Submission to Senate Committee on Out-of-Pocket Costs in Australian healthcare and the $7 co-payment

My major reservations about co-payments as set out in my earlier submission-Number 6- still stand. On its own the $7 co-payment is a silly suggestion. There are major problems with our co-payments "system" that need to be fixed. In fact it is not a "system". It is a "dog's breakfast" and the $7 proposal on its own would make it more complicated and unfair.

However the debate has moved on since my earlier submission which raises further concerns about a proposal which covers not only GP consultations but pathology and radiology tests and pharmaceutical prescriptions as well.

My first concern relates to process and where this co-payment issue might be headed. Minister Dutton has repeatedly said that he wants 'to start a national conversation' about health. I agree. But the minister doesn't do what he has promised. He has barged in with a 'solution' to the "unsustainability of Australian healthcare", without any 'conversation'. In practice what he is proposing in the budget is a mechanism to kill bulk billing and clear the ground for Private Health Insurance to fill the gap. Minister Dutton has said repeatedly that the government has an interest in greater involvement of PHI in primary healthcare. He said 'we will be... looking over the next few years at new and innovative ways in which we might fund and deliver primary healthcare, including through partnerships with private insurers'. He has expressed interest in trials of PHI in primary care in Queensland.

In terms of equity and efficiency it is remarkable that the government proposes a $7 co-payment, but maintains the $5 billion p.a. subsidy for PHI. That is real corporate welfare at the expense of low income earners and our health service in general.

The intrusion of PHI into primary healthcare should be strenuously resisted. The experience with PHI around the world is clear, particularly in the US. It pushes up costs dramatically and does not improve health outcomes. There is no benefit to the Australian community if the government saves $1 in official taxes, only to turn round and for the community to pay a lot more in 'taxes' to BUPA, Medibank Pte or NIB, for the same or an inferior service. Because of its intrinsic inefficiency PHI will always be more expensive than Medicare. Since 1999 average PHI premiums have increased 130% whilst the CPI has increased by only 50%. PHI administrative costs are about three times higher than Medicare's

I have written extensively about the damage that PHI does wherever it gets a foothold. The encroachment of PHI into primary healthcare as suggested by the minister is a much more serious threat to our universal system of healthcare than the co-payment in itself.

Warren Buffet has described PHI as 'the tapeworm in the US health sector'. It is also true in Australia. Its expansion here should be opposed. Minister Dutton is quoted as saying that he 'will never go down the path of a US style healthcare system'. But allowing PHI into primary healthcare would take us down the American path. Private doctors and private hospitals have enormous power to set prices unless there is some effective counter. Multiple private insurers have little power to control these prices as the US shows. Only a single payer, usually a public payer has the power to control prices

My second concern is that co-payments could discourage disadvantaged patients from seeing their GP. The COAG Reform Council has just reported that 5.8% of Australians delayed or did not see a GP because of cost and 8.9% delayed or did not fill a prescription from their GP because of cost. A co-payment will make that worse. It will force some patients to use more expensive and less appropriate emergency department services in public hospitals which are already under great pressure.

Third, the proposed co-payment will undermine preventive health services and continuity of care for people with chronic conditions. The best place to focus on prevention and at an early stage is in primary care. Any discouragement of access to GPs because of the co-payment would be detrimental to preventive healthcare. The decision by the government to abolish the National Preventative Health Agency is an indication of the government's lack of concern on health prevention. The tobacco, alcohol and the junk food industries will be pleased with that abolition decision. A strong primary health care sector is the key to an equitable and efficient health care system anywhere in the world

Fourthly, the best way to reduce costs and pressures in primary care is not through a co-payment but to move away from fee-for-service remuneration. This type of remuneration promotes 'turnstile medicine'. FFS may be appropriate for occasional and episodic care but it is not appropriate for long-term and chronic care. We need a major review of remuneration practices in primary care with more emphasis on capitation and bulk-charges for chronic care to keep people well at minimum cost. The British single payer system has many advantages. One advantage is as the Economist of May 31 2014 put it, "doctors are paid to keep people well, not for every extra thing they do so they don't make money performing unnecessary tasks and tests." Addressing this remuneration question is far more important than a co-payment.

Fifthly, there will probably be unintended consequences for the $7 co-payment. If the co-payment takes effect, it is likely to result in an increase in doctor's fees. The attraction of bulk billing for the doctor is that it removes the cost of handling and accounting for transactions. An invoice is sent directly to Medicare. Once the doctor is obliged to handle the $7 co-payment, another transaction occurs, either by cash or probably credit card. This inevitable patient/doctor money transaction will provide the doctor with an opportunity to charge above the bulk billing rate. As soon as doctors stop bulk billing, we can expect a rapid rise in doctors' fees on top of the $7 co-payment.

Sixthly there are numerous other ways to reduce health costs and by billions of dollars e.g. the duplication and gaps in health care between the Commonwealth and the States, the out of date list of medical services funded under the MBS,, adverse events, archaic workforce structures and high drug costs resulting in us paying more than $2b pa than our New Zealand friends for equivalent drugs. But real savings in these areas means tackling vested interests like the AMA, the Pharmaceutical Guild, Medicines Australia, State health departments and the PHI sector. It is politically easier to attack the less powerful by a co payment