CATHOLIC HEALTH AUSTRALIA

SENATE SELECT COMMITTEE ON MEDICARE

10 JULY 2003

SUPPLEMENTARY SUBMISSION ON PROVISIONS OF THE HEALTH LEGISLATION AMENDMENT (MEDICARE AND PRIVATE HEALTH INSURANCE) BILL 2003

10 July 2003

The Secretary
Senate Select Committee on Medicare
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The Catholic health, aged and community care sector

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Dear Secretary

Catholic Health Australia previously made a submission to the Senate Select Committee on Medicare on 20 June 2003. CHA welcomes the Committee's invitation to make a supplementary submission relating to the specific provisions of the Health Legislation Amendment (Medicare and Private Health Insurance) Bill 2003, following its referral to the Committee on 19 June 2003.

Inquiries about this and CHA's earlier submission are welcome and may be directed to:

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Yours sincerely

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Questions about the Provisions of the Bill

The Bill gives effect to the Government's proposal to introduce a voluntary program – the General Practice Access Scheme – under which financial incentives are provided to those general practices which guarantee to provide services at no cost to those patients who are covered by a Commonwealth concession card. A practice which chooses not to participate in the scheme will still be able to charge patients in the usual way – either bulkbilling at no out-of-pocket cost to the patient (but forfeiting the proposed $1-6.30 incentive), or leaving it to the patient to seek their rebate from Medicare and the HIC.

Assigning the Medicare Benefit

Under proposed Section 20 A (1) of the Bill, it is proposed that the patient can choose to assign their Medicare benefit to a doctor participating in the General Practice Access Scheme. A key part of the reform proposal to which the Bill gives effect is the provision enabling general practices which agree to participate in the General Practice Access Scheme to offer to non-concession card holders a facility under which they will only have to pay the gap between the Medicare rebate and what the doctor chooses to charge (Schedule 3 1). The new sub-section 20 1 (A) does not require the doctor to accept the assignment in full payment of the medical expenses incurred in respect of the medical service. Therefore, the doctor is free to charge any extra fee in addition to making a direct claim on Medicare.

Price Signals and the Real Cost of Care

The argument that patients who are only required to pay the gap at the doctors office and are not required to present to the HIC, are now less out-of-pocket up-front is spurious in terms of its potential implications. This approach does not fit with the Government's rhetoric and policy about seeking to improve patients' awareness of the true cost of general practice services, pharmaceuticals and health care in general. It removes a price signal and makes the value of their public health insurance (Medicare) even less transparent to consumers.

If one of the benefits of the Medicare reform package is intended to be no paperwork between the doctor and the HIC, it is questioned, what form the contract will take between the patient and the doctor in which the patient assigns their Medicare benefit to the doctor. This issue raises a number of related questions:

- whether this contractual arrangement will continue to require the patient's signature, as one mechanism for reducing potential fraud. Is this intended to be an electronic signature from the patient or will the general practice be required to keep copies of all signed Medicare forms for auditing purposes?

- whether this form will include complete information identifying the full fee paid by the patient so as to enable the HIC to document out of pocket charges required for private insurance arrangements, and then pass this information onto relevant private health insurers.

- whether this form will also identify those services that might be considered to be part of an in-hospital episode (eg follow-up postnatal), as opposed to being exclusively an out-of-hospital episode.

- whether through this contractual arrangement, doctors are aware that they may be assuming an administrative role currently provided by the HIC (when patients present their paid invoice to the HIC for collection of their rebate). Presumably for all patients, doctors will be required to advise the HIC of the full charge made to the patient, and each of the specific medical benefit services, so that the HIC can calculate the total out of pocket costs for both private health insurance and safety net arrangements.

- whether the financial implications for the HIC have been taken into account. In the 2003-4 Budget, the HIC required top-up funding to cover its operations.

- whether there are provisions within the agreements under the General Practice Access Scheme to protect doctors whose patients with a concession card want to pay the doctor's account rather than assign their right to the Medicare benefit. Practices which sign up to the General Practice Access Scheme will presumably be obliged under the agreement they enter into with the HIC to bulkbill the HIC for services provided to concession card holders, thus taking assignments from those patients in accordance with subsection 20 A (1). Practices should not be prejudiced financially under these agreements if they have a large number of concession card holders who choose to pay the account rather than assigning their right to the Medicare benefit in full payment for the service. Would there be penalties imposed on general practices that sign up to the General Practice Access Scheme but are unable for any number of reasons to convert fully to the paperless arrangement.

Presumably in terms of informed financial consent, doctors will be required to advise patients at the time of appointment booking of their expected charges. While this might be good practice it imposes yet another administrative burden on general practices that claim to be increasingly adversely affected by time and administrative constraints associated with incentive schemes, taking time away from their patients.

Bulkbilling

In further analysing this policy and the provision in this Bill, one could question whether the proposed reforms are in any way are intended to support bulkbilling. While Medicare as it was established was never intended to be about achieving 100% bulkbilling levels, the system should at least support bulkbilling to the level at which people on low to average incomes are not unduly discriminated against in their capacity to access essential health care services. The outcome of declining MBS remuneration and consequent bulkbilling levels that diminish to such a level that low to middle income earners are rarely if at all able to access it, is that the value of their entitlement to Medicare is eroded.

CHA believes there is value in using incentives to improve geographical access to GPs and to improve bulkbilling. For example:

- Any incentive should be linked in some way to encouraging GPs to achieve a realistic bulkbilling target. Any such target can really only be achieved by matching a proposed target with appropriate funding, and the proposed $1-$6.30 at face value appears to continue to undervalue MBS services and the value of Medicare as a public insurance entitlement. In this sense it would be preferable to direct the additional funds to the MBS rebate rather than to an incentive type scheme.

- There is value in setting a differential MBS fee between metropolitan and rural and remote so as to encourage existing rural and remote general practices to remain viable, and to provide incentives for others to establish practices in rural and remote areas.

Private Health Insurance Issues

The Bill introduced amendments to the National Health Act to enable private health insurers to offer insurance coverage where the cost of out-of-hospital Medicare funded services in a calendar year exceeds a 'gap charge threshold' of $1000.

CHA questions the economic responsibility of a proposal that guarantees a public subsidy in the form of the 30% rebate to be applied to a product for which there is no guaranteed price known at the time of the introduction of this Bill. Although it would be presumed that the health funds would seek to levy a premium that is competitive and the initial premiums presumably would need to be approved by the Government, this is an unknown. One or all of the funds may choose to offer the product at any price they choose.

CHA believes further that this private insurance arrangement may be an inducement for doctors to increase or introduce copayments. The moral hazard associated with such a scheme becomes increasingly stark as the patient approaches the $1000 threshold. Where there are perceptions that there might be little additional impact on the patient at this point, there will be increasing incentive placed on the general practice to begin to charge higher copayments to privately insured patients.

There is every possibility that in the passage of this legislation, doctors may in fact be increasingly motivated not to sign up to the General Practice Access Scheme and not to maintain or improve bulkbilling. Instead, they may be induced to begin to charge concession card holding patients a copayment in the belief that the patient will be able to seek compensation through the safety net arrangements and/or private insurance.

It should also be asked, what happens in the future if and when copayments increase to a point that the $1000 threshold / front end deductible for private health insurance is reached quickly by patients. At the moment, it is argued that very few people would ever qualify to receive a benefit from this insurance; if this is the case it is in effect catastrophic type insurance. However constant copayment growth will soon alter that scenario. Given the medical profession's claims about the seriously undervalued state of the MBS, the potential for rapid copayment increases are real and significant, even more so in areas where there is little competition among general practices. There is no guarantee that the $1000 threshold will not be raised and/or that premiums for out of hospital private insurance will not rise rapidly as may be necessary to meet financial viability requirements of the private health funds that offer this product. Further, just as it is a

concern that the public health insurance Medicare program should not come to be regarded as a safety net arrangement, equally it would be of extreme concern if private health insurance were to be regarded as a safety net arrangement.

Compensation

CHA has contended throughout the debate that these proposed Medicare reforms essentially undermine the purchasing power of peoples public health insurance. The implementation of this Bill and the reforms are likely to impact most negatively on those people with low to average incomes (without a concession card) particularly if they have children and/or chronic illnesses. This is inequitable. Private health insurance which has been proposed as an alternative is not an equitable option for people with minimal discretionary income. The private health insurance proposal offers a level of catastrophic type insurance but this does not take away the fact that the value of their public insurance has been diminished over time.

CHA acknowledges that compensation measures are tenuous and can erode in real terms over time. People on low incomes are vulnerable where compensation measures are instigated as safety nets. Thus CHA supports an entitlement program approach as opposed to safety net structures as a more certain and sustainable structure to safeguard the interests of people on average to low incomes. However, if the Parliament determines it will support this Bill, CHA contends that measures must be taken to limit the potential negative consequences for those on low to average incomes who do not currently qualify for a concession card. Some options available for example are:

- Use of tax offsets to alter the threshold at which people qualify for out-of-pocket medical expenses. It is noted that even this option has been reduced recently, probably as part of the mechanism to encourage private health insurance uptake. Recent legislative changes mean that from 2002-3 people now only qualify for 20% of qualifying medical expenses that exceed $1500 (rather than the previous $1250). If this legislation is to pass then it will be crucial that those on low incomes qualify for the tax offsets at a significantly reduced threshold – more like $500 rather than $1500.

- Expand the scope of the health care concession card to encompass those people on low to average incomes, that is, those on less than average weekly earnings.

Conclusion

CHA is concerned that the proposed reforms and the legislation supporting it, essentially diminish and erode the value of peoples public health insurance. The Bill and the reforms do not appear to value medical services to a level that would either halt the further demise of bulkbilling or improve its current state. Instead, underpinning the multi-pronged approach of this reform is a number of measures that seem to be much more directed at breaking down a long-held Australian communitarian value. As an entitlement program and public health insurance program (albeit underfunded) Medicare relies on community solidarity, sharing the risk, and an attitude that does not seek to not impose copayments that ‘tax the sick’.