MEDICINE AND THE MARKET

Deregulating medical fees and embracing the market may be an ambitious project, argues **Dr Mark J Walland**

The ageing population, technological advances and an ever-expanding embrace of 'preventive healthcare' mean that the proportion of GDP consumed by health spending seems destined to increase. The Centre for Independent Studies (CIS) has been responsible for much innovative thinking to ensure affordable funding of health into the future, including market-based reforms to contain costs.

For instance, in a 2015 CIS report on deregulating medical fees and co-payments, David Gadiel advocates disbanding both the Medicare Schedule of Fees and the AMA Schedule Fee list to remove 'floor price' signals in setting fees. This assumes a freer market will foster greater competition and a subsequent reduction in fees.[1]

Yet both self-interest and the appeal of existing entitlements for patients and doctors are barriers to be overcome in any redesign of healthcare funding and payments.

Although apparently sanguine about meeting non-rebatable (and sometimes hefty) out-of-pocket costs for paramedical and alternative health practitioners, Australian patients are encouraged to see any threat to contributions by third-party payers for doctors' fees as raising the spectre of the much-feared US model.

Meanwhile doctors—and particularly procedural specialists—are often depicted as rapacious buccaneers who roam freely in the fee marketplace without restraint, covertly supported by hostage governments and compliant private health insurers.[2]

Doctors have historically regarded discussion of fees as a grubby intrusion into the gentility of medical practice. Informed financial consents, gap issues and characterisations such as those above mean that they must now engage in the debate.

How are fees set?

Notwithstanding the Medicare schedule fee and bulk-billing, doctors may charge any amount for a service. Specialist colleges urge that members' fees should be 'reasonable' and 'not excessive', but generally do not play any role in determining them. Doctors' fees are no longer particularly aligned with the Medicare Benefit Schedule (MBS) so that, apart from public hospital care and bulk-billed services, medical care is not 'free'.

The Australian Medical Association (AMA) asserts that MBS rebates have, since the

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inception of Medicare, not been indexed to keep pace with the consumer price index (CPI).[3] It therefore publishes its own schedule of fees reflecting CPI indexation over time. Gadiel labels the AMA fee list 'inflated' but ultimately does not contest the facts underpinning it. Whilst all medical practice costs including wages have risen substantially over more than 30 years, rebates have not (even excluding the recent rebate freeze).

A genuine free market in surgical fees perhaps exists only in cosmetic surgery. Fees for an operation performed for medical reasons are often modified by the various pricing recommendations made by Medicare and private health insurers, which condition the expectations of doctor and patient alike. Doctors are nevertheless under no obligation to adhere to insurers' fees, and it is worth noting that most insurers' fees not only fall short of the CPI-adjusted AMA fee schedule, but also that many doctors already charge significantly less than the AMA fee.

What about gap payments?

Given ever-increasing insurance premiums, however, patients perceive private health cover as deficient: they do not understand why they sometimes face significant medical costs after surgery that their policy won't meet.

Private insurance is most deficient when doctors decline to charge the insurer's fee in a 'no gap' plan, or if doctors' gap amounts exceed the insurer's gap threshold (by even a dollar) in some 'known gap' plans. Insurers will then often refuse to pay *even to the level of their own rebates*, and will only reimburse patients up to the level of the MBS schedule fee.

In this way insurers—with governmental connivance—seek to coerce doctors into limiting gap fees. They trade on doctors' altruism, knowing that it is patients who will suffer the extra financial burden whilst insurers pocket the rebate that would otherwise be paid in excess of the MBS schedule fee.

Insurers thus hardly 'lack power to bargain with doctors', as Gadiel claims, nor are they 'effectively doing the doctors' bidding with their gap cover arrangements'.[4] Insurers clearly stand to benefit, and can sometimes be reluctant to reveal to patients by how much their cover falls short of a surgeon's fee in gap cover plans.

Can doctors' fees be fixed?

Medicine has traditionally 'paid well' in keeping with other vocations that attract similarly capable and academically high-achieving individuals. Adequate compensation for the decade or more of study and financial sacrifice that is an inevitable preparation for a medical career seems justifiable. Yet even an explanation of medical fees—let alone any defence—sounds self-serving in the face of vulnerable patients apparently being overcharged.[5]

If medicine were a true marketplace, Medicare would stand aside and doctors and patients (with or without insurers) would come to their own arrangements.

Gadiel expresses distaste that doctors 'set fees that suit themselves'.[6] Yet a private medical practice is a small business, which involves all the usual costs including rent, wages and equipment leases as well as continuing professional development, indemnity insurance and membership of professional organisations and credentialing bodies. Medical practices are also subject to more stringent ethical, regulatory and advertising restrictions than other businesses. Whilst innovation and technology can increase efficiency and throughput of cases, these are seldom cost-free, and such equipment may be a further practice overhead.

Abolishing the MBS and AMA schedules as reference points might result in fees that are more free-floating and thus more 'market-based'. It is assumed that this will drive fees down. The desire to retain benefit payments for patients, however, means that the rebate amount will constitute a new reference point for doctors and insurers, simply one 25% less (for surgery), so that the 'market price' will again not be truly free-floating. If medicine were a true marketplace, Medicare would stand aside and doctors and patients (with or without insurers) would come to their own arrangements.

Doctors are 'rational market players'. If medicine is to function more like a market, one cannot expect doctors to respond in less market-based ways. They will likely try to maintain their income status quo, whatever their altruism. If fees are driven down, then one must expect a compensatory change in

practice costs, or perhaps a reduction in any pro bono aid, volunteer or teaching work undertaken.

The private practice model of medicine in Australia must remain attractive and viable. It is hard to imagine an Australian government that would be prepared to disband this model to take on the service provision overheads on its own. And although health is regarded as an essential service, medical conscription is constitutionally not allowed.[7]

Opposition to legislative caps on fee increases in Australia was successfully led by libertarian Dr John Whiting four decades ago, and a cap on fees has not been mooted since. Indeed, it would be a novel interpretation of a market to restrict the fees that private practice doctors can charge whilst still expecting these small businesses to be exposed to all the vagaries of their expenses in the face of such an income cap.

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Most doctors are mindful that they are earning their living from the health misfortunes of their patients. Most try to allow for the financial status of their clientele, as commonly evidenced by reduced fees for pensioners. Most would also recognise that medicine is not a discretionary purchase, although it has been argued that moral hazard on the part of doctors *and* patients makes it more discretionary than it should be.[8] Yet while moral hazard related to third party payers distorts the functioning of medicine as a market, outside of fully bulk-billed services the lower percentage contribution that rebates make in payment of the total fee (for instance, for specialists) surely diminishes this hazard.

Is the market for fees competitive?

The ACCC regards medical practitioners as competing with each other and they are not permitted to confer on fees, even within a practice. This competition notionally puts downward pressure on fees.

The referral system means the apparent mobility this competition should allow is illusory: patients are not at liberty to transfer to another (cheaper) specialist without a new referral (if they want Medicare to contribute to costs), and starting over means a new assessment and cost.

It is alleged that specialist colleges in particular are guilty of restricting the number of doctors admitted so as to protect against over-supply and fee competition. Such closed shop allegations do not address just how to train a vastly increased number of surgeons to the same (world class) standards that are currently achieved in Australia. Where will trainees acquire their supervised hours of clinical experience?

There is a genuine limit to the number of quality training posts in Australia—certified indeed by the colleges—but determined by state government budgets, the number of hospital jobs and supervisors, and access to sick people on/from whom to learn. The ACCC has already addressed issues of adequate training opportunities not being accredited.[9] Private practice training is under-utilised in part because patients often pay to *avoid* the ministrations of trainees—however good their supervision—in the public system. It should also be noted that almost all the college members who are trainers and supervisors are not paid for their teaching work.

What of the future?

It is likely that the paradigm of fee-for-service delivery will soon be reviewed, not least because it is perceived—when it comes to chronic disease—as rewarding frequent service rather than an enduring health outcome. What then is the desired end-point in any redesign of fee structures?

Inspired by the Singapore model of health savings accounts, David Gadiel and Jeremy Sammut have proposed models that make patients more responsible, at least for smaller and earlier payments.[10] Greater personal responsibility for healthcare costs may promote debate in preventive care, forcing individuals to assume some of the risks

and costs of their lifestyle preferences. However, free access to public hospital care, third party payers in the form of Medicare and community-rating of current private health insurance, and the political poison of co-payments confound such responsibility and debate.

At present, given the required balance of responsibility, equity, access and competition in Australian medicine, vested participants will not likely agree on the direction of market-based reforms. An apparently paralysed policy climate also means that increased embrace of the market in healthcare funding and payments may be an ambitious project.

Endnotes

1 David Gadiel, *Towards a More Competitive Medicare: The Case for Deregulating Medical Fees and Co-Payments in Australia*, Research Report 1 (Sydney: The Centre for Independent Studies, May 2015).
2 As above.
3 https://ama.com.au/system/files/Gaps chart - November 2015 - colour.pdf
4 Gadiel, *Towards a More Competitive Medicare*.
5 Ross Gittins, 'Doctors Share the Blame for a Sick Budget, *Sydney Morning Herald* (1 March 2016).
6 Gadiel, *Towards a More Competitive Medicare*.
7 Australian Constitution, section 51 (xxiiiA).
8 Jeremy Sammut, *Saving Medicare But Not As We Know It*, Target30 03 (Sydney: The Centre for Independent Studies, April 2013).
9 https://www.accc.gov.au/system/files/Review%20of%20Australian%20specialist%20medical%20colleges%20July%202005_0.pdf
10 David Gadiel and Jeremy Sammut, *Lessons from Singapore: Opt-Out Health Savings Accounts for Australia*, CIS Policy Monograph 140 (Sydney: The Centre for Independent Studies, 28 July 2014).

The perennial spotlight on doctors' fees is less about healthcare and more about the politics of health, argues **Jeremy Sammut**

Since at the least the establishment of Medicare, politicians on both sides of the spectrum have been eager to pander to community expectations that medical care should be consumed at best for 'free', or at worst with only minimal direct out-of-pocket charges levied on patients. Yet both Labor and Coalition governments (under Hawke in 1991 and under Abbott in 2014 respectively) have aspired to introduce mandatory Medicare co-payments to limit the cost of 'bulk-billed' GP visits to the federal budget.

David Gadiel's report, *Towards a More Competitive Medicare,* argued that the evident confusion of means and ends can be resolved by abolishing the 'Schedule Fee'.

Clarifying that Medicare payments for doctor's services are simply a 'benefit'—and not a fee covering the full cost of consultations and procedures—would make it more transparent that patients may incur a direct charge to cover the doctor's entire fee. As Gadiel rightly reasons, the value of a co-payment will be determined in the market, as doctors compete for the custom of newly price-conscious consumers.

Many members of the medical profession are understandably touchy about the subject of medical fees: their incomes are chained to the chariot wheels of the political economy of Medicare, and are heavily reliant on the $20 billion worth of 'fee-for-service' payments distributed via the Medicare Benefits Schedule (MBS) each year.

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Proposals to disrupt the Medicare payment status quo thus attract the profession's special ire. Unfortunately, many doctors tend to take it personally; no-one begrudges them making high incomes that reflect their training, expertise and experience.

What is questioned is the 'input' nature of the health system—the fact that Medicare and the private health insurance system are third-party payment systems that, by their very nature, encourage over-use and over-servicing, combined with inadequate focus on and rewards for improving the overall cost-effectiveness of healthcare.

The Australian Medical Association is always prepared to run what wags have dubbed a 'Managed Scare' campaign that forecasts the end of bulk-billed doctors' appointments and the 'Americanisation' of the health system.

These structural inefficiencies—which mean we spend too much on some kinds of health service and not enough on other kinds of services that might lower costs and improve patient outcomes—have been estimated to waste at least $17 billion annually, or 11% of the current $155 billion total national health spend (see the article 'Defusing Mediscare' in this issue of *Policy*).

This is why increasing numbers of health stakeholders are expressing interest in exploring integrated payment models, which would enable the development of innovative preventive and chronic care services that could reduce the disease burden, manage chronic illness more effectively, and minimise the use of high-cost hospital services.

Doctors fear what would happen to their incomes under an integrated model. Hence the Australian Medical Association is always prepared to label moves in this direction as 'US-style Managed Care', and run what wags have dubbed a 'Managed Scare' campaign that forecasts the end of bulk-billed doctors' appointments and the 'Americanisation' of the health system.

Yet under a reformed payment system, doctors would, of course, assume the lead role in re-organising superior care pathways that delivered better financial and patient results. The logic of integrated payments is that since providers will bear the financial risk for the full cycle of patient's care, they will thereby be incentivised to discover more efficient ways of delivering quality services and share in the savings achieved.

With $17 billion sitting on the table in structural inefficiencies, it is entirely conceivable that doctors' incomes could increase under an integrated payment and service structure.

Moving to a more market-based, outcomes-focused system for the delivery of Australian health care would do in health what markets do best in the rest of the economy: reward those who deliver to the community the best quality services at the best price—especially doctors.