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SUMMARY OF AHCRA'S POSITION ON GOVERNMENT PROPOSALS TO AMEND MEDICARE PAYMENT FOR GP VISITS

The Australian Health Care Reform Alliance (AHCRA), a national alliance of 35 health professional and consumer organisations is concerned about the Federal Government's revised health policy measures that will see GPs charging their patients (including Health Care and Pension Card holders) more for their health care.

Given AHCRA's commitment to an equitable and sustainable health system, AHCRA has serious concerns about the current proposals on several grounds.

- **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.

- **Poor effectiveness:** Discouraging consumers' use of a relatively low cost and modest slice of health spending (7% of total health costs) that encourages basic prevention and early intervention makes little health policy sense. Early intervention reduces the severity of illnesses and eventual costs, and two tier systems tend to have poorer overall health outcome impacts. For example people with mental illness are very significantly under-treated/cared for at primary health care level, and regular monitoring of the impact of medication is essential.

- **A move against universal health care**: The government proposals are part of a pattern of attacking bulk-billing and increasing costs in primary health care (PHC), hence clearing the path for future private health insurance coverage of PHC fees (c.f. the Medibank Private trials in several states). In fact bulk-billing has been seen as a very effective market control mechanism dampening incentives for GPs to increase out of pocket charges (given consumers have an alternative of attending bulk billing clinics). Bulk-billing has always been promoted by the Commonwealth through incentives to do so for very sound reasons.

- **Move to two-tier system:** This is a key step towards a two-tier health system on the American model. However that is a discredited model, inequitable and inefficient. The USA has the highest per capita health care costs by far in the OECD and the worst overall outcomes on a wide range of measures.[1]

[1] References for all figures in this paper are available, eg Wilkinson & Pickett, *The Spirit Level*.

- **Inequity**: The combined effect of the changes will mean GPs will be forced to either take a pay cut or increase or introduce co-payments for all their consumers (given the majority of GPs' time is spent with Health Care Card holders). Over time, the outcome will be less bulk billing and higher co-payments in a country that already has one of the highest levels of health co-payment in the OECD. The proposals will likely have the most negative impact on the health of more vulnerable Australians: a $5 to $7 co-payment will have minimal impact on the behaviour of middle to high income earners.

- **Poor health economics policy**: evidence about health and sustainability suggests we should be investing more in primary health care that will lead to lower downstream (esp. hospital) costs, not discouraging its use. International evidence shows that health systems built on a strong primary health care sector achieve better health outcomes for a lower cost than those focussed on other sectors (such as hospitals). There is other health spending that could be better targeted: medication costs, specialist fees, over-use of pathology and radiology.

- **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.

- **Cost-shifting**: the need for appropriate community health care will remain, and the outcome of increased direct GP consultation costs will likely lead to increased pressure on hospital emergency departments, with no net reduction in taxpayers' contributions..

- **Clumsiness of fee-for-service funding:** this debate has highlighted again that fee-for-service is a clumsy funding mechanism that has outgrown its usefulness and often counter-productive. More varied payment systems including some capitation funds, need to be developed to address the needs of high rates of chronic disease and to encourage more innovative care arrangements. It is time to undertake a national review of primary health care funding.

Other key factors are:

- Other proposed measures (re Level A consultations, and not indexing MBS rebates) will both inevitably force GPs to charge all consumers more, including Health Care Card holders.
- Deterring people from using GP services by making them more expensive will be counter-productive for many, especially those on lower incomes, young people. E.g. the Government's recently launched 7th National HIV Strategy had increasing testing as a major priority. Preventive care saves more GP visits, reduces absences from work because of illness, and reduces productivity. We know that 32% of the burden of health is preventable through lifestyle improvements. Adding copayments will make this % even higher.
- 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.
- It is unclear how this proposal will affect the work of Practice Nurses and Nurse Practitioners, whose roles we should be encouraging on quality and efficiency grounds.