DOCTORS REFORM SOCIETY

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Submission to Senate Community Affairs Committee Re Private Health Insurance Bill (2006)

The DRS is an organization of doctors and medical students supporting health care reforms
to ensure justice, equity and quality care for all regardless of social or economic status.

The Private Health Insurance Bill (2000) seeks, amongst other things, to broaden the scope of coverage of Private Health Insurance (PHI) to non hospital based services. Whilst this would might superficially appear to benefit those who can afford PHI, it will have a negative effect on the availability of services for those who cannot afford PHI.

The Productivity Commission was asked to look at the medical workforce situation in 2005, mainly because of the identification of the fact that in almost all areas of medical workforce there is a nationwide shortage. This manifests most particularly in shortages of medical professionals in rural and remote Australia and in poorer urban areas. It manifests least in private hospitals in major cities where waiting lists for most forms of care are measured in weeks rather than months and years as is the case in the public system and in rural and remote Australia.

The expansion of PHI to cover such items as dialysis, chemotherapy, and radiotherapy, will lead to the provision of such services in private facilities in the community. Such centres can only be staffed by taking highly trained professionals such as doctors, nurses, and radiotherapy technicians from the public system where shortages are already apparent. This will inevitably result in a decreased ability of public facilities to provide services to the most needy people in the community. The suggestion that patients without PHI will still be able to access such facilities and be rebated 85% of the Schedule Fee and have access to the Medicare Safety Net ignores the reality that many such facilities will have prohibitive copayments despite such safety nets and that many patients will simply continue to line up at the public hospital.

The expansion of PHI to cover preventive health type programs which are not covered by Medicare will also lead to the provision of such services in the community. Once again however, the staff to run such programs must come from somewhere, and in an environment of workforce shortages, they will come from the public system.

In the case of the Medicare type items like dialysis, most of the funding for such services will come from the taxpayer. The Medicare rebate will contribute up to 75% of the cost, whilst at least 30% of the PHI contribution will come from taxes via the PHI rebate.
In the case of non Medicare items, at least 30% will come from taxes through the PHI rebate.

These facilities will be available in the community only where economic factors make them viable. Thus, they will not be found in the country, in rural and remote Australia, or in poor areas of the cities. In such areas choice is usually not an option, either because there are insufficient health professionals to enable choice, or because of economic circumstances. Those taxpayers who live in such areas will contribute to the provision of these services through taxes despite the very limited access to the services. Indeed, the effect of these changes will be a net transfer of money from rural, remote, and poor areas of Australia to the better off areas of the larger cities.

Provision of choice for a limited number of Australians is being placed before a fair go for all Australians. Does this emphasise Australian values?

Dr Tim Woodruff, President