

Access, affordability and equity

Access and affordability of primary care is currently a major focus of health politics. Bulk-billing rates for GPs have now fallen to around 65%, from a high of about 80% in 1997. A range of factors, including the supply of GPs, changing consumer expectations, shifts in practice patterns, increasing costs and declining relative incomes have probably contributed to the fall in bulk billing. As bulk-billing rates fall, out-of-pocket costs for patients go up and affordability and access to services is reduced, at least for people on lower incomes. Access and affordability are particular problems for people in rural areas where bulk-billing rates are generally 10% to 20% below those in metropolitan areas.

In response to falling bulk-billing rates, increasing out-of-pocket costs and significant differences between rural, provincial, outer metropolitan and inner city access to general practitioners, the Howard Government has introduced a "Fairer Medicare" package and subsequently, a "MedicarePlus" package. There has been a mixed reception to the Government's proposals. Some elements have been widely welcomed, particularly funding for practice nurses and additional training places for general practitioners.

The main components of the proposals are much more controversial. In particular, rebates for bulk billing concessional patients and children under 16, and the introduction of a safety net for out-of-hospital costs paid by patients, have been widely criticised. Many see these initiatives as undermining the fundamental principle of universality that has underpinned Medicare since its introduction in 1984. There are concerns that these measures will lead to a two-tier health system: one based on welfare support for designated groups including people on low incomes, children under 16, those who live in rural areas, and Tasmanians; the other increasingly based on user pays principles.

It seems unlikely that the MedicarePlus changes will restore GP affordability and access to the levels of the mid-1990s for non-concessional patients. Nor does it appear that this is the primary intent of the package. Setting aside some of the more obvious compromises to ensure its passage through the Senate, the package is designed to protect and increase the affordability of general practice for people on low incomes through a series of specifically targeted measures. It does not include any initiatives to directly increase universal bulk billing.

The extent to which MedicarePlus will achieve its aims is open to debate. It is arguable that even with falling bulk-billing rates, the overwhelming majority of concessional patients continue to be bulk billed. Not surprisingly, GPs seem to recognise that co-payments produce hardship and potential adverse health consequences for people on low incomes, and, in general, bulk-billing rates have not fallen below the rate of concessional service use, even in rural areas, where there are fewer GPs. A significant proportion of the funding for MedicarePlus is therefore inefficiently targeted, to

support bulk billing for people who are already bulk billed.

It seems likely that the fall in bulk billing has mainly affected non-concessional patients, particularly in outer metropolitan areas. Of course the increased rebate for bulk billing concessional patients will have a direct impact on GP incomes, which may take some pressure off the general decline in bulk billing. But, apart from children under 16, there are no incentives for bulk billing non-concessional patients. In the absence of significant changes to the supply of GPs in the short term, it is therefore likely that bulk billing for concessional patients and children under 16 will be protected; on current trends, however, other patients are increasingly likely to be charged co-payments.

The new safety net also introduces a set of issues. At one level it has been criticised because it signals a step away from universality. At another it may have paradoxical effects on overall Medicare costs both for government and patients.

The safety net is structured so that out-of-pocket costs for non-hospital services are very significantly reduced once an initial threshold has been exceeded.

Clearly the value of the initial out-of-pocket "front end deductibles" and fees set by practitioners are related. The lower the initial threshold, the more likely there will be significant fee increases.

The effect of the current threshold is unknown. However, it may well have an overall inflationary impact, particularly for non-concessional patients. It may also have an adverse impact on bulk billing for patients whose practitioners currently bulk bill because they are concerned about overall service costs over time. This would particularly affect older people with complex ongoing and chronic conditions.

The debate around the MedicarePlus package raises a host of questions about the principles and design of the Australian primary care system. To date, most of this debate has focussed on the narrow issues of affordability and access to GP services. More broadly, there are a range of issues about the impact of primary care services on equity of access, utilization, and health outcomes.

Overall, the effects of the new arrangements on access, equity, costs and quality are open questions for debate, research and discussion. So are alternative proposals. More broadly access, affordability and equity are issues for a range of primary health services.

It is particularly important and timely that affordability, access and equity be considered as part of the broader debate about the role of primary health services. It is exactly this debate that the *Australian Journal of Primary Health* will take up this year in a special edition on addressing inequity through primary health care.

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