Family First Dissenting Report

Inquiry into the Health Insurance Amendment (Medicare Safety-nets) Bill 2005[1]

***The health of the nation starts with the health of each family*[2]**

The retention and improvement of Medicare is important to ensure all Australians have access to necessary health services.

The *Health Insurance Amendment (Medicare Safety-nets) Bill 2005* would authorise the increase of Medicare safety net thresholds from $306.90 to $500 for those who have a concession card or who are eligible for Family Tax Benefit Part A, and from $716.70 to $1000 for other individuals and families. Once a family or individual has out-of-pocket non-hospital medical expenses reaching the threshold in a calendar year, they receive back from the Government 80 cents for every additional dollar they spend.[3]

If a family or individual does not reach the threshold within the calendar year, they get no financial relief and the costs incurred are not counted in the following calendar year.[4]

The bill is disturbing because it constitutes a breaking of a major commitment the Coalition made to the people during the recent federal election when it pledged to keep the lower thresholds. Breaking election promises, especially major promises and particularly so quickly after the election, reinforces the alienation of significant sections of the community from politicians and the political process. To justify this reinforcement of community alienation and breakdown of trust would require an overwhelming case.

The Government has justified its decision on the basis of cost. The Health Minister, Tony Abbott, noted that "an overriding concern for the government was the long-term sustainability of the safety net. When first announced, the estimated cost of the extended safety net was just $440 million over the four years to 2006-07. … If the government had not acted quickly, costs would have blown out to $1.4 billion over the four years to 2007-08."[5] However, the Government knew the cost of its policy was blowing out before the election was held.

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1 The Parliamentary Library gave valuable assistance for some aspects of this report.

2 *Family First Party: Our Values*, page 10

3 Pratt, A (2005), *Bills Digest: Health Insurance Amendment (Medicare Safety-nets) Bill 2005*. Department of Parliamentary Services, Canberra. Page 2.

4 Submission 9, page 3 (Catholic Health Australia).

5 Minister for Health and Ageing, Second Reading Speech, 23 June 2005.

This bill is important because of the effect it will have not only on community attitudes, but also on the cash flow of families and individuals facing high out-of-pocket medical expenses.

The objectives of Medicare

The Medicare safety net is a two edged sword. It provides some certainty for people facing high out-of-pocket medical expenses. However, it also gives greater priority to enabling people to exercise choice than to ensuring that all families can afford to access good quality medical services. Consequently it constitutes a movement of Australia's health care system away from what is commonly referred to as the universal Medicare system.

According to Jeff Richardson, Professor of Health Economics at Monash University, the changing social objectives for Medicare are reflected in such developments as the increasing use of co-payments to shift cost to the user and special welfare bulk billing incentives for particular groups. He argues that "over the longer term the pursuit of these values would redistribute income to the healthy, wealthy and away from the unhealthy unwealthy which is the antithesis of the communitarian/solidarity value system."[6]

We need to ensure that choice is not delivered at the expense of affordability and that appeals to 'choice' are not a disguise for reducing the focus on affordability. This issue is critical to ordinary Australians and their families who stand to be the big losers if the affordability of medical services becomes a second priority.

Cost blow out

The complexity of Medicare and the new safety net is illustrated by the difficulty the government has had in accurately costing the scheme. The Parliamentary Library has tracked the rapid rise in government estimates of the cost of the safety net scheme, from $266 million over the four years to 2006-07 in November 2003, to $440 million over four years in March 2004, $1.05 billion over four years in September 2004 and $1.65 billion over four years in April 2005.[7]

The high cost also illustrates the extent of patient out-of-pocket costs.

The government has estimated a saving from the bill of $499 million over the four years to 2008-09.[8] But this estimate must be in doubt given earlier difficulties producing accurate costings.

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6 Richardson, J (2005), Priorities of health policy: cost shifting or population health. *Australia and New Zealand Health Policy*, Vol 2 No 1.

7 Pratt, A (2005), *op cit*, page 4.

8 Explanatory Memorandum, page 1

The Parliamentary Library explains that:

> …the structure of the Medicare Safety Net means that the effects of the increases to the Safety Net thresholds on total expenditure on the scheme in the medium and longer terms are more uncertain [because]…Safety Net benefits are entirely contingent on the amount charged by the practitioner.
>
> …in a scheme where the level of benefit is not tied to any price signal, and therefore effectively unregulated, it is potentially extremely difficult to control the overall cost of the scheme.[9]

The effect of raising the thresholds

The government has estimated that the effect of raising the thresholds will be that over one million fewer people will access the safety net next year:

> The total number of people who were expected to reach the thresholds (before amendment) in 2006 was 2,573,723. The number expected to reach the revised safety net thresholds in 2006 is 1,502,883. Therefore it is expected that 1,070,840 fewer people will now qualify in 2006.[10]

Many of this million are ordinary families living in the outer suburbs and regional areas.

Because of the indexation of the thresholds, the Department of Health points out that "families and singles that are eligible for the lower threshold will need to incur additional out of pocket costs of $184.90 before extended Medicare safety net benefits become payable ... Families and singles that are eligible for the higher threshold will need to incur additional out of pocket costs of $264 before extended Medicare benefits are payable."[11]

An estimate of the average total out-of-pocket cost per person for non-hospital Medicare services in 2004-05 was approximately $266.60, which means that many families will not get relief from the safety net.[12]

The additional costs incurred by families and individuals to meet the new thresholds were described by Catholic Health Australia as effectively representing a new health tax.[13]

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9 Pratt, A (2005), *op cit*, pages 5 and 6.

10 Submission 6, page 1 (Department of Health and Ageing)

11 Submission 6, page 1 (Department of Health and Ageing)

12 Specific data is not available from the Department of Health, but an estimate can be calculated by multiplying the total average patient contribution per service for all non-hospital services, by the average number of all non-hospital services per capital per year. *Medicare Statistics*, Tables A5 and C1B.

13 Submission 9, page 5 (Catholic Health Australia).

The most common encounter people have with the health system is through their general practitioner. The Australian Medical Association explained the effect of the new thresholds in terms of the number of visits to a GP:

> The new safety net kicks in at around 13 GP consults if you are on a health care card and accessing at $300. Increasing the safety net to $500 means that you would have to have 22 GP consults to get to the safety net. If we go on to the full safety net it is 31 consults and 44 consults for the $1,000 threshold.[14]

The average number of non-referred GP attendances per person in 2004-05 was 4.54.[15] Visits to the GP can have a big impact on the budget of a family because the average upfront fee for a GP is approximately $40-45, before the family can claim a rebate of $30.85.[16] Many families find it hard to find a spare $40 when it is needed.

It is clear that "the safety net provisions will be invoked more quickly when specialist medical practitioners, diagnostic imaging services and pathology are required. Average co-payments are two or three times higher for specialist medical practitioners than for GPs."[17]

The Department agreed that out-of-pocket costs were rising faster than CPI:

> …the average patient contribution per service for patients billed out of hospital…in the 2001-02 financial year was $18.12 and, in the first quarter of 2004, it was $22.20. [18]

There is very little statistical information available to assess the effect of the safety net in more detail. It is regrettable that the Health Department "… has not released any figures regarding the breakdown of how many people will be affected by the increased thresholds at each of the threshold levels."[19]

The Australian Medical Association says that:

> …we do not know how much is spent on the safety net per annum, nor do we know the number of people achieving eligibility per month and per year, the average safety net benefit per transaction, the

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14 Committee Hansard, 18 August 2005, page 1 (Australian Medical Association).

15 *Medicare Statistics*, Table C1B

16 The average patient contribution for patient-billed GP services in 2004–05 was $14.70 (*Medicare Statistics*, Table B5). From 1 November 2005, the Medicare rebate for a standard GP consultation was $26.25, but from 1 January 2005, following the implementation of the 100 per cent Medicare policy, the rebate went up to $30.85.

17 Swerissen, H and Jordan, L (2004), Factors affecting Medicare affordability. *Australian Journal of Primary Health*, Vol. 10 No. 3, pages 148-149.

18 Committee Hansard, 18 August 2005, page 14 (Department of Health and Ageing)

19 Pratt, A (2005), *op cit*, page 5.

> services and specialties which attract safety net benefits etc. We think having this information in the public arena would be useful.[20]

The Health Department ought to release the relevant information it has. Its failure to do so reinforces the community suspicion that many of those affected by this broken promise will be ordinary families battling to get ahead.

Access and equity

The National Rural Health Alliance argued that:

> Because it is based on the tax system, Medicare is administratively efficient and progressive – the more you earn the more you pay…Co-payments and private heath insurance do not have these positive characteristics. They are regressive, more complex and partial.[21]

The safety net "…is a welfare measure not a mechanism to ensure access to essential health services. The safety nets are more akin to handouts rather than safeguarding low income people from the invidious decision as to whether cost will inhibit their access to health care."[22] The handouts are to help with costs after the fact and do not assist with ability to pay in the first place.

There are a number of examples of inadequate access and equity under the current Medicare system.

While "…older and poorer people are high users of medical services"[23] and "…people are more likely to consult a GP in areas of high socioeconomic disadvantage ..."[24], "…those families and individuals making safety net claims were more likely to be located in wealthy electorates."[25]

The Australian Consumers' Association points out that "the safety net …disproportionately benefits those who see private specialists, and access expensive out-of-hospital medical treatment such as diagnostic scans, where the gap between the schedule fee and the fee charged is much greater."[26]

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20 Submission 5, supplementary information page 2-3 (Australian Medical Association)

21 Submission 8, page 2 (National Rural Health Alliance)

22 Submission 9, page 3 (Catholic Health Australia).

23 Submission 1, page 1 (Professor Stephen Leeder)

24 Day, S et al (2005), Strengthening Medicare: Will increasing the bulk-billing rate and supply of general practitioners increase access to Medicare-funded general practitioner services and does rurality matter? *Australia and New Zealand Health Policy*, Vol. 2 No. 18

25 Submission 4, page 1 (Australian Consumers' Association)

26 Submission 4, page 1 (Australian Consumers' Association)

People with chronic illness

In response to claims that people with chronic illnesses would be made worse off by the change to the thresholds, the Health Department argued that "because [the safety net] is essentially a financial measure, the design does not favour or disfavour any particular group; it is just people who have high costs."[27]

But the Australian Consumers' Association explained that people with chronic illnesses "… tend to accrue medical costs slowly throughout the year. They would have to visit a general practitioner many times to qualify for the safety net", while "… wealthier families or individuals paying high fees for private obstetricians for example will easily qualify for the safety net with just a single doctor's bill."[28]

People in regional and rural areas

People in rural and regional areas do not have good access to Medicare funded services. Policies focusing on bulk billing rates and the supply of fee-for-service GPs to rural and regional areas have not improved access "…because they fail to address problems caused by geographic inaccessibility in rural and remote areas."[29]

The Rural Doctors Association of Australia states that:

> The 30 per cent of Australians who live in rural and remote areas carry a higher disease burden and tend to be poorer than urban Australians, yet they do not have equitable access to either public or private health services. This 30 per cent of the population accesses only 21 per cent of Medicare-funded GP services.[30]

Further, the RDAA says that "…the average per capita Medicare benefit paid in metropolitan areas was $125.59, compared to $84.91 in other parts of Australia", suggesting that the regional areas are subsidising the metropolitan areas. "Due to their lower rate of private health insurance coverage, rural and regional areas receive an estimated $100 million less of the Government's private health insurance rebate than they would if funds were allocated on a per capita basis."[31]

The National Rural Health Alliance concluded that "raising the threshold for eligibility in the safety net means that a higher proportion of health care costs will be borne by those who can least afford it: low income families, of which there is a higher proportion in rural and remote areas."[32]

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27 Committee Hansard, 18 August 2005, page 14 (Department of Health and Ageing)

28 Submission 4, page 2 (Australian Consumers' Association)

29 Day, S et al (2005), *op cit.*

30 Submission 7, pages 1-2 (Rural Doctors Association of Australia)

31 Submission 7, pages 3 (Rural Doctors Association of Australia)

32 Submission 8, page 3 (National Rural Health Alliance)

Conclusion

The Government has not made an adequate case for breaching a major election promise. The *Health Insurance Amendment (Medicare Safety-nets) Bill 2005* is likely to adversely affect more than a million Australians. It also entrenches the policy of giving priority to choice of family doctor over the affordability of the doctor.

It is ironic that the Senate is considering this bill at a time when there appear to be billions of dollars available for tax cuts. In this climate it is difficult to believe there is an economic imperative for this bill. What the bill does do is to invite suspicion that the next round of tax cuts will be funded at the expense of services which are vital to families living in outer suburbs and regional areas in particular.

Steve Fielding

Family First Senator for Victoria