

doi: 10.1111/1753-6405.12348

Proposed changes to Medicare: undermining equity and outcomes in Australian primary health care?

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Since the announcement of the budget bill on May 13, 2014, Australia's Coalition Government faced concerted criticism over the equity and coherence of proposed changes to Medicare, particularly regarding the introduction of a co-payment for GP consultations, radiology and pathology services or, more latterly, reductions in Medicare rebates. The current surviving policy iteration, effective from 1 July 2015, cuts rebates by \$5 for non-concessional patients.

The proposals continue to be debated: the Australian Medical Association proposed an alternative model designed to protect financially vulnerable populations and strategic interventions;¹ the Labor opposition, Greens and minority parties opposed the proposal. After failing to secure support in the Senate for the legislation, and objections to its proposed use of regulation to achieve the changes, the Government has re-entered dialogue around this proposal. From 1 July

2015, "for non-concessional patients, the Medicare Benefits Schedule (MBS) rebates for common GP consultations will be reduced by \$5 from 1 July 2015. Doctors may choose to recoup this amount from the patient through an optional co-payment."² Notwithstanding the nature of the eventual deal between the Government and minor parties, the general Coalition drive toward introducing co-payments for access to primary health care is just one important element of a budget that had presaged an \$8.5 billion cut to the overall health budget.

In this paper we express a number of concerns about the impact and wisdom of introducing these changes, detailing their regressive impact on the less well-off and on primary health care more broadly.³

Co-payment is not new to considerations of Australian primary care: both major parties have proposed co-payments at some point, and under Medicare, Australian GPs can independently set their fees and require a co-payment, although 81.1% of current GP services are bulk-billed (DoH. 2014).⁴

Despite precedent, present intentions for the introduction of the fee represent a symbolic and practical shift in Australia's orientation to health and social welfare, with a move away from universality and social redistribution of costs to support health care access. Opposition to the fee has therefore naturally focused on the unfairness and inequity of introducing a flat rate co-payment for access to primary care, and the limited logic and coherence of this shift with respect to health and social outcomes. In response to these charges, the Treasurer, Joe Hockey, has stated:

*"The truth is governments have never been able to achieve equality of outcomes. In our view it is the responsibility of government to provide equality of opportunity with a fair and comprehensive support system for those who are most vulnerable."*⁵

However, the co-payment will not fulfil what the Treasurer identifies as a government's prime responsibility – to provide the conditions for equality of opportunity. This is a familiar principle often invoked by Western governments when seeking to cut or roll back the provision of primary goods, social welfare, support and services – all policy platforms commonly linked with delivering (the principle of) equality of outcomes. In fact, the co-payment may act as a barrier to achieving both of these social goals. Equality of opportunity and outcome are not binary options: the principles of equality of outcomes and opportunity are understood as indivisible with regard to population health, as they are mutually supported social objectives. By eroding the health and equitable outcomes that flow from universal access to primary care a new and basic source of inequity in health and society will be created.³ The poor health outcomes that arise will then further serve as an obstacle to opportunity for those who are most marginalised. As Starfield⁶ states:

"Policy decisions to restrict utilization by imposing barriers such as copayments are ill-advised on many grounds: they are unlikely to reduce costs; they interfere with the receipt of needed care; and they heighten inequity by preferentially disadvantaging those who need care the most."

Firm evidence on the expected impact of introducing a co-payment on the health of the Australian population does not exist, nor is it likely to become available, given the nature of the experiment that would be required to link the fee with health outcomes.

However, it is clear from most evidence that imposing a financial disincentive in the form of a fee will impede access for those with fewer economic resources and consequently greater health needs, resulting from the reduced opportunities and choices associated with poverty.^{7,8} The available international evidence on the negative consequences of user-pays systems for health outcomes,^{9,10} though not directly applicable across all national health systems, confirms this trend. A recent WHO report stressed that out of pocket payment for access to health services is the major impediment to universal health coverage, and serves as a barrier to opportunities to enjoy a healthy life – a core human right.¹¹

The Federal Government's own expectation around decreasing the rebate is that it will reduce demand for primary care, critical to reining in escalating costs in the overall health care budget. Initial modelling on a \$6 co-payment anticipated a reduction in services that would save \$750 million over 4 years.¹² Yet, if the rationale of the co-payment is to contain "unsustainable" health spending, it is unlikely to make a major contribution – Richardson estimates the \$750 million represents only 0.14% of total health spending.¹³ The "price signal" may reduce demand for services, but the co-payment will not offset health care costs; it will be diverted to a medical research future fund. Within this there is an implicit – but perhaps unintentional devaluing of the role of primary health care, consistent with other budgetary cuts targeting preventive health and primary health care agencies: the National Preventive Health Agency, General Practice Education and Training Limited and the Australian Medicare Local Alliance.¹⁴ The fund will focus on developing therapeutic interventions for a disease burden that may have been largely prevented with investment in primary health care, health promotion and attention to the social determinants of health.

Any suggestion that the high rate of Australian usage of primary care is a result of over-servicing and 'unnecessary' visits is an assumption that "presumes that consumers know the severity and prognosis of their condition before their consultation".¹⁵ On balance, available evidence suggests this is a poorly conceived line of argument based on moral hazard, which has been widely discredited in relation to health care use.¹⁶ With regard to general practice, Del Mar further cautions against the characterisation

of some visits as 'unnecessary'.¹⁷ 'Unnecessary' consultations can have far more utility than may appear by providing reassurance and promoting self-management. It is worth noting the extent to which preventive medicine is delivered on an opportunistic basis – reducing so-called 'unnecessary' visits may erode already limited opportunities for prevention and early management.¹⁸ The potential exists for harm where presentations are incorrectly deemed 'unnecessary' leading to delayed presentation.

Despite the promise of cost savings, and the exemption of children and concession card holders, the currently proposed co-payment remains a regressive charge, particularly for patients with complex and chronic health needs, disproportionately represented in lower income quintiles. These patients not only bear a greater proportion of the nation's burden of disease, but have proportionately less resources (and opportunities) to service those needs.¹⁹ The disincentive to access primary care will collide with high and more complex disease burdens (often associated with multiple access to the services affected by the fee): Aboriginal health services argue the co-payment will further negatively impact on access for their clientele and have committed to absorbing this cost.²⁰

A co-payment has particular repercussions for the growing number of people with multiple chronic conditions and complex health care needs who require ongoing care from multiple providers.²¹ Roughead et al. estimate the average older person with three or more chronic conditions requires upwards of 80 health services per year including a median of 12 GP visits, 5 specialist visits, 11 claims for pathology services and 5 radiology services.²² These contacts generate 60 pharmacy prescriptions, already subject to a co-payment that is also predicted to rise. The direct cost of co-payments to those individuals and other high users may be substantial, with proposed safeguards still to be detailed.

The impact the Federal Government's proposed co-payment will have on preventative health activities within primary health care have been outlined, but the implications extend beyond health promotion and education.^{14,23} A solid body of evidence from around the world clearly indicates stronger primary health care produces better outcomes: reducing access to primary health care reduces population

health.⁶ Primary health care is not only a gateway into the health system, but has the additional role of co-ordination, streamlining, advocacy, prevention, early intervention, continuity of care and family care. In short, it is the site of complex and undifferentiated presentations that provides a vital psychosocial support role.

A recent survey of over 300 patients at three GP 'superclinics' across south-east Queensland confirms the wider value added social utility of primary health care. It identified that 80% of patients visiting a GP were experiencing one or more social problems (e.g. stress, financial difficulties, relationship problems) and half of these patients saw an association between these problems and their current health issues.²⁴ The presentation of patients to primary care should therefore be recognised as a critical opportunity for support and referral to relevant services,²⁵ with international evidence demonstrating the broad health and social outcomes that can be achieved by this gateway function.^{26,27} The presumption that primary care is being over-used also overlooks the enormous opportunities that it provides for people and society. It is, after all, one of the only services in the community to see 83.8% of the population each year,¹⁷ and provides a channel to wider support for the many in the community experiencing difficulties. Any fee that acts as a disincentive to use this service, will risk lost opportunities for Australian society beyond poor health outcomes.

The policy shift to co-payments is therefore not evidence-based with respect to their potential for further meeting health or social needs, nor for providing equality of health-based opportunities. Strong and consistent evidence indicates primary health care improves equity and should be the cornerstone of the health system because it is associated with a more equitable distribution of health in populations.²⁸ Furthermore, the demonstrated benefits of a strong primary health care system are wide-ranging and "not limited to one or only a few aspects of health but, rather, extend to the major causes of death and disorders as well as to reducing disparities in health across major population subgroups, including racial and ethnic minorities as well as socially deprived adults and children".²⁴ It is precisely because of its simplicity, affordability, universality, efficiency and access, that Australia has provided universal and equitable access to primary care since 1983.²⁹ The system has its flaws and

costs, but it is nonetheless a primary health care system that is largely consistent with the evidence of the efficiency and obvious social utility of free primary health care that has been readily apparent in decades of research.^{3,7,24} Despite renewed dialogue, it is unlikely that the Government will abandon its attempts to introduce 'price signals' into Medicare. There is an urgent need to maintain a clear public profile on the likely impact of co-payment or reduced rebates on access to health care for those whose need is greatest.

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