Chapter 4

Current market drivers and the sustainability of the health system

4.1 This chapter discusses the following terms of reference:

(h) market drivers for costs in the Australian healthcare system; and

(d) the implications for the ongoing sustainability of the health system.

Market drivers

4.2 The Minister for Health, the Hon Peter Dutton MP has characterised the ageing population, chronic disease and higher costs as the key drivers of costs in the healthcare system. The Minister noted that these drivers have placed increasing pressure on Medicare, the Pharmaceutical Benefits Scheme (PBS) and public hospitals.[1]

4.3 Several submitters and witnesses also identified the ageing population and increased incidence of chronic and long term illnesses as the key areas placing additional pressure on the healthcare system.

4.4 Evidence to the inquiry suggested that these drivers will continue to place additional pressure on health costs as the population ages and individuals are required to manage chronic and complex illnesses for longer periods. It was noted that the ability to respond to these changing health needs is not reflected in the current model of funding.[2]

4.5 The Australian Medical Association (AMA) explained that one of the primary drivers of cost is the volume of treatment during episodes of care:

> I think what that is referring to is not just the medical costs associated with that care but also the other costs that come into play with an episode of care. An episode of care might be, for instance, a hospital admission, but there are a lot of other services that we now provide for patients, including things like physiotherapy, occupational therapy, the use of a pharmacist and a whole bunch of other allied health professionals. There is an increase in the volume of services that are provided per episode, so it is not just one fee but multiple fees across different providers.[3]

4.6 Other witnesses also identified that individuals' health needs are becoming more complex. Occupational Therapy Australia suggested that adopting a

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1 The Hon Peter Dutton MP, *Speech to the Australian Institute of Policy and Science*, 15 May 2014, https://www.health.gov.au/internet/ministers/publishing.nsf/Content/D650B8CD02CBEC46CA257CDD000B593F/$File/PDSP140515.pdf, p. 1 (accessed 8 August 2014).

2 See for example, Consumer's Health Forum of Australia, *Submission 17*.

3 Associate Professor Brian Owler, *Committee Hansard*, 29 July 2014, p. 26.

multidisciplinary approach may assist health professionals to address these complexities more efficiently. A multidisciplinary approach will facilitated improved communication and improve efficiencies as there will be a reduction in duplicating delivery of health care services.[4]

4.7 Witnesses identified reforms to the PBS as a mechanism to reduce overall expenditure in health. The Grattan Institute proposed a number of budget saving initiatives that it considers should be pursued as alternatives to increasing the PBS co-payment, including establishing an independent expert pharmaceutical pricing authority. Dr Stephen Duckett, Director, Health Program suggested that $580 million could be saved annually if the cost of Australian pharmaceuticals was benchmarked internationally. Further to this, Dr Duckett suggested that the government should consider a one-off price cut on all generic drugs.[5]

4.8 The committee is aware that price disclosure is a routine part of maintaining PBS listings for medicines where more than one brand has been listed. The objective of the policy is to ensure that PBS prices for these brands more closely reflect the prices in the market. Where discounting is occurring as a result of competition, price disclosure progressively reduces the price of PBS medicines and ensures better value for money. The Government requires pharmaceutical companies to provide information relating to the sales of brands subject to price disclosure. This information is then used to determine the PBS price.[6]

4.9 The Consumers Health Forum (CHF) recommended the acceleration of price disclosure measures to reduce the cost of pharmaceuticals. CHF advised that pharmaceutical prices are currently checked every 12 months and there would be benefits if this timeframe was reduced and prices were checked more frequently.[7]

4.10 Officials from the Department of Health explained that 326 drugs are currently subject to price disclosure calculations. Since price disclosure began in 2007, approximately 50 per cent of drugs have reduced in price. Under simplified price disclosure (the new price disclosure process[8]) the calculation is undertaken after six months of data instead of 12 months. Following the most recent price review, 95 drugs will reduce in price.[9]

4.11 The Pharmacy Guild of Australia (the Pharmacy Guild) also expressed support for price disclosure as an 'appropriate mechanism to ensure that prices paid for

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4 Mr Peter Bothams, *Committee Hansard*, 29 July 2014, p. 39.

5 Dr Stephen Duckett, *Committee Hansard*, 29 July 2014, p. 29.

6 Department of Health, *Simplified Price Disclosure (SPD) Frequently Asked Questions, updated June 2014*, accessible at: http://www.pbs.gov.au/industry/pricing/price-disclosure-spd/updated-faq-simplified-price-disclosure.pdf (accessed 7 August 2014).

7 Ms Priyani Rai, *Committee Hansard*, 29 July 2014, p. 7.

8 Simplified price disclosure streamlines price disclosure processes and allows PBS prices to be adjusted to market prices more quickly. The first price reduction under simplified price disclosure will occur on 1 October 2014.

9 Ms Felicity McNeill, *Committee Hansard*, 29 July 2014, p. 70.

PBS medicines reflect the competition in the market for those medicines' and that expenditure on the PBS is now well contained as a result of price disclosure.[10] However, the Guild noted that price disclosure is lowering remuneration levels for community pharmacies which may limit the range of services that can be provided by these pharmacies.[11]

Access to comprehensive health data

4.12 The committee notes that an accurate understanding of the drivers of costs in the healthcare system is dependent on the availability of reliable health data. The committee notes advice received throughout the inquiry from a range of witnesses that various data sets are either not routinely collected, unavailable at the level of detail requested or unreliable due to the data collection methodology.

4.13 The committee recognises the value of drawing data from different sectors of the health system together in order to develop a comprehensive understanding of the interactions between health services as well as trends across different sectors of the community.

4.14 The committee asked the Australian Institute of Health and Welfare about the information that could be made available if MBS and PBS data was analysed together. Representatives from the AIHW told the committee that:

> The legislation as currently written precludes the linkage by a Commonwealth agency of MBS and PBS data, so we are currently doing a range of work where we can link the two. You can link Medicare data to a group of people and separately you can link PBS data to that group of people but we as a Commonwealth agency cannot actually bring those two together.[12]

4.15 The committee discussed this further with the Department of Health and was advised that such analysis was not currently possible due to the legislative restrictions in place that prohibited sharing of each of these data sets.

> There are specific prohibitions on Medicare data, MBS data, being linked with PBS data. That is within the health portfolio. There are rules set by the Privacy Commissioner about the terms under which it can be done, how long it can be kept, and how it has to be destroyed. Tax data is surrounded by a whole raft of its own secrecy provisions. It is collected under very strict conditions, and one of those very strict conditions is very tight restraints on how it can be used to inform other things. So there is no routine way we could seek to link those datasets.[13]

4.16 The committee notes that some broad level data is publicly available on the Department of Human Services website relating to particular areas of the health

10 Pharmacy Guild of Australia, *Submission 41*, p. 5.

11 Pharmacy Guild of Australia, *Submission 41*, p. 9.

12 Ms Justine Boland, *Committee Hansard*, 29 July 2014, p. 48.

13 Mr Richard Bartlett, *Committee Hansard*, 29 July 2014, p. 61.

system. While this data enables interested parties to gain a general understanding of health services activity, the information is not available at a sufficient level of detail to facilitate analysis and evaluation.

4.17 The committee notes the Australian Healthcare and Hospitals Association (AHHA) submission that publication of more detailed bulk billing data would support analysis of bulk billing practices at the patient level rather than the service item level. The AHHA noted:

> Readily accessible bulk-billing data reflects services (MBS item numbers) and does not give an indication of the number of bulk-billed individuals—data on the proportion of people who are bulk-billed, sometimes bulk-billed and never bulk-billed should be publicly reported so that the impact on out-of-pocket costs can be assessed.
>
> Further detail on the distribution of these groups of people by socio-economic status and by geographic region will also provide a more informative analysis that reliance on existing publicly available data sets which focus on the proportion of service items that are bulk-billed.[14]

4.18 The Department advised the committee that work is currently being undertaken to look at making more data available at a more detailed level.[15]

Sustainability of the health system

4.19 In its report, the Commission of Audit highlighted projections from the Productivity Commission that suggest Commonwealth Government spending on health will rise from around 4 per cent of GDP in 2011–12 to 7 per cent in 2059–60. The Commission observed that 'health care spending represents the Commonwealth's single largest long-run fiscal challenge, with expenditure on all major health programmes expected to grow strongly to 2023–24 and beyond'.[16]

4.20 When discussing the proposed co-payments and the healthcare system generally, Government Ministers have reflected on healthcare in Australia and described the system as unsustainable, with particular focus on growth in expenditure on the Medicare Benefits Schedule and the Pharmaceutical Benefits Scheme. The introduction of co-payments has been explained as necessary to increase the sustainability of the health system.

4.21 When discussing the PBS co-payment during Budget Estimates, Assistant Minister for Health, Senator the Hon Fiona Nash noted that over the last 10 years, the PBS has risen by 80 per cent and in order to ensure that the system is sustainable; decisions need to be made now to facilitate sustainability.[17]

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14 Australian Healthcare and Hospitals Association, *Submission* 43, pp 2-3.

15 Mr Richard Bartlett, *Committee Hansard*, 29 July 2014, p. 62.

16 National Commission of Audit, *Towards responsible government. The report of the National Commission of Audit, Phase One*, February 2014, pp 99-100; 111–112.

17 The Hon Senator Fiona Nash, *Estimates Hansard*, 2 June 2014, p. 45.

4.22 The Assistant Minister provided the following evidence about the sustainability of the MBS:

> We have gone from a cost of $8 billion for the MBS 10 years ago. In 2007–08, it was $13 billion and it has gone up to a bit over $18½ billion now. It is projected to go to $34 billion. We have got 263 million free services occurring at the moment. That is unsustainable. As has been very clearly pointed out, we have chosen with the co-payment to put in place a change to the system which we believe will make the system sustainable.[18]

4.23 In proposing the new GP co-payment and the increase to the PBS co-payment, it appears that these measures are intended to alleviate costs associated with these two areas of the health system, with the intended result being a more sustainable health system.

4.24 Several submitters and witnesses also expressed reservations regarding predictions that costs associated with the MBS and the PBS are increasing unsustainably.[19]

4.25 The AMA told the committee:

> There is no evidence that our healthcare system is unsustainable. When we look at the proportion of the federal budget that has been spent on health care, in 2006 it was 18.1 per cent. In the last federal budget it was 16.1 per cent. In fact, it has actually gone down. So, while the overall amount might be going up, it is certainly not out of control. The federal government's proportion of money that they contribute to the overall health spending in Australia is still 41 per cent, and it has been between about 40 and 43 per cent for the past 10 years.[20]

4.26 Dr Duckett observed that Australia has a very efficient health system:

> Australia has one of the most efficient health systems in the world. We are below the OECD average in health expenditure and above the OECD average in life expectancy. Although we have increased our spending on health over the last decade or so, we have actually dramatically reduced the death rate from people who die from conditions that the health system might be able to address. When you are looking at sustainability, you look at both how much you spend and what you get for your spending. We have got a very good health system in international terms.[21]

4.27 The Pharmacy Guild argued that there is overwhelming evidence that current PBS expenditure is sustainable:

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18 The Hon Senator Fiona Nash, *Committee Hansard*, 2 June 2014, p. 64.

19 See for example, Pharmacy Guild of Australia, *Submission 41*, p. 14.

20 Associate Professor Brian Owler, *Committee Hansard*, 29 July 2014, p. 23.

21 Dr Stephen Duckett, *Committee Hansard*, 29 July 2014, p. 33.

> … and is in fact rising at a rate significantly lower than the rest of the health system due to a combination of price disclosure and strong competition in the community pharmacy sector.[22]

4.28 Submitters and witnesses emphasised that the Australian healthcare system is generally performing well overall and delivering good health outcomes across a range of areas. At the same time, it was acknowledged that there are areas where significant improvement is required to ensure that everyone is able to access and benefit from the health system.

4.29 Evidence indicated that there would be benefit in undertaking a review of all health services prior to implementing further reforms. Such a holistic review would facilitate a better understanding of the health system overall and the structural changes that may be required to service the community better. This is particularly relevant given the connections and inter-relationships between areas of the health system and the drivers of cost in different areas.

Effectiveness of co-payments to increase sustainability of the health system

4.30 Several submitters and witnesses did not support the view that the introduction of co-payments would ensure the sustainability of the health system. In particular, evidence provided to the committee questioned whether the introduction of a co-payment for GP visits and out-of-hospital pathology and diagnostic imaging was the appropriate mechanism to address any perceived sustainability issues in the healthcare system.

4.31 The committee received evidence that, instead of reducing health system costs, co-payments would create cost and access barriers for those seeking primary health care and therefore inhibit the management and treatment of ongoing chronic conditions. Such barriers would in turn impact on the sustainability of the healthcare system due to the high costs of receiving hospital treatment.[23]

4.32 Witnesses advocated for a broad review of the healthcare system that would identify areas of reform and develop new and innovative models of health financing and models of care. Such a broad review would analyse possible changes to the health system in the context of their impact on other health services.

4.33 The Australian College of Nurse Practitioners submitted:

> Conversely, to identify "real savings" and build sustainability, the health system as a whole needs to be considered. This includes building on the work that has already been done to successfully introduce new models of care that are cost effective, safe and efficacious. Integral to this is a systematic review of healthcare funding to ensure the patient journey, through the system, is streamlined and efficient. Where appropriate, it is

22 Pharmacy Guild of Australia, *Submission 41*, p. 14.

23 Healthcare Consumers' Association ACT, *Submission 66*, p. 17.

> suggested that funding needs to facilitate early intervention and management in the community to avoid unnecessary hospitalisation.[24]

4.34 Dr Stephen Duckett, Director, Health Program, Grattan Institute, argued that, instead of the focus being on co-payments, the focus of healthcare discussions should be about the problems in the system and how they can be addressed.

> It is important that we are fiscally responsible in health care, as in every area of expenditure. But in ensuring our financial rectitude we need to look first to where we can save money without impacting adversely on patients. The budget proposals jump too quickly to a cost-shifting solution when there are cost-saving opportunities that have not been pursued.[25]

Committee view

4.35 The committee notes that the GP co-payment and the increase to the PBS co-payment have been proposed as a mechanism to address issues affecting the sustainability of the health system. Evidence provided to the inquiry questioned both the appropriateness of these measures as well as the effectiveness of the co-payments to increase the sustainability of the healthcare system. On the basis of this evidence the committee believes that the GP and PBS co-payments are likely to decrease patient access and make the health system less sustainable over the long term.

4.36 The committee recognises that Australia's healthcare system requires reform to both increase the effectiveness of the system and improve health outcomes. The committee notes the evidence recommending that any further changes should be informed by a much broader review of the healthcare system.

24 Australian College of Nurse Practitioners, *Submission 70*, p. 7.

25 Dr Stephen Duckett, *Committee Hansard*, 29 July 2014, p. 29.