Executive Summary

Following the Committee's first report *Medicare: healthcare or welfare?* in October 2003, the government released its revised package for health reform, titled 'Medicare Plus'. The Committee's second inquiry into the provisions of 'Medicare Plus' discovered mixed reactions across the community. Although in many respects, the new package was considered an improvement on the old, widespread concern remains over the underlying policy directions that remain implicit in the proposals.

This view was summed up by the Queensland Nurses Union:

> In summary, while there are some aspects of the *Medicare Plus* package that the QNU supports, the overall thrust of the package is towards a residual rather than universal model of health care with a greater emphasis on individual (financial) responsibility through co-payments rather than a societal or collective responsibility for the health of a nation through our taxation system.[1]

The Committee considered all aspects of Medicare Plus, and the findings are summarised below. However, at the outset, care must be taken with a piecemeal analysis of the package by its individual components. Medicare is 'greater than the sum of its parts', and because all elements are closely interconnected, it is essential to keep a focus on the ultimate policy intention of the system.

In this respect, the Committee remains uneasy about the policy fundamentals of the government package. Although containing worthwhile initiatives, the implicit message in Medicare Plus is that the role of Medicare in future should be that of a welfare system: not the universal insurer that should deliver equal benefits to all Australians alike, based on health needs, not income levels, and the understanding that the richest have paid for the system through tax.

The main elements of the package relate to the proposals for two new safety nets, a $5 incentive payment to bulk bill concessional patients and children under 16, and a number of workforce measures.

Safety nets

In considering the proposals for new safety nets, the first step for the Committee was identifying the underlying need for changes to the current arrangements.

It is clear that, under existing arrangements, out-of-pocket costs are mounting up to levels which are unaffordable for many Australians. The lack of adherence to the Schedule Fee and the drop in bulk billing rates has eroded the effectiveness of the

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1 QNU, Submission 62, p. 7

existing safety net. The result has been reduced affordability and access to even some basic medical services.

The Committee agrees that action is required by government to address these problems, and a new safety net offers one possible option. The government's proposal is likely to bring some relief to the relatively small number of Australians who would qualify for it.

However, the safety net proposal before the Senate is problematic for a number of philosophical and practical reasons.

At a fundamental level, the separation of the proposed safety net into two thresholds creates winners and losers in the health system and thereby offends the principle of universality lying at the heart of Medicare. The Committee rejected the previous safety net proposal on this basis, and has concerns with these ones for the same reason.

It is also evident that both the $500 and $1000 thresholds are too high to deliver meaningful benefits to any more than a tiny handful of Australian families and individuals each year. While the proposals certainly benefit those few recipients, the safety nets would do nothing for the majority of Australians. In the context of falling levels of bulk billing and rising gap charges, the thresholds are set too high to effectively tackle the significant costs of accessing basic health care, and are instead likely to pick up those with high cost specialist fees. Addressing these specialist gaps is important, but this is not an adequate or sustainable policy response.

Moreover, the simultaneous operation of the existing and proposed safety nets will further complicate for claimants the calculation of likely benefits, and weaken their ability to budget effectively.

The Committee also finds that the two categories chosen by the government for receiving the lower threshold – concessional status or receipt of the Family Tax Benefit (A) – are a poor measure of need. In particular, too many working people on low incomes and individuals with chronic illnesses struggle to meet health costs, but do not qualify for concession cards.

A further problem with the proposed link is discrimination against those without dependent children. The relatively generous FTB (A) income thresholds that apply to those with dependent children contrast markedly with the low cut-off levels for those without. A couple with dependent children may enjoy a concessional safety net threshold, notwithstanding that their income is over $80,000 per annum, whereas a single person without children would be subject to the $1,000 threshold on an income of less than one quarter that of their neighbours. As well as being in many particular instances unfair, this deepens the poverty trap for many more Australians.

Already a complex, confusing and time-consuming feature of the tax system, the FTB(A)'s inherent reliance on income estimation by recipients has caused widespread concern for many since its introduction, due to the accumulation of debt through the

difficulty of estimating income. Attempts by families to diminish the likelihood of incurring debt can meet with other difficulties, such as denial of access to a Health Care Card, causing added pressure to families often already facing financial catastrophe.

In relation to concerns over the inflationary effects of the proposed safety nets, the Committee finds no probable reason why practitioners would deliberately raise fees if and when they know a particular patient to be beyond the relevant threshold.

However the more significant impact of a system which includes uncapped out-of-pocket benefits exhibits the potential for a relaxation in price discipline by doctors, whereby prices rise under the belief that an uncapped safety net guaranteed by government will be there to catch patients with high costs or needs.

The Committee has considered very carefully whether these flaws are sufficiently serious to justify not supporting the proposals in their current form.

The difficulty of this decision was recognised by many witnesses during discussions with the Committee, and a number of respondents who on balance advocated rejection of the legislation was persuasive. These included representatives from key stakeholder groups such as the Australian Consumers' Association and the Australian Council of Social Services backed by, among others, Professor Deeble, Mr McAuley and Ms Mohle. Mr McCarthy put his and St Vincent de Paul's views strongly:

> The legislation in its present form, even with the proposed amendments, would not even be a bandaid solution to what is a grave national problem. The idea of a safety net is a cruel hoax on those who live in low- to middle-income families.[2]

In the Committee's view, the most obvious and viable alternative, which side-steps many of these problems, is to minimise the need for safety nets through the provision of health care that is affordable in the first place. As the Committee heard:

> A safety net is very much like the ambulance at the bottom of the cliff rather than the fence at the top.[3]

This can only be achieved through the restoration of a public health insurance system that more comprehensively covers health needs, primarily achieved through increasing the availability of bulk billing.

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2 Mr McCarthy, Proof Committee Hansard, Canberra, 19 January 2004, p. 84

3 Mt. Druitt Medical Practitioners' Association, Submission 1, p. 2

Recommendation 2.1

The Committee recommends that the proposed safety nets contained in the Health Legislation Amendment (Medicare and Private Health Insurance) Bill 2003 be rejected in their current form.

The question remains whether modifications to the proposals would rectify the identified problems, and more importantly, would represent a move toward better health outcomes for Australians. Three main alternatives were put to the Committee:

- reducing the proposed threshold levels and applying them to all Australian Medicare card holders;
- amalgamating the existing and proposed safety nets, including the PBS into a single integrated safety net system; and
- capping payments in the safety net.

The Committee agrees that the adoption of a single threshold would substantially improve the government's proposed new safety net and be consistent with the universality of Medicare. Similarly, lowering the threshold below the proposed $500, and/or modifying the method of calculating the threshold, would improve the effectiveness of the safety net by bringing more people within its protection.

These alternatives therefore have merit. But, to return to a point made earlier, the creation of a new safety net is less critical than reducing health costs to patients at the point at which they need them. It both increases the level of complexity of the system and moves away from a commitment to bulk billing as a sound mechanism for delivering access and affordability.

Patients would benefit from the proposal to merge the MBS and PBS safety nets, not least in terms of patient convenience, and added accuracy for policy makers in determining the distribution of health expenditure. While acknowledging the practical and technical difficulties that may be involved, the Committee encourages the development of a mechanism to implement this proposal.

Recommendation 2.2

The Committee recommends the integration of the MBS safety net with the Pharmaceutical Benefits Scheme safety net.

Professor Deeble, proposed amending the existing MBS safety net, by retaining the principle of linking the benefit to the schedule fee but allowing total costs of up to 130% of the schedule fee to count toward the threshold.

This idea has some positive elements, particularly the retention of the MBS Schedule Fee as a key benchmark for setting prices. However, this would still leave many patients with large out of pocket costs, particularly for high specialist and diagnostic costs. The Committee therefore does not agree with this proposal.

What, then, is the Committee's preferred alternative? The only long term solution that will effectively and fairly minimise medical cost induced hardship in Australia is a system that enables better and fairer access to bulk billing. To better Australia's health outcomes, we need a system that enables GPs and specialists to embrace bulk billing as more of a norm, and less of an exception.

$5 bulk billing incentive

The second principal part of Medicare Plus is the proposal to pay a $5 incentive payment for every service delivered to concessional patients and children under 16 that is bulk billed.

In the view of the Committee, the government's proposal raises a profound question over the concept of a universal Medicare and the role that bulk billing plays in this system.

The Committee does not agree with the government's view that the measures are consistent with the principle of universality. The simple fact is that although everyone remains entitled to the basic rebate payment, the end result is that different categories of people in Australia would receive different benefits, and doctors receive different incentives, based on the government's perception of their relative need.

Added to this are the signals that this policy sends. The policy gives encouragement to the medical profession to bulk bill concessional patients and children, but by giving no incentives or encouragement for any other group, the implicit message is that these two groups are the only ones the government wants to be bulk billed. The government's arguments to the contrary are, to be blunt, circular and disingenuous. The clear purpose of the policy is to direct bulk billing to those perceived as 'welfare recipients' and away from everyone else.

At the heart of this debate is the importance of bulk billing in the Medicare system. The government's proposals are underpinned by the view that bulk billing is not, and was never intended to be universal.

The Committee argues, however, that there are sound practical reasons why the ability of all patients to access bulk billing is important: it is a powerful element in the compact of risk sharing through public insurance; it is a crucial foundation stone for building a primary health care system that fosters prevention; and it does much to prevent overflows to the hospital and welfare systems.

Secondly, there is abundant evidence to demonstrate that a substantial majority of Australians want bulk billing. The NSW Nurses Association drew the Committee's

attention to polling that confirms 'strong support for the maintenance of Medicare and the central importance of bulk billing':

> For example, a recent survey conducted by Australian Research Consultant[4] that sought the opinions of 1000 voters nationwide found:
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> - 75 per cent of voters, including 69 per cent of federal government supporters, would prefer more spent on hospitals and schools, rather than tax cuts;
> - 71 per cent of those surveyed thought they would be better off if the government preserved bulk billing;
> - 69 per cent would support an increase in the Medicare levy if it was the only way to allow continued access to bulk billing.

The St Vincent de Paul society told the Committee that:

> The most pressing imperative … is the restoration of bulk billing as the normal process of access of GP services to all Australians.[5]

A policy commitment to bulk billing does not necessarily mean 100% bulk billing, however, high levels of bulk billing remain important, if not essential elements of the system. The Committee agrees with the view put by Catholic Health Australia:

> While Medicare as it was established was never intended to be about achieving 100 percent bulkbilling levels, and a reasonable co-payment from patients who could afford it was expected, 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. Clearly it is difficult to prescribe an arbitrary number at which this occurs. But it is not difficult to appreciate that communities experiencing less than 40 percent rates of bulkbilling are at a significant disadvantage … 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 purchasing power of their public insurance and the value of their entitlement to Medicare is eroded.[6]

Perhaps the most important requirements from government therefore, are a strong and explicit government commitment to achieving a high level and more even distribution of bulk billing and/or MBS fee adherence, that does not institutionally discriminate between classes of Australians based on perceptions of their wealth or 'neediness' and/or their location.

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4 The Age, August 17, 2003

5 SVDP, Submission 58, p. 12

6 CHA, Submission 80, p. 4

Aside from these general considerations, it is also evident that membership of the two groups selected – concessional patients and children under 16 – is not always an equitable or accurate measure of need.

The proposed target groups overlook many people who have limited resources, particularly young people and those on low incomes, as well as those with high health needs, but who are still working.

As with the safety nets, the Committee received various suggestions for modifying the proposals. These were:

- paying the $5 extra rebate to all bulk billed patients;
- raising the rebate for all consultations; or
- additional targeted measures.

The Committee sees considerable merit in some of these alternatives. In particular, the Committee considers that the $5 incentive payments must be extended to all bulk billed patients, consistent with the principle of universality and the need to address falling levels of bulk billing.

These actions will not be sufficient to – nor are targeted towards – bring about any substantial change to the current level of bulk billing or its overall downwards trend, and as such can only be an interim solution. In the longer term, the fundamental issue of rebate levels and/or schedule fee and the significant regional variations in bulk billing rates must be addressed for both general practitioners and specialists.

This Committee is not in a position to make substantive recommendations on what these levels should be. What is clear though, is that both the current levels and the ways in which they are set, are discredited in the eyes of the medical profession as being out of touch with practice costs and wages increases more generally in the community, together with doctor income expectations. This dissatisfaction is evident in the rising gap payments across almost all medical services. As stated above, the Medicare Benefit Schedule sits at the heart of the public insurance system and if it is perceived to have become irrelevant, the viability of Medicare as a universal health insurer is undermined.

The Committee concludes that reform of the current system for determining the MBS is needed and a more transparent method of considering the complex matrix of issues that relate to practice costs and remuneration. A great deal of work has already been done, including the finding of both the Relative Values Study and the Attendance Item Restructure Working Group. These initiatives must be pushed through to a conclusion that will restore the integrity of the Schedule fee for GPs. Further work will be required to develop funding mechanisms for new technologies and services so that out of hospital services remain affordable for Government and patients.

An outcome is required that has the necessary credibility with both the medical profession and the general population. This credibility is needed both to encourage the medical profession to recommit to the bulk billing system, and to sustain the confidence of the Australian public who pay for Medicare.

Recommendation 3.1

The Committee does not agree that the $5 bulk billing incentive payment be limited to concession card holders and children under 16 years of age. Rather, the Committee recommends that the additional $5 rebate payment be extended to all bulk billed services.

Recommendation 3.2

The Committee recommends that the government initiate discussions with key stakeholder groups, including medical and health consumer groups, to revise the method for setting and indexing items on the Medical Benefits Schedule, with the aim of improving the transparency of the process and the legitimacy and acceptance of the outcome.

Finally in relation to specialist costs, the Committee considers that a three-fold approach offers the best approach.

First, the government should initiate (where they have not already) negotiations with each of the colleges and professional organisations with the objective of raising bulk billing levels and minimising gap payments. These negotiations must be underpinned by a national policy commitment by the government to the objective of bulk billing, as well as a preparedness to fund increases – where necessary – to the Medicare Benefits Schedule to reflect real costs.

Second, and in recognition of the limits of the above approach, the government should explore alternative models of providing specialist and diagnostic services.

Third, the government must take further steps to reduce barriers to entry to specialist colleges in order to increase the number of specialists.

Recommendation 3.3

The Committee recommends that the government adopt, as a formal policy objective, the raising of the level of bulk billing and adherence to the schedule fee by specialists.

The Committee recommends that the government pursue this policy objective by means of negotiation with the relevant professional specialist groups and the development of agreements with those groups to improve the outcomes in line with these objectives.

Where such agreements are impractical, the government should actively explore and adopt other options some of which have been outlined by the Committee.

Workforce measures

The workforce measures in Medicare Plus includes provision for additional doctors and nurses, a new Medicare Item Number for practice nurses, additional placements for trainee medical practitioners, and increases in the numbers of overseas-trained doctors (OTDs).

This package is not a panacea for workforce problems, particularly in rural areas. There are also doubts that the government's predictions for the number of 'new' doctors and nurses are actually achievable.

However, the package does represent a substantial effort to redress many of the difficulties being faced by both providers and consumers as a result of workforce shortage. Taken as an overall package and assuming a substantial increase in the number of new practitioners and nurses can be achieved, it is commendable.

Notwithstanding its positive attributes, one element of the proposal is problematic: the increasing reliance on OTDs should represent both a moral and practical warning to policy makers. While Australia's recruitment from overseas of a number of doctors roughly equivalent to those Australian doctors choosing to leave is acceptable, the country's continuing status as a net importer of medical practitioners is morally questionable, and substandard from a policy perspective.

However, training new doctors takes many years and Australia continues to suffer a doctor shortage. OTDs are an important resource in this context, and for as long as we continue to require their services in any great number, the government must reform entry and work mechanisms, including the lifting of the disincentive relating to medically trained applicants within the permanent skilled migration program. The government should also ensure adequate resourcing of professional transition training for both temporary and permanent OTDs, particularly pertaining to appropriate and accessible bridging programs for the purposes of professional competency.

The government should give careful consideration to developing ways of bringing about parity in the entry and work requirements for temporary and permanent resident OTDs without dissuading temporary residents from continuing to serve Australia's needs. This is consistent with the Committee's findings during the first inquiry.

While there is a foreseeable risk that increased incentives for nurses in general practice will draw much-needed staff away from public hospitals, the fact remains that nurses working in general practice provide a highly valuable service, and that the risk is worth taking. The real answer to the problem lies in training enough nurses to meet demand in both sectors.

The Committee also urges the government to look more closely at bonded scholarships for those medical students wishing to practice in areas of workforce shortage. While supporting the proposed bonded medical school places, the Committee concludes that the expansion of existing scholarship programs could play a highly beneficial role in both recruitment and retention of doctors to the bush.

Taken as a whole, the Committee **supports** the proposals.

A Commonwealth Dental Health program

Perhaps the most significant omission in the government's healthcare proposals was a response to the large and growing problems of many Australians in accessing dental care. The Committee reiterates its view that the Commonwealth government must take a significant leadership role in the provision of dental and oral health. The Commonwealth role stems from its responsibility not only for dental health – explicitly recognised in the Constitution – but also its responsibility for aged care, education and welfare.

The Committee, noting again the importance of oral health to general health, as well as the almost totally preventable nature of dental disease, reiterates its recommendation to implement a new Commonwealth Dental Health Program, and to actively consider these proposals to expand the size and distribution of the dental workforce.

Recommendation 5.1

The Committee again recommends the creation of a new Commonwealth Dental Health Program and the active consideration of measures to address workforce shortages in dentistry.

The Committee's first report recommended the use of community health care centres as a means of improving access to primary health care in areas in which there are identified problems in accessing health services.

These community health centres, using salaried health professionals including GPs, practice nurses, and other health professionals such as pharmacists, health educators, midwives or dieticians, can provide a single source of high quality integrated primary care in areas where mixed private practices could not survive. The exact form of these centres will vary according to the particular needs of each area.

The Committee has already observed the significant inequities that exist between the benefits from the Medicare system received by a person in a rural town compared to inner city Sydney, and in simple terms, this means that people in the rural town are not getting the health care resources they are entitled to. Where the calculations reveal that an area is under-funded, the difference in funding should be allocated to that area and invested in community health care facilities.

For these reasons, the Committee reiterates its earlier recommendation:

Recommendation 5.2

The Committee again recommends that the Commonwealth government promote the use of Medicare grants to enable Community Health Centres to be provides in areas of identified need.

National health reform

Finally, some evidence to the inquiry expressed disappointment that the revised package still fails to tackle the big issues in Australian health care – in particular, the ongoing problems with health funding arrangements between states and the associated jurisdictional conflicts, and the cost shifting and blaming that seems to inhibit solutions to many problems plaguing health care in Australia.

Country Women’s Association had the view that:

> While ever the Government fiddles with the peripherals and fails to come to grips with the need to completely overhaul the whole question of Health Care in Australia, any proposals come across largely as policy being made on the run, band aids being applied to carry through to the next election.[7]

The Committee agrees and reiterates its earlier call for the establishment of a National Health Reform Council.

7 CWA, Submission 70, p. 2

Recommendation 5.3

The Committee again recommends the establishment of a National Health Reform Council.