Health system deserves keener scalpel than GP co-payments

By Adam Elshaug

The Abbott government is bracing against a storm of opposition to its proposed budget items that would see the introduction of co-pays for GP consults, pathology and radiology test orders, and pharmaceutical prescriptions. Even the most centrist of commentators are expressing concerns that the risk of unintended consequences of these measures stand as a real and present danger for the health of Australians. Co-pays might add revenue and/or decrease demand and hence Medicare expenditure (in the short term at best). On this front, had the proposal been submitted as an assignment by a student of macro accounting, it might scrape a pass grade. It represents a fail, however, of sound health economic policy, for it is too blunt a tool to reduce with scalpel precision those supposed ‘unnecessary’ GP visits, tests and medicines. Instead, we know from international evidence that necessary care will drop, and with it will go opportunities for prevention and low-cost disease management. That other advanced economies, with high performing efficient health care systems, are moving in the opposite direction and strengthening the foundations of access to primary health care should be strong cause for modest, impartial reflection.

But what if the government had up its sleeve a series of yet unutilised – Plan B - policy options that represent a win-win for them and their constituents, with the potential to save money (more than the co-pays will generate!) while at the same time improving the healthcare of Australians? Surely no government could be this fortunate! Well, the Abbott government most certainly is.

One ‘Plan B’ option was laid out as a recent Commission of Audit recommendation to “review the Medicare Benefits Schedule [MBS] to identify and remove ineffective items, replace expensive items with less expensive alternatives...”. There is waste in all health care systems around the world and Australia is no different. Exposing patients to ineffective health care not only causes them harm, but it wastes scarce taxpayer dollars that could be used to better effect elsewhere in our system. I have highlighted over 150 services on Australia’s MBS that were once thought safe and effective but new evidence has called them in to serious question, yet they continue in Australia daily. Or, we know that some services are effective and appropriate for certain patients, but of little or no value for others. Sometimes a service is delivered more frequently than is of any value to the patient. An example in point is blood (pathology) tests for Vitamin D. Back in 2003, 90,000 Vitamin D tests were billed to Medicare. In 2013 the number of tests had blown out to a staggering 4.3 million, representing a rise of 4800%. In dollar terms we went from spending $3 million in 2003 to $145 million in 2013, on a single blood test. This trend for Vitamin D testing has occurred worldwide, and while no-one is questioning the importance of the test for certain patients at certain time intervals, there is widespread agreement that rises of this magnitude cannot be justified on any grounds. The Ontario Ministry of Health (Canada) recently tackled this problem and, in just two years, have managed a 90% reduction in Vitamin D testing, taking them back to the levels considered clinically appropriate. Translated to Australia, a 90% reduction would equate to $130 million in year-on-year savings for this single example. So, what is the scope for improved care and savings of a program of this kind? A hint comes from the United States where this month I co-authored a ground-breaking analysis of waste in U.S. Medicare where we found that up to 42% of patients received at least one
low-value service in 2009 (the most recent year available for analysis) at an annual cost of up to USD$8.5 billion. Incredibly, for this analysis we looked at a small sample of just 26 low-value services and so we think this represents the tip of the iceberg of waste, and potential for improved care and savings. Translating these U.S. results to Australia would equate to over $500 million per annum from curtailing use of just 26 low-value services. The good news for government is that analyses of this sort are underway in Australia, including by the Department of Health, but to succeed they will require a strong commitment from this government. Insert any sporting analogy you like, Minister Dutton can score with this program if it is seen through with his support. If it falters, he may instead be seen as snatching defeat from the jaws of victory.

Other ‘Plan B’ options that sit on the sidelines have appeared on these very pages (and as Commission of Audit recommendations), where Professors Stephen Duckett and Philip Clarke have separately yet cohesively outlined thoughtful, practical policies for tweaking Australia’s pharmaceutical purchasing to bring us more in line with countries like New Zealand, which achieve significant discounts for generic medicines in particular, and would see medicine prices in Australia slashed, with over $1 billion saved year-on-year. Once-conventional thought would instruct us, at this point, to consider that any government neglect of such policies might lie in their weighing and valuing of some interests over others. That is, they may not truly see advantages for all.

For example, the pathology company which receives income from the Vitamin D test is valued more highly than patients receiving useless interventions and Medicare saving millions; or the pharmaceutical company which might see lower revenue achieved for their products.

Arguably, thought has evolved beyond this. Reducing waste and inefficient spending represents a win-win even for industry, as it frees resources and allows patients and governments to spend more on high-value care that we know is often underutilised.

Eliminating waste from the bottom also creates room for new pharmaceutical and other healthcare products. Without a growing pie, we need to reallocate a slice from low-value to high-value uses.

Replacing co-payments with just two Plan B policy options is legitimate, would accrue double or even triple the savings of the co-payment measures, and offers a release valve for the Abbott government.

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