Tony Abbott's GP Co-Payment A Major Headache For Process And Policy

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The federal government's $5 co-payment doesn't look like getting any healthy returns (in the polls or the treasury) anytime soon. Ian McAuley explains.

The government's GP co-payment proposals have disingenuously combined bad policy and bad process. Ben Eltham has clearly pointed out the policy shortcomings, calling the government's latest version – a $5 cut in the Schedule Fee and a few exemptions – a "superficial revamp".

I want to look at the process that led the Government to dig a hole for itself (from which its preferred escape has been to dig another almost identical hole).

The proposal goes back to the work of the Commission of Audit, appointed by the Abbott Government "to review and report on the performance, functions and roles of the Commonwealth government" – and to do it all in less than six months.

That brief was ridiculous. It would have been far more honest if the government had said "because we have a pathological dislike of the public sector we want recommendations for cuts to public expenditure". The rationale is in the Liberal Party statement "Our beliefs": no economic good comes from government – that's up to "businesses and individuals". All those teachers, engineers, economists, scientists, nurses and doctors employed in the public sector are simply unproductive overheads.

That philosophy absolved the Commission from any obligation to gather evidence, conduct enquiries, or perform cost-benefit analysis – all impossible in a six-month time frame. If all public expenditure is wasteful, it doesn't really matter where cuts occur, and there is certainly no point in raising taxes to pay for public services.

Therefore, to use its own words, the Commission simply "focused on the 15 largest and fastest growing programmes which have driven the unsustainable increases in expenditure commitments".

The Commission saw estimates of Commonwealth health spending, with projections that it would double over the next 10 years. It saw budget estimates that the cost of Medicare services would increase by $9 billion over the forward estimates period, and the cost of pharmaceutical benefits would increase by $3 billion. It also had Medicare statistics showing that over the last 10 years the number of services per person has risen from 11 to 15. That quick and dirty look at a few bits of data generated the proposal for a $15 co-payment, subsequently watered down to $7 and most recently $5, as Eltham points out.

The government's attempt to sell this proposal is about the need for "price signals" to patients – an argument with some economic merit, but which is laden with hypocrisy when it comes from a government encouraging people to take out full cover private health insurance. In making a service free at the point of delivery, private insurance encourages the very over-servicing Abbott and Dutton complain about, and it's much more likely to be for a $10 000 surgical procedure rather than for a GP consultation charged at the $35 Schedule Fee – a consultation which may save the need for more expensive treatment.

Although the government seems to think that a $5 co-payment will be only one third as politically costly as a $15 co-payment, its value is hardly the issue – a bus fare or a parking fee associated with a GP visit can cost more. That's not where the problem lies.

In practical terms the co-payment is designed to break bulk-billing, which has steadily risen from 45 per cent to 77 per cent over Medicare's 30-year history. If a doctor has to go to the trouble of collecting $5, she may as well collect more. The average GP patient contribution for non bulk-billed services is $30, and it has been rising steeply since the previous government froze Medicare rebates. Without bulk-billing, and with a $5 cut in the Schedule Fee, many more people are going to be looking at a $65 GP fee.

And the concessions offered in the latest round of bargaining – mainly about exempting pensioners and concession card holders – should be seen in the context of a government determined to re-define services such as health and education away from universal shared services to services for the poor (or "indigent" to use the degrading American term). It's yet another assault on community solidarity.

All health care systems have co-payments, and if well-designed they can serve a useful purpose. Even the Nordic countries, which stand out for their generous public services, have substantial co-payments in health care, but they are shaped by considerations of equity and efficiency. By contrast, as John Menadue points out,

Australia's system of co-payments is a dog's breakfast, lacking any consistency. Some people can get a free run through the health system, while people with chronic conditions can find themselves facing thousands of dollars of out-of-pocket costs.

As Menadue and many others point out, primary care may be the worst place to seek cost savings, because early attention to conditions can reduce the need for much more expensive hospitalisation if those conditions are not addressed.

There is a strong case for a review of Australia's health funding policy. It should consider the complete set of arrangements, and not just those parts causing the most recent fiscal panic. It should engage with the public on basic questions, such as what people want funded by taxes and what they want to fund from their own pockets – instead of paternalistically assuming that people prefer lower taxes to better government services.

It should look at how the parts (public health, primary care, chronic illness management, hospital care) interrelate, and at problems of perverse incentives, missed opportunities and overlap – particularly relevant in view of split Commonwealth-state responsibilities. It should examine critically the role of private insurance, a funding system that perversely combines incentives for over-use, inequity and high bureaucratic costs.

Good public policy does not come about from the sort of bargaining we have seen to date – a process akin to what goes on when one is buying a Persian rug in a tourist bazaar. Our best hope is that the Senate keeps rejecting these ill-considered proposals, forcing the government to commission a proper policy review by a body with analytical expertise, such as the Productivity Commission.

Otherwise, we will have to wait until we can elect a government with competence in policy development and economic management.