What is wrong with Medicare?

Lack of audit control and inability to adapt to change leads to massive waste

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As Director of Professional Services Review (a role established to protect the integrity of Medicare and the Pharmaceutical Benefits Scheme) for over 6 years, I gained an insider's insight into how dysfunctional the Medicare/Medibank Scheme has become since the *Health Insurance Act 1973* (Cwlth) was introduced. The then Minister for Health, the Hon. Bill Hayden, stated in his second reading speech that the purpose of the scheme was to create the "most equitable and efficient means of providing health insurance coverage for all Australians".[1] The universality of medical insurance coverage benefited all Australians, particularly those for whom a doctor's visit represented a significant proportion of income. From the beginning, there were inadequate safeguards in a scheme based on the honour system. In no other area of public expenditure where recipients have significant control has so little attention been paid to audit.

Medicare Australia administers over half a billion transactions every year for the Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS). Medicare is very efficient at its core business — that of distributing benefits. Electronic claiming has addressed criticism of earlier inefficiencies. However, Medicare's ability to ensure benefits have been paid appropriately has never fully coped with the medical business environment. Extrapolating modestly from the misuse of the MBS, PBS and the Medicare Safety Net (financial assistance for high out-of-pocket costs for out-of-hospital MBS services) that I am directly aware of, I estimate that 2–3 billion dollars are spent inappropriately each year. Unfortunately, there are no attempts to quantify these losses more accurately. The reasons for this leakage are diverse.

The MBS is riddled with misdirected incentives for practitioners, contains items that have not been reviewed despite advances in technology, and has many examples of good public policy thwarted by the MBS rules.

In general practice, general practice management plans (GPMPs) and team care arrangements (TCAs) have created opportunities for a bonanza for some practices. Several practitioners I have reported on had admitted that their corporate owner had a business plan based on a defined number of these items claimed every week, irrespective of clinical need. Medicare Australia is also aware that a significant proportion of these plans are not carried out by a patient's usual doctor's practice.[2] Anecdotally, claiming for clinically unnecessary GPMPs is significant throughout Australia. The policy intent of GPMPs was to provide a higher standard of care for patients with complicated chronic disease. While many doctors use these items appropriately for positive patient outcomes, a proportion of claimed items have added nothing materially to patient care.

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The TCA items are based on a model of care that works well in an inpatient setting, but does not translate to general practice. This item has created a whole industry of allied health practitioners and dentists who, through a TCA, draw on the public purse. Under a TCA, there is incentive for doctors to be pressured to provide the paperwork for "free" podiatry, physiotherapy, psychology, and dental care, facilitated by computer systems that can generate the necessary paperwork in minutes. The MBS rebate for a GPMP is $138.75, and for a TCA is $109.95. The policy intention was to allow patients with chronic or terminal disease to receive previously unaffordable care, but has created perverse incentives for all parties involved. This is bleeding several hundred million dollars per year as the policy intention is buried by inappropriate claims.

The approach of the Department of Health and Ageing (DoHA) in not allowing discretion to doctors to refer purely on clinical grounds has led to this situation. The policy intent by government was sound. However, the DoHA developed MBS items that create incentives to easily misuse and work around the MBS requirements, leading to their misuse by a proportion of both medical and allied health practitioners. Some practitioners consciously misuse the MBS occasionally, and some do so regularly. The policy intent could have been achieved by allowing direct referral, without financial incentive to the doctor. This measure alone would have saved the health budget well over a billion dollars over the life of the program. Instead, a monster was created, eroding the integrity of the health budget.

Items are added to the MBS after a long and exhaustive process of evaluation. This includes consideration of the skill level involved, the cost of necessary equipment, time taken for a procedure, and the overall cost–benefit to the community. However, once items are on the MBS, as long as they are still being used, they are rarely re-evaluated, and they attract the yearly rise in benefit level. Minister Roxon, in her first term as Minister for Health, bravely tried to reduce ophthalmologists' fees for cataract surgery by 50%.[3] These items were introduced when the procedure was not considered routine, took much longer than today, and required an inpatient stay of more than a week. The benefit reflected this. In the nearly 40 years since, technology has moved on and now this surgery can be performed under local anaesthetic as a day-procedure lasting 20 minutes. Private patients are sometimes charged more than $4000 for this procedure. In the end, the Minister was only able to achieve a 12% reduction on the MBS fee.[4] The top providers of this item have performed more than 20 procedures in one day, according to Medicare Australia data. Not bad work if you can get it, but very poor public policy!

The same lack of rigour in reviewing items also applies to gastroenterology and cardiology. While most gastroenterologists and cardiologists practise ethically, there are a few practitioners whose repeated use of procedures and investigations is highly questionable in patients whose clinical condition appears not to warrant them. However, there is no one asking the questions.

The Medicare Safety Net is one of the most poorly thought-through pieces of health legislation. Despite its laudable policy intent — to help those with severe and chronic disease afford the cost of modern medical care — its implementation has gaping holes. The open-ended nature of the Safety Net offers the minority of unscrupulous and greedy practitioners opportunities to exploit it. After the Safety Net was introduced, a small group of obstetricians raised their fees for antenatal care from around $3000 to nearly $10 000. Such use of the Safety Net was perfectly legal, thanks to sloppily drafted legislation. During my time as Director of Professional Services Review, the Safety Net was used in effect to subsidise cosmetic procedures such as surgery for "designer vaginas" at $5000–$6000 each. I knew that the DoHA was aware of such misuses of the Safety Net. However, there seem to be no politicians with the appetite to face the problem and rein in millions of dollars in potentially inappropriate payments.

Another major concern of mine has been the quantity of prescription drugs, particularly narcotics and benzodiazepines, finding their way onto the street. These drugs are well controlled by the manufacturer and the supply chain to the pharmacy. The weak link is the doctor's prescription pad. Throughout my term as Director of Professional Services Review, I saw extreme examples of drug prescriptions that were clearly being misused or dispensed for resale by patients. In one instance, a doctor was prescribing 100 ampoules of 30 mg of morphine every week to a young patient without an appropriate indication. The state pharmaceutical branches are underresourced to track the prescription of benzodiazepines. Medicare is unable to identify abnormal prescribing patterns because many benzodiazepines are supplied on a private prescription. It is cheaper for a patient on a federal government benefit to pay for one private prescription for 200 diazepam tablets (less than $20) than to pay for four subsidised prescriptions of 50 tablets. I found many instances where a practitioner had supplied a PBS prescription for 50 tablets and a private prescription for 200 tablets.[5]

It is not only the MBS and the PBS where maladministration occurs. On several occasions I came across significant cost-shifting between the states and the federal government. Medicare was being used to subsidise state health budgets. Private radiology and pathology services were used for public inpatients, Medicare benefits were used to fund staff specialist study tours and to buy essential equipment. This is against the provisions in the Council of Australian Governments National Health Care Agreement. When this was pointed out to officers in the DoHA, I was told not to say anything.

There is significant wastage within the Medicare scheme, which is threatening our ability to maintain first world standards in health care delivery. Australians are fortunate that, in the main, we do have a motivated and ethical health workforce. However, many of our colleagues feel let down by a system that so often does not deliver a timely or cost-effective service with proper controls. Many doctors I have spoken to are disillusioned by the inappropriate claiming and practice they are aware of. They feel disempowered to be able to effect change in our current health system.[6]

It is time for a thorough review of the manner in which health care is delivered in Australia. Piecemeal policy changes and bandaids are no longer adequate. To be of any value, a major review needs bipartisan political support. However, so long as health policy is used to bludgeon the other side of politics, we will never have meaningful change.

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