report contained 25 recommendations across nine strategic directions which guide a detailed implementation framework of activity over the next decade.

The Australian Government established a Mental Health Expert Reference Group (ERG) to provide advice to inform the response to the Review of mental health programmes and services. In November 2015 the Australian Government released its response to the Commission’s mental health review:

LIKELY OPTIONS:
In its response to the Review Paper, the Government acknowledged that while there is significant spending on mental health, too many Australians fall through the cracks or do not receive the full support they need. It stated that our current “one-size-fits-all approach” is not providing optimum care and support for Australians suffering from mental illness.

The Government committed to the following actions, recommended in the Review Paper:

- Contestable mental health services will be commissioned, not delivered, through the recently established Primary Health Networks (PHNs);
- Coordinated packages of care will be created for people with severe and complex needs and flexible support for mild and moderate needs;
- A new Digital Mental Health Gateway will optimise the use of digital mental health services;
- A new approach to suicide prevention, co-ordinated by PHNs.

The reforms will be rolled out over a three year period between 2016 and 2019 and delivered within the existing funding envelope.

To provide a coherent policy framework for these reforms, the Commonwealth will work with states and territories to develop the Fifth National Mental Health Plan. This plan will also include a strong focus on the physical health of people experiencing mental ill-health.

The National Mental Health Commission has already held one consultation on this issue. Further consultations on the Consensus Statement addressing the physical health of people with a mental illness are planned in early 2016. The National Mental Health Commission will seek the views of:

- people with a lived experience of mental health issues and their families and support people
- the clinicians and professionals who provide care for people with mental health conditions, and the colleges that train them
- service providers who work with people with mental health conditions, Primary Health Networks and non-government organisations
- universities and research institutes
- the Commonwealth and state and territory governments
- other national organisations and peak bodies.

Based on their input, a statement will then be produced by mid-2016, to be endorsed by these important groups as a demonstration of their commitment to take collective action. The Government has not outlined any other processes that will be used to develop the National Plan.
The ISSUE
Many Australians experience poor oral health due to barriers in accessing dental care. This leads to a range of social, economic and health problems with flow-on effects to the community as a whole. Currently, responsibility for dental arrangements is split between the Australian Government and the states and territories. Like many areas of health care, this system is fragmented and results in inefficiencies and service gaps.

Prior to its election in 2013, the Coalition Government committed to ongoing funding for the National Partnership Agreement (NPA) on Dental Services between the Commonwealth and State/Territory governments. However, once in office it deferred the promised funding for one year. This funding was partially restored in the 2015/16 Budget which established a one year National Partnership Agreement (NPA) on dental services.

The Budget also included a pause in indexation arrangements for the Child Dental Benefits Scheme (CDBS) to bring the CDBS indexation arrangements in line with the paused indexation arrangements for other Medicare Benefits Schedule items.

The Minister for Health has also committed to working with stakeholders to reform current dental funding arrangements. In particular she has stated that the Reforming the Federation process provides a ‘once-in-a-generation opportunity for constructive reform’ to ‘ensure Australians get seamless access to the services they need’.

THE PROCESS
Currently, the Minister is working with a coalition of health groups to develop options for reform of the dental sector. This is being undertaken on a confidential basis and no details of the process are publicly available. The Minister has stated that she expects to make a decision about the options developed in the consultation process sometime in 2016.

LIKELY OPTIONS
With modelling showing that a universal dental scheme would require a doubling/tripling of the Medicare levy, a ‘Denticare’ program is not going to be on the Government’s agenda.

Key priorities for the Minister will be to target people who currently are unable to access dental care, including people on low incomes and those with chronic illnesses. Workforce and infrastructure mal-distribution will also be a priority, although it will be important that any option being considered does not duplicate existing state dental services. Avoiding the problems associated with poorly targeted past programs will be crucial and this will require the cooperation of the states and territories.

Increasing support for state/territory public dental services, in order to target the most disadvantaged in the most cost-effective way, is likely to be one of the strategies being considered.