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Agreement on Medical Treatment for Temporary Visitors between the Government of Australia and the Government of the Kingdom of Norway

Introduction

6.1 The *Agreement on Medical Treatment for Temporary Visitors between the Government of Australia and the Government of the Kingdom of Norway* provides residents of either country with reciprocal access to the public health system of the other country for any immediately necessary treatment that is required before returning home. It contributes to a safer travel environment for Australians visiting Norway by giving them access to immediate and necessary health care. In particular, it covers the traveller for pharmaceuticals, public hospital, and 'out-of-hospital care'.[1]

Background

6.2 The Committee was advised by the Department of Health and Ageing that Australia has concluded eight agreements with countries which

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1 National Interest Analysis (NIA), para. 4.

have health systems of an equivalent standard to Australia,[2] and which can provide a high level of health care:

> We have these agreements with countries which we believe have matching health systems and their major function is to protect the Australian population when they are travelling overseas, to ensure them a safe health environment when travelling for business, tourism or family reunions.[3]

Features of the Agreement

6.3 The Agreement provides health care in a range of situations, however, in particular, it:

- assists persons with pre-existing medical conditions who are perfectly fit to travel overseas but are unable to obtain travel insurance to cover their health needs;
- assists the aged who find it difficult to obtain travel insurance to cover their health needs;
- creates a safer environment for tourists, working holiday-makers and business people, which in turn strengthens ties between the two countries; and
- promotes goodwill by creating a welcoming environment for all visitors.[4]

6.4 The Committee has been advised that Article 3 of the Treaty provides that a person from the territory of one Party to whom the Agreement applies may receive treatment for any episode of ill-health which requires prompt medical attention, while in the territory of the other Party.[5]

6.5 Article 4 of the Treaty requires each country to provide visitors from the other with any immediately necessary treatment as is clinically required for diagnosis, alleviation or care of the condition requiring attention. This may occur in three ways, namely in-patient and out-

2 These countries are New Zealand, the United Kingdom, Italy, Malta, the Netherlands, Sweden, Finland, and the Republic of Ireland, NIA, para. 5.

3 Mark Burness, *Transcript of Evidence*, 23 June 2003, p. 42.

4 NIA, para. 6.

5 NIA, para. 7.

patient care in a public hospital, subsidised out-of-hospital medical services and subsidised prescription drugs.[6]

6.6 The Agreement does not cover treatment for which there is no immediate medical necessity and it specifically excludes:

- those entering for the specific purpose of receiving medical treatment;
- Norwegian visitors entering Australia on student visas; and
- diplomats, consular officers and their families.[7]

6.7 The Committee notes that Norwegians holding student visas are excluded from this Agreement, because the Australian Immigration Department requires overseas students to obtain student health cover before a visa is granted.[8]

6.8 The Committee notes that under this Agreement, medical costs are borne by the injured person and not by either party to this Agreement.[9] This reinforces the need for travellers to hold the requisite travel health insurance, whether that person is in Norway or Australia.

Costs

6.9 The Committee was advised that it is not possible to undertake a strict cost benefit analysis of the Agreement, since there is insufficient data available in either Australia or Norway.[10]

6.10 Notwithstanding the lack of data, the NIA stated that an estimation of the reciprocity of the Agreement can be made based on the numbers of people travelling between the two countries. The costs associated with the provision of any necessary hospital care to Norwegian visitors in Australia will be offset by a similar cost being borne in Norway for Australian visitors.

6 NIA, para. 8.

7 NIA, para. 9.

8 Mark Burness, *Transcript of Evidence*, 23 June 2003, pp. 45-46.

9 Treaty text, p. 3, and NIA, para. 6.

10 NIA, para. 13.

6.11 Statistics gathered by the Australian Bureau of Statistics (ABS) indicate that there were a total of 2,149 Australians travelling directly to Norway and 14 100 Norwegian visitors to Australia in 1999-2000.[11] The ABS data, however, underestimates the number of Australian travellers to Norway as it counts only those who indicate they are travelling directly to Norway. It does not account for the numerous visitors who visit Norway as part of a wider European tour.[12]

6.12 The Committee is concerned that there is no specific data revealing the numbers of Australians visiting Norway as part of a wider European tour. Clearly, without comparative data it is not possible to determine accurate health costs under the Agreement.

6.13 The NIA however provides an indication of costs:

> … the total cost of Medicare Benefits provided to RHCA [Reciprocal Health Care Agreement] visitors in 2001-2002 was $5.9 million, covering some 1.6 million visitors. This was 0.08% of 7.8 billion, being the total Medicare outlays for the Australian population.[13]

6.14 The Committee notes that collection of data on usage of the Pharmaceutical Benefits Scheme (PBS) has been facilitated by the *National Health Amendment (Improved Monitoring of Entitlements to Pharmaceutical Benefits) Act 2000* (IME Act), which came into full effect in May 2002.[14]

6.15 Although limited, the data shows that in July 2002 RHCA visitors to Australia were supplied with a total of 1 135 scripts. This represents 0.007 percent of 15 551 165, being the total number of scripts supplied to the Australian population.[15]

6.16 The Committee was advised that since visitors from Norway will account for only around 0.9 percent of all RHCA visitors to Australia, the annual Medicare and PBS outlays for this group will be proportionately small.[16]

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11 NIA, para. 14.

12 NIA, para. 14.

13 NIA, para. 15.

14 NIA, para. 16.

15 The original NIA read 0.02 percent (NIA, para. 16), however this figure was rectified at the hearing by Mark Burness, *Transcript of Hearing*, 23 June 2003, p. 42.

16 NIA, para. 17.

6.17 The Committee understands that it is the responsibility of the Australian States and Territories to have accurate reporting mechanisms for eligible visitors.[17]

6.18 Some State and Territory health departments have introduced procedures to record data on hospital usage by eligible visitors, but such data is neither comprehensive nor reliable. The NIA claims that availability of such data, in the future, together with Medicare and PBS information, should provide an overall picture of the use of these services by visitors from Norway.[18]

6.19 The Committee was informed that data on usage of health services in Norway by Australian visitors under the Agreement is not collected by the Norwegian authorities. This is due to Australian usage of the Norwegian health system comprising such a small number of services and cost relative to the Norwegian health budget so that expenditure of human and financial resources to monitor usage under the Agreement is not considered worthwhile.[19] In the absence of such data from Norway, comprehensive cost comparisons are not possible at this time.

Other issues

Travel insurance

6.20 The Committee sought information on whether travel health insurance premiums will decrease with the expansion of reciprocal health care agreements.

6.21 Mr Burness advised that the reduction of travel health insurance in light of this Agreement would be minimal:

> … a lot of people would still take out travel insurance, because [Norway] is one country out of many which they would visit where we do not have reciprocal health care agreements. Therefore its impact, in terms of the overall

17 Mark Burness, *Transcript of Hearing*, 23 June 2003, p. 47.

18 NIA, para. 18.

19 NIA, para. 19.

> market of travel insurance, I would have thought, was very small.[20]

6.22 The Committee was advised that, unless a traveller was transferring directly to the country with which Australia has an agreement, private health insurance was advisable. Nonetheless, there were some benefits to be obtained from the Agreement:

> Let us assume someone is going overseas for six months and for three months they are going to be in Norway. It does mean that they have the option to take out an insurance policy that covers them for the rest of their trip, but not for the time that they are in Norway. In that regard it would assist them as an individual. I presume it also gives a person peace of mind. Insurance, as I said, has pre-existing conditions limits on policies, and all those things are forgone in terms of your access to good and adequate health care whilst you are in that foreign country.[21]

Aged travellers

6.23 The Committee was advised that the Agreement is beneficial to aged travellers, particularly in light of the cost of travel health insurance, and exclusion as a result of pre-existing medical conditions:

> The process then, as I understand it, was basically to protect Australian citizens overseas in terms of their health costs. That is particularly relevant to people who, for instance, are aged or have significant pre-existing conditions for which they cannot get insurance or cannot get any insurance at all but, in terms of a medical assessment, are perfectly fit to travel. Simply, because they cannot get insurance, they are somewhat entrapped, and this was seen as a very good way of enabling those sorts of people to have the ability to travel overseas, where it was possible.[22]

Student visas

6.24 As previously mentioned, the Agreement does not apply to students. The Department of Health and Ageing advised the Committee that 1 529 Norwegians arrived in Australia on student visas in 2000,

20 Mark Burness, *Transcript of Hearing*, 23 June 2003, p. 45.

21 Mark Burness, *Transcript of Hearing*, 23 June 2003, pp. 46-47.

22 Mark Burness, *Transcript of Hearing*, 23 June 2003, p. 46.

representing 9.2 percent of Norwegians entering Australia in that year.[23] The Committee was advised that the Australian Government requires overseas students intending to study in Australia to obtain health cover. On that basis, the Norwegian Government decided that students studying in Norway should also be excluded from this Agreement.[24]

Consultation

6.25 The NIA states that information on the proposed Agreement has been provided to the States and Territories through the Commonwealth-State Standing Committee on Treaties Schedule of Treaty Action. All State and Territory health authorities were specifically advised of the proposed Agreement with the Kingdom of Norway in writing on 20 June 1999, 10 August 2000, 12 July 2002 and 21 March 2003. In addition, the Medicare Eligibility Section of the Health Insurance Commission has been made aware of the proposed Agreement with Norway.[25]

6.26 The NSW Government indicated that while it had no concerns in relation to the Agreement with Norway, it was 'particularly concerned that States and Territories receive no additional funding to cover the cost of health care provided to overseas vistors.' The NSW Government also referred to a Commonwealth review of RHCAs in 2001 and indicated to Committee that it would appreciate advice as to the outcome of this review, including an analysis of costs and benefits.[26]

6.27 The Committee noted that no reference had been made in the NIA to consultation with the private sector or industry groups. Mr Burness advised the Committee that:

> We have got a very good network with the industry. We have a network with the medical profession, the Pharmacy Guild and the hospital system through web sites, newsletters and information leaflets which we send out giving them

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23 Department of Health and Ageing, *Submission 28*, p. 1.

24 Mark Burness, *Transcript of Hearing*, 23 June 2003, p. 46.

25 NIA, paras. 20-22.

26 NSW Government, *Submission 17*, p. 1.

> information, but they have basically said: 'We're happy. Let us know when the next agreement is coming onstream through this network'.[27]

Implementation

6.28 The Committee was advised that relevant legislation is in place and no further legislative action by the Commonwealth or the States and Territories is required to implement the Agreement.[28]

6.29 Section 7(1) of the *Health Insurance Act 1973* provides that the Government of Australia may enter into agreements with the Governments of other countries for the purpose of providing health care to visitors to the host country as if they were residents of that country.[29]

6.30 Section 7(2) of the *Health Insurance Act 1973* provides that a visitor to Australia to whom an agreement under section 7 relates shall, subject to the agreement, be treated as an "eligible person" for the purposes of the Act during his or her stay in Australia. This means that, once the Agreement has come into force, the Act applies automatically to visitors covered by the Agreement.[30]

Entry into force

6.31 The NIA states that the Agreement was signed on 28 March 2003. Article 6(3) of the Agreement provides for entry into force on the first day of the third month after the date of the last notification between the parties through diplomatic channels notifying each other in writing that their respective requirements for its entry into force have been fulfilled.[31]

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27 Mark Burness, *Transcript of Hearing*, 23 June 2003, p. 47.

28 NIA, para. 12.

29 NIA, para. 10.

30 NIA, para. 11.

31 NIA, para. 3.

Conclusions and recommendations

6.32 The Committee is concerned that the limited data collection and monitoring of eligible patients both in Australia and Norway does not provide a realistic picture of the costs incurred by the Agreement.[32]

6.33 However, the Committee recognises that, although there are few situations in which Australians travelling to Norway could dispense with the need to take out travel insurance, there are significant benefits to people who are ineligible through age or pre-existing medical conditions for travel insurance cover.

6.34 The Committee therefore supports the Agreement and urges the Department to implement effective measures for accurate monitoring of usage under the Agreement.

Recommendation 7

The Committee recommends that the Government investigate ways of improving data collection for the purposes of monitoring costs associated with similar agreements.

Recommendation 8

Although reservations are expressed concerning the adequacy of the data collection, the Committee supports the Agreement and recommends that binding treaty action be taken.

32 These same issues were raised in the Joint Standing Committee on Treaties (JSCOT) *Report 50: Treaties Tabled 15 October 2002*, p. 11; JSCOT, *Report 20: Two Treaties Tabled on 26 May 1998, the Bougainville Peace Monitoring Group Protocol and Treaties Tabled on 11 November 1998*, p. 31; JSCOT, *Eleventh Report*, p. 40.