SENATE SELECT COMMITTEE INTO THE ABBOTT GOVERNMENT'S COMMISSION OF AUDIT

STATEMENT BY TERRY BARNES

I appreciate the opportunity to appear before this Committee, noting that I was invited to appear not having made a submission to the Committee, and that I did not seek this appearance. The Committee's invitation presumably is about the paper I wrote for the Australian Centre for Health Research canvassing re-introducing the Hawke government's co-payment on bulk-billed GP visits that was briefly in place in 1991-92.

My proposal, and my additional suggestion that at least a matching co-payment applies to GP-type services in public hospital emergency departments, generated animated comment over summer. The critics included at least some members of this Committee. Certainly, my suggestions were the basis of a sustained political attack on the Abbott government, including "Save Medicare" rallies hastily organised around Australia. There has been an aggressive fear campaign around a "GP Tax" and, judging by the result of the Griffith by-election, this seems to have had some political effect.

I therefore welcome a measured conversation about my proposal, the need to restructure Medicare to keep it sustainable, and public attitudes to increasing price signals in both primary and acute care services.

Before doing so, however, I wish to put this statement on the record. I am very happy to discuss these comments, my paper and its recommendations – including obtaining Medicare savings by minimising GP visits for what I called "administrative presentations", especially unnecessary referrals, repeat prescriptions and medical certificates. I am also very happy to wider discuss health programme savings possibilities, as the Health portfolio is a veritable forest of hollow logs.

The Australian Centre for Health Research and the proposal

In May 2013, the Executive Director of the ACHR, the Hon Neil Batt AO – a former Leader of the Tasmanian Labor Party and National President of the ALP – commissioned me to write this paper. My brief simply was to revisit the Hawke government's 1991 Budget measure providing for a $3.50 co-payment and consider how it might apply today. The paper itself was released publicly by the ACHR last October.

This policy paper is one of many commissioned by the ACHR since it was established in 2006. The ACHR sees itself as a catalyst of reasoned and informed policy debate about healthcare provision, policy, regulation and funding. It has received funding from both the Howard and Rudd governments. While it a think tank with private health industry connections, the ACHR is not a politically partisan organisation.

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In regard to my own role, I have been a self-employed social policy consultant since 2007. I have a secondary income stream as a freelance opinion writer and commentator in which I have always expressed my own views, and indeed have not been uncritical of Coalition policy and performance in that capacity. I am not a Coalition mouthpiece. That I was the Prime Minister's senior policy adviser when he was Minister for Health therefore is simply coincidental.

The co-payment proposal was commissioned by the ACHR, and written by me, wholly independently of the Coalition, the Abbott government, or the Prime Minister and Minister for Health. The ACHR, or myself, are not their surrogates or Trojan horses.

Comments on the proposal

The $6 co-payment figure is simply the Hawke government's original $3.50, indexed to 2013 using a Reserve Bank of Australia inflation calculator. It was not plucked out of the air.

What I outlined has essentially the same features of the 1991 Hawke Budget measure. The substantial difference is that I provided for the co-pay to be covered by private health insurance, while the original did not. The main reason I did this was because the Australian Medical Association wanted the gap insurance option back in 1991.

Provided it has a reasonable ceiling to protect the less well-off, chronically ill and families with young children, there is no reason why a co-payment on bulk-billed services should stop people going to the GP when they need to. In my view, proposals routinely advocated by health policy experts for "fat taxes" on junk food and soft drinks would have a far harder financial effect on the less-advantaged than the 12 visit co-payment ceiling ($72 per year) in my paper.

In terms of estimating the demand effects of my proposal, I was deliberately conservative. In terms of the Rand Health Insurance Experiment, the effects are probably understated. The $750 million saving I estimated over four years relates only to Medicare rebates for GP services. I did not calculate flow-on savings such as specialist referrals, PBS prescriptions, care planning and referrals to allied health professionals. The reason was that take-up assumptions about these flow-ons are difficult to generalise.

My rough estimate, however, is that savings from flow-ons that would have originated with the foregone GP services would be double or more of the GP rebate saving. Verifying this would, however, require hard modelling with generalisable assumptions.

The extension of co-payments to public hospitals

GP-type services in public hospitals should attract the same price signals they would in a GP's surgery. If a GP is readily accessible outside an ED, public hospitals should send a price signal to patients that low-level services should be sought elsewhere unless there is no realistic alternative.

EDs are for genuine emergencies. Public hospitals therefore should also be able to use discretionary charging to send a message to those presenting if had they been prudent and responsible they never would have presented in the first place and wasted publicly-funded time and resources.

Similarly, provided it is done compassionately and sensitively, there is no reason why public hospitals couldn't charge excesses for public inpatient admissions. If a person can afford to make a small contribution to their public patient care, my personal view is that they should.

Expanding price signals

If Medicare is about everyone paying according to their means, surely those with means should pay.

The myth of universality in Australian healthcare must be broken if we are to keep our mostly successful healthcare infrastructure capable of coping with a growing, ageing and more morbid Australian population into the middle of this century.

While the healthcare "establishment" is hostile, feedback from the wider public to my proposal is that there is a willingness not only to at least consider not just it, but also the much wider questions about how we pay for GP and other services, and who should contribute.

What was particularly striking as the debate progressed is the willingness of people who could be presumed as being most affected by a co-payment – the less well-off, concession card holders and people with chronic conditions – to make an affordable contribution to their GP care. Clearly, those who receive GP services most frequently value them the most.

If bulk-billing is reserved only for those most needing it, a government taking this step will not be out of step with public opinion, nor would be the Commission of Audit if it so recommends.

Wider health policy and regulatory reform and tolerant debate

Contrary to assertions by some critics, this proposal was never put forward as a "magic bullet" to fix miraculously Australian health service delivery and financing.

What the resulting controversy has done, however, is kick-start a long-overdue national conversation about the sustainability of our healthcare infrastructure, and put health firmly back on the policy and political agenda. People want to talk about these issues, and health interest groups, experts and policy-makers have a higher duty to the Australian public both to engage them, and treat them with respect.

While these experts endlessly tell us how we can remake the world (if only we could start with a clean slate), the political reality is that Australian public will countenance evolutionary rather than revolutionary reform to their healthcare infrastructure. Extended price signals within Medicare and public hospitals can be politically-acceptable steps along the path of such incremental reform, but they are no quick fix in themselves to the problems of the system as a whole.

Whatever the perceptions of my proposal, its reception demonstrates that any dissent from the health commentariat's status quo is ridiculed and shouted down by self-interested Medicare McCarthyites and opportunistic politicians. Unless there is tolerant, informed and, above all, honest debate of health financing challenges and how best to address them, Australian healthcare will not move with the times, become more expensive and less efficient, and find its quality compromised. Surely nobody wants that.

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