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17 August 2005

Elton Humphery
Committee Secretary
Australian Senate Community Affairs Legislation Committee
Parliament House
CANBERRA ACT 2600

Dear Mr Humphery

Submission regarding the Health Insurance Amendment (Medicare Safety-nets) Bill 2005

Formed in 1991, the Rural Doctors Association of Australia (RDAA) is a national body representing the interests of rural medical practitioners around Australia. Our vision is for excellent medical care for rural and remote communities.

As the only advocacy body with a specific mission to support the provision of medical services in the bush, RDAA has a particular responsibility to ensure that the needs of people who live there are heard by decision makers and incorporated into the design and implementation of national policies and programs.

Inequitable access to Medicare-funded services for rural Australians

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. On the basis of population and Health Insurance Commission (HIC) figures for 1999-2000, it has been estimated that the average per capita Medicare benefit paid in metropolitan areas was $125.59, compared to $84.91 in other parts of Australia. This suggests that approximately $221,009,162 of the Medicare levy collected in non-urban areas flowed back to subsidise metropolitan services.[1]

RDAA believes that a differential Medicare rebate for rural Australians is required to redress this inequity in health funding, and to reflect the higher rate of socio-economic disadvantage and the higher cost of delivering medical services in rural and remote Australia.[2]

Introducing a differential rebate based on existing geographic classifications of rurality and remoteness would better support rural and remote Australians in accessing the healthcare they need. It would also help to address the declining rate of bulk-billing in country areas (already lower than in the city) and help to keep rural medical practices viable and address health workforce shortfalls.

Inequities in private health insurance for rural Australians

There is good international evidence that heavy reliance on private sector funding of health services results in higher overall public expenditure on health,[3] although one author, from a study commissioned by a private health fund, has argued that *it would cost the government more to allow PHI to dwindle than to continue to support it*.[4]

In Australia, the recent policies supporting uptake of private health insurance have been extremely costly, but alternative methods of subsidising private hospital services, other than indirectly through the private health funds, have not been considered. For example, it has been suggested that government could directly fund the current level of private hospital services for approximately the same amount as the 30 per cent insurance rebate. Furthermore, private *insurance* (as distinct from private health *services)* is relatively inefficient compared with public insurance of health services, with 11.3 per cent of precious healthcare resources diverted to administration in 2001-02 (compared to approximately 4.8 per cent administrative costs for Medicare, including taxation collection costs).[5]

It has also been suggested that the redirection of (financial) resources into the private hospital system has meant that doctors are spending less time providing services in public hospitals where remuneration is generally lower and this is why waiting lists for public hospital services have seen little relief despite the increase in private hospital service provision.[6]

> *In health care, particularly hospital care, which is intensive in skilled labour, the most crucial resources are in constrained supply. There are shortages of both medical practitioners and nurses, and any replenishment of supply will take many years. When more money is directed at one sector (i.e. at private hospitals through the private health insurance subsidy), then there is no subsequent increase in resources in the system as a whole. Unless there are productivity improvements available, the inevitable result is some combination of movement of skilled staff from one sector to the other, or a rise in the payment necessary to retain the services of skilled staff.*[7]

This potentially affects rural areas even more acutely. Private hospitals tend to be concentrated in metropolitan regions.[8]

Private hospital beds account for 34 per cent of total hospital beds in capital cities, but for only 17 per cent in small regional centres and 6 per cent in other rural and remote areas.[9]

One of the main benefits of private health insurance cover is to have access to private hospitals.[10] Private hospitals make location decisions primarily on financial criteria based on projected numbers of users. Therefore people living in rural and remote areas of Australia are highly unlikely to have the same level of access to private hospitals as those living in metropolitan areas. Furthermore, *the indirect nature of the private health insurance rebate means that the Government is unable to influence the regional distribution of private health services.*[11] People living in rural and regional areas are missing out on both public and private health services.

RDAA believes that the unique conditions of health service delivery in rural areas must be explicitly considered in any initiatives designed to improve *relationships between private health funds, private and public hospitals, medical practitioners, other health professionals and agencies in various levels of government*. In fact, rural Australia has led the way in developing innovative and collaborative models of care involving private general practitioners, outreach medical specialists, allied health and hospital services, local governments and the community. These moves must be fostered and resources made available to communities to facilitate similar initiatives focused on their particular local needs and circumstances. Innovative models such as 'place based health planning' should be fostered as a means of more effective health resource allocation.[12]

Given income levels are lower in rural and regional areas compared to the national average, private insurance, and the considerable gap fees that accompany use of private services, will be less affordable for a higher proportion of the population in these areas.

Because people who live in rural Australia have less access to private hospitals, those with incomes above $50,000 (the level at which the tax penalty kicks in) are doubly disadvantaged by being forced to carry private insurance, even though it carries no benefit. If they do not carry it, they may suffer the Lifetime Health Cover penalty for taking out private insurance after age 30 if their circumstances change and they can or need to access private sector services. The private health insurance rebate thus exacerbates the existing health inequalities between metropolitan and regional Australia.

It has been estimated that: *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*.[13] Further, it has been estimated by the National Rural Health Alliance that rural and remote Australians pay $43 million more in out-of-pocket costs on a proportional basis for their health services than those living in urban areas, due to higher average out-of-pocket expenses relating to gap payments for GP and pharmacy services and travelling costs.

The 2004-05 Federal Budget provided funding of $830.2 million over 4 years for the Rural Health Strategy, which includes the Regional Health Services, Medical Specialist Outreach Assistance and More Allied Health Services programs, GP and Registrar recruitment and

retention programs, rural medical scholarships and the rural private access initiative.[14] In contrast, the private health insurance rebate is estimated to cost anywhere from $2.5 to $3.7 billion *per annum*, which, it has been shown, is distributed inequitably between urban and rural areas.

Additional resources must be directed to rural communities to provide greater access to affordable healthcare for the almost one-third of Australians who reside there, and to redress the inequitable distribution of federal health funding due to lower uptake of private health insurance by rural Australians.

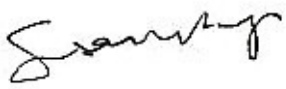
RDAA position on increasing the Medicare safety net

RDAA believes raising the safety net threshold to be an inappropriate response to the initial funding blowout. 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.

While RDAA would be prepared to consider the merits of a combined Medicare and Pharmaceutical Benefits Scheme (PBS) threshold, any new combined threshold **must not exceed** the current threshold levels. To do so would mean that rural and remote Australians—already disadvantaged by having inequitable access to healthcare services—would be further disadvantaged by reason of their lower health and financial status.

RDAA would welcome the opportunity to further discuss its concerns at a hearing of the Committee. RDAA's Policy Advisor, Susan Stratigos, can be contacted on tel: (02) 6273 9303 to this effect.

Yours sincerely



Dr Sue Page
President, Rural Doctors Association of Australia

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[1] Wagga Wagga City Council (2003) – Medical services in rural, regional and outer metropolitan areas in Australia, (unpublished), in RDAA submission to the Standing Committee on Health and Ageing Inquiry into Health Funding (May 2005).

[2] RDAA (1999) – *RDAA responses to Regional Australia Summit. Theme 3: Health*. Canberra: RDAA.

[3] McCauley I (2004) – Stress on public hospitals – why private insurance has made it worse. A discussion paper for the Australian Consumers' Association and the Australian Healthcare Association. January 2004, p 19

[4] Harper IR (2003) - Health sense: when spending money saves money. *Policy*, Spring, www.cis.org.u/policy/spr03/polspr03-3.htm, accessed 21/04/05

[5] McCauley (2004), *op cit.*, p 13

[6] Duckett SJ (2005) - Private care and public waiting. *Australian Health Review* 29:1

[7] McCauley (2004), *op cit.*

[8] Australian Institute of Health and Welfare (2004) - *Australian Hospital Statistics 2002-03.* Canberra, AIHW, [HSE 32] p 173

[9] Strong K, Trickett P, Titulaer I and Bhatia K (1998) - *Health in rural and remote Australia.* Australian Institute of Health and Welfare, Canberra, cited in Denniss R (2003) – *Health spending in the bush: an analysis of the geographic distribution of the private health insurance rebate*. Canberra, The Australia Institute.

[10] Denniss (2003), *op cit*.

[11] *Ibid*.

[12] Yeboah DA (2004), A framework for place based health planning. *Australian Health Review*, 29: 1; 30-36.

[13] Denniss (2003), *op cit.*

[14] Australian Government Department of Health and Ageing (2004). Budget 2004-2005, Fact Sheet Health 4.