Overview

Under the original version of the Abbott Government's proposed co-payment, patients would have been charged a co-payment of $7 per visit to the GP, and for each episode of pathology testing and diagnostic imaging. The co-payment was to be waived for concession card holders after 10 visits, offering them some protection against high out of pocket costs.

In the next iteration of the proposal, the Government made the co-payment optional (the decision being left to the GP) but also proposed to reduce the Medicare rebate by $5 for short consultations. It expected some GPs to 'choose to recoup the $5 rebate reduction through an optional co-payment'. In order to protect vulnerable people, the Government proposed to keep in place incentives that encourage GPs to bulk-bill concession card holders and children under 16.

Subsequently, the Government proposed changes to the funding rules for GP consultations along with substantial rebate reductions for short (Level A) consultations; the changes were meant to discourage 'six-minute medicine'. The Australian Medical Association (AMA) complained that the changes would disadvantage experienced and efficient GPs, and would exacerbate problems with timely access to care. It also pointed out that the costs (of the rebate reduction) would likely be passed on to patients.

Because of the outcry from health, community service and rights-based interest groups (including the medical profession) over these proposed changes, the Government is now consulting with the sector. However it appears to be committed to bulk-billing only for 'vulnerable' and concession patients.

The Government's intention to move away from pursuing high bulk-billing rates is an important change in policy direction and its implications for Medicare, and the principles it was founded on, need to be closely examined. In our view, restricting bulk-billing only to vulnerable patients would be a retrograde step. It is vital that the cost of care does not prevent people from using primary care services. However there is evidence that this is already happening. As an alternative, we believe that the Government should:

- maintain Medicare as a universal scheme because it already provides a means of leveraging greater financial contributions towards health care costs from those with greater means; and
- consider alternative options for cost containment that pose less of a risk to equitable access to care (experts are already able to identify many options that could be implemented in Australia).

The organisations that are signatories to this document are keen to work collaboratively with the Government to find ways of maintaining Medicare and ensuring that our health system, of which Medicare is a part, is sustainable into the future.
The importance of keeping Medicare universal

Medicare was designed to provide Australians with universal access to high-quality health care regardless of where they live, or their ability to pay. It was not designed to be a safety-net scheme for those without the means to pay for private insurance, nor was it meant to compete in the market alongside private health insurers. When past governments have experimented with reforms to health insurance along these lines, they found that the results were disappointing. Rather than helping to constrain expenditure on health, opt-out versions of Medicare made it more difficult to contain health care costs because the anticipated benefits of competition - lower prices - did not materialise in the insurance or medical markets.¹

Because it is financed through taxation, Medicare provides an equitable means of paying for health care. Those with greater means contribute more through our progressive taxation system and help cover the health care costs of those with less. The facility to leverage larger contributions towards the cost of health care from those on higher incomes already exists under Medicare. As a result, less equitable policies, such as compulsory co-payments, are unnecessary in the Australian context.

We believe that the universal nature of Medicare embodies the Australian spirit of 'a fair go for all'. Not only does the principle of universality reflect our past and our values, it also provides an efficient and equitable means of funding access to health care. For these reasons, we oppose any reforms that undermine the universal nature of Medicare and seek to transform it into a safety net scheme for the poor. Instead, we urge the Government to look for alternative means of protecting the sustainability of Medicare: changes that will preserve both equity and efficiency.

Co-payments are unlikely to help make Medicare more sustainable

Health expenditure is rising in Australia, just as it is in other advanced economies. The main reason health expenditure is rising, however, is because GDP per capita is rising. A recent internal report from the Department of Health shows that between 1995 and 2010, almost 85 per cent of the growth in health expenditure per person was due to growth in Australia's per capita GDP. The report points out that health policymakers need to be empowered to make the argument that 'there is nothing... wrong with societies choosing to make greater investments in health (that is, with health forming an increasing share of GDP).¹ It goes on to explain that because health is a 'superior good', health expenditure should, to a degree, be considered as an investment in society, not just a cost.

Australia's health system is amongst the most efficient in the world. Recent analyses from the Institute for Health Metrics and Evaluation shows that Australia, when compared with 14 other high income countries, is among the lowest spending countries but achieves health outcomes that are among the best. By international standards, Australia has also done reasonably well at constraining growth in health expenditure. In 2000, for example, total health spending as a proportion of GDP in Australia was 8.1 per cent, higher than the OECD

average that year of 7.7 per cent. By 2011-2012, total health spending as a proportion of GDP in Australia was 9.1 per cent, which was slightly lower than the OECD average of 9.3 per cent.

Although Australia’s health system has performed relatively well in the past, governments do need to continue to ensure that funds are spent wisely; health experts know that past a certain point, not all additional investment in health care delivers major benefits in terms of health outcomes. Governments around the world are looking for ways of constraining health expenditure and making their health system as efficient as possible. A recent report from the OECD outlines a wide range of mechanisms that have been used in an attempt to contain costs. They include:

- making changes to the way providers are paid (for example, on a fee-for-service model or a payment for each person cared for);
- encouraging greater competition (for example, between hospitals or health insurers);
- imposing caps on budgets or on benefits paid for certain services;
- changing workforce arrangements (for example, to the way workforce supply is determined, wages are set, or roles defined);
- making changes to the mix of funding sources (for example, shifting from insurance models to general taxation);
- implementing stronger controls on the use of various health technologies (this includes health interventions as well as medications and diagnostic tests); and
- greater use of cost-sharing (for example, co-payments or gap insurance).

The report also details the impact of each these mechanisms on cost containment and health outcomes in the countries where they have been trialled. It found that while cost-sharing (including co-payments) generally achieves its primary objective of decreasing health expenditure in the short-term, in the long-term it tends to have a deleterious effect on patient outcomes and equitable access to care. In particular, cost-sharing tends to discourage or inhibit vulnerable patients from using necessary health care services. In its report, the Government’s National Commission of Audit also recognised the potential risks of co-payments. It pointed out that co-payments have the potential to act as a barrier to accessing care for low income groups and heavy users of the health system, and they can increase costs over the long term if treatment is delayed.

Given the evidence on the effectiveness of cost-sharing, and the fact that out of pocket costs are already relatively high in Australia by world standards, there seems little justification for introducing a compulsory co-payment for GP services as a means of constraining health expenditure.

To ensure the fiscal sustainability of Australia’s health system into the future, the Government should look to the evidence and international experience for the most efficient and effective reform options. Documents recently released by the Department of Health under Freedom of Information requests reveal that the Government is well aware of the need to look for alternative ways of constraining costs and improving efficiency, and has
begun considering some of them at senior level meetings. Some broad categories of options for cost containment include:

- Minimising the use of low-value (or no-value) interventions - for example through initiatives such as Choosing Wisely, systematic reviews of the MBS, and more rigorous testing of new technologies.
- Finding lower cost alternatives without compromising quality - for example, by making changes to the scope of practice for some health professional groups, substituting generic drugs for branded ones, or buying supplies in bulk order.
- Reducing waste - for example, by reducing the amount of time spent unnecessarily in hospitals, over-prescribing an intervention or diagnostic test, or allowing stock to expire.
- Minimising the use of strategies that deliver savings in the short-run but cost more in the long run - for example, imposing budget cuts on staffing that ultimately leads to fewer patients being treated in primary care.

There are no shortages of options for governments to choose from in their quest to make the Australian health system more sustainable. None of them, however, are easy options. To succeed, all will require extensive consultation with the sector, and careful planning and implementation.

**The importance of bulk-billing**

For decades, the World Health Organization (WHO) has been promoting equitable and universal access to primary care as a means of improving the health and wellbeing of populations. A recent analysis of health data shows that countries with strong primary health care systems tend to have better health outcomes.

Equitable access to care, however, does not necessarily mean equal access to care. The WHO acknowledges that there is a strong social gradient in health where the poorest people tend to also have the worst health outcomes. This social gradient holds across the socioeconomic spectrum, and across countries. In practical terms it means that people with less means often have a greater need for health care, but the least capacity to pay for it.

To ensure Australia has a strong primary care system - one that is universal and equitable - it is essential that the cost of care does not impose a financial barrier to people, particularly those on low incomes. However, evidence from a study published recently in the Medical Journal of Australia shows that there are many factors influencing a GP’s decision whether or not to bulk-bill, not all of them relate to health need or capacity to pay.²

The study found that while patients with concession cards and chronic illnesses were more likely than not to be bulk-billed, patients with private health insurance were also more likely to be bulk-billed when they went to the GP. The study also found that it was not just patient characteristics that influenced the likelihood of being bulk-billed. Patients living in regional

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areas were less likely to be bulk-billed than those in cities, perhaps because of the high concentration of GPs in major cities.

Although bulk-billing is not (nor ever has been) universal in Australia, successive governments have endeavoured to keep bulk-billing rates high because, in the absence of robust safety nets, it is an important way of ensuring that the cost of care does not deter people from using primary care services.

**The effectiveness of safety nets**

There is an array of safety nets in place for people with high out of pocket costs. The **Pharmaceutical Benefits Scheme Safety Net** applies to spending on pharmaceuticals, and the **Medicare Safety Net** and Extended Medicare Safety Net applies to spending on Medicare services. Another safety net - the Net Medical Expenses Tax Offset - applies to a broad range of health services and products, but it is currently being phased out.

In the 2014-15 budget, the Government began the work of reforming Australia's complex system of safety nets. However much more needs to be done to ensure that people with high out of pocket costs but limited means are well protected. Currently, people can face high out of pocket costs because they need to spend over the threshold amount on each individual safety net before they are eligible to receive financial support from the government. People can also be exposed financially because there are some limits on the amount the government will pay if patients are charged fees well in excess of the scheduled fee (something, of course, the patient has little control over).

There is growing evidence that despite the safety nets that exist in Australia, some people are suffering major financial stress as a result of ill health. In 2009, for example, just over one in 10 people who declared bankruptcy in Australia said that the main cause was ill health or the fact that they did not have health insurance. Other studies have shown that co-payments are deterring people from using necessary health services such as filling scripts, visiting the GP or going to the dentist. Research also shows that despite the safety nets in place, some people are falling through the gaps. They tend to be people with multiple chronic conditions, the retired, and those from lower socioeconomic backgrounds. Being a concession card holder or purchasing private health insurance appears to offer little extra protection.

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