The Amendments to Medicare of 28 April

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The changes to Medicare announced last week will have a limited immediate effect upon access to health and healthcare. In the longer term, however, their effect may be far reaching.

Medicare has not been overturned. Free hospitalisation is still universally available and there will be a rebate on all medical services. The likely reduction in bulk billing for general patients should not, at first, have a serious effect upon access.

Two of the announced changes may, however, have a profound long run effect. First, the rebate for pensioners has been separated from the rebate for other patients. Secondly, private health insurance has been reinstated in the marketplace for out of hospital medical care.

The first of these changes allows the government, in subsequent years, to index the pensioner rebate but to allow the general rebate to decline in real terms. This will place irresistible pressure on GPs to end bulk billing for general patients.

The significance of the second change is that uncapped private insurance of medical fees will have an inflationary impact. At present expenditures must exceed $1,000 before insurance is permitted. But this can change. In subsequent years health funds might be " deregulated in the interests of competition" ie allowed to offer full insurance cover. Alternatively, the $1,000 ceiling could be kept but with rising out of pocket expenditures and the inflation of medical costs, the $1,000 will be reached more quickly in the future.

Medicare presently has three elements which are designed to limit inflationary pressures and all three are to be removed. First, bulk billing was specifically designed so that a doctor who ceased bulk billing inconvenienced their patients who must seek reimbursement of their expenses. Bulk billing avoided this which increased the effects of price competition. Secondly, the elimination of copayments, by definition, minimises fees. Thirdly, patients presently see the total bill and will recognise (more or less) excessively high charges.

Together, the two key changes provide a simple structure for the progressive transfer of expenditures from public to private sectors. Non indexation of the general rebate will coerce doctors into raising copayments This will create pressure for increased private insurance. This, in turn, will inflate fees. A three-tier system is likely to emerge viz pensioners and card holders, the privately insured and the remainder of the population (the poorer, less educated and less politically articulate households).

Perhaps the most controversial element of the changes is that they signal a new social role for Medicare. The scheme presently reflects a particular social view viz that the financing of health and health care should be "removed from the economic reward system". Canadian commentators have articulated this perspective very clearly, Evans and Law, for example, claim that Canadian Medicare is **" far more than just an administrative mechanism for paying medical bills, it is widely regarded as an important symbol of community, a concrete representation of mutual support and concern … it expresses a fundamental equality of Canadian citizens in the face of death and disease … As the Premier of Ottawa pointed out … "there is no social program that we have that more defines Canadianism""**. [1]

From this communal perspective Canadians have regarded copayments as "a tax upon the sick" and under the Canada Health Act copayments have been prohibited.

There is, of course, an alternative perspective, namely that our society is a group of individuals responsible for themselves, except in special circumstances. Equity refers to the fair treatment of those who cannot help themselves. The government health scheme is primarily about a safety net and about the welfare system.

The important question is not about the "correct" perspective and the "correct" view of equity. The issue is about the sort of society Australians wish to have and the implications of this for Medicare. Supporters of the original Medicare scheme rightly point out that most Australians appear to share the Canadian view that healthcare should be a communal responsibility.

There is a final intriguing question. The changes to Medicare have been introduced because, it is claimed, that they will "improve the availability of bulk billing for concession card holders". In December 2002 81% of GP bills for people over 65 were bulk bills. In rural areas the figure was between 65% and 75%. The average copayment for all persons above 65 was 94 cents. It is worrying that such a fundamental change has been introduced to solve a problem that does not seem to exist.

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1 Evans, R and Law, M. The Canadian Healthcare System. Where are we and how did we get here. In Dunlop and Martens, an International Assessment of Healthcare Financing, Economic Development Institute of the World Bank edi seminar series 1995.