Chapter 3

Patient co-payments, cuts to hospital funding and preventative health

Introduction

3.1 During the committee's inquiry one issue has dominated the evidence: concern over the $7 co-payment. This chapter will examine the concerns raised about the proposed $7 co-payment.

3.2 As discussed in chapter 2, from July 2015, the government will introduce a $7 co-payment on all bulk-billed GP consultations, out-of-hospital pathology and diagnostic imaging services. The government also plans to increase the current Pharmaceutical Benefits Scheme (PBS) co-payment by an extra $5 for each PBS prescription for non-concession card holders from July 2015. Concession card holders will pay an extra 80 cents.

3.3 The committee notes that this policy area has recently been the subject of a Senate Community Affairs References Committee inquiry and report into out-of-pocket healthcare expenses.[1] That report, *Out-of-pocket costs in Australian healthcare*, was tabled on 22 August 2014 and provides a useful summary of the information known about the proposed co-payment post the 2014-15 Budget. As there has been minimal new information released by the government about the PBS and $7 co-payments since the May Budget, the committee reproduces parts of the background information from that report below.

Background—patient co-payments[2]

3.4 At the time of writing the government continues to assert that from 1 July 2015, bulk-billed patients will be required to pay $7 per visit toward the cost of GP consultations, and out-of-hospital pathology and imaging services. Under the proposed changes, $5 will be invested in the Medical Research Future Fund and $2 will be paid directly to the doctor or service provider. Medicare rebates for items attracting a patient contribution will be reduced by $5.

3.5 The government has indicated that doctors will be paid a 'low gap incentive payment' to encourage them to charge concession card holders and children under 16

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1 Senate Community Affairs References Committee, *Out-of-pocket costs in Australian healthcare*, August 2014, www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Australian_healthcare (accessed 3 November 2014).

2 Much of this section of the report is reproduced directly from the Senate Community Affairs References Committee, *Out-of-pocket costs in Australian healthcare*, August 2014, pp 25–27.

no more than a $7 "contribution" for their first 10 visits, and to bulk-bill these patients (after 10 initial visits) and not charge them for subsequent visits.

3.6 Currently, the incentive payment for bulk-billing concession patients is $6 for metropolitan areas and $9.10 for regional areas and Tasmania. GPs do not receive an incentive payment when bulk-billing patients without a concession card.

3.7 In the Budget, the government also announced that from 1 January 2015, general patients will pay an extra $5.00 towards the cost of each PBS prescription. Patients with a concession card will pay an extra $0.80 towards the cost of each PBS prescription.[3]

3.8 Following the tabling of the 'out-of-pocket' report, there has been continued critical commentary on both types of co-payment proposals. During the same period there has been no new information from the government about the policy itself. The committee observes that across its broad remit of health portfolio matters, a key concern of witnesses has been the serious and harmful effects of this policy, particularly the $7 co-payment.

Policy development

3.9 Three key themes emerged from the evidence presented to the committee regarding the government's policy development process:

- the $7 co-payments were based on an assertion by the government of an unsustainable healthcare system—in particular that expenditure on the MBS was not sustainable;
- the $7 co-payments proposal was not based on credible evidence; and
- the government did not consult stakeholders during the policy development process.

Sustainability

3.10 Both before and after the May 2014 Budget the government has claimed that Australia's healthcare system is unsustainable. For instance the Health Minister, the Hon Peter Dutton MP, stated at the February 2014 CEDA Conference that the health budget was 'tracking on an unsustainable path with no prospect of meeting the needs of the health of our nation in the 21st century.'[4]

3.11 Post-Budget, in September 2014, the Health Minister told *Lateline*:

> We're determined to make sure that Medicare is sustainable into the 21st Century. We've got an ageing population, huge costs coming down the line. The fact that we spend $20 billion today on Medicare, but only raise about

3 Department of Health, *Portfolio Budget Statements 2014-15*, Budget Related Paper No. 1.10, p. 63.

4 The Hon Peter Dutton MP, Minister for Health, *Address to CEDA Conference*, 19 February 2014.

> $10 billion from the Medicare levy and the gap grows and grows each year. It's absolutely necessary that we introduce sensible reforms…[5]

3.12 This notion of unsustainability has repeatedly been cited as the rationale for the government's $7 co-payment policy intervention. However, the evidence provided to the committee does not support the government's assertions. For example the AMA's submission states that:

> The Government is justifying the health budget measures on the basis that Australia's health spending is unsustainable. It is not.
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> - Health is 16.13% of the total 2014-15 Commonwealth Budget, down from 18.09% in 2006-07.
> - Health was 8.9% of Australia's GDP in 2010, stable when compared with 8.2% in 2001, and lower than the OECD average of 9.3%.
>
> The Government fails to acknowledge that Australia's nominal GDP continues to grow at rates that are above OECD averages. Australia can afford the health system it currently has.[6]

3.13 The College of Medicine and Dentistry, James Cook University pointed out that general practice is not driving force in any increase in MBS expenditure:

> There is concern about a rise in health care costs driven by an increase in Medicare spending. Further analysis suggests that most of the increase in spending has come from an increase in specialist and hospital spending and from areas such as pharmaceuticals and medical imaging (ie. New, improved and more spending per person). Productivity commission figures indicate that in 2012-13 Australian Government expenditure on general practice was $286 per person, but in the same period government spending on public hospitals was $1792 per person. General practice is not the cost driver in the Medicare Benefit Scheme (MBS).[7]

3.14 The Australian Medical Association Victoria supported the view that health expenditure is not unsustainable:

> Whichever set of numbers you want to look at, we can look at the percentage of the Commonwealth budget, in terms of health. We have said that it was 18 per cent and it is down to 16 per cent. On that measure alone it is not unsustainable. If we look at general practice, in this whole co-payment argument general practice has been hit over the head with a very big stick as being to blame for the problem, but nothing could be further from the truth. In fact, general practice is the solution to the problem, not the problem.[8]

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5 The Hon Peter Dutton MP, Minister for Health, *Lateline*, 8 September 2014.

6 Australian Medical Association (AMA), *Submission 48,* p. 4.

7 College of Medicine and Dentistry, James Cook University, *Submission 17*, p. 5.

8 Dr Anthony Bartone, President, Australian Medical Association Victoria, *Committee Hansard*, p. 43.

3.15 Associate Professor Sarah Larkins who is the Director of Research and Postgraduate Education at the College of Medicine and Dentistry, James Cook University cited Productivity Commission analysis to demonstrate that primary care is not driving healthcare expenditure:

> 'Productivity Commission figures suggested in 2012 and 2013 that Australian government expenditure on general practice is around $304.10 per person but in the same period government spending on public hospitals was $1,792 per person thus general practice spending is 15.5 per cent of the total government spending. General practice is not the cost driver in the [Medicare Benefits Schedule].'[9]

3.16 While acknowledging that healthcare expenditure is rising gradually over time, Dr Stephen Duckett, Director of the Health Program at the Grattan Institute, explained that Australia's healthcare system is not unsustainable and that increased investment in healthcare is often a deliberate choice made by wealthy countries:

> Australia…is one of the better performing health systems in the world. In terms of health expenditure, for example, we are below the comparable OECD average in terms of share of GDP and cost per capita. That is not to say that we should not be doing something. I am not one who thinks the health system is unsustainable. We have seen an increase in its share of gross domestic product over time; in fact, it is projected to increase [from approximately 9 per cent] to a bit over 12 per cent of GDP over the next 20 or so years. That does not mean it is unsustainable. What it does mean is that we have to think about what it is that we are going to trade off, what it is that we are going to give up, and whether that is what we want. Basically all wealthy countries spend more on health care as they get wealthier; it is a choice that society makes, that we want to invest in health care.[10]

3.17 Finally on this point the committee notes that, contrary to the Health Minister's argument about unsustainable health funding, the Australian Institute of Health and Welfare (AIHW) report *Health expenditure Australia 2012-13* states that health funding in that year had in fact decreased:

> Expenditure on health in Australia was estimated to be $147.4 billion in 2012–13, 1.5% higher than in 2011–12 and the lowest growth since the mid 1980's. In 2012–13, governments provided $100.8 billion (or 68.3%) of total health expenditure. Government funding of health expenditure fell in real terms for the first time in the decade by 0.9%, largely a result of a decline in Australian Government funding of 2.4%. State and territory government funding was also relatively low, growing just 1.4% in real

9 Associate Professor Sarah Larkins, Director of Research and Postgraduate Education, College of Medicine and Dentistry, James Cook University, *Committee Hansard*, 21 August 2014, p. 19.

10 Dr Stephen Duckett, Director, Health Program, Grattan Institute, *Committee Hansard*, 8 October 2014, p. 26.

terms in 2012–13. In contrast, growth in non-government funding was relatively strong at 7.2%.[11]

Committee comment

3.18 The committee considers that the government's argument that the MBS is unsustainable is not supported by the witness testimony or submissions. The AIHW report also reveals the fallacy of the government's claims.

$7 co-payment not supported by modelling

3.19 During the Senate Community Affairs References Committee's out-of-pocket expenses inquiry, the Department of Health explained that it produced 'estimates', not 'modelling' for the government of two academic papers, the RAND study and the Keel and Hillberg paper. The latter paper is a meta-analysis of a 'range of co-payments which have been introduced in a variety of countries around the world and what their effects have been'. The department did recognise that each health system is unique, and that the Australian system is quite unique, as are some of the issues it faces,[12] which calls into question the application of the papers' findings to an Australian policy context. Further, the Department also admitted that '[it] did not make estimates about impacts [of $7 co-payments] on emergency departments.'[13]

3.20 The committee is surprised at the Department's use of papers analysing overseas jurisdictions as evidence of modelling having been undertaken for the introduction of the $7 co-payments. Given the uniqueness of the Australian health system, it is surprising that overseas models are being used, especially given the Department's own admission that it had not undertaken modelling of the compounding effects of the $7 co-payment on emergency departments. The impacts on NSW and South Australia's emergency departments are detailed below.

Co-payments—ideologically driven and not evidence-based

3.21 The committee heard evidence that the government's proposed $7 co-payment and the increased PBS co-payment were not based on credible evidence. The policy originates from Mr Terry Barnes, a former policy adviser to the Hon Tony Abbott MP when the Prime Minister was Health Minister and later Opposition Leader. It was picked up by the government's National Commission of Audit and subsequently adopted by the government in the 2014-15 Budget. It was described by its author as 'sending a price signal to people, there's no doubt about that... the level of co-payment

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11 AIHW, *Health expenditure Australia 2012-13*, 23 September 2014, www.aihw.gov.au/publication-detail/?id=60129548871.

12 Mr Bartlett, Department of Health, *Senate Community Affairs References Committee Out-of-pocket costs in Australian healthcare inquiry*, *Committee Hansard*, 29 July 2014, p. 58.

13 Mr Bartlett, Department of Health, *Senate Community Affairs References Committee Out-of-pocket costs in Australian healthcare inquiry*, *Committee Hansard*, 29 July 2014, p. 59.

we're suggesting is equivalent to a hamburger and fries or a schooner of beer, it's not a great deal.'[14]

3.22 However the AMA, amongst others, has criticised the policy as both ideologically driven and not based on credible evidence:

> The AMA is concerned that the Government's Budget measures therefore appear to ignore systemic opportunities to address health care spending. They appear to be driven by ideology rather than based on evidence and have not been developed within a vision and framework of systemic reform.[15]

3.23 This view was supported by submitters such as the Queensland Nurses' Union, which stated:

> This federal budget marks the beginning of a wide-ranging agenda to change Australia's health system through economic policy based on neo-liberal principles of small government and large private interests. An outdated ideology that finds its origins in the 1980s moves to dismantle the mixed economy and reduce the role of government informs the audit commission's reports and thus underpins the 2014 federal budget.[16]

No consultation

3.24 The committee was consistently told that the government had either failed to, or deliberately avoided consulting on the $7 co-payments prior to their announcement in the 2014-15 Budget. The following organisations/sectoral interests confirmed that the government had not consulted with them prior to Budget night:

- Australian Medical Association Tasmania[17]
- Royal Australian College of General Practitioners[18]
- Royal Australasian College of Physicians[19]
- The Hon. Jay Weatherill, Premier, South Australian Government[20]

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14 Mr Terry Barnes, Australian Centre for Health Research, *Former Abbott adviser flags possible fees to visit hospital emergency wards*, ABC website, 30 December 2013, www.abc.net.au/news/2013-12-30/emergency-room-fee-to-match-doctors-fees/5178156 (accessed 3 November 2014).

15 Australian Medical Association (AMA), *Submission 48*, p. 5.

16 Queensland Nurses' Union, *Submission 44*, p. 3.

17 Associate Professor Timothy Moore Greenaway, State President, Australian Medical Association Tasmania, *Committee Hansard*, 3 November 2014, p. 37.

18 Dr Bastian Seidel, Deputy Chair, Tasmanian Faculty, Royal Australian College of General Practitioners, *Committee Hansard*, 3 November 2014, p. 19.

19 Professor Nicholas Talley, President, Royal Australasian College of Physicians, *Committee Hansard*, 8 October 2014, p. 8.

20 The Hon. Jay Weatherill, Premier, South Australian Government, *Committee Hansard*, 28 August 2014, p. 3.

- The Grattan Institute[21]
- Australasian College of Emergency Medicine[22]
- Australian Diagnostic Imaging Association[23]
- Residential aged care[24]
- Ambulance Employees Australia of Victoria[25]
- Australian Nursing and Midwifery Federation (SA Branch)[26]
- Aboriginal Health Council of South Australia[27]
- Health Consumers Alliance of South Australia[28]

Minimal modelling of impact on disadvantaged and young Australians

3.25 The committee is particularly concerned at the lack of data or modelling from the Department of Health relating to the numbers of eligible concession card holders and under 16 year olds who would not be liable to pay the $7 co-payment after 10 visits. The complicated system of visit caps and patient co-payments has demonstrated that the Department of Health either has no data to clearly explain the proportion of the Australian population that would pay the $7 co-payment for the first 10 visits or is refusing to release it.

3.26 In Senate Estimates hearings, the Department of Health was asked to quantify the total number of concession card holders who will meet the cap:

> There were 7.8 million people who had a concession card at any time during the 2012-13 financial year who had at least one Medicare service in that year. Of these people, 3.1 million (40 per cent) had more than 10 in-scope services (that is, out-of-hospital services for which the patient

21 Dr Stephen Duckett, Director, Health Program, Grattan Institute, *Committee Hansard*, 8 October 2014, p. 35.

22 Dr Simon Antony Judkins, Victorian Councillor, Australasian College of Emergency Medicine, *Committee Hansard*, 8 October 2014, p. 23.

23 Ms Pattie Beerens, Chief Executive Officer, Australian Diagnostic Imaging Association, *Committee Hansard*, 8 October 2014, p. 43.

24 Mr Stephen Burgess, Innovation, Policy and Research Officer, Benetas, *Committee Hansard*, 7 October 2014, p. 11.

25 Mr Danny Hill, Assistant Secretary, Ambulance Employees Australia of Victoria, *Committee Hansard*, 7 October 2014, p. 19.

26 Adjunct Associate Professor Elizabeth Dabars, AM, CEO and Secretary, Australian Nursing and Midwifery Federation (SA Branch), *Committee Hansard*, 9 October 2014, p. 32.

27 Mr Shane Mohor, Acting Chief Executive Officer, Aboriginal Health Council of South Australia, *Committee Hansard*, 9 October 2014, p. 45.

28 Ms Stephanie Miller, Executive Director, Health Consumers Alliance of South Australia, *Committee Hansard*, 9 October 2014, p. 65.

contribution measure applies). Some of these services are not currently bulk billed.[29]

3.27 The committee is disappointed that the Department was unable to provide detailed modelling of the expected numbers of patients who would be required to pay the $7 co-payment following its introduction.

Committee comment

3.28 Given that this was to be a government of no nasty surprises,[30] it is of great concern that a policy of the scale and impact of that proposed in the $7 co-payment was done without consultation with consumers of the healthcare sector and was not revealed to the Australian public prior to the 2013 election.

Negative impacts

3.29 Witnesses' concerns about the negative impacts of the $7 co-payments and the increased PBS co-payment were a regular feature of the evidence put before the committee. They can be divided into the following five areas:

1) **Undermining universality** – the diminution of the principle on which universal healthcare and Medicare is based.
2) **Inequity** – concern that the patient co-payments will be detrimental to the health and life opportunities of the most vulnerable sections of the Australian community.
3) **Economic** – cost shifting to the states via increased emergency department visits and public hospital admissions as well as cost shifting to the Australian community through payment of the patient co-payments. Concerns were also raised about the potential for the patient co-payments to lead to higher system-wide healthcare costs as a result of increased reliance on highly expensive hospital treatment over more cost-effective primary care.
4) **Health prevention and management** – that the patient co-payments will delay or prevent people seeking primary healthcare from GPs, pathology and imaging specialists, and by filling prescriptions and thus fail to treat preventable illnesses or make early interventions. Concerns were also raised that the patient co-payment would impose additional cost burden on patients managing chronic disease, leading to worse health outcomes.
5) **Administration** – how the $7 co-payment will operate in practice; what services will attract the co-payment; how can it be collected; additional costs for administration and collection of the co-payment on GPs and other health providers.

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29 Answer to Question on Notice, Senate Community Affairs Legislation Committee, Budget Estimates 2014-15, SQ14-000985, p. 1.

30 www.smh.com.au/business/federal-budget/abbott-pledges-no-nasty-surprises-no-lame-excuses-20130516-2jpen.html (accessed 20 November 2014).

6) **Links to the Medical Research Future Fund** – widespread support for increased investment in medical research but not via the proposed $7 co-payment.

Undermining universality

3.30 The risk posed by the government's proposed patient co-payments to Australia's system of universal healthcare was a grave concern to many submitters. The St Vincent de Paul Society explained to the committee the government's obligation to provide universal healthcare:

> …there is an internationally recognised right to health. Moreover, Australia has ratified international human rights treaties which include sustaining this right. The provision of universal healthcare therefore plays an important component of our government's legal, moral, and social responsibility to its citizens. The Medicare system has been providing this universal healthcare for decades, which has gone a long way in preventing major health disparity in our communities. This has been particularly important for those who are socioeconomically disadvantaged or marginalised, and who cannot afford alternative (private) health services.[31]

3.31 The Public Healthcare Association of Australia raised similar concerns:

> Universal access to primary health care based on need and not on the ability to pay is a fundamental human right. Providing access to primary health care is an essential role of Government and not a cost that can be shifted onto those in the community who least can afford to pay.[32]

Inequity

3.32 Closely linked to the question of universality of healthcare coverage is the inequity in access to healthcare for disadvantaged sections of our society.

3.33 An official from the South Australian Department of Health and Ageing effectively summarised the concerns expressed by many witnesses about the disproportionate impact the $7 co-payment will have on Australia's most vulnerable:

> South Australia is significantly concerned about the disproportionate detrimental impact the co-payments will make on the most vulnerable people in the community, particularly Aboriginal and Torres Strait Islanders, older people, those with low socioeconomic status and those with chronic conditions needing primary management in order to avoid hospital. It is concerning that these at-risk patients may see the co-payment, in particular, as a prohibitive barrier and be discouraged from seeing their doctor or filling their prescriptions. In turn, these conditions could worsen or place increasing pressure on our hospitals but also impact on quality of life and health outcomes.[33]

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31 St Vincent de Paul Society, *Submission 22*, p. 3.

32 Public Health Association of Australia, *Submission 76*, p. 8.

33 Mr Steven Archer, Deputy Chief Executive, Finance and Business Services, Department for Health and Ageing, South Australia, *Committee Hansard*, 9 October 2014, p. 4.

3.34 The Dieticians Association of Australia (DAA) provided a starting point for the categories of vulnerable communities that will have their access to healthcare diminished by the $7 co-payment:

> DAA is concerned that additional costs will further disadvantage vulnerable groups in the community. People experiencing socioeconomic difficulties, Indigenous Australians, people living with mental illness, people with disability, and rural and remote residents shoulder a greater chronic disease burden. Yet they have poorer access to comprehensive healthcare through Medicare with a limit of five face-to-face allied health visits under MBS Chronic Disease items per year.[34]

3.35 Similarly, ACOSS provided this overview of the types of groups that will experience further access issues because of the proposed $7 co-payments:

> We are also concerned that proposals may further disadvantage groups in the community that already are not sharing in the good health experienced by most Australians. Particular groups in the community including Aboriginal and Torres Strait Islander communities, those with chronic illnesses, and people with disabilities and mental health issues need to be supported to access the services they need, rather than facing additional barriers to access.[35]

3.36 Benetas, as a large provider of aged care services supporting over four thousand older people requiring aged care, noted there were significant issues with the imposition of a $7 co-payment on the ability of older Australians to obtain advice and treatment for medical conditions. Benetas's submission noted:

> Older people consistently identify access to affordable and quality health care services as an area of concern. Chronic disease and poorer health status preferentially affects those on the lowest incomes and those that live in areas of concentrated disadvantage.[36]

3.37 Benetas argued that older people with multiple chronic medical conditions should be encouraged to seek primary medical care, as early treatment and management would reduce admissions for acute hospital care.[37] This would result in significant savings to the Commonwealth, and corroborates evidence from multiple witnesses that demonstrates that preventative health programs are effective in reducing both hospital admissions and costs.

3.38 Organisations representing young people also raised objections to the introduction of the $7 co-payment, suggesting that the government's cost cutting agenda would further disadvantage young people, who already experience significant cost barriers to obtaining medical care:

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34 Dieticians Association of Australia, *Submission 59*, p. 2.

35 Australian Council of Social Service, *Submission 67*, p. 2.

36 Benetas, *Submission 42*, p. 2.

37 Benetas, *Submission 42*, p. 2.

> YACSA [Youth Affairs Council of South Australia] strongly opposes the government's transparent cost-cutting agenda as set out in the 2014 budget. The changes proposed by the Federal Government including the Medicare and PBS medications co-payments, if undertaken in the current and proposed income and social service support environment, has the potential to increase disadvantage and negative health impacts amongst already vulnerable young people.[38]

3.39 The National Aboriginal Community Controlled Health Organisation (NACCHO) also argued for more investment in preventative treatments, arguing benefits to Aboriginal and Torres Strait Islander people would be significantly enhanced through the provision of comprehensive primary health care. Its submission also strongly opposed the imposition of additional cost barriers to accessing medical services, arguing:

> ...the form of a GP co-payment and a rise in the cost of accessing PBS medicines...would discourage Aboriginal and Torres Strait Islander patients seeking preventative health care and proactively managing chronic disease.[39]

3.40 NACCHO noted that Aboriginal and Torres Strait Islander people already delay GP treatment for preventable illness. This trend was expected to worsen if the government proceeded with a $7 co-payment:

> On average 12 per cent of Aboriginal Australians defer GP visits for more than a year because of costs. This is more than twice the rate of the general population. Aboriginal Australians also represent a disproportionately high number of 'potentially avoidable GP-type presentations' to hospital outpatient centres, particular in major cities and inner regional centres. Additional costs to accessing healthcare [a $7 co-payment] would result in further delays to seeking care, resulting in greater health risks to patients.[40]

3.41 The Aboriginal Health Council of South Australia supported the arguments made by NACCHO. Mr Shane Mohor, Acting Chief Executive Officer of the Aboriginal Health Council of South Australia told the committee that the $7 co-payment would have severe flow on effects across the whole community:

> When we look at the current health status of our community we are at the lowest end of the margin and by not accessing GPs and by not seeking preventative health care, you are going to increase the rates of illnesses and morbidity and mortality rates will increase. So there are significant flow-on effects…The impact that this will have on the youth right across Australia, whether you are Aboriginal or not, is an unforeseen example of not a measured response to a budget cut which could see youth crime increase to pay for a GP visit. It will potentially have non-adherence to medication or prescribed medication based on the cost…We already have elderly who are

38 Youth Affairs Council of South Australia Inc, *Submission 38*, p. 2.

39 National Community Controlled Health Organisation, *Submission 86*, p. 3.

40 National Community Controlled Health Organisation, *Submission 86*, pp 4–5.

> noncompliant with medications because they forgo their medications to provide food and clothing to their grandchildren, as opposed to going to a GP for their own medical problems.[41]

3.42 The Aboriginal Health Council of Western Australia argued strongly for the government not to implement the $7 co-payment:

> For a government who has repeatedly made verbal expressions of commitment to improving the health and living standards of Australia's Aboriginal people, such budget changes not only fail to reflect these expressed commitments, but will lead to catastrophic outcomes for Australia's first people. AHCWA urges the federal government to recognise its obligations under internationally recognised human rights conventions, to which it is signatory, and to work closely with Aboriginal communities and service providers, particularly ACCHS, to close the unforgiving gap between the health outcomes of Aboriginal and other Australians.[42]

3.43 While noting that access to health services is a human right, St Vincent de Paul Society submitted that research into social determinants of health has concluded that health outcomes are often closely intertwined with socio-economic status.[43] Its submission noted:

> Increasing the cost of healthcare must also be seen against the background of other financial pressures on the most disadvantages. Housing affordability is decreasing, income support payments from the government are decreasing (either directly or due to lack of indexation), the cost of education is increasing, and utility prices are increasing far above inflation. Adding further barriers to healthcare will not just add to, but will compound, these issues. The costs will be severely detrimental to the wellbeing of those who are already doing it tough.[44]

3.44 The Australian Federation of AIDS Organisations (AFAO) argued that Australians living with HIV/AIDS would also be disadvantaged by the introduction of cost barriers to medical care services. AFAO's submission argued that the $7 co-payment would undermine years of work undertaken by previous Federal and State Governments in formulating a comprehensive and effective response to blood borne viruses in Australia:

> The introduction of any new mandatory healthcare co-payments and the increase of any current healthcare co-payments would undermine prevention efforts by imposing perceived or real cost barriers to testing for HIV (and for other BBVs and STI tests). Initiatives to address barriers to accessing testing services and thereby enhance HIV testing rates and frequency have been carefully framed over the last few years, under the

41 Mr Shane Mohor, Acting Chief Executive Officer of the Aboriginal Health Council of South Australia, *Committee Hansard*, 9 October 2014, pp 44–45.

42 Aboriginal Health Council of Western Australia, *Submission 63,* p. 13.

43 St Vincent de Paul Society, *Submission 22*, p. 2.

44 St Vincent de Paul Society, *Submission 22*, p. 4.

> Sixth HIV Strategy and enhanced under the new Strategy [2014-17], with Commonwealth resources committed to the rollout of rapid HIV testing services in community settings for gay men and other men who have sex with men. Essential to marketing these services is that they are free of charge; any perception that the introduction of mandatory co-payments would mean that all BBV and STI tests would incur a co-payment would necessarily undermine these efforts.[45]

3.45 For Australia's most vulnerable groups, there are already numerous barriers to accessing healthcare. The committee consistently heard evidence that the $7 co-payment and the increased PBS co-payment would add an additional damaging cost barrier and act as a disincentive for people to seek medical assistance and to access medicines under the PBS. For instance Mr Bonner, the Director of Operations and Strategy, Australian Nursing and Midwifery Federation (SA Branch), argued that Australia was already behind other countries in terms of healthcare costs impacting on disadvantaged groups:

> The Commonwealth Fund study [*How the Performance of the U.S. Health Care System Compares Internationally*] showed that Australia was the third worst of the 11 countries in the study. [Australia] ranked only really behind the US and the Netherlands in relation to prescription costs impacting on low-income people. So this idea that we need to put more costs into the system to disincentivise people from unnecessarily taking drugs or turning up at GP services is just clearly a nonsense because we are already up there amongst the most highly hit for co-payments, whether you are talking about scripts, GPs or other tests…
>
> It is frightening when you think that one in six people of below-average income is skipping, already, some or all of their prescription medications. If you are getting that level of noncompliance now, what would that look like if you increased by another $7 the level of the price of each of those scripts?[46]

3.46 The perspective from Victoria's frontline of hospital care, the Ambulance Employees Australia (Victoria), was that disadvantaged groups would be the first to be negatively affected by the $7 co-payment and this would result in a reliance on hospital care rather than less costly primary care:

> So much of paramedics' work is [generated] because patients feel they do not have any other alternative. It could be that they perhaps do not understand the system. People of limited English may not understand the health system and what is available to them. They do not understand about preventive care and things like that. As I said, we need to see people being comfortable and having GPs and other health providers more accessible to people, particularly in low socioeconomic areas. There needs to be a way of

45 Australian Federation of Aids Organisations, *Submission 108*, p. 2.

46 Mr Rob Bonner, Director, Operations and Strategy, Australian Nursing and Midwifery Federation (SA Branch), *Committee Hansard*, 9 October 2014, p. 34.

> bringing people into the system, trusting the system and building up that trust. To me, the co-payment just puts another barrier in front of that.[47]

Negative economic impacts

3.47 The government has stated its intention in introducing the $7 co-payments is to create a 'price signal' to reduce the number of visits to GPs and for out-of-hospital pathology and diagnostic imaging services.[48] The Department of Health informed the committee that it anticipates a one per cent reduction (equivalent to approximately 1 million fewer visits) in the number of GP attendances in the first 12 months of the $7 co-payments.[49] The committee is aware of anecdotal evidence indicating an immediate decline in GP visits following the Budget announcement due to patients' misunderstanding that the $7 co-payment was already in force.[50]

Price signals inappropriate for primary care

3.48 Experts in health economics have argued that price signals are inappropriate and ineffective in the context of primary care:

> Price signals work by encouraging consumers to think about whatever it is they are about to buy, and whether it's worth the cost. They assume some consumer knowledge of the product, and its value. We rely on prices right through the economy to temper consumption.
>
> But this economic common device is inappropriate for primary care because health care is not a commodity or luxury service; it is an essential service that can create much greater downstream costs if not used at the right time.
>
> Evidence from Australia and other countries shows that low-income groups are much more likely to rely on general practitioners than visit more expensive specialists. But it is this less expensive and more accessible (and accessed) service that's being targeted by the government's proposal.
>
> The chairman of the National Commission of Audit, the treasurer and the health minister have all claimed that Australians go to the doctor too often. They suggest the introduction of a price signal for health in the form of co-payments will only reduce trivial visits.

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47 Mr Danny Hill, Assistant Secretary, Ambulance Employees Australia of Victoria, *Committee Hansard*, 7 October 2014, p. 18.

48 The Hon Peter Dutton MP, Minister for Health, *Address to Australian Medical Association National Conference*, 23 May 2014.

49 Mr Richard Barlett, Acting Deputy Secretary, Department of Health, *Committee Hansard*, 8 October 2014, p. 56.

50 ABC News, *GP co-payment proposal causing a drop in visits to the doctor, AMA says*, 23 May 2014, www.abc.net.au/news/2014-05-22/visits-to-gp-fall-after-co-payment-budget-announcement/5469642 (accessed 5 November 2014).

> …Co-payments cannot operate as an effective price signal if people can't judge the quality of what they're buying. They will simply stop going if they cannot afford to pay.[51]

3.49 The need for price signals in primary health care has been much criticised since the $7 co-payment was announced in the 2014-15 Budget. Ms Carter from the Victorian Medicare Action Group (VMAG) was one witness who discussed the irrationality of a price signal on access to primary health:

> In terms of price indicators, it is very clear from the patterns of access to GPs that co-payments are not effective in either deterring overuse of GP services or encouraging use of necessary health services by the people who most need them. I note that the report of the Senate committee [inquiring into out-of-pocket expenses] suggests that at least six percent of the population are already deferring access to general practice because of the costs involved in accessing health care—that may not be co-payments for the GP service but other costs—and that the most marginalised, Indigenous people, are 12 percent more likely not to access general practice costs and in fact to defer them up to a year, according to the data in the [out-of-pocket expenses] report. It is a very crude instrument for dealing with the subtle nuances—and the not-so-subtle nuances, I guess—of our health system, and it is not very creative.[52]

Cost-shifting to the states

3.50 Other witnesses argued that an unintended consequence of the $7 co-payment would be to shift the cost of treatment from primary health to hospitals and so from the federal government to the states. This position was not declared prior to the federal election of 2013. Professor Dabars, CEO of the Australian Nursing and Midwifery Federation (SA Branch) explained that the $7 patient co-payment would cause people to defer primary health care with the result that treatable conditions would eventually require hospital care:

> …the introduction of co-payments for a range of health services—GP visits, pathology tests, radiology services—and the increases in pharmaceutical payments will, in our submission, likely lead to those people most in need of attending those services either avoiding them or delaying seeking care due to costs. In addition to the personal and unintended social and economic impacts that co-payments will have, they will add to the cost of our healthcare system over time. People avoiding visiting the GP and whose health conditions worsen will ultimately attend the hospital emergency department acutely unwell. People taking multiple medications for chronic health conditions and who become partially or wholly noncompliant with those directions again will become more unwell

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51 Professor Jane Hall, Director, Centre for Health Economics Research and Evaluation, University of Technology, Sydney and Richard De Abreu Lourenco, Research Fellow, University of Technology, Sydney, *GP co-payments: why price signals for health don't work*, 10 July 2014, http://theconversation.com/gp-co-payments-why-price-signals-for-health-dont-work-28857, (accessed 4 November 2014).

52 Ms Jane Carter, Spokesperson, VMAG, *Committee Hansard*, 7 October 2014, p. 3.

> and require additional services. Those costs will impact the most vulnerable in our community: those on benefits or pensions, the lower paid and especially those with families, but also, research suggests, disproportionately on Indigenous people, on women, on the elderly and on those with chronic diseases such as asthma or mental health conditions.
>
> I noticed you were talking earlier about studies that are available. There was a study undertaken by the Commonwealth Fund, reported in June 2014, [*How the Performance of the U.S. Health Care System Compares Internationally*] that in below average income households 14 per cent of people had not seen a doctor for a medical problem in the previous year, and in above average households the result was five per cent. Fourteen per cent of below average income households had avoided or skipped medications, while the figure for above average income people was eight per cent.[53]

3.51 In a similar vein, Professor Mike Daube, Curtin University, Perth, and former head of the WA Health Department, stated:

> I also note that I have concerns about the proposed co-payment scheme. Others with more expertise in that area will have spoken with you and will have made submissions. From my perspective, I have to say, firstly, I simply do not understand the rationale for it and, secondly, I have no doubt whatever that it will increase the burdens on the states and territories, everything from increased pressures on [Emergency Departments] to the flow-on there—why would you not go to an [Emergency Department] if you do not have to pay for it, you just have to wait a while?[54]

3.52 Several state governments have estimated the increased pressure on emergency departments and hospital admissions resulting from the $7 co-payments. For example a preliminary study conducted by the NSW Health Department shows an expected increase of 500 000 people visiting the state's emergency departments if a $7 co-payment was enforced.[55] This represents a 27 per cent increase from 2.6 million presentations to NSW emergency departments in 2012-13 to approximately 3.1 million per annum once the $7 co-payment is introduced. The committee notes that emergency department admissions can cost up to ten times that of a typical GP visit.[56]

3.53 Similarly concerning figures were provided to the committee by officials from the South Australian Department of Health and Ageing:

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53 Adjunct Associate Professor Elizabeth Dabars, AM, CEO and Secretary, Australian Nursing and Midwifery Federation (SA Branch), *Committee Hansard*, 9 October 2014, p. 29.

54 Professor Mike Daube, *Committee Hansard*, 10 October 2014, p. 21.

55 The NSW assessment was made on the earlier mooted figure of $6 so the 500 000 figure is likely to be a conservative estimate.

56 Daily Telegraph, *NSW emergency fears due to GP co-payment*, 8 October 2014, www.dailytelegraph.com.au/news/breaking-news/nsw-emergency-fears-due-to-gp-co-payment/story-fni0xqi3-1227084184963?nk=1a57d6e6da6b96f6fb43b8fa4a8086c0 (accessed 4 November 2014).

> Mr Archer: We are anticipating another 290,000 presentations in our emergency [departments due to the introduction of the co-payment].
>
> Senator CAMERON: So 290,000 in South Australia, 500,000 in New South Wales. New South Wales have estimated that this is a significant cost burden on hospitals. Is that the same here?
>
> Mr Archer: Absolutely, we have estimated that the cost will be $80 million.[57]

3.54 Finally on the issue of cost-shifting to the states, the government has indicated that it will allow state emergency departments to introduce a similar co-payment to prevent or reduce the flow of patients.[58] However the committee understands that many state governments have rejected this option outright.[59]

Cost-shifting to patients

3.55 In addition to the cost-shift to the states, the AMA clearly outlined the very significant costs being shifted by the government from the 2014-15 Budget to individual patients:

> Through [the government's proposed] structural changes to Medicare and the PBS, the Government is shifting $8.4 billion of health care costs onto patients over the next four years.
>
> Assuming that the $5 rebate cut is offset by the $7 co-payment, the $2 difference imposes a further cost on patients of around $1.4 billion.[60]

3.56 Dr Stephen Duckett, Director of the Health Program at the Grattan Institute explained to the committee the risks associated with burdening patients with additional healthcare costs, which in his view was a return to the healthcare model that pre-dated Medicare:

> Certainly, we do not want a system which shifts more costs onto consumers. We do not want a system which introduces financial barriers to access so that people have to find money to see a GP, for example. We do not want systems of that kind. Certainly, I do not think Australians want that…

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57 Mr Steven Archer, Deputy Chief Executive, Finance and Business Services, Department for Health and Ageing, South Australia, *Committee Hansard*, 9 October 2014, p. 5.

58 The Hon Peter Dutton MP, Minister for Health, *Address to Australian Medical Association National Conference*, 23 May 2014, p. 3.

59 For example NSW–ABC News, *Jillian Skinner says NSW considering inviting GPs to treat patients in hospital to avoid $7 co-payment*, 17 May 2014, www.abc.net.au/news/2014-05-16/ministers-blast-federal-government-over-missing-80-billion/5458614 (accessed 5 November 2014) and South Australia–ABC News, *Senate health inquiry: GP co-payment will increase SA hospital visits 'by 290,000 people'*, 9 October 2014, www.abc.net.au/news/2014-10-09/co-payment-to-increase-sa-hospital-visits-committee-told/5801886 (accessed 5 November 2014).

60 AMA, *Submission 48*, p. 5. With respect to the $1.4 billion figure, the AMA noted that 'as the AMA does not have any information about the Government's modelling, this is a simple calculation.'

> We had a huge debate in Australia in the sixties and seventies about what sort of health system we wanted. Did we want a system where people who needed to get access to general practitioners or hospitals had to find money to do so? One of my first jobs in the health system was taking people to court to force them to pay their hospital bills… I was working in a public hospital—the Prince Henry Hospital and Prince of Wales Hospital in Sydney. This was before Medicare. I may look like I am only 35, but this was a long time ago!...
>
> This was a debate that was resolved in Australia in the seventies and eighties. It is highly undesirable to have a system where people cannot afford to go to hospital or cannot afford to go to the GP…
>
> There is word—I do not know whether it exists any more—which is 'garnishee', where we actually took almost all of their wages to pay their unpaid public hospital debts.[61]

Increase system-wide healthcare costs

3.57 Dr Stephen Duckett has detailed the false economy of the government's $7 patient co-payment proposal:

> In addition to problems of fairness, the $7 policy is probably bad economics as well. The government's modelling however has been pretty crude: all that's been announced so far is that there will be about 1 per cent fewer visits, that's a drop of about a million visits.
>
> But it's which visits are reduced that is crucial – if they are the wrong ones, health costs could go up instead of down. A GP visit costs government, as a conservative estimate, about $100, taking into account possible pathology tests or x-rays. If a person doesn't go to a GP and their condition deteriorates, they may end up in a hospital emergency department (which costs at least three times as much as a GP visit), being admitted to hospital (50 times the cost) or both.
>
> If patients make the wrong judgment call about whether to see a GP just once in every 50 times about whether they should see a GP, and they end up in hospital, then any system savings have vanished. Other costs, such as additional days off work because of worsening conditions or hospital admissions make the economics look even sicker. On top of that, some modelling suggests that waiting times in hospital emergency departments will blow out because of increased demand shifted from GPs.[62]

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61 Dr Stephen Duckett, Director, Health Program, Grattan Institute, *Committee Hansard*, 8 October 2014, pp 28–29.

62 Dr Stephen Duckett, Director, Health Program, Grattan Institute, *The Drum*, 14 August 2014, http://grattan.edu.au/news/can-the-coalitions-copayment-policy-be-repaired/, (accessed 7 November 2014).

3.58 Many other witnesses shared Dr Duckett's concerns, arguing that the impact of the $7 co-payments will lead to an overall increase in system-wide health costs.[63] A compelling example of this was provided by Mr Vahid Saberi, the CEO of Northern NSW Medicare Local:

> We did a quick calculation in terms of access to general practice. If a person goes and visits their GP once a week for a whole year, it costs $1,872 for that whole-year, every-week access. If they go to hospital once at the average rate, which is our average rate of 3½ to four days, that costs $6,200. So, you can see the difference. Everything we do is to avoid having people go to hospital, because that is where the high costs are, and to provide all the care that we can outside the hospital.[64]

3.59 Drawing on research from the United States, health policy analyst Mr Martyn Goddard confirmed that the proposed $7 co-payment would increase overall healthcare expenses and not raise any additional Commonwealth revenue:

> …it does not take very many people who need to [see a GP] and do not go and who then get sick and then have to go to hospital and have a whole complicated range of things done. As soon as you go into a hospital, the costs are hugely expensive. It does not take very many of those people to massively outweigh the people who drop in [to the GP] for a chat. We have got some data now on that from pretty well designed studies, some in this country but mostly in North America. The study of US medicare with people over 65, which was published in the *New England Journal*, found that for every dollar saved through the payment of a $7 co-payment itself or through reduced demand could be directly traced to an increase of $3.35 in patient costs…
>
> One of the things that occurred to me is that if the figure is more than about two-and-a-bit times bigger, which I suspect it might be, then because the Commonwealth funds 43 per cent or thereabouts of public hospital costs the cost to the federal budget of hospital costs is probably going to outweigh what it earns or saves through co-payments.[65]

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63 For instance Ms Julie Leete, Area Manager, Lismore, Interrelate, *Committee Hansard*, 15 September 2014, p. 34; Mrs Annette Alldrick, Secretary and Delegate, Shoalhaven Branch, NSW Nurses and Midwives' Association, *Committee Hansard*, 16 September 2014, p. 32; Mr Steven Archer, Deputy Chief Executive, Finance and Business Services, Department for Health and Ageing, South Australia, *Committee Hansard*, 9 October 2014, p. 2; Mr Darren Carr, Chief Executive Officer, Mental Health Council of Tasmania, *Committee Hansard*, 3 November 2014, p. 9; Dr Judith Watson, Chair, Tasmanian Medicare Local, *Committee Hansard*, 4 November 2014, p. 5; and Mrs Neroli Ellis, Branch Secretary, Australian Nursing and Midwifery Federation (Tasmanian Branch) *Committee Hansard*, 4 November 2014, p. 19.

64 Mr Vahid Saberi, CEO, Northern NSW Medicare Local, *Committee Hansard*, 15 September 2104, p. 23.

65 Mr Martyn Goddard, private capacity, *Committee Hansard*, 3 November 2014, p. 23.

Health prevention and management

3.60 As a barrier to accessing healthcare, the $7 co-payment is also a deterrent to people who may be seeking preventative healthcare. This is apparent from the evidence of Mr Stephen Burgess, Innovation, Policy and Research Officer of the aged care service provider Benetas, Victoria, who explained that in deciding whether to seek medical advice, people may consider cost above whether the condition requires treatment or prevention:

> The other problem with cost disincentives and barriers to people which are designed, purportedly, to reduce inappropriate use of Medicare funded services by GPs is that the appropriateness or otherwise of a medical consultation is something that can only be made in retrospect, by the doctor, after the consultation… laypeople use a very different rubric for decision making to seek health care, particularly in settings of urgency or emergency cases, and they are not driven by the clinical urgency of the program but rather their emotional reaction to the symptoms that are presenting at the time, whether or not they are in fact life threatening. In fact, there is quite poor correlation between life-threatening symptoms and people recognising how serious they are. Given that laypeople, by necessity, are not experts in health, putting a financial barrier to them accessing people who are is very counterproductive...[66]

3.61 It is clear from evidence presented to the committee that the multiple GP visits, pathology and imaging services required for the management of a chronic disease will soon cause significant cost for users of the healthcare system. Ms Carter, VMAG provided a succinct and personal example of this situation:

> My dad needs podiatry every six weeks for a severe hammer toe that impedes him in wearing shoes. But he did not get [his treatment] for a while and developed an ulcer on one of his toes. The GP told him it could result in him losing the toe without proper attention. And that would undermine his mobility, probably put him in a wheelchair faster than the direction he might be heading in…and cost the community far more than a regular podiatry visit every six weeks.
>
> Through community health services, those sorts of services, even for self-funded retirees, can be accessed relatively cheaply. But, for people who are on fixed and low incomes, even the cost of accessing those services through community health services can be significant when you add up all of the co-payments that people are confronted with, particularly as they age or if they have a chronic condition earlier in their lives.[67]

3.62 Mr Hill, Ambulance Employees Australia (Victoria) argued that the consequence of rising costs for those managing a chronic illness would be a lapse in treatment and increased hospital admissions:

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66 Mr Stephen Burgess, Innovation, Policy and Research Officer, Benetas, *Committee Hansard*, 7 October 2014, p. 8.

67 Ms Jane Carter, Spokesperson, VMAG, *Committee Hansard*, 7 October 2014, p. 6.

> There are a lot of people in the community who may have, say, a back injury, chronic pain, and they are out of work because of that injury. So they are not on a lot of money and they cannot afford to be seeing their doctor every week. Whether they go to the doctor or not depends on how much money they have in their pocket. This is just a further disincentive to keep in touch with the doctor, to keep on track with whatever medical condition it is they are dealing with. Mental health is a good example where people regularly need to see their doctors and their counsellors. Sometimes they have a GP, a psychiatrist, a psychologist, counsellors, the works. When they are not adhering to their medical schedule, that is when they fall into a bit of a pit and paramedics get called out when they are at the point of real despair.[68]

Administration

3.63 The committee also heard evidence relating to the practical implementation of collecting the co-payment. The evidence of Mr Burgess, Benetas, Melbourne, was particularly concerning as it highlights the complexities and cost implications of administration which will be needed to collect the $7 co-payment:

> Specifically to your question on the realities of making [the administration of the co-payment] work: for every client who has a scheduled GP coming that day—not to mention unscheduled GP visits from locums or for an acute problem—they will need $7 in cash sitting on the bedside table which then gets handed over to the GP, who must then write a cash receipt for it so it can be recorded in the client record and acquitted under their monthly account under client directed care. Each client is issued a monthly statement which must be accounted for to the cent. Alternatively, the $7 will need to be taken out of that client's essential pool of care funds and remitted to the GP, whose clinic then has to account for it and send a receipt back for it so it can be accounted for. The practicalities of doing that are very difficult.
>
> The overhead and staff costs are going to vastly exceed the cash amount involved, and it is a perverse incentive because the relationship is actually between the client and the general practitioner. Residential aged care is housing. All of a sudden you have the provider of the housing and the daily support services mediating the relationship with the GP. 'Will I call the GP for client X, who does not appear to be quite as well as usual? Their cognitive impairment seems a bit worse. Some of their behaviours are a little bit more extreme than normal, but they do not appear actually unwell. If I make the call then the client will be bearing the financial cost. If I do not make the call then the client bears the health risk of not receiving the medical care that they might need'—not to mention the administrative burden that sits there. It may well be that there are tensions between the provider of the residential aged-care facility and, for example, family members who might get the monthly statements and wonder where all this

68 Mr Hill, Ambulance Employees Australia of Victoria, *Committee Hansard*, 7 October 2014, p. 18.

> money has gone. 'Why did you ring the doctor for my mother when the doctor turned up and said there was nothing wrong?'[69]

3.64 The committee heard about administrative and cost burden the $7 co-payment will have on the thousands of GP practices across Australia. Dr Carlson who operates a general practice on the South Coast of NSW explained of the unexpected impacts of the $7 co-payments to small private GP practices:

> …there is not a hope in Hades of developing by July next year the software that can cope with it [the GP co-payment]—for us to have real-time information and to know, 'They have just been for an X-ray. Was that their 10th visit or not?' There is an impact upon general practice and pathology and radiology practices in terms of managing the collection of that small amount. What do we do? Put an extra secretary on? Except we are not able to afford it because we are giving up $16 out of $45 per consultation.[70]

3.65 The committee also heard evidence from the South Australian Department of Health and Ageing about the practical administrative burden of collecting a $7 co-payment. Although the response was given in the context of a state-based emergency department co-payment, which the Federal Government has promoted but the South Australian Government has firmly rejected, and although the South Australian official was cautious in his response, it shows that the significant cost burden that could potentially flow from the $7 co-payments:

> …we have not looked specifically at what the cost of administering it would be, because at this point in time we do not know how we would administer it or what we would do. The comments [that the cost of administering a $7 co-payment would be significantly more than $7] were based on the normal cost of collection for our current debtors, if you like—what that normally costs to process. It is significant. I think it is of the order of $30 per transaction, from memory. That is purely through our shared services arrangements.[71]

3.66 The administrative burden resulting from the $7 co-payment would also be felt by organisations providing Indigenous health services. The Aboriginal Health Council of South Australia told the committee that Aboriginal Australians, being amongst the lowest income section of the Australian population, would struggle to pay the $7 co-payment. In order to incentivise their community to use health services and seek early treatment, groups would have to take the co-payment cost on themselves. Ms Amanda Mitchell, Health Development Coordinator, Aboriginal Health Council of South Australia, told the committee that the issue had been raised at a roundtable with Assistant Minister for Health, Senator the Hon Fiona Nash:

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69 Mr Stephen Burgess, Innovation, Policy and Research Officer, Benetas, *Committee Hansard*, 7 October 2014, p. 10.

70 Dr Martin Carlson, Moruya General Practitioner, *Committee Hansard*, 16 September 2014, p. 10.

71 Mr Steven Archer, Deputy Chief Executive, Finance and Business Services, Department for Health and Ageing, South Australia, *Committee Hansard*, 9 October 2014, p. 6.

> This issue was brought up on that teleconference with Minister Nash and some of the CEOs of the others state affiliates mentioned some of these flow-on effects to on-the-ground services. A question was asked, 'Can't the Aboriginal people who work pay the $7 and the unemployed not pay?' That would mean the services would have to do means testing, they would have to have cash on premises. Just because an Aboriginal person works does not mean they can pay this all the time. A lot of the time we are supporting other family members, extended family. There are costs that everyone has for themselves. There was quite a bit of concern about this question when it was raised. One of the CEOs said if we do not charge the $7 it could be $350,000 per year that we would have to find out of our own money to make sure that Aboriginal people come to our service. There are extra costs that are involved in seeing patients.[72]

Links to the Medical Research Future Fund

3.67 In the 2014-15 Budget the government announced plans to establish a $20 billion Medical Research Future Fund (MRFF).[73] The government has directly linked the MRFF to the $7 co-payments, with $5 of every $7 going to the MRFF.

3.68 Witnesses to the inquiry were highly critical of the government's decision to link these two proposals. Witnesses generally expressed strong support for increased public investment in medical research, but not at the expense of burdening the most vulnerable in our community with a $7 co-payment. Professor Mike Daube, Curtin University, and former head of the Western Australian health department expressed the sentiment of many witnesses:

> …of course I strongly support medical research but I cannot see any reason to tie medical research into the co-payment process. We should be funding more medical research from other sources and there are ready-made sources. Examples would be the $14 billion or so that we get from alcohol and tobacco tax...[74]

3.69 A similar concern was expressed by the VMAG spokesperson:

> I certainly agree that there are very mixed messages about precisely what the government's motivation is [in implementing the co-payments]. Ostensibly, it was to fund this medical research fund—on the backs of the people who need the health system most. That seems extremely bizarre, particularly given that they will not benefit from this medical research fund,

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72 Ms Amanda Mitchell, Health Development Coordinator, Aboriginal Health Council of South Australia, *Committee Hansard*, 9 October 2014, p. 47.

73 Budget Paper No.2: Budget Measures – Health. www.budget.gov.au/2014-15/content/bp2/html/bp2_expense-14.htm.

74 Professor Mike Daube, Professor of Health Policy and Director, Public Health Advocacy Institute of Western Australia, Curtin University; and Director, McCusker Centre for Action on Alcohol and Youth, *Committee Hansard*, 10 October 2014, p. 21.

given that it is estimated that it will take quite a while to actually build up a significant corpus in it.[75]

Committee comment

3.70 The committee is deeply concerned by the substantial body of evidence it has received regarding the negative effects of the government's proposed $7 co-payments and increased PBS co-payment. More than 100 submitters and countless witnesses have expressed consistent and overwhelming opposition to the proposed $7 co-payments.

3.71 Grave concerns were expressed about the government's plan which was described as fundamentally undermining the principle of universal primary healthcare. In the committee's view, the government's $7 co-payment is a significant regressive step.

3.72 Perhaps the strongest objection to the government's $7 co-payment is the disproportionate impact it will have on the most vulnerable sections of the Australian community. The list of vulnerable groups ranges from the elderly to the poor, from Indigenous Australians to those in rural and remote areas, from those with chronic conditions to those with mental illnesses. These Australians will bear the brunt of the financial costs associated with the government's $7 co-payment but also will suffer worse health outcomes as a direct result.

3.73 Several significant and perverse economic outcomes were also raised as a highly problematic aspect of the government's $7 co-payment. Firstly, the tax was described by economic health experts as ineffective in the area of primary care. It cannot possibly target the GP visits, pathology and imaging services and prescription medicines that the government has described as "unnecessary" without also increasing preventable illnesses through the deferral of necessary healthcare. Secondly, it poses a substantial cost-shift from the Commonwealth Budget to state emergency departments and individual patients. In doing so it would lead to even greater pressures on already overstretched emergency departments as well as higher system-wide healthcare costs due to a greater reliance on more expensive hospital treatments.

3.74 For patients with complex chronic health conditions such as diabetes and obesity, the government's $7 co-payment will result in people delaying much needed primary care treatments. This will ultimately lead to patients needing attention for acute conditions, greater cost imposts on both the patient and the health system, and worse health outcomes for the patient and the system.

3.75 Finally, the $7 co-payment will create additional cost and administrative burdens and red tape for healthcare providers across Australia. This appears to be inconsistent with the government's mantra about reducing red tape.

3.76 Collectively, these concerns demonstrate the sheer size and scale of the impact of the government's proposed $7 co-payment.

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75 Ms Jane Carter, Spokesperson, Victorian Medicare Action Group, *Committee Hansard*, 7 October 2014, p. 3.

3.77 Accordingly, the committee makes the following recommendation.

Recommendation 1

3.78 The committee recommends that the government should immediately abandon its plan to implement the $7 co-payments.

3.79 The committee is deeply concerned by the substantial body of evidence it has received regarding the negative effects of the government's proposed patient co-payments. More than 100 submitters and countless witnesses have expressed consistent and overwhelming opposition to the proposed $7 co-payments.

Cuts to hospital funding

3.80 Many organisations and individuals have expressed frustration and disappointment at the government's announcement in the 2014-15 Budget that $50 billion would be cut from the public hospital system over ten years. Similarly, all state premiers and territory chief ministers reacted negatively to this announcement.[76]

3.81 Witnesses and submitters to this inquiry, including the South Australian Premier and the South Australian Department of Health and Ageing, the Royal College of Physicians and the Australasian College of Emergency Medicine, all relayed their strong opposition to the cuts. Many submitters and witnesses argued that the cuts would place an already overstretched public hospital system under unnecessary additional pressure.

3.82 The Premier of South Australia, the Hon Jay Weatherill detailed the severity of cuts in funding and services to his state. While acknowledging a total reduction of $80 billion in health and education funding, the Premier submitted:

> I want to direct my remarks today to essentially the federal budget and the changes in the budget which affect all states and territories, [which is] in the order of $80 billion in cuts to our state health and education systems over the next 10 years. South Australia's share of that is $5.5 billion over the next 10 years. Most of that is in health... It is $4.6 billion over the next 10 years in health. In the next four years alone, the health cuts amount to $655 million.[77]

3.83 Premier Weatherill explained that the federal government had reneged upon the previously signed health expenditure agreements between the Commonwealth and South Australian governments. These agreements, equating to funding cuts of $655 million over four years included the:

- National Health Reform Agreement;

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76 www.abc.net.au/news/2014-05-14/budget-2014-states-react-to-health-and-education-cuts/5452234) (accessed 20 November 2014).

77 Hon Jay Weatherill MHA, Premier, South Australian Government, Committee Hansard, 28 August 2014, p. 1.

- National Partnership Agreement on Improving Public Hospital Services;
- National Partnership Agreement on Financial Assistance for Long Stay Older Patients;
- Health National Partnership reward payments;
- National Partnership Agreement on Preventive Health; and
- National Partnership Agreement on Indigenous Early Childhood Development.[78]

3.84 Finally, Premier Weatherill described the frustration felt by premiers and chief ministers, who in Council of Australian Government (COAG) meetings with the Prime Minister in early May, less than two weeks before the budget, were not told of the $80 billion in cuts to state and territory governments for health and education services.[79]

3.85 In related evidence from the South Australian Department of Health and Ageing, the committee learned of the additional pressure that the announced cuts will place on public hospitals in South Australia. Mr Archer, Deputy Chief Executive Officer of the department explained that of the total $5.248 billion in the South Australian health budget, $1.5 billion is sourced from the federal government. As the federal government is a significant financial partner in the health of Australians, it was particularly difficult for the department to plan over the short term, due to the severity of the cuts:

> The federal health budget reductions will mean that South Australia will receive approximately $444 million less over the next four years for public hospital services when compared to what was published in the 2013-14 Mid-Year Economic and Fiscal Outlook. This grows to a loss of $4.6 billion over the next 10 years. These reductions relate to the cessation of funding guarantees under the National Health Reform Agreement, not increasing contributions to 50 per cent of the efficient public health service expenditure and new indexation arrangements from 2017-18 to a composite CPI and population growth.[80]

3.86 The AMA Victoria argued that the cuts would be detrimental to the Victorian health system. The AMA Victoria's analysis revealed that cancellation of the health reform agreements would result in cuts of about $676 million over the next three years.[81]The AMA Victoria's President, Dr Bartone told the committee of likely

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78 Hon Jay Weatherill MHA, Premier, South Australian Government, *Committee Hansard*, 28 August 2014, p. 1.

79 Hon Jay Weatherill MHA, Premier, South Australian Government, *Committee Hansard*, 28 August 2014, p .1.

80 Mr Stephen Archer, Deputy Chief Executive, Department of Health and Ageing, South Australia, *Committee Hansard*, p. 1.

81 Dr Anthony Bartone, President, Australian Medical Association Victoria, *Committee Hansard*, p. 38.

outcome to the Victorian public hospital system if funding uncertainty continued in the short and medium term:

> Simply there is a lot of ambiguity and uncertainty going forward. The decisions around health care need to be planned well in advance. We cannot have a system of changing or moving the chess pieces. Hospitals need to forward plan their budgets more than the current financial year. Putting the horse before the cart is only going to result in programs getting lost, elective surgery waiting lists falling apart and operating theatres being brought to a halt because suddenly they are running out of money.[82]

3.87 The AMA Victoria also gave evidence that, the federal government did not consult stakeholders or service providers prior to the removal of $50 billion from the health system, stating that there was 'zero' consultation prior to the announcement in May. Dr Bartone expressed frustration at having being 'stonewalled' by the government following the release of the National Commission of Audit report:

> Dr Bartone: There were a lot of murmurings and gestures. There was a lot of corridor discussion of what was going to happen. I heard this and I heard that, but there was no formal meeting to say what was being proposed. Our previous federal president did try to meet on many occasions to get a better understanding of what was going to be released but was stonewalled in terms of clarity about where the government was heading. We did put on record, as soon as the Commission of Audit came out with its findings, that we were opposed to even its more adventurous, shall we say, targets. We clearly put that out there at the time. We were expecting some bad news but not what we got.
>
> CHAIR: They are important numbers—zero for consultation and $50 billion for cuts over 10 years. It is a dangerous mix—is it not?
>
> Dr Bartone: Absolutely.[83]

3.88 The Australasian College of Emergency Medicine argued that continued cuts to health funding and services could result in an exodus of medical professionals overseas due to the compounding effect of additional pressures public hospitals are experiencing:

> I am saying with the budget cuts and the increasing requirement to do more with less, the impost on people's working conditions, the requirement to actually do things that are outside your ability to do—which is what is happening in the UK. I am looking at what has happened overseas and hoping that we do not go down that pathway.[84]

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82 Dr Anthony Bartone, President, Australian Medical Association Victoria, *Committee Hansard*, p. 41.

83 Dr Anthony Bartone, President, Australian Medical Association Victoria, *Committee Hansard*, p. 44.

84 Ms Alana Killen, Chief Executive Officer, Australasian College of Emergency Medicine, *Committee Hansard*, 8 October 2014, p. 20.

3.89 The Grattan Institute submitted that the government's decision to cease activity based funding and return to block funding would create incentives for the states to cost-shift back to the Commonwealth:

> I think the shift away from the shared activity based funding was a retrograde step. It had a number of attributes which you have mentioned, one of which is transparency. Importantly, from my perspective was the alignment of incentives. If the Commonwealth government were at risk of spending additional money because of hospital activity increases then it was in the Commonwealth's interest to actually improve primary care services to reduce demand on hospitals…
>
> [Shared activity based funding] gave the Commonwealth skin in the game to try to reduce public hospital expenditure. Interestingly, the budget has increase the incentives on the states to cost shift to the Commonwealth. It is the most amazingly perverse policy you could possibly imagine in that regard. It now says that there is no reward to the states for doing additional activity, so they can say, 'We will label this additional activity as Commonwealth activity,' and cost shift it.[85]

3.90 The AMA was also critical of the moves by the federal government to move away from activity based funding, arguing that block funding adjusted for population growth and CPI would result in more inefficiencies in the public hospital system:

> Activity based funding provides transparency in terms of the activities that are funded. It provides a mechanism to deal with inefficiencies in the public hospital system by enabling comparison of costs and the activities and services produced. [Activity Based Funding] classification of activities, together with the transparent application of standard costs, enables better assessment of performance and informed consideration of issues like unwarranted clinical variation.[86]

Committee comment

3.91 The committee is greatly troubled by the evidence relating to the government's cuts of $50 billion to hospitals across Australia which demonstrates the detrimental effects of these cuts on public hospital systems already under pressure.

3.92 The committee is concerned by the government's decision to renege on hospital funding agreements, the abandonment of activity based funding and the return to block funding for public hospitals. The committee strongly supports activity based funding as it incentivises system-wide efficiency improvements and minimises the cost-shifting associated with block funding.

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85 Dr Stephen Duckett, Director, Health Program, Grattan Institute, *Committee Hansard*, 8 October 2014, p. 33.

86 Australian Medical Association, *Submission 48*, p. 3.

Recommendation 2

3.93 The committee notes the evidence of the negative implications of the government's:

- **changed hospital funding indexation arrangements that will see public hospitals funded on the basis of population growth and CPI;**
- **cuts to the National Health Reform Agreements and associated National Partnership Agreements; and**
- **lack of commitment to Activity Based Funding.**

3.94 The evidence points to a significant loss of health services in Australia's public hospitals if these changes proceed.

3.95 On the basis of the evidence to the committee, the government should restate its commitment to Activity Based Funding and associated reforms.

Abolition of the Australian National Preventative Health Agency

3.96 The committee heard that investment in health promotion is both highly cost effective and relatively cheap. It has been estimated that for every dollar spent on health promotion and prevention five dollars in healthcare expenditure alone is saved.[87]

3.97 The Victorian Health Promotion Foundation observed that despite the cost effectiveness of health prevention, Australia invests just two per cent of all health expenditure in health promotion and disease prevention programs—low by international standards.[88]

3.98 The committee heard persuasive evidence from numerous submitters that the government's decision to abolish of the Australian National Preventative Health Agency (ANPHA) was a critical mistake that would result in significantly higher health expenditure over the long term. Many witnesses and submitters argued that the abolition of the ANPHA was a regressive step that ignored significant research that demonstrates the enormous financial, social and health benefits of preventative health programs.

3.99 For instance the AMA Victoria argued that as chronic disease is the driving force in healthcare funding in Australia, further cuts to health prevention programs would have a profoundly negative effect on both health and financial outcomes for Australians:

87 Dr Bruce Bolam, Executive Manager, Programs Group, Victorian Health Promotion Foundation (VicHealth), *Committee Hansard*, 7 October 2014, p. 22.

88 Dr Bruce Bolam, Executive Manager, Programs Group, Victorian Health Promotion Foundation (VicHealth), *Committee Hansard*, 7 October 2014, p. 22.

> In Australia, chronic disease is the dominant driver of health care spending. It accounts for half of all hospital costs. Further cuts to prevention and health promotion will only compound the problem. The best way to treat chronic diseases is to prevent people developing them in the first place.[89]

3.100 VMAG was also strongly critical of the abolition of the ANPHA. It argued that it would result in Australia's health system mirroring the two-tier system in the United States, and consequentially see less use of preventative health measures. VMAG argued:

> So we support a strong shift in emphasis to evidence-informed prevention and health promotion strategies. Again, things like the abolition of the Australian National Preventive Health Agency, we think, send the wrong message.[90]

3.101 The Australian Nursing and Midwifery Federation South Australia (ANMFSA) argued that the Commonwealth, through the abolition of the ANPHA and the National Partnership Agreement on Preventative Health was effectively walking away from its role in primary and preventative health care:

> Under the reform agreement, the Commonwealth was to assume a greater role for the funding of primary health services. That is a wider role than the historic federal role in the funding of primary medical services. It took the Commonwealth into a greater responsibility for funding of community based health care, particularly into the areas of multidisciplinary healthcare delivery for disease prevention and for health promotion.[91]

3.102 The ANMFSA argued that the cuts by the Commonwealth government to preventative health programs are both short-sighted and counterintuitive. It submitted that any short-term "saving" would result in a significant increase in demand in the long-term.[92]

3.103 The AMA also shared the view that the cancellation of the National Partnership Agreement on Preventative Health would result in significantly higher costs to the health system.[93]

3.104 The legislation to abolish ANPHA was defeated in the Senate on 25 November 2014.[94] Despite this, by 2 July 2014 the government had completed the

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89 Dr Anthony Bartone, President, Australian Medical Association Victoria, *Committee Hansard*, 7 October 2014, p. 37.

90 Ms Jane Carter, Spokesperson, VMAG, *Committee Hansard*, 7 October 2014, p. 2.

91 Adjunct Associate Professor Elizabeth Dabars AM, CEO and Secretary, Australian Nursing and Midwifery Federation (SA Branch), *Committee Hansard*, pp 29–30.

92 Adjunct Associate Professor Elizabeth Dabars AM, CEO and Secretary, Australian Nursing and Midwifery Federation (SA Branch), *Committee Hansard*, p 30.

93 AMA, *Submission 48*, p. 3.

94 *Journals of the Senate*, 25 November 2014, p. 1848.

transfer of staff, files and functions from ANPHA to the Department of Health.[95] The 2014-15 Budget removed ANPHA's future funding, claiming this as a "savings" measure.[96]

Committee comment

3.105 The committee is not satisfied that the abolition of ANPHA will result in any significant budgetary savings. The government has proposed that ANPHA's functions will be integrated into the Department of Health so the cost of running ANPHA's programs will still be a Commonwealth responsibility.

3.106 The committee is however persuaded by the evidence that the work of ANPHA is crucial to reducing illness in the medium and long term, and would provide significantly greater health and financial outcomes for both patients and governments. The committee notes the extensive evidence that demonstrates the positive outcomes of investments in preventative health.

3.107 The committee considers the defeat of the bill to abolish ANPHA sends a clear signal to the government of the lack of support for this measure. The committee urges the government to reconsider its proposal to abolish ANPHA.

Recommendation 3

3.108 The committee recommends that, based on the evidence before it, and the demonstrated benefits arising from the work of the Australian National Preventive Health Agency (ANPHA) and the National Partnership Agreement on Preventive Health, the government should drop its plans to abolish ANPHA and reinstate the National Partnership Agreement on Preventative Health.

95 Mr Andrew Stuart (Deputy Secretary) and Mr Nathan Smyth (First Assistant Secretary, Population Health Division), Department of Health, Senate Community Affairs Legislation Committee, *Committee Hansard*, 2 July 2014, Canberra, p. 48.

96 'Smaller Government – Australian National Preventative Health Agency – abolish' Budget Measures 2014-15 – Part 2, p. 145.