Chapter 2

The Australian healthcare system – expenditure, access and outcomes

Introduction

2.1 The government has stated that it remains committed to its election promise of not making cuts to the health budget. However, the National Commission of Audit (the commission) is looking for areas of waste and inefficiency. The government has indicated that if any savings are identified by the commission, these funds would be reallocated to other priority areas in the same portfolio.[1]

2.2 This chapter will examine government healthcare expenditure and suggested areas where efficiencies may be found. It will also consider the importance of primary and preventative healthcare, the specific proposal to charge a $6 Medicare co-payment and other related areas raised with the committee.

Government expenditure on health

2.3 Healthcare has been highlighted as an area of growing government expenditure, with the system under pressure from a growing and ageing population with high expectations around their level of healthcare.[2] However, the committee notes that Australia's health expenditure is moderate when compared to international benchmarks (see figure below).[3]

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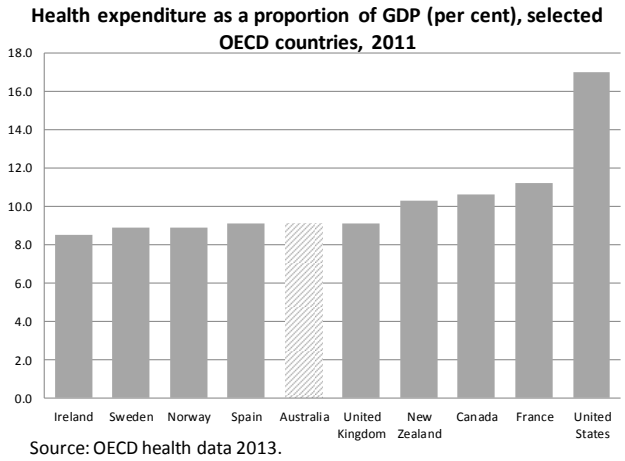
1 See the Hon Joe Hockey MP, Shadow Treasurer and the Hon Andrew Robb AO MP, Shadow Minister for Finance, Deregulation and Debt Reduction, Joint Press Conference, 5 September 2013; 7.30, 'Joe Hockey blames Labor's legacy as debt ceiling rises', 22 October 2013, Transcript available from www.abc.net.au/7.30/content/2013/s3874679.htm (accessed 17 March 2014); Paul Osborne, 'Debt ceiling lifted as audit announced', *Sydney Morning Herald*, 22 October 2013.

2 7.30, Health Minister flags increasing healthcare costs, 19 February 2014, Transcript available from: www.abc.net.au/news/2014-02-19/health-minister-flags-increasing-healthcare-costs/5270840 (accessed 17 March 2014)

3 OECD, *OECD Health Statistics 2013 – Frequently Requested Data* (2013). See also Professor Geoffrey Dobb, Vice-President, Australian Medical Association, *Proof Committee Hansard*, 1 April 2014, p. 1.



2.4 Total health expenditure in Australia has increased substantially over the last decade from $82.9 billion in 2001-02 to $140.2 billion in 2011-12 in real terms.[4] However, it should be noted that as a proportion of GDP this represents an increase of just 1.2 per cent, which suggests that health spending has been reasonably stable over time.[5]

2.5 Despite this, the committee acknowledges that recent *Intergenerational Reports* have suggested rising healthcare costs will put increasing pressure on the health budget in coming decades.[6] This will be compounded by an ageing population, the cost of new technologies and pharmaceuticals, the introduction of programs such as the National Disability Insurance Scheme, and the growing burden of chronic disease.[7]

Effectiveness

2.6 The committee notes Australia's healthcare system is reasonably efficient when compared to international benchmarks.[8] The Organisation for Economic Co-operation and Development's (OECD) *Health at a Glance 2013* indicates that Australia's health system achieves excellent outcomes at an efficient price:

> Australians also enjoy good access to a high quality health care system. It consistently rates among the top five countries in terms of survival after

4 Australian Institute of Health and Welfare (AIHW), *Health Expenditure Australia 2011-12* (2013), p. viii.

5 Mr Simon Cowan, Research Fellow and TARGET30 Program Director, Centre for Independent Studies, *Proof Committee Hansard*, 18 February 2014, p. 20. Note: figures from the AIHW state that: 'In 2011–12, health expenditure as a percentage of gross domestic product (GDP) was 9.5 per cent, up from 8.4 per cent in 2001–02.' See *Health Expenditure Australia 2011-12* (2013), p. viii.

6 The Treasury, *Australia to 2050: future challenges* (2010), p. 8.

7 Mr Phil Bowen, Parliamentary Budget Officer, *Committee Hansard*, 5 February 2014, p. 60; Dr John Daley, *Committee Hansard*, 5 February 2014, p. 2; Mr Simon Cowan, Research Fellow and TARGET30 Program Director, Centre for independent Studies, *Proof Committee Hansard*, 18 February 2014, p. 18.

8 OECD, *OECD Health Statistics 2013 – Frequently Requested Data* (2013).

> being diagnosed with cancer or after suffering acute myocardial infarction (heart attack). These good outcomes are achieved at a reasonable price, with Australians spending 8.9% of their GDP on health compared to an OECD average of 9.3%.[9]

2.7 Dr John Daley, CEO of the Grattan Institute, who appeared before the committee in a private capacity, commented that the efficiency of the Australian system meant that finding substantial savings in health expenditure would be challenging:

> The issue with health is that Australia has one of the most efficient health systems in the world. We looked at this in the supplementary materials to [the Grattan Institute] *Game changers* report. That showed that Australia has some of the best health outcomes in the world, if you measure them by mortality, but you can use lots of other measures as well. And we have what you might describe as middle-of-the-road spending. So, in terms of outcome for the amount we spend, we do it about as well as anyone else in the world and indeed better than most people.[10]

2.8 Ms Alison Verhoeven, Chief Executive Officer of the Australian Health and Hospitals Association (AHHA), noted that Medicare was the foundation of the Australian healthcare system, and that its provision of universal access to good treatment was one of the reasons why health indicators are predominantly good, while costs are reasonable.[11]

2.9 Mr Ian McAuley, Adjunct Lecturer, University of Canberra, noted that most successful health systems were built around a single national insurer, such as Medicare, that kept costs low:

> The huge cost is the incapacity of a fragmented private insurance system to control the costs imposed by service providers. That is why, for instance, the USA stands out there with health expenditure of 18 per cent of GDP—a huge burden on that country—whereas most developed democracies were around nine per cent of GDP. The countries which have been most successful are those which have used a single national insurer to keep costs under control.[12]

2.10 The figure below shows that countries that rely more heavily on private insurance to fund healthcare have more expensive health systems.[13]

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9 OECD, *Health at a Glance 2013 – Australia* at www.oecd.org/australia/Health-at-a-Glance-2013-Press-Release-Australia.pdf (accessed 4 March 2014). See also Professor Geoffrey Dobb, Vice-President, Australian Medical Association, *Proof Committee Hansard*, 1 April 2014, p. 1.

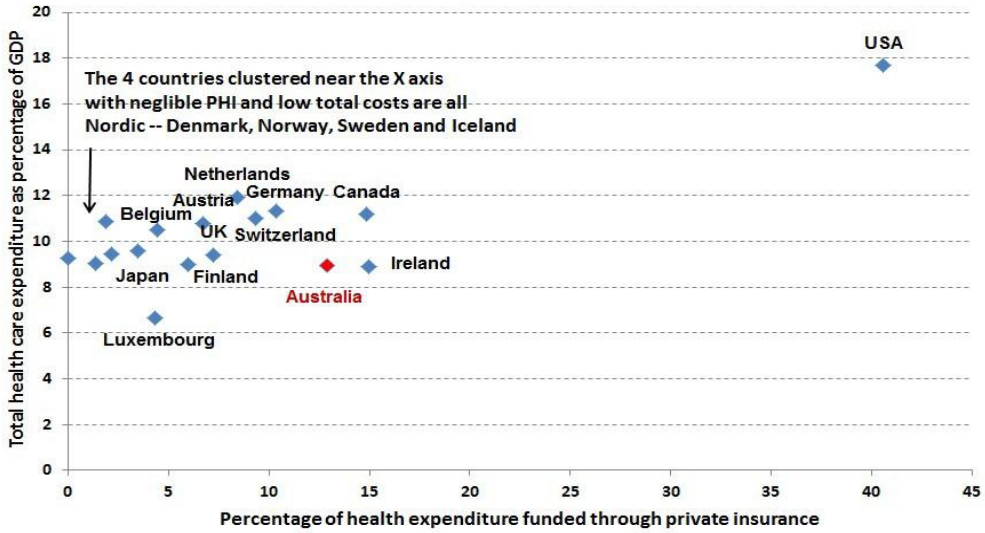
10 *Proof Committee Hansard*, 5 February 2014, pp 2-3.

11 *Proof Committee Hansard*, 18 February 2014, p. 7.

12 *Proof Committee Hansard*, 5 February 2014, p. 41.

13 Mr Ian McAuley, Ms Jennifer Doggett and Mr John Menadue, *Submission 6*, p. 27.

Figure 14: National Health Expenditure and Funding through Private Health Insurance -- High income OECD countries



The importance of expenditure on primary care and preventative health measures

2.11 To address the burden of complex conditions and chronic disease in the future, the committee heard of the importance of primary care and preventative health measures. An increased focus on and investment in primary care and preventative health campaigns has the potential to alleviate the burden of health costs over time as people would stay healthier for longer and manage complex or chronic conditions with the assistance of their General Practitioner (GP) rather than enter expensive hospital care. Ms Verhoeven summarised this view:

> We know that preventive health is critical in the long term to getting good health outcomes, but we also know that there are not short-term wins from investment in preventive health. So, if you want an investment win from a dollar spent last year or the year before, you are not going to see it. The reality is that those wins will not be seen for 20, 30 or 40 years.[14]

2.12 Ms Jennifer Doggett, Fellow, Centre for Policy Development, also emphasised that the dividends of public health campaigns only become apparent over time:

> There is a lot of data which shows that, in a number of areas, it is a sensible investment: investment in preventative care in particular strategies will deliver significant gains down the track. That does not necessarily mean every health promotion campaign or every preventative strategy; it means evidence based preventative health care….Certainly you would have to look at the fact that Australia is a global leader in reducing smoking; you would have to look at government's investment in, say, the 1970s and 1980s

14 *Proof Committee Hansard*, 18 February 2014, p. 12.

> in anti-smoking campaigns paying dividends now in the reduction of smoking-related illnesses that we are seeing turning up in our hospitals.[15]

2.13 The submissions made to the committee by the Grattan Institute and the Public Health Association of Australia also highlighted how some preventative health strategies, such as raising excises on tobacco and alcohol, could help reduce health costs in the long run while also lifting government revenues.[16]

2.14 Investment in prevention measures was also supported by Mr Chris Twomey, Director of Social Policy, West Australian Council of Social Service, as a way to reduce costs in certain areas:

> Any analysis of the health budget shows the areas we have been blowing out have been hospitals, crisis care, PBS and so forth, and what we actually want to do to reduce the blow-out in those costs is more primary care and more prevention and early intervention. We want to get people to see their GPs more, not less.[17]

2.15 Professor Michael Daube, Professor of Health Policy, Curtin University and Director, Public Health Advocacy Institute of Western Australia, was concerned that funding for preventative health services is not seen as a 'soft target' for cuts to the health budget. Professor Daube highlighted the substantial reductions in preventable death and disease, and the reduced costs to the community and health system from the modest funding for prevention measures in areas including immunisation, tobacco, road safety and HIV-AIDS. [18]

2.16 Professor Geoffrey Dobb, Vice-President, Australian Medical Association, (AMA) stressed that preventative health should be a major part of making healthcare funding sustainable:

> The effects will not be short term, but if we are to achieve sustainability in health care funding in the budget in 10 or 15 years time, then we need to be doing those things right now. On the other side, in terms of managing chronic disease that is already here, yes, general practice is the key to that, and it is key to keeping people out of hospital and improving the quality of their lives. General practitioners are increasingly becoming experts in the management of chronic and complex disease in the community. The costs of caring for people in the community are far less. What we need to do is support the general practice model to provide those services where they are

15 *Proof Committee Hansard,* 5 February 2014, p. 40.

16 Grattan Institute, *Submission 1*¸ Attachment 1, p. 71; Public Health Association Australia, *Submission 14*¸ pp 8-9.

17 *Proof Committee Hansard,* 1 April 2014, p. 10.

18 *Proof Committee Hansard,* 1 April 2014, pp 60-61.

> delivered in a way that is better for patients, more appropriate for the health care system and, ultimately, will bring a smile to the faces of treasurers.[19]

Suggestions to fund preventative health measures

2.17 Professor Daube noted that the taxation of harmful products such as tobacco and alcohol brings in around $14 billion a year and some of this could be used for prevention measures. Professor Daube also noted that the introduction of a volumetric tax for alcohol could bring another estimated half a billion dollars a year which could be used to fund preventative health services.[20]

Committee view

2.18 The committee notes the long-term success of preventative health measures including tobacco control and sun protection/skin cancer prevention and believes that there should be a greater focus on evidence based preventative health programs to reduce acute healthcare costs in the future.

Recommendation 1

2.19 The committee recommends that the government use funding found through efficiencies to increase evidence based preventative health measures aimed at reducing the burden of chronic conditions in the future.

Potential efficiencies in Australian health expenditure

2.20 The committee received evidence that areas of the Australian health system could be more efficient, and these are discussed below.

Duplication across agencies and levels of government

2.21 One area put forward for increased efficiency was the duplication of services across Commonwealth and state health agencies. Mr Frank Quinlan, Chief Executive Officer, Mental Health Council of Australia, stated that in relation to mental health programs:

> What we see in the interactions between state and territory governments and the Commonwealth government currently is a considerable overlap in programs and a considerable gap in programs, so we see some Commonwealth programs taking on similar roles to some state programs. We have traditionally seen state governments providing direct services, hospital based services and supporting community mental health services for instance. We have seen the Commonwealth as a relatively recent entrant into the mental health domain having provided funding to a range of

19 *Proof Committee Hansard*, 1 April 2014, pp 61-62. Note: regarding potential efficiencies, Professor Dobb stressed the need to improve arrangements for GP management of chronic and complex disease which has the potential to save $1.3 billion a year by managing people in the community rather than in the public hospital sector. See *Proof Committee Hansard*, 1 April 2014, p. 1.

20 *Proof Committee Hansard*, 1 April 2014, p. 61, 64. Note: a volumetric approach to the taxation of alcohol was supported by Professor Geoffrey Dobb, AMA, *Proof Committee Hansard*, 1 April 2014, pp 64-65.

> programs. What we principally mean by that statement is not so much that one government or the other ought to abandon the space but that we ought to find ways for state and federal governments to work together to ensure that we are less burdened by overlaps and less burdened by gaps between the programs. It is about building a cooperative relationship between the states and the Commonwealth.[21]

2.22 Ms Verhoeven questioned the recent increase in bureaucratic infrastructure:

> So one does have to query why there has been so much bureaucratic infrastructure set up to handle something which six or seven years ago was done by one or two agencies. I do think there is some scope for rationalisation there. Just looking at the infrastructure needed to support each of these individual agencies—and I talk about IT services, human resource services, communications services and website building services—it is really very complex and it is not money well spent.[22]

The duplication of services - private and public health providers

2.23 The committee heard evidence there is duplication of funding and services between public and private providers, as there is not a clear distinction between the different roles they play and the services they provide. Ms Verhoeven told the committee:

> There are clearly issues with a system that sees private hospitals contracted to treat public patients while public hospitals compete for private patients. Like all industries and systems there are opportunities to improve efficiencies and value in the system. There is significant variation in the costs of health service delivery across the country, some of which is explained by complexity in the patient mix, by geography and by market forces, but there are also avoidable aspects to these cost variations.[23]

2.24 Dr Anne-marie Boxall, Director, Deeble Institute for Health Policy Research, AHHA, spoke about duplication between public and private health insurance providers:

> The problems with Australia's health insurance arrangements go back to the origins of Medicare and Medibank, where we had an existing private health insurance system that had tax subsidies and then we created a universal healthcare system. The problem has always been that we have had two competing systems, but the private health insurance does not necessarily add function as a top-up, an optional extra. In some ways it duplicates what Medicare does and in other ways it is a top-up. So the structure of the system is problematic compared with most other countries.[24]

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21 *Proof Committee Hansard*, 18 February 2014, p. 5.

22 *Proof Committee Hansard*, 18 February 2014, p. 9.

23 *Proof Committee Hansard*, 18 February 2014, p. 7.

24 *Proof Committee Hansard*, 18 February 2014, p. 9.

Private health insurance rebates

2.25 The last Intergenerational Report, *Australia to 2050: future challenges*, stated that private health insurance rebates were a substantial and growing component of government health expenditure, predicted to increase 'by 9 per cent a year over the 10 years from 2012-13, adding a cumulative $33 billion to spending'.[25]

2.26 These rebates were not only seen as an inefficient and costly tax expense for the Commonwealth, but it was also suggested that they had not achieved their intended purposes. The Grattan Institute submission included a report that identified the health insurance rebate as a potential expenditure saving for government in the Australian health budget:

> Removing the private health insurance rebate could save $3.5 billion in expenditure. Savings of $5.5 billion from the cost of the rebate would be offset by an increase in demand for public hospital services.[26]

2.27 Dr Stephen Duckett, Program Director for Health for the Grattan Institute, appearing in a private capacity, also commented that the private health rebate was not effective in reducing demand on public hospital services:

> The argument for the private health insurance rebate when it was first introduced was that it would reduce demand on public hospitals. My reading of the evidence is that there was not a great impact on public hospital utilisation with the introduction of the rebate.[27]

2.28 Mr Peter Davidson, Senior Adviser, Australian Council of Social Service (ACOSS), suggested that the private health insurance rebate for ancillaries[28] was not achieving its intended results:

> The 30 per cent to 50 per cent private health insurance rebate for ancillaries cover, we believe, should go. The main justification for that rebate was to reduce public expenditure on hospitals. There is not a direct link between ancillary benefits and those expenditures. Indeed, we have inequity where people who can afford private health cover are being subsidised substantially for private dental care while people on poverty-level incomes are waiting a year on year or more for a lower quality public dental care.[29]

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25 The Treasury, *Australia to 2050: future challenges* (2010), p. 8.

26 Dr John Daley, *Balancing budgets: tough choices we need* see Grattan Institute, *Submission 1, Attachment 1*, p. 71; these figures were based on The Treasury, *Commonwealth Budget Papers 2012-13*, Statement 6, p. 26 at www.budget.gov.au/2012-13/ (accessed 3 March 2015).

27 *Proof Committee Hansard*, 18 February 2014, p. 33.

28 Ancillaries includes extras such as dental or physiotherapy services. See www.privatehealth.gov.au/healthinsurance/howitworks/ (accessed 11 March 2014)

29 *Proof Committee Hansard*, 18 February 2014, p. 53.

Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS)

2.29 The committee heard evidence that supported full-scale reviews of the MBS and PBS, as well as expediting the ongoing review of MBS item numbers. Ms Verhoeven stated:

> Both the MBS and the PBS programs would benefit, in our minds, from a review to determine opportunities for disinvestment of, for example, redundant treatments and technologies, particularly at a time where there is an increasing demand to add new treatments and technologies to these schedules. We argue that regular scheduled review of MBS and PBS items would ensure that the schedules remain current and appropriate in terms both of their content and the rebate levels.[30]

2.30 Dr Duckett agreed the MBS could be reviewed, though advised that any changes be undertaken with caution so disadvantaged individuals are not negatively affected financially or in relation to access:

> There are obviously parts of the [MBS] that have not been revised and reviewed for decades, so you end up with certain items being over-renumerated relative to others.[31]

2.31 The AHHA also recommended that the ongoing review of MBS item numbers by the Department of Health be expedited and its recommendations prioritised by government.[32] Dr Boxall told the committee:

> [The Department of Health's review of the MBS have] started their work and they do have a very rigorous process set up through the…Medical Services Advisory Committee. It does involve stakeholder consultation and the reports are produced publicly. The problem with the process is that they have done about 23 and there are more than 5,000 items on the MBS, so it is really the scale of the project rather than the nature of it in itself.[33]

2.32 The Grattan Institute's submission noted potential Commonwealth savings of $2 billion from PBS expenditure.[34] This drew on evidence in a previous Grattan report by Dr Duckett that argued three reforms to Commonwealth pharmaceutical subsidies were necessary:

> The first is to establish a truly independent expert board. Like New Zealand's Pharmaceutical Management Agency, it would manage pharmaceutical pricing within a defined budget.
>
> The second and vital change is to pay far less for generic drugs, which can be bought for low prices because they are off-patent. In Australia drug

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30 *Proof Committee Hansard*, 18 February 2014, p. 7.

31 *Proof Committee Hansard*, 18 February 2014, p. 30.

32 More information on this ongoing review of MBS item numbers can be found at www.msac.gov.au/internet/msac/publishing.nsf/Content/reviews-lp (accessed 5 February 2014).

33 *Proof Committee Hansard*, 18 February 2014, p. 8.

34 *Submission 1 Attachment* 1, p. 71.

> companies must cut prices by 16 per cent when a patent expires. Many countries require much bigger cuts….
>
> Down the line, a third reform should encourage people to use cheaper but similar pharmaceuticals, which could save at least $550 million a year more.[35]

2.33 Mr Davidson also commented that PBS subsidies should be reduced for medicines that are off-patent to reduce costs for government and to deliver more effective treatment to individuals.[36]

Committee view

2.34 The committee considers that more resources should be provided to progress the ongoing review of MBS item numbers currently being undertaken by the Medical Services Advisory Committee. This review is looking at all MBS items to assess clinical need, appropriateness, and the currency of treatments to improve both health outcomes for individuals and the financial sustainability of the MBS more generally.

Recommendation 2

2.35 The committee recommends that the government commit to provide additional resources to progress the review of Medicare Benefits Schedule item numbers being undertaken by the Medical Services Advisory Committee.

Examining the proposal for a Medicare co-payment

2.36 Although the commission's findings have not been made public, there has been some indication that the government is considering the introduction of a co-payment for accessing GP services.[37]

2.37 The committee heard evidence from Mr Terry Barnes, Principal, Cormorant Policy Advice, about a submission he drafted for the Australian Centre for Health Research (ACHR) to the commission. The ACHR submission advocated introducing a $6 co-payment on bulk-billed GP and emergency department visits. It estimated that this would reduce Commonwealth health expenditure by $750 million over the forward estimates from 2014-15 to 2017-18.[38]

2.38 The ACHR submission argued that a $6 co-payment would send affordable – 'less than the price of two cups of coffee' – and 'clear price signals to Australians that their basic health care services are not free goods'.[39] This would lead to consumers

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35 Stephen Duckett et al. *Australia's bad drug deal: high pharmaceutical prices* (2013), Grattan Institute, p. 2.

36 *Proof Committee Hansard*, 18 February 2014, p. 53.

37 Dan Harrison 'Health Minister Peter Dutton opens door to GP co-payment', in *Sydney Morning Herald*, 20 February 2014.

38 Australian Centre for Health Research, *A proposal for affordable cost sharing for GP services funded by Medicare* (October 2013), pp.1-2.

39 Australian Centre for Health Research, *A proposal for affordable cost sharing for GP services funded by Medicare* (October 2013), p. 2 and p. 11

thinking twice before going to a GP with a minor complaint, thus reducing the chance of over-servicing by GPs.

2.39 Mr Simon Cowan, Research Fellow and Target 30 Program Director from the Centre for Independent Studies, supported the introduction of GP co-payments generally, but suggested an additional reduction in the Medicare benefit paid:

> …Our model involves not just a $5 co-payment but a $5 reduction in the Medicare benefit that is paid, and that is where the savings to government will come from.
>
> Applying that to GP visits, specialists, pathology tests, diagnostic tests and optometry—which is a total of something like 292 million services—the $5 payment will generate about $1.45 billion in savings. That does not take into account any potential reduction in use as a result of changing behaviours from co-payments. That is simply taking the number of services that are currently provided and applying a $5 co-payment together with a $5 reduction in [services funded by the Commonwealth]…[40]

2.40 Both Mr Barnes and Mr Cowan contended that people would not start attending emergency departments instead of GPs, in an effort to sidestep a modest co-payment. Mr Barnes stated that emergency departments should also implement a co-payment for unnecessary visits.[41] Mr Cowan told the committee:

> I think that the majority of people will continue to consume health as they have before. As a result of the co-payment they will not go instead to an emergency department because there are a variety of other costs associated with going to an emergency department.[42]

2.41 Mr Barnes also suggested:

> Provided it has a reasonable ceiling to protect the less well-off, chronically ill and families with young children, there is no reason why a co-payment on bulk-billed services should stop people going to the GP when they need to.[43]

2.42 Mr Barnes told the committee that it was difficult to prove over-servicing was endemic in the Australian system as this data is not collected. However, he suggested that anecdotal evidence suggested there may be a problem:

> …what Medicare records is simply quantitative information. If you go to the GP and claim a benefit for a visit, a visit is recorded. We do not, as we do with acute care in hospitals, code what the person presents for. So we do not really have as good a fix on how GP services are used. But, anecdotally, particularly in areas where there are high concentrations of doctors or of

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40 *Proof Committee Hansard*, 18 February 2014, p. 22. See also Mr Jeremy Sammut, 'Co-payment plan is no mortal blow against Medicare', *Sydney Morning Herald*, 12 March 2014.

41 *Proof Committee Hansard*, 18 February 2014, p. 60.

42 *Proof Committee Hansard*, 18 February 2014, p. 21.

43 *Proof Committee Hansard*, 18 February 2014, p. 60.

> health services, there is at least anecdotal evidence that services are overused.[44]

2.43 The committee notes there is research suggesting that the assumptions in the ACHR submission are flawed.[45] In addition, those opposed to the co-payment argued that 'anecdotal' evidence is not sufficient to model the effects of a co-payment. Moreover, witnesses suggested there is actually no problem with over-servicing in the health system at the moment.[46]

The case against co-payments

2.44 The committee heard evidence that a co-payment would not reduce health expenditure substantially, and that it would negatively affect access to quality and timely healthcare for some Australians, especially those on low-incomes.

Reducing access for low-income earners

2.45 Ms Jackie Brady, Acting Executive Director, Catholic Social Services Australia, told the committee:

> On the issue of co-payment…I would hope to impress that given the low incomes that many of the people at the lower end of the spectrum are surviving on—and I do describe it as surviving because it is a week-to-week existence—and even though it is sometimes hard for some of us to believe that a $6 co-payment is going to be enough to dissuade somebody from going to the GP, that is in fact a reality.[47]

2.46 Professor Laurie Brown, Research Convenor, National Centre for Social and Economic Modelling, University of Canberra (NATSEM), also saw the burden of a co-payment falling disproportionately on low-income groups:

> I think it will be absolutely clear that the distributional impacts will fall onto socioeconomically disadvantaged families, and then there is an additional question of what the administrative costs of implementing that type of policy are.[48]

2.47 Dr Boxall advised that there was evidence showing that increases to co-payments had had this effect in other areas of healthcare:

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44 *Proof Committee Hansard*, 18 February 2014, p. 61.

45 Australian Medical Association, 'AMA reveals flaws in Australian Centre for Health Research co-payment proposal' at https://ama.com.au/gpnn/ama-reveals-flaws-australian-centre-health-research-co-payment-proposal (accessed 27 February 2014); see also " Doctors in cities unlikely to charge proposed $6 GP fee "at www.news.com.au/lifestyle/health/doctors-in-cities-unlikely-to-charge-proposed-6-gp-fee/story-fneuz9ev-1226834097608 (accessed 27 February 2014).

46 Ms Doggett, *Proof Committee Hansard*, 5 February 2014, p. 38; Dr Duckett, *Proof Committee Hansard*, 18 February 2014, p. 31; Ms Vassarotti, *Proof Committee Hansard*, 18 February 2014, p. 15.

47 *Proof Committee Hansard*, 18 February 2014, p. 71.

48 *Proof Committee Hansard*, 18 February 2014, p. 49.

> There is also some evidence looking at increasing co-payments for pharmaceuticals, and it was a substantial increase. When they did it in 2005, they found that the volume of scripts filled for essential medications—so not things like coughs and colds but things like epilepsy drugs—dramatically reduced, including for concession card holders. I do not think that in the space of a couple of months you can see that people have been cured of epilepsy, so co-payments are having a substantial effect on people and their access to health services.[49]

2.48 The committee heard that out-of-pocket healthcare costs in Australia have risen at much faster rates than most other countries, which has already placed a cost-barrier in the path of low-income groups. For instance, Dr Boxall said:

> There was a survey done by the Australian Bureau of Statistics in 2009 where they found that one in 10 people reported that they either delayed or sacrificed treatment by a specialist because of the cost, and one in 11 did not fill a script because of the cost[50]

2.49 Ms Rebecca Vassarotti, Director of Policy, Consumers Health Forum (CHF) Australia, also saw co-payments affecting those least able to afford it. Additionally, she highlighted the other costs of accessing health services including, transport, parking and possibly accommodation.[51]

Deferred GP consultations will increase health problems in the future

2.50 Evidence considered by the committee suggested that co-payments would lead to many people deferring seeing a GP for minor ailments that had the potential to become major conditions if left unchecked. Ms Vassarotti suggested that this was already happening, due to existing cost barriers in healthcare:

> I think often the response that consumers give us is that they will delay care, meaning they will probably end up in emergency when they are much sicker, and it will be much more expensive to treat their illness. So from our perspective the introduction of co-payments, particularly in areas such as primary health, seem on the evidence of it very counterintuitive in terms of resulting in a decrease in spend.[52]

2.51 Dr Duckett agreed:

> …the RAND study [done in the USA between 1972 and 1982] found that the reduction in use occurred in both what doctors judged as necessary care and what doctors judged as unnecessary care. Patients are not themselves very good people to choose, when they have got something wrong with them, whether it is necessary or not, so by reducing what doctors think is

49 *Proof Committee Hansard*, 18 February 2014, p. 10.

50 *Proof Committee Hansard*, 18 February 2014, p. 10.

51 *Proof Committee Hansard*, 18 February 2014, pp 14-15.

52 *Proof Committee Hansard*, 18 February 2014, p. 15. See also Ms Sue Ash, Chief Executive Officer, UnitingCare West, *Proof Committee Hansard*, 1 April 2014, p. 21.

> necessary care there is the potential to increase costs for the health system in the longer term and also people suffer illness worse.[53]

2.52 Professor Dobb from the AMA noted their concerns about a lack of detail and certainty around the co-payment proposal as well as that:

> …a significant across-the-board increase in people's out-of-pocket expenditure may act as a deterrent for people who need to see a medical practitioner, allowing their disease to get worse to the detriment of themselves and, ultimately, of the healthcare system if they present later with more serious and complex disease that requires hospitalisation and a much more costly course of treatment.[54]

2.53 Professor Dobb also queried the evidence base for the co-payment and particularly the assumption that it would save the government money:

> The AMA has done some modelling, based on the best information available, about how such a measure might look. That was done by Access Economics. It suggests that it will be at best cost-neutral and might actually end up costing governments collectively—if you include state governments, which look after the hospital system—more taxpayer dollars. At the end of the day there is only one kind of government dollar, and it comes out of the pockets of taxpayers.[55]

Cost-shifting to hospitals

2.54 The committee heard that some people who would be deterred from visiting a GP by the introduction of a co-payment may instead seek treatment at emergency departments in hospitals. This would lead to increased costs for government in hospital expenditure. Ms Vassarotti told the committee:

> Also there are issues such as co-payment being put in part of the system. Potentially they recognise the differentiating value of those services. So you get these potential perverse incentives where you might be putting a co-payment on a GP service in primary health care but no co-payment in an emergency room. So you are actually being forced into accessing services that are more costly and less effective because of the way that co-payments have been implemented, particularly because of that ad hoc manner.[56]

2.55 Dr Duckett agreed that co-payments could lead to cost shifting behaviour instead of cost savings:

> The other point I would make is that the estimates of savings are highly sensitive to what people might do. For example, if only one in four or one in five people who might otherwise have gone to a doctor decides to go to a hospital emergency department then there are no savings for the

53 *Proof Committee Hansard*, 18 February 2014, p. 29.

54 *Proof Committee Hansard*, 1 April 2014, p. 62.

55 *Proof Committee Hansard*, 1 April 2014, p. 62.

56 *Proof Committee Hansard*, 18 February 2014, p. 16.

> Commonwealth government at all and substantial increased costs for state governments through increased costs on the public hospital system.[57]

2.56 Moreover, the South Australian Health Department estimated that a $6 co-payment for a GP visit would actually cost the Commonwealth and state governments almost $2 billion, because at least four per cent of people would bypass a GP and attended emergency departments for minor ailments instead.[58]

Adding to regulatory burden

2.57 Evidence received by the committee also pointed to the potential for GP co-payments to increase red tape for GPs and lift Commonwealth administration costs.

2.58 Professor Brown, NATSEM noted the administrative burden of charging a $6 co-payment:

> What I do not know is how you implement that type of system of adding a $6 fee and what are the administrative costs of implementing that. I think that is another element.[59]

2.59 Ms Verhoeven agreed:

> More broadly, I think our concern around co-payments is that there are administrative costs in collecting them. We do not think that it is actually going to drive big returns back into the system anyway and that there are probably better and smarter ways to save money.[60]

2.60 A recent report by Ms Doggett for the Consumer Health Forum also raised this issue:

> In fact, shifting expenditure to consumers can actually increase overall costs if it requires a more complex system to administer or results in a less efficient allocation of resources. For example, the introduction of a $5 co-payment for bulk billed GP services would require significant additional administration for general practices resulting in higher transaction costs compared to the administratively simple process of bulkbilling.[61]

Committee view

2.61 The committee acknowledges that the most important weapon in good preventative health strategies is effective primary care delivered by GPs. A GP can identify emerging conditions early before they require hospital or specialist treatment. They can also assist people to manage complex, multiple and chronic ongoing conditions more effectively. The role that GPs play in the health system leads to better

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57 *Proof Committee Hansard*, 18 February 2014, p. 29.

58 Bianca Hall, 'Proposed GP co-payment would add $2 billion to Australia's health bill, modelling shows' in *Sydney Morning Herald*, 23 February 2014.

59 *Proof Committee Hansard*, 18 February 2014, p. 49.

60 *Proof Committee Hansard*, 18 February 2014, p. 9.

61 Consumer Health Forum Report by Ms Jennifer Doggett, *Empty Pockets: Why Co-payments are not the solution* (March 2014), p. 31 at www.chf.org.au/pdfs/chf/Empty-Pockets_Why-copayments-are-not-the-solution_Final-OOP-report.pdf (accessed 5 March 2014).

health outcomes for individuals and families. Moreover, it also leads to more efficient health expenditure for government. Early intervention can arrest or alleviate some of the complex and chronic diseases that see people end up in our hospitals which is the most expensive place for people to be treated.

2.62 The committee believes measures which place a barrier to a person seeing a GP are not in the best interests of keeping people healthy. Moreover, that the proposal for a co-payment for GP and emergency department visits may cause people to delay treatment and they would be more likely to need more expensive hospital care.

2.63 The committee sees this co-payment as a blunt instrument that has the potential to hurt the most vulnerable in our society, both financially in the short-term and by risking their future health.

Recommendation 3

2.64 The committee strongly recommends that the government does not implement co-payments for GP consultations and emergency department services.

Other issues raised with the committee

Data collection

2.65 The committee heard that health data collection and sharing across levels of government and between government departments should be improved, to support the development good health policy that would achieve efficiencies for government health expenditure in the long term.

2.66 Ms Verhoeven noted duplication of data collection across governments and departments:

> There are any number of agencies collecting data in some shape or form from the states and territories and, by extension, from the hospitals themselves. That is delivered to the Commonwealth. It is handled in multiple agencies. Sometimes one agency collects the data from another agency but then has to be signed off by the state and territory provider. The mechanisms are cumbersome. We are in a position where we have a number of new agencies now all responsible for data reporting, yet most of them are relying on the services of the Australian Institute of Health and Welfare in any case for original data sources.[62]

2.67 Dr Duckett's submission to the commission advocated that Department of Health data be made more widely available for policy evaluation and research purposes.[63]

2.68 Mr Barnes proposed that more data on the activity of GPs needed to be collected:

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62 *Proof Committee Hansard*, 18 February 2014, p. 9.

63 Dr Stephen Duckett, *Submission to the National Commisison of Audit*, p. 8 at http://grattan.edu.au/static/files/assets/f2bad06b/225_duckett_audit_health.pdf.

> …more work needs to be done to understand qualitatively the activity profile of general practice. As I said, in terms of hospital admissions, with the national morbidity database and now with activity based pricing, we effectively code why people are admitted and what they are treated for. We do not do that at the general practice level. I think we need to do the qualitative work to make sure that this measure or any other demand management measure is on the right track.[64]

2.69 The National Rural Health Alliance suggested that the government should aim to improve available data on health outcomes and services in regional and rural areas:

> The capacity of [the Australian Bureau of Statistics, the Australian Institute of Health and Welfare and the COAG Reform Council] to deliver the data required for evidence-based health funding, policy and programs is an important component of the ability of the public service to provide good and timely advice to government.[65]

Committee view

2.70 Reliable data is essential for developing evidence based health policies designed to improve health outcomes and increase efficiency in government spending. The committee believes the collection and sharing of health data could be greatly improved across levels of government and between government departments. Consolidating the data held by agencies dealing with health and care could reduce duplication and bureaucracy, thereby reducing government expenditure.

Recommendation 4

2.71 The committee recommends that the government review health data collected with a view to: consolidating data held by different departments across different levels of government; and collecting data on the value of preventative healthcare and the primary care function of GPs.

Harmonisation of the safety nets in Australian healthcare

2.72 The committee heard that there is scope for government to harmonise the different safety nets in the healthcare system. This would protect people from unaffordable costs, especially for the cost of co-payments not fully covered by or outside Medicare. It could also reduce the current duplication of administration between the existing MBS and PBS safety nets.[66]

2.73 Dr Duckett told the committee:

> Basically, at the moment, there is a separate safety net for Medicare, the MBS, and there is a separate safety net for the Pharmaceutical Benefits

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64 *Proof Committee Hansard*, 18 February 2014, p. 67.

65 National Rural Health Alliance, *Submission 22*, p. 4.

66 See Doggett, *Empty Pockets: Why Co-payments are not the* solution, p. 26; see also the Henry Tax Review's report, which recommended 'the scope and structure of safety net arrangements be reviewed' *Australia's future tax system, Part 2 Detailed Analysis*, Chapter A1 at http://taxreview.treasury.gov.au/content/

> Scheme, but there is no safety net for allied health costs—dental costs or something like that. One of the things that the [National Health and Hospitals Reform Commission] recommended was that there should be harmonisation of the safety nets so that if you have racked up a huge amount on pharmaceuticals you might be able to get medical services at no cost to yourself sooner. We said that we need to be looking at how the existing safety nets work together with some of the other programs—I think the words that the [NHHRC] used were 'the patchwork of government programs'—that meet the cost of some services like diabetes equipment. The incidence of these things can be really detrimental to some people with, say, diabetes. The two safety nets were developed differently and structured differently but they are still run by the same department, so there ought to be some sort of harmonisation of the two, especially with the phasing out of the tax rebates for medical expenses.[67]

2.74 However, Dr Duckett advised that, although reform was necessary, any harmonisation of Medicare safety nets would require careful planning and design by government to ensure individuals are not disadvantaged.[68]

Committee view

2.75 The MBS and PBS provide very different safety nets that support users with high medical costs. However, because they are not harmonised, many users fall through the cracks and receive less support than they should – especially where medical conditions accrue high costs from both medical services and pharmaceutical prescriptions.

Recommendation 5

2.76 The committee recommends that the government explore the effectiveness of the safety nets relating to medicines and primary care, including the consideration of potential options for improving access and reducing out-of-pocket costs to patients.

Conclusion

2.77 The committee notes that Australia's health expenditure is not high by international standards and that its healthcare system is reasonably efficient. However, the committee acknowledges the challenges that the health system faces, including the ageing of the population and the rollout of new programs such as the NDIS.

2.78 The committee believes it is timely to start a conversation about the healthcare system Australians want to have in the future, including the challenges, opportunities, how to ensure fairness and equity and how this system should be financed. The conversation started by the commission process, including the suggestions made to it by individuals and organisations, is welcome. However, the committee is concerned that this conversation will be cut short by the government when the recommendations of the commission are made public.

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67 *Proof Committee Hansard*, 18 February 2014, p. 32.

68 *Proof Committee Hansard*, 18 February 2014, p. 32.

2.79 The committee is concerned that the commission will take a quick fix approach for savings that will not improve the health of Australians over the long term. It urges the government to look to the long-term viability of our healthcare system, especially by considering improvements to preventative and primary care to alleviate future cost pressures.

2.80 The committee supports greater efficiency in expenditure and the delivery of health services, as long as these efficiencies provide for:

- Medicare to remain the cornerstone of the healthcare system;
- no reduction in the overall Commonwealth health funding envelope, and that the proceeds of any efficiencies are reinvested directly into the health sector;
- no degradation in the quality of healthcare and good health outcomes; and
- no additional barriers to access healthcare put in place for low socio-economic, disadvantaged or regional populations.