Chapter 2

Safety nets

Introduction

2.1 The Committee's Terms of Reference require an examination of the government's proposals for new Medicare safety nets. These are the only elements of the government's proposals which require legislative approval. Hence, the Terms of Reference relating to the Health Legislation Amendment Bill, set out below, deal exclusively with changes to safety net arrangements:

> [That] the [C]ommittee inquire into and report on the Government's 'Medicare plus' package including, but not limited to:
>
> (i) the Government's proposed amendments to the Health Legislation Amendment (Medicare and Private Health Insurance) Bill 2003

2.2 The additions to the Medicare 'safety net' comprise a substantial plank of the government's revised Medicare package. In the absence of universal bulk billing of all out-of-hospital medical services, an effective and efficient system to protect patients against large, and frequently unexpected, out-of-pocket expenses is critical. In its absence, necessary medical care would become unaffordable for a large number of Australians, and in the case of the socio-economically disadvantaged and those with chronic illness, the people often most at risk.

Overview of safety net proposal

2.3 According to the government's proposal, all concession card holders,[1] and families[2] in receipt of Family Tax Benefit A[3] will be eligible for an 80% rebate of all

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1 For the purposes of Medicare Plus, Concession Card holders include those with Health Care Cards, Pensioner Concession Cards, and Commonwealth Seniors Health Cards.

2. For the purposes of safety nets, a person's family is defined under Section 10AA of the *Health Insurance Act* 1973 as being their spouse (including de facto), their dependent child, or their spouse's dependent child. The dependent child must:

- be in your care and you must be responsible (whether alone or jointly with someone else) for their day-to-day care, welfare and development;
- be an Australian resident or live with you;
- not be your spouse;
- not reside outside Australia for longer than 3 years;
- have an adjusted taxable income (ATI) that is less than the income limit in the Adjusted taxable income limits for a dependent child table (see ATO website); and
- not receive (or have paid to someone on their behalf) a social security pension or benefit or a payment under a labour market program, and if aged 16 or older, not receive payments under a prescribed educational scheme.

out-of-hospital out-of-pocket expenses in excess of $500 in each calendar year. According to the Department of Health and Ageing, 80% of families will be eligible for the lower threshold.

2.4 All other families, and all individuals, will be eligible for an 80% rebate of all out-of-hospital out-of-pocket expenses in excess of $1,000 in each calendar year.

2.5 It is forecast that the new arrangements will cost $266.3 million over four years.

2.6 This proposal essentially retains the first safety net proposed in *A Fairer Medicare* with a $500 threshold but with the addition of recipients of the Family Tax Benefit A. However, the new package replaces the earlier private health 'gap' insurance product for costs over $1000 with a government funded safety net, covering all Australians.

How many Australians would qualify for the $500 threshold?

2.7 The Department of Health and Ageing claims that the lower $500 threshold safety net will cover 12 million Australians, including about 4 out of every 5 families.[4] This leaves another 8 million Medicare-eligible individuals and families who will fall outside the requirements for the $500 safety net and instead be entitled to the 'default' safety net with the higher $1,000 threshold. In that sense, all Australians holding Medicare cards are eligible for one of the new safety nets.

2.8 The number of people who are likely to actually access the safety nets is somewhat lower, at around 200,000 in any given year.[5] However, the Department of Health and Ageing point out that it is not the same people who benefit each year, and that cumulatively, a much larger number of people are assisted by safety nets than is at first evident.[6] The Department provided the following graph, which tracks existing, new and cumulative claimants under the current safety net scheme.

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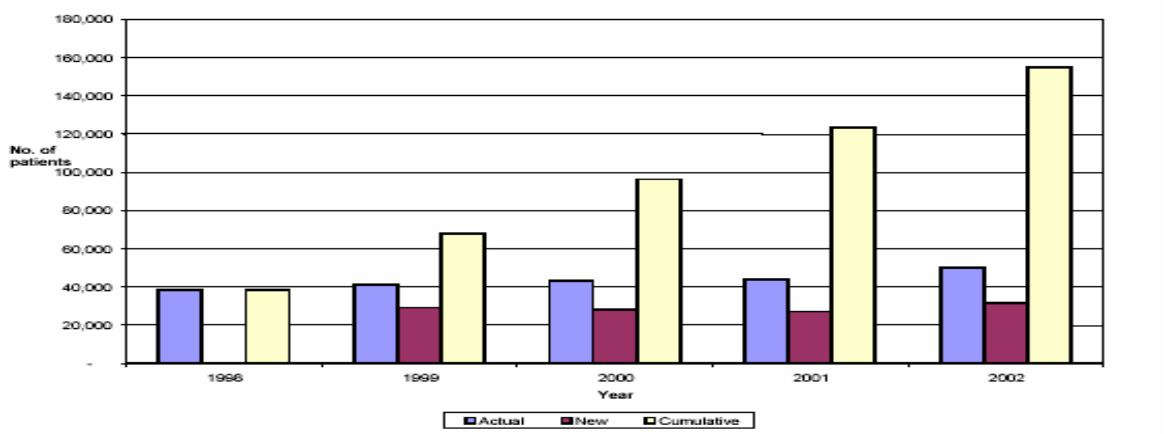
3 Family Tax Benefit (A) is available to families with children under 18 years whose adjusted income is below $85,702 a year with one child, $92,637 with two children, and $99,572 with three children. Full details are available at www.ato.gov.au/individuals

4 Medicare Plus website www.Health.gov.au/medicareplus/strengthen. Accessed 25 November 2003

5 Department of Health and Ageing, Submission 54, p. 17

6 Department of Health and Ageing, Submission 54, p. 18

Table 1. Actual, new and cumulative usage of the current MBS Safety Net[7]



Who will not qualify for the $500 threshold?

2.9 Those families who are not in receipt of Family Tax Benefit A and those individuals and families who do not hold a concession card at any point during the year, will only be eligible for the higher threshold safety net.

2.10 Most families are eligible to claim FTB (A), which has a relatively generous family income cut-off level of $83,184 for one child under 18, through to $111,703 for 5 children under 18. Individuals without dependent children are by default ineligible for either FTB (A) or (B).

Table 2. FTB(A) income thresholds[8]

		Number of dependent children under 18 years					
		0	1	2	3	4	5
		$	$	$	$	$	$
Number of dependent children aged 18 to under 25 years	0		83,184	89,936	96,689	104,196	111,703
	1	84,401	91,153	97,906	105,412	112,919	120,426
	2	92,370	99,122	106,629	114,136	121,643	129,150
	3	100,339	107,846	115,353	122,859	130,366	137,873
	4	109,062	116,569	124,076	131,583	139,090	146,597
	5	117,786	125,293	132,800	140,306	147,813	155,320

7 Department of Health and Ageing, Submission 54, p. 18

8 Department of Health and Ageing, Submission 54, p. 18

2.11 The only remaining gateway to the lower safety net for individuals, or those without dependent children, is eligibility for a concession card. Currently, Health Care Cards are available to individuals earning below $336 per week,[9] leaving all individuals and people without dependent children who earn above this amount, ineligible for the $500 safety net threshold.

Table 3. Commonwealth Concession Cards, income limits and eligibility[10]

Card	Income Limit*	Eligibility	Examples
Health Care Card	$17,472 pa	Singles	People with low incomes, on Newstart, Youth Allowance, Parenting Payment (partnered)
(including Low Income Health Care Card)	$29,068 pa	Couples (combined income)	
	$30,836 pa	Singles or couples with one child	
	+ $1768 pa	for each additional child	
Health Care Card through FTB(A)	$31,755 pa	Families who receive full rate Family Tax Benefit Part A	
Pensioner Concession Card	$32,929 pa	Singles	Age pensioners, disability support pensioners
	$33,569 pa	Singles with one child	
	$55,029 pa	Couples (combined income)	
	$65,130 pa	Illness separated couple (combined income)	
	+ $640 pa	for each additional child	
Commonwealth Seniors Health Card	$50,000 pa	Singles	Self-funded retirees
	$80,000 pa	Couples (combined income)	
	$100,000 pa	Couples (combined income, if separated by illness, care or gaol)	

9 Maximum gross income to qualify for a Health Care Card, when applying purely as a low income earner. A Card may be granted, exclusive of the income test, where an applicant receives other Centrelink allowances. Eg. Youth, Newstart, Widow or Partner allowances. Centrelink website (www.centrelink.gov.au) accessed on 7 January 2003

10 Department of Health and Ageing, Submission 54, p. 13. While equivalent annual incomes are given on this table, income tests for pensions and allowances are fortnightly, and for low income earners are measured over eight weeks. There are also assets tests for some concession cards. In certain circumstances, concession cards can also be retained for short periods when incomes exceed these limits, to enable recipients to return to work.

The safety net in context

2.12 It is important to note that the proposal, if implemented, would operate alongside the three existing safety nets, comprising the MBS safety net; the Pharmaceutical Benefits Scheme safety net, and the medical expenses tax offset scheme.

MBS safety net

2.13 Under Medicare at present, an individual or registered family is entitled to a benefit of 85% of the MBS scheduled fee for non-hospital medical and related services (except those covered by Private Health Insurance). Once the cumulative 'patient contributions' for the other 15% of the scheduled fees reaches $319.70 in a calendar year, the Medicare Benefit increases to 100% of the scheduled fee. However, this scheme does not cover any gap fees charged above the MBS schedule fee.

Pharmaceutical Benefits Scheme (PBS)

2.14 The cost of many prescription medicines is subsidised through the Government's Pharmaceutical Benefits Scheme. Patients make a fixed payment for each subsidised medicine of $23.10 (at 1 Jan 2003, indexed annually), or $3.70 for people with pensioner or health cards (at 1 January 2003, indexed annually). Those not on Concession cards pay a lower rate per script when their pharmaceutical expenses in a calendar year exceed $708.40, while Concession card holders pay nothing after their expenditures exceeds $192.40.

Tax offset[11]

2.15 This measure, the Net Medical Expenses Tax Offset, operates where an individual (and their family) has out of pocket medical expenses above $1,500 in a financial year. The taxpayer can reduce their tax payment by 20% of the excess expenditure over that threshold. This applies to all expenditure less any benefits received from Medicare or a Private Health Fund and covers a wider range of services including medical, dental, pharmaceutical, optical services, certain other therapies, aged care, carers, guide dogs and medical aids.

The need for a new safety net

2.16 A key objective of any health safety net is the minimisation of hardship resulting from incurring medical costs. This often involves identification of those in the community who are economically disadvantaged, and/or those who incur above-average medical expenses. In assessing the proposed new safety nets, it is important to establish the situation as it presently exists.. The rationale behind the current safety net system was explained to the Committee by Professor Deeble:

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11 Text on the Tax offset and the PBS safety net was kindly provided by Ms Julia Perry

> The underlying reasoning was that a combination of bulk billing by doctors and access to free public hospital care should and would ensure that people with unavoidably high medical use were not forced to pay out large amounts themselves … the primary concern was with high medical use, **not** high doctor fees. Benefits have therefore been limited to the full schedule fee, not the doctor's charge. If the schedule fee was 'fair and reasonable' covering higher charges was seen as unjustified and contradictory.[12]

2.17 While mechanisms devised and implemented at Medicare's inception may well have served their purpose, changes have taken place in the meantime which impact on their effectiveness in current times. The government suggests three principal factors have been at work.

2.18 First and most critical is the problem of rising out-of-pocket costs for those seeking medical care. The Committee's inquiry into *A Fairer Medicare* dealt with the issue in detail, but noted that while the existing safety net has been in place, out-of-pocket contributions by patients increased from an average of $3.95 (in 1984/85) to $19.72 (2002/03),[13] also adding that:

> … out-of-pocket costs are not simply a phenomena experienced in the GP context. Many patients, especially those with more complex needs (who tend also to be poorer) encounter these costs with ancillary and allied health services. The cumulative effect of out-of-pocket costs, which individually may seem small, could test the finances of even those not normally considered as socio-economically disadvantaged.[14]

2.19 The submission from the Department of Health and Ageing argued that while out-of-pocket expenses for GP services have increased over time, patient contributions for specialist, diagnostic and treatment services have increased by dramatically more. The Department's Submission indicates that between 1984-85 and 2002-03, average patient contributions for GP services increased by 65% in real terms, compared with a 310% real increase for non-GP services.[15]

2.20 Coupled with this there has been a steady and significant shift in services from the hospital to the out-of-hospital sectors, particularly with regard to diagnostic, specialist and other GP-referred services. For example, specialist attendances per

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12 Professor Deeble, Submission 60, p. 3

13 Department of Health and Ageing, *Medicare Statistics: 1984/85 to June quarter 2003,* Table A5

14 Senate Select Committee on Medicare, *Medicare – healthcare or welfare?,* p. 41

15 Department of Health and Ageing, Submission 54, p. 4

capita since 1984-85 have grown from .70 to 1.01 per annum in 2002-03, representing an increase from 11,124,158 to 20,095,345.[16] The first inquiry noted that:

> In addition to chronic-care management, other services provided outside the hospital setting have also increased in the last two decades, driven somewhat by technical innovation These services have been funded by a combination of patient and MBS contributions. They tend to be supplied by practitioners in private practice, who can set their own fees, and whose patients face an increased possibility of incurring gap charges. It should be noted that it is not simply GP services which are growing. Non-GP services are also contributing to out-of-pocket expenses.[17]

2.21 While it is certainly true that GP services account for the single biggest proportion of all MBS billed services,[18] trends like this are of critical importance in the discussion of safety nets, as they represent the most likely way many people will reach the relevant threshold. As in the first inquiry, the Committee identifies specialist fees as a particular area of concern, and sees their escalation as playing a central role in defining the need for new safety nets. The containment of specialist fees must be addressed as a matter of urgency. This is discussed further in chapter 3.

2.22 The added popularity and expense of out-of-hospital non-GP services augers particularly poorly for those with chronic conditions, or other maladies associated with ageing. While such people would frequently reach the relevant threshold quickly, entitling them to minimise (though not entirely expunge) further out-of-pocket expenses, assembly of the threshold amount in such a short period may prove very financially trying for many.

2.23 Second, and as outlined earlier, the existing net covers extends only as far as the 15% gap between the rebate and the Schedule Fee. Therefore, under the present safety net, patients have no insurance against charges which, in some cases, greatly exceed the Schedule Fee. This can lead to difficulties with out of pocket expenses.

2.24 Third, these cumulative out of pocket expenses have inevitable consequences for the accessibility and affordability of health care. In the first inquiry, the Committee concluded that:

> Access to effective, timely and affordable primary care is fundamental to Australia's continued health and prosperity. General practice plays a pivotal role in this, and must be accessible when and where it is needed, regardless [of] patients' economic or geographical situation[19]

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16 Department of Health and Ageing, *Medicare Statistics 1985-85 to June quarter 2003*, p. 51 and 68

17 Senate Select Committee on Medicare, *Medicare – healthcare or welfare?*, p. 48

18 Department of Health and Ageing, *Medicare Statistics 1985-85 to June quarter 2003,* p. 8

19 Senate Select Committee on Medicare, *Medicare – healthcare or welfare?*, p. 53

2.25 The implications for access posed by these cumulative expenses were not lost on a number of respondents.[20] UnitingCare had this to say:

> The consequences of having to pay up-front fees may mean that the socio-economically disadvantaged, who already have less access to bulk-billing, will not seek medical attention, or will attend a hospital accident and emergency service for free treatment, putting pressure on hospital accident and emergency departments.[21]

2.26 Mr Davies, of the Department of Health and Ageing, summarised that:

> [O]urs is an environment where individual practitioners are at liberty to set their own professional fees. Ours is also an environment where technological change means that more – and indeed more sophisticated – services can be delivered outside the public hospital setting. In such an environment the risk of significant cumulative out-of-pocket costs will always be present, if unpredictable, for the individual household. The current Medicare safety net can no longer offer the protection that people need. That is why the third component of Medicare Plus will see the introduction of a new and more robust safety net to protect and reassure all Australians.[22]

2.27 Implicit in Mr Davies' statement is that the schedule fee has become less relevant in recent years. Importantly, the proposal does not seek to solve the problem through making the schedule fee more relevant, but rather, seeks to add a new mechanism through which the effect of an 'irrelevant' schedule fee is softened. The Committee sees the marginalisation of the status of the schedule fee as a cornerstone of price setting as a major problem. This is elaborated on at the conclusion of this chapter.

Conclusion

2.28 It is clear to the Committee that, under existing arrangements, there is potential for out-of-pocket costs to mount up to levels which are unaffordable for many Australians. The interaction between the Medicare rebate and Schedule Fee and the reality of what many practitioners charge their patients, has eroded the effectiveness of the existing safety net resulting in reduced affordability and access to even some basic medical services.

2.29 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

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20 See, for example, National Council of the St. Vincent de Paul Society, Submission 58, p. 8; Doctors' Reform Society, Submission 16, p. 2; National Association of People Living with HIV/AIDS, Submission 44, pp. 5-8

21 UnitingCare, Submission 55, p. 4

22 Mr Davies, *Proof Committee Hansard*, 20 January 2004, p. 28

qualify for it. However, in considering the safety nets proposal, it is important to keep in mind that other options do exist, including those discussed later in this and the next chapters.

Effectiveness of the government's proposal

2.30 This section examines the degree to which the current proposal achieves its stated aims and provides a fair, robust and comprehensive health 'insurance policy' for all Australians. Concerns over the safety nets proposal focused on seven issues:

- it runs counter to the principle of universality that underpins Medicare;
- it will not adequately address financial hardship caused by medical costs;
- a range of health care costs will not be picked up by the safety nets;
- Health Care Cards are not an accurate measure of need;
- there are problems linking access to the lower $500 threshold to the Family Tax Benefit (A) status; and
- the uncapped safety nets will have an inflationary impact.

Safety nets in a universal Medicare

2.31 One of the key objections to the proposal from the outset was the lack of universality inherent in its design. By delineating between those eligible for a $500 threshold, as opposed to those eligible for $1,000, the concept of universal access is eroded; there fails to be a universal bar above which Australians are able to seek assistance. This represents a practical and philosophical direction of great concern to the Committee.

2.32 A comprehensive system which guarantees access regardless of income and circumstances, largely negating the need for safety net, was a very popular option.[23]

> Targeted safety nets, by their very nature, will always disadvantage some health care consumer, and require considerable bureaucratic resources and infrastructure in order to be maintained. By contrast, universal health insurance, and access to primary health care facilitated through the bulk billing of all service users, disadvantages no one, and has proven to be a highly cost effective and efficient health insurance system, and has been

23 See, for example, Geelong Medicare Action Group, Submission 46, p. 2; Catholic Health Australia, Submission 48, p. 2, 7 and 9; UnitingCare, Submission 55, p. 5; Queensland Government, Submission 59, p. 3; Victorian Council of Social Service, Submission 80, p. 3; National Rural Health Alliance, Submission 65, p. 5; Doctors' Reform Society, Submission 16, p. 2-3; NSW Retired Teachers Association, Submission 21, p. 1

> responsible for Australians enjoying one of the highest standards of health in the world.[24]

Effectiveness in preventing hardship

2.33 The Committee received evidence that, even for those for whom the safety net would cut in at $500, significant financial hardship could occur in reaching that threshold.[25] These include many on average or marginally below-average incomes who have moderate to severe medical requirements, but for whom earning an income is still possible. Thus, it is argued that the way is left open for poverty traps, particularly for single people and couples without children.[26]

2.34 A number of examples of 'perverse outcomes' were given, including the following:

- A self-funded retiree couple of pension age, earning up to $80,000 per annum is eligible for a health care card (and hence for the $500 safety net), but a working couple without children earning the same amount will only be eligible if their out-of-pocket costs exceed the higher $1000 threshold.
- A couple with three children under 18 years, earning up to $99,572, combined gross annual income, will benefit from the $500 threshold.
- An individual working full-time earning $35,000 per annum who has a chronic medical condition will enter the safety net only after $1,000 out-of-pocket costs, but a self-funded retiree of pension age earning up to $50,000 will qualify for the lower threshold.[27]

2.35 Mr McCarthy from the St Vincent de Paul Society put it very plainly:

> The ludicrous implication that low- and middle-income families have a spare $500, much less a spare $1,000, available for emergencies seems to show either a total disregard for the five million or so Australian in this deprived situation, or a total lack of understanding of the struggle that they have to make ends meet.[28]

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24 Geelong Medicare Action Group, Submission 46, p. 2

25 City of Darebin, Submission 42, p. 1; Geelong Medicare Action Group, Submission 46, p. 1-2; Victorian Medicare Action Group, Submission 27, p. 2; National Association of People Living with HIV/AIDS, Submission 44, p. 3-4

26 See, for example, National Council of the St Vincent de Paul Society, Submission 58, p. 7

27 Australian Greens, Submission 53, p. 2

28 Mr McCarthy, *Proof Committee Hansard*, Canberra, Monday 19 January 2004, p. 84

2.36 Catholic Health Australia agreed, arguing that the cashflow implications for many people, and even for many families eligible for the lower threshold, could be significant:

> In terms of the safety net, these people would be unlikely to see the value of spending $500 (or $1000) out of their pocket on health care costs before they begin to get a look at what a safety net might do for them. The fairness of the proposed system at this point becomes very questionable. The increasing copayment that these people will face each time they visit the doctor should be of critical concern. The cashflow implications for the family budget on low to middle incomes will be significant … [t]he potential impact on patients forgoing important treatments is obvious.[29]

2.37 UnitingCare take a similar approach:

> The Safety nets make health care less unaffordable rather than affordable. Up-front costs of $500 for concession card holders and Family Tax Benefit A recipients are not affordable, as the former exist on very limited incomes, which for some types of recipients, are beneath the poverty line.[30]

2.38 The Doctors Reform Society succinctly expressed a common feeling:

> Even for those [patients] who might reach the threshold, the proposal does nothing for them until they reach that threshold. Thus, if they are struggling with costs in January, or June, before they reach the threshold, they may simply delay their visit until desperate, or seek the cheaper alternative at the public hospital emergency department. The concept of a 'safety net' which cuts in after a certain threshold spending requires a capacity to budget for the year. Many of the patients who are struggling financially have trouble budgeting for a week, let alone a year, and will be little helped by this proposal.[31]

Health care services falling outside the net

2.39 The Public Hospitals Health and Medicare Alliance of Queensland made the point that not all services are eligible to be counted toward the threshold, and that even after the threshold is reached, many popular services are not covered by it. PHHAMAQ argued that:

> Safety nets are an inappropriate mechanism for protecting people from huge out-of-pocket expenses, because the safety nets do not recognise that people must choose health care treatments that work for them, and not because the treatment is one covered by the safety net … [i]t also fails to support those

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29 Catholic Health Australia, Submission 48, p. 2

30 UnitingCare, Submission 55, p. 4

31 Doctors Reform Society, Submission 16, p. 2

> people who have massive dental and other non-medical costs or those who do not find western medicine helpful … costs for psychologists, speech therapists, podiatrists and many wound care products and services are not covered. Australians are paying significant amounts on health services not covered by safety nets which makes the concept of a safety net threshold absurd.[32]

2.40 The Psychotherapy and Counselling Federation of Australia submitted that the lack of comprehensive coverage of mental services under the MBS Schedule, and therefore under the safety net, meant that there were:

> Gross inequalities in the current provision of counselling and psychotherapy in Australia, both for the practitioner and the patients. These anomalies have a significant impact on the delivery of mental health services in Australia.[33]

2.41 On the other hand, as the Department of Health and Ageing told the Committee, any item provided outside hospital which has a Medicare Benefits Schedule item number is counted toward the relevant threshold.[34] This includes items such as blood tests, psychiatry, X-rays, CT scans, tissue biopsy, radiotherapy and pap smears. While there would seem to be genuine problems with the coverage of the safety nets, these reflect the limits of the current MBS rather than flaws in the safety net.

Reliability of health care cards as indicators of need

2.42 Throughout the first inquiry, many respondents (particularly doctors) argued that Health Care and other Commonwealth concession cards were, at best, a crude indicator of need, and that as a result, practitioners were loathe to automatically offer bulk billing to all card holders.[35] This reticence to accept concession cards as being *prima facie* evidence of need was echoed in this inquiry.[36]

2.43 Darebin City Council, drawing on data from the 2001 census, argues that:

> … there is a mismatch between those individuals eligible for a health care card and those people reported in the census as earning very low incomes. There is a difference of 15,568 people or 15.2% of the Darebin population that do not receive benefits but are earning under $600 per week.[37]

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32 Public Hospitals Health and Medicare Alliance of Queensland, Submission 51, p. 2

33 Psychotherapy and Counselling Federation of Australia, Submission 71, p. 2

34 Department of Health and Ageing, Submission 54, p. 19

35 Senate Select Committee on Medicare, *Medicare – healthcare or welfare?* p. 67

36 Catholic Health Australia, Submission 48, p. 2

37 Darebin City Council, Submission 42, p. 2

2.44 Darebin Council goes on to argue that government policy in relation to determining need must look to actual income, and not simply those receiving government benefits.

2.45 Conversely, this inquiry also heard that concession card eligibility may sometimes be denied to those in real need.

2.46 One method of accessing a Health Care Card is through receipt of the *full rate* of the Family Tax Benefit (A). Professor McMillan pointed out that:

> [I]f a family dips below [the] maximum rate, their eligibility for the health care card goes, even though they are still eligible for some family tax benefit … [a]n aspect of that problem is that the formula for Family Tax Benefit (A) does not take into account—at least at the maximum rate—the number of children in the family.[38]

2.47 Another method of accessing concession cards is by meeting an income test. As noted above in Table 3, a single person with no children may only earn up to $17,472 before they cease to be eligible for a Health Care Card.[39] This is a very low income, and where a person earns slightly above it, and has no dependent children, the potential for hardship through the denial of concessional status is obvious.

2.48 The difficulties involved with accurately matching concession cards with those in need are explored at length in the original inquiry report.[40]

Linking the $500 safety net with Family Tax Benefit (A)

2.49 In a similar vein, the Committee heard evidence from a number of witnesses expressing concern at the potential difficulties in linking concessional safety net eligibility with receipt of Family Tax Benefit (A), or FTB(A). The objectives and operation of the Family Tax Benefit were described by the Department of Family and Community Affairs as follows:

> The purpose of FTB part A is to help families with the cost of raising children. It is a targeted payment and assessed on the family's combined adjusted taxable income. Families have the choice of receiving FTB fortnightly as a direct payment from the Family Assistance Office or as reduced tax withholdings or an end of year lump sum through the tax system. Over 1.8 million families with over 3.4 million children are currently receiving the payment on a fortnightly basis. Around 95 per cent of FTB part A recipients receive payments on a fortnightly basis through

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38 Professor McMillan, *Proof Committee Hansard,* Canberra, January 20 2004, p. 6

39 Department of Health and Ageing, Submission 54, p. 13. In the case of a pensioner, the threshold is $32,929.

40 Senate Select Committee on Medicare, *Medicare – healthcare or welfare?*, pp. 67-73

> Centrelink and there are more families receiving it the through the tax system.[41]

2.50 FTB(A) can be claimed as a regular payment, received through Centrelink after income estimations falling within prescribed limits have been made by the claimant. At the end of the financial year, an income reconciliation is undertaken, and where income was underestimated, a debt may be raised against the claimant.

2.51 Alternatively, a claim may be lodged at the end of a financial year, when a claimant has conclusively ascertained that they fall within the relevant limit, and a lump sum is paid as part of the tax return. As such, FTB(A) may be claimed based on either prospective or actual income, and the decision as to which method to use rests with the claimant.

2.52 One area of criticism centred on the notion that families (as defined by the *Health Insurance Act*) included only those with dependent children, implicitly excluding single people and couples without children from concessional status, unless they hold a concession card.

2.53 Many respondents objected to what they saw as using children as an indicator of need. Ms Bolton from the National Welfare Rights Network put her concern this way:

> We are … concerned about the use of the FTB threshold in terms of the inequities that [it] may cause … [f]or example, a family with one child on an income of $83,000 per year will be eligible for the safety net of $500. However, an individual on an income of $20,000 per year will not be [because] their income is too high for them to be entitled to a concession card.[42]

2.54 Respondents also pointed out the difficulties currently experienced by families seeking to claim FTB, and expressed concern at the prospect of eligibility for the MBS safety net being 'caught up' in a system which can cause some families tremendous confusion and frustration.[43] As the Commonwealth Ombudsman, Professor McMillan put it:

> If there are any problems in calculating a person's entitlement to Family Tax Benefit (A), it can flow through to their eligibility for a health card and their ability to access concessional health benefits.[44]

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41 Mr Kalisch, *Proof Committee Hansard*, Canberra, 20 January 2004, p. 3

42 Ms Bolton, *Proof Committee Hansard*, Canberra, 20 January 2004, p. 5

43 See, for example, Ms Bolton, *Proof Committee Hansard*, Canberra, 20 January 2004, p. 5; Professor McMillan, *Proof Committee Hansard*, Canberra, 20 January 2004, p. 6

44 Professor McMillan, *Proof Committee Hansard*, Canberra, January 20 2004, p. 6

2.55 Witnesses recalled that the cause of most difficulty was in the area of income estimation, and the burden of debt sometimes created through inaccurate forecasting by claimants.[45] The Commonwealth Ombudsman produced a report on the impact of FTB(A) largely as a result of complaints made to his Office relating to the difficulties in estimating income.[46] Professor McMillan effectively conveyed the scale of the problem as follows:

> [The Ombudsman's Report] arose from 2,000 complaints we received early in the period of the new family tax assistance scheme. The report drew attention in particular to the problems that have arisen from the inherent requirement that people estimate the income they will receive in the following year and to make some educated guess at that stage about their eligibility for family tax assistance and the manner in which it will be paid. Our experience is that very few families get the estimate correct. Indeed, the report drew attention to the fact that about 50,000 people under-estimated their income, with a total tax debt of around $400 million. By contrast, there are about 380,000 who were entitled to a small tax refund at the end of the year. So the inherent requirement of estimation is part of the problem.[47]

2.56 One way claimants have commonly avoided this predicament is by choosing to claim at the end of the financial year, when they know their actual income. However, this has its own problems, as pointed out by Professor McMillan:

> The Health Care Card is a prospective entitlement. If a family, for example, overestimates their income, they can deny themselves the advantages that attach to the health care card.[48]

2.57 Evidence also suggested that some families do not bother to lodge an application at all. The National Tax and Accountants' Association pointed out that the TaxPack 2003 devoted almost twelve pages to discussing taxpayer entitlement to FTB and related issues, and predicted that applicants attempting to use their TaxPack to prepare their 2003 individual returns would find it 'almost impossible' to correctly calculate their entitlement.[49] The Association went on to say that:

> These taxpayers may therefore choose to ignore their claim because they are concerned about making errors … [s]ome members have indicated that their

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45 See, for example, Ms Bolton, *Proof Committee Hansard*, Canberra, 20 January 2004, p. 4; Professor McMillan, *Proof Committee Hansard*, Canberra, 20 January 2004, p. 6

46 *Own Motion Investigation into Family Assistance administration and impacts on Family Assistance Office customers*, February 2003, available at www.ombudman.gov.au/publications_information/special_reports

47 Professor McMillan, *Proof Committee Hansard*, Canberra, 20 January 2004, p. 6

48 Professor McMillan, *Proof Committee Hansard*, Canberra, 20 January 2004, p. 7

49 National Tax and Accountants' Association, Submission 97, p. 1, 2

> clients have decided not to make a claim for FTB to reduce the cost of preparing their individual tax return. The client was concerned that the time and cost needed to correctly claim the FTB may, in some cases, have exceeded the actual claim.[50]

2.58 An added factor for families in making this decision is the fact that, where claimants lodge an application with their tax return and it is retrospectively determined that FTB(A) was payable based on the income received during the previous year, but at a rate less than the maximum, a Health Care Card will not be issued. Whereas, where a family underestimates their income, receives FTB(A) through Centrelink at the full rate (and is therefore in receipt of a Health Care Card), but at reconciliation is determined not to have been so entitled, there is no mechanism to 'retrieve' the benefit enjoyed by the family through the Card. Hence, as Professor McMillan observed:

> In summary, there is an advantage in overestimating and there is an advantage in underestimating and families are faced with that contradictory pressure.[51]

2.59 However, Professor McMillan summed up the attitude of many with his illustration of the finely tipped financial scale which many people live on:

> … [I]t is the human dimension that our office sees from so many complaints. The human dimension is that we are talking about a very finely tuned exercise for families on low income levels. To take the simple figures, the difference between a $31,500 and $32,000 family income will determine your eligibility for the Family Tax Benefit. For families at that level, as we see constantly in complaints, repayment of a small debt at the end of the year can be an exercise fraught with difficulty. So if they overestimate even by $500 or $1,000 to avoid a small debt they can deny themselves the Health Care Card because of that sudden death – that fixed cut-off at the maximum rate … [a]gain, the human dimension at that level of income is that the single visit to the doctor or the single prescription for pharmaceuticals can be an exercise fraught with financial difficulty if the family does not have that entitlement.[52]

Effectiveness of the safety net in rural areas

2.60 The National Rural Health Alliance considered that the proposals would have a 'limited value for Australians living in rural and remote areas' although they did not expand on why they held this view. However, some insight can be gleaned from their suggestion that the situation could be improved through the adoption of a lower

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50 National Tax and Accountants' Association, Submission 97, p. 2

51 Professor McMillan, *Proof Committee Hansard*, Canberra, 20 January 2004, p. 7

52 Professor McMillan, *Proof Committee Hansard*, Canberra, Tuesday 21 January 2004, p. 21

threshold than that contained in the proposal, and the reduction of the threshold for single people by 50%.[53]

The safety net and inflationary impacts

2.61 A number of submissions highlighted the possibility of medical practitioners increasing their charges when they know the patient is close to or has reached the threshold for the relevant safety net. Because the proposal entails coverage of 80% of all out-of-pocket, out-of-hospital expenses once the threshold has been reached, many argue that doctors, particularly specialists and other practitioners who regularly charge far in excess of the schedule fee, will elevate their charges in the knowledge that the patient will only be responsible for 20% of any excess.[54]

2.62 PHHAMAQ went on to argue that:

> There is no open and transparent mechanism for establishing and reviewing what doctors charge. This is a significant deficiency in terms of accountability for ensuring taxpayer funding is being appropriately spent. [There needs to be] a mechanism to establish a fair system of remuneration for medical officers that is regularly reviewed … [and] in our view it is appropriate to link such an examination of remuneration to negotiations on indemnity issues.[55]

2.63 The Department of Health disagrees, arguing that:

> Doctors will generally not be aware when a patient or family reaches the safety net threshold. Costs that contribute to the threshold will come from a diverse range of services and often from several family members. If a Doctor does become aware that a patient has reached the threshold, they will also be taking into account that the patient is continuing to pay 20 percent of the fee beyond the level of the rebate.[56]

2.64 Indeed, the Department argues that setting the safety net to 80% augers well for the containment of prices:

> …[T]he Government covers a very significant portion of out-of-pocket costs, across a wide range of services and for costs over and above the schedule fee. Retaining a small contribution reduces the likelihood of over-

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53 National Rural Health Alliance, Submission 65, p. 2

54 Australian Council of Social Service, Submission 45, p. 3; Australian Consumers' Association, Submission 36, p. 9; Australian Healthcare Association, Submission 56, p. 5; Doctors Reform Society, Submission 16, p. 2; Tasmanian Medicare Action Group, Submission 22, p. 3

55 Public Hospitals Health and Medicare Alliance of Queensland, Submission 51, p. 2

56 Department of Health and Ageing, Submission 54, p. 20

> servicing by the doctor for unnecessary use by the patient, and avoids a potential 'moral hazard' for doctor charging.[57]

2.65 A more general, though similar, argument was made that the mere fact that uncapped safety nets exist would be a sufficient signal to doctors that a rise in fees could now be more easily absorbed by patients, and that outright financial hardship as a result of high fees was less of a possibility.[58] To quote Professor Deeble:

> If doctors and patients both believed that nobody was going to be really hurt, because the safety net was going to look after them, then there was no reason why the doctors should not just gradually edge fees up. That is the experience in the in-hospital area, where gap insurance and rising fees have gone together.[59]

2.66 What, then, would be the inflationary effect of lowering the safety net threshold as argued by those who feel it imposes too big an impost at current proposed levels?[60] Lower thresholds would allow more people into the net at any given time, and would mean that the uncapped provisions applied for a greater number of services performed. If it is accepted that the current proposal contains the potential to inflate medical costs, through a perception on the part of doctors that an uncapped safety net makes financial suffering much less likely, then it could be argued that lower thresholds would exacerbate the situation.

Administrative feasibility and patient ease-of-use

2.67 One of the key aspects of the proposed safety net arrangement is the linkage between eligibility for Family Tax Benefit (A) and the $500 threshold. Catholic Health Australia predicted that:

> The infrastructure and administrative processes necessary to implement the measures will be costly [and that the proposal] will rely on a sophisticated link between the Australian Taxation Office, Centrelink and the Health Insurance Commission in terms of exchanging information and processing appropriate and accurate payments to Australian individuals and families.[61]

2.68 The technical feasibility of establishing such a link between relevant government agencies was identified as an issue, but the Committee received very little evidence on this point, and is therefore unable to express a view.

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57 Department of Health and Ageing, Submission 54, p. 20

58 See, for example, Professor Deeble, Submission 60, p. 6

59 Professor Deeble, *Proof Committee Hansard*, Canberra, 19 January 2004, p. 25

60 See, for example, UnitingCare, Submission 55, p. 10

61 Catholic Health Australia, Submission 48, p. 8

2.69 The other foreseeable difficulty, from the perspective of the patient, is the retention of the existing safety net alongside its proposed stable mate. The different mechanisms operate on radically different premises. As the government points out, each product potentially affects different groups, at different threshold levels, and offers different levels of benefit.[62]

2.70 However, the flip side is that the system will be very difficult to explain to the public, especially where there is some confusion about the relationship between the rebate and the schedule fee. In addition, there will certainly be widespread confusion about which safety net threshold different out-of-pocket costs are contributing toward (in some cases, out-of-pocket costs count toward both thresholds) and difficulty with the concept that, depending on whether a patient is typically billed for much more than the schedule fee, different thresholds will be reached at different times.

Record keeping

2.71 A number of submissions anticipated a need for meticulous record keeping to effectively access safety nets.[63] UnitingCare expressed a typical concern:

> [P]atients will have to be meticulous in keeping receipts and monitoring their own spending. This will be impossible for people who lack literacy or numeracy and difficult for transient people such as the homeless, and for persons with intellectual disabilities.[64]

2.72 However, the Department of Health and Ageing submitted that there would be minimal difficulty for families and individuals, and that the benefits would be calculated automatically and paid to the individual at the point of claiming.[65]

Privacy implications

2.73 With respect to data being transmitted between practitioners and the HIC, via HIC Online, the Department of Health and Ageing's Submission claims a high level of security, through the use of public key infrastructure encryption system.[66] No further relevant evidence was received by the Committee, and so comprehensive analysis of risks to privacy associated with the proposal is unavailable.

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62 Department of Health and Ageing, Submission 54, p. 17-18

63 See, for example, Geelong Medicare Action Group, Submission 46, p. 2

64 UnitingCare, Submission 55, p. 5

65 Department of Health and Ageing, Submission 54, p. 18; see also Mr Davies, *Proof Committee Hansard*, Canberra, 20 January 2004, p. 30

66 Department of Health and Ageing, Submission 54, p. 16

Conclusions

2.74 The safety net proposal before the Senate contains philosophical and practical problems of sufficient number and gravity to justify its rejection. At a fundamental level, the separation of the proposed safety net into two thresholds creates classes of winners and losers in the proposed health system that offends the principle of universality lying at the heart of Medicare. The Committee rejected the previous safety net proposal on this basis, and the concern remains.[67]

2.75 As this chapter also shows, both thresholds are too high to deliver meaningful benefits to any more than a tiny handful of Australians each year. While the proposals would be of undoubted benefit to 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 be effective in tackling the lower but still significant costs of accessing basic health care, and are instead focused on covering high cost specialist fees. While this is also important, it is not an adequate policy response.

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

2.77 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 each poor measures of need. In particular, too many working people on low incomes and chronically ill individuals have a struggle meeting health costs, but do not qualify for concession cards.

2.78 Another inherent element of 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 patently unfair, this deepens the poverty trap for many more Australians.

2.79 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 angst 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 a Health Care Card, causing added pressure to families often already flirting with financial catastrophe.

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67 Senate Select Committee on Medicare, *Medicare: healthcare or welfare?*, p. 92

2.80 In relation to the feared 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.

2.81 However the more general 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.

2.82 The Committee has considered very carefully whether these flaws are sufficiently serious to justify not supporting the proposals. The difficulty of this decision was recognised by many witnesses during discussions with the Committee, but the 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[68] and the Australian Council of Social Services[69] backed by, among others, Professor Deeble,[70] Mr McAuley[71] and Ms Mohle.[72] 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.[73]

2.83 On balance therefore, the Committee **concludes** that the proposed safety nets should be rejected in their current form.

2.84 In the Committee's view, the most viable alternative, which side-steps many of these problems, is to minimise the importance of safety nets through the provision of health care that is affordable in the first place. After all, 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.[74]

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68 Mr Goddard, *Proof Committee Hansard, Canberra*, 19 January 2004, p. 38

69 Mr Harvey, *Proof Committee Hansard, Canberra*, 19 January 2004, p. 38

70 Professor Deeble, *Proof Committee Hansard*, Canberra, 19 January 2004, p. 14

71 Mr McAuley, *Proof Committee Hansard, Canberra*, 19 January 2004, p. 13

72 Ms Mohle, *Proof Committee Hansard, Canberra*, 19 January 2004, p. 37

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

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

2.85 This can only be achieved through the restoration of a comprehensive health care system, primarily achieved through a commitment to bulk billing and MBS fee adherence as a sound mechanism to deliver access and affordability.

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.

Alternatives

2.86 The Committee noted a number of alternative proposals, which would modify the operation of the safety net:

- changing the proposed system of thresholds;
- amalgamating the existing and proposed safety nets into a single integrated safety net system; and
- implementing a capped safety net.

Modifying the thresholds

2.87 Some submissions have proposed changes to the thresholds of the proposed safety net system that might mitigate some of the problems detailed above.

2.88 The first possibility is to remove the dual thresholds of $500 and $1000, and replace them with a single entitlement threshold. This would address the problems associated with a differentiated entitlement by ensuring equal access to the safety net and avoiding the arbitrary outcomes as people fall across one or other side of the threshold.

2.89 The second is to lower the thresholds at which the safety net applies, enabling entry at a lower level of health expenditure. As the Departmental representatives told the Committee during the first inquiry, the $500 and $1000 threshold levels are relatively arbitrary: if they are set lower, more people receive the benefits and the program costs more. If they are set higher, the reverse applies.[75]

2.90 As the discussion earlier in the chapter demonstrated, while all Australians are eligible for one or other of the safety nets, very few will actually benefit given the focus of the proposal on meeting high cost specialist fees rather than mounting expenses over time from visits to GPs. A lower threshold would be more likely to see these types of costs picked up by the safety net, with important benefits for access to GP level health care.

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75 Senate Select Committee on Medicare, *Medicare: Healthcare or Welfare?*, p. 84

2.91 Finally, the method of calculating the thresholds could be modified to individual circumstances. The Australian Healthcare Association suggested a progressive safety net based on individual or family income, with thresholds for individuals falling marginally below those for families. Under their proposal, the safety net threshold would increase by $200-$300 for every $20,000 earned, starting at $300 for individuals earning below $20,000 and holders of concession cards.[76]

2.92 The AHA also suggest a 'rolling' 12 month period for safety net qualification. It is argued that people may be excluded from the safety net unfairly because their costs are split between calendar years.[77]

A single safety net

2.93 As discussed earlier in the chapter, the outcome of the government proposal would be a system comprising five different safety net mechanisms. The complexity and potential for confusion inherent in this proposal is self evident.

2.94 An obvious solution is to instead reduce the number of safety nets. This could be done in several ways. One is to remove the existing safety net and replace it with a single new mechanism, broader in coverage with a single threshold.

2.95 Instead of – or as well as – this, the PBS and MBS safety nets could be amalgamated into a more integrated system.[78] Among respondents, too, the proposal was popular.[79]

2.96 The Department responded that PBS and MBS systems were administered in such different ways that amalgamation was impractical. In particular, different repositories for patient data meant that total PBS and MBS patient out-of-pocket costs could not be readily calculated.[80]

A capped safety net

2.97 Professor Deeble suggested the modification of the existing system rather than the addition of a new one. As discussed earlier in the chapter, he argues that provision of an uncapped benefit is a recipe for escalating health care costs, and that discarding

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76 Australian Healthcare Association, Submission 56, p. 5

77 Australian Healthcare Association, Submission 56, p. 6

78 See, for example, Osborne Division of General Practice, Submission 24, p. 1

79 See, for example, Australian Medical Association, Submission 9, p. 2; Royal Australian College of General Practitioners, Submission 67, p. 7; Australian Council of Social Service, Submission 45, p. 4

80 Department of Health and Ageing, Submission 54, p. 21

the schedule fee as a benchmark for defining benefit is fraught with danger.[81] As Professor Deeble submits:

> I have no objection to compensating those people whose high out-of-pocket expenses arise only from high medical care use. However, it is a different matter if most of the compensation is for over-schedule doctor charges. That is really an admission of either the government's unwillingness to raise benefits, or its inability to control, or otherwise limit, medical fees, particularly for specialists … [b]ut if both patients and doctors believe the message that safety nets will stop anyone from being really hurt, what would prevent fees from rising?[82]

2.98 Professor Deeble suggests the retention of a capped benefit, to no more than the schedule fee. However, Professor Deeble's model would see the rate of contribution toward attaining the threshold accelerated to about 130% of the schedule fee. Thus, more people would reach the threshold, and would do so faster, but once in receipt of benefits they would still receive only 100% of the schedule fee.

2.99 Professor Deeble argues that this model would bring more people within the ambit of the safety net, but would still send an effective price signal to practitioners. In setting the threshold, there would be no distinction set between individuals and groups, such as families. It is further argued that:

> [That benefit] would be a simple and easy figure to calculate and it would prevent a government from simply letting its own benefits stagnate while indirectly raising co-payments for patients. There would still be a compromise with Medicare principles but one with the least costly and distorting effects.[83]

2.100 However, the proposal has two distinct weaknesses. In setting the rate of contribution toward attainment of the threshold at 130% of the schedule fee, it undermines the perceived accuracy of the fee as a benchmark for costs. Somewhat paradoxically, it then uses the schedule fee as a basis for paying benefits once the threshold is reached. This raises the potential for large out of pocket costs to patients, as is being seen under current arrangements.

Conclusion

2.101 Recommendation 2.1 rejected the proposed safety nets in their current form. The question remains whether the suggested alternatives, discussed above, would rectify the identified problems with the proposals, and more importantly, would represent a move toward better health outcomes for Australians.

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81 Professor Deeble, Submission 60, p. 6

82 Professor Deeble, Submission 60, p. 6

83 Professor Deeble, Submission 60, p. 6

2.102 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.

2.103 Fundamentally though, the creation of the proposed new safety net is not a long term solution. It both increases the level of complexity of the system and moves away from a commitment to bulk billing as the foundation of access and affordability.

2.104 While there is merit in taking measures to simplify the overall safety net system, the Committee does not support any replacement of the existing safety net with the proposed uncapped versions. There were sound policy reasons behind the design of the existing safety net, which remain valid today – in particular, the avoidance of inflationary pressures.

2.105 However, there is much potential benefit in 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 health expenditure. While acknowledging the practical and technical difficulties that may be involved, the Committee encourages the development of a mechanism to implement the proposal.

Recommendation 2.2

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

2.106 Professor Deeble's proposal to amend the existing MBS safety net contains some positive elements, particularly the retention of the MBS Schedule Fee as a key benchmark for setting prices. However, many of the weaknesses exhibited currently in the system would replicate themselves in the amended version. Most seriously, the change would not address the potential for large out of pocket costs, particularly for those incurring high specialist and diagnostic costs. In addition, it could undermine the benchmarking qualities of the schedule fee, which in Professor Deeble's own submission are critical. The Committee therefore rejects the proposal.

2.107 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 commitment to bulk billing and MBS fee adherence. To better our nation's health outcomes, we need GPs and specialists to embrace bulk billing as more of a norm, and less of an exception. The success of such an objective hinges partly on restoring the underlying integrity of the MBS itself, and providing rebates which positively reinforce the message that bulk billing is a critical cornerstone of access, and hence of good health, in Australia. These issues are addressed in the next chapter.