GOVERNMENT SENATORS MINORITY REPORT

Introduction

The Government Senators believe that public consultation regarding the sustainability of Australia's health system is a useful and productive exercise. Access to and affordability of general practice services under Medicare are issues that concern all Australians. Unfortunately, the opposition parties have skewed the inquiry, resulting in a narrow ideological debate about the concept of universal health care and the ensuing belief that bulk billing is its embodiment.

The Terms of Reference also perpetuate the misconception that the Howard Government is attempting to undermine the universality of Medicare. *A Fairer Medicare* is an integrated set of measures that builds on the Government's commitment to Australia's universal health system. All Australians will continue to be eligible for the Medicare rebate. Further, doctors will remain in control of their billing practices and can choose to provide care at no cost to the patient, regardless of whether or not they hold a Commonwealth concession card.

Medicare is an Australian Government funded health insurance scheme designed to increase equity and access to medical services within the confines of private enterprise. As former Labor Health Minister Dr Neal Blewett stated in 1983,

> Medicare will restore the right of access to health care. It is the comprehensive, universal, equitable, scheme that we see as essential to guarantee access within the limits of a fee-for-service system.

A Fairer Medicare maintains these universal principles of Medicare. However, it also brings new and very significant financial protection to those with the greatest health and financial needs. Moreover, the package strives to address some of the inequities in Australia's health care system such as timely access to medical services, which is currently largely determined by geographical location.

The focus of the Government package is achieving equitable access to GP and other health services. No political party, including the government, proposes to dismantle Medicare. This proposition is arrant nonsense and reflects the criticism – bordering on hysteria – that some in the community reacted with, and evident in the views expressed by Dr Costa of the Doctors Reform Society, who told the Committee:

> It is turnstile medicine. It is not good enough. This is not Africa; this is Australia, and yet we are being treated like sub-Saharan Africa when it comes to health care.[1]

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1 Dr Costa, *Proof Committee Hansard*, Sydney, 22 July 2003, p. 52

Australia's health in context

Throughout this inquiry, opposition Senators have painted a bleak picture of health care in Australia. But Australia's health system is not in crisis – claims of a crisis are an overreaction. Medicare can certainly be improved, and the Government's *A Fairer Medicare* package has been created to do this, but it is important to keep in mind that Australia's health care system is either the best or among the best in the world.

Health outcomes in Australia compare favourably with other OECD countries, demonstrating the high quality of the Australian system. For example, Australian males are expected to live 76.6 years, the fifth highest of all developed countries, while females in Australia have a life expectancy of 82.1, the sixth highest.[2] Another useful indicator of Australia's good health is our low rate of infant mortality, with only one percent of Australian infants dying within one year of being born.[3]

The high standard of Australia's health care means that Australians are less likely to die from infectious disease and are living longer than ever before. Consequently, our ageing population is increasingly prone to chronic illnesses such as diabetes, heart disease, stroke and dementia, placing increased pressure on Australia's health care costs now and into the future as many Australians move into later life. Already, chronic diseases are responsible for up to 80% of the total burden of disease.[4]

Again though, it is important to note the significant progress already made in preventive health care: Australia's smoking rates are among the lowest in the western world, and recently, the National Obesity Taskforce was established to look at factors contributing to ill-health among both adults and children. Added to this, is the recently released National Health and Medical Research Council (NHMRC) Nutritional Guidelines, while Government Senators and Members of Parliament have also taken the initiative by hosting healthy lifestyle forums to combat childhood obesity.

Seven years ago, immunisation rates among children in Australia ran at 53%, while today they stand at over 90%,[5] while rates of vaccine-preventable childhood diseases are at a record low.

The 2003-04 Budget builds on this record by providing $4.3 million over three years to promote the prevention role of general practice to both GPs and to the community. Specific elements of the initiative include a national approach to lifestyle prescriptions, encouraging for example, physical activity, moderate drinking, and healthy eating.

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2 Australian Institute of Health and Welfare, *Australia's Health 2002*, p. 12

3 Australian Institute of Health and Welfare, *Australia's Health 2002*, p. 37

4 Senator the Hon. Kay Patterson, Media Release, *Budget Delivers Prevention, Safety and Quality for a Healthier Australia*, 13 May 2003

5 Senator the Hon. Kay Patterson, *Medicare – for all Australians*, May 2003, p.3

The recently negotiated Australian Health Care Agreements (AHCA) reflect the Government's commitment to meeting Australia's burgeoning health care needs. Despite the erroneous claims of the State Premiers, the new AHCA increased health funding to the States by seventeen percent in real terms, meaning an increase of $10 billion to a total of $42 billion over the next five years. This represents the largest increase in Australian Government health funding in history. The growing commitment is also evident in the fact that over the past decade, the Australian Government's share of overall health expenditure has grown from 3.3 as a per cent of GDP in 1990-91, to 4.3 per cent in 2000-01, while state and local government contributions have remained static at 2 per cent.[6] Similarly, Australian Government share of public hospital funding has increased from 44.6% in 1992-93 to 47.9% in 2001-2, while over the same period, state and territory government funding has declined slightly from 46.3% to 46.2%.[7]

However, the increasing costs associated with an ageing population must be addressed as a matter of urgency as Australia's demographic shift continues. For example, the cost to the Australian taxpayer of the PBS has escalated dramatically over the last ten years, from $1 billion in 1990-91, and is expected to reach almost $6 billion in this financial year.[8] This is estimated to rise even further, to $7 billion in two years. The Government has recently introduced a system of full disclosure for the PBS, whereby prescribed medicines covered under the PBS are subject to package labelling outlining the actual cost of providing the medicine, which can sometimes run into thousands of dollars. This measure is intended to lessen waste of prescribed medicines by raising patient awareness of the cost of the PBS, thus saving public funds.

Government Senators believe the principle of full disclosure should also be extended to include patients' attendance at their GP. As with prescription medicine, patients utilising GP services should do so with a full understanding that a major (or total) proportion of the cost is borne by the taxpayer. This measure would help prevent misuse of GP services and relieve pressure on Medicare and overworked GPs.

Recommendation

Government Senators recommend that requirements be introduced to ensure that the real costs of a GP attendance and the extent of the government rebate payment are clearly displayed to patients.

Viable General Practice in Australia

Term of Reference (a) directly implies that the current levels of the MBS schedule are resulting in general practice becoming financially non-viable in Australia.

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6 Department of Health and Ageing, Submission 138, Answer to Question on Notice No. 6

7 AIHW, *Health expenditure Australia 2001-02*, Health and welfare expenditure series No. 17, September 2003

8 Department of Health and Ageing, Submission 138, p. 5

Government Senators do not believe this is the case. As figures from the Department of Health and Aged Care demonstrate, GPs around the country still receive significant incomes – with, for example, those in outer metropolitan centres averaging $236,328, which rises to $239,960 for those in large rural centres.[9] Allowing for practice costs of around 50%, this still allows for take-home pay for most GPs that easily exceeds $100,000, which is equivalent to 4.7 times the level of Average Weekly Ordinary Time Earnings (AWOTE).[10]

However, it is also evident that in many cases, especially for some country GPs, real incomes have declined.[11] Overall, GPs' income expectations, which are based on their perceptions of other specialists' and professionals' incomes, is one of the key factors driving the need for an increase in the rebate.

It is important that General Practice is an attractive career option both to current and prospective practitioners, and a central plank of achieving this is to ensure that General Practice is financially viable and can deliver reasonable incomes for doctors.

A number of actions have been taken by the Government to address these income issues. Importantly, there has been an increase in Australian Government payments for general practice services of around 30% from 1996-97 to 2002-03, rising from $2,400 million to an estimated $3,130 million. The six years since 1996 have also seen the Medicare rebate for a standard GP consultation increase by 20%, and for longer consultations by 26%.[12] This compares to increases of 9% for a standard consultation and 5% for a long consultation that occurred during the preceding six years of the Labor Government.[13]

The government has also made important contributions to GP incomes via the Practice Incentive Program (PIP) (described in paragraphs 3.44 – 3.51 of the Majority Report). PIP complements fee-for-service payments and recognises the importance of a broader practice-based approach to the delivery of health care. It aims to compensate for the some of the limitations of fee-for-service such as the perverse incentive for faster throughput of patients.

The PIP provides direct financial support to regional and rural practices, and encourages practices to operate in more efficient ways by supporting practice infrastructure such as information technology and practice nurses.

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9 Department of Health and Ageing, Submission 138a, Attachment A: referring to RRMAs 2 & 3.

10 This has declined from 5.2 times AWOTE ten years ago. AIPC Report to Select Committee on Medicare, p. 11

11 Department of Health and Ageing, Submission 138a

12 Department of Health and Ageing, Submission 138, pp 18 and 19.

13 Sen Knowles, *Proof Committee Hansard*, Melbourne, 24 July 2003, p. 22

In 2002-03, around $284 million will be paid to general practices through the PIP, with $21 million of this allocated to the management of specific conditions such as asthma, diabetes and mental health. PIP comprises around 10% of Australian Government remuneration to GPs.[14]

Ultimately, GPs are responsible for running their own businesses and setting their own fees in order to meet their income expectations, within the limits of what the market will pay. It is not the responsibility of the government to make general practice viable. However, existing government programs make a significant contribution to overall practice incomes, and have benefited from substantial increases over time.

Improved viability under A Fairer Medicare

A Fairer Medicare contains a number of initiatives that will benefit General Practice. Mr Davies of the Department of Health and Ageing made clear during the public hearings that the package has been carefully designed to ensure that GPs will be better off by signing on, and that the incentive to bulk bill will be highest in those areas currently witnessing low levels of bulk-billing availability. These same areas are also marked by relative declines in GP income compared to their city colleagues.[15] In addition, participating practices will receive a financial contribution toward the cost of accessing HIC Online, and in the case of practices in areas of workforce shortage, toward hiring practice nurses.

Government Senators are also mindful that the viability of general practice is as much a function of practice costs as it is of gross earnings and although the MBS rebate has increased in-line with the Consumer Price Index (CPI), many GPs reported an extraordinary increase in practice costs over recent years. Key contributors to these rising costs are medical indemnity insurance and administrative costs.

The Howard government has taken measures to address both issues.

The financial collapse of the Medical Defence Organisation UMP triggered a crisis in Australian medical indemnity arrangements. Although this crisis fundamentally represents a problem arising from the failure of a commercial entity, in the course of normal business operations, the Australian Government has stepped in to assist and has taken a number of important actions to ensure the continued protection of medical practitioners from insurance risk. These actions include a rescue package under which the Government has assumed responsibility for $460 million worth of UMP's unfunded liabilities plus $353 million of subsidies and exemptions for doctors.[16] The Government has also announced an extension of the high cost claims scheme to cover fifty percent of claims between $500,000 and $20 million, and exempted those doctors

14 Department of Health and Ageing, Submission 138, pp 18 and 19

15 Department of Health and Ageing, Submission 138a, Attachment A. ie RRMAs 4-6.

16 Senator The Hon. Helen Coonan, Minister for Revenue, Media Release, *Paying for doctors' past mistakes?*, 1 October 2003.

in public employment or aged over 65 from the IBNR (Incurred But Not Reported) levy.[17]

In addition, the Minister for Health The Hon. Tony Abbot MP, announced the formation of a new Medical Indemnity Policy Review Panel which will make recommendations to ensure a fair, affordable and sustainable medical indemnity insurance system. This panel is to report in December.[18]

These actions represent a strong commitment by the Government to assist the medical profession. As the former Minister for Health, Senator Kay Patterson, stated:

> By any measure, the Australian Government has implemented far-reaching reforms and has given very generous taxpayer-funded assistance to doctors. No profession has ever received this much assistance for insurance costs from any government.[19]

This Government support for the viability of general practice must also be taken into account when considering the wider issues of GP remuneration and rebates, discussed below. It should also be noted though, that part of the reason for the failure of UMP and the current medical indemnity problems is the lack of tort law reform by state and territory governments.

The Government has also recognised the important issue of practice costs, especially in relation to the blended payments schemes, and this has already seen the creation by the Minister for Health and Ageing of a Red Tape taskforce. While recognising the importance of the fee-for-service model, Government Senators are mindful of the benefits and underlying worth of blended payments such as the Practice Incentive Program (PIP) and are committed to its retention. However, a large number of respondents expressed frustration at the administrative requirements of the system as it currently operates, including the disproportionately large amounts of time required by the claims process. Government Senators reiterate the importance of the Minister's Red Tape Taskforce in addressing these concerns and returning the financial as well as clinical benefits to the blended payment system.

For these reasons, Government Senators endorse the conclusions of the Majority Report in relation to importance of the Red Tape Taskforce, and support Recommendation 3.1 that the Australian Government undertake a similar review of the Practice Incentive Program (PIP).

Addressing the problem

17 The Hon. Tony Abbot MP, Minister for Health and Ageing, Media Release, *New Medical Indemnity Arrangements*, 10 October 2003. Note that the rescue package also contains a range of other measures not detailed here.

18 The Hon Tony Abbot MP, Media Release, *The New Medical Indemnity Policy Review Panel*, 16 October 2003.

19 Senator The Hon. Kay Patterson, Media Release, *Australian Government committed to fair and manageable scheme to assist doctors to meet their liabilities*, 28 September 2003.

However, Government Senators recognise that the Medicare rebate constitutes a central element of GP remuneration and this method of remuneration enjoys support from the majority of general practitioners. At the same time, it is clear that an increase to the rebate does not guarantee an increase in the bulk-billing rates. When every $1 increase in the rebate costs the Australian taxpayer $100 million, increases must be carefully assessed.

Government Senators believe that the process of setting the rebate, and rises in it, would benefit from greater transparency. This would have the effect of demonstrating to practitioners the process through which the rebate is determined and while many may still consider the level at a given time is insufficient, might reduce the sense that levels are set arbitrarily, and with little reference to realistic need.

A useful example of this process is the current Review of Pricing Arrangements in Residential Aged Care, in which economist Professor Warren Hogan has been asked to provide information on the financial situation in the aged care sector and recommend new pricing mechanisms to underpin planning for residential aged care. The report is expected to be completed in December.[20]

Recommendation

Government Senators recommend reforms to the method of determining the level of the rebate, to increase the transparency and accountability of the process and to reflect more accurately the cost of running a general practice.

Government Senators also call for the finalisation of the Relative Value Study (RVS), in order to inform the determination of the rebate. The RVS failed to emerge with any clear outcome, due to lack of agreement by the overseeing committee on assumptions relating to GP workload, practice costs, target income, and the work value of a standard consultation.[21] Unfortunately, the overall outcome of the process has been the widespread, but incorrect, view within the medical profession that the RVS estimated the value of a GP consultation to be in the order of $50, but that its findings have been ignored by the Government.

Recommendation

Government Senators recommend that further work needs to be undertaken to either finalise the outcomes of the Relative Value Study (RVS) or utilise other relevant means to assess the costs of running a general practice.

20 The Hon. Kevin Andrews MP, 'A National Vision for Community Care: An Australian Government Perspective', 28 March 2003

21 DOHA, Submission 138b, Answer to Question on Notice No. 10

Access to General Practice

By focussing the discourse on the notion that the proposed changes to Medicare will result in a 'two-tiered American-style' health system, the opposition parties have limited what could have been a highly informative and comprehensive inquiry. The emphasis of the Terms of Reference on the bulk billing practices of general practitioners and the subsequent focus on declining bulk billing rates at the public hearings have similarly narrowed and politicised the debate. The Government considers that it is the shortage of services (of whatever billed nature) which is of most concern, and has acted to address workforce supply and retention issues as a priority. As Dr Robert Bain of the AMA stated:

> Access is much more important. We hardly ever get a complaint about a GPs charge.[22]

The key issue here is partly an outright shortage of GPs but, more particularly, the mal-distribution of the existing medical workforce. Further, declining morale and a shift in the make-up of the GP workforce could see a further worsening of the workforce shortage over the next 10- to 15 years. Therefore, while the decline in bulk billing is of concern to the Government Senators, of greater concern is equitable access to GP and other health services across Australia. An example of this problem was given by Dr Sprogis of the Hunter Urban Division of General Practice:

> I will go to work this afternoon in a socio-economically deprived area and the copayments range between $10 and $30 on top of Medicare fees, and our books are closed in this practice I am in. The problem in our region is not the availability of bulk billing; that is a non-issue in this town. It is whether you can get in to see a doctor at all … [i]n fact, new people coming to this region could expect to ring six to ten surgeries before they were accepted as a new patient …[23]

A Fairer Medicare maintains the universal principles of Medicare. However, it also brings new and very significant financial protection to those with the greatest health and financial needs. Further, the package strives to address some of the inequities in Australia's health care system such as timely access to medical services, being largely determined by geographic location.

The relationship between bulk billing and access

The Government Senators are concerned about the declining rate of bulk billing. However, they also recognise that bulk billing figures can be misleading because they hide inequalities within the system. Bulk-billing rates vary widely between regions, with rural and outer-metropolitan areas recording some of the lowest levels. Mr Davies from the Department of Health and Ageing analysed the situation this way:

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22 Dr Bain, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 90

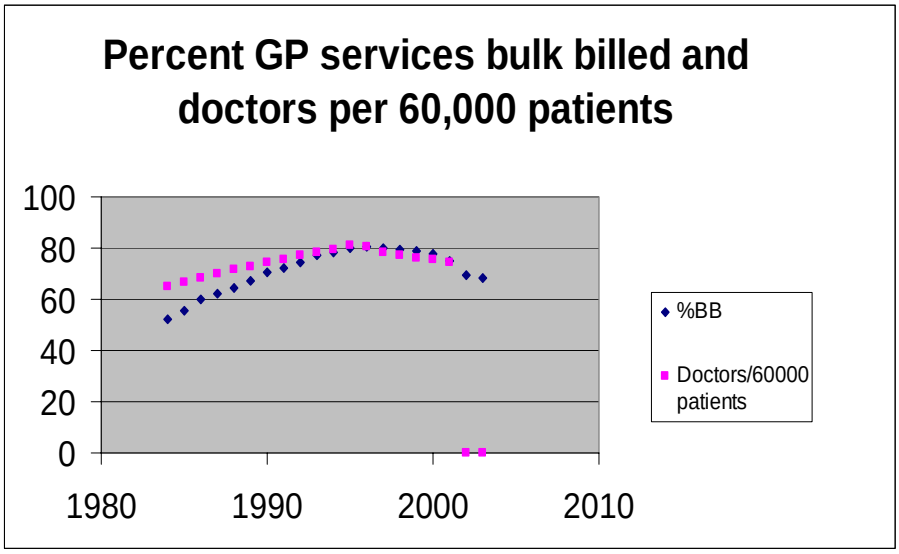
23 Dr Sprogis, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 2.

> [bulk billing rates] are unrelated to people's means. Much of the debate in recent months around reform to the health system has focused on the one-dimensional measure of the headline bulk-billing rate. But the headline bulk-billing rate is simply a gross measure of how many items of service are bulkbilled. The headline bulk-billing rate tells us nothing about how many individuals or households benefit from bulk-billing. It tells us nothing about the characteristics of the people who are bulkbilled, where they live or, for example, what their health status might be. So the headline bulk-billing rate, which we do tend to focus on, is at best a very crude indicator of the well-being of Medicare and general practice. For example, this next slide shows you that bulk-billing rates are much higher in capital cities than in rural and remote areas of our country. In fact, that difference is almost 30 percentage points between your likelihood of being bulk-billed in a capital city and your likelihood of being bulk-billed in rural and more remote areas.[24]

Dr James Moxham, President of the Australian College of Non Vocationally Registered General Practitioners, explained the cause of the disparity at the Adelaide hearing:

> The doctor to patient ratio and bulk billing percentages are very closely related, and that is not surprising, because it is simple economic supply and demand: If you increase the supply of doctors, the price goes down and bulk billing increases.[25]

This relationship is also evident in the following graph:[26]



The Government believes this uneven distribution of both doctors and benefits under Medicare is unfair and has structured the *A Fairer Medicare* package to focus on rectifying these problems of access in those areas of highest need.

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24 Mr Davies, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 3

25 Dr Moxham, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 1

26 Dr Moxham, tabled documents, Adelaide, 30 July 2003.

Improving access in Rural and Remote Regions

Government Senators point to the comprehensive range of measures put in place by the Government, prior to the *A Fairer Medicare* package, to address medical workforce shortages both in GPs and nurses.

In the short term, the Australian Government has been able to direct overseas-trained doctors to provide medical care to rural and regional communities by granting conditional Medicare provider numbers, requiring them to work in districts experiencing workforce shortage. This meant that in 2001-02, an estimated 4,910 exemptions were granted to 1,279 overseas-trained doctors to work in areas of workforce shortage, mostly in rural and remote areas.[27]

Other medium- to long-term strategies to redistribute the medical workforce have also been introduced, many as part of the *More Doctors, Better Services – Rural Health Strategy* released with the 2001-02 Budget. These programs are detailed in paragraphs 8.1-8.11 (in relation to GPs) and 8.56-8.59 (in relation to nurses) of the Majority Report.

Since 1996, the Australian Government has spent more than $2 billion on rural health initiatives including more than $500 million through *More Doctors, Better Services*, to get more doctors and health workers out to areas of need and keep them there.

The evidence shows that these policies are working. The number of full-time equivalent general practitioners in rural Australia has increased by 11.4% over the past five years, including a 4.7% rise in the most recent year. In addition, as at the end of June 2003, some 58 general practitioners are receiving assistance to relocate to outer metropolitan areas under the *More Doctors for Outer Metropolitan Areas* program, with a further 22 general practice registrars undertaking 6 month placements in these areas. [28]

The Government committee members also recognise that Aboriginal health continues to be an enormous challenge for all levels of government across Australia. In response to this challenge, the Government has committed $264 million per annum to Indigenous specific health services by 2004-05, which amounts to a doubling of funding since 1996.[29]

A major component of this spending commitment is the Primary Health Care Access Program, commenced in 1999. This innovative scheme uses a funding formula and funds pooling arrangements with State and Territory Governments to address the current inequitable access to health care services for Indigenous Australians. The

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27 Department of Health and Ageing, Submission 138, p. 39

28 Department of Health and Ageing, Submission 138, p. 39

29 Senator the Hon Kay Patterson, Media Release, *Major funding announced for new and improved indigenous health facilities*, 27 March 2003

arrangement locks in funding commitments, and helps to ensure greater resources and access to health care for aboriginal people living in remote areas of Australia.[30]

What else is being done?

A Fairer Medicare makes a significant long-term investment of around $300 million to ensure the medical workforce is of a sufficient size and availability to meet the projected future needs of the Australian population.

Government Senators reiterate that the package provides an additional 234 medical school places every year commencing in 2004. These places are bonded to areas of workforce shortage for six years. This represents an increase of 16% in medical school intake on current levels and ensures that around 20% of the future medical workforce are contracted to work in areas of workforce shortage for a period of their career. The quantum of the increase is in line with recommendations from the Australian Medical Workforce Advisory Committee.[31]

In addition, the package provides an additional 150 training places each year for GP registrars. These registrars will work primarily in areas of workforce shortage while they are training, providing an immediate increase in the number of practitioners working in those areas. Government Senators believe it is worth considering increasing the numbers of registrar training places even further.

Recommendation

Government Senators recommend that consideration be given to increasing the number of additional registrar training places beyond the additional 150 places provided for in *A Fairer Medicare* package.

Funding for 457 nurses to be employed in general practices that are part of the General Practice Access Scheme is also provided, and it is anticipated that around 800 practices will be assisted to employ nurses through this initiative. This measure was met with universal approval by both individual doctors and doctors' groups throughout the inquiry.

Practice nurses provide a valuable tool in providing GPs with clinical support and assisting with the management of chronic conditions such as diabetes. This leaves the doctors free to concentrate on the 'high-end' tasks of diagnosis and illness management, and makes the most effective use of Australia's limited number of GPs. As Dr Sprogis, Chief Executive of the Hunter Urban Division of General Practice advised:

> I think the answers are really simple and really straightforward. You make up for doctor undersupply by other workforce … [The region has seen an

30 AMSANT, Submission 157a, Attachment 1, p. 3

31 Department of Health and Ageing, Submission 138, p. 31

> increase] in the last two years from 40 nurses in general practices to nearly 170, and the numbers are still growing. It has been a great advantage to us.[32]

Professor Marley made a similar observation:

> [Nurses are] liberating doctors to do the things they are really trained for, and which you need all of that training to be able to do, and making it more appropriate for other professionals to deliver the care that doctors do not need essentially to do.[33]

Importantly, the scheme provides the flexibility to employ allied health professionals such as physiotherapists, podiatrists and Aboriginal health workers.

Given this important role, the Government Senators support the recommendation in the Majority Report to expand the number of practice nurses proposed in *A Fairer Medicare*. However, Government Senators do not agree with the recommendation to uncouple provision of the additional practice nurses to practices signing on to the General Practice Access Scheme. It is entirely legitimate for the Government to link the two measures, as part of developing an attractive package for GPs.

Government Senators also note that, as with GPs, there is likely to be a considerable number of qualified nurses in Australia who are not currently working. These are likely to be either Australian trained nurses who have left the hospital nursing system, or overseas trained nurses who for various reasons may not be working. Many of these nurses are likely to find the flexibility of work hours in general practice very attractive.

This group constitute an important resource, and every effort must be made to bring the skills and experience of this group back into the medical workforce. The Government's *Rural Health Strategy* has already initiated important workforce programs to achieve this, although it is too soon to assess the success of this program. However, Government Senators see merit in an early review of these programs, with a view to directing additional resources to those measures that are having the greatest success.

As identified in the Majority report (paragraphs 12.80 onwards), a major disincentive to many practices making the greatest use of their practice nurses is the fact that under present Medicare arrangements, GPs are the only member of the medical team that have provider numbers and can charge a service against a MBS item number. This is a serious impediment to giving full scope to the additional practice nurses that will be provided under the Government's *A Fairer Medicare* package, but one that is relatively easily rectified.

Government Senators note that a number of initiatives that form part of the Enhanced Primary Care package go some way to introducing these measures. EPC health

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32 Dr Sprogis, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 2

33 Professor Marley, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 32

assessments include provision for nurses to work under the supervision of the GP in collecting information about the patient for the health assessment. There is also scope under the Medicare Benefits Schedule for nurses and other health professionals to assist in care deliver whilst acting under the supervision of a GP.[34]

Government Senators applaud these developments but consider there is scope to go further.

Recommendation

Government Senators recommend the Government consider the creation of a number of new Medicare item numbers that would enable practice nurses to charge under the Medicare system for a range of routine medical procedures such as wounds treatment and immunisations.

Government Senators also note the important role of the Australian Government in funding a range of models for after hours access to general practice.[35] One example of the operation of this program is *GP Assist*, which has emerged out of a successful Australian Government funded trial program, with a full program now due to commence operation in Tasmania on 1 November this year. Australian Government funding of $6.5 million has enabled the development of a state-wide call centre using a telephone triage service. The service is staffed by experienced Nurse Practitioners, who are supported by computerised decision making software, and who will either provide advice, call an ambulance or arrange a home visit by a GP, according to the circumstances. The trial program met with a high degree of patient satisfaction, and during the trial period, up to 70% of calls resulted in patients' medical needs being met in the comfort of their own home.[36]

Government Senators commend the success of this and similar trials, which provide a model for improving better after-hours GP services around Australia, with the associated reduction in the work pressures on GPs to provide these services themselves.

Recommendation

Government Senators recommend additional funding be given to the After Hours Primary Care Development Grants Program to enable the extension of the program to other areas of need.

Two final areas of special need must be considered. Firstly, Government Senators acknowledge that many Accident and Emergency Departments in hospitals around the country are struggling to cope with the numbers of patients seeking attention. To some

34 Department of Health and Ageing, Submission 138b, Answer to Question of Notice, no. 9

35 See DoHA, Submission 138b, Answer to Question on Notice No. 16

36 Senator the Hon Kay Patterson, Media Release, *$6.5 million for 24 hour medical care across Tasmania*, 13 July 2003.

extent, this is driven by difficulties in accessing GPs (especially after hours). Accordingly, Government Senators consider there is a need for the Government to develop a program of special incentives for GPs to practice in or around Public Hospital Accident and Emergency Department areas.

This could be done by means of salaried GPs, or preferably, by funding enabling hospitals to tender for GP services.

Secondly, Government Senators saw evidence during the inquiry of considerable difficulties experienced by people in aged care facilities in gaining access to GPs. This problem has particularly severe implications for aged care residents given their inability – in many cases – to travel to see doctors in other locations.

Government Senators consider that this problem needs to be addressed, possibly through a program of special targeted measures.

Enhanced use of Overseas Trained Doctors

Another key to resolving the current shortage of GPs is to make better use of Overseas Trained Doctors (OTDs). Although agreeing with much of the discussion on OTDs in the majority report, Government Senators wish to stress several additional points.

First, there is evidence to suggest that there may be as many as two thousand OTDs in Australia who are not currently working,[37] which seems to be caused in part by disincentives to enter Australia as a doctor (as discussed at paragraphs 12.39 onwards). This represents a major un-utilised resource that, by itself, could do much to meet the unmet need for GPs. The challenge for Government is therefore to focus on removing any obstacles that currently prevent these doctors from working, and develop a package of incentives that will bring this group back into the workforce, and working in areas of need.

The Government Senators agree in general with recommendations of the Majority Report, but consider that more needs to be done.

As a first step, immediate steps should be taken to clarify the current situation. For a number of reasons, it is impossible to ascertain the exact number of OTDs currently in Australia and how many of them are working. A starting point for any program to better utilise OTDs must be to rectify this program, coordinating information from sources such as the Royal Australian College of General Practice, the Australian Government Departments of Health and Immigration,[38] and Medical Registration Boards.

Secondly, as part of a number of workforce measures introduced during the late 1990's, changes were made to the system of Medicare provider numbers, limiting

37 Dr Bain, Canberra, 21 July, p. 17

38 DoHA and DIMIA.

their availability for OTDs. Some of these measures may still perform a useful role, such as those requiring a Temporary Resident Doctor to work in districts of workforce shortage, however, a review of the operation of these measures would be timely to ensure that they are still delivering outcomes in accord with public policy. This review should be coordinated between the health and immigration portfolios. The review should also include the extent of the current scope for mutual recognition of overseas medical and specialist qualifications such as with New Zealand, and whether these may be extended to additional countries to provide greater ease of access to practice in Australia.

Thirdly, Government Senators believe additional measures are needed to encourage more OTDs to come to Australia to work, both on a temporary and permanent basis.

It is noteworthy that the National Health Service (NHS) in the UK has embarked on a dedicated program to recruit OTDs from selected countries. Measures include a website to provide a central point of information, as well as the creation of two schemes aimed at medical practitioners:

- a managed placement scheme, offering the opportunity to work as an NHS consultant on a temporary basis; and

- NHS International Fellowships, running for a two year period.

Government Senators consider there is merit in developing a similar program in Australia.

However, for both OTDs coming to Australia and those already here, a concerted effort must be made to ensure that they receive the necessary support and training. This should include bridging training programs addressing the specialist needs for general practice requirements in Australia as well as training to enable OTDs to meet Australian GP accreditation standards. Importantly, the Government should also consider providing financial assistant to these doctors to enable them to undertake this training.

Government Senators also note the model of a joint venture between the Outer Metropolitan Workforce Planning Group, the Australian Medical Association Western Australia, and the Royal Australian College of General Practitioners Western Australia, titled *GP Workforce Solutions*. This plan brings together a number of measures to better utilise the skills of permanent resident OTDs who are not working. Government Senators commend the plan to the Government.

Recommendation

Government Senators recommend:

- **a program to ascertain the exact numbers and skills of OTDs currently in Australia;**

- **a review of the operation of the current immigration laws with respect to OTDs entering or working in Australia as medical practitioners, with a view to removing any unnecessary obstacles. This review should include an assessment of the scope and extent of recognition of foreign qualifications.**

- **the development of a program of targeted measures to encourage and assist OTDs to come to Australia to work;**

- **the development of an integrated series of support measures to ensure that both OTDs in Australia and those coming here to work are given coordinated training, support and mentoring in a timely manner to assist them to gain Australian medical qualifications and to practice effectively in Australia.**

Finally, Government Senators stress that the use of OTDs is a temporary solution that would complement existing measures to relieve pressure on areas of workforce shortage, until the effects of the wider workforce measures come into effect.

A Fairer Medicare Package

Government Senators wish to state their disagreement with the criticisms and findings of the Majority Report in relation to specific aspects of the *A Fairer Medicare* package.

Bulk billing for Concessional Patients

A Fairer Medicare will not disadvantage the 'working poor' for the simple reason that the package takes nothing away from the current system – it simply adds key measures that will act to address the current gaps. It is these gaps that are unfair, and that are causing hardship, as explained in detail by Mr Davies, Deputy Secretary in the Department of Health and Ageing during the Canberra hearings.

Under *A Fairer Medicare* package, all Australians will continue to be eligible to receive Medicare rebates and will remain eligible to be bulk billed. They will continue to benefit from free care in public hospitals and subsidised medicines through the pharmaceutical benefits scheme. These universal elements of Medicare will not change.

The Majority Report criticised the focus on concession cards, and their usefulness as a measure of need, pointing to those who will not be covered. Three points must be made in response to this criticism.

First, the three Commonwealth concession cards, which are used as the basis of a number of entitlements including the PBS, provides a fair, constantly updated and government-wide system for identifying need. As with any system, it is possible to find examples where the system does not work perfectly. However, it remains the best and simplest way of targeting need. It is certainly less arbitrary than relying on individual doctors' decisions to discount patients they perceive as being in financial need. It is also more accurate than any of the other generalised indices of

disadvantage, as demonstrated in the majority report. As the majority report also correctly identified, it would be too expensive and administratively unwieldy to attempt to construct a separate, additional, concessional system exclusively for Medicare.

Second, those who do not fall within one of the concession card categories still have the protection offered by one, or possibly both, of the two added safety nets that will provide protection from out-of-pocket expenses for Medicare services provided outside hospitals. These are discussed in more detail below.

Third, there is nothing in *A Fairer Medicare* package that will cause doctors to increase their fees. Since doctors have always been free to set their own fees, it is a question of incentives, and as Mr Davies told the Committee, the government modelling was premised upon practices that sign onto the General Practice Access Scheme being financially better off through the incentive payments. Participating GPs will enjoy higher incomes with no need to raise their fees.

The Government Senators also note that the calculations made by many doctors about the lost revenue arising from bulk billing all concession card holding patients appear to be based on the assumption that they currently charge all these patients full private billing rates. However, both the statistics and the anecdotal evidence of doctors themselves indicate that many practices already bulk-bill some or all of their concessional patients, and discount their fees for those who are privately billed. This suggests that many GPs have over-calculated the effects of moving to full bulk-billing of these patients, particularly after including the additional revenue from the government incentive payments.

Direct rebate at point of service

Under A Fairer Medicare, participating practices will be able to receive their Medicare rebate directly at the point of service, via HIC Online. HIC Online is an internet-based electronic lodgement, claiming and payments facility.

This change offers major improvements for patients, doctors and the system as a whole.

For patients, it means that when they visit a doctor at a participating practice, they can assign their Medicare rebate to the doctor and pay only the gap rather than the full up-front fee. They can leave the surgery with no more to do and no more to pay. A lower upfront fee, where a doctor chooses not to bulk-bill, will make visiting a GP more affordable, and will make a big difference for many poorer families for whom trying to find the $30-odd dollars up-front for a consultation is a significant obstacle to seeing a GP. It will also make it more difficult for doctors to increase their fees without patients noticing the increase. It will be very clear, arguably for the first time, how much they are out of pocket.

For doctors, HIC Online provides substantial benefits, including improved cash flow resulting from improved edit checking which will substantially reduce the number of

claims that are rejected and have to be re-submitted. This means faster payments, and greatly reduced administrative costs from billing and debt collection.

Doctors still have the choice of whether to direct bill in relation to a service or charge the patient. The decision to direct bill a patient service is one for the doctor to determine taking into account the patient's circumstances and their ability to pay for the service. HIC Online will have no bearing on this decision.

Feedback from doctors indicates that they recognise the benefits of lodging direct bill claims using HIC Online.

For the Medicare system, the widened use of HIC Online will increase transparency and convenience, and greatly save on the current administrative costs involved in the cumbersome procedure of mailing cheques to individuals.

Safety nets

A Fairer Medicare is designed to benefit all Australians, and despite claims made by the opposition parties, the Howard Government is committed to protecting those in greatest need. One of a number of initiatives encompassed in the *A Fairer Medicare* package is the introduction a new safety net for Commonwealth concession card-holders whose illness, frailty or level of need exposes them to high medical costs.

The existing safety net only calculates the gap between the rebate fee and the scheduled fee, but does not include the actual out-of-pocket costs incurred. With these average gap payments increasing over time, this can add up to a significant amount, particularly for individuals and families who require multiple visits to GPs, need to make frequent use of specialist services, and/or are high users of diagnostic and treatment services.

The new MBS safety net will pay 80% of all out-of-pocket costs once a $500 threshold is reached. The threshold amount of $500 was calculated using data produced from Medicare statistics identifying concessional families that would receive the most benefit. This means the proposed safety net will provide a major benefit for around 50,000 of the poorest and sickest in our society.

At the same time, the new safety net will not involve any new administrative work for GPs or patients. Once patients register with the HIC, the safety net will be calculated and paid automatically.

The second proposed private health insurance safety net also rectifies a long-standing hole in the health insurance arrangements. In an era where best practice medical care is increasingly being provided on an out-of-hospital basis, it is an anomaly that patients are only able to have insurance protection for hospital treatments. The current arrangements are therefore both unfair to individuals and present a disincentive for medical service providers to minimise hospital treatments. This is likely to result in higher costs for the hospital system at a time when they are already under considerable pressure from high patient numbers.

This additional protection offered by the proposed private health insurance safety net is likely to cost as little as $50 per year for a family, making it easily affordable for many who are currently forced to 'self-insure' for these risks.

Departmental estimates put the number of potential beneficiaries of these reforms at 50,000 in the case of the safety net for concession card holders[39] and 30,000 for the opening up of the opportunity for gap insurance for out-of-hospital out-of-pocket expenses.[40] Government senators believe that it would be irresponsible to deny these Australians access to relief from these increasing expenses.

With respect to the issue of gap insurance, Australians are able to insure commercially against a large range of risks. It is illogical to single out health for a special prohibition on the offering of a product to a willing market. We note that the Association of Independent Retirees called for:

> ... consumer freedom of choice to insure against such out of pocket expenses.[41]

The Private Health Insurance Rebate

The 30 per cent private health insurance (PHI) rebate is vital to maintaining Australia's balance between public and private sector provision of health services. This mix of public and private funding maximises the capacity of the dollars available to meet Australia's health needs. As intended, the PHI rebate has allowed millions of Australians to benefit from the health care choices associated with PHI and has reduced pressure on an overburdened public hospital system, while its removal would have serious detrimental consequences for Australia's mixed health system.

The success of the PHI Rebate

Since the introduction of the PHI Rebate and Lifetime Health Cover, the uptake of private health insurance hospital cover has increased from 32 per cent of the population in June 2000 to 43.8 per cent in March 2003.[42] Notably, the rebate has also assisted over one million Australians earning less than $20,000 per year to take out PHI cover,[43] and will see Australians receive private health insurance benefits worth an estimated $7 billion in 2003-04.[44] Currently, a total of 9.9 million Australians – or nearly 50% – have some form of private health insurance cover.[45]

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[39] Mr Davies, *Proof Committee Hansard*, Canberra 21 July 2003, p.4

[40] Mr Davies, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 89.

[41] Association of Independent Retirees, Submission 97, p.8.

42 Department of Health and Ageing, Submission 138, p. 6

43 Department of Health and Ageing, Submission 138, p. 6

44 Australian Health Insurance Association, Submission 105, p. 1.

45 Australian Health Insurance Association, Submission 105a, p. 14.

This increasing membership means that more Australians have the opportunity to benefit from a substantially improved range of choices when planning for their future health care needs. Private health cover allows patients to decide who they are treated by; where they are treated; and, perhaps most importantly, when they are treated. For Australians with PHI, knowing that they will avoid lengthy waiting times if and when they require treatment provides valuable peace of mind.

Increased numbers of people with private cover also enhances the timely access to care of those reliant on the public hospital system. By encouraging more people to move into the private hospital system, the PHI rebate has significantly reduced pressure on public hospitals. Despite claims to the contrary, there is a plethora of evidence to support this position. As Dr Glasson, President of the AMA, said:

> The only reason the public hospitals are surviving to any extent that they are at the moment is because of the 30 per cent private health insurance rebate.[46]

In 2000-01, total public hospital admissions fell by 4,591 while private hospital admissions rose by 245,129,[47] and in 2001-02 private hospitals accounted for 76 per cent of new hospital separations.[48] With the number of total separations in Australian hospitals increasing by 4.4 per cent per annum over the past seven years, these figures demonstrate that the private hospital system is carrying the majority of the increasing burden on Australian hospitals.[49] While the argument is made that public hospital admissions are still increasing, the fact remains that they are not increasing at a rate nearly as high as if the rebate were not in place.

Data from the Australian Institute of Health and Welfare further demonstrates the effect of the rebate in easing pressure on the public system. Figure 1 demonstrates that private hospital sector growth has outstripped public sector growth every year since 1997-98.[50]

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46 Dr Glasson, *Doctor's waiting room the great divide*, Courier-Mail newspaper, Thursday 31 July 2003, p. 1

47 Australian Health Insurance Association, Submission 105, Executive Summary, paragraph iii

48 Australian Health Insurance Association, Supplementary Submission 105a, p. 2

49 Australian Health Insurance Association, Supplementary Submission 105a, p. 2

50 Australian Health Insurance Association, Supplementary Submission 105a, p. 4

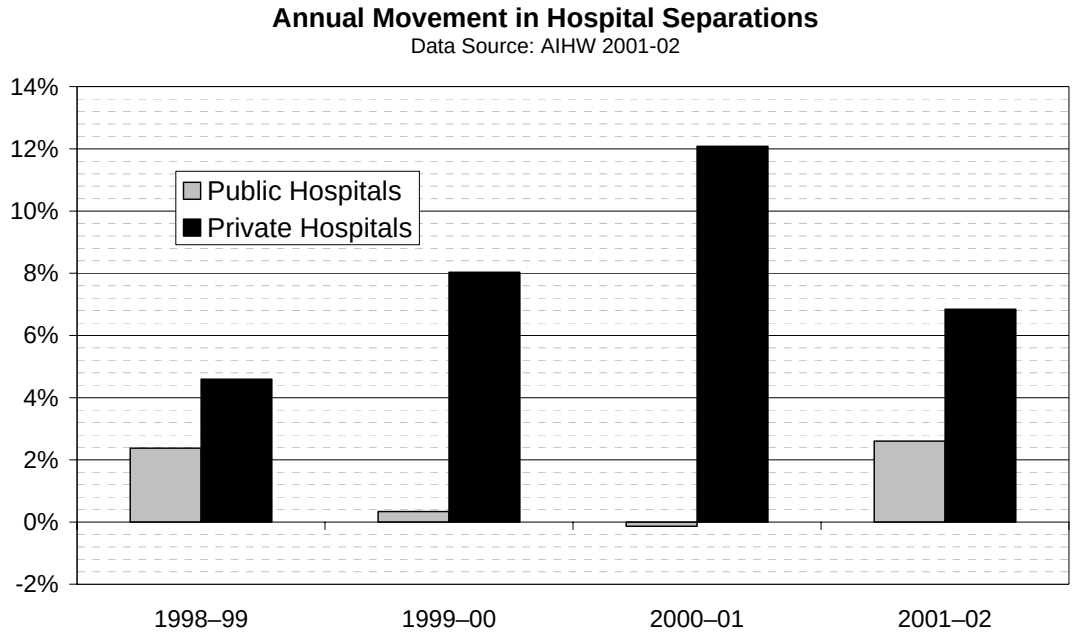
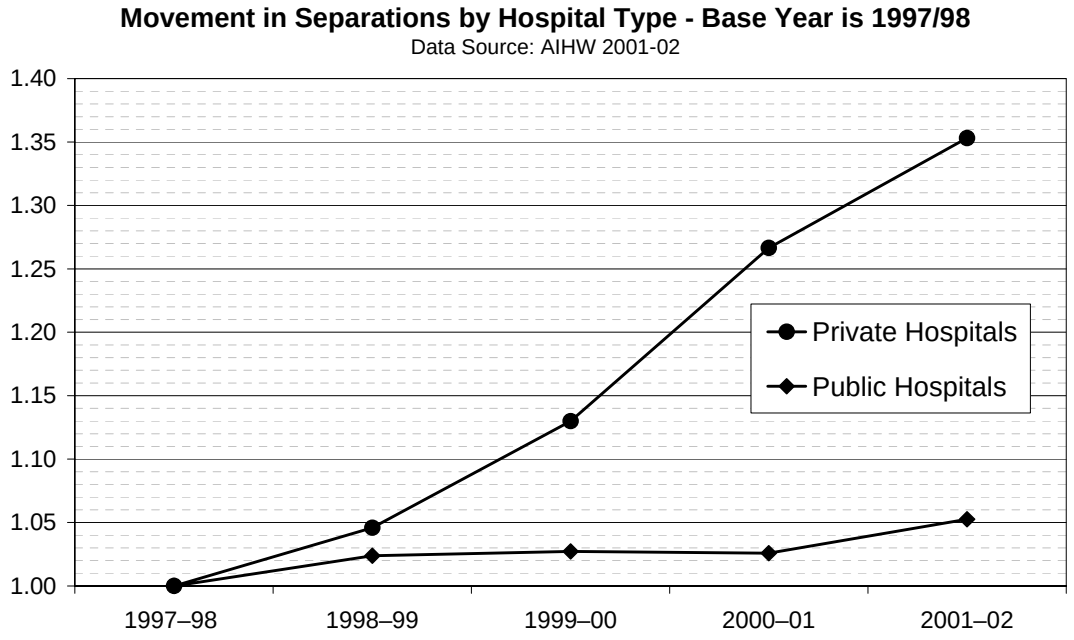


Figure 2 shows that over the same period the private sector workload has increased 35 percent, compared to a much lower five per cent increase for the public sector.[51]



It is also important to note the nature of the work carried out in private hospitals, which is clearly contrary to some claims that private hospitals 'cherry pick' only the most profitable procedures.[52] Private hospitals, for example, currently perform more

51 Australian Health Insurance Association, Supplementary Submission 105a, p. 4

52 For example see WA Government, Submission 177, p. 15

than half of all malignant breast conditions, chemotherapy, cardiac valve and hip replacement procedures.[53]

The rebate is also critically important to providing access for many Australians to a range of other health services, through support to those opting to take out ancillary cover, which includes services such as dentistry, physiotherapy and optometry. As the Department of Health and Ageing stated in its submission:

> Most dental and allied health services are provided in private practice. For many Australians, especially families, the key to accessing affordable services has been through private health insurance ancillary cover. Eighty percent of ancillary benefits paid to members were for core health services of dental (48%), optical (17%), chiropractic (7%) and physiotherapy (7%).[54]

Australian Government support for these services adds up to over $1,500 million a year, paid via the private health insurance rebate.

Removal of the rebate on ancillary benefits would be likely to triggering a sharp reduction in the numbers of people electing to retain ancillary cover, with an estimated 3.8 million Australians no longer be to affordable the extra cover.[55] Again, the impact on the public system would be considerable. For example, the already overburdened state-run public dental programs would face significantly higher demand if Australian Government funds directed to dental services through the PHI rebate were to disappear.

Similarly, a number of respondents called for the scrapping of the PHI rebate in its entirety. However, the consequences of dismantling the rebate would be disastrous for Australia's entire health system.

Should the rebate be fully removed, privately insured Australians would face a 43 percent increase in their premiums.[56] For the private health funds attempting to maintain relatively low premiums, the effects would be immediate, as the first to leave PHI would be the young and healthy, who provide the best risk to the health funds and effectively subsidise the cover of older insurees. Premiums would then spiral upwards, forcing a vicious cycle of declining membership, leading to a smaller pool of higher risk people, leading in turn to higher premiums. This would replicate the situation prior to the Government's reforms. The effect would be an increasingly unviable private health industry, and reduced availability of private health insurance for many low income Australians, a large proportion of whom are aged over 65 and most in need of cover. This would inevitably exacerbate existing pressures on the already overburdened public health system.

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53 Australian Health Insurance Association, Submission 105, p. 8 and Australian Health Insurance Association, Supplementary Submission 105a, p. 11

54 Department of Health and Ageing, Submission 138, p. 41

55 Australian Health Insurance Association, Submission 105, p. 17

56 Australian Health Insurance Association, Submission 105, p. 17

The effects would also be seen in other aspects of the health system. Even taking into account the 30 per cent rebate, Australians with private health insurance voluntarily contribute $5.1 billion to the total health pool in addition to their taxes and Medicare levies.[57] The pre-rebate trend suggests that, without the rebate, only 3.5 million people would today be insured – 5.1 million less than with the rebate.[58] If this money were removed from the private system, the overall health system would be required to recoup this lost funding through tax increases.

Overall, it is clear that the PHI rebate generates significant leverage for health funding and saves the Australian Government billions of dollars annually by encouraging ordinary Australians to contribute to the cost of their own health care.

Labor policy on the PHI Rebate

Although the Federal Labor Party has yet to clarify its position on the PHI rebate, the positions taken by their state counterparts provides a likely indication of their views. Of the eight Labor state and territory governments, five told the Committee they did not support the rebate. These were the governments of Queensland, South Australia, Tasmania, the Northern Territory and the ACT.[59] For example, the ACT Minister for Health, The Hon Simon Corbell MLA, stated in evidence that:

> Given the level and pressure for services in the public health system, the ACT government's view is that that $2 billion to $3 billion could be better spent and that you would get better outcomes – certainly more significant than just a shift of 200,000 people across the country – by putting it into public health systems. So we are quite unashamed about saying that the private health insurance rebate could be better spent in the public health system.[60]

The New South Wales and West Australian state governments also expressed concerns over the policy, noting the potential benefits of redirecting the funds to other areas of the health system, and calling for an independent assessment into the rebate's effectiveness.[61] This view is mirrored in both the discussion and recommendation of the Majority Report and, in light of the views of the state and territory governments, is clearly code for the eventual abolition of the rebate by any Federal Labor government.

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57 Australian Health Insurance Association, Submission 105, p. 18

58 Australian Health Insurance Association, Supplementary Submission 105a, p. 23

59 See Queensland Government, Submission 32, p. 9, South Australian Government, Submission 161, p. 4, Tasmanian Government, Submission 147, p. 6, Northern Territory Government, Submission 82, p. 7 and Simon Corbell MLA, *Proof Committee Hansard*, Canberra, August 28 2003, p.28 respectively

60 Simon Corbell MLA, *Proof Committee Hansard*, Canberra, August 28 2003, p.28

61 See Professor Picone, *Proof Committee Hansard*, Sydney, 22 July 2003, p. 85 and West Australian Government, Submission 177, pp. 14-15

The NSW government support for an increase in the Medicare levy should also be noted.[62]

Conclusion – strengthening the PHI rebate

Government Senators fully endorse this successful government initiative and based on its success, further recommend increasing the PHI rebate to 35 per cent and 40 per cent, or higher, over time. This measure would allow even more low income Australians to access PHI and the benefits of choice it provides, while continuing to ease pressure on the public system. As rising levels of private health insurance continue to reduce the workload of public hospitals, there is likely to be a commensurate reduction in the need for public spending on public hospitals. These savings could potentially be redirected into raising the level of the rebate even further.

Australia's health system requires an appropriate mixture of public and private sector involvement to maximise the capacity of Australians to fund high quality health services. The PHI rebate is a crucial policy in achieving the right balance.

Recommendation

Government Senators recommend consideration be given to increasing the level of the PHI Rebate from 30% to 35%, with a subsequent increase to 40% or higher over time, subject to the results of careful monitoring and analysis of its effect, including the outcome on public hospital workloads.

Government Senators further recommend consideration of a special rebate increase for people aged 65 years of age and over.

The ALP Medicare policy

Relatively little attention to the ALP policy was given by many individuals and groups during the inquiry, and it is perhaps unfortunate that it has not been subject to a proper degree of public scrutiny.

Government Senators make three comments in relation to the ALP policy.

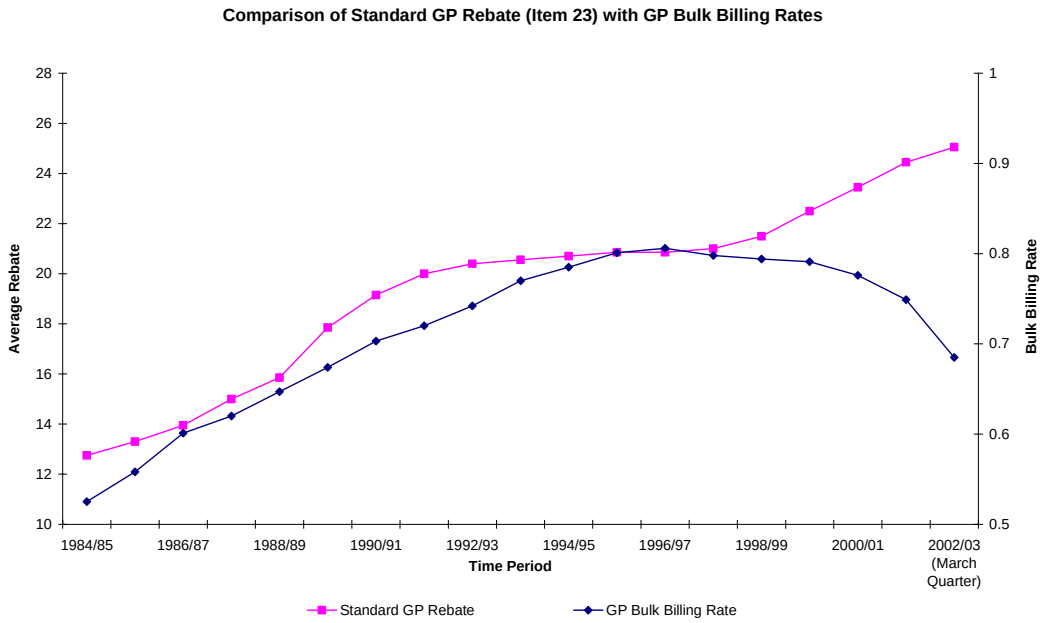
First, and as discussed in greater detail above, bulk billing is not and should not become, the definitive reference point for the success of the Australian health system. Access and affordability are, and it is these elements that the Government package addresses.

The ALP package, by its over-emphasis on the issue of bulk-billing misses the point.

Secondly, by setting of lower target levels of bulk-billing in regional and country areas, the ALP package sets up a two-tier system, which treats rural and regional Australians as second class citizens.

62 NSW Department of Health, Submission 154, p. 24

Thirdly, Government Senators consider that the emphasis in the ALP package on raising the level of the rebate as a means to achieve higher bulk-billing rates is misguided. What is evident from both the evidence provided by the Department and in the following graph,[63] is that there is no guarantee that raising the rebate will increase bulk-billing. Despite blanket increases in the rebate from 1996-97 to the present, the bulk-billing rate continued to fall.



The AIPC Report

Finally, Government Senators wish to reiterate their views of the research commissioned by the Committee from academics at the Australian Institute of Primary Care. The key to any proper academic research, particularly when it is paid for by public funds, is the independence of the researchers. From the beginning, Government Senators were opposed to the selection of the research team – comprising Associate Professor Hal Swerissen, Professor Stephen Duckett and Mr Charles Livingstone – on the grounds of clear bias.

In particular, Professor Swerissen is a former staff member for Labor Member of Parliament Ms Carmen Lawrence, Professor Duckett, at the time the research was commissioned, had already put on the public record his critical views of the Government's *A Fairer Medicare* package in a submission to the Committee.[64] Similarly, Mr Livingston published an article highly critical of the government in the magazine *Dissent*.[65]

63 Department of Health and Aged Care, tabled documents, Canberra, 21 July 2003

64 Prof Duckett, Submission 93

65 Livingstone, C., & Ford, G., 'Paying for Medicare', *Dissent*, No 11, Autumn/Winter 2003

It remains the view of Government Senators that it is inappropriate for the Committee to commission work from academics with a known and public bias in relation to the work they are being asked to undertake. This bias casts into serious doubt the findings of the AIPC Report.

Dental services

Government Senators also wish to record their disagreement to Recommendation 10.1 of the Majority Report for the reintroduction of a Commonwealth dental health program.

Government Senators concur with the long held view of the Howard Government that the provision of public dental services have long been and remain the responsibility of the State and Territory governments. This view is set out in paragraphs 10.18 & 10.19 of the Majority Report.

As described elsewhere in this report, States and Territories will enjoy an increased level of funding under the new Australian Health Care Agreements that will increase the overall resources they have to address public dental health issues. This comes on top of the additional funds already delivered to the States and Territories via the dedicated stream of GST funds.

Conclusion

The proposed reforms enveloped in the Australian Government's *A Fairer Medicare* package are long term, economically responsible measures aimed at strengthening Australia's universal health system. It strives to enlarge Australia's medical workforce, ensure more equitable access to medical services across Australia and provides significant protection to those with the greatest health and financial needs.

Recommendation

Government Senators recommend the adoption of the Government's *A Fairer Medicare* package.

Senator Guy Barnett (Deputy Chair)

Senator Gary Humphries

Senator Sue Knowles