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Abstract

Forget semantics; Federal health policies that undermine bulk billing and encourage 'user-pays' charging of patients for primary care move Australia towards a US-style health care system. They are expected to cost the health system more, not A$12 billion less, and undermine Medicare's bottom-line universal access equity, efficiency and health outcome objectives.

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Supporting Medicare Health, Equity and Efficiency in Australia: Policies Undermining Bulk Billing Need to Be Scrapped

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Forget semantics; Federal health policies that under-mine bulk billing and encourage 'user-pays' charging of patients for primary care move Australia towards a US- style health care system. They are expected to cost the health system more, not A$12 billion less, and under-mine Medicare's bottom-line universal access equity, efficiency and health outcome objectives.

Australia's Medicare system enables universal free access for Australian citizens to necessary care and is key to satisfying underlying equity (universal access) and population health outcomes, but also health system efficiency objectives [1]. The Australian practice of bulk billing allows patients free universal access to primary care, where general practitioners (GPs), allied health services and specialist health professionals accept the Medicare benefit (currently typically A$37.05 for a service) as full payment for a service and do not charge patients any copayment [2]. Bulk-billed patients cannot be charged for any other costs, such as booking, administration or record- keeping fees, or use of dressings and bandages. Currently, 83.6 % of GP services are bulk billed [3].

The claim has been put forward prior to, during and after election-related Medicare debates that extension of the Australian Federal Liberal-National Coalition's policy of not indexing GP, allied health service and other specialist bulk-billing payments would save A$2.4 billion over the next 4 years and A$12 billion over the next 10 years [4, 5]. However, empirical and theoretical health economic analysis of the Coalition's recent policies and policy framework, with sustained attacks on bulk billing— charging patients for GP and allied health services either directly via mandatory copayments or indirectly by freezing bulk-billing payments—will cost the health system more, not less, over time [6–11].

The evidence internationally is clear that charges in primary care settings lead to reduced access for 'at-need' populations to primary care prevention, health promotion and treatment services, such as those provided by GPs, which leads to greater needs for, and use of, downstream services by those underserviced populations [12, 13]. However, this would also be expected to lead to overservicing of those who remain able to pay, with GPs inducing demand in such populations to help fill holes in the patient list and achieve the associated target income of their practices [14–16]. Hence, such policies move Australia towards the exact problems of a US-style user-pays health care system—underservicing of those who reduce their access for financial reasons, and overservicing of those who remain—with the associated higher health system costs and worse health outcomes that reduced equity leads to [17, 18].

In estimating the impacts of charging patients for primary care on those objectives, the best evidence internationally comes from the USA, where such policies have been used extensively, with strong empirical evidence of the impacts on primary care access, health system costs and patient access. Indeed, the evidence goes back to the 1970s, with analysis of the bottom-line impacts of introducing a US$1 Medicaid copayment in California and, more recently, 21st-century analysis of increasing charges for US Medicare patients (populations aged over 65 years) by about US$7 a visit [13, 14]. In terms of equity and universal access, this evidence points to reducing use of primary care services by at-need populations with the introduction of any charge, while increasing their need for, and use of, inpatient services [12, 13]. In California, in the 1970s, the US$1 copayment resulted in an overall 17 % increase in inpatient admissions, while there was an 8 % reduction in the rate of primary care physician visits [12]. In the 2000s, an average US$7 copayment increase for the elderly resulted in an additional inpatient stay for every nine out- patient services reduced, leading to a net increase in annual Medicare health expenditure of US$169, with a reduced outpatient cost of US$71 being more than offset by increased inpatient costs of US$240 [13]. That is, an additional three dollars and twenty cents was spent in more complex care for every dollar 'saved' in primary care—a result magnified in diabetes, hypertension, myocardial infarction and low-socioeconomic populations.

Hence, the claim of a A$12 billion saving to the Federal budget bottom line in Australia, by moving away from bulk billing in coercing GPs to charge patients, moves Australia towards a US-style user-pays system and would be expected to cost in

the order of A$38 billion ($3.20 for every dollar 'saved') in downstream health costs, given US evidence. These downstream costs would not appear directly in the Federal health budget, which accounts only for the projected direct cost 'savings' in GP care, but are expected to impact overall negatively on the Federal and State budget bottom lines from downstream additional hospital use and costs.

Given an additional A$3.20 in downstream costs for every dollar saved in GP payments—even if the Federal Government paid 45 cents in every dollar for additional hospital activity cost, as expected under current Council of Australian Governments (COAG) arrangements [19]—the net impact on the Federal budget would be expected to be negative overall. That is, the Federal budget would face funding equivalent to an extra A$1.44 spent (45 % of A$3.20) for every A$1 saved—in net terms, being A$5 billion worse off over 10 years, with A$17 billion additional downstream costs to the Federal budget more than offsetting the A$12 billion GP 'savings'. Additionally, State health budgets would be expected to be even worse off by A$21 billion over 10 years, given that they would be expected to face A$1.76 of additional hospital costs (55 % of A$3.20) for every A$1.00 'saved' in Federal provision of GP services. Overall, the Australian Federal and State budgets (and the publicly funded health system) would be A$26 billion worse off over 10 years, while also imposing costs on patients, thereby undermining Medicare universal access, health out- comes and health system efficiency bottom-line objectives.

In the USA, such bottom-line impacts of user-pays policies have been reflected in the most recent 2013 Organisation for Economic Co-operation and Development (OECD) analysis, where, despite spending more than 18 % of gross domestic product (GDP) on health expenditure (compared with an OECD average of 9 %), and more than US$8500 per capita, they had some of the worst health outcomes in terms of life expectancy currently or life expectancy improvement over the last 50 years [17]. Indeed, the USA had worse life expectancy outcomes than all countries with health expenditure of more than US$2000 per capita. This is also reflected in a Common- wealth Fund comparison on the key bottom-line objectives of equity, efficiency and health outcomes across 11 first- world countries (including the USA and Australia), in which the USA came last (11th out of 11) on each of these health system objectives, while Australia was fourth overall and first in terms of efficiency [18].

It should be clear to health policy makers that health care services are not like other economic goods where Economics 101-style modelling of quantity reduction and budget cost savings arise as impacts from user payments. Ideological rhetoric for user payments creating appropriate use and increasing efficiency—such as that underlying the various policies and proposals for undermining bulk billing and charging patients for primary care [4, 5, 20–22])—are diametrically opposed to what can be expected from such policies being applied to the Australian health care system.

If the Coalition's health policy reform is aimed at reducing supplier-induced demand (SID), it should be clear that charging patients is misguided and does not work to address this. Rather it results in underservicing and higher downstream costs in those who no longer access primary care, while GPs are expected to respond by inducing demand and overservicing populations who can still afford to pay. That is, GPs maintain their target incomes and fill the holes in their lists left by reduced use on the part of at- need populations not able to afford services, by increasingly overservicing those who remain able to. Such over- servicing can manifest in unnecessary tests, procedures and/or use of prescription medications. Importantly, like underservicing, such overservicing can also be expected to lead to adverse health effects and their subsequent increased downstream costs [14–16].

If policy reform really wants to tackle SID in GP and primary care settings, then a capitation-based system, where GPs are paid for the populations they service—such as the core primary care payments in the UK [23]—should be considered. In Australia's case, such a policy could also be expected to address the skewed density of working GPs per 100,000 population in urban regions (228/100,0000 compared with rural regions [145/100,000] or remote regions [113/100,000]) [24]. Reductions in the availability of bulk-billing doctors, with a continuing freeze on GP bulk-billing payments, can be expected to be greatest in rural and remote regions because of a lack of alternative local options and the high travel time/costs of 'shopping around' for bulk-billing services in these areas.

Unless GP Medicare payments move from fee for service to capitation payments, bulk billing is the key feature that supports health system universal access, population health outcomes and efficiency; policies that undermine bulk billing (patient copayments or freezing bulk-billing payments to GPs) move us towards a more costly and less efficient US-style health care system.

Alternatively, if the objective of Federal health policy reform is to improve the budget bottom line—without impacting on Medicare and health system equity, and health outcome objectives—then removal of the private health insurance rebate is the obvious reform. While now costing more than A$6 billion annually[4], the private health insurance rebate has abjectly failed to meet the stated objective of taking pressure off the public health system. Cumulative evidence since the

introduction of the rebate in 2000 suggests it has, in fact, placed net pressure on the public system [11, 25–27]. The private health insurance rebate, by reducing the threat of higher future premiums with lifetime cover, itself had little (or no) net impact on private health insurance rates despite reducing current premiums. However, increased health insurance rates attributable to threats of lifetime cover and Medicare levy surcharges, while having limited reduction in public patient hospital use for necessary care, have resulted in substantial increased private activity for unnecessary treatment, creating added wage pressure on the public system. So, removing the subsidy on private health insurance currently would not impact on access to necessary care or health outcomes, while saving the Commonwealth budget more than A$6 billion annually.

In the short term, regardless of what arrangements for government are in place after the 2016 Federal election, current Federal health policies that attack access to primary care need to be reversed. GPs, whose income is currently being eroded, cannot indefinitely defend Medicare universal access, efficiency and health outcomes against the policy mechanisms moving Australia towards US-style user payments and poorer health outcomes.

Compliance with Ethical Standards

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