NSW.ACT

Submission to the Senate Select Committee on Medicare

June 18 2003

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UnitingCare NSW.ACT

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This submission is made on behalf of UnitingCare NSW.ACT

UnitingCare NSW.ACT is an agency of the NSW Synod of the Uniting Church in Australia. It has responsibility for assessing issues of public policy in which the church has an interest. In 2002, the NSW Synod adopted *Directions for Health Policy*, which include support for the principles on which Medicare was founded.

UnitingCare NSW.ACT also provides a range of community services including aged care, child care, work with children and young people who are at risk and their families, disability support and tenants services.

The agency is an expression of the Uniting Church's belief in the God of the universe as a God of compassion and love who calls all people to respect the human rights of every person and to act as neighbour to those in need. These qualities were demonstrated in Jesus Christ, God incarnate. The same God holds governments accountable for the way they govern, and for the effects of their policies. In the Christian tradition, God has a special interest in the health and wellbeing of human beings.

The questions that UnitingCare asks, therefore, in assessing the proposed changes to Medicare is how the changes are likely to affect, firstly, the most disadvantaged in society and, secondly, families with dependent children.

Our comments are presented under those terms of reference on which we wish to comment, followed by a conclusion. We would be happy to meet with the committee to further clarify our concerns.

The access to and affordability of general practice under Medicare, with particular regard to:

(c) the likely impact on access, affordability and quality services for individuals, in the short- and longer-term, of the following Government-announced proposals:

(i) incentives for free care from general practitioners limited to health care card holders or those beneath an income threshold,

(ii) **a change to bulk-billing arrangements to allow patient co-payment at point of services co-incidental with direct rebate reimbursement,**

(iii) **a new safety net for concession cardholders only and its interaction with existing safety nets, and**

(iv) private health insurance for out-of-hospital out-of-pocket medical expenses;

We will comment on these terms of reference together.

While the proposed changes appear superficially to deal with problems of bulk-billing, they seriously undermine a number of important features of Medicare.

The government's proposals will not result in a "fairer Medicare". They move Medicare further away from the principles on which it was founded and thus make it less fair.

Medicare is intended to be universal, accessible, equitable, efficient and simple. This means that it should be the primary system for ensuring that all Australians have access to health care services and that all Australians contribute to the cost of health care through the tax system. It is not intended to be merely a safety net.

Even as a safety net, the proposed new version of Medicare is highly questionable. While simplifying the claims process through electronic processing directly at the doctor's surgery is in itself a good idea, it comes, in this package, at too high a cost – damage to Medicare generally by removing the constraints that previously encouraged doctors to bulk bill rather than charging a fee. Now they can do both. "A Fairer Medicare" on page 8 says that the point of the safety net is "to protect Commonwealth concession card holders from the cumulative cost of Medicare funded services, including those that are above the scheduled fee." 80% of costs will be refunded, including costs above the scheduled fee (pages 8 and 9).

The changes in the system remove current constraints on doctors who wish to charge up front fees to patients who do not have concession cards. While many people will find it hard to pay the first $500, doctors have permission to charge what they like since once bills go above this 80% of the out of pocket expenses will be paid by the government. The document "A fairer medicare – questions and answers", issued by the department, on page 8 makes it clear that this is about covering costs above the scheduled fee.

"A Fairer Medicare – questions and answers" page 8 says that families with concession cards will have to register with the HIC for the safety net to operate. This complicates Medicare, and will mean that many people who don't know their entitlements or have difficulty providing the requisite information will in fact not be covered. Increased complexity is likely to result in a less effective coverage, breaching the principle of universality. Moreover, the people most likely to find the mechanism difficult are those who are also most likely to need the safety net.

The incentives for bulk billing are poorly thought out. To the extent that they work, they will create a two tiered system, since they only provide incentives for the bulk billing of concession card holders. Everyone else, even families on moderate incomes with children, will be left to pay what the doctor prescribes. While it can be argued that this is the case at present, the situation will be significantly changed. The move to allow private health insurance to cover up front fees removes previous disincentives on doctors charging fees.

There is, however, a question as to whether the incentives are adequately targeted to those places where bulk billing is low and where doctors have the greatest need to increase their incomes to viable levels.

The government's concept of a safety net for families seems to lack awareness of the financial stringency under which many families without concession cards already operate. The proposals mean that individuals and families will have to pay through the tax system, private insurance and up front fees (first $500 or $1000). As the unions have pointed out, families also pay in a further way, through wages having been discounted in the past decade to take account of Medicare being established. In addition, under the watered down pharmaceutical benefits scheme they already face

costs of over $700 for medicines. Many of these families also have other types of additional costs (time off work to care for sick family members, over the counter medicines, special health appliances, and so on).

We illustrate this point from some cases studies prepared by UnitingCare Burnside in 2001. Only the relevant material is quoted here.

Case Study 1.

Unexpected circumstances add extra pressure to an already tight budget. Recently, the oldest son had a bad throat injury which required him to be hospitalised for a number of weeks. The costs of medication for the boy were high - the first two lots of prescribed tablets cost $ 80 each. A hospital social worker was able to help the family obtain a Health Care Card for the child, but medicines still cost the family at least $10 per week. At present the boy must be taken to hospital twice a week for outpatient care. Vichet has used all his sick leave, holiday and long service leave in order to help care for his son while he has been ill. This family was only able to afford to allocate $10 per week for medical expenses from its net income (after tax wages and centrelink payments) of about $650 per week.

The impact of a low income is felt not only in material ways. Before their son was sick they had been planning to buy him a bike for his birthday and have a family BBQ to celebrate the event. Because of the extra costs associated with his illness the party could not take place and they could no longer afford the bike. This was a cause of real sadness to them… ' But when he get sick like that, we spent the money, we lost everything, the plan is failed and make everyone depressed, you know – not happy. We just wanted to make the son happy'.

Theary and Vichet spoke about how, in their life in Cambodia, powerful people could come and take what belonged to them – even their lives. They both expressed enormous gratitude that they could now live in Australia and how different it was, but commented that life in Australia produces its own pressures:

'We always think that Australia is very good for us – a very peaceful country for us and we are happy to live here. But sometimes it's a little bit something like pressure on us to budget to organise money for our living. Nobody is pointing a gun to our back but we have to control ourselves to do something right. If you do not do something right, one day maybe no home to live. …..Something may happen for us so we have to be prepared, it's a bit uncertain for us, it's a little bit of worry for that.'

Case study 2
Medical costs are a significant burden on the family. The child with a disability needs regular medication. Also, if one family member becomes sick eg with the flu, often other family members will become ill as well. Dental bills are extremely difficult to cover. The children have regular dental checks at school and one child has a Health Care Card so is able to attend the community dentist. Brett never goes to the dentist (although, based on his comments, this appears to be as much because of a negative experience with a dentist as a child as to avoid expense). ((Extracts from Case Studies prepared by UnitingCare Burnside and used in the UnitingCare submission to the Australian Industrial Relations Commission, in relation to the award safety net adjustment case in 2001)

The so-called "safety net" for families without a health concession card depends on their taking out private insurance. Many families on moderate incomes will not take out private gap insurance, in an attempt to save money because of very limited budgets, and will face catastrophic fees for unexpected medical expenses.

The government's claim that the private insurance for out of hospital expenses will only cost $1 a week lacks credibility, as the restraints on doctors up-front fees are being removed. These restraints were the refusal to allow bulkbilling by doctors who charged a fee, and the refusal to allow gap insurance so that doctors had to keep their fees affordable. The premiums for gap insurance are likely to rise rapidly as more GPs decide to charge fees because Medicare rebates are low and they can now claim the rebate directly even if they charge additional fees.

Many people will find that they cannot afford a GP and there will be increased burdens on casualty and emergency departments at hospitals.

These changes continue the Government's move towards requiring that people have private insurance instead of reliance on Medicare. They are also a recipe for increasing costs without increasing the quality of care.

As the USA shows, reliance on private health care and private health insurance, with only a safety net provided by Government results in very high costs for health care and leaves large numbers of people without any safety net.

Michael Wooldridge, in a speech in 1998 made some comments about Medicare that the present inquiry, and the current Government, should consider seriously. He said:

"Time and again, the Australian people have shown they wanted the Commonwealth to take a national lead in developing a health care system that was affordable, of a high quality and guaranteed access to all."

He argued "In discussions about co-payments or proposals to finance health through 'managed care', the flawed premise is that these economic solutions, or similar ones are the key." He argued that the real issue was providing quality care, and that the Australian Government should address this in the following ways, all of which, in the general terms in which they are stated below, UnitingCare would support:

1. by managing illness better by focusing on prevention not treatment

2. by coordinating care so ending fragmented and piecemeal care given by multiple providers of health care and reorienting the health system so that if focuses on the needs of individuals;

3. by getting different Australian Governments to work together cooperatively.

4. by reforming the Australian system to focus on quality by introducing reforms such as evidence based medicine.

5. by building on the strengths of the Australian medical system:

The strengths of the Australian Medicare system that he enumerated included the following points relevant to this inquiry:

- universal health system;
- excellent network of primary health care through GP's;
- our relative efficiency in health - Australia spends a little over 8.5 per cent of GDP in health, about the middle on the OECD scale and better still when compared to 14 per cent for US.

"This cost-efficiency in health is a sign that one of the ways Medicare works is because it enables Governments to maintain sustainable health budgets."

The proposed changes to Medicare in 2003 seem to rely on the economic solutions Woolridge rejected, namely allowing doctors to charge a co-payment, rather than encouraging the bulk billing for all patients that makes Medicare a universal, simple, and cost effective system. At the same time as they undermine universality, the changes will also damage cost efficiency.

(d) alternatives in the Australian context that could improve the Medicare principles of access and affordability, within an economically sustainable system of primary care, in particular:

(i) whether the extension of federal funding to allied and dental health services could provide a more cost-effective health care system,

UnitingCare NSW.ACT supports the inclusion of dental treatment that addresses health issues (fillings, extractions, dentures, peridontal work and so on) in Medicare. The current exclusion of oral health from Medicare is somewhat nonsensical, since the mouth is part of the human body and oral health impacts on the wellbeing of the person in the same way as any other physical health problem. The current exclusion of oral health services from Medicare places heavy burdens on many families either through long waiting periods for the few free dental health services that are available, or through expensive fees for service.

See Case Study 2 above.

Case Study 3

(Family income, including Centrelink payments and wages, $627 per week) Unexpected expenses put additional pressure on the budget. Recently Mony had a bad tooth ache and went to the Dentist. This cost him $ 80. His teeth required further work but he could not afford another visit. (Same source as previous case studies).

(ii) the implications of reallocating expenditure from changes to the private health insurance rebate, and

The private health insurance rebate effectively drains billions of dollars from public health. This drain will be worsened by the provision of the 30% government rebate for the private gap insurance. Many people on moderate incomes are unable to afford private health insurance, and the system therefore is inequitable, since it serves better those on higher incomes.

One recent article suggested that for every $1 that the government saves by someone using the private health system, it pays $2 in health insurance rebate. We urge the Medicare Committee to seek proper and adequate data and analysis about this.

UnitingCare supports, as does the NSW Synod of the Uniting Church, a universal, simple, efficient and accessible system of health care, rather than a two tiered system of health care using private health insurance. If the government were to reallocate the money currently spent on the health insurance rebate to public hospitals, this would be a very significant injection of funds directly into the public health system, which is demonstrably what most people want to use, and do in fact use. Many people resent having to have private health insurance as a backup system. They would prefer to pay for an adequately funded public system. Michael Woolridge understood that in the speech to which we have referred above.

Conclusion

UnitingCare NSW.ACT calls on the Government to abandon its proposed changes to Medicare. The Howard Government should return to Medicare based on its original principles, public hospital care and the PBS as universal systems, funding them through an adequate Medicare levy with surcharges on very high incomes. It should focus on accessibility and affordability of health care through Medicare alone, rather than through a joint system with private health insurance, the subsidies for which bleed the government purse and divert money from the public system. It should end its promotion of private health care and private health insurance and ensure that the cost-effective PBS is in no way jeopardized in free trade negotiations.

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This submission was prepared by Rev. Dr. Ann Wansbrough on behalf of UnitingCare NSW.ACT.