ACHR
AUSTRALIAN CENTRE FOR HEALTH RESEARCH

A PROPOSAL FOR AFFORDABLE COST SHARING FOR GP SERVICES FUNDED BY MEDICARE

October 2013

NEW POLICY PROPOSAL

To revive the Hawke government's 1991 Budget measure to impose modest co-payments on Medicare Benefits Schedule (MBS) non-referred general practitioner (GP) attendances.

DETAILS

Estimates for the Forward Estimates period from 1 July 2014[1]

	2014-15	2015-16	2016-17	2017-18
No. GP services				
1. No co-pay[2]	122,600,000	126,250,000	130,050,000	133,950,000
2. With co-pays[3]	120,200,000	121,200,000	122,400,000	123,650,000
Difference (1 minus 2)	2,400,000	5,050,000	7,650,000	10,300,000
No. bulk-billed services				
1. No co-pays[4]	98,100,000	101,000,000	104,000,000	107,200,000
2. **With co-pays**	96,200,000	97,000,000	97,900,000	98,900,000
Difference (1 minus 2)	1,900,000	4,000,000	6,100,000	8,300,000
Net rebate savings ($)[5]	70,110,000	147,600,000	225,090,000	306,270,000
Estimated net saving over FE period:	**$749,000,070**			

Some minor reduction of the estimated savings could be expected due to some patients and families reaching the Extended Medicare Safety Net and concessional limits. As reaching these thresholds would require many GP visits in a year, however, relatively few patients would be affected.

Policy justification for the proposal

The unambiguous purpose of this proposal is to find savings in the MBS that either reduces or significantly slows the growth in MBS outlays over the first full Forward Estimates (FE) period of the new Coalition government from July 2014.

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[1] For more details of underlying assumptions, please refer to page 4-5.

[2] 30 June 2014 baseline calculated from 2012-13 actual outcome increased by 3 per cent. For FE period, previous year's GP attendances were multiplied by 1.03 (3 per cent annual growth factor) under the no co-payment scenario.

[3] 30 June 2014 baseline then year-on-year growth of 1 per cent thereafter. For the FE period, previous year's GP attendances under co-payment option were multiplied by 1.01 (1 per cent annual growth factor) under the co-payment scenario.

[4] Assumes average bulk-billing rate of 80 per cent. Bulk-billing figures therefore are total volume for each year multiplied by 0.8.

[5] Assumes 2013 standard Level B GP consultation schedule fee of $36.90 frozen constant through the FE period. Annual indexation not included in these calculations. The estimated benefits saved figure is the amount payable on the difference between the volume of bulk-billed services with and without co-payments.

Nevertheless, savings must be based on sound policy justification. There are a number of reasons why there is policy merit in attaching modest co-payments to GP services. These include:

- Reducing avoidable demand for GP services, particularly in outer suburban and regional areas where GPs are in relatively short supply. By helping to manage demand, GPs will be able to concentrate more of their scarce time on patients who most need treatment or care management.

- Reducing incentives for GPs to overservice where there are high concentrations of general practitioners – the principal justification of the 1991 Budget measure.

- For Unreferred Attendances (ie GP services), in which 80 per cent of services are bulk-billed, sending a price signal to consumers and reminding them that GP services are **not** a free good.

- Provided that co-payments are not large enough to deter people from going to the GP if that is what their health indicates, reducing moral hazard risks by making people think twice about going to the doctor about minor ailments treatable with rest and/or over-the-counter medications.

- Offering a simple yet powerful reminder that, as far as possible, we have a responsibility to look after our own health, not simply pass on all the costs of, and the responsibility for, caring for ourselves to fellow taxpayers.

Features of the proposal

The proposal would follow the 1991 precedent, updated for inflation and for evolution in Medicare since 1991. As modelled, it would take effect from **1 July 2014** and include:

- Costed as applying to GP personal attendances **only** (Levels A, B, C, D)

    - But obviously there is scope to apply it to services **arising** from GP attendances, including Practice Nurse, Care Planning and Extended Primary Care items.

- Freezing MBS GP attendance schedule fees at current levels until 1 July 2018 – ie $36.90 for level B standard vocationally-registered GP consultation

    - Rather than a substantial immediate cut GP rebates to be made up by co-payments, as happened in 1991 (see below), freezing rebates means minor real reductions in their value over time, giving GPs greater incentive to offset their income stream by charging co-payments for bulk-billed services.
    - Introduce a flat co-payment on MBS Levels A-D GP rebates of $6.00, making the value to the doctor of a bulk-billed standard (Level B) consultation $42.90.
    - There could be scope to increase the co-payment for longer consultations, but for transparency and equity single a flat co-payment rate is preferred.

- An perhaps more palatable alternative starting point could be rebates as indexed to 1 July 2014, with annual indexation retained thereafter

    - This would minimise objections from medical interest groups that GPs are being penalised.
    - This would, however, have a moderate effect on the quantum of savings identified in this paper.

    Indexation issues are discussed further below.

- It is essential to ensure that any co-payment regime is fair and does not compromise healthcare choices on personal cost grounds. This indicates minimising the financial impact on concessional patients and families with children under 16

    - Concessional patients and families with children under 16 would reach a safety net threshold after 12 visits to a GP in a year – ie averaging one visit per month, or a maximum co-payment of $72.
    - After that, the Commonwealth would pick up the full cost of GP visits for the rest of the year, including the co-payment equivalent.
    - In practice, this should only effect FE costings marginally over time, as in 2012 the average number of GP visits per capita was 4.9[6]. The proposal is modelled on that per capita ultilisation.

- For general patients, Extended Medicare Safety Net thresholds (EMSN) would not change, and existing EMSN caps on GP services would be removed

    - GP co-payments for general patients would count towards the EMSN.
    - Once the relevant EMSN threshold or co-payment ceiling has been reached, the Commonwealth would pay the full cost of the consultation to the GP (ie schedule fee plus $6.00).
    - Again, this should only affect costings marginally over time (if at all), but would help to protect non-concessional individuals and families if and when confronted with a health crisis leading to large medical bills.

- GPs may waive the co-payment on compassionate or financial grounds, at their own discretion

    - This involves no additional cost to the Commonwealth.

- Co-payments, and expenses below the EMSN threshold, **could** be covered by private health gap insurance

[6] Department of Health and Ageing, *Medicare statistics tables 1984-2012*, Table B1: Medicare services per capita by financial year of processing and broad type of service http://www.health.gov.au/internet/main/publishing.nsf/Content/3A0C9E346B14F36FCA257A640009024E/$File/tableb1b.pdf

- This would be the biggest variation from the 1991 measure, when the then Labor government flatly rejected gap insurance.

- Administrative expenses to be absorbed by the Department of Health and Medicare Australia from existing allocations.

Indexation

To mimimise resistance from the medical profession and GPs in particular, it may be prudent to ensure that the co-payment measure is implemented in conjunction with assured GP rebate indexation.

Since 2005 GP rebates increased by an average of around 2 per cent[7]. If annual indexation assumption is included, this will affect MBS costs volumes and offsets for Government.

Incorporating a historically-generous but practically realistic 3 per cent indexation factor, with all other modelling assumptions unchanged, would increase the value of benefits saved from foregone GP services by about $73 million, but this would be offset by higher overall MBS benefit costs for services provided.

The preferred position, therefore, is to freeze indexation across the FE period. This would give GPs the greatest possible incentive to charge the co-payment, while not giving them the opportunity to double-dip by pocketing both rebate indexation and a co-payment.

- Even assuming constant fee indexation of 3 per cent annually over the period to July 2018, the MBS Level B consultation fee at the end of the period would still be **less** than the $42.90 of the current Level B fee plus $6.00.

Other policy changes to support the proposal

To ensure that this measure is viable and fair, it also would be desirable to reduce or remove policy and regulatory requirements where GPs' time is imposed upon for non-treatment reasons, such as:

- Obtaining doctor's certificates simply for minor ailments that may not otherwise require a medical consultation for a patient's effective treatment and recovery, such as uncomplicated cold and flu episodes in winter.

- Obtaining specialist referrals; or

- Obtaining repeat prescriptions.

Costing assumptions

- Co-payments on bulk-billed services notionally would reduce the volume of **all** GP services by 3 per cent per year.

[7] Australian Medical Association press release, 16 October 2012.

- That is, service volumes over the FE period would remain relatively flat around 2013-14 levels, as decline in demand cancels out growth.
- But allowing for utilisation and demographic factors (especially population growth and ageing population) there would still be some net growth.
- There is no hard and fast support for any demand dampening figure. On the qualified evidence of the RAND Health Insurance Experiment, however, this dampening of demand actually may be conservative and understated.

- After the co-payment effect, a **net** year-on-year growth of 1 per cent in GP services over the FE period, based on:

  - Demographic utilisation factors for population growth and ageing tend to increase demand.
  - Year-on-year growth in the volume of MBS-rebated GP services has averaged 3 per cent since 2009-10. Assuming that average remains constant for the FE period.

- MBS benefit values calculated on current MBS schedule fees, and base volumes for calculating FE period volume are for financial year 2012-13, with growth assumptions applied to 2013-14

  - Indexation discounted for costing calculations.

- The 1991 standard consultation rebate reduction of $3.50 would be $5.97 as indexed using Reserve Bank of Australia calculations[8] – rounded to $6.00

  - In this model $6.00 becomes the non-concessional co-payment.
  - This allows direct comparison with the Hawke government's 1991 measure.
  - Like the schedule fees, the co-payment would remain constant.

- Bulk-billing rates remain constant at a nominal 80 per cent for the FE period starting in 2014-15, assuming a slight drop-off from the current June Quarter 2013 peak (82 per cent).

- There would be a **marginal** offset in the savings from patients and families reaching the Extended Medicare Safety Net threshold, but quantifying this requires further analysis and therefore has not been costed for this paper.

Relevant recent Medicare GP service data

To obtain a trend to estimate the forward effect of the proposal, obtaining trends from recent years' MBS statistical data assists in making assumptions and predictions.

Key baseline data used to estimate the demand and savings effects of this proposal are contained in the following table:

[8] Reserve Bank of Australia, Indexation Calculator, http://www.rba.gov.au/calculator/annualDecimal.html

Medicare statistics: Non-referred attendances (GP and non-vocationally registered GP)

2009-10 to 2012-13[9]

	2012-13	2011-12	2010-11	2009-10
Number of services	115,510,216	111, 720, 675	108,004,281	106,206,128
% change on previous year	3.8	3.3	1.7	N/A
Benefits paid ($)	4,908,060,947	4,604,161,206	4,326,812,541	4,122,383,679
% change on previous year	6.6	6.4	5.0	N/A
Schedule fee observance (%)	81.1	80.1	79.2	78.8
% change on previous year	1.0	0.9	0.4	N/A
Bulk-billing rate (%)	81.1	80.0	79.1	78.6
% change on previous year	1.1	0.9	0.5	N/A

BACKGROUND

The Hawke government's 1991 Budget Medicare co-payment measure

Drawing on work done for the National Health Strategy review that commenced in 1990, the Hawke government in its 1991 Budget announced that from November that year a co-payment of $2.50 per service would be applied to all bulk-billed GP services.

Key features of the Budget measure were:

- The MBS schedule fee for non-referred (GP) attendances would **increase** from $22.50 to $23.50 from 1 November 1991, and indexed thereafter.
- MBS rebates for non bulk-billed GP attendances would be **reduced** by $3.50 from 1 November 1991.
- Rebates would be **reduced** by a further $1.50 from 1 November 1992.
- Bulk-billed patients would make a co-payment of $2.50 per service for non-referred services from 1 November 1991, rising to $4.00 from 1 November 1992.
- Pensioners and welfare recipients (health care cardholders) would be exempt from the GP co-payment.

[9] Department of Health and Ageing, *Annual Medicare Statistics, Financial Year 2007-08 to 2012-13*, 2013.

- A new MBS safety net to put a ceiling on patient contributions to reduce the impact of co-payments on low and fixed income earners - $246 for a family of two adults and two children.

- The co-payments could **not** be covered by private health gap insurance. This was ostensibly to stop GPs gaming, but also reflected the then Government's hostility to PHI versus the universality of Medicare.

The then savings assumptions were:

- Biggest savings measure in the 1991 Budget.

- $164 million in MBS savings in 1991-92 and $305 million in $1992-93.

- Expected decline in the number of visits to the GP.

- GPs would make up the decline in their rebate income from co-payments.

The 1991 Budget papers did **not** quantify the number of foregone GP visits. In hindsight, this appears to be partly due to the relative lack of detail in Budget papers at the time, and Treasury and the Government wanting to avoid the political sensitivity of making public a hard estimate.

Relationship to other 1991 Budget measures

The MBS co-payment measures were part of a wider Budget package of Health portfolio budget measures. The Government also announced a set of medical workforce initiatives designed to constrict the growth of the workforce, particularly GPs.

The prevailing view at the time, which held into the first term of the Howard government, is that there were too many GPs in crowed urban markets who generated services to maximise their incomes (ie the theory of supplier-induced demand).

Development of the co-payment measures

The measures were flagged in the weeks before the Budget. Newspaper reports canvassing their content turned out to be more or less accurate.

The measures themselves were originated in Treasury, not by then Human Services and Health minister Brian Howe or his Department. It appears that Treasury drew on research done for the National Health Strategy review, coordinated by future Labor minister Jenny Macklin. Particular reliance was placed on evidence considered in a discussion paper by Professor Jeff Richardson of Monash University, *The Effects of Co-Payments in Medical Care*[10].

[10] J Richardson, *The Effects of Co-Payments in Medical Care*, National Health Strategy Background Paper No 5, 1991. Interestingly, after outlining the empirical RAND findings and other evidence, Richardson himself did not endorse co-payments.

The Richardson paper looked at evidence from Australia and overseas, especially the RAND Corporation's Health Insurance Experiment of the 1970s and 1980s which actually applied a range of co-payment regimes to large cohorts of real people to ascertain effects on service demand and consumer behaviour.

It also appears that Treasury used demand evidence from the Pharmaceutical Benefits Scheme following the introduction of PBS co-payments in their modern form from the late 1980s.

History of the operation of the 1991 co-payment measure's operation

As announced in the Budget, the Hawke government commenced the co-payment measure on 1 November 1991, as part of the normal update of the MBS Schedule.

The co-payments themselves, however, were highly contentious from the outset. They were almost universally condemned by health interest groups. The Australian Medical Association and doctors' groups welcomed the co-payment but condemned the cut in MBS rebates. Consumer groups, academics and commentators opposed co-payments because, they argued, these:

- Undermined the universality of Medicare.
- Did not discriminate on basis of a patient's ability to pay.
- Raised concerns that poorer patients would forego treatment for themselves or their families because they could not afford it.

Much more seriously for the Government, these also raised concerns in the ALP Caucus. John Kerin became Treasurer after Paul Keating's unsuccessful first leadership challenge earlier in 1991, and he was roundly criticised for his Budget as a whole, and the MBS co-payments in particular.

Capitalising on Caucus discontent, coupled with John Hewson's release of *Fightback!* and its user-pays plan for Medicare, Keating saw an opportunity to build his support against Hawke. It became clear that if he succeeded in toppling Hawke that the co-payment would go too. Keating's position helped bring waverers to him.

After Hawke reluctantly sacked Kerin as Treasure in late 1991 and replaced him with Ralph Willis, and Hawke's position weakened against Keating, co-payments became the central policy difference for the final leadership showdown. When Keating won his second leadership ballot on 21 December, he made clear that the co-payment would go as soon as possible.

The Keating government accordingly removed the MBS co-payments from 1 March 1992. Effectively, therefore, they operated for only one quarter. Anecdotal reporting at the time indicated that they did have an immediate dampening effect on demand for GP services, but given that overall

GP service provision still grew by 4 million services in in 1991-92[11] it is not possible to corroborate this from currently publicly-available MBS data.

Unfortunately quarterly data from 1991-92 is no longer publicly available, but should be able to extracted from the Department of Health and Ageing's MBS statistical database.

CO-PAYMENTS AND THE RAND EXPERIMENT[12]

The 1991 National Health Strategy review, common with other significant consideration of medical co-payments, considered evidence from the RAND Corporation's Health Insurance Experiment (HIE) of 1971-92.

The HIE selected large randomised cohorts of Americans to and enrolled them in healthy plans with different levels of co-payment. The objective was to observe and measure the effects of co-payments on participants' health care choices and utilisation on the one hand, and the quality of the care they received on the other.

There were four co-payment levels in the HIE: free care; 25 per cent co-payment; 50 per cent and 95 per cent, plus a non-profit Health Maintenance Organisation (HMO) co-operative that managed and purchased services for free care participants.

Unlike this proposal's focus entirely on GP services, the HIE's co-payment regimes applied to all services (including hospitalisations) covered by the participant's plan.

Effects on use of health services

HIE results showed that co-payments at whatever level reduced the use of nearly all health services compared to free care. This included:

- One to two fewer GP visits annually and 20 per cent fewer hospitalisations.
- Participants generally spent less on health care because of using fewer services.
- Reduced use of services resulted primarily from participants deciding not to initiate care
  - Once in the system, co-payments only modestly affected the costs of an episode of care.

[11] In 1990-91, non-referred (GP) attendances fell by a quarter of a million on the previous year, and increased by 4.2 million in 1992-93. To see the effect of the 1991 co-payment quarterly data is essential.

[12] This discussion draws heavily on a RAND Health research brief, *The Health Insurance Experiment: A classic RAND study that speaks to the current health care reform debate*, RAND Corporation, 2006 http://www.rand.org/content/dam/rand/pubs/research_briefs/2006/RAND_RB9174.pdf

Effects on appropriateness and quality of care

The HIE analysis found that co-payments reduced the use of both effective and less effective care, including inappropriate hospitalisations and the inappropriate use of antibiotics. It also emerged, however, that co-payments did not affect the quality of care received by participants. One they were in the system, participants' patient experiences were relatively consistent.

Effects on participants' health

In general, the reduction in services induced by co-payments appeared to have no adverse effect on participants' health. It did appear, hover, that the poorer and sicker on free plans fared better for 4 out of 30 conditions measured, including hypertension, vision, dental care and the prevalence of serious symptoms.

Patient satisfaction was lower among participants assigned to the free care HMO. This indicates that personal direction over one's care, rather than out-of-pocket costs, is a prime determinant of consumer satisfaction.

Finally, the HIE considered where participants taking some payment responsibility for their own health care led to them taking better care of themselves. Surprisingly, it did not. Risky behaviours, such as rates of smoking and obesity, were not affected.

Key HIE conclusions

For this proposal, there are three relevant key findings from the RAND Health Insurance Experiment:

- Participants who paid for a share of their health care used fewer health services than those who were given free care.

- Co-payments reduced the use of both highly effective and less effective services in roughly equal proportions
  - But the *quality* of services used did **not** suffer.

- Co-payments generally had no effects on participants' state of health, but free care demonstrated relative improvements in a small number of studies areas including hypertension, dental health, and vision.
  - This appeared to most benefit poorer and sicker patients.

It also appeared that the higher the co-payment, the more likely a participant was to defer or not pursue health services essential to treating or managing health conditions. Conversely, lower co-payments seemed to have little effect on demand for services that patients deemed essential rather than discretionary.

This was borne out in the findings of an extensive literature search published in 2007, particularly in relation to pharmacy-related ultilisation[13].

PROS AND CONS OF THE PROPOSAL

Imposing MBS co-payments on GP services is very narrow compared to the comprehensive and very broad application across services in the HIE. GPs, however, are the gatekeepers to both our primary and acute care systems, and Australians would need to be confident that their access to clinically necessary medical services is not going to be prevented or compromised.

This includes access to services referred by GPs, including diagnostics, specialist referrals and other health professionals (especially through the Enhanced Primary Care programme).

Pros

Above all, the proposed co-payment approach is narrow rather than broad. By focusing exclusively on GP services, it does not affect access to referred services, nor does it affect the bulk-billing practices for those other services.

The proposed general co-payment of $6 is only 16 per cent of the current MBS schedule fee for a standard GP consultation, considerably lower than the lowest 25 per cent co-payment tier in the RAND Health Insurance Experiment.

- This is very affordable to most Australian households, even the less well off. It is less than the price of two cups of coffee, or a Big Mac with a side of fries.

Even set at this modest rate, GP co-payments have the potential to make a very significant saving on MBS outlays, which then can be reallocated to more essential health and aged care priorities without making added calls on the Budget.

Not insignificantly, imposing co-payments on GP services would send clear price signals to Australians that their basic healthcare services are **not** free goods, coming to them with a real financial cost, and therefore are best valued by consumers if they come with a price signal:

- Co-payments have the potential to dampen avoidable demand for GP services by asking consumers to decide whether their visit to the GP is necessary.
- The HIE's evidence is that co-payments do **not** in themselves lead people to modify their personal health management behaviours.

The key point is that a $6.00 co-payment would be high enough to send a price signal to consumers and deter moral hazard, but not high enough to deter consumers from seeking essential GP services.

[13] Goldman, Joyce and Zheng, Prescription drug cost sharing: Associations with medication and medical utilization and spending ad health, *Journal of the American Medical Association*, 2007, volume 298(1), pages 61-69: http://jama.jamanetwork.com/article.aspx?articleid=207805

Cons

The HIE indicates that there is a risk that **some** people will be deterred from seeking GP attention because of the direct cost factor. If people miss or received delayed treatment for significant acute and chronic conditions because of co-payment factors, obviously these will become controversial and sensitive.

- The key issue is ensuring that any co-payment imposed on the less well-off does not become a significant cost impost on them.

- This applies to the concessional and children under 16 groups in particular.
  - This is why a reasonably low co-payment safety net for more vulnerable consumers is necessary.

The RAND experiment and other analyses support the conclusion that co-payments are a blunt rather than a sophisticated demand management instrument. Whatever the set levels of co-payments and safety net arrangements, there needs to be careful management of risks, especially in relation to consumers deciding to forego essential GP services.

It therefore would be **desirable** to ensure that implementing co-payments is monitored closely and the effects evaluated independent and thoroughly after several years' operation.

FURTHER ANALYSIS NEEDED TO ASSESS THE VIABILITY OF THE PROPOSAL

Given the history of the 1991 Budget GP co-payments, the lessons from the RAND study, and anticipating the likely criticism of MBS co-payments as regressive and potentially forcing people to forego essential treatment, further research and analysis is desirable.

This would involve drawing on the Department of Health and Ageing's and Medicare Australia's extensive internal data collections, expertise and their ability to commission external advice if required.

Specific points that the ACHR has identified as needing further investigation to refine this proposal are:

Access to MBS data not publicly available

- Quarter-by-quarter data for financial year 1991-92 to confirm that there was a significant dip in demand for GP services while the co-payment was in force.
  - Quarterly MBS data for the time before 2006-07 is no longer available publicly.

Qualitative analysis of GP service usage

More empirical evidence and analysis is needed in the following areas:

- The proportion of GP services provided to concessional patients
  - There is no MBS data collection of patient status, as this currently is not a factor affecting the availability of or access to GP and other medical services.

- The reasons that people attend a GP.

- the proportion of all GP services by reason for visiting
  - Especially the volume of presentations due to low-level causes such as colds, flu, and other common conditions that can safely be managed without medical intervention.
  - "Administrative" presentations – eg to obtain a doctor's certificate for otherwise self-manageable illnesses simply to satisfy employer requirements.

- The proportion of GP services that lead to MBS or PBS-subsidised flow-ons to:
  - Pathology and/or imaging services.
  - Specialist referrals.
  - Enhanced Primary Care services; and
  - Pharmaceutical prescriptions and dispensing.

CONCLUSION

Further research and analysis is needed to refine this proposal, particularly in relation to data and analysis not in the public domain. To do this, more extensive data and expertise is readily available to the Minister for Health, through his Department.

Nevertheless, ACHR's conclusion is that the risks of GP co-payments can be managed by sensible parameters; prudently setting any co-payments at <u>modest</u> levels; and by keeping their operation under continuous expert review to ensure against the unlikely possibility of unintended clinical consequences.

Australian Centre for Health Research
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