CHAPTER 2

The Medicare System

To most Australians, good insurance means no out-of-pocket costs. Bulk-billing provides that. It is the only device that has. How much was expected or wanted? One of the great advantages of a universal system, if it is truly universal, is that you do not have do worry that the people within it are being treated fairly. You do not have to make special provision for the underprivileged…[1]

Introduction

2.1 This chapter lays out in broad terms the overall terrain of the Australian health system and general practice, by outlining the basis for the Medicare system, the main elements of its operation, and key participants in the health debate.

Australia's Constitution and a shared responsibility for Health[2]

2.2 The axiom of the Australian federal system is that the Commonwealth can exercise only those powers conferred on it by the Constitution, and that the States and Territories have carriage of all residual unspecified matters. There is no specific Commonwealth power with respect to health, though many heads of power will support laws that touch on different aspects of health policy. The range of the references in the Constitution defines a scope of Commonwealth responsibility that has, through creative adaptation, been expanded gradually.

2.3 In defining and expanding its role in health, the Commonwealth has also made use of the Executive power contained in section 61, which empowers the administration to undertake many administrative activities without prior authorisation from an Act of Parliament.

2.4 The social services powers of the Commonwealth inserted into section 51 of the Constitution by the 1946 referendum contain a prohibition on civil conscription with respect to medical and dental services. Civil conscription has been interpreted quite broadly, referring not only to actual compulsion to perform services, but also to indirect or practical measures which may constitute it.[3]

2.5 In practical terms, the Commonwealth provides direct financial support for both the Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme

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1 Prof Deeble, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 10

2 Discussion of the constitutional basis to Australia's health system is drawn from John McMillan, *Commonwealth Constitutional Power over Health*, ISBN 0646110128.

3 Ibid. See also *General Practitioners Society v Commonwealth* (1980) 31 ALR 369

(PBS), while also undertaking a leadership role in issues of national policy significance.

2.6 States and Territories provide public hospital infrastructure and services, and the majority of community health programs. Traditionally, allied and public dental health have been driven primarily though State and Territory Governments. In addition, there is a broad range of health services provided on a cooperative basis between the federal and state jurisdictions.

Australian Health Care Agreements (AHCAs)

2.7 In order to determine the respective responsibilities of the Commonwealth and the States and Territories, all parties enter a five yearly bilateral agreement, called an Australian Health Care Agreement (AHCA), and previously known as Medicare Agreements. Under the AHCAs, the Commonwealth provides financial assistance to the States and Territories to meet part of the cost of providing public hospital services (and comprising approximately 48 percent of total recurrent funding).

2.8 The Agreements contain certain principles by which the recipient states agree to abide, including that hospital services must be provided free of charge to public patients on the basis of clinical need and within a clinically appropriate period, regardless of geographic location.

2.9 The 2003-2008 Australian Health Care Agreements provides State and Territory Governments with a total of $42 billion from the Commonwealth.

History and purpose of Medicare[4]

2.10 Medicare is the Commonwealth funded health insurance scheme that provides free or subsidised health care services to the Australian population. It covers both in-hospital services for public patients in public hospitals, through Australian Health Care agreements with the States, and provides subsidised or free (bulk-billed) access to doctors' services, plus certain pathology, psychiatry and optometry services.

2.11 Medicare's predecessor, Medibank, was introduced by the newly elected Whitlam Labor Government, and commenced on 1 July 1975 after the passing of the Medibank legislation by a joint sitting of Parliament on 7 August 1974. The Health Insurance Bill 1973 was the main bill establishing Medibank, together with several accompanying bills, including the Health Insurance Commission Bill 1973.

Original Purpose

2.12 According to the Second Reading Speech of the Health Insurance Bill 1973 delivered by the Hon. Bill Hayden on 29 November 1973, the purpose of Medibank

4 The following description of Medicare's history and operation is exerted with minor changes from Amanda Biggs, *Medicare – Background Brief*, Parliamentary Library, 14 May 03

was to provide the ‘most equitable and efficient means of providing health insurance coverage for all Australians’, based on underlying principles of universal coverage, equitable distribution of costs, and administrative simplicity.

Financing and Cost

2.13 The original legislation proposed financing the program through a taxpayer levy of 1.35 per cent on taxable income, with exemptions for low income earners. However the Senate rejected the bills dealing with financing of the program in August 1974 and again in December 1974. Consequently, the final program was funded entirely from general revenue.

2.14 The hospital component of Medibank entailed free treatment for public patients in public hospitals, and subsidies to private hospitals to enable them to reduce their fees. Benefits for public hospitals were provided through hospital agreements with state governments, under which the federal government allocated grants equal to 50 per cent of net operating public hospital costs.

Changes under the Fraser Government

2.15 The Medibank program had only a few months of operation before the dismissal of the Whitlam Government on 11 November 1975, and the subsequent election of the Fraser Liberal-National Coalition Government in December 1975. Following the election, a new program was announced in a Ministerial Statement to Parliament on 20 May 1976. ‘Medibank Mark II’ was launched on 1 October 1976 and included a 2.5 per cent levy on income, with the option of taking out private health insurance instead of paying the levy.

2.16 Other significant changes in 1976 included the federal government declaring the hospital agreements with the states invalid, and the subsequent introduction of new hospital agreements where the federal government provided 50 per cent funding for *approved* net operating costs. Also in 1976, legislation was passed allowing the Health Insurance Commission (HIC) to enter the private health insurance business. This led to the establishment of Medibank Private on 1 October 1976.

2.17 In 1978, medical benefits were reduced to 75 per cent of the Schedule fee and bulk-billing was restricted to holders of Pensioner Health Benefits cards and those deemed by the doctor to be, in the Minister's words, ‘socially disadvantaged’. The health insurance levy and the compulsion to insure were abolished in 1978.

2.18 In 1979, Medicare benefits were limited to the difference between $20 and the scheduled fee. In 1981 access to free hospital and medical care was restricted to pensioners with health care cards, sickness beneficiaries, and those meeting stringent means tests. An income tax rebate of 32 per cent was introduced for those with private health insurance.

Medicare from 1984

2.19 The major changes introduced by the Fraser Government were largely rejected by the Hawke Labor Government, who returned to the original Medibank model. Although the financing arrangements were different and there was a name change from Medibank to Medicare, little else differed from the original. Medicare, as it now exists, came into operation on 1 October 1984 following the passage in September 1983 of the *Health Legislation Amendment Act 1983*, including amendments to the *Health Insurance Act 1973,* the *National Health Act 1953* and the *Health Insurance Commission Act 1973.* It differed from the original Medibank program only in matters of detail.

2.20 In his Second Reading Speech in September 1983, Dr Blewett described the legislation as 'a major social reform' that would 'embody a health insurance system that is simple, fair and affordable'. He also emphasised the 'universality of cover' as being 'desirable from an equity point of view' and 'in terms of efficiency and reduced administrative costs'.

Medicare cost and financing

2.21 Funding for Medicare was to be 'offset' by a Medicare levy, originally set at 1 per cent of taxable income, with a low income cut-off point of $7110 per year for a single person and $11,803 for married couples and sole parents. Below these income levels no levy was payable. More details are provided in the Second Reading Speech made by The Hon Chris Hurford when he introduced the Medicare levy bill in September 1983.

2.22 The Medicare levy is currently set at 1.5 per cent of taxable income. In 2000/2001, the levy raised $4.58 billion. This equates to 15.9% of the total Commonwealth expenditure on health for that year of $28.845 billion.[5]

The operation of Medicare – an overview

2.23 Medicare is a universal insurance scheme which provides financial assistance to Australians who incur medical expenses in respect of professional services rendered by eligible qualified medical practitioners, participating optometrists, pathologists and psychiatrists. Medicare also provides free in-hospital services in public hospitals for patients who choose to be treated as public patients. Funding for these services is shared between the Federal and State and Territory Governments under the Australian Health Care Agreements.

2.24 When an eligible patient presents at an eligible medical practitioner, a consultation takes place, and the practitioner provides the consultation for no more than the rebate available from Medicare (85% of the Schedule Fee), the patient signs

5 The Committee notes that the Medicare Levy was never intended to fully cover Commonwealth expenditure on health care.

the Medicare claim form at the point of service. This allows the practitioner to directly bill the Health Insurance Commission along with other similar patients ('bulk-billing').

2.25 In the event that the practitioner charges more than the Rebate for the consultation, the patient is charged for the entire cost of the consultation. The patient then presents their receipt and Medicare Card at a Medicare office and a rebate is issued for 85% of the Schedule Fee. Alternatively, the patient may take an unpaid account from the practitioner to a Medicare office, in response to which a cheque is drawn for 85% of the Schedule Fee. This cheque, along with any difference between the amount rebated and the amount owing is then issued to the practitioner by the patient.

2.26 At this point, it is also worth making a brief comment on terminology. During the inquiry, the terms 'gap' and 'copayment' were often used interchangeably, and both terms were also frequently taken the mean difference between the rebate and the actual fee charged by the GP. This is likely to add to existing confusion over the operation of Medicare.

2.27 The term 'gap' has been historically used to refer to the difference between the rebate and the Medicare schedule fee. The term 'copayment' technically refers to a dual billing arrangement whereby GPs claim the rebate directly from Medicare, as ordinarily occurs where a patient is bulk-billed, but also receive an additional payment from the patient. It is important to note that 'copayments' are technically illegal under current Medicare rules.

2.28 In this report, the Committee has endeavored to use the terms with their correct meaning, and the difference between the rebate and the actual fee charged is referred to as an 'out-of-pocket cost'. However, in many cases, quotes from witnesses have been reproduced containing terms that are, from a technical perspective, incorrect.

Eligibility

2.29 Medicare eligibility largely rests on Australian residency, except for foreign diplomats and their dependants. People who reside in Australia are eligible if they meet any of the following criteria:

- they hold Australian citizenship;
- they have been issued with a permanent visa;
- they hold New Zealand citizenship; or
- they have applied for a permanent visa (in most cases).

2.30 As of 29 August 2000, holders of Temporary Protection Visas have access to Medicare. Asylum seekers have access if they have an unfinalised application for a permanent residence visa (either for migration or asylum) and hold a valid visa with work rights in force. Some asylum seekers without work rights are eligible for

Medicare if they are the spouse, child or parent of an Australian citizen or permanent resident.

Safety Net Arrangements

2.31 Under Medicare, Safety Net Arrangements apply which protect patients from significant out-of-pocket costs for GP services.

2.32 Once payments up to the level of the Schedule Fee for an individual or family exceed a total of $319.70 (indexed annually) in a calendar year, Medicare benefits increase from 85% to 100% of the Schedule Fee for any further non-inpatient costs incurred in that year.

2.33 A Medical Expenses Tax Offset is also available where out-of-pocket medical expenses exceed $1,500 in one calendar year. Eligible expenses include those incurred through the services of doctors, nurses, chemists or hospitals. Where net expenses exceed the threshold, claimants may receive a 20% tax offset on the balance after $1,500.[6] For further discussion about safety net arrangements see chapter 7.

Blended payments [7]

2.34 The Medicare framework also encompasses two additional payments schemes - the Enhanced Primary Care (EPC) scheme, and the Practice Incentive Payments scheme (PIP). EPC provides a framework for a multidisciplinary approach to health care and the 28 EPC Items on the Medicare Benefits Schedule (MBS) include health assessments for people aged 75 and over (or 55 and over for Aboriginal and Torres Strait Islander people), and multidisciplinary care planning.

2.35 PIP aim to recognise general practices that provide comprehensive, quality care, and which are either accredited or working towards accreditation against the Royal Australian College of General Practitioners' (RACGP) *Standards for General Practices*. Payments focus on aspects of general practice that contribute to quality care, such as provision of after hours care, student teaching and better prescribing, with a loading paid to practices in rural and remote locations.

2.36 The PIP scheme grew out of the Better Practice Program in response to a series of recommendations made by the General Practice Strategy Review Group (GPSRG) that reported to the Government in March 1998.

Consumer organisations

2.37 There are a number of organisations that play an important role in lobbying on behalf of consumers in relation to health issues. In acknowledging the valuable work of these groups, the Committee is also mindful of the difficulties they face in

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6 Australian Taxation Office website – (www.ato.gov.au) – accessed on 3 September 2003.

7 Department of Health and Ageing website (www.health.gov.au) accessed on 4 September 2003

performing their task given the limited resources available to them. Key challenges in this respect are finding the time and resources to widely consult their 'constituency', as well as getting across the technical and statistical complexity inherent in many aspects of public health policy issues.

2.38 These groups include but are not limited to:

Australian Consumers' Association

2.39 The Australian Consumers' Association is an independent advocacy and information organisation. It promotes consumer rights through its publications, including Choice magazine, and through policy advocacy. Specialist policy officers are employed in the areas of health, financial services, communications and IT, and food. The ACA is not funded by industry or government, and is a not-for-profit company limited by guarantee.[8]

Consumers' Health Forum of Australia

2.40 The Consumers' Health Forum of Australia Inc (CHF), established in 1987, is a peak non-government organisation representing consumers on national health care issues. CHF establishes policy in consultation with members, comprised of over one hundred health consumer organisations. CHF states that they 'provide a national consumer voice to balance the views of government, industry, service providers and health professionals'.[9]

State Based Health Consumers' Organisations

2.41 The Health Consumers' Council (WA) is an independent community based organisation, representing the consumers' 'voice' in health policy, planning, research and service delivery. The Council advocates on behalf of consumers to government, doctors, other health professionals, hospitals and the wider health system and is funded by the Western Australian Department of Health. The Council has 600 members across Western Australia, including remote, rural and metropolitan consumers.[10]

2.42 Health Issues Centre (Victoria) is an independent not-for-profit organisation promoting consumer perspectives in the Australian health system. The Centre states that 'particular areas of interest include health financing, quality in health services, consumer protection and complaints mechanisms, community development and

8 Martyn Goddard, Australian Consumers Association, Additional information, 15 September 2003.

9 Consumers' Health Forum of Australia, Submission 102, p. 1.

10 Health Consumers' Council (WA), Submission 62, p. 1.

evaluation'. The organisation also claims a strong reputation for public interest research and health system analysis.[11]

2.43 There are also a number of other state based state based organisations including the Public Hospitals and Medicare Alliance of Queensland.

General Practice in Australia

2.44 The Royal Australian College of General Practitioners[12] defines general practice as part of the Australian health care system, operating predominantly through private medical practices, and providing universal unreferred access to whole person medical care for individuals, families and communities.

2.45 To be a general practitioner, a person must be a registered medical practitioner in Australia under the rules of the RACGP.[13]

2.46 For the purposes of Medicare, a 'recognised' GP is one who is vocationally registered under Section 3F of the *Health Insurance Act 1973* (Cth), holds fellowship of the RACGP or equivalent, or holds a recognised training placement.[14] In national terms, the proportion of GPs who are vocationally registered is increasing, though not across all jurisdictions.[15]

2.47 In 2001/02 there were approximately 24,000 GPs and other medical practitioners in Australia, representing about 123.3 medical practitioners per 100,000 population. Of these, there were 84.9 full-time equivalent GPs per 100,000 population on average nationally.[16]

Vocationally registered and non-vocationally registered practitioners

2.48 A general practitioner may or may not be vocationally registered (VR). Approximately 90% of GPs in Australia are VR, meaning that they have either completed the Royal Australian College of General Practitioners' Fellowship Examination or are fellows of the College by virtue of their year of graduation from Medicine.[17] The major practical significance of the distinction is that the service

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11 Health Issues Centre, Submission 63, p. 2.

12 Royal Australian College of General Practitioners website (www.racgp.org.au) 2 July 2003

13 Royal Australian College of General Practitioners website (www.racgp.org.au) 2 July 2003

14 Royal Australian College of General Practitioners website (www.racgp.org.au) 2 July 2003

15 Report on Government Services 2003, page 10.35, Productivity Commission, February 2002, available at www.pc.gov.au/gsp/2003. See also below *Vocationally registered and non-vocationally registered practitioners*

16 Report on Government Services 2003, page 10.5, Productivity Commission, February 2002, available at www.pc.gov.au/gsp/2003.

17 Dr Moxham, Submission 48, p. 6

provided by a non-VR GP attracts a lower Medicare rebate of $17.85,[18] compared with around $25 for those who are registered.

Professional Organisations

2.49 Doctors are represented through a number of professional organisations. These include:

The Royal Australian College of General Practitioners

2.50 The College is a representative body and plays a central role in setting and maintaining the standards for quality practice, education and training for general practice in Australia. The RACGP also acts as advocate for Australian GPs on issues affecting the profession and its ability to provide quality primary health care to health consumers.[19]

The Australian Medical Association

2.51 The AMA represents 27,000 doctors, of which about one-third, or approximately 8,500, are general practitioners.[20] The AMA aims to promote and advance public health, medical standards, ethical behaviour, and the independence of the medical profession, as well as protecting its political, legal and industrial interests.[21]

Divisions of General Practice

2.52 The Divisions of General Practice began as part of the Commonwealth Government's 1991-2 major reforms and budget initiatives. As a component of the Demonstration Practice Grants Program ten Divisions were originally piloted and by 1993 there were 100 Divisions in place across most of Australia.[22] Following the Report of the General Practice Strategy Review in 1998, the national and state Divisions were formed. Today, there are 120 Divisions covering all of Australia, with 94 per cent of GPs being members of their local Division.[23]

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18 Dr Moxham, Submission 48, p. 1

19 Royal Australian College of General Practitioners website (www.racgp.org.au) accessed on 4 August 2003

20 Which would amount to around one-third of overall GP numbers, or half based on full-time workload equivalents. See chapter 4, paragraph 4.19 for a discussion of GP numbers in Australia.

21 Australian Medical Association website (www.ama.com.au) accessed on 4 August 2003.

22 Department of Health and Ageing, *General Practice in Australia: 2000*, p210, available at http://www.health.gov.au/gpconnections/pdf/chpsix.pdf

23 Australian Divisions of General practice website (www.adgp.com.au) accessed on 14 October 2003

2.53 The Australian Divisions of General Practice (ADGP) is the peak national body representing these local Divisions of general practice across Australia. The primary objectives of the ADGP are to facilitate communication between Divisions as well as to support and represent their interests to the Commonwealth Government. The ADGP plays an important role in marshalling local Divisions, State-based organisations and other medical and consumer bodies in providing national programs over a broad range of primary care issues.[24]

2.54 The role of the Divisions that make up the organisation varies somewhat in focus across the nation, but generally centres on programs to support general practice, including:

- organising education programs;
- supporting practices in adopting information management and information technology;
- helping practices implement population health programs including programs in relation to chronic disease management, and
- providing advice about practice management issues.[25]

24 Australian Divisions of General practice website (www.adgp.com.au) accessed on 5 August 2003

25 Department of Health and Ageing, *The future role of the divisions network*, June 2003, p. 6.