

Supplementary submission to Senate Select Committee on Health: Why the proposed rebate reductions will damage the health system

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In January Health Minister Ley confirmed a \$5 cut to GP funding for each service a GP performs for patients who are over 15 and don't have a concession card. She also confirmed an across the board freeze for three years on all Medicare rebates including those GP items. The proposed minimum time for a Level B consultation – the most common type of patient visit -- has been scrapped.

Although verified estimates don't appear to be in the public domain, the savings to the Commonwealth from these two policies are reportedly estimated at roughly \$1 billion each over the forward estimates period of four years.

However, coupled with the freeze, the cumulative impact of the \$5 rebate reduction on general practices and therefore on patients will be substantial. Non-concession patients may have to pay a \$30 co-payment, not a \$5 one.

Part of the policy rationale for co-payment policies 1.0 and 2.0 is about 'making Medicare sustainable'.

This begs two key questions:

1. Is Medicare's sustainability a real issue?
2. What is the likely impact – fast or slow -- of the rebate reductions?

Medicare sustainability

Ministerial media releases on the co-payment policies have cited two grounds for the claim that Medicare is not sustainable.

First, Health Ministers Dutton and Ley have both highlighted that Medicare outlays have increased by more than 100 per cent over the last decade. This is true and any growth in spending must be justified. But in order to develop sensible policies it is important to disentangle reasons for growth in outlays.

Inflation has increased over the period, as has GDP, as has population. To illustrate the issue, over the decade to 2012-13 expenditure on un-referred medical services (primarily general practitioner consultations) increased at an average annual rate of 7.1 per cent. The increase for referred items (specialists and diagnostics) went up somewhat faster, at an

average of 8.2 per cent a year.¹ But when inflation is factored in, these annual rates drop by around 2.7 per cent. Over the decade to 31 December 2012 Australia's population grew by about 1.6 per cent a year so the real annual per capita growth in spending is 3 to 4 per cent - not much above GDP growth in this period.

The second issue raised by the Ministers was the extent of revenue from the Medicare levy. The Medicare levy was never intended to cover the full cost of Medicare. It didn't when it was first introduced, it doesn't now. The Medicare levy doesn't even get allocated to the health portfolio – it is simply another revenue source for government, like petrol taxes. Revenue from the most recent increase in the Medicare levy was used to offset costs associated with trials of the National Disability Insurance Scheme.

There is no doubt the costs of health care are increasing, and increasing faster than inflation, population growth, and tax receipts. Therefore choices must be made. For governments, those choices can be about expenditure, revenue or both.

The government's policy announced in the 2014-15 Budget and continued in its revision of the policy is to focus on outlays. It believes the reduction in Commonwealth government outlays should fall most heavily on primary care, particularly by increasing consumer co-payments.

Previous Grattan Institute submissions to the Senate Standing Committee on Community Affairs have shown that a focus on consumer co-payments has severe and adverse equity consequences.² A focus on primary care for budget cuts is also inappropriate. Primary care is generally seen as the most efficient locus of care. Overseas, most OECD governments are expanding investment in primary care rather than cutting back.

If the focus is on outlays, there are better places to start. Grattan Institute has published several reports that question current spending priorities. Reports in 2013 on the Pharmaceutical Benefits Scheme identify substantial savings of up to \$1 billion a year if the Commonwealth adopted a different pricing strategy for generic drugs.^{3 4} Essentially, the reports argue that government should benchmark the prices it is prepared to pay against those paid in similar countries such as England, Canada and New Zealand.

Further, public policy should be based on both costs and benefits. Purely focussing on outlays without considering the benefits from those outlays can again focus policy attention in the wrong place.

The principal driver of spending growth is neither inflation nor ageing but the fact that health care is changing. More can be done to treat illnesses. New drugs and new procedures are

¹ Australian Institute of Health and Welfare (2014) *Health expenditure Australia 2012-13*, AIHW

² Duckett, S. and Breadon, P. (2014) *Out-of-pocket costs: hitting the most vulnerable hardest* - Grattan Institute submission to the Senate Standing Committee on Community Affairs Inquiry into the out-of-pocket costs in Australian healthcare, Grattan Institute

³ Duckett, S., Breadon, P., Ginnivan, L. and Venkataraman, P. (2013) *Australia's bad drug deal: High pharmaceutical prices*, Grattan Institute

⁴ Duckett, S., Breadon, P., Ginnivan, L. and Nolan, J. (2013) *Poor pricing progress: Price disclosure isn't the answer to high drug prices*, Grattan Institute

improving treatment, and there have been significant decreases in amenable mortality – deaths from conditions for which health care interventions make a difference.⁵

Medicare per capita spending is increasing at 3 to 4 per cent a year in real terms, somewhat faster than GDP. If that trend continues Medicare will consume a larger share of GDP over time. Total health care spending (all areas of health spending, not just Medicare) as a share of GDP is projected to increase by one percentage point of GDP each decade, reaching 12.3 per cent in 2032-33.⁶

Such a level of spending on health care would not make Australia an outlier internationally. It would simply reflect priority choices, including those of both individuals and government. There is no economic evidence to suggest that spending at this level is unsustainable.

Rebate reductions

The two remaining elements of the government's policy concern rebate reductions. Both are likely to lead to increased co-payments.

The first is a \$5 reduction in rebates for general practitioners for patients without concession cards and for children over 15. Data from University of Sydney BEACH surveys suggest that about 60 per cent of patient visits would be exempt from the reduced rebate.⁷ The average practice (with an average distribution across the four consultation items, an average proportion of exempt patients and an average bulk billing model), would suffer about a 4 per cent reduction in revenue on level A-D consultation items (the levels reflecting the length and complexity of a patient visit).

The second, stealth reduction is the freeze on all rebates, not only on general practice. The table shows the estimated impact on per patient revenue in general practice under this policy for the four common consultation items.

Assuming inflation of 2 per cent a year, the cumulative impact on the freeze between now and June 2018 will be a further 6 per cent cut in general practice revenue.

In total, if inflation runs at 2 per cent and the \$5 rebate cut goes ahead with its 4% revenue impact, general practices will face reductions in rebates from these consultation items of just over 10 per cent. Cuts of that magnitude will challenge the business model of most general practices.

The result is likely to be a move away from bulk billing. This is indeed the object of the government's policy.

⁵ Page, A., Tobias, M., John, G., Wright, C., Hetzel, D. and Fisher, E. (2006) *Australian and New Zealand atlas of avoidable mortality*, Public Health Information Development Unit, University of Adelaide

⁶ Goss, J. (2008) *Projection of Australian health care expenditure by disease, 2003 to 2033*, Australian Institute of Health and Welfare

⁷ Britt, H., Miller, G. C., Henderson, J., Bayram, C., Harrison, C., Valenti, L., Wong, C., Gordon, J., Pollack, A. J., Pan, Y. and Charles, J. (2014) *General practice activity in Australia 2013-14*, Sydney University Press

Table: Estimated average funding reduction per patient in 2018

Consultation type	Inflation at 1.5%		Inflation at 2%		Inflation at 2.5%	
	Cut from rebate freeze	Cut from freeze plus \$5 rebate reduction	Cut from rebate freeze	Cut from freeze plus \$5 rebate reduction	Cut from rebate freeze	Cut from freeze plus \$5 rebate reduction
Level A	4.4%	11.4%	6.8%	13.6%	7.3%	14.1%
Level B	4.4%	8.1%	6.8%	10.4%	7.3%	10.9%
Level C	4.4%	6.5%	6.8%	8.8%	7.3%	9.3%
Level D	4.4%	5.9%	6.8%	8.2%	7.3%	8.7%
Weighted avg.		7.8%		10.1%		10.6%

Assumptions:

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Funding reductions are in mid-2018 relative to today (in real terms).

Analysis is restricted to four types of GP services: Level A-D consultations reflecting length and complexity of patient visits.

To estimate which patients will receive a \$5 funding cut we used BEACH data (Brit et al, 2014), which estimates that 57% of GP visits are for patients with a Commonwealth Concession Card, Repatriation Card, or who are children up to the age of 15. To account for other exclusions (15-year-olds, patients getting GP health plans and GP management plans) and to be conservative, we assume that two thirds of patients are exempt from the \$5 funding cut.

As currently, 84% of consultations attract a bulk-billing incentive under the freeze scenario, falling to 67% under the \$5 cut scenario due to GPs passing costs on to previously bulk-billed patients (in each case, 30% of incentives are at the higher rate for regional areas). If bulk billing rates did not fall and co-payments for other patients increased or GPs absorbed the costs, it would make a negligible difference to the weighted average subsidy per patient visit (<0.1% in all inflation scenarios).

If a practice decides to reduce bulk billing, what fees will they charge? For bulk billing practices, the cost of introducing fee collection processes, including potential cash handling, is not trivial and may be more than \$5 a consultation. A move away from bulk billing also means that the practice will lose the current bulk billing incentive of \$6.15 or \$9.25 (depending on location and other factors).

In deciding their strategy, practices would need to consider not only the immediate impact of the \$5 rebate reduction, but also the slower but greater impact of the rebate freeze. If practices know that the value of the government rebate will erode over time, it would be prudent to set fees now which take that into account, especially as they have absorbed the impact of the existing freeze initiated by the previous Labor government.

The average out-of-pocket payment, when there is one, is \$31 at present.⁸ The combined impact of the freeze and the \$5 rebate reduction raises the risk that practices would move to the prevailing non-bulk billed co-payment.

Imposing a \$31 fee may cause a reduction in demand as patients balk at paying the fee, defer the visit until they have multiple problems, or go to a hospital emergency department or pharmacy instead.

The impact on practices of a reduction in daily demand is unclear. At present many fill more appointments than they have available on any given day and patients have a waiting time of a day or two for appointments. Some patients don't wait and seek care elsewhere, from pharmacies or other GPs. But if demand drops as a result of co-payments, waits might reduce and patients who might otherwise have sought alternative treatment sources would obtain a GP consultation. The overall impact might be no reduction in realised demand.

If practices decide to maintain bulk billing for some non-concessional patients subject to the \$5 rebate reduction, GPs may offset the reduction by increasing the co-payment for people who already pay one. The average co-payment for non-bulk-billed services could then increase significantly above its current level.

In summary, the rebate reductions and the freeze are likely to lead to reductions in bulk billing and increases in co-payments. The increase in co-payments is likely to be significantly greater than the \$5 rebate reduction.

⁸ <http://health.gov.au/internet/main/publishing.nsf/Content/Quarterly-Medicare-Statistics>