



SPEECH NOTES

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DO NO HARM – HEALTH POLICY ISSUES IN 2007

The Howard Government is sometimes said to have “neutralised” health. It’s an ambiguous compliment because it suggests that administering the health portfolio is about deft political management. In fact, as Paul Keating used to say, get the policy right and the politics will nearly always follow. The Government has built credibility, by defending and strengthening Medicare against Labor plans to reform it out of existence, not just by proclaiming that it’s “the best friend Medicare has ever had”.

These days, it’s the Government which looks comfortable with the basic principles of our Medicare system. By contrast, Labor says it supports Medicare but is always criticising the way it actually works and sometimes seems addicted to creating an Australian copy of the UK National Health Service in the 1950s.

The Howard Government’s concern is to improve Medicare, not change it. On health, “conservative incrementalism” has been the Government’s characteristic approach. Our aim has been to make a good system better. Still, health programmes are too important not to be constantly improved and better health outcomes are too important ever to be taken for granted. As far as possible, then, over the coming year, the Government will work with the states and other key stakeholders to build further on our systems’ strengths.

A key overall challenge will be working with health professionals, institutions and systems to try to ensure that they respond as effectively to chronic disease as they do to acute episodes. Through measures such as GP management plans, team care plans and the introduction of nurses into general practice, the Government has already helped to improve the prevention and treatment of chronic disease in the community. Importantly, it’s done so in ways consistent with the fee for service principles on which private professional practice has always depended in this country.

For 2007, the Government’s top three priorities are: to extend and improve the private health system; to prepare for the next Health Care Agreements in ways which best lead to more seamless patient care; and to finalise with the states arrangements for a system of national registration for health professionals. Each of these should further erode the “silo” approach to health care which patients find so frustrating.

Improving the private health sector also has three elements: to steer improved legislation through the parliament; to boost rates of informed financial consent; and to encourage doctors and funds to make arrangements with each other that minimise patients’ out-of-pocket costs.

One of the principal objectives of the new health insurance legislation is to allow funds to cover a wider range of treatment from their main tables. The Government consulted widely prior to drafting the legislation, released an exposure draft for public discussion, and promised to consider further amendments after the legislation's introduction last December.

The Government does not propose to specify, in advance, what these treatments and programmes might be as long as they can prevent or substitute for hospital treatment. The funds should initiate these new programmes and the Government will monitor them. In the first instance, it's not for government to prescribe what products should be available to the public as long as they comply with the legislation. Competition between funds and portability of fund membership should mean that funds make something of their new opportunities. Post-April, it should not be business as usual, at least for services such as dialysis, cataracts and chemotherapy which, in many instances, can now be provided safely, conveniently and efficiently outside hospital.

A survey released in mid-2005 showed that 21 per cent of private hospital episodes involved gap expenses for which no informed financial consent had been given. Extrapolating these results suggested that about 800,000 patients a year faced unexpected doctors' bills averaging \$720 per private hospital admission. Since then the Government has been working with the AMA to try to ensure that patients know in advance their likely out-of-pocket medical expenses for procedures in private hospitals.

In mid 2006, with Government help, the AMA launched its "let's talk about fees" campaign to try to ensure that patients' recovery was not marred by nasty surprises when the bills turned up. A survey of privately insured patients taken last December shows that the AMA campaign has made a significant difference. This time, in 84 per cent of privately insured episodes, patients faced no out-of-pocket expenses or gave informed financial consent in advance.

This is a 20 per cent improvement in about six months. It's a big step in the right direction but more is needed. Another survey will be taken in April/May to see whether obtaining informed financial consent has become standard practice for all elective procedures. If not, the Government intends to make obtaining consent in advance compulsory where patients are to face significant out-of-pocket medical expenses.

Discussing fees in advance of procedures, when patients have the option to seek a reduction or to shop around, should help to keep fees down. On the other hand, given that the alternative to paying for private hospital treatment is waiting for free treatment in a public hospital, it might also make patients more aware of medical gaps and foster discontent with the private health system.

No government has ever sought to impose price control on doctors and the Howard Government certainly won't be the first to try. Still, the rapid growth in procedural fees, averaging about 10 per cent a year over the past three years according to private health data, and the consequent out-of-pocket expense to patients, risks undermining the private health sector.

It's not that doctors don't deserve their incomes. Given the years of training they undergo, the hours they work and the responsibilities they carry, they ought to be among the best-remunerated professionals. The problem is not so much high medical fees but the large out-of-pocket expenses sometimes faced by patients who have already paid private health insurance premiums on top of taxes.

For years, the AMA has argued that there should be a big increase in fees paid under the Medicare Benefits Schedule. Recently, the Government has made some adjustments to the fee schedule designed to produce fewer unexpected gap expenses for anaesthesia. Even so, large across-the-board increases in scheduled fees would be a costly remedy for a problem that's most acute in more affluent areas.

An alternative would be for doctors and funds selectively to negotiate their own standard fees, provided doctors also agree to charge fund members no more than a modest gap. This would require the funds to deal more directly with doctors than in the past. For their part, doctors would have to accept that negotiating fair fees does not mean turning doctors into virtual employees of the funds (especially with patient portability of cover and doctors' greater capacity for collective bargaining under the new legislation)

For many doctors, the result of such negotiations could be some increase in fee income. For patients, the result ought to be more no-gap services and a sharp reduction in the number of medical services with very large gaps (such as the \$850 average gap for orthopaedic services).

It's possible that more widespread no-gap and known-gap arrangements could put some pressure on premiums. On the other hand, allowing funds to cover out-of-hospital substitutes for hospital treatment should help to keep premiums down. Price is always important but the most important aspect of any purchase is the quality of the product. Lifetime health cover and the rebate have meant three million more fund members than in the mid-1990s. The best way to build on these achievements is to focus on improving the private health insurance product.

One of the perennials of health policy is argument over the quantum of federal support for state public hospitals. Compared with their predecessors, the current Health Care Agreements, running from 2003 to mid 2008, provide for a 17 per cent real increase in federal funding for public hospitals. This hasn't ended the blame-game; in part, because the states have increased their spending at least as fast but also because being responsible for delivering services but not fully funding them or vice versa inevitably lends itself to "I would if only I could" buck-passing.

In theory, the best way to resolve this might be to give one level of government, inevitably the federal government, overall responsibility for all health services. For better or worse, it's almost inconceivable that the states would surrender their health responsibilities without unacceptable trade-offs. For its part, the federal Government has no intention of seeking to run public hospitals that, for the foreseeable future, will remain the responsibility of the states.

The Opposition has repeatedly toyed with the idea of a single funder for all health services. It's recently been raised again for debate by the new Deputy Leader of the Opposition Julia Gillard and endorsed by Victorian Premier Steve Bracks. Under this proposal, all federal and state health programme funding, for Medicare, the PBS and aged care as well as for hospitals, would be tipped into a \$60 billion dollar a year pool to be administered by a management board.

Pooled funding has two insurmountable problems. First, no one would really be in charge. Existing federal and state ministerial responsibilities would pass to a board accountable to no one. Second, the board would almost inevitably decide that more money was required whereupon the age-old argument about which level of government should pay would begin again. At some point, the board would cannibalise demand-driven, market oriented programmes such as Medicare and the PBS to support bureaucratically-driven, budget-limited programmes such as public hospitals. It would be the health version of British Leyland, an out-of-control conglomerate dominated by internal politics rather than service to patients. It's worth noting that New Zealand, which has a form of pooled funding, has not yet decided to fund the anti-cancer drug Herceptin. Certainly, pooled funds would mean the end of Medicare in the form it has operated since 1984.

The next Health Care Agreements should be about clarifying responsibilities not further blurring them. The states should be able to deliver services to public patients in the most convenient and efficient way. The federal government should have at least some authority over the funding it provides for public hospital services.

At a recent conference, Professor Stephen Duckett, currently working with the Queensland health department, suggested a formal extension of Medicare to public patients in public hospitals. He estimated that paying the states the equivalent of the Private Health Insurance rebate plus allowing them to claim Medicare benefits for public as well as for private patients could provide a state such as Queensland with about the same quantum of support as the current Health Care Agreement.

There is much anecdotal evidence that states are already transferring as many patients as they can from Health Care Agreement-funded public hospitals to Medicare-funded private in-patient and public out-patient services. One Victorian public hospital, for instance, has signs in corridors and lifts urging patients to use their private health insurance. For the relatives of patients at this hospital, "customer service calls" stress that electing to be a private patient will not reduce service quality but will mean more money for the hospital.

One benefit of formalising these rather furtive arrangements, with commensurate reductions in bloc funding, could be much better data on public hospital performance. It could lead to the collection of much more detailed service-delivery data (as in private hospitals) and enable better comparisons to be made between the performance of different hospitals.

It wouldn't entirely take the politics out of hospital funding (the states would doubtless argue, for instance, with the AMA, that the scheduled fees were too low) but it would substitute a well-established, pay-by-performance mechanism, for political bargaining based on past practice. At this stage, it's just one idea in the debate over the shape of the next agreements. It could not even be considered without detailed modelling but it offers one potential basis for constructive change.

At the Council of Australian Governments meeting last June, the Prime Minister and the Premiers agreed on a national registration system for doctors and other health professionals. Regardless of any "blame game" on other issues, this could turn out to be one of the many areas of sensible cooperation between the Commonwealth and the states. Certainly, it is a necessary national project which cannot proceed without the states' involvement and support.

The basic objective is to ensure that a doctor registered anywhere in Australia can practice everywhere in Australia in the appropriate setting or specialty. Uniform high standards of competence for task should apply everywhere. Of course, only an experienced and capable doctor is able to judge the competence of another doctor. This suggests that, in order to practice in Australia, a doctor should be a fellow of the relevant Australian medical college, a fellow of an equivalent overseas college (as judged by the relevant Australian college), or on a college approved training programme.

As presently, the Australian Medical Council should continue to accredit Australian medical colleges and medical schools and their training programmes. Provided credentials have been properly checked, training and supervision thoroughly undertaken and medical mistakes appropriately reported and reviewed by peers, patients should be confident that their treating doctors meet the best Australian professional standards. There should be no more Dr Deaths.

As part of the COAG process, a draft scheme was circulated for consultation late last year. As a result of feedback, it now seems that the best way forward is to have separate national registration boards for medicine and for each of the other health professions, supported by profession-specific committees in each of the states and territories.

The national medical board, for instance, would be appointed in much the same way as the state boards are currently appointed with strong representation from medical bodies and would report to government as now. There would need to be state committees with their own responsibilities including disciplinary matters and doctor support programmes but following standards established by the national board. Over time, arrangements for the other professions would largely mirror those for medicine as it generally has the most developed professional standards and disciplinary procedures.

The draft scheme circulated last year proposed a single national health registration board with authority over all the professions. A national advisory committee (perhaps comprising the chairmen of the various national registration boards) now seems more feasible. This committee would meet regularly to discuss issues of common interest and would report to the Health Ministers' Council but would not have authority over the professions' individual national boards. It would operate in much the same way as the committee of medical college presidents, a sounding board for ideas and a forum for finding common ground.

Some of the professions are concerned that any national health registration board could be used to determine function rather than competence. As far as the Commonwealth is concerned, national health registration is about guaranteeing public safety, enabling portability of practice and reducing red tape. It's not about changing existing professional demarcations. It's worth noting that practice nurses have arguably been more effective than nurse practitioners in reducing "doctor-centric" primary care because they have worked with doctors rather than independently of them in ways that respect the traditional leadership role of the medical profession.

Debate about whether pharmacists or nurses, for instance, might take on some of the responsibilities of doctors or whether state governments or professional colleges should accredit surgical training places is better not mixed into the process for national registration. Any attempt to use national registration to drive reform in other areas could jeopardise its prospects of success and perpetuate the existing hodgepodge of standards and registration requirements.

There will never be problem-free health systems, if only because the public demand for the best, immediately, for free is all-but-impossible to meet. There will always be aspects of the way health systems work which can be improved. Still, dismay at their occasional failures should not obscure their great strengths and achievements. Trying to change too much too soon can easily make an unsatisfactory situation worse. Particularly in an area of policy as important and sensitive as health, there's much to be said for being content with the change that can be achieved rather than pining for the kind of perfection which is usually only achieved in text books. For reformers as for medical practitioners, the guiding principle should be “do no harm”.

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