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ASSOCIATION OF INDEPENDENT RETIREES (A.I.R.) LIMITED

ACN 102 164 385

From the Office of the President
PO Box 12, KEILOR VIC 3036
Phone (03) 9361 0660
Facsimile (03) 9390 8733
MOBILE 0429 148 615
EMAIL j.k.heard@bigpond.com

The Chair
Senate Select Committee on Medicare
Parliament House
Canberra ACT 2600

Dear Senator McLucas,

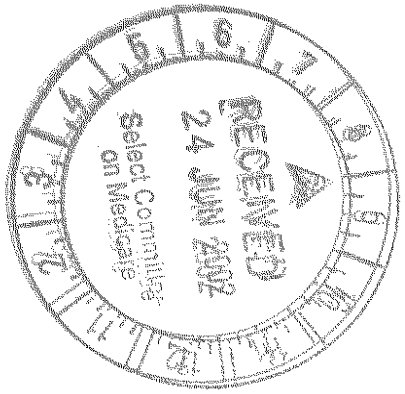
Enclosed is our Association's submission to the Senate Inquiry on Medicare. I apologize for it being lodged after the closing date.

The Association looks forward to appearing before the Committee to speak to the submission when the timetable is finalized.

Yours Sincerely

Joan Heard (Mrs)
President

23 June 2003



ASSOCIATION OF INDEPENDENT RETIREES (A.I.R.) LIMITED.

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Submission

to

Senate Select Committee on Medicare

June 2003

Mrs Joan Heard
President

Dr Clyde Scaife
Chairperson, Health Committee

Summary

The Association of Independent Retirees (A.I.R.) Limited. believes the current level of the Medicare Benefits Schedule is directly responsible for the decline in assignment of benefits (bulk-billing).

The Association strongly urges the committee to acknowledge the impact of the cost of pharmaceuticals under the PBS as a component of the cost of GP services which should be viewed in conjunction with those services.

A.I.R. is unable to detect any commitment from either side of politics to increase, index, or submit to conciliation / arbitration, the schedule fee or the percentage level of benefits under Medicare.

A.I.R. believes it is self evident that shortage of available GP hours of service has a direct impact on patients' ability to access appropriate care in a timely manner.

A.I.R. supports the initiative to encourage bulk-billing of card holders and has no fundamental objection to an attempt to focus this funding according to geographic location but believe that there will be anomalies in practice.

A.I.R. does not accept means testing for benefits related to health care, which contradicts the so called universality principle of Medicare.

A.I.R. supports the proposed co-payment at the point of service in conjunction with bulk-billing as it is cash flow positive for the consumer.

A.I.R. supports the safety net proposals for card holders which offers a degree of protection against catastrophic expense.

A.I.R. strongly supports the amendment to allow private insurance for out of hospital out of pocket expenses and the extension of the government 30% subsidy for this insurance.

The state should encourage private insurance, not forbid such prudence.

A.I.R. does not see any significant improvement to health service by direct Commonwealth funding of Allied Health Care services nor do we see any significant saving to the Commonwealth.

A.I.R. is strongly opposed to any attempt to prop up Medicare by diverting funds from the private health insurance subsidy to Medicare.

A.I.R. believes that, in general, fee for service offers the patient maximum freedom of choice and directly rewards doctors for effort.

Doctor payment alternatives do not seem to hold any benefit for consumers and, of the two major alternatives, a whole time salaried service may be the better. However, we believe the expense to the Commonwealth may be increased

A.I.R. generally supports the provision of safety nets as a component of a health care funding system, allowing protection of individuals from catastrophic financial burdens whilst preserving a degree of personal accountability.

A.I.R. strongly supports the existing 30% subsidy of private health insurance and will oppose any attempt to divert those funds to Medicare.

A.I.R. believes that, on balance, fee for service, the original base of Medicare, best serves the consumer with optimum choice of practitioner, provided it is adequately funded.

A.I.R. believes that the government initiatives to increase the number of medical school places with a bonding to general practice is too little too late, will have no impact for a decade and does not compensate for the productivity loss due to change in the gender balance of the profession.

Introduction

A.I.R. has a membership of upwards of 16,000 in 80 branches across Australia, embracing retired people who are making a significant contribution to funding their own retirement. Some have part pensions, some have Veterans' Gold Cards. About half our A.I.R. members have no concession card.

Members are acutely aware that the cost of accessing medical care does not cease with the doctor's consultation but includes the cost of medication.

Pharmaceutical Benefit Scheme (PBS) subsidised drugs now cost our members $3.10 (concession) or $23.10 per prescription.

There may be two items and three to five repeats between doctor's visits. Consequently, our members may pay up to $37.20 (concession) or $277.20 for medication even if the doctor has accepted assignment of benefits. (bulk billed)

A modest co-payment to the GP is insignificant in comparison.

A.I.R. remembers that it was Health Minister Brian Howe, who introduced a PBS charge for pensioners, in effect, a co-payment for general practitioner services.

The Medicare Benefits Schedule

Reference (a) :
The impact of the current rate of the Medicare Benefits Schedule and Practice Incentive Payments on practitioner incomes and the viability of bulk-billing practices

The Association notes that it appears to be agreed that the incidence of bulk billing has declined over recent years. This is the experience of our members.

Thus it seems self evident that the Medicare schedule fee has fallen below the threshold at which general practitioners (GP's) will take the major administrative step to abandon bulk-billing, even for pensioners for whom the profession has a long standing tradition of discounted services.

The Schedule fee from which rebates are calculated is the prerogative of the Minister. It is not the result of arbitration nor conciliation.

The Medicare Levy has, in fact, never met the full cost of Medicare rebates and has been increased only once in the thirty years since the scheme was first devised, from 1.25% to 1.5% of taxable income.

The range of funded services has increased dramatically in this time, particularly in investigative services such as ultra sound and computer-assisted tomography, as well as in procedural services.

Income from the levy is highly dependent on the level of employment as the unemployed pay no levy.

The levy as a flat rate tax, is highly regressive and, if Medicare is regarded as an insurance scheme, the levy as premium, it fails to meet insurance standards of funding the scheme's liabilities.

Many A.I.R. members are adversely affected by the fact that the levy is charged against imputed credits from share income although the recipient does not have this nominal income as cash in hand.

A.I.R. recommends that the Committee should report on the level of the levy and the inability to fund the current range of services from the existing levy.

A.I.R. members are aware of reluctance of GPs to bulk bill non pensioners, particularly those seen as asset rich even though they may be income poor.

The decline in GP bulk billing of card holders reflects the fact that, whilst government gives the card, the GP is expected to give the discount by accepting

the bulk bill rebate.

Seven million Australians out of a population of almost twenty million now hold Commonwealth concession cards relating to health care.

The Productivity Commission found that administrative and compliance costs of general practice amounted to 5 per cent of a GP's income, or $228 million p.a. (BMJ 326 3 May, p951)

Reference (b) ***:***
The impact of G P shortages on patients' ability to access appropriate care in a timely manner.

Availability is the primary concern of A.I.R. members, with significant variation between suburbs, rural towns, retirement localities and residential facilities, particularly nursing homes.

When choosing a location for retirement, prudent people place high value on availability of GP services, closely coupled with hospital services.

However, rural medical services have been in steady decline for over fifty years and there is no reason to anticipate reversal of the trend. Small town population declines, the doctor retires, dies or disappears, the hospital becomes a "Community Health Service", the chemist closes.

Why would we expect a young doctor, recruited from the top level of matriculants, married to a city spouse, to go to live in a town from which everybody else is eager to flee as soon as they can sell their house ?

Nursing Homes

Location of service is a significant factor for A.I.R. members in residential care.

There is a shortage of GPs willing to face the cost and disruption of travel to see one or two patients in a nursing home, for a discounted fee, hedged around with restrictions and liability.

A.I.R. understands how this leads nursing home proprietors to prefer doctors with a whole institution commitment, bordering on contract, but this can mitigate against the direct personal care of an individual.

Nursing home residents should have access to a personal choice of GP and the schedule should fairly remunerate this service.

One significant factor in this trend is the cost of time spent in travel. Another factor is the administrative burden associated with ordering of treatment and

compliance with accreditation demands.

The low level of remuneration for nursing home services, available from bulk-billing, is a significant factor.

Gender balance of the profession.

A.I.R. believes the committee should acknowledge that a contributing factor to any shortage of GPs is the otherwise welcome increase in the proportion of female graduates over the past two decades.

There is abundant evidence that female graduates are less likely to work full time than males.

Dr Sue Page, President NSW Rural Doctors' Association, was quoted in 'The Weekend Australian' [14/15/6/03]
"(women doctors) are less likely to work full time and less likely to do procedural work in hospitals ...but if you are a part time female GP with family commitments you don't necessarily want to be on call for a 24 hour shift every second night."

Impact of Government initiatives.

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

Reference (c) (i):
Incentives for free care from general practitioners limited to health care card holders, or those beneath an income threshold.

The Government's proposal Is for a contracted participation package and, as such, will stand or fall as a package, to date opposed by every significant G P organisation.

The relevant section offers doctors who agree to bulk bill all seven million concession card patients a tiered additional individual fee, above the rebate amounting to $1.00 in capital cities, $2.95 in outer metropolitan, $5.30 in rural centres, and $6.30 in remote areas.

A.I.R. members with cards would welcome this initiative as it would guarantee free 'at the point of service' care from a GP. The crucial issue is the extent to which GP's take up the package.

A.I.R. does not expect this initiative to reverse trends away from rural practice but it may allow some marginal practices to cling on longer.

A.I.R. notes that the term of reference extends the government proposal to embrace others " beneath an income threshold."

A.I.R. is opposed to means-tested access to service for retirees who, having paid taxes throughout their working life, believe that concessions should be available without a means test, as is the Veterans Gold Card.

A.I.R. advocates a Silver Card, for all retirees above a certain age, say, seventy years.

The current means testing causes massive distortion of saving and investment patterns and actually discourages saving, with negative impact on the economy.

Reference (c) (ii)
The government proposal for a change of bulk billing arrangements to allow patient co-payment at point of service co-incidental with direct rebate reimbursement.

This initiative would be welcomed by A.I.R. members without cards as it would be cash flow positive for the individual although it would certainly facilitate an increase in GP fees as the patient would focus on the small amount of direct payment rather than on the total of rebate and co-payment.

Clearly it signals an intention by government to resist increasing the schedule fee and shift to a user pays system, perhaps moving to the New Zealand model with higher benefits for children and Kiwi card holders.

It would be of logistical benefit to members without easy access to a Medicare office, or agent.

(iii) The Government's proposed safety net for card holders, limiting personal liability for card holders out of pocket expenses for out of hospital services to 20 per cent over the first $500 in any one year.

These fees would be predominantly for specialist, investigative or perhaps non participating GP's fees.

Again, A.I.R. would welcome this initiative for cardholders as presumably it is a universal free standing initiative, not dependent on GP participation.

A.I.R. card holders would welcome this initiative but with concern that it leaves the patient with an open ended liability, one having maximum impact on those most affected by illness.

Reference (iv) ***:***
The Government's proposal : to allow Private Health Insurance for out of hospital medical expenses.

Knowing that the Health Insurance act has prohibited consumers taking out so called "gap" insurance since the inception of Medicare, A.I.R. welcomes this initiative.

A.I.R. notes with approval that this new private health insurance will also attract the 30% government subsidy.

The Government estimation of costs may be optimistic but A.I.R. strongly supports consumer freedom of choice to insure against such out of pocket expenses.

Alternatives

Reference (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 :

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

A.I.R. is primarily concerned to preserve or enhance the quality and availability of existing G.P-based services before advocating government expenditure on allied health services

Dentistry.

Dentists accredited for facio-maxillary surgery are currently included in the Medicare system but primary care dentistry is excluded.

Within the private insurance system, dentistry attracts the highest dollar payment of the ancillary cover group.

Home and Community Care (HACC)

This scheme, providing assistance to enable people to remain in their own homes, is highly valued by A.I.R. members and all retirees and, whilst the services provided are not strictly speaking allied health, there is no doubt that there is a health return, and a saving of the expense and disruption inevitably associated with institutional care.

Unfortunately the program suffers from divided control and funding between the three levels of government.

The Veterans Affairs Department, with a Commonwealth wide organisation, used to dealing with elderly people, and with a declining demand for its primary responsibilities, could perhaps be used.

On balance, A.I.R. believes that extension of allied health services to Medicare would be of little benefit to members, but would add significantly to the expense of Medicare.

The Medicare system is already failing to meet its declared objective of funding "medical services reasonably necessary for the medical care of the patient."

Reference (d) (ii) :

The implications of reallocating expenditure from changes to the private health insurance rebate.

There is absolutely no doubt where A.I.R. stands on this issue.

A.I.R. strongly supports the 30 per cent rebate for private health insurance, carried by over half its members, and will oppose any attempt by any party to remove or reduce this subsidy.

A.I.R. is aware that the government at the beginning of Medicare removed the bed day subsidy and made the private funds liable for the gap between the 85% rebate and the schedule fee.

The same government reduced the rebate for in hospital services from 85% to 75%, thereby further increasing the burden on private health insurance.

These initiatives, in today's dollars, almost exactly match the value of the private health insurance rebate currently provided.

A.I.R. strongly recommends that the present Federal Opposition cease its rejection of the private health insurance rebate and recognise that every dollar of subsidy is matched by two dollars of citizens' money.

A.I.R. seeks a bi-partisan commitment to both Medicare and private health insurance.

Reference (d) (iii) :
Alternative remuneration models that would satisfy medical practitioners but would not compromise the principle of universality which underlies Medicare.

A.I.R. has no interest in the mode of payment of doctors, except to the extent that this is seen as having impact on patient freedom of choice, or on the availability and quality of service.

The fee for service mode of payment has served the Australian people for over fifty years. It is worth remembering that it is the only system which enables a citizen of modest means to access a doctor of choice,and to dismiss that doctor by simply moving to another doctor.

Fee for service in Australia was first supported by private insurance, offered by mutual funds initially created by doctors and pharmacists with government subsidy, enabling most Australians access to medical care at affordable cost.

Fee for service motivates productivity and maximises patient freedom.

Patient co-payment allows patient monitoring of service quality and value.

Medicare preserved fee for service, but the availability of universal bulk billing, with no cost at the point of service, creates unlimited demand.

The capitation system , which dominated the Australian scene for the first fifty years of the twentieth century, requires patients to be enrolled with a contracted doctor.

A.I.R. believes that the capitation system, because it requires a "patient list" and requires a doctor to provide unlimited volume of service for a fixed per capita payment, inevitably places the interest of consumer and provider at odds.

Capitation offers no benefit to consumers compared to a properly funded fee for service system. Furthermore, it has negative impact on freedom of choice.

The cost to the funding authority is more a function of the level of payment rather than the method of payment.

Salaried service is attractive to many doctors, providing benefits such as superannuation, guaranteed leave, long service leave, study leave, on call allowance, sick leave, paid overtime and limited hours.

However, some Health Maintenance Organisations (HMO) actually reward doctors by bonus schemes for under servicing patients, thus improving the financial position of the HMO.

There is always some limitation of clinical freedom, some loss of direct accountability to the individual patient, although many salaried doctors will vehemently deny this.

The individual patient has virtually no choice of doctor.

Productivity is not motivated by the salaried system

A.I.R. believes that Treasury is opposed to fee for service because bulk-billing has made it an open ended expenditure.

Governments have responded by complicating the fee schedule and failing to index it to inflation, thus precipitating the decline in bulk-billing.

Over the past decade various strategies have been tried by governments to avoid lifting the schedule fee such as the funding of Divisions of General Practice, the Practice Incentive Payments, etc, but A.I.R. is not aware of any positive results of these initiatives.

Appendix

Expenditure by Health Funds 2001/2002

Dental	$945 million
Optical	$288 million
Physiotherapy	$138 million
Chiropractic	$132 million
Pharmaceutical	$ 63 million
Podiatry	$ 43 million
Ambulance	$ 28 million
Fitness Products	$ 14 million