The Senate

Community Affairs Legislation Committee

Provisions of the Health Insurance Amendment (Medicare Safety-nets) Bill 2005

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HEALTH INSURANCE AMENDMENT (MEDICARE SAFETY-NETS) BILL 2005

THE INQUIRY

1.1 The Health Insurance Amendment (Medicare Safety-nets) Bill 2005 (the Bill) was introduced into the House of Representatives on 23 June 2005. On 10 August 2005, the Senate, on the recommendation of the Selection of Bills Committee (Report No. 7 of 2005), referred the provisions of the Bill to the Committee for report.

1.2 The Committee considered the Bill at a public hearing on 18 August 2005. Details of the public hearing are referred to in Appendix 2. The Committee received 11 submissions relating to the Bill and these are listed at Appendix 1. The submissions and Hansard transcript of evidence may be accessed through the Committee's website at http://www.aph.gov.au/senate_ca

1.3 The Parliamentary Library Bills Digest No 17 dated 9 August 2005 also discusses a number of issues relating to the Bill and may be accessed at www.aph.gov.au/library/pubs/bd/2005-06/06bd017.htm

THE BILL

1.4 The purpose of the Bill is to amend the *Health Insurance Act 1973* to increase the annual thresholds above which benefits under the extended Medicare safety net are payable. The thresholds will increase from $306.90 to $500 for concession card holders and families in receipt of Family Tax Benefit Part A (FTB (A)) and from $716.10 to $1,000 for all other families and individuals from 1 January 2006. The Bill also changes the date for beginning the indexation for both the upper and lower thresholds from 2005 to 2007.[1]

1.5 The Minister for Health and Ageing stated that the measures will:

> maintain the sustainability of the extended Medicare safety net and ensure Australians will continue to receive additional protection for high out-of-pocket medical costs.[2]

ISSUES

1.6 The extended Medicare safety net came into effect on 12 March 2004. The extended safety net covers 80 per cent of the out of pocket costs for Medicare services provided outside hospital once an annual threshold is met. It was estimated that the cost of the safety net would be just over $440 million over four years to 2006-07. The Minister for Health and Ageing stated that 'after the safety net came into operation it

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1 Explanatory Memorandum, p.4.

2 Minister for Health and Ageing, Second Reading Speech, 23.6.05.

became clear that these estimates needed to be revised'. The increase in costs was due to three factors: more people than expected qualified for safety net benefits; out-of-pocket medical expenses were higher; and some specialities shifted charges on to Medicare out of hospital items so that their patients could claim safety net entitlements. The Minister concluded 'if the Government had not acted quickly, costs would have blown out to $1.4 billion over the four year to 2007-08'.[3]

1.7 The measures in the Bill have a total saving over 2005-06 to 2008-09 of $499 million.[4]

Impact on affordability of medical services

1.8 The primary area of concern for witnesses was the impact of the change to the threshold on the affordability of medical services, particularly for low income earners and those with chronic medical conditions.[5] The Australian Medical Association (AMA) stated that the safety net should have been given more time to settle in as:

> …the measure will impact hardest on those who are in most need of health services (chronically ill) and those least able to afford to pay for such services (low income groups). Although we think the threshold provisions of the new Bill are a step back from the original thresholds, we still consider the new thresholds are a big step forward from where we were prior to March 2004.[6]

1.9 The AMA stated that, although it was concerned about the thresholds proposed, it still supported the safety net 'quite strongly'. It noted that the safety net uses real fees as opposed to the schedule fee as its basis and commented that this 'is significant. It emphasises that the safety net is catching up with real life'.[7]

1.10 Catholic Health Australia (CHA) described the changes to the thresholds as a 'cruel blow' to average and lower income earners and that it was in effect a $200 per year health tax.[8]

1.11 The Australian Consumers Association (ACA) commented that the changes will exacerbate the existing problems and inequities in the system. In particular, the ACA stated 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'.[9]

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3 Minister for Health and Ageing, Second Reading Speech, 23.6.05.

4 Explanatory Memorandum, p.1.

5 *Submissions* 7, p.4 (RDAA); 11, p.1 (Public Health Association).

6 *Submission* 5, p.2 (AMA).

7 *Committee Hansard* 18.8.05, p.1 (AMA).

8 *Submission* 9, p.5, *Media Release,* 'Safety Net change a cruel blow to the sick and poor', 14.5.05 (CHA).

9 *Submission* 4, p.1 (ACA).

The National Rural Health Alliance (NRHA) also commented that evidence from the early days of the safety net 'suggested that doctors in affluent areas were the ones charging more and leading to their patients incurring costs against the safety net'.[10]

1.12 The Department of Health and Ageing noted that it is expected that 1,070,840 fewer people will qualify for the safety net in 2006. Those that are eligible for the lower threshold will need to incur additional out of pocket costs of $184.90 before the safety net benefits become payable, while those eligible for the higher threshold will need to incur an additional $264. The maximum out of pocket over the course of 2006 for those on the lower threshold is estimated at $147.92 and for those on the higher threshold an estimated $211.68 (over and above the out of pocket cost expected under the current thresholds).[11]

1.13 In relation to the impact of the change, the Department commented that it did not have evidence to indicate that those with chronic illness would be hardest hit. The Department stated that 'you need to be a heavy user of GP services to access the safety net. Typically, it will be diagnostic services – services like radiotherapy – that will take you over [the threshold]'.[12]

1.14 The Department concluded:

> The extended Medicare safety net continues to provide protection against high out of pocket costs for out of hospital services for all Australians. It benefits every Australian by providing certainty that Medicare will provide additional assistance with their expenses if they incur costs above the thresholds. It is expected to directly benefit about 1.5 million people in 2006 through additional benefits.[13]

Impact on costs of medical services

1.15 Submissions raised the practice of shifting charges on to Medicare out of hospital items to ensure that they were caught under the safety net provisions. Professor Stephen Leeder noted the case of IVF treatment:

> The Medicare benefit is around $1000 and the procedure costs at least $3000. Before the safety net, two accounts would be rendered to the patient, one for submission to Medicare and the other to be paid out of pocket. Now they are rolled together because the remaining $2000 can be covered through the net.[14]

10 *Submission* 8, p.3 (NRHA).

11 *Submission* 6, p.1 (DoHA).

12 *Committee Hansard* 18.8.05, p.15 (DoHA).

13 *Submission* 6, p.2 (DoHA).

14 *Submission* 1, p.1 (Prof Stephen Leeder).

1.16 The ACA also noted that once the safety net is reached there is no incentive for consumers to limit the number of times they access service and no incentive for service providers to reduce fees.[15] CHA commented:

> This impost on families is unlikely to address the major reason for the budget blow-out which has been caused by much higher charges by some medical specialist groups since the safety net was introduced.[16]

1.17 The AMA stated that:

> On the evidence available to us, doctors' charges did not cause higher expenditure on the safety net. Our understanding is that doctors' charges have risen in line with increases in the Medicare Benefits Schedule as indexed by the Government. There has been a small drift upwards in the complexity of items used but this is an entirely expected continuation of past trends as medicine becomes more complex and affordable to Australians.[17]

The AMA stated that it would be concerned if doctors could not justify a fee.[18] It indicated that it had developed policies for responsible behaviour under the safety net including that doctors should not alter the actual location of the service to financially benefit the patient, nor shift an inpatient gap to an associated outpatient consultation. The AMA has promulgated these policies widely to the AMA membership.[19]

1.18 The Department also commented that there was no evidence that the introduction of the safety net had led to an increase in medical fees:

> With the exception of the initial phenomenon around obstetric items coming within the scope of the safety net, which evidenced itself as an increase in fees but was actually a widening of the scope of Medicare, there has been nothing of great concern. We have also looked at IVF as another area where there has been some growth but, other than those two, we have seen no systematic evidence of anything other than normal inflationary increases in fees – normal secular trends in fee growth.[20]

The Department advised that it has also taken steps to ensure that certain items can only be claimed as an in-hospital item and 'therefore cannot be brought into the scope of the safety net'.[21]

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15 *Submission* 4, p.1 (ACA).

16 *Submission* 9, p.5, *Media Release,* 'Safety Net change a cruel blow to the sick and poor', 14.5.05 (CHA).

17 *Submission* 5, p.1; *Committee Hansard* 18.8.05, pp.4-5 (AMA).

18 *Committee Hansard* 18.8.05, p.6 (AMA).

19 *Submission* 5, p.1; *Committee Hansard* 18.8.05, p.6 (AMA).

20 *Committee Hansard* 18.8.05, p.11 (DoHA).

21 *Committee Hansard* 18.8.05, p.16 (DoHA).

Recommendation 1

The Committee reports to the Senate that it has considered the Health Insurance Amendment (Medicare Safety-nets) Bill 2005 and recommends that the Bill be passed without amendment.

Senator Gary Humphries
Chairman

September 2005

DISSENTING/MINORITY REPORT

Australian Labor Party, Australian Democrats and Australian Greens

Health Insurance Amendment (Medicare Safety-nets) Bill 2005

The Labor Party, the Australian Democrats and the Greens have two broad concerns about this report – that it does not adequately address the known adverse impacts of the Medicare safety net, and that the restricted time allowed for consideration of this legislation has meant that a full examination of the impacts of the new changes has not been possible.

The Labor Party, Australian Democrats and the Greens (hereafter referred to as "opposition parties") are concerned that the committee's report does not take into account other publicly available evidence which illustrates that the safety net is contributing to health inflation and larger out of pocket costs for health consumers, problems which could fundamentally weaken Medicare in the future.

The opposition parties also believe it is unsatisfactory for key health stakeholders and policy makers, present at the hearings on this Bill, to cite insufficient or no evidence as a reason for not addressing major weaknesses in the Extended Medicare Safety Net, particularly when this evidence is well publicised and readily available via internet or other public sources.

We also note the short period of time allowed for submissions to be made and for attendance to the single public hearing, which was held a week after the Bill was referred to the committee. Given the controversy surrounding the government's pre-election campaigning on this policy and the subsequent reversal of this position, the opposition parties believe more time was required to allow for greater input and consideration of the costing and policy development elements of this policy.

Further consideration of these matters is detailed below.

Affordability of medical services

The opposition parties believes there is ample evidence on the public record which supports the assertion that the Medicare safety net has contributed to ongoing decline in the affordability of medical services, and in particular, medical services offered by specialists. The Chair's report correctly notes that both the Department of Health and Aged Care and the Australian Medical Association have denied that there is any evidence to suggest that this is the case. However, official data sources provide ample evidence.

The Health Insurance Commission produces a comprehensive set of data on its HIC online web site, at: http://www.hic.gov.au/providers/health_statistics/statistical_reporting.htm. According to the data on this web site, both the cost to the budget (benefits paid out) and the number of services have been significantly affected by the government's policy introduced in 2004.

In the area of diagnostics, benefits paid increased by 6.4 per cent in the first quarter of the Medicare safety net's operation in 2004, and then by 10.2 in the subsequent quarter. This compares with two previous consecutive quarters in which rebates for diagnostic imaging fell by 3.3 per cent in the fourth quarter of 2003 and 2.2 per cent in the first quarter of 2004.

In the area of obstetrics, the effect of the safety is well defined, and even though this can be partially explained by the creation of a new Medicare item "to make explicit the nature of these charges for the out of hospital management of the pregnancy beyond 20 weeks"[1], this is still much evidence to suggest that the safety net provides incentives for doctors to adjust billing practices to meet the new requirements of the extended safety net.

In the first year of the safety net's operation, Medicare rebates for obstetric services experienced a dramatic quarter on quarter increase: in the first quarter after the safety net's introduction rebates increased by 13.5 per cent, and then by 50.9 per cent. The third quarter saw rebate growth continue, by 26 per cent. There was also evidence of delays in scheduling procedures as rebates fell sharply in the first quarter for 2005 but then resumed their quarter on quarter growth by 30 per cent in June 2005. The data does not appear to suggest that this rebate growth was matched with a corresponding increase in obstetric services.

The opposition parties also note that in the first quarter of 2005, the rebates paid for diagnostics also fell, before increasing by 14.7 per cent in the second quarter of 2005. This pattern, which is seen in other types of Medicare services, suggests that the qualification period for the safety net is affecting the timing of medical services. This can be seen in either lags or reductions in service levels in the first stages of the year, as people wait until they have qualified for the safety net, and by spurts in the latter stages of the calendar year, where more services are likely to be captured by the safety net. We question the efficacy and appropriateness of the incentives being offered by the Medicare safety net which in this case could be some postponing necessary care or promoting the over use in the latter stages of the year.

Recently, the government has initiated an investigation in the area of IVF, in response to attempts by the Health Minister to reduce access to IVF procedures provided under Medicare. While the opposition parties acknowledge the increase in rebates in this area since the commencement of the safety net, they also maintain that the safety net

[1] Senate Community Affairs Committee, Additional Estimates 2004-05 17 February 2005, Answer to Question on Notice: E05-208

provides specialists with incentives to adjust billing and timing of procedures to maximize the benefits for the patients to be attained from Medicare. The opposition parties do not believe it is appropriate for government to provide doctors and specialists with incentives to re-structure their services or fees to maximize benefits. Rather, its role is to ensure access and equity with regard to the provision and cost of medical services. Furthermore, the opposition parties call on both the government and medical groups to address the ongoing issue of rising specialist fees, given the ongoing evidence of these increases[2].

Beneficiaries of the safety net

During the 2005-06 Budget senate estimates hearings, Health Department officials admitted that in excess of 1 million people who previously qualified for the safety net will now miss out under the lower thresholds. However, the department continues to refuse access to data which will disclose what proportion of this 1 million will be covered by the lower threshold and therefore be low income earners and concession card holders.

The opposition parties have maintained that the safety net is geared toward those who have the capacity to spend more on health. It follows that Australians with higher incomes and a higher capacity to undertake discretionary spending in health are more readily able to access the safety net and faster. This is evidenced in the recent ABS Survey of Household Expenditure which shows that the lowest household income quintile spends just $22 on average per week while the highest household income quintile spends $77 per week. In the last 5 years, household spending on health has increased by over 40 per cent – this means that in 1998-99 an average family spent around $14 per week on health care and medical expenses, but in 2003-04 this weekly average is at $46.

The governments own Medicare data, as released by the Minister for Health in September 2004, has shown that there is a high correlation between incomes and levels of Medicare Safety net rebates claimed.

While the government has maintained that this safety net helps those with a chronic illness, what the government has failed to acknowledge is that this safety net has inflationary effects. It has contributed to increasing levels of health inflation, with health costs rising at almost double the rate of CPI, and with the component including medical specialists fees rising by 4.8 per cent. While it may be the case that making it more difficult to qualify for the Medicare safety net will reduce the costs of the safety net in the short term, because safety net benefits are uncapped and unregulated there is no evidence to support the assertion that this proposal will have any long term impact on the overall inflationary and unsustainable effect of the safety net scheme.

[2] June Quarter Medicare data available on www.health.gov.au shows that in the last year fees have increased by 9.5 per cent, with Obstetric fees increasing by 111 per cent and diagnostic services increasing by 9.7 per cent.

Further evidence that the policy has resulted in large income transfers to doctors can be found in a recent BRW article[3]. This article reports that the government's election policies are expected to give a boost to the earnings of listed health service companies, including radiology and pathology companies – where Medicare payments have increased by 11 and 8 per cent respectively; ophthalmology by 13 per cent and 80 per cent for obstetrics. The CEO of Primary Health care, Edmund Bateman, has already said that the government's policies will add about $1 million to the company's bottom line.

We also note that Committee's report did not take into account alternative proposals to raising the safety net thresholds. The Rural Doctors Association of Australia suggested that "raising the threshold is likely to penalise poorer patients and those with chronic conditions. A more equitable approach would be to cap safety net payments per individual Medicare item."

Costing of the Safety net

Labor the Democrats and the Greens maintain that sufficient information regarding the extreme variations in the actual cost and the estimated cost of the safety net was available to warrant attention by policy makers and the government prior to the 2004 Federal Election. Indeed, this information was confirmed during the 2004 Federal Election by the "Charter of Budget Honesty" process, which revealed that the cost of safety net had doubled since the previous budget estimate.

Throughout the first year of the safety net's operation, the Minister repeatedly issued statements, through regular press releases, which publicized the high level of registrations and successful claimants for the safety net. Throughout this process, the Minister failed to acknowledge the fiscal and policy implications of such data, which, as confirmed by the Health Insurance Commission, was being provided to the Department of Health on a daily and weekly basis.

The Department now admits[4] that it underestimated registrations, "substantiations", and medical fees which subsequently caused the well known cost blow out.

However, through the 2005-06 Budget estimates process, and other public sources, the opposition parties maintain that there was a sufficient level of advice and warning regarding the safety net's increasing cost and declining sustainability throughout 2004. In June 2004, actual spending on the safety net was 40 per cent more than estimated in the budget and his own department has confirmed that this would have been known by the Minister by mid July 2004. In July 2004, actual spending on the safety net was 60 per cent more than estimated in the budget and the Minister would have known this by mid August 2004. Labor notes that the government did not go into caretaker mode until 30 August.

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[3] Beth Quinlivan, *Medicare Windfall* BRW 4-10 August 2005

[4] Community Affairs Legisaltion Committee Hansard Thursday 18 August 2005, CA 11-12.

The Department of Finance has also confirmed, though the 2005-06 Budget Estimates process, that in June Finance was also examining the estimates, as there were "indications" of that the program was growing more rapidly than estimated[5].

In addition to departmental information, in July 2004 the Herald Sun reported that an internal HIC audit revealed evidence of changed billing practices amongst doctors to help patients reach the safety net faster. This same report showed that more than 3000 patients in Victoria slipped into the safety net in only one month. This audit revealed a $1.4 million blow out in the scheme in Victoria, in June alone.

In August, according to Department of Finance officers, it then "became clearer that this program was increasing faster than we had estimated at budget time"[6] and an officer was sufficiently concerned that he contacted the Finance Minister's office about the matter and spoke to the Minister's advisers, who subsequently briefed their Minister, Nick Minchin. This occurred prior to the caretaker period, as explicitly stated by the Deputy Secretary of Finance, Mr Phil Bowen, in this Budget Estimates hearing. During this same hearing, the Finance Minister has dismissed his knowledge of this advice by stating that the briefing was oral in nature and:

> *"it was not formal advise to me…it was hearsay"* and… *"it was not actionable information …"* and…*"I am not going into the detail of what, if any, communications go on within the government on this or any other matter…"*[7]

The opposition parties call on the committee to note that the policy development and costing of the Medicare safety net was significantly compromised by the government's intention to campaign heavily on this policy irrespective of the longer term impact it would have on both the costs of medical care and the impact on the budget. Furthermore, we maintain that the there is sufficient evidence to show that Senior Minister ignored advice in order to maintain a campaigning opportunity, even though any competent Minister would have realized it could not be sustained beyond after the election campaign.

Recommendation

For the reasons outlined above, Labor, the Australian Democrats and the Greens will not support the passage of this Bill. Labor believes that the government should be held accountable for its questionable heath and fiscal management, as demonstrated by the introduction, promotion, and subsequent cuts to this policy.

We are of the opinion that the government needs to reconsider the safety net scheme and consider greater investment in the public primary health scheme to deliver a much more equitable and affordable health care system and one that is sustainable well into

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[5] Source – Budget 2005 Senate Estimates Hansard FPA 59

[6] Source – Budget 2005 Senate Estimates Hansard FPA …

[7] Source: Budget 2005 Senate Estimates Hansard FPA 62

the future. This might require new and flexible ways of achieving a more equitable distribution of Medicare resources through initiatives such as supplementing state government-operated community health centres, funding free or low cost specialist outpatient clinics, extending affordable access to allied health professionals and flexible grants for those areas where per capita Medicare expenditure is below average.

In addition, the opposition parties note the continuing erosion in the ministerial standards set by the Howard government and in particular, in the Prime Minister's failure to hold his Minister for Health and Minister for Finance accountable for failing to address the known problems of this policy, which then required urgent attention following the election, and the expenditure of up to $20 million promoting the policy through a cross – media advertising campaign.

SENATOR JAN MCLUCAS (ALP, QUEENSLAND)

SENATOR CLAIRE MOORE (ALP, QUEENSLAND)

SENATOR HELEN POLLEY (ALP, TASMANIA)

SENATOR LYN ALLISON (AUSTRALIAN DEMOCRATS, VICTORIA)

SENATOR KERRY NETTLE (THE GREENS, NSW)

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

APPENDIX 1

Submissions received by the Committee

1 Leeder, Professor Stephen (NSW)

2 Australian Coalition for Equality (WA)

3 Woulfe, Mr Jim (NSW)

4 Australian Consumers' Association (NSW)
Supplementary information
Supplementary submission received 25.08.05

5 Australian Medical Association (AMA) (ACT)
Supplementary information
Additional information following public hearing 18.08.05 dated 20.08.05

6 Department of Health and Ageing (ACT)

7 Rural Doctors Association of Australia (ACT)

8 National Rural Health Alliance (ACT)

9 Catholic Health Australia (ACT)

10 Pilgrim-Byrne, Kelly and Samantha (WA)

11 Public Health Association of Australia (ACT

APPENDIX 2

Public Hearing

A public hearing was held on the Bill on 18 August 2005 in Senate Committee Room 2S1, Parliament House, Canberra.

Committee Members in attendance

Senator Humphries (Chairman)
Senator Moore (Deputy Chair
Senator Adams
Senator Allison
Senator Fielding

Witnesses

Australian Medical Association

Dr Mukesh Haikerwal, President
Dr Choong-Siew Yong, Vice-President
Mr John O'Dea, Director Medical Practice Department

National Rural Health Alliance

Mr Gordon Gregory, Executive Director

Department of Health and Ageing

Mr Philip Davies, Deputy Secretary
Ms Samantha Robertson, A/g Assistant Secretary, Medicare Benefits Branch