NATIONAL RURAL HEALTH ALLIANCE INC.

Submission to the

Senate Community Affairs Legislation Committee

on the

Health Insurance Amendment (Medicare Safety-nets) Bill 2005

August 2005

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This Submission is based on the views of the National Rural Health Alliance, but may not reflect the full or particular views of all of its Member Bodies.

In previous submissions to the Senate on Medicare, the Alliance has asserted the central importance of Medicare's principle of universality. Because it is based on the tax system, Medicare is administratively efficient and progressive – the more you earn the more you pay. The universality of Medicare provides medical care as a right and not as a welfare safety net. It is a relatively simple system. Also, a universal system is politically stronger and safer than a targeted safety net.

Co-payments and private health insurance do not have these positive characteristics. They are regressive, more complex and partial.

For these reasons the Alliance feels some concern about the institution of a safety net provision under Medicare. Having said that, the Alliance is an organisation whose work is based on principles of equity and access so that, if some people are to be in and some out, we support the differential assistance to those who are young and those with healthcare cards. However, there is not a one-to-one correlation between financial need and access to a healthcare card. Some of the working poor will be doubly affected through bearing greater costs and not recouping through the safety net at the lower level.

One of the phenomena to which the Alliance has been drawing people's attention is 'No doctor: no Medicare'. A number of people in more remote parts of Australia have no access to a doctor so that they are not subject to the provisions of the notional contract between the Australian Government and its people that no cost or low cost primary care will be provided through Medicare. When the safety net was first introduced the Minister argued that:

> The Medicare safety net is universal. It operates in the same way as the Medicare system. It is a demand driven program to benefit patients. The safety net operates exactly the same for everyone regardless of where they live. Regardless of where they live, people have exactly the same access to Medicare and the safety net. *(Media Release, 21 September 2004)*

So to the phenomenon of 'no doctor: no Medicare' can be added 'no doctor: no safety net'.

The extent to which people in more remote areas are missing out on access to Medicare is measured in the notion of a Medicare deficit. This was estimated by the RDAA at over $500 million a year when specialist services shortfalls are included.[1]

Rural, regional and remote areas still have lower rates of bulk-billing than the major cities. The national rate of bulk-billing is now said to be around 70% overall (compared with 80% ten years ago), but it is still as low as 30-40% in some rural areas. Coupled with higher costs of access to medical care due to travel time and average prices charged, the lower rate of bulk-billing means that out-of-pockets costs

[1] The shortfall is the cost in Medicare Benefits of providing extra private medical services to the point at which average per capita payments in rural and remote areas equal the average in the major cities.

are both higher and more up-front in rural areas than in the cities.[2] In its February 2003 paper on Medicare the Alliance estimated the extra out-of-pocket costs for people in rural and remote areas at $43 million for 1996-97.

The Alliance will continue to argue that the Medicare shortfall and the extra out-of-pocket costs in rural and remote areas are among the key factors which justify special national programs for rural and remote health, such as targeted recruitment and retention programs for rural health practitioners, the Regional Health Services Program, the Primary Health Care Access Program and funding for the RFDS.

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. If, as we understand it, the change will result in a saving of something like $900 million over four years, there is at least a notional argument[3] to commit these funds to other areas of the health budget. Among the areas crying out for further national investment are public oral and dental health, investments in community based primary care in areas of poor supply, and programs to support healthy pregnancies and early childhood.

Unlike the situation for some specialties, as far as we are aware there is no evidence that the safety net has resulted in higher medical fees in rural areas. Rural GPs have a strong tradition of commitment to their patients and their communities. In fact the evidence, such as it is, 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. Although there is no evidence of increasing prices in country areas, there is also no mechanism in place to control or measure the extent of out-of-pocket costs. Every time one hears of a family where medical care was not affordable due to its costs, one has to be more concerned about the impact of out-of-pocket costs of primary care.

In a number of submissions recently the Alliance has had cause to comment on the relationship between health care costs, the structure of the health care system and its financing, and the demand for health professionals of various types. We see questions relating to Medicare and its safety net as being related to current issues of health reform and workforce shortages.[4] Many agree that Australia needs to increase its emphasis on alternative means of delivering effective primary care. This will have effects on the incidence and size of out-of-pocket costs, as well as on the demand for health care professionals. The major health care reforms that might be considered include moving to more salaried health professional positions, and having more Medicare items for interventions by non-medical professionals, over and above the current ones for practice nurses and some allied health work.

Overall then, the Alliance regrets the need for the safety net which confirms the increasing burden of out-of-pocket costs on health consumers. It also regrets the

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[2] The Alliance has a particular interest in the travel costs directly associated with health care and is currently finalising a Position Paper on the Patients' Accommodation and Travel Scheme (PATS) and its equivalent.

[3] arguments against hypothecation notwithstanding!

[4] See the Alliance's Submission on the health workforce to the Productivity Commission, 4 August 2005.

changes to the threshold and, rather, would support the sort of health reforms currently being discussed which would enhance Australia's health system as a universal arrangement under which access to care will be determined by the need for health care. This might require some changes in the nature of Medicare and the MBS and will lead to changing demands for health care professionals which will be in the interests of both Australia and the more needy nations from which it currently draws trained staff.

NRHA
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