Chapter 3

Government healthcare policy and sector responses

Introduction

3.1 Since the 2014-15 Budget, government policy regarding general practice has changed five times:

- May 2014 – the 2014-15 Budget introduced the $7 co-payment on GP visits, diagnostic imaging and pathology, as well as a pause on indexation of some MBS fees.
- December 2014 – the then Health Minister, the Hon Peter Dutton MP announced that the $7 co-payment has been dropped. In its place the government introduced a package of reforms: reduction of the MBS rebate for short consultation times; a $5 co-payment with certain carve outs; and a four year extension of the previously announced indexation freeze out across all specialist and GP services under the MBS.[1]
- January 2015 – after a concerted campaign from GPs and health consumers, the newly appointed Health Minister, the Hon Sussan Ley MP dropped the short consultations policy and the $5 co-payment policy. The indexation freeze remained in place and the Minister announced her intention to consult with GPs and other stakeholders 'in order to come up with sensible options to deliver appropriate Medicare reforms'.[2] The Minister said consultations would include the need to 'insert a price signal of a modest co-payment into the health system for those who have the capacity to pay'.[3]
- March 2015 – while the Health Minister's consultations continued with little available information, primary healthcare stakeholders voice concern over the lack of detail of government policy direction prior to the 2015 Budget. The Health Minister announced that the $5 co-payment 'has been taken off the table' as it lacks broad support. But the Minister argued that expenditure on Medicare is unsustainable and 'to ensure we protect Medicare for the long-term, the Government would be proceeding with its pause on indexation

1 Mid-Year Economic Fiscal Outlook (MYEFO) 2014-15, p. 166. See also the Hon Tony Abbott MP, Prime Minister, the Hon Peter Dutton MP, Minister for Health, transcript of media conference, 9 December 2014.

2 The Hon Sussan Ley MP, Minister for Health, 'Government to consult on Medicare reform', Media release, 15 January 2015.

3 The Hon Sussan Ley MP, Minister for Health, 'Government to consult on Medicare reform', Media release, 15 January 2015.

of Medicare rebates for GP and non-GP items'.[4] During her press conference to abandon the co-payment, Minister Ley indicated ongoing interest in a price signal: 'It's definitely good policy to put the right price and value signals in health to make sure that number one people value the service they get from doctors…and also that they make that modest contribution according to their capacity to pay, and those who can pay a bit more are asked to pay a bit more. It's really that simple.'[5]

- May 2015 – the 2015-16 Budget introduced a broad ranging review of MBS items, major cuts to Flexible Funding programs, maintained the MBS indexation freeze and confirmed $57 billion cuts to public hospitals in the medium term.

3.2 The changes in government policy have been uppermost in the public debate about primary healthcare in Australia. This chapter provides a record of the public debate, as facilitated by the committee's many hearings and roundtable discussions, alongside the government's policy changes.

3.3 The chapter is divided into sections which reflect the policy announcements and major developments: May 2014, December 2014, January 2015, and March 2015. Chapter 4 examines the 2015-16 Budget health measures, with particular focus on those measures which effect primary healthcare and general practice.

3.4 As noted elsewhere in this report, due to the fluid and uncertain nature of the government's policy priorities for primary healthcare and general practice, the committee has decided not to make recommendations as part of this interim report. For this same reason the following record of the government's decisions and ensuing public debate is highly necessary.

May 2014: the 2014-15 Budget

3.5 The first patient co-payment policy was introduced in the 2014-15 Budget. The patient co-payments (comprising the $7 co-payment for GP visits, out of hospital pathology and diagnostic imaging) were raised as a key issue at every one of the committee's 15 hearings in the second half of 2014. The policy drew strong and consistent criticism across the health sector. The committee's first interim report, tabled on 2 December 2014,[6] examined the co-payment policy, amongst other issues arising from the 2014-15 Budget.

3.6 In examining the criticisms of the co-payment policy the committee also undertook to continue to monitor this issue.[7]

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4 The Hon Sussan Ley MP, Minister for Health, transcript of press conference, 3 March 2015.

5 The Hon Sussan Ley MP, Minister for Health, 'Government continues Medicare consultation', Media release, 3 March 2015.

6 *Journals of the Senate*, 2 December 2014, p. 1948.

7 Senate Select Committee on Health, *First interim report*, 2 December 2014, p. 3.

3.7 The committee noted that it was 'deeply concerned by the substantial body of evidence it has received regarding the negative effects of the government's proposed patient co-payments'. Further, 'more than 100 submitters and countless witnesses have expressed consistent and overwhelming opposition to the proposed $7 co-payments'. The committee recommended that 'the government should immediately abandon its plan to implement the $7 co-payments'.[8]

3.8 Further discussion on the $7 co-payment can be found in the committee's first interim report.

December 2014: short consultation times, $5 co-payment and indexation freeze

$7 co-payment dropped

3.9 On 9 December 2014, the Prime Minister, the Hon Tony Abbott MP, and the former Minister for Health the Hon Peter Dutton MP, announced that 'the $7 Medicare co-payment measure announced in the 2014-15 Budget will no longer proceed'.[9] Instead, the government committed to introduce a new package of changes to Medicare largely through regulation. This package included:

- a $20 reduction in the Medicare rebate for short GP consultations of less than 10 minutes;
- a $5 reduction in the Medicare rebate for non-concessional patients (the $5 co-payment); and
- a four year freeze on the indexation of Medicare fees for all services provided by GPs, medical specialists, allied health practitioners, optometrists and others until July 2018.[10]

3.10 In their joint press conference, the Prime Minister and the former Health Minister estimated that each element of the new package of changes amounted to around $1 billion. According to the Prime Minister, the overall savings projection for the new package of changes would be around $3.5 billion over the forward estimates.[11] The original $7 co-payment was expected to achieve a similar savings

8 Senate Select Committee on Health, *First interim report*, 2 December 2014, p. xix.

9 The Hon Tony Abbott MP, Prime Minister, the Hon Peter Dutton MP, Minister for Health, 'A Strong and Sustainable Medicare', Joint Press Release, 9 December 2014, p. 1.

10 The Hon Tony Abbott MP, Prime Minister, the Hon Peter Dutton MP, Minister for Health, 'A Strong and Sustainable Medicare', Joint Press Release, 9 December 2014, pp 1–2.

11 The Hon Tony Abbott MP, Prime Minister, the Hon Peter Dutton MP, Minister for Health, transcript of press conference, 9 December 2014, p. 3. It should be noted that representatives from the Department of Finance indicated at a public hearing on 5 February 2015 that the overall projected savings of the 9 December package was $3.6 billion. It should also be noted that this estimation of savings is for the package announced on 9 December 2014. The changes announced on 15 January 2015, which included the removal of the proposal for a reduced rebate for shorter consultations, was estimated by Finance officials to reduce the projected saving to $2.6 billion over the forward estimates.

figure. As with the $7 co-payment, the savings from the new package of changes would go into the Medical Research Future Fund.[12]

Changes to short GP consultation times

3.11 The MBS currently defines four levels of consultation type (Levels A to D) and sets a rebate to each level. Writing in *The Conversation* shortly after the 9 December 2014 announcement, Dr Duckett noted that a majority of consultations are under 20 minutes and so fall within Level B, which attracts a $37.05 rebate.[13] The change proposed by the government would have put a minimum time limit on Level B consultations of 10 minutes.[14] As a result, any consultation under 10 minutes would then attract a Level A rebate of $16.95. Dr Duckett described the effect of the change to consultation times:

> This change will dramatically reduce the rebate for those shorter consultations, from $37.05 to…$16.95 for general patients. Again it is highly likely that GPs will pass on $20+ gap to patients. The $5 co-payment has quickly morphed into a $25 one.[15]

3.12 The former Health Minister stated that the reduced rebate for short consultations would:

> …ensure that Medicare expenditure more accurately reflects the time a GP spends with a patient. It encourages a shift away from 'six minute medicine' so that appropriate, comprehensive care is better rewarded over patient throughput.'[16]

3.13 At the press conference announcing the new package of Medicare changes, the former Health Minister elaborated on the meaning of 'six minute medicine'. The Minister argued that the rebate change for short consultations would encourage GPs not to 'churn people through':

> The only other point that I'd make is about seven out of 10 non-concessional patients at the moment, so seven out of 10 people without a pension or a concession card, are bulkbilled and this is the element around the six-minute medicine. We think the change in the way in which the [Level] A and B can be charged, so having a minimum of 10 minutes before they can charge for a level B consultation, that that will concentrate a lot of the doctor's effort on those who are most in need of help, those with

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12 The Hon Tony Abbott MP, Prime Minister, the Hon Peter Dutton MP, Minister for Health, 'A Strong and Sustainable Medicare', Joint Press Release, 9 December 2014, p. 2.

13 Dr Stephen Duckett, 'GP co-payment 2.0: a triple whammy for patients', *The Conversation*, 11 December 2014.

14 The Hon Tony Abbott MP, Prime Minister, the Hon Peter Dutton MP, Minister for Health, 'A Strong and Sustainable Medicare', Joint Press Release, 9 December 2014, p. 2.

15 Dr Stephen Duckett, 'GP co-payment 2.0: a triple whammy for patients', *The Conversation*, 11 December 2014.

16 The Hon Tony Abbott MP, Prime Minister, the Hon Peter Dutton MP, Minister for Health, 'A Strong and Sustainable Medicare', Joint Press Release, 9 December 2014, p. 2.

> chronic diseases. It will skew the finances, if you like, when the doctors are considering this, towards spending more quality time with patients as opposed to just churning people through, so there are a number of benefits out of what we propose.[17]

3.14 According to data collected by the University of Sydney's Family Medicine Research Centre, approximately one-quarter of all consultations billed to Medicare in 2013-14 lasted less than 10 minutes.[18]

3.15 The Prime Minister estimated that the rebate change for short consultations would create savings 'in the order of $1 billion'.[19] Regulations were formalised by the former Health Minister in mid-December 2014 which would have brought the short consultations change into effect on 19 January 2015.

$5 co-payment

3.16 The revised co-payment announced in December 2014 reversed several unpopular aspects of the original version. Unlike the $7 co-payment policy, the new $5 co-payment would not apply to diagnostic imagining and pathology services.[20] In response to criticisms about the disproportionate impact of the $7 co-payment on disadvantaged groups, the revised $5 co-payment would not apply to the following vulnerable groups:

- Pensioners
- Concession card holders
- Children under 16 years of age
- Veterans for services funded through the Department of Veterans' Affairs
- Attendances at residential aged care facilities
- GP mental health plans
- GP management plans[21]

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17 The Hon Tony Abbott MP, Prime Minister, the Hon Peter Dutton MP, Minister for Health, transcript of press conference, 9 December 2014, p. 4.

18 Britt H, Valenti L, Miller G, Debunking the myth of general practice as '6 minute medicine' University of Sydney 2014, http://sydney.edu.au/medicine/fmrc/beach/bytes/BEACH-Byte-2014-002.pdf. According to this study about 35 million GP consultations of the total 134 million lasted less than 10 minutes.

19 The Hon Tony Abbott MP, Prime Minister, the Hon Peter Dutton MP, Minister for Health, transcript of press conference, 9 December 2014, p. 5.

20 The Hon Tony Abbott MP, Prime Minister, the Hon Peter Dutton MP, Minister for Health, 'A Strong and Sustainable Medicare', Joint Press Release, 9 December 2014, p. 2.

21 Government Factsheet 'A Strong and Sustainable Medicare: How is the co-payment changing?', Department of Health, December 2014, p. 1.

3.17 In announcing the new policy, the former Health Minister argued that without the $5 rebate reduction and the $5 co-payment, Medicare would become unsustainable:

> Medicare will not survive in the long term without changes to make it sustainable…
>
> In the last year alone, 275 million services were provided free to patients. That's three out of every four Medicare services being bulk billed.
>
> These changes will contribute more than $3 billion to the Medical Research Future Fund which will fund the research needed to find cures to the health problems of today.[22]

3.18 The practical effect of the policy would have been to reduce Medicare funding for GP services, unless individual GPs chose to pass on the cost to non-concessional patients, an estimated 70 per cent of whom are normally bulk billed:

> Currently, 70 per cent of non-concessional patients are bulk billed. For doctors who choose to continue to bulk bill non-concessional patients, they will receive $5 less for eligible services.[23]

3.19 In their press conference of 9 December 2014, both the former Health Minister and the Prime Minister stated that the co-payment, if passed onto patients, would be no more than five dollars. For example, the Prime Minister explained:

> …this is a question for the doctors and what we're saying to the doctors is for adults who aren't on concession cards we don't think it's unreasonable for you to charge a co-payment and what we want to do by legislation is enable them to directly claim the rebate, provided the co-payment they charge for that particular class of patients is $5 or less.[24]

3.20 The assertions by the government that GPs would have a choice as to whether to pass on the $5 co-payment, and that the co-payment would only amount to five dollars were widely criticised. The government's argument that non-concessional patients should be easily able to afford a co-payment has also drawn substantial criticism.

Government's extended indexation freeze

3.21 Mentioned almost in passing at the 9 December 2014 press conference was a further measure aimed at reducing Medicare funding. The Prime Minister briefly added at the end of his description of the consultation time changes and the

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22 The Hon Tony Abbott MP, Prime Minister, the Hon Peter Dutton MP, Minister for Health, 'A Strong and Sustainable Medicare', Joint Press Release, 9 December 2014, p. 2.

23 Government Factsheet, 'A Strong and Sustainable Medicare: What it means for doctors', Department of Health, December 2014, p. 1.

24 The Hon Tony Abbott MP, Prime Minister, the Hon Peter Dutton MP, Minister for Health, transcript of press conference, 9 December 2014, p. 3.

$5 co-payment, that the government would extend the freeze on indexation of Medicare rebates over the forward estimates.[25]

3.22 In practical effect, this measure means the freezing of Medicare fees for services provided by all GPs, medical specialists, allied health practitioners, optometrists and others at the current level until 2018.[26] Justification for the government's extended indexation freeze can be found in a factsheet produced by the Department of Health in December 2014:

> The previous Government, in the 2013-14 Budget, announced a pausing of indexation of rebates – changing the indexation period from November to July each year. In the 2014-15 Budget, the Government paused specialist rebates for two years which commenced on 1 July 2014.
>
> Rebates for Medicare-eligible consultations and procedures performed by GPs, specialists, allied health professionals, nurse practitioners, midwives and dental surgeons will now be paused until 1 July 2018 to ensure Medicare remains sustainable.
>
> Pathology and diagnostic imaging are not currently indexed and therefore not affected by this measure.[27]

3.23 The 2013-14 Budget had introduced the MBS short-term indexation measure as a means of realignment of the indexation with the financial year:

> The Government will realign the indexation of Medicare Benefits Schedule (MBS) fees to the financial year in line with many other Government programs. MBS fees, which are currently indexed on 1 November each year, will be indexed on 1 July each year. The next indexation date will be 1 July 2014. This measure will result in savings of $664.4 million over four years.[28]

3.24 The Prime Minister stated that the three measures announced—the $20 reduced rebate for short consultation times, the $5 rebate cut/$5 co-payment, and the extended indexation freeze—amounted to a saving of around one billion dollars each over the forward estimates.[29] This was, the Prime Minister advised, a collective saving of around $3.5 billion in comparison to the $3.6 billion anticipated from the measures in the 2014-15 Budget.

3.25 Department of Health figures released through a Freedom of Information request by *The Australian* show that the extension of the indexation freeze announced

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25 The Hon Tony Abbott MP, Prime Minister, the Hon Peter Dutton MP, Minister for Health, transcript of press conference, 9 December 2014, p. 2.

26 The Hon Tony Abbott MP, Prime Minister, the Hon Peter Dutton MP, Minister for Health, 'A Strong and Sustainable Medicare', Joint Press Release, 9 December 2014, p. 2.

27 Government Factsheet, 'A Strong and Sustainable Medicare: What it means for doctors', Department of Health, December 2014, p. 2.

28 2013-14 Budget, Budget Paper 2, p. 177.

29 The Hon Tony Abbott MP, Prime Minister, the Hon Peter Dutton MP, Minister for Health, transcript of press conference, 9 December 2014, p. 5.

in December 2014 would have a $1.3 billion impact on Medicare rebates for GP services. This would partially account for the increase in savings from the 2014-15 Budget to MYEFO in December 2014.[30]

Stakeholder criticisms

3.26 The proposed change to short consultations were strongly criticised by peak health groups such as the AMA, RACGP, Consumers Health Forum of Australia, and other health advocates. The criticisms raised included:

- the government's lack of consultation about the proposed changes;
- the absences of evidence linking short consultation times with poor quality healthcare practices; and
- the significant negative impacts that would flow from the changes.

No consultation

3.27 The committee heard that the government developed the proposed Medicare changes without consultation with the health sector or consumer groups. For example Associate Professor Owler told the committee that the announcement of the short consultations policy came as a 'complete surprise' to the AMA:

> I think co-payment mark 1 and co-payment mark 2 were both instances where the announcements were made without any consultation with the medical profession. The announcements in the budget, I have to say, were a complete surprise…
>
> Regarding co-payment mark 2, again we found out 20 minutes before the announcement was made. In fact, I was in the United States in Chicago, in my hotel room, when the phone rang from the minister stating that these were the changes about to be made. But there was absolutely no consultation with the AMA. I understand you will hear from other groups as well. I suspect no-one else had any consultation about the impact of those changes.[31]

3.28 Similarly, Dr Jones, President of the RACGP, was not informed until just before the Government announced the proposed changes to Medicare:

> …we think that what we need to do is be able to advise government on the implications of policy changes. Their policies seemingly have been made on the run, with no consultation. Like my colleague Professor Owler, I also received a phone call about half an hour before the announcements were made. There was no consultation with our college or our members whatsoever.[32]

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30 Freedom of Information Request, Mr Sean Parnell, Health and FOI Editor, *The Australian* to Department of Health, 27 April 2015, p. 1.

31 Associate Professor Brian Owler, President, AMA, *Committee Hansard*, 5 February 2015, p. 3.

32 Dr Frank R Jones, President, RACGP, *Committee Hansard*, 5 February 2015, p. 10.

3.29 The concerns about the lack of consultation were also expressed by members of the GP panel who appeared before the committee. Sole-practitioner Dr Richard Terry of the Whitebridge Medical Centre in Newcastle, NSW, told the committee:

> The total number of GPs in Australia, as far as I can see, is about 43,000. It is interesting that the RACGP, who presented here earlier today, say they have a membership of 28,000 GPs and, by their own admission, they are an educational body. That leaves at least 15,000 GPs in the community. Essentially, taking both of those numbers into account, there are 43,000 grassroots GPs who represent thousands of patients who have not been consulted on these healthcare changes.[33]

3.30 Officials from the Department of Health however claimed that this was the government's typical approach to Budget measures:

> Between the May announcement and the December announcement there was significant consultation—again, as has been said in these hearings—with a whole range, and we have a significant number of people we consulted with. Those consultations raised a number of issues and concerns with that proposal from the May budget and raised a number of areas that they had particular concerns with. We did not consult specifically on the actual budget measures that were then announced in December, but we were informed by those consultations.[34]

No evidence base

3.31 As outlined previously, the government's justification for proposing the short consultations policy was to avoid the problem of 'six minute medicine'. However, medical experts that appeared at the committee's public hearing argued that there is no evidence to support the government's assertions.

3.32 For instance the Australian Health Care Reform Alliance (AHCRA) criticised the unsubstantiated link the government had made been short consultations and poor practices:

> Addressing 'six-minute medicine' is not an unreasonable strategy if directed at poor quality practice only (six minutes may be totally appropriate for some brief consultations). Short consultations do not necessarily mean poor quality. However change needs a carefully planned approach, based on evidence and consultation with GPs and consumers, not used as a post-hoc rationale for previously determined budget cut.[35]

3.33 The RACGP also criticised the lack of evidence base:

> …the evidence that time based consultations improve quality is relatively poor. It is not good but there is some evidence. In our modelling for

33 Dr Richard Terry, Practice Principal, Whitebridge Medical Centre, *Committee Hansard*, 5 February 2015, p. 27.

34 Ms Kirsty Faichney, Acting First Assistant Secretary, Medical Benefits Division, Department of Health, *Committee Hansard*, 5 February 2015, p. 92.

35 Australian Health Care Reform Alliance (AHCRA), *Submission 90*, p. 2.

> government—this is one of the discussions we wish to have with them—we wish to remodel the [current consultation level] system. We have some ideas and we have done some financial modelling as well. Tagged on to that—very importantly—is improving the quality of care.
>
> We have a proposal whereby the items of service would be reframed, if you like, and it would encourage longer consultations and disincentivise superficial consultations. Tagged onto that—very importantly—are payments for practitioners to provide quality care, for practices to be able to enable practitioners to do that, and, thirdly, reflecting the complexity of the local demography. We have modelling along those lines. So I think that we do have some potential solutions (a) to improve the health of the population, which is by far the most important thing, and (b) to help this government out of the dilemma that it is in.[36]

3.34 According to several witnesses the lack of policy rationale and the rapid changes from one policy to the next demonstrated the ad hoc nature of the government's policy development process. For instance Dr Duckett told the committee:

> We had the unusual situation which I do not think I have seen in health policy in this country of three health policies in less than a month, which suggests that policy is being made on the run. As I said earlier, we do need to look at [the effectiveness of] primary care in general practice and we do need to think about whether the current arrangements are right for the future. That is not something that can be done in a two-week period.[37]

3.35 Furthermore, the AMA explained that the policy changes appeared to be ideologically-driven fiscal measures rather than policies to improve health outcomes:

> I have also said publicly that one of the reasons we are in this mess in the first place is that the changes that were flagged were always designed as fiscal measures, they were never viewed through the prism of health policy and I think that has been the failing of both sets of policies.[38]
>
> …whoever is in government or whoever is Prime Minister needs to consult with the profession and go away from being driven only by personal assertions and ideology and get back to looking at evidence and data. As I said before, the ideology that has driven most of these proposals has ended up becoming the natural enemy of common sense, moderation and logic. We need to get back to talking about good health policy and map out a program of how we are actually going to make our healthcare system better not only for general practice but across the board and to make Australians healthier and safer as well.[39]

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36 Dr Frank R Jones, President, RACGP, *Committee Hansard*, 5 February 2015, p. 12.

37 Dr Stephen Duckett, Director, Health Program, Grattan Institute, *Committee Hansard*, 5 February 2015, p. 67.

38 Associate Professor Brian Owler, President, AMA, *Committee Hansard*, 5 February 2015, p. 4.

39 Associate Professor Brian Owler, President, AMA, *Committee Hansard*, 5 February 2015, p. 6.

3.36 Health Department officials were not able to explain to committee the health outcomes that could be expected from the proposed changes to Medicare:

> Health outcomes are a very difficult thing, because there are so many elements that impact it.
>
> …we cannot say one thing versus another thing will affect health outcomes. There are a lot of things, including a person's individual decisions, as to what will happen with health. So it is very difficult to ever have a broad comment as to what the health outcomes are, and we do not tend to, as a result, make comment as to what we anticipate a health outcome will be. We anticipate what we are looking for, which is improved health through whatever the policy might be covering at the time.[40]

Unprecedented protests by GPs

3.37 Despite the announcements being made in the lead up to the busy Christmas period and the proposed implementation date being in the midst of most Australians annual summer holiday, health sector advocates reported an unprecedented reaction from medical professionals and patients. The RACGP launched a campaign called *You've been targeted* to publicise its concerns throughout GP practices.[41] In early January 2015, the AMA announced plans for rallies to be held in capital cities for GPs and others to protest against the proposed changes, including the short consultation time changes.[42]

3.38 Perhaps the most vocal response was generated by the RACGP's *You've been targeted* campaign:

> The government's changes in December [2014] lead to an unprecedented protest from GPs. Thousands of GPs contacted the RACGP with concerns regarding the changes and requested advice on how to implement them. Nearly 47,000 patients, GPs and other medical specialists signed our petition to the health minister. Others wrote to their MPs and displayed posters in their waiting rooms informing their patients of the impending changes. We do not often mount campaigns. We are an academic college. But this situation warranted an immediate response.[43]

3.39 The response from the AMA's membership was also resounding:

> …the amount of feedback that we [the AMA] had on that initiative in particular exceeded the feedback that we have had on just about anything else. I think a lot of people felt very insulted, particularly experienced GPs,

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40 Ms Kirsty Faichney, Acting First Assistant Secretary, Medical Benefits Division, Department of Health, *Committee Hansard,* 5 February 2015, p. 90.

41 Networking Health Victoria, 'RACGP releases information sheet on co-payment and rebate freeze', Media release, 14 January 2015.

42 Lenore Taylor, 'Doctors to demonstrate in protest at 'plan B' proposed Medicare changes', *The Guardian*, 7 January 2015.

43 Dr Frank R Jones, President, RACGP, *Committee Hansard,* 5 February 2015, p. 9.

> who were saying, 'We can provide quality care in eight or nine minutes.' The issue is not whether it is 10 minutes or above.[44]

January 2015: short consultation times dropped

Short consultations policy dropped four days before implementation

3.40 The proposed $20 reduction of the Medicare rebate for short GP consultations was to have begun by regulation on 19 January 2015. However due to the significant grassroots pressure from GPs[45] and health consumers, as well as concerted advocacy from the AMA, the RACGP and other health organisations, on 15 January 2015 the newly appointed Health Minister, the Hon Sussan Ley MP announced that the planned changes would not be implemented.[46]

3.41 Minister Ley said that 'the Government is responding to concerns that have been raised about the new Medicare measure' by not commencing the changes to short GP consultation times. Instead the Minister announced that the government would undertake:

> …wide ranging consultation on the ground with doctors and the community across the country in order to come up with sensible options to deliver appropriate Medicare reforms.[47]

3.42 At the same time the new Health Minister confirmed the government's intention to press ahead with the $5 co-payment:

> We must insert a price signal of a modest co-payment into the health system for those who have the capacity to pay.[48]

3.43 The Minister's announcement to withdraw the proposed changes to short consultation rebate structures was welcomed by GP representative bodies such as the AMA,[49] Rural Doctors Association of Australia (RDAA)[50] and the RACGP.[51] In particular, groups welcomed the consultation with government which had been

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44 Associate Professor Brian Owler, President, AMA, *Committee Hansard*, 5 February 2015, p. 3.

45 The RACGP noted in their media release of 15 January 2014 that in less than seven days 'a staggering 44,000+ signatures from GPs and patients' had been added to an online petition against the consultation time changes. RACGP, 'Sanity prevails in proposed Medicare shakeup', Medial Release, 15 January 2015.

46 The Hon Sussan Ley MP, Minister for Health, 'Government to consult on Medicare reform', Media Release, 15 January 2015, p. 1.

47 The Hon Sussan Ley MP, Minister for Health, 'Government to consult on Medicare reform', Media Release, 15 January 2015, p. 1.

48 The Hon Sussan Ley MP, Minister for Health, 'Government to consult on Medicare reform', Media Release, 15 January 2015, p. 1.

49 Associate Professor Brian Owler, President, AMA, transcript of doorstop, Gold Coast, 15 January 2015.

50 RDAA, 'Rural Doctors welcome Minister's announcement on Medicare', Media Release, 15 January 2015.

51 RACGP, 'Sanity prevails in proposed Medicare shakeup', Media Release, 15 January 2015.

missing from the formulation of the previous policies. Associate Professor Owler, said he looked forward to the opportunity to work with the government on any future changes to Medicare:

> We are very pleased that the changes to the [short consultation] rebates have been taken off the table. This was really essential if we were going to move ahead with having a proper consultation and discussion about the sustainability of Medicare and making our health system better for patients but also more sustainable in the longer term.[52]

3.44 Of the package of reforms announced on 9 December 2014 the short consultations policy attracted the majority of criticism, due to its planned implementation in January 2015. However with the announcement on 15 January 2015 that the short consultation changes had been dropped, attention then focused specifically on the $5 co-payment and the extended indexation freeze. These measures too were roundly criticised.

$5 co-payment remains

3.45 The short consultation times policy had gone, however the healthcare community remained concerned about the government's continued imposition of a price signal. After the 15 January 2015 announcement, stakeholder attention focused on demonstrating to the government the detrimental effects of the $5 co-payment and continued indexation freeze.

3.46 While initial stakeholder comments had welcomed the dropping of the $7 co-payment, there was disappointment that the government had seemed not to have listened to the concerns raised about co-payments and the deleterious effects of a price signal on health outcomes. The RACGP, for example made this statement on 9 December 2014:

> The RACGP is pleased the Government has listened to the profession and the community and compromised on its proposed $7 co-payment model.
>
> We are disappointed the Government has proposed a $5 cut in Medicare rebates for standard GP consults.[53]

3.47 Further, peak groups argued that the government's single-minded focus on "budget repair" had created policies which will damage Australia's primary healthcare system. Associate Professor Owler told the committee:

> I think the proposals that have been made, as I have said, have all been fiscal. They have all been about saving money. No-one would introduce those measures if they were to look at the impacts through the prism of health. I think one of the most disappointing things over the past 12 months is that we have just had no health policy developed in this country. We need to get back to talking about how we are going to make the health system

52 Associate Professor Brian Owler, President, AMA, transcript of doorstop, Gold Coast, 15 January 2015.

53 RACGP, 'RACGP pleased vulnerable patients protected under changes to co-payment model', Media Release, 9 December 2014.

> better. I am pleased that the new minister appears to be embarking on that process, but I think it has been a disappointing 12 months from that perspective.[54]

3.48 The AHCRA submission gave a similar summation of the government's proposed Medicare reforms:

> - Lack of policy framework: The proposal is not based on any overall articulated and coherent health policy, analysis or framework from the Government. It appears to have been developed solely to save the Government money with no clear rationale why this area of health spending was targeted and not other more wasteful ones…
> - Lack of transparency: the moves have been made with little regard for or consultation with the practitioners or consumers as to the impact on the effectiveness and delivery of care.[55]

Disadvantaging vulnerable groups

3.49 In addition to these criticisms, stakeholders felt that, despite making concessions to disadvantaged groups such as pensioners, concession card holders and children (see paragraph 3.16), the government was refusing to take into account the effect of a price signal on other vulnerable groups, which also faced difficulties accessing primary healthcare such as:

- those in rural health settings;
- people with a mental health condition;
- Indigenous Australians;
- residents of aged care facilities;
- women with specific health concerns;
- the chronically ill;
- those in the LGBTI community; and
- people with a disability.

3.50 Witnesses at the committee's public hearings argued that a price signal on healthcare access unfairly targeted vulnerable groups as these people would be least able to afford additional out-of-pocket costs. Stakeholders argued that such a policy undermined the principle on which Medicare was based: universality of access to healthcare.

3.51 Dr Anne-marie Boxall, Senior Policy Adviser with the National Rural Health Alliance argued that universality—a key aspect of Australia's Medicare system—has been lost in the current healthcare funding debate:

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54 Associate Professor Brian Owler, President, AMA, *Committee Hansard*, 5 February 2015, p. 7.

55 Australian Healthcare Reform Alliance (AHCRA), *Supplementary Submission 90*, p. 1.

> We have been talking a lot about the impact on patients of the potential changes, which is right, but the potential changes also have a big impact on our health system if they are implemented. One of those is that threat to universality. High bulk-billing rates have been pursued by both sides of government for a long time, and there is a reason for that. It is because it essentially functions as a safety net. Whilst some people may be able to afford to pay more, and they do, through the taxation system, bulk-billing is seen as a universal benefit. So if we are undermining a system and scaling back bulk-billing and making it a targeted system, we then need to be very sure that the safety nets we have in place are effective, and that is something that we are not entirely sure about at the moment, and we have evidence that people are falling through the safety nets.[56]

3.52 The Consumers Health Forum of Australia agreed that any further pressure on GPs would result in a drop in bulk billing and access to primary healthcare for non-concession card holders. Its CEO, Mr Adam Stankevicius argued:

> And it will be patients who will suffer, as many doctors will have no option but to demand the $5 from patients. It will be the chronically ill, families and the elderly not covered by concessions, who will be hit hardest. While pensioners and other concession patients, children and veterans may still be covered by bulk billing, the squeeze on doctors' income could well see a dramatic downturn in their ability to continue bulk billing which currently benefits more than 80 per cent of cases.[57]

3.53 Despite the concessions included in the revised co-payment policy (see paragraph 3.16), criticisms from other groups focused on concerns that the new co-payment would continue to create a barrier to access to primary healthcare. Some groups, such as National Aboriginal Community Controlled Health Organisation (NACCHO), believed that it would force community health organisations and GPs to carry the cost of the co-payment so as to ensure access to healthcare, particularly for those with chronic illnesses:

> …the majority of Aboriginal Community Controlled Health Services, whose overriding purpose was to encourage Aboriginal people through their doors, would choose to absorb the discretionary $5 co-payment.
>
> "Aboriginal Community Controlled Health Services are making the biggest gains against the closing the gap targets – helping Aboriginal people to live longer and healthier," Mr Cooke said.

56 Dr Anne-marie Boxall, Senior Policy Adviser, National Rural Health Alliance, *Committee Hansard*, 5 February 2015, p. 44.

57 Consumers Health Forum of Australia, '$5 cut to doctor equals co-payment by default', Media Release, 9 December 2014, p. 1.

> "Many Aboriginal people do not fit in the exemption categories but still have low disposable incomes and can ill-afford to pay extra for their often complex medical needs and repeat appointments.[58]

3.54 Professor Andrew Bonney, University of Wollongong, agreed that improving access to primary healthcare is vital:

> The premise of the price signal is that people are unnecessarily seeking health care and that it was for trivial reasons and therefore it was a waste of the taxpayer's money. We know health-policy-wise that the things that improve overall health outcomes are four components of primary care. The first is access to care, and following on from that, once they are in the primary care system, is continuity, comprehensiveness and coordination…
>
> We are in a small town, and we are under-doctored, so my waiting time is two or three weeks, or longer. And to try to improve access, because we are dealing with so much chronic disease, we have an hour walk-in clinic in the morning. So, if there is an acute problem, you can just turn up and we will see you… [W]ithin that walk-in clinic, the people turning up just for things like, 'I'm a bit worried about this, Doc' included two patients who had lost sight in an eye because of diabetic haemorrhages and a fellow who had a lump in his groin, which turned out to be lymphoma... [H]aving a walk-in clinic so that people can access care when they need to means that people with very significant, serious things can have those picked up and dealt with quickly. Now, if we had just standard appointments at standard rates, I am not quite sure when those folk would have turned up. But by improving access to care—because patients do not understand sometimes when they truly are ill—you can prevent an awful lot of grief and mortality down the track…
>
> [A]bout 10 per cent of my patients are Aboriginal. Those folk do it very tough, and a co-payment for my Aboriginal patients would significantly restrict their access to our care. And I know just from prescribing and medication that the Close the Gap incentive, such that Aboriginal patients do not have a co-payment for their medications, has made a huge difference.[59]

3.55 Ms Jennifer Johnson, Chief Executive Officer of the RDAA explained that putting a price signal on healthcare access would impact severely on rural communities. She noted that not all non-concessional patients were necessarily able to afford a co-payment:

> We have already stated that a co-payment—a price signal, for example—will probably impact more severely on rural doctors and rural communities. We know that rural patients are far more reluctant to seek medical assistance. That is for a number of reasons—one of which is access. Most

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58 National Aboriginal Community Controlled Health Organisation (NACCHO), 'NACCHO Media Release: Revised GP co-payment policy remains a hit to Aboriginal health', Media Release, 10 December 2014, p. 1.

59 Professor Andrew Bonney, Roberta Williams Chair of General Practice, Graduate School of Medicine, University of Wollongong, *Committee Hansard*, 5 February 2015, p. 29.

> times, they obviously have to travel much further to see a GP. We know that economic and social circumstances are quite often poor, and particularly economic situations. In rural communities that might not necessarily be reflected in eligibility for, for example, healthcare cards. So quite often in farming communities you will have people who are asset rich, for example, but cash poor.[60]

3.56 Despite the government's assurance that vulnerable groups would be exempt from the co-payment, peak groups like the AMA argued that all health consumers will be affected because the changes force GPs to pass on the additional costs:

> Even if the Government abandons the rebate cut for shorter consultations, the AMA President warned other changes, including a $5 cut to Medicare rebates for general patients from 1 July and a freeze on Medicare rebate indexation through to mid-2018, amounted to an attack on general practice that would inevitably lead to increased out-of-pocket expenses for patients and undermine health care.
>
> [Associate Professor Brian Owler] said the policies were likely to lead to higher health costs in the long-term, as patients deterred by increased expenses put off seeing their doctor. Eventually, as their health deteriorates, they will need more intensive and expensive treatment, possibly even hospitalisation.
>
> "Primary health care is provided primarily by practitioners who practice in a small business setting," A/Prof Owler said in his letter to Mr Abbott.
>
> "These practices will not be able to absorb the cuts your Government has made to the Medicare rebate. Costs will be passed on to patients. Some will be able to make these payments but many will not. These costs may deter many patients from seeking early treatment."[61]

March 2015: $5 co-payment dropped, non-indexation retained

3.57 On 3 March 2015, recognising that 'it is clear the proposal for an optional $5 co-payment does not have broad support' the Health Minister announced that:

> The measure, including the proposed $5 reduction to the Medicare rebate, will therefore no longer proceed and has been taken off the table...[62]

3.58 During the Minister's press conference she confirmed a 'pause on indexation of Medicare rebates for GP and non-GP items while we work with the profession to develop future policies.'[63]

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60 Ms Jennifer Johnson, Chief Executive Officer, RDAA, *Committee Hansard*, 5 February 2015, p. 19.

61 AMA, 'Time for Prime Minister to abandon rebate cut', Media Release, 15 January 2015.

62 The Hon Sussan Ley MP, Minister for Health, 'Government continues Medicare consultation', Media Release, 3 March 2015, p. 2.

63 The Hon Sussan Ley MP, Minister for Health, 'Government continues Medicare consultation', Media Release, 3 March 2015.

3.59 The Minister confirmed that the government is committed to introducing a price signal into the Medicare system:

> …it's definitely good policy to put the right price and value signals in health to make sure that number one, people value the service that they get from doctors…and also that they make that modest contribution according to their capacity to pay and those that can pay a bit more are asked to pay a bit more. It's really that simple.[64]

3.60 The Minister's announcement was welcomed by stakeholders. The RACGP, for example, had called for a six-month moratorium on further policy announcements and the establishment of a 'GP health reform advisory committee consisting of the Government, patients and GP representatives to guide informed consultations'.[65] The RACGP implored the government to conduct a constructive discussion with all stakeholders as the best way to:

> …inform the development of a sustainable and efficient healthcare system that meets the needs of all Australians, now and into the future.
>
> At the very least, we believe a structured review of all time-based and content-based consultation item numbers would work towards ensuring the long-term sustainability and quality of general practice patient services.[66]

3.61 Several other organisations supported the call for a six month moratorium including: the RDAA;[67] the National Rural Health Alliance;[68] the PHAA;[69] the ACEM;[70] and Dr Stephen Duckett, Director, Health Program, Grattan Institute.[71] Others, such as Dr Fiona van Leeuwen, Vice Chair of the HGPA told the committee that the government needed to work collaboratively with general practice:

> …we urge against any further erosion of what is an essential part of the Australian healthcare system—that is, general practice. We urge against proceeding with both the GP co-payment and the freeze on MBS rebates. Limit the damage with regard to both financial and human currency. Instead, use our collective knowledge and experience to help to begin to craft a health system that can improve the patient experience and improve

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64 The Hon Sussan Ley MP, Minister for Health, 'Government continues Medicare consultation', Media Release, 3 March 2015.

65 RACGP, *Supplementary Submission 115*, p. 2.

66 RACGP, *Supplementary Submission 115*, p. 2.

67 Mrs Jennifer Johnson, Chief Executive Officer, RDAA, *Committee Hansard*, 5 February 2015, p. 24.

68 Mr Gregory Gordon, Chief Executive Officer, National Rural Health Alliance, *Committee Hansard*, 5 February 2015, p. 42.

69 Public Health Association of Australia (PHAA), *Supplementary Submission 76*, pp 6–7.

70 Mrs Alana Killen, Chief Executive Officer, Australasian College of Emergency Medicine, *Committee Hansard*, 5 February 2015, p. 58.

71 Dr Stephen Duckett, Director, Health Program, Grattan Institute, *Committee Hansard*, 5 February 2015, p. 67.

> the health of all Australians. We want your help to rebuild the trust. Please let us use this opportunity to take the first step towards working in partnership with grassroots general practice for a health system that will meet both the healthcare needs and the financial challenges of Australia for generations to come.[72]

Health Minister's consultations continue

3.62 In January 2015, when the planned $20 cut to rebates for short consultations was dropped, the Minister gave an undertaking that she would conduct 'wide ranging consultation on the ground with doctors and the community across the country'.[73]

3.63 According to the Minister the consultations would be guided by four principles:

- We must protect Medicare for the long term
- We must ensure bulk billing remains for vulnerable and concessional patients
- We must maintain high quality care and treatment for all Australians
- We must insert a price signal of a modest co-payment into the health system for those who have the capacity to pay[74]

3.64 The Minister's announcement was well received by many peak groups. The AMA and the RACGP both welcomed the removal of the short consultation policy[75] and stated their willingness to work with the government on its planned consultations.

3.65 Although no details were made available through the Department of Health's website about the consultations, peak groups such as the AMA and the RACGP had meetings with the Minister. During a round of consultations with GPs in Albury and Wodonga, Minister Ley told *The Border Mail* that the timeframe for the consultations was quite restricted:

> Ms Ley said the timetable for consultations was constrained by the May budget and changes scheduled to come into effect in July.
>
> "We're talking weeks here, not months," she said.[76]

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72 Dr Fiona van Leeuwen, Vice Chair, Hunter General Practitioners Association, *Committee Hansard*, 5 February 2015, pp 26–27.

73 The Hon Sussan Ley MP, Minister for Health, 'Government to consult on Medicare reform' Media Release, 15 January 2015, p. 1.

74 The Hon Sussan Ley MP, Minister for Health, 'Government to consult on Medicare reform' Media Release, 15 January 2015, p. 1.

75 Associate Professor Brian Owler, President, AMA, transcript of doorstop, Gold Coast, 15 January 2015; and RACGP, 'Sanity prevails in proposed Medicare shakeup', Media Release, 15 January 2015.

76 Natalie Kotsios, 'Sussan Ley delivers Medicare consultation as prescribed', *Border Mail*, 28 January 2015, www.bordermail.com.au/story/2845272/sussan-ley-delivers-medicare-consultation-as-prescribed/.

3.66 Dr Jones, President of the RACGP, told the committee that his understanding was that the consultations would be quite short:

> While I have had brief discussions with the minister since she took charge...I understand that consultation will end in a couple of weeks, and this is simply not enough time to analyse and identify the serious implications of these changes and will likely result in more budget measures that damage the most effective part of Australia's health system.[77]

Minister conducting consultations

3.67 Information regarding the consultations announced by the Health Minister has been limited and largely available only via the media.[78]

3.68 The committee sought details from the Department of Health regarding the consultation process, asking for example whether there was a plan for the consultations and a time limit. Ms Kirsty Faichney, Acting First Assistant Secretary of the Medical Benefits Division advised that the consultations were being conducted by the Minister and organised through the Minister's office:

> …the minister is undertaking consultation. I understand her office has provided advice, and we sought it as well when we heard the comment regarding the time limit. We are not aware of any time limit with regard to the consultations… At the moment the minister is meeting directly with GPs. She is meeting directly with the peak bodies, literally one-on-one or in groups. She is doing forums, she is visiting clinics and she is going to hospitals. I am trying to think of other ones that have been happening.[79]

3.69 The Department also advised that the Minister's office was setting the topics for consultation:

> [Senator O'Neill]: Could you provide us with the areas of primary health care that are being consulted on, specifically with regard to general practice and matters that relate to general practice? Could you also provide us with a schedule of consultations that are anticipated and ones that have already occurred and the groups that are to be invited or have been invited?
>
> Ms Faichney: We can ask the minister's office.
>
> Mr Stuart: We can ask the minister and the minister's office if they are willing to provide it. We will take that on notice.[80]

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77 Dr Frank Jones, President, Royal Australian College of General Practitioners (RACGP), *Committee Hansard*, 5 February 2015, p. 9.

78 See for example Natalie Kotsios, 'Sussan Ley delivers Medicare consultation as prescribed', *Border Mail*, 28 January 2015, www.bordermail.com.au/story/2845272/sussan-ley-delivers-medicare-consultation-as-prescribed/.

79 Ms Kirsty Faichney, Acting First Assistant Secretary, Medical Benefits Division, Department of Health, *Committee Hansard*, 5 February 2015, pp 94–95.

80 Ms Kirsty Faichney, Acting First Assistant Secretary, Medical Benefits Division, Department of Health; and Mr Andrew Stuart, Acting Secretary, Department of Health, *Committee Hansard*, 5 February 2015, pp 94–95.

3.70 The Department of Health's response to the question on notice regarding the Minister's consultation was:

> The Minister has been travelling the country consulting with GPs, health works, medical and consumer groups and a range of medical associations. These consultations are ongoing.[81]

3.71 It appears from the evidence that the Minister's office organised the consultations with little or no support or interaction with her Department.

3.72 The Department of Health's own previous consultations have left much to be desired in terms of thoroughness. Ms Faicheny explained that:

> Between the May announcement and the December announcement there was significant consultation… Those consultations raised a number of issues and concerns with that proposal from the May budget and raised a number of areas that [stakeholders] had particular concerns with. We did not consult specifically on the actual budget measures that were then announced in December, but we were informed by those consultations...[82]

3.73 Ms Faichney then clarified that by 'consultation' the Department meant 'providing information' and 'receiving communications':

> I did not say people were consulted; I said there was a range of information provided, as you well know, including what we all get all the time, whether it is through media or correspondence to the department or direct contact to us or to the minister's office. A significant amount of the information gets provided in those ways, and that gets taken into account. You would have to ask the government how they then took that into account in making the decision on 15 January.[83]

Response to Minister's announcement of 'wider consultations'

3.74 When the consultations were first announced the RACGP President, Dr Frank R Jones was positive about the opportunity for discussions with government, saying that the RACGP looked forward to:

> …constructive discussion to inform the development of a sustainable and efficient health system that meets the needs of Australia.[84]

3.75 However, between 15 January 2015 and the committee's hearing on 5 February 2015, the RACGP had discovered that the Minister's consultations would not be as comprehensive as promised:

> The RACGP participated in discussions with the Minister for Health in late January 2015 as part of United General Practice Australia (UGPA) and

81 Answer to Question on Notice No. 12, Department of Health, 5 February 2015.

82 Ms Kirsty Faichney, Acting First Assistant Secretary, Medical Benefits Division, Department of Health, *Committee Hansard*, 5 February 2015, p. 92.

83 Ms Kirsty Faichney, Acting First Assistant Secretary, Medical Benefits Division, Department of Health, *Committee Hansard*, 5 February 2015, p. 92.

84 RACGP, 'Sanity prevails in proposed Medicare shakeup', Media Release, 15 January 2015.

> anticipates further discussion with the Minister in February. However, the Minister for Health has indicated the consultation process is likely to be completed within the next month.
>
> We consider this insufficient to adequately consider and analyse the most effective options for reforming Australia's complex healthcare system.[85]

3.76 Dr Duckett summed up the views of several witnesses with his observations on the progress of the Minister's 'wider consultations' process:

> We had the unusual situation which I do not think I have seen in health policy in this country of three health policies in less than a month, which suggests that policy is being made on the run. As I said earlier, we do need to look at primary care in general practice and we do need to think about whether the current arrangements are right for the future. That is not something that can be done in a two-week period.[86]

Conclusion of the Minister's consultations

3.77 On 22 April 2015 the Health Minister announced the outcome of her consultations, which began in January 2015. The result of the consultations was:

> …overwhelming feedback…[that] Medicare's structure no longer efficiently supported patients and practitioners to manage chronic conditions or the complex interactions between primary and acute care.[87]

3.78 In reporting the outcomes of the Minister's consultations, the media release noted that the government continues to categorise Medicare funding as unsustainable. However, the release insists that the government's process in response to the consultation will not seek savings.[88]

3.79 In comparison to the announcement of the Minister's consultation in January 2015 (see paragraph 3.63 above), the Minister's media release of 22 April 2015 stated that 'the Government's consultations did not include a co-payment policy – or proposal to examine one.'[89]

3.80 The government's response to the findings of the Minister's consultation are:

- establishment of the MBS Review Taskforce;
- establishment of the Primary Health Care Advisory Group; and

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85 RACGP, *Supplementary Submission 115*, p. 2.

86 Dr Stephen Duckett, Director, Health Program, Grattan Institute, *Committee Hansard*, 5 February 2015, p. 67.

87 The Hon Sussan Ley MP, Minister for Health ' Abbott Government to deliver a healthier Medicare', Media release, 22 April 2015.

88 The Hon Sussan Ley MP, Minister for Health ' Abbott Government to deliver a healthier Medicare', Media release, 22 April 2015.

89 The Hon Sussan Ley MP, Minister for Health ' Abbott Government to deliver a healthier Medicare', Media release, 22 April 2015.

- the government working with clinical leaders, medical organisations and patient representatives to develop clearer Medicare compliance rules and benchmarks.[90]

3.81 Each taskforce will report back with priority areas in the later part of 2015.[91]

3.82 Chapter 4 provides a further discussion of the government response and the establishment of the MBS review as part of examination of the health measures in the 2015 Budget.

Committee observations

3.83 Associate Professor Owler wrote in March 2015 that health policy development in Australia has stagnated:

> The co-payment has sucked the life out of health policy development, discussion, and debate. This has not only been detrimental to the Government, it is also harmful for the practice of medicine and for our patients.[92]

3.84 As this chapter records, it has been difficult for everyone in the healthcare sector to understand whether or not the current government has a strategic plan for healthcare reform. Ms Alison Verhoeven, CEO AHHA, summed up a view that many witnesses had put to the committee over the course of its public hearings:

> It is not clear at all to me that there is a strategic vision or an articulated policy. What we do see is a compendium of attempts to address health budgets by measures that are aimed at cutting dollars from the health budget but then that are often reversed, such as the co-payment, obviously, and we welcome that reversal. It is indicative of the approach. A policy is put out into the public domain. It has largely got a funding cut element to it rather than a strategic objective. It is tested in the public domain and found wanting and then it is reversed or partly reversed, and then we see another measure put out into the public domain to be tested. I think that testing approach is really problematic. We need from the government a very clear strategic vision articulated so that health stakeholders can respond appropriately.[93]

3.85 Constant changes in government policy have been uppermost in the public debate about primary healthcare in Australia. The committee notes that while the major policy announcements from the government have become less frequent in recent months, the transparency around consultations and decision making has not improved. The committee observes a significant gap between the government's and the healthcare sector's perspective on public consultation and effective policy

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90 The Hon Sussan Ley MP, Minister for Health ' Abbott Government to deliver a healthier Medicare', Media release, 22 April 2015.

91 The Hon Sussan Ley MP, Minister for Health ' Abbott Government to deliver a healthier Medicare', Media release, 22 April 2015.

92 AMA, 'Health Policy Stagnation', Media Release, 2 March 2015.

93 Ms Alison Verhoeven, CEO, AHHA, *Committee Hansard*, 9 June 2015, p. 20.

development. The committee's view accords with that of the majority of witnesses being that there is a lack of evidence to indicate careful consideration or evidence-based policy making.

3.86 Although no further co-payment has been introduced, there appears to be conflicting comments from the government about its commitment to a price signal. The Minister for Health began her consultation in January 2015 with one of her four stated principles as 'we must insert a price signal of a modest co-payment into the health system for those who have the capacity to pay'.[94] She re-emphasised the importance the government places on a price signal while dropping the $5 co-payment in March 2015. But once the consultation was finished on 22 April 2015, the Minister's media release insisted that 'the Government's consultations did not include a co-payment policy – or proposal to examine one.'[95] The committee, in addition to those in the healthcare sector, and health consumers, wonder which statement in fact reflects government policy.

3.87 The other constant in government health policy, alongside the on again-off again co-payment, has been the MBS indexation freeze. This policy has, unlike the co-payment, endured throughout two budgets and numerous revised policy announcements. As discussed in Chapter 4, the indexation freeze has effectively become the price signal the government seems determined to implement. By being a significant constraint on the revenue for general practice, the indexation freeze will force general practice to pass on more costs to patients in order to remain viable. One witness observed that this shifts 'the odium [of the budget measure] from the government to the GP practice.'[96] As Chapter 2 outlined, this is the same effect as the co-payment would have had on general practice.

3.88 At the time of writing, the committee has begun hearings with stakeholders to determine the effects of the health measures in the government's 2015-16 Budget. These findings are detailed in Chapter 4 of this report. From this recent evidence, and the evidence the committee has heard so far—as detailed in this chapter—the committee is concerned that the government has failed to heed to the calls of general practice to work with it on positive reforms to primary healthcare in Australia.

94 The Hon Sussan Ley MP, Minister for Health, 'Government to consult on Medicare reform', Media Release, 15 January 2015.

95 The Hon Sussan Ley MP, Minister for Health, ' Abbott Government to deliver a healthier Medicare', Media Release, 22 April 2015.

96 Mr Robert Bonner, Director, Operations and Strategy, Australian Nursing and Midwifery Federation, South Australia Branch, *Committee Hansard*, 11 June 2015, p. 17.