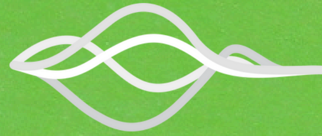

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Australian Health Economics Society

THE FUTURE OF MEDICARE

RESEARCH-INFORMED POLICY FOR BETTER ACCESS & HEALTH

19 JUNE 2024 | CANBERRA

SYMPOSIUM SUMMARY REPORT

INTRODUCTION

Medicare stands as a remarkable success in achieving and sustaining transformative social and economic impact. It was initially designed to provide universal healthcare and reduce the financial and health burden of prohibitively expensive hospital and medical services. Over its 40-year history, Medicare has retained many of its pre-existing funding models and streams of funding, such as fee-for-service. However, the numerous complexities in the system both necessitate improvements and make reforming Medicare more challenging.

On 19 June 2024, the Academy of the Social Sciences in Australia (the Academy), in partnership with the Australian Health Economics Society (AHES) and the Independent Health and Aged Care Pricing Authority (IHACPA) jointly organised a one-day symposium to celebrate 40 years of Medicare and highlight the central role that research will play in safeguarding a modern, accessible and enduring Medicare infrastructure.

The symposium brought together more than 100 leaders in health policy, practice and research to explore the current challenges facing Medicare and the research investment needed to ensure a continuous flow of evidence to support reform.

This summary provides an overview of the discussion and outcomes from the symposium.

(L-R): Dr Chris Hatherly (CEO, the Academy), Professor Josh Byrnes (President, AHES) and The Hon Dr Andrew Leigh MP with symposium co-convenors Professor Jane Hall AO (University of Technology Sydney) and Professor Anthony Scott (Monash University). Photo by Ari's Pixels.

The symposium opened with a panel reflecting on the evolution of Medicare and Australia's healthcare system, with a focus on access, quality and affordability. The panel, moderated by the Academy's President Professor Richard Holden, included Dr Elizabeth Deveny, Consumers Health Forum of Australia, Dr Pradeep Philip, Deloitte Access Economics, and Professor Jane Hall AO, University of Technology Sydney. The panel was also joined by Minister for Health and Aged Care The Hon Mark Butler MP via a recorded video message.

Minister Butler set out many of the challenges facing Medicare today. These ranged from accessing bulk-billing doctors and the size of out-of-pocket payments to an ageing population and the burden of chronic disease. Minister Butler made clear that innovation is needed to ensure a sustainable, fit-for-purpose Medicare; research and long-term investments in such have a critical role to play.

On the back of the Minister's comments, the panellists reflected on the debates around the shifting focus on how current challenges might change the composition, funding and human resourcing of the system. The panel drew particular attention to the shift from emergency services to chronic conditions and preventative medicine. The current system does not adequately fund screening and preventative care, with these services often not assigned a Medicare Benefits Schedule (MBS) line item. This does little to reduce the long-term financial and health burden on the system, nor does it support Australians to live well for longer. As Dr Deveny observed,

> 'we used to die fast, now we die slow ... Cancer, heart disease, diabetes ... you have to have to manage over 10, 20 or 30 years, until eventually they are the primary cause of your death. Now, that change in the way that we can keep you alive rather than you dying quickly as you might have in the 80s or the 60s, means that our healthcare system has to radically change to support people ... to stay well and then to give them that wraparound care they need to support them during the last 10, 20, 30, 40 years of their life as they manage ... chronic diseases.'

The panel also reflected on the lack of engagement with citizens when deciding on funding priorities. They called for an increased focus on the needs of citizens to better respond to the contemporary demand for preventative care and wraparound support for chronic disease. Strategies to increase consumer and citizen representation and better understand what Australians want from their healthcare system included more public inquiries and deliberative processes.

The panel agreed that a radical transformation is needed for funding mechanisms. Professor Hall proposed the creation of Medical Research Future Fund (MRFF) funding reform initiative, with a 10-year commitment to piloting alternative models. A mission-oriented approach that provides the operating environment to experiment and build an evidence base on what works would support the government to drive innovative, long-term design of healthcare funding models.

SESSION ONE

Data, data everywhere ... Making the best use of the revolution in access to administrative data to modernise Medicare

The first session of the day included presentations from Teresa Dickinson PSM, Australian Bureau of Statistics (ABS), Dr Phillip Gould, Department of Health and Aged Care, and Professor Denzil Fiebig, UNSW. The session explored the power of administrative data to transform the research landscape and support Medicare reform, as well as highlighting inherent challenges.

The presenters welcomed the development of new data assets that link administrative data sets at the individual level, offering new opportunities for research and evaluating policies and programs. They supported researchers' access to these data assets on a trusted basis, stressing the need to ensure that time and financial barriers do not hinder robust research.

In recent years, Australia has taken steps towards improving data infrastructure, access and governance. These developments recognise that government-collected administrative data is a national asset, with the potential to inform and enhance service delivery, inform policy and programs, and support research and innovation. The ABS's Person-Level Integrated Data Asset (PLIDA) is a key piece of Australia's data infrastructure. PLIDA securely combines administrative data from multiple government agencies to provide rich insights into populations, the interactions between their characteristics, and how they engage with services over their lives. There are various applications for healthcare and policy, including modeling and targeted public health campaigns.

Over 100 attendees from across academia, government, private and the not-for-profit sector attended the symposium. Photo by Ari's Pixels.

Ms Dickinson explained that Medicare data is vital to PLIDA in two ways:

1. The Medicare datasets and what that reveals about people's usage of the health system and, when linked with other datasets, how it relates to other facets of their lives.
2. The Medicare datasets form part of the PLIDA linkage spine that allows the ABS to correctly confirm and identify people in different datasets.

'Without the Medicare data,' she said 'and the coverage of the population that it provides, we wouldn't have nearly such high-quality data available [for research and policy and program development] ... The Medicare data gives us double dose value, the content of the data and the ability to use it to create the linked datasets.'

Administrative data is not without its limitations. These data are not immune to gaps, measurement errors and selection bias, often because they have not been collected with research in mind. The presenters accordingly encouraged more collaboration between data custodians, government and researchers to identify and fill gaps with different types of data. Randomised control trials (RCTs) and causal inference methods, for instance, have applications for modelling individual behaviours and estimating individual treatment effects, while survey data can contextualise individual-level administrative data. As reforms to Medicare are introduced, surveys and other qualitative research will be particularly valuable in yielding deep behavioural insights about how citizens and providers react to change, ultimately helping to predict potential policy and implementation problems.

Building a stronger Medicare is one of the Department of Health and Aged Care's priority reforms. Within this context, there is a need for data to inform policy and program development and evaluate their effectiveness and impact. Dr Gould discussed the Department of Health and Aged Care's Evaluation Strategy 2023-26, which supports the evidence generation needed to embed robust evaluations for evidence-driven Medicare reform.

Discussions extended to concerns about the use of procured evaluations for evidence-based policy decisions. Professor Fiebig noted that the research accepted into high-ranking journals was increasingly narrow and more needed to be done to translate findings into broader contexts and guidance for practical application. More partnerships between departments and researchers to undertake independent evaluations and publish evaluation reports would support transparency, improve methodology, and build capability.

SESSION TWO

Medicare and equity of access

This and the next session highlighted the types of research that can help improve Medicare. In recognising the ongoing challenges of access and affordability, particularly for those most in need, it was clear that new ideas and a strong foundation of data, research, and evidence are crucial. These tools are essential to determining what truly works in healthcare delivery and funding, detail that supports informed decisions about design, implementation and scalability.

This session included presentations from Professor Kees van Gool, University of Sydney, Dr Li Huang, University of Melbourne, Associate Professor Dianne Currier, University of Melbourne, and Dr Karinna Saxby, University of Melbourne.

The principles underpinning Medicare emphasise universality of access to comprehensive, high-quality care based on needs rather than income, that the cost of this care should be equally distributed, and that the system should deliver incentives for providers. Various research examples illustrated how Medicare has improved heath access and delivered welfare gains. However, there is also evidence of persistent financial barriers, particularly for specialised services and vulnerable population groups, such as children and First Nations peoples.

Professor van Gool examined the effect of out-of-hospital MBS services out-of-pocket costs in the Medicare system, as well as examining how reforms have created barriers to equity of access.

Out-of-hospital MBS services out-of-pocket costs:

- creates patient price sensitivity to provider fees 'because Medicare is basically the floor price, it's what the government is willing to pay for a service, anything above that ... floor price is being provided by the patient'
- limits and reduces demand, with effects on government expenditure
- shifts the financial risk from the government to the patient, and
- reduces inefficiency in terms of moral hazard aspects if insurance has led to 'overconsumption'.

Professor van Gool explained how the bulk billing incentives introduced in 2004, intended to make out-of-hospital services more affordable for concession card holders had adverse effects for non-card holders. While the concession card did incentivise doctors to bulk bill, it was also a signal for doctors to charge more for out-of-pocket costs for non-card holders. This was particularly prevalent for patients requiring specialist and intensive services. While concession cards play an important role in protecting some patients from out-of-pocket costs, Professor van Gool concluded that it is a poor proxy for income and needs—not taking a disease or systems point of view—nor does it protect against provider price discrimination.

Further discussion highlighted other equity of access issues arising from a failure to take a whole-of-system approach to Medicare policy and funding decisions. In a study drawing on the nationally representative Longitudinal Study of Australian Children and link MBS billing data, Dr Huang and colleagues analysed government spending on children's healthcare. They focused on distribution across income levels to determine how much of the Government subsidy is benefiting higher socioeconomic cohorts.

Lower income families are more likely to consult with a GP, while higher income families are more likely to seek specialist care. While spending on GP care was relatively equal, spending on specialist out-of-hospital care benefited higher socioeconomic cohortsthe poorest 20 per cent of families received less than 20 per cent of government spending on specialist care, while wealthiest 20 per cent of families received 26 per cent. This disparity was more pronounced when age was considered. The highest level of inequality was during the first three years of a child's life, a critical window in childhood development with downstream impacts on health and wellbeing outcomes. One possible way to remedy this disparity is an integrated GP-paediatrician model of care that strengthens the paediatric care skills of GPs and supports more equitable servicing. This approach is currently being piloted in the Strengthening Care for Children Program.

These case studies remind us of the value of research in uncovering how well-intentioned policies can lead to unintended consequences for patients and taxpayers. This risk is particularly evident when 'band-aid' solutions address only parts of the healthcare system without considering the broader implications. Therefore, policy design must be evidence-informed and consider the responses of both consumers and providers to funding changes, as these reactions significantly impact access, quality of care, and costs.

Echoing the discussion from the first session of the day, speakers highlighted the importance of linked administrative data for understanding the impacts of discrete policy interventions and the valuable contribution that research makes to guiding evidence-informed reform.

Associate Professor Currier shared findings from the Evaluation of the Better Access initiative, which provides rebates to people accessing a range of mental healthcare services, including General Practitioner Mental Health Treatment Plans (GPMHTP) and assessment and treatment by psychologists, psychiatrists, GPs and other medical practitioners. Analysis of data from PLIDA revealed patterns of use and access barriers among different cohorts. Despite an increasing demand for services—with 1 in 10 people using at least one Better Access service, up from 1 in 19 in 2009—more than a third of people with a GPMHTP do not progress to treatment. The factors associated with this pattern of use included being younger—despite 18-24-year-olds being the most likely to access a GPMHTP—identifying as First Nations, living in a low-income household, or living in a disadvantaged, outer regional or remote area. These cohorts are disproportionality affected by strain on Australia's mental healthcare system and access barriers such as affordability (e.g.. increased out-of-pocket cost, fewer bulk-billing providers) and system capacity (e.g. longer wait times, workforce capacity and distribution, particularly in regional and remote areas).

The granularity of linked administrative data helps researchers understand the effectiveness of policy measures targeted to specific cohorts. The Indigenous Practice Health Incentive and Closing the Gap Pharmaceuticals Benefits Scheme Co-payment Program are targeted, complementary measures designed to prevent, identify and manage chronic disease among First Nations people by incentivising GPs to provide chronic disease care and reduce the cost of prescriptions. Using various linked data assets, Dr Saxby identified increased engagement with preventative healthcare and a reduction in inequities in access following the introduction of the measures. However, this was not equally distributed across the country, with implications for further research to understand what drives regional variation and, in turn, the development of more targeted, place-based measures. If this work is to progress, there must be better integration of Remote Area Aboriginal Health Service Program data and Aboriginal Community Controlled Health Organisation (ACCHO) data into PLIDA.

SESSION THREE

Medicare and the healthcare system

The third session included presentations from Ms Rosemary Huxtable AO PSM, Focal Point Consulting, Dr Nathan Kettlewell, University of Technology Sydney, Dr Michael Wright, Avant, and Professor Anthony Scott, Monash University. The session centered on the need for a whole-of-system approach to healthcare reform.

The 2011 National Health Reform Agreement (NHRA) set out the shared intention of the Commonwealth, State and Territory governments to work together to deliver a locally responsive, nationally consistent healthcare system. Governments acknowledged that a high-quality, coherent and sustainable healthcare system was a shared national priority. The NHRA made provisions for transferring funding from the Commonwealth to the States and Territories and set out the roles, responsibilities and accountability mechanisms. The NHRA also explicitly reaffirms the Medicare principles of choice, access and equity.

The NHRA has provided a sound foundation for the structural reform of Australia's healthcare system. However, for the agreement to continue to deliver on the Medicare principles and remain fit-for-purpose, Ms Huxtable identified five areas for reform:

1. Take a whole-of-systems view to deliver health reform, to redefine and broaden the scope of the NHRA so that it moves beyond administering the technical aspects of hospital financing to better measure and understand the enablers of health system performance.
2. Respond to an ageing population and the burden of chronic disease, developing integrated, patient-centered models of care that support people to manage their health across primary, secondary, aged and disability support care.
3. Take activity-based funding beyond counting and systematising to shaping demand, focusing on the value of care pathways and how to reward and promote them in funding arrangements.
4. Overcome funding disputes between the Commonwealth, State and Territory governments through an effective, equitable sharing of risk in the system.
5. Plan for the future by resourcing innovation and reform.

> 'We need a [NHRA] that's data informed, that's future focused and doesn't react to legacies of the past. We need to be able to take good ideas, evaluate them and take them to scale.' - Ms Rosemary Huxtable AO PSM

Discussion extended to hospital funding, private health insurance, aged care funding, and aligning workforce planning with population needs, areas where research offers indispensable insights.

(L-R): Dr Nathan Kettlewell (University of Technology Sydney), Professor Anthony Scott (Monash University), Dr Michael Wright (Avant) and Rosemary Huxtable AO PSM (Focal Point Consulting) discuss Medicare and the health system with moderator Dr Catherine de Fontenay (Productivity Commission). Photo by Ari's Pixels.

Despite the existence of Medicare, around 45 per cent of Australians hold private health insurance (PHI). There are two key reasons for this:

1. The quality gap between public and private care, particularly faster treatment in the private system.
2. The incentives in the system that encourage PHI take-up.

Dr Kettlewell unpacked these reasons and tested some of the assumptions about the effect that PHI has on Medicare. The typical argument in favour of PHI is that it relieves pressure from the public system. However, PHI does not necessarily translate to a higher standard of care for public patients. Doctors often work across both the private and public sector, likely reducing their supply to the public system. As more patients use the private system, activity-based funding means that savings will translate to less funding for the public system. Indeed, evidence shows that the upswing in PHI purchase following the introduction of incentives in 1999 and 2000 had a negligible impact on surgery wait times for public patients.

As the government considers the future of Medicare funding mechanisms, more research is needed to better understand the role of PHI within the healthcare system. This includes applying an efficiency and equity lens to incentives and the capacity strain as specialists move from the public and into the private system.

Dr Wright discussed the areas for reform to strengthen primary care, including improving access, supporting innovation and encouraging multidisciplinary approaches. Primary care—including GPs, pharmacists, ACCHO and other allied health services—is the first contact care that individuals seek in their community, and it provides the foundation for universal healthcare in Australia. Primary care plays a crucial role in preventive care and removing pressure on the hospital system, benefits that will be increasingly important as Australia's population ages. Despite this, primary care makes up less than 6 per cent of total government health expenditure, a proportion that has decreased over the last decade. Funding arrangements need to be strengthened and remodelled to support all parts of the primary care workforce to provide high-quality, wrap-around care. Reform should prioritise mechanisms that support coordinated care and ongoing relationships between patients and their primary care team. This could take the form of incentives for longer consultations and bundled funding alongside the fee-for-service models to better support multidisciplinary approaches.

The COVID-19 pandemic brought into sharp focus that Australia's health workforce is the key mechanism for delivering improved outcomes. As Professor Scott observed,

> 'the provision of routine healthcare, as well as the adoption of innovations in diagnosis and treatment, depends on a healthy, motivated, flexible and appropriately skilled health workforce, providing high-value health care distributed according to need.'

Research on the health workforce challenges such as burnout, bullying, capability and workforce incentives and distribution is essential for coordinated, evidence-informed workforce policies and, in turn, a strong and sustainable Medicare system. Barriers to this kind of research include fragmented, inconsistent and inaccessible data. To overcome these barriers, Professor Scott called for funding for improved workforce data linkage and proactively planning for long-term research agendas, ideally aligned with the Strengthening Medicare Taskforce Report and various health workforce reviews and strategies. Areas for focus include reviewing incentive programs—particularly for nurses and GPs to work in rural areas—evaluations of health workforce wellbeing policies, and how organisational level issues influence team-based care.

SESSION FOUR

How can we build research capacity to modernise Medicare

The symposium closed with reflections from The Hon Dr Andrew Leigh MP, Assistant Minister for Competition, Charities, Treasury and Employment, Professor Joshua Byrnes, Australian Health Economics Society, Professor Emily Lancsar, Department of Health and Aged Care, and Dr Sally Redman AO, formerly Sax Institute. The session explored the actions needed across government, universities and the healthcare sector to build the research capacity to address the challenges facing Medicare. The speakers emphasised the importance of collaborative, multidisciplinary approaches and the need for long-term and more flexible funding models for research and development.

The Assistant Minister discussed the promise that advances in genomic testing, longitudinal surveys and RCTs have for providing better quality evidence to make decisions about policy and models of patient care. The Assistant Minister advocated for making health data available for public benefit research, however, expertise, ethics, privacy, and security must be addressed before implementing data-driven healthcare research and reform.

Discussion extended to the institutions and incentives needed to grow and develop the capacity and capability within government for evaluation and evidence-informed reform. A particular focus was the role that organisation such as the Australian Centre for Evaluation (ACE) play in identifying evidence gaps and making this public so that researchers can step forward to fill these gaps. This propagates and makes available robust evidence and prevents duplication of effort, both in Australia and in similar countries. Professor Lancsar and Dr Redman discussed the opportunity for organisations like ACE to pursue collaborative partnerships between the public sector, academia and health sector to build cross-sectoral capacity and bring a multidisciplinary lens to research, policy development and evaluation.

Understanding and leveraging data also relies heavily on sustained investment in research to prioritise and incentivise research agendas, fund training and support researcher career development. Social science research is critical to ensuring that Medicare adapts to the ever-changing landscape of healthcare. The often-groundbreaking work of social science researchers is often devalued, and population health suffers when the healthcare system's funding and organisation inhibit innovation and access to treatments based on need.

Several speakers throughout the day called for a substantial, long-term investment in research programs focused on the healthcare system and healthcare funding reform. Currently, only a handful of Australian researchers are actively engaged in this field, relying on limited, typically cyclical and project-specific funding, rather than supporting the growth of larger-scale programmatic research required for transformative change. This situation has led to patchy capacity and skills that are neither sustainable nor scalable.

A dedicated, long-term funding commitment is essential to addressing the complexity of these issues, to grow and sustain research teams, and ensure a continuous flow of evidence. New MRFF Fellowships on Healthcare, Financing, Funding and Reform are one option for generating a pipeline of evidence aligned with priority research areas. Such research should be ongoing and conducted before, during, and after the regular policy cycles of health funding reform and various Medicare initiatives. This approach will help align research timelines with cyclical policy imperatives, enabling the development of new research capacities, the effective use of emerging data assets, and fostering collaborative relationships between government, the health sector, and academia.

(L-R): Moderator Dr Liz Develin (Department of Health and Aged Care) discusses how can we build research capacity to modernise Medicare with panellists Dr Sally Redman AO (Former CEO, Sax Institute), Professor Emily Lancsar (Department of Health and Aged Care), Professor Josh Byrnes (President, AHES) and The Hon Andrew Leigh MP. Photo by Ari's Pixels.

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Image: Rosemary Huxtable AO PSM presenting at 'The Future of Medicare' symposium in Canberra. Photo by Ari's Pixels.