The Senate

Select Committee on Medicare
Second Report

Medicare Plus: the future for Medicare?

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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:
>
> - 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.

Chapter 1

Introduction

Background to the Inquiry

1.1 On 25 November 2003, the Senate resolved to reappoint the Select Committee on Medicare (appointed by resolution of the Senate on 15 May 2003), with the same powers and membership as previously agreed, to inquire and report into the following matters, with a reporting date of 11 February 2004:

a) the Government's proposed amendments to the Health Legislation Amendment (Medicare and Private Health Insurance) Bill 2003,

b) the Government's proposed increase to the Medicare rebate for concession cardholders and children under 16 years of age, and

c) the Government's proposed workforce measures including the recruitment of overseas doctors.

1.2 This inquiry follows the first inquiry which was announced on 15 May 2003 into the government's '*A Fairer Medicare – Better Access, More Affordable'* package, which had been released as part of the May 2003 Budget measures. On 19 June 2003, the Senate also referred to the Select Committee the Health Legislation Amendment (Medicare and Private Health Insurance) Bill 2003 which was the legislative enactment of the budget announcements.

1.3 The Select Committee tabled its response to its first terms of reference on 30 October 2003.

1.4 The Health Legislation Amendment (Medicare) Bill 2003 was introduced into the House of Representatives on 4 December 2003.

Conduct of the Inquiry

1.5 The Committee wrote to all individuals and organisations, including all State and Territory governments, who lodged submissions with the first inquiry, as well as advertising in the *The Australian* newspaper on 3 December 2003. The initial closing date for submissions was 19 December.

1.6 In response, the Committee received ninety-eight submissions. A list of all submissions and other documents authorised for publication that were received during the inquiry is at Appendix 1.

1.7 The Committee held a single public hearing in Canberra on 19 and 20 January 2004. A full listing of the Committee's public hearings, and the witnesses who appeared, is at Appendix 2. Transcripts of the public hearings and roundtable

discussion may be accessed through the Internet at
http://www.aph.gov.au/hansard/index.htm

Structure of the report

1.8 The report is structured to reflect the specific terms of reference (b)(i-iii): thus the three chapters that follow examine the proposed new safety nets; billing arrangements and workforce measures respectively. Chapter 5 then addresses a number of other matters, including the health information technology and aged care proposals.

Assistance with the Inquiry

1.9 In the course of the Inquiry, the Committee received a large number of submissions from a range of organisations and private individuals, together with a wealth of supporting documents, reports, and other references. Others gave freely of their time in appearing before the Committee at its public hearings, and in many cases, undertook additional work to provide follow up information to the Committee in response to questions raised during the discussions.

1.10 The Committee would like to record its appreciation to all of these people for the time taken in preparing their evidence to the Inquiry, all of which contributed greatly to the Committee's consideration of these complex issues.

1.11 Finally, the Committee thanks the officers of the Secretariat team who administered the Inquiry, and assisted with the research and drafting of the report.

Medicare Plus - Overview

1.12 Following the release of the report of the Select Committee on Medicare on 30 October 2003, the Government announced a revised Medicare package entitled Medicare Plus. Under the new proposal, about $2.4 billion (or $1.5 billion more than in the Fairer Medicare package) will be allocated to Medicare up to 2007. The new package picks up a number of issues and recommendations raised by the Committee – both in the majority and Liberal Senators reports. A key distinguishing characteristic between Medicare Plus and *A Fairer Medicare* is that there is no requirement for practitioners to 'sign up' to the package.[1]

Changes to the 'safety net'

1.13 The Government will not proceed with the dual safety net proposal contained in *A Fairer Medicare*, which included a private health insurance 'gap' product. Instead, it has expanded the MBS concession safety net as follows:

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1 With the exception of direct rebate crediting services, for which doctors must subscribe to HIC Online.

- All concession card holders and families in receipt of Family Tax Benefit (A) will be eligible for an 80% rebate of all out-of-hospital out-of-pocket expenses in excess of $500 in each calendar year. According to the Department of Health, 80% of families will be eligible for the lower threshold.

- 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.[2]

- 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.

- The current MBS safety net will be retained.

- The proposed changes to the safety net arrangements are the only part of the Medicare Plus package that require legislative change, and are contained in the Health Legislation Amendment (Medicare) Bill 2003, which was introduced in the House of Representatives on 4 December 2003.

Rebate payments

1.14 The Government has decided not to proceed with geographically-based bulk billing bonuses. Instead, it proposes to provide an increase of $5 in the MBS rebate where concession card holders and children under 16 years are bulk billed. According to the Department of Health, around 7 million Australians are covered by the three categories of concession card (comprising Pensioner Concession Cards, Health Care Cards and Commonwealth Seniors Health Cards).

1.15 The Government also proposes not to proceed with allowing patients to pay only the copayment at the point of service. Instead, MBS claims can be lodged electronically at the point of service, with the payment made directly to patients' accounts within about two working days. Unlike the original proposal, therefore, where a patient is privately billed, they must still pay the full amount up-front.[3]

1.16 In order to provide this service, practitioners must participate in HIC Online. Under Medicare Plus, the Government now offers a grant to all medical practices to assist in accessing the HIC Online. This grant amounts to $750 for metropolitan practices and $1,000 for rural, regional and remote practices. Although the system can

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2 For full details of this policy, see: www.ato.gov.au/individuals

3 Assuming the practitioner does not offer a 'pay doctor cheque' option, which will still be catered for under the revised package but is usually not offered by practitioners.

operate on normal 'dial-up' connections, $9.2 million has been allocated to assist practices establish broadband access.

Workforce proposals

1.17 Medicare Plus proposes:

- Funding an additional 1500 full time equivalent doctors and 1600 full time equivalent nurses in the period 2003 – 2007.
- A new Medicare Item Number to provide a rebate of $8.50 to practice nurses undertaking immunisation and wound management. This will be in addition to a grant of $8,000 per Full Time Equivalent (FTE) GP in a practice to assist in employing practice nurses in urban areas of workforce shortage.[4]
- Introduction of short term placements for trainee medical practitioners in outer metropolitan, regional and rural/remote areas in an attempt to address the supply shortage.
- Incentives for Non-Vocationally Registered (NVR) doctors to practice in areas of medical shortage for a period of five years.
- Increases in the number of Overseas-Trained Doctors (OTDs), with a specific focus on areas of workforce need.
- Measures, as yet unspecified, to encourage the continued practice of doctors in areas of workforce need, and to bring doctors who have left the system back into it.
- Various measures aimed at addressing the shortage of medical services in the aged community.[5]

1.18 The bonded medical school places remain, but Medicare Plus will enable students willing to undertake postgraduate vocational training in rural areas to attribute the period spent (up to three years) against their bond term. Otherwise, extra under- and post-graduate training places for GPs, as well as for nurses and allied health workers, remain from the original package.

Aged Care

1.19 The Government proposes to introduce a new Medicare Item Number, worth about $140 million, covering health assessments for residents of aged care facilities.

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4 Practice nurse incentives will also be available to practices that participate in the PIP, and which are located in these urban areas of workforce shortage

5 See 'Aged Care'.

1.20 It also proposes adding to the number of GPs providing medical services for the aged, and has signalled extra funding for out-of-hours care for the elderly. This would involve a payment of up to $8,000 per GP (over and above those payments received through Medicare) to form part of a panel of practitioners on hand to deal with emergencies or after-hours services in aged care facilities. The initiative would also include funding Divisions of General Practice to support the development of these groups.

Measures retained from 'A Fairer Medicare'

1.21 Measures retained from the original package include:

- additional utilisation of HIC Online, but with different methodology for processing rebates;
- additional use of overseas-trained doctors; and
- additional under- and post-graduate medical school positions, including bonded places.

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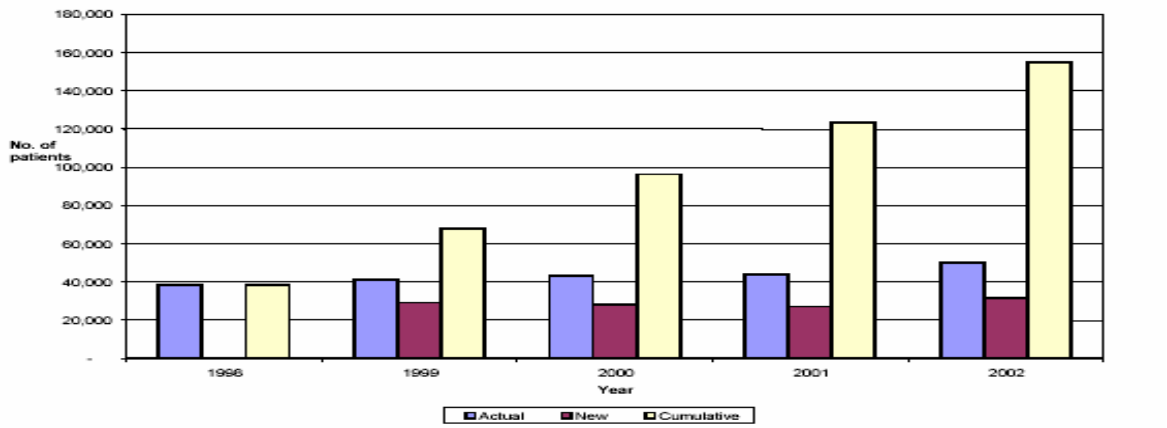
3 Family Tax Benefit (A) is available to families with children under 18 years whose adjusted income is below $85,702 a year with one child, $92,637 with two children, and $99,572 with three children. Full details are available at www.ato.gov.au/individuals

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-

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.

Chapter 3

Billing arrangements

Introduction

3.1 The terms of reference require the Committee to:

> inquire into and report on the Government's 'Medicare Plus' package including, but not limited to:
>
> (ii) the Government's proposed increase to the Medicare rebate for concessional cardholders and children under 16 years of age.

3.2 Under the Medicare Plus package, the Government proposes to provide an increase of $5 in the MBS rebate[1] where concession cardholders and children under 16 years are bulk billed. This additional payment will also be indexed in the same manner as other MBS items.[2]

3.3 According to the Department of Health, around 7 million Australians are covered by the three categories of concession card (comprising Pensioner Concession Cards, Health Care Cards and Commonwealth Seniors Health Cards). In contrast to the earlier '*A Fairer Medicare*' package, Medicare Plus does not proceed with either the geographically-based bulk billing bonuses or the system that would have enabled patients to pay only the gap payment at the point of service.

3.4 The aim of the measure is, according to the Department of Health and Ageing: 'to make it easier for GPs to bulk bill patients in financial need and children.'[3]

Reactions to the proposed billing arrangements

3.5 Reactions to this proposal are mixed, with submissions to the inquiry raising four general issues in relation to the proposal:

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1 The $5 increase applies to all services provided out of hospital that have an MBS number, including GP consultations, pathology and diagnostic imaging services. The $5 increase will also apply to services provided by a practice nurse using either of the two new MBS items for wound management and immunisation. Both vocationally registered and non-vocationally registered doctors will be eligible to claim the extra $5 on top of their respective rebate amounts.

2 Using Treasury's WCI5 (Wage Cost Index). Mr Davies, *Proof Committee Hansard*, 20 January 2004, p. 68

3 DHA, Submission 54, p. 10

- Whether the $5 incentive payment to targeted groups is consistent with the principle of a universal Medicare system.
- The equity of targeting concession cardholders and children under 16 years of age as categories of need.
- Whether the additional targeted payment will rectify existing problems in bulk-billing.
- A range of alternatives.

Universality, bulk-billing and the Medicare system

3.6 For many, a key philosophical objection is that the proposals constitute a step away from universality. The essence of this argument is that creating incentives to bulk bill certain groups, and – by implication – not others, Medicare no longer provides a universal benefit to everyone, irrespective of financial means. This point was expressed by many submissions. The Australian Council of Social Services (ACOSS) submission argued that:

> The objection to the proposal lies with the continuing attempt to divide patients into two groups – those who are expected to make a co-payment and those who are expected to get a 'free' service.
>
> This approach undermines both the concept of a universal health care system and the practice of a fair approach to meeting the costs of illness based on need.[4]

3.7 Catholic Health Australia agreed:

> Only concession card holders and young children are the targets for bulkbilling. In other words the Government is content that nearly half of all GP patients can hold little hope of being bulkbilled.[5]

3.8 The National Rural Health Alliance put a similar argument:

> Universality is the keystone of Medicare. In essence universality means that everyone in Australia contributes on the same basis to Medicare and its provisions apply equally to everyone. Achieving the other principles of access, equity, efficiency and simplicity is made possible through maintaining universality.
>
> Once universality is removed the other principles are immediately threatened. Access for everyone to affordable services becomes problematic when policy selects some groups for special arrangements, leaving other

4 ACOSS, Submission 45, p. 1

5 Catholic Health Australia, Submission 48, p. 1

> groups in similar or worse circumstances on the wrong side of the line. New poverty traps are created. Equity questions come to dominate, with some groups inevitably feeling disadvantaged. Efficiency is reduced and complexity increased. Administrative costs rise and uncertainty about entitlements causes extra worries at times when people need access to health services.[6]

3.9 UnitingCare, although finding the proposal superficially appealing, concluded that the policy amounts to:

> a deliberate attempt to undermine the general provision of bulk-billing. To undermine access to bulk-billing, by making it less attractive to doctors to bulk-bill some patients than others undermines Medicare as a universal system of health insurance.[7]

3.10 Mr Goddard, the Health Policy spokesperson of the Australian Consumers' Association concluded that if the targeted $5 incentive payment is accepted:

> We are giving up the universality of Medicare. That is what universality is. It is not about 100 per cent bulk-billing; it is about the promise that when people go to a doctor they will be treated equally based on what they clinically need rather than on what their income is. And this seems to us to be a strike against that.[8]

3.11 Two further issues are also relevant to the consideration of the concept of universality in Medicare: the role of community support through participation; and the importance of bulk billing to universality.

Universality, participation and community support

3.12 A view put by some witnesses and submissions relates to the practical importance of a system delivering undifferentiated, identical benefits to everyone. Mr McAuley, an academic from the University of Canberra explained that:

> We tend to forget the difference between welfare benefits and welfare intention. Medicare has huge welfare benefits, but it has those partly because it is a very low-cost social contract. … the universality of Medicare has been a low-cost way of enforcing a social contract. If that social contract breaks, if higher-income households no longer feel part of the system, they

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6 NRHA, Submission 65, p. 5

7 UnitingCare, Submission 55, p. 6

8 Mr Goddard, *Proof Committee Hansard*, 19 January 2004, p. 29; see also Ms Wentworth, *Proof Committee Hansard*, 19 January 2004, p. 30; Geelong West Branch of the ALP, Submission 41, p. 5; Doctors' Reform Society, Submission 16, p. 1; NAPWA, Submission 44, p. 9; QNU, Submission 62, p. 4

> are not going to feel so happy about paying their taxes to support the poorer households. Fred Argy has a very nice term: downward envy.[9]

3.13 ACOSS put a similar view:

> Those who are encouraged to pay out of their own pockets may start to resent those who receive 'free' care and it is possible that Medicare could become a source of division in the community, a form of welfare rather than a symbol of what is shared by all.[10]

3.14 The Australian Consumer's Association provide detailed figures for the redistributive effects of Medicare. These illustrates the fact that those on lower incomes, who tend to have the highest health needs, receive the greatest dollar value benefits from the public health system.

Table 1. Publicly-funded health benefits, $ per week per head, by household income quintile

	Lowest 20%	Second quintile	Third quintile	Fourth quintile	Highest 20%
Hospital care	29	23	13	11	11
Medical clinics	13	12	10	10	10
Pharmaceuticals	7	6	3	2	1
Other health benefits	3	3	3	3	3
Total health benefits	53	44	29	26	25
Private income	10	90	227	342	592
Health benefits as percentage of private income	534%	49%	13%	7%	4%

Source: ABS *Household Expenditure Survey* 1998-99 Cat 6537.0 – household data divided by household size.

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

10 ACOSS, Submission 45, p. 1. See also Catholic Health Australia, Submission 48, p. 4; VCOSS, Submission 80, p. 1

3.15 The ACA conclude that:

> What this means is that universalism is inexpensive, because people in higher income households do not draw much benefit from publicly funded health programs. Universalism is a low-cost social contract.[11]

The importance of bulk billing

3.16 A second – but closely related – issue is whether the concept and objective of 'universality' includes universal bulk billing. Advocates of bulk billing point to four of the most important rationales for maintaining bulk billing as a key element of a universal Medicare:

- it is a crucial underpinning for encouraging preventive primary care;
- the unavailability of bulk billing GPs triggers overflows to other parts of the public health and welfare systems;
- the gap payments for those who are not bulk billed are increasingly unaffordable; and
- the widespread decline in bulk billing will see a return to a focus on discretionary billing by GPs and associated change in the power relationships between doctor and patient.

Preventive primary care

3.17 Bulk billing is an important mechanism to encourage preventive primary care. The Committee's first report described the changing patterns of disease in Australia, and the increasing importance of chronic illnesses such as diabetes, arthritis and depression relative to acute illnesses.[12] Many of these problems are chiefly associated with ageing and lifestyle factors, but, most importantly, these conditions are preventable. The National Health Reform Alliance explained that:

> Many significant health problems cause damage for years without producing significant symptoms – hypertension, high cholesterol levels, worsening lung function associated with smoking and even some cancers fall into this category. … Osteoporosis, which costs the taxpayer $1.5 billion in annual expenditure, and bowel cancer, the fastest growing cause of cancer deaths in this country, should both be recognised as preventable diseases.[13]

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11 ACA, Submission 36, p. 8

12 Senate Select Committee on Medicare, *Medicare: Healthcare or Welfare?*, Chapter 4.

13 NHRA, Submission 94, p. 9 & 11

3.18 Preventive health care, principally delivered by GPs, is therefore crucial to lowering the long term economic and social costs of these illnesses. However, cost plays an important part in peoples' decisions to go to GPs for preventive care, because the demand elasticity for this type of medical care is high: in other words, people suffering from an acute medical condition **must** go to the doctor, even if it costs a lot. However, the higher the cost of a GP consultation, the less likely it is that people will see a doctor for seemingly minor ailments. This is particularly true for poorer socio-economic groups, who also have the poorest general health and suffer most from lifestyle related illness.[14]

3.19 In the longer term, bulk billing is arguably as important for 'lower priority' consultations and routine check-ups, as it is for more immediately serious conditions. Gap payments are a disincentive for preventive care even for the relatively wealthy, so ensuring the availability of bulk billing is a crucial underlying precondition to encouraging preventive care.

3.20 While there are obvious cost implications for a policy that maximises bulk billing, contributors to the inquiry argued in favour of the long term cost effectiveness of this policy. If these conditions are not treated and worsen, the down-stream costs for the public health system are much greater than the earlier preventive treatment would have been. In a wider sense, there are also the social costs associated with increased human suffering, lost productivity, and premature deaths.

3.21 A good example was provided by Ms Mohle, representing the Public Health, Hospitals and Medicare Alliance of Queensland, who told the Committee of concerns expressed by Women's Health Queensland Wide over the decreasing availability of GPs who bulk-bill for Pap smears:

> This is extremely concerning given that Australia has made tremendous improvements in recent years in the early detection and treatment of cervical cancer. A recent report released by the Australian Institute of Health and Welfare shows that pap smear screening decreased mortality rates for cervical cancer by 53 per cent between 1982 and 2001.[15]

Overflows to other parts of the system

3.22 If people cannot access bulk billing doctors nor afford gap payments, there can be immediate costs to other parts of the medical and social system. First, people who need medical care will go to Accident and Emergency wards of public hospitals. This issue was considered in detail in the Committee's first report.[16] The Committee notes

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14 SVDP, Submission 58, pp. 1 & 6

15 Ms Mohle, *Proof Committee Hansard*, 19 January 2004, p. 33

16 Senate Select Committee on Medicare, *Medicare: Healthcare or Welfare?*, p. 50

additional evidence to this second inquiry, such as that of the NSW Nurses Association:

> The impact of this response to the lack of access to bulk billing has been reflected in a 14% increase in presentations to emergency departments for services more appropriately managed by GPs.
>
> The impact has also been examined by the Independent Pricing and Regulatory Review Tribunal of NSW. Its report, *Focusing On Patient Care*, details the adverse effects this decline has for the efficient operation of the health care system:
>
> Between 1996/97 and 2000/01 the number of GPs in Australia decreased by nearly 3 per cent, while their bulk-billing rates fell by 3.6% and the availability of after-hours GP services declined, especially in rural areas. In NSW, this has resulted in:
>
> - increased pressure on public hospital emergency departments. Over this time, emergency department attendances increased from 1,240,460 to 1,441,5957 while the GP bulk billing rate decreased from 82.7 per cent of all visits to GPs to 79.1 per cent
>
> - increasing hospital costs and average length of stay in hospital for patients located in areas with no local GP services. This suggests that reduced access to GP services may contribute to more and longer hospitalisations, because these patients present in crisis and with greater complications than would have been the case if they had seen a GP earlier.[17]

3.23 Second, as discussed above, people will delay seeing a doctor, with the result that treatment is delayed, medical conditions deteriorate and long run costs are higher. Professor Dwyer told the Committee:

> We have just done a survey in my hospital looking at all the geriatric admissions to the hospital over the last year … Sixty per cent of those admissions could have been prevented if earlier interaction had occurred. In other words, the people were not perfectly well 24 hours before they came into the hospital.[18]

3.24 Third, the overflow can run into the welfare sector. The submission from the Tasmanian Medicare Action Group stated that in a recent Anglicare Tasmania survey, the cost of medical care is a major issue for families seeking Emergency Relief

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17 NSW Nurses Association, Submission 63, p. 10. The submission quotes: IPART, Focusing On Patient Care, August 2003, p 10. See also Tasmanian Government, Submission 61, p. 2; Queensland Government, Submission 59, p. 2.

18 Prof Dwyer, *Proof Committee Hansard*, 19 January 2004, p. 11

Assistance, while the Salvation Army in Tasmanian presented evidence at a recent inquiry into poverty that:

> Those that do not have the money to cover gap fees often put off seeking medical attention. One of the issues that impact on our emergency relief in Tasmania is that we are being asked to pay the gap fees for doctors …[19]

3.25 Similar evidence came from the National Association of People Living with HIV/AIDS (NAPWA):

> The Bobby Goldsmith Foundation, a NSW-based charity for people living with HIV/AIDS reports that in the year 2002-2003 they paid out a total of $7,514 to 87 HIV positive people unable to meet the gap fees between the Medicare rebate and the cost of consultation, and a total of $22,176 for 136 clients unable to meet the costs of their co-payments for prescription pharmaceuticals.[20]

Affordability of gap payments

3.26 A related point is that, according to the evidence of some groups, the gap payments incurred when bulk billing is not available are simply not affordable for some members of the community. The Catholic Health Australia submission stated that:

> In each iteration of the Australian Government's Medicare reform package, there appears to have been a failure to understand the extent of the impact of copayments on low to middle income families, and generally for anyone who has to find increasing copayments each time they visit their GP. The impact will be hardest felt by those with chronic illnesses and multiple conditions.[21]

3.27 A similar perspective came from the NAPWA, relating to the roughly 14,000 people living with HIV and AIDS across Australia:

> our membership reports that they, like many Australians, are affected by the national decline in bulk-billing rates. NAPWA has confirmed that several metropolitan General Practices with high numbers of HIV patients (practices where antiretroviral Section 100 drugs are prescribed) are now no longer bulk-billing any patients at all, including pensioners and Health Care Card holders. This has represented a sufficient financial burden for some

19 TasMAG, Submission 22, p. 2

20 NAPWA, Submission 44, p. 8

21 Catholic Health Australia, Submission 48, pp. 2-3

> people that they are no longer able to receive their primary care from GPs who may have been caring for them for many years.[22]

Charity and the doctor/patient relationship

3.28 Fourthly, where bulk billing is not generally available, the inevitable result is an alternate system that expects, and relies on, a doctor's discretion to charge a sliding scale of fees according to an individual patient's capacity to pay. This already occurs to some extent, as the Committee's first report discussed, and in this respect the Committee has already expressed its concerns at the inappropriateness of GPs making such judgements and the arbitrary outcomes likely to emerge.[23]

3.29 However, this discretionary system introduces an inevitable degree of charity that fundamentally alters the power relationship between poorer patients and their doctors. According to the Queensland Nurses Union, the government response:

> … shows a fundamental lack of appreciation of the inherent power imbalances between doctors and their patients. There is a need for government intervention in transactions between doctor and patient because patients who cannot afford to access health services should not have to go through the humiliating experience of asking for charity from doctors. Doctors should also not be expected to dispense charity.[24]

3.30 As Ms Mohle told the Committee, doctors are trained to assess health not wealth and 'the power imbalance inherent in the patient-doctor relationship is large enough without instilling an economic dimension to it.'[25]

Perverse incentives and welfare categories

3.31 Finally, the creation of separate categories of beneficiaries can create perverse incentives for people to avoid getting jobs, earning money or becoming self sufficient in order to remain in the better rewarded welfare categories. This point was made in the submission from the National Association of People Living with HIV/AIDS:

> There is also a substantial disincentive to return to work for this group of people, since, by remaining on a pension a person would be able to more readily access bulk-billing and concessional-rate pharmaceuticals. However, a low-paid job may disqualify people from a health-care card, and introduce the spectre of substantially higher medical bills and the loss of the safety net, which would serve only to eat unreasonably into any additional income gained through working. In particular, people returning into the workforce

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22 NAPWA, Submission 44, p. 8

23 Senate Select Committee on Medicare, *Medicare – Healthcare or Welfare?*, p. 42

24 QNU, Submission 62, p. 4

25 Ms Mohle, *Proof Committee Hansard*, 19 January 2004, p. 34

> after a long absence due to illness are more likely to go initially into lower-paid or part-time positions.

3.32 As NAPWA points out, this disincentive to return to work is not in the interests of the individuals concerned, nor the government or the economy.[26]

The government view

3.33 Unsurprisingly, the government and its departmental officers do not share the views discussed above. According to the government, the proposed policy measures are in no way inconsistent with the government commitment to a universal Medicare or with the principles of universality.

3.34 The Prime Minister has continued to reassert the principle of universality:

> All Australians have the right to universal access to the three pillars of Medicare: a universal Medicare rebate for medical services; a universal Pharmaceutical Benefits Scheme; universal access to free public hospital care.
>
> The Australian Government remains firmly committed to the principles of Medicare, which have guided it over the past two decades.[27]

3.35 Mr Davies, from the Department of Health and Ageing, rejected the view that the proposed $5 incentive payments offered for bulk billed services to concessional patients and children under 16 years amounts to any deviation of these principles, arguing that:

> the universality offered by Medicare since its establishment has always been that all Australians receive the same MBS rebate. MedicarePlus does not change that. The eligibility of all Australians to be bulk-billed is also a key feature of Medicare, and it is not compromised by MedicarePlus. Under MedicarePlus all Australians will continue to receive the same level of Medicare rebate, and all Australians will continue to be eligible to be bulk-billed. Bulk-billing will not be limited to concession card holders and children. MedicarePlus simply makes it financially more attractive for GPs to bulk-bill people in those groups.

3.36 And:

> There is nothing in this package that says who does or does not get bulk billed. … To claim that this package is directing bulk billing towards a

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26 NAPWA, Submission 44, p. 9; see also COTA, Submission 73, p. 2

27 Prime Ministerial Media Release, 1st October 2003

> particular subgroup of the population in a legislated or regulated way is to misrepresent the package.[28]

3.37 A significant factor underpinning these views is the differing view of the role that bulk billing was intended to, and should in the future, play in the Medicare system. Mr Davies told the Committee:

> Medicare has never offered a guarantee of bulk-billing and it has never delivered 100 per cent bulk-billing. Therefore, it is clearly misleading to argue, as some have, for 'a return to universal bulk-billing'. Indeed, while we continue to allow doctors to set their own professional fees, universal bulk-billing can never be guaranteed.[29]

3.38 This view is also evident in the comments of the Minister for Health, the Hon Tony Abbott MP, who told the House of Representatives that while 'the government is committed to a high level of bulk billing as a key element of Medicare':

> no government can force any particular level of bulk billing, although governments certainly can take measures that support doctors and encourage them to bulk bill, as this particular bill does.[30]

3.39 Some submissions to the inquiry support this view as well. Dr Gault, a General Practitioner from Port Fairy in Victoria, argues that:

> The only aspect of Medicare that is universal is the rebate, which is the major 'safety net' of the system. …
>
> Historically, I cannot find evidence that bulk-billing was ever an integral part of the Medicare concept. Instead it is an arrangement, which, if properly funded, benefits all four parties involved.

3.40 Dr Gault points out that the Pharmaceutical Benefits Scheme introduced co-payments in 1990, and has since increased them under both major political parties, and the MBS should be no different:

> With ever-increasing non-G.P. costs competing for the health dollar I doubt G.P.s will ever again be funded adequately for their services through rebates alone. The fact that patients still have a large proportion of their bill rebated and that the G.P. will always be paid at least that proportion is a vast improvement on the days before Medicare. [31]

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28 Mr Davies, *Proof Committee Hansard*, 20 January 2004, p. 44

29 Mr Davies, *Proof Committee Hansard*, 20 January 2004, p. 29

30 The Hon. Tony Abbott MP, Health Legislation Amendment (Medicare) Bill, Second Reading Speech, House of Representatives Hansard, 4 December 2003, p. 23331

31 Dr Gault, Submission 25, pp. 2-3

3.41 An important assumption in this argument is that it is neither unreasonable nor unaffordable for many people to afford a small gap payment, particularly where in practice, these gap payments vary significantly based on the GP's judgements of the patients' needs. Dr Gault concluded:

> The assertion that one third of Australia's population cannot afford to pay, say, $5, of their own money to see their G.P. is the greatest falsehood at the heart of this debate. …
>
> The old days of Medicare are gone. Long live Medicare, but as the universal insurer, not the universal payer.[32]

Conclusion – universality and the Medicare system

3.42 In the view of the Committee, the government's proposal to introduce a separate additional $5 payment for all bulk billed services delivered to concessional patients and children, raises a profound question over the concept of a universal Medicare and the role that bulk billing plays in this system.

3.43 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 receive different benefits 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 to 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.

3.44 At the heart of this debate is the role of bulk billing in the Medicare system. The government's policy is underpinned by the view that universal bulk billing is not, and was never intended to be, a part of a universal Medicare.

3.45 The Committee disagrees, for two reasons. First, as the arguments set out above demonstrate, there are sound practical reasons why the ability to access bulk billing for all patients is important: it is a powerful element in the social compact of risk sharing; it is a crucial foundation stone for building a primary health care system focused on prevention; and it does much to prevent overflows to other parts of the hospital and welfare systems.

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

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32 Dr Gault, Submission 25, pp. 2-3. Other submissions expressing a similar view include: Ms Hemlof, *Submission 4*, p. 2; Ms Thallur, *Submission 84*, p. 1; Mr Boyapati, *Submission 93*, p. 1

attention to polling that confirms 'strong support for the maintenance of Medicare and the central importance of bulk billing':[33]

> For example, a recent survey conducted by Australian Research Consultant[34] that sought the opinions of 1000 voters nationwide found:
>
> - 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.[35]

3.47 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.[36]

3.48 A policy commitment to universal bulk billing does not necessarily mean 100% bulk billing, particularly in the broader context of specialists, diagnostic testing and imaging. This is neither constitutionally nor practically feasible. 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.[37]

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33 For example, Newspoll Polling For ACTU Congress 2003 conducted 8-11 August, 2003 http://www.actu.asn.au/public/news/files/newspolm.pdf

34 The Age, August 17, 2003

35 NSW Nurses Association, Submission 63, pp. 5-6

36 SVDP, Submission 58, p. 12

37 CHA, Submission 80, p. 4

3.49 Perhaps the most important requirement is a strong and explicit government commitment to a high level of bulk billing, that does not institutionally discriminate between classes of Australians based on perceptions of their wealth or 'neediness'.

Equity and the targeted groups as a measure of need

3.50 Setting aside the issue of universality, does the creation of incentives to bulk bill concession card holders and children under 16 years represent an effective measure of need for bulk billing? Evidence to the inquiry has raised two principal objections to the scheme.

3.51 Firstly, a focus on concession card holders and children tends to exclude a group loosely categorised as 'the working poor'. The Country Women's Association pointed to those who:

> do not have Concession Cards, yet their incomes are too often just above that threshold for eligibility. The lowest paid workers in our economy, shop assistants, hospitality workers, casual employees are all left out of this equation. So too, and this is of particular concern to our members, are young persons, over 16, who are usually on low wages as they work their way through traineeships, for example, or are in casual employment, that does not bring in an adequate income but nonetheless in our 'reformed' welfare systems classes them as 'employed' and therefore ineligible for assistance. They are often away from home, struggling to pay rent and look after themselves and it is their health care that regularly is ignored as being too expensive.[38]

3.52 The Liquor Hospitality and Miscellaneous Union made a similar case:

> There is another group of Australians, the forgotten Australians, that are key to this debate, they are low paid Australian workers.
>
> These workers cannot afford to lose access to Medicare, they cannot afford to lose access to bulk billing and they cannot afford to lose access to health care.
>
> It is these workers that must be remembered when considering reforms to the basis of our health care system, being Medicare. There are hundreds of thousands of low paid workers that do not qualify for Commonwealth concession cards, … primarily found in service industries, such as cleaning, security, hospitality, and a range of care and support work, including aged care, in-home care, childcare and teaching assistant work.[39]

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38 CWA, Submission 70, p. 3; see also Blue Mountains DGP, Submission 82, p. 1; Consumers Health Forum, Submission 66, p. 2; NSW Retired Teachers' Association, Submission 21, p. 1

39 LHMU, Submission 68, p. i and 2-3

3.53 This problem is detailed by ACOSS:

> Our analysis shows that people without children and earning the minimum wage (around $450 a week) and part time workers earning more than the concession card cut-off point of $340 a week, will miss out on the bulk billing incentives. They face a current average co-payment of $13 for every GP visit and $45 for an x-ray.
>
> Aside from the manifest unfairness of the proposal, the crude targeting of MedicarePLUS will create a poverty trap for people moving from government benefits to work and from very low paid to higher paid jobs.[40]

3.54 Secondly, the selection of the two categories of those more likely to be bulk billed is likely to have anomalous results. The Geelong and Region Trades and Labour Council argued that:

> The direct targeting of these groups will disadvantage those who do not fit into these categories, often inequitably. For example, while a millionaire's child (under 16 years) will be targeted for a bulk billed consultation with a GP under the MedicarePlus package, a woman with a low income job, no dependant children and a chronic disease such as multiple sclerosis (which requires periodic general practice and specialist consultations) would have to pay the full fee. This is … one example of the many anomalies that will become obvious under MedicarePlus.[41]

3.55 The Council on the Ageing (COTA) pointed to the illogical differences that would emerge:

- between concession card holders and those whose income is only marginally beyond eligibility limits;
- between low wage earners and people on income support payments; and
- between dependants who are 16 and dependants who are 17 – both still in education and being supported by their parents.[42]

3.56 Many submissions saw the proposal as ill-considered. UnitingCare described the policy as 'illogical and unrealistic'[43] while their representative, the Reverend Dr Wansbrough, explained at the public hearings:

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40 ACOSS, Submission 45, p. 2

41 Geelong and Region Trade and Labour Council, Submission 83, p. 2

42 COTA, Submission 73, p. 2. See also City of Whittlesea, Submission 86, p. 1; Geelong Medicare Action Group, Submission 46, p. 2

43 UnitingCare, Submission 55, p. 6

> The additional $5 rebate offered to GPs who bulk-bill concession card holders and children under 16 should be extended to all occasions of bulk-billing. There is a serious anomaly, in particular with families, in bulk-billing children under 16 but not their older siblings or their parents. As those families take their money from one purse, it does not really matter whether it is the children or the adults – the whole family is affected by the health care costs, whoever incurs them.[44]

3.57 Catholic Health Australia made the similar point that:

> [T]here are people with concession cards who have better means than average working families. The claim by both groups to affordable and certain health care are equal. Yet their opportunities to access care are not. When income levels determine capacity to access crucial human service the inequities are obvious.[45]

3.58 The Doctor's Reform Society conclude that:

> Doctors who currently bulk bill everyone are being told that they will be paid less for seeing a struggling worker in a low paid job than a comfortable pensioner or the children in a wealthy family. The message to the doctor is that he/she should charge the struggling worker a co-payment.[46]

3.59 Dr Lambie, a Queensland GP, felt:

> This idea will introduce discrimination between those hard working people who not only pay their taxes but also their Medicare levy and those who for many reasons pay no tax at all nor do they pay the Medicare levy.[47]

A tiered health system?

3.60 Many of these groups fear that the practical outcome of this differentiated system will be the creation of a multi-tiered health system. The Australian Council of Social Services argued:

> In the face of clear problems in the health system there is no point encouraging divisions between groups of patients and between public and private provision. This can only divert attention from desirable reform and create a political environment where a genuinely two-tiered system – in which the comfortably off provide for themselves under private health

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44 Rev Dr Wansbrough, *Proof Committee Hansard*, 19 January 2004, p. 79

45 Catholic Health Australia, Submission 48, pp. 2-3

46 DRS, Submission 16, p. 1. See also Consumers Health Forum, Submission 66, p. 2

47 Dr Lambie, Submission 34, p. 1

> insurance while an under-funded public system struggles to deal with the 'charity' cases – becomes possible.[48]

3.61 There is already evidence of such a system emerging. The Moreland City Council submission warned that over the past year, their area has seen the emergence of general practices that are offering speedier access to individuals who pay a premium, with similar developments in neighbouring municipalities.[49] Similarly, the NSW Retired Teachers' Association have experience of some general practices in which:

> those patients wishing to bulk bill are made to wait long periods of time and in others there is no bulk billing after 3PM or at weekends. This arrangement could create a two-tier health system with low income patients facing increasing health costs.[50]

Conclusion – the targeted groups as a measure of need

3.62 The Committee concludes that, setting aside the general undesirability of targeting categories of people for bulk billing, membership of the two groups selected – concessional patients and children under 16 – is not an equitable or accurate measure of need.

3.63 The proposed target groups overlook many people who have limited resources, particularly young people and those on low incomes, as well as those with chronic illness, but who are still working. At the same time, the policy includes target groups who may have the income to afford gap payments – such as the 'millionaire's child' mentioned by some submissions.

3.64 This is not to suggest that concessional patients and children under 16 are not deserving of bulk billing. Quite the opposite. Rather, these inequitable and arbitrary outcomes serve to reinforce the Committee's preference for a universal system with a general commitment to providing access to GP services that are bulk billed or charged at the schedule fee. Most importantly, this universal system should not be concerned with capacity to pay a gap fee, but focus solely on medical need. This avoids the inevitable administrative complexity and arbitrary results of a system that tries to 'pick winners'.

Effective reforms? Fixing the problems in bulk-billing

3.65 The third issue that must be considered in assessing the proposed $5 rebate bulk billing incentive payment is the extent to which it will address the current problems in

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48 ACOSS, Submission 45, p. 1. See also NSW Nurses Association, Submission 64, p. 12; Geelong West Branch of the ALP, Submission 41, p. 5

49 Moreland City Council, Submission 81, p. 2

50 NSW Retired Teachers' Association, Submission 21, p. 1

Medicare. The Committee's first report found equitable access to primary health care in Australia is being compromised by four key problems:

- declining rates of bulk billing;
- an uneven distribution of bulk billing, both by State and region;
- rising average gap payments; and
- an uneven distribution of Medicare benefits.

3.66 The September Quarter 2003 Medicare statistics show that the national bulk billing rate has fallen to 66.7%, amounting to a 1.7% fall since the previous year. Although this reflects a problem in itself, a closer examination of the statistics shows the uneven distribution of bulk billing rates. In Tasmania and the ACT, for example, the bulk billing rates are well below the national average, standing at 55.2 and 53.2 percent respectively, in comparison to 72.5% in NSW.[51] Looked at in terms of region, the pattern also reveals inequitable results: in 2002, 80.8% of GP services delivered in capital cities were bulk billed, contrasting with 56.6% in rural and remote areas.[52] As the Department of Health and Ageing point out, geographical location is a much greater determinant of access to bulk billing than income, with an analysis of GP bulk billing rates by income showing a remarkably even distribution.[53]

3.67 In assessing access to health services however, access to bulk billing GPs is not the whole picture. With the increasing use of specialist and diagnostic services, it is of considerable concern that only 27% of specialist visits are bulk billed, with levels of only 19.6% for obstetrics; 9.3% for anaesthetics; and 58.8% for diagnostic imaging.[54]

3.68 Another way of analysing this issue is in terms of observance of schedule fee – that is, cases in which specialists do not bulk bill their patients, but still only charge the fee set out in the Medicare Benefits Schedule. In 1984/85, although only 21% of specialist services were bulk billed, a further 52% were charged at the MBS fee. So overall, 73% of services were either free of extra charge or were only subject to a 15% gap payment. Over the years, specialists have rarely bulk billed more than a third of their services, but what has declined rapidly in the past few years is their adherence to the scheduled fees. In 2002/03, some 27% of specialist services were bulk billed but only a further 14% were charged the schedule fee.

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51 Department of Health and Ageing, Medicare Statistics 1984/85 to Sept. Quarter 2003, p. 11

52 Senate Select Committee on Medicare, *Medicare: Healthcare or Welfare?*, 2003, pp. 38-39

53 DHA, Submission 54, pp. 3-4 and Figure 1.

54 Department of Health and Ageing, Medicare Statistics 1984/85 to June Quarter 2003, p. 11

3.69 Another problem is the rising levels of out-of-pocket costs or gap payments. As evident from earlier discussion, the level of gap payments are closely related to low bulk billing rates, low per-capita doctor numbers – particularly in rural and regional areas – and the limited availability of after hours care in many parts of Australia. The average GP gap payment has risen to $12.77,[55] however the Department of Health and Ageing states that 'by far the largest increase in cost to patients has been in specialist, diagnostic and treatment services':

> In 1984/85, patients contributed an average $2.86 for GP services and $5.03 for non-GP services. In 2002/03, patient contributions to GP services increased to $12.90 (65 percent in real terms) while patient contributions to non-GP services increased to $41.82 (310 percent in real terms).[56]

3.70 While fixing these problems is obviously the priority, solutions must also work within the context of the changing health care environment, which is characterised by an ageing population with growing health needs; a shift from acute to chronic health conditions; increasing levels of out-of-hospital treatment; and a dramatic increase in medical technology and associated diagnostics and treatments. These factors are driving attendant rises in both costs and consumer expectations.[57]

3.71 Overall statistics can distract attention from the important human realities: increasing levels of out of pocket costs means a decreased access to health care and it is clear that in some parts of Australia, the system is failing Australians. Professor Dwyer told the Committee that:

> if you live in the poorer suburbs of Sydney's outer-west region you are five times more likely to die prematurely from what doctors can demonstrate to be largely preventable problems than if you live on Sydney's more affluent north-shore.[58]

3.72 Similarly, life expectancy for those in country areas is shorter than in cities,[59] and the continuing problems in indigenous health are well known. Given the generally lower incomes in regional areas, this all means that if you are poor and/or live outside a major city, you are more likely to get seriously ill and to die younger than the rest of the population. NATSEM research shows that if the entire population had the same health status as those in the highest income quintile:

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55 DHA, Medicare Statistics, p. 41

56 DHA, Submission 54, p. 4

57 For general a discussion on these background issues see the Department of Health and Ageing submissions to both inquiries: DHA, Submission 138 [First inquiry], p. 7 *et seq*; and DHA, Submission 54, p. 2

58 AHRA, Submission 94, p. 9

59 Prof Dwyer, *Proof Committee Hansard*, 19 January 2004, p. 13

- around 180,000 life years could be saved annually;
- around 800,000 fewer persons would have been disabled in 1998, and 1 million fewer in 2018; and
- savings of around A$4 billion a year could be achieved in 1998 (and A$5 billion in 2018), due to lower health care costs and lower government outlays on Australia's disability support pension.[60]

3.73 This section therefore considers the likely outcome of the targeted $5 payment on bulk billing rates, distribution, and gap payments.

The effects on bulk-billing

3.74 Consideration of the effects of the $5 incentive payment naturally has two elements: first, the implications on bulk billing rates for those in the two target groups – concessional patients and children under 16 – and second, for the remainder of the population.

Bulk billing for target groups

3.75 Various groups and individuals were pessimistic about the implications of the package for concessional patients and children. The Doctors' Reform Society felt that:

> It will lead to a fall in the bulk billing rate.
>
> The average copayment for GP consultations is now $13.61. A GP currently charging anything more than $5 copayment to any of the eligible group is very unlikely to revert to bulk billing them because it will mean less income. With the average copayment at that level now it is clear that most doctors are charging more than $5.
>
> Doctors charging less than $5 copayment to such patients may decide to bulk bill them but with the average copayment being $13.61, the number of patients paying less than $5 copayment is small.[61]

3.76 Professor Hall from the Centre for Health Economics Research and Evaluation told the Committee that current average gap payments across electorates range from about $8 to about $22. That suggests that:

> for those practices that are already not bulk-billing, $5 does not sound like it is going to be enough to throw a lot of them over the line. One of the problems in the area … is that there is no such thing as an average general practice. There are all sorts of different styles of practice with numbers of practitioners practising in different areas with different attitudes to bulk-

60 SVDP, Submission 58, p. 2

61 DRS, Submission 16, p. 1

> billing and so different practices will react differently. Certainly it would seem to me just on those data that the $5 additional rebate for bulk-billed patients is unlikely to reverse current bulk-billing rates, though it may do something to change things on the margin to halt the decline.[62]

3.77 The view of the Royal Australian College of General Practitioners' (RACGP) was very similar:

> In submissions provided to the Committee during the first Senate Select Committee, GPs often reported that their private billing 'gap' fee was the difference between the rise in practice costs and the lagging value of the rebate. Therefore, given that gap fees, on average, are significantly higher than the proposed $5.00 incentive per consultation, it would be unlikely that this initiative will bring about a change to the level of bulk billing.[63]

3.78 However, there is also evidence to support a more optimistic view.

3.79 The two target groups between them constitute 63% of GP consultations,[64] and currently this group is bulk billed at a level of 79% – well above the overall national average.[65] This amounts to a total of around 50 million GP services annually provided to concession card holders and their dependents, with a further 10 million services provided to children not covered by concession cards.[66]

3.80 In this context, it is therefore possible that these measures will at least maintain or improve levels of bulk billing for the target groups. As the Department of Health and Ageing submission points out, more than 95% of GPs already bulk bill at least some of their concessional patients, with (perhaps more significantly) most GPs bulk billing a sizeable majority of the concessional group. The breakdown of these figures is shown in the table below, reproduced from the Departmental submission.

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62 Prof Hall, *Proof Committee Hansard*, 19 January 2004, p. 4. On this issue, see also Mr Lyons, Submission 2, p. 1; NSW Retired Teachers Association, Submission 21, p. 1; VMAG, Submission 27, p. 4; Geelong and Region Trades and Labour Council, Submission 83, p. 3

63 RACGP, Submission 67, p. 6

64 NRHA, Submission 65, p. 7. See also DHA, Submission 54, p. 10 which puts the figure at 'around 60% of all services'.

65 Mr Davies, *Proof Committee Hansard*, 20 January 2004, p. 34

66 DHA, Submission 54, p. 10

Table 2: Bulk billing range of concessional patients by full time workload equivalent GPs, 2002[67]

% Proportion of Full Time GPs	% Bulk Billing Range
25.3%	100%
35.0%	90-<100%
10.2%	80-<90%
6.4%	70-<80%
3.9%	60-<70%
3.2%	50-<60%
2.7%	40-<50%
3.0%	30-<40%
3.1%	20-<30%
3.1%	10-<20%
2.8%	>0-<10%
1.3%	0%

3.81 A GP providing around 7000 services per year, with a typical patient profile, and receiving the additional $5 payment certainly has every reason to maintain or increase the percentages of concessional and child patients who they bulk bill. Mr Davies, representing the Department, told the Committee:

> There is one group for which the rational response of a doctor would be to either continue or begin bulk-billing. That group is those concession patients and children under 16 who are either currently bulk-billed or charged a gap of $5 or less. The rational thing for a GP to do for those patients would be to bulk-bill. If we assume that a GP is an income maximiser, that would be the rational thing for the GP to do.[68]

67 DHA, Submission 54, p. 12

68 Mr Davies, *Proof Committee Hansard*, 20 January 2004, p. 45

3.82 Professor Deeble generally agreed:

> the $5 is not going to lure back people who have reduced or ceased bulk-billing, but I think it will hold the proportion up. Doctors in the metropolitan areas who have built their practices on bulk-billing will take that extra $5 and they will be under great pressure from their patients to bulk-bill children under 16 because the government has virtually promised it.[69]

Bulk billing for non-target groups

3.83 Assessing the implications of the measure for the non target groups is a more complex task. In the view of some submissions to the inquiry, the outcome:

> [W]ill almost certainly do little to encourage bulk-billing for low-income Australians more generally.[70]

3.84 According to the Mt Druitt Medical Practitioners' Association:

> It seems unlikely that Medicare plus will produce any change in the trend away from bulk billing, nor in itself facilitate the provision of comprehensive preventative care. … The targeted incentives are unlikely to be enough to ensure access to bulk billing for non card holders and adults, and will in fact send an implicit message to those doctors who are currently bulk billing all consultations that they will need to change their billing patterns or be expected to continue subsidising the system.[71]

3.85 On this analysis, the overall bulk billing rate could be expected to drop from its current level of 67% to a floor of around 60% as bulk billing becomes confined to concession card holders and children. This would be due to the combination of: incentive payments for the bulk billing the target groups; the implicit message this sends to doctors as to who should be bulk billed; and the fact that bulk billing the target group will be considerably more profitable than general bulk billing.

3.86 This is not a far fetched scenario given the preponderance of bulk billing already going to the target groups in current conditions – that is to say, statistically the target groups are already much more likely to be bulk billed than the average, and account for the majority of overall bulk billed services.

3.87 A further concern is that not only will bulk billing become scarcer for patients not in the target groups, but that gap payments for this group will also increase. This could be triggered by cross-subsidisation in practices where existing gap charges are

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69 Prof Deeble, *Proof Committee Hansard*, 19 January 2004, p. 5

70 NAPWA, Submission 44, p. 9. See also Moreland City Council, Submission 81, p. 3; AHRA, Submission 94, p. 17; CWA, Submission 70, p. 2; COTA, Submission 73, p. 2

71 Mr Druitt Medical Practitioners Association, Submission 1, Attachment 1, p. 1

more than $5, but which decide to begin bulk billing concessional patients and children in order to receive the $5 incentive payments. To recoup their losses they would then raise the gap charges for everyone else.[72] As Dr Lim, a GP from Western Sydney told the Committee:

> it does send an implicit message to doctors currently bulk-billing all consultations that they will be expected to either cross-subsidise other patient groups with this or change their billing patterns, which may well lead to a decrease in the availability of bulk-billing. This is going to impact most heavily on those with chronic diseases and low incomes …[73]

3.88 The danger of inflationary pressures on the gap payments on non concession card holding patients was examined in the Committee's first report, and was also a focus on the research commissioned from the Australian Institute for Primary Care. The Committee found that in relation to *A Fairer Medicare*, there was considerable likelihood of these gap payments being driven upwards.[74]

3.89 While it is not possible to directly extrapolate these findings in relation to the government's revised package, the similar structure of the incentives program invites the comparison.

3.90 These outcomes are not certain however. Dr Moxham, President of the Australian College of Non-Vocationally Registered GPs, suggests that:

> There are many doctors who are 'thinking about giving up bulk billing'. Such doctors would be encouraged by this measure to continue bulk billing, at least for their more disadvantaged patients.[75]

3.91 The Department argues that the potential dangers of an overall reduction in bulk billing rates and cross subsidisation is substantially mitigated by three factors. First, the $5 payment is expected to add around $15,500 to a GP's income:

> To the extent that the $5 payment adds to the GP's income … it may even make it easier for a GP to maintain or even possibly to extend the scope of bulk billing should they choose to share some of that financial benefit with their patients. [76]

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72 Catholic Health Australia, Submission 48, pp. 1-2. See also Ms Gilmore, *Proof Committee Hansard*, 19 January 2004, p. 80

73 Dr Lim, *Proof Committee Hansard*, 19 January 2004, p. 56

74 Senate Select Committee on Medicare, *Medicare: Healthcare or Welfare?*, p. 74

75 ACNVRGP, Submission 35, p. 2

76 Mr Davies, *Proof Committee Hansard*, 19 January 2004, p. 30

3.92 Secondly, the combined effect of all elements of the government package add substantial amounts to overall practice incomes, amounting to $35,051, $43,056 and $39,525 for practices in RRMA 1, 2 and 3-7 respectively, of which the $5 bulk billing payments comprise less than half.[77] This overall increase in practice income must substantially address many concerns GP's have raised in relation to the viability of practices and remove at least some of the downward pressure on general bulk billing rates.

3.93 The table overpage, reproduced from the Department of Health and Ageing submission, demonstrates these expected increases in GPs' income.

3.94 Thirdly, to the extent that bulk billing rates are a function of GP supply, the workforce measures in the package are predicted to increase doctor numbers across Australia, which can be expected to increase overall levels of bulk billing.

3.95 However, exact predictions of the outcome are difficult. Mr Davies of the Department of Health and Ageing concluded that ultimately, the question is:

3.96 [W]hat will the GP choose to do with that additional income? They can either add it to their practice income and take it to the bottom line – and improve the viability of the practice or their annual remuneration as an individual – or use that $15½ thousand to eliminate or reduce the gap charges that they levy off non-bulk-billed patients. So the impact it has will ultimately be a reflection of the accumulation of those individual decisions made by GPs as to whether they want to take this additional income to their bottom line or to share all or some of it with patients.[78]

77 DHA, Submission 54, p. 33. Note the corrections to the figures in this table, provided in the corrigendum: DHA, Submission 54A, p. 2

78 Mr Davies, *Proof Committee Hansard*, 19 January 2004, p. 45

Table 5: Additional Income under MedicarePlus per full time equivalent GP by Rural, Remote, Metropolitan Area classification[179]

Measure	**Per Full Time Equivalent GP in:**		
	RRMA 1	**RRMA 2**	**RRMAs 3-7**
More affordable health services – for children and Commonwealth Concession Card holders	$17,780	$15,785	$13,370
Patient convenience through new technologies	$250	$250	$333
Support for practice nurses through a new Medicare item	$3,570	$3,570	$3,570
Extension of grants for employment of practice nurses to urban areas of workforce shortage	$8,000	$8,000	Already available
Better access to medical care for residents of aged care homes	$2,765	$2,765	$2,765
More GP training places, and support for practices and GP supervisors	$2,667	$2,667	$2,667
Bringing more graduate doctors to outer metropolitan, regional, rural and remote areas.	$0	$10,000	$10,000
Supporting rural and remote GPs, especially procedural GPs	$0	$0	$6,800
TOTAL	**$35,051**	**$43,056**	**$39,525**
Existing grants for employment of practice nurses in rural and remote areas			$8,000
Total For Comparison	***$35,051***	***$43,056***	***$47,525***

Note: Costs assume that the GP will subscribe to all measures for which they may be eligible under **MedicarePlus.**

79 DHA, Submission 54A, p. 2

Addressing regional imbalances

3.97 Some commentators feel the package fails to address the current low rates of bulk billing in rural and regional areas, or the higher per capita distribution of Medicare benefits to city areas. The Rural Doctors' Association argue that:

> The proposed $5 incentive payment to GPs to bulk bill certain patients will not bring bulk billing back to higher levels in rural areas.
>
> [quoting a procedural rural doctor:] 'There is nothing in it for the majority of rural patients and rural docs! An extra $5 for bulkbilling will make little difference in rural areas except for those who still bulkbill and I don't believe there are many left.'[80]

3.98 Similarly, the National Rural Health Alliance point out that:

> the proposal provides the greatest rewards in areas with current high levels of bulk-billing. In areas where bulk-billing rates are currently low and out-of-pocket costs are high, levels of bulk-billing are unlikely to increase substantially. The measure is a reward for General Practitioners who currently bulk-bill their patients, rather than an incentive to increase bulk-billing for those General Practitioners who tend not to.
>
> The likely impact of this is that there will be little change in bulk-billing rates in the short-term in rural and remote areas with already low levels of bulk-billing. This is of major concern to the Alliance as cost barriers for General Practitioners' services are already high and increasing in country areas.[81]

3.99 In this view, the decision not to proceed with the geographically-based bulk billing bonuses contained in the earlier *A Fairer Medicare* package is a retrograde step. Doctors in urban areas, with already high rates of bulk billing, will receive an extra $5 (up from $1 and $2.95 in RRMAs 1 and 2) while doctors in rural areas get less ($5, which is down from $5.30 and $6.30 in RRMAs 5-7 respectively).

3.100 However, to return to the point made above, rural practices will benefit from a range of measures under the package which will serve to lift their overall practice incomes. As well, the workforce measures have a particular focus on rectifying workforce shortages of both doctors and nurses in rural areas. The combined effect of raising incomes and increasing supply can be expected to work to increase access to medical care and bulk billing rates in these regions.

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80 RDA, Submission 87, p. 8

81 NRHA, Submission 65, p. 7. See also RACGP, Submission 67, p. 6; Prof Hall, *Proof Committee Hansard*, 19 January 2004, p. 4; Mr Gregory, *Proof Committee Hansard*, 19 January 2004, p. 81

3.101 Professor Deeble told the Committee that the new package is an improvement on the original, since fixing the rural problems is more complex that simply 'throwing more money at them by way of higher fees':

> [I]t was unlikely to raise the amount of services that people got in country areas by paying the doctors a bit more, and I think that the [revised] package is better for that. My view would be that you may not even be able to do what is in this package, because of the constraints on the supply of doctors and nurses. … If you want to retain people in the country areas I think you have to identify the reasons why doctors are not in there – and it is not just money.[82]

Specialist bulk billing rates

3.102 A final issue, and one that is often overlooked in a debate on Medicare that generally focuses on general practice, is the levels of bulk billing and gap fees for specialist services.[83] As discussed above and in the previous chapter on safety nets, bulk billing is virtually non-existent among some specialists, with the resulting gap fees an increasingly important issue in access to health care.

3.103 The government package does little, if anything, to address these issues. The $5 incentive payment applies to any specialist MBS item that is bulk billed. However low rates of bulk billing in combination with average gaps of – for example – $29.11 for specialists and $44.65 for diagnostic imaging,[84] are unlikely to see this measure exert any influence on current billing patterns. As officials of the Department of Health and Ageing admitted, the net effect is a 'business as usual' price signal to specialists.[85]

3.104 The evidence suggests that the workforce measures designed to increase supply are also unlikely to have any discernable effect. While the Department expects a proportion of both the newly trained doctors and the Overseas Trained Doctors to be specialists, the 'impact in terms of competition, to put it bluntly, on specialists as a results of this package will be less than marked.'[86]

3.105 The impact of supply measures on specialists is, in any case, questionable, as Professor Deeble explained:

> If you look at how competition works in the medical profession, you will see that it does not work in the specialist area, because the specialist does

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82 Prof Deeble, *Proof Committee Hansard*, 19 January 2004, p. 21

83 – a point made by the Doctors' Reform Society, Submission 16, p. 4

84 Department of Health and Ageing, *Medicare Statistics*, p. 41

85 Mr Davies, *Proof Committee Hansard*, 20 January 2004, pp. 49 & 63

86 Mr Davies, *Proof Committee Hansard*, 20 January 2004, p. 63

> not tout for patients. The specialist operates by referral. The doctor who is referring refers on the basis of clinical competence and very rarely on the basis of what that specialist charges. For general practitioners, where the service is regarded by the patient as much the same, price is important. For a specialist, price is not so important, because it is very much associated with the referral to that individual doctor. Flooding the market with specialists is not going to lower the price even as much as it would for GPs.[87]

3.106 Given the increasing shift of specialist and diagnostic services to the out-of-hospital, private consultation setting as well as the increasing range of diagnostics available, it is curious that this issue receives so little public attention. Dr Gault, a Victorian GP, noted that:

> The expectation to bulk bill rarely seems to extend to medical specialists. Public dental care is a disgrace but private dentists are rarely criticised for providing so little of it.[88]

3.107 As Mr Goddard of the Australian Consumer Association comments, 'the failure to deal with specialists is one of the great failures of Medicare.'[89] The focus in the government's proposals on safety nets may therefore reflect an acceptance of the inability of government to control high medical costs – as Professor Deeble suggests.[90]

Predicting bulk billing rates

3.108 A key problem in assessing the impact of the $5 incentive payment is that there is little consensus on the determinants of bulk billing behaviour among doctors. Evidence from the medical profession tends to focus almost exclusively on price issues – that is, the inadequacy of the rebates compared to real practice costs. Thus for example, Professor Dwyer of the Australian Health Reform Alliance stated that:

> … the history of Medicare in Australia tells us that 'when the Medicare rebate available for a specific service approximates a fair remuneration to a general practitioner very high rates of bulk billing are guaranteed'.[91]

3.109 Government officials, supported by some academics, place more importance on workforce supply issues and the effect of the laws of supply and demand. The Department of Health and Ageing submission considers that of several key factors, the predominant one is supply: 'The impact of competition between GPs in a local area

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87 Prof Deeble, *Proof Committee Hansard*, 19 January 2004, p. 18

88 Dr Gault, Submission 25, p. 1

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

90 Prof Deeble, *Proof Committee Hansard*, 19 January 2004, p. 6

91 AHRA, Submission 94, p. 8

remains a primary influence on the numbers of services that a GP bulk bills.'[92] Similarly, the Australian Consumer Association submission concluded that:

> The fall in bulk billing is largely related to changes in demand and supply. In markets where both demand and supply are reasonably inelastic, small changes in either demand or supply can have a strong effect on prices.[93]

3.110 However, the University of Canberra's Mr Ian McAuley (who was involved in the research for the ACA) also submits that 'there is no generalisation about the behaviour of medical practices.'[94] In research presented to the Committee, he tested the supply related hypothesis that bulk billing rates are highest in high income regions on the basis that there is likely to be a higher concentration of medical practitioners. He found that there is evidence of a relationship but it is not a simple linear one, and the causal factors are not clear:

> The relationship between income and bulk billing is complex. Bulk billing does, indeed, rise with income, but only up to a point, and the relationship is probably explained by region as much as by income. The lowest incomes and the lowest bulk billing rates are in rural electorates. As one moves to provincial cities, and on to outer metropolitan regions, incomes and bulk billing rates increase, but, for electorates in the three highest income decile groups, bulk billing falls with income.[95]

3.111 Explaining this relationship further during public hearings, Mr McAuley told the Committee that:

> Bulk-billing is highest in those outer metropolitan electorates which have reasonably high incomes – they probably also have very high needs – but it is lowest in the very poorest electorates, the country electorates in particular and the provincial cities. There it is very hard to see, given the very low supply, that there would be any significant boost to bulk-billing, even if there are these minor increases in supply.[96]

3.112 A different view was presented by Professor Deeble:

> I know that economists like to go back to the principles of economics and say that if the you increase the supply then the price will drop. I do not believe that that always holds. I think the level of bulk-billing … was partly a set of expectations that the doctors had about what the government might

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92 DHA, Submission 54, p. 3

93 ACA, Submission 36, p. 5

94 Mr McAuley, *Proof Committee Hansard*, 19 January 2004, pp. 11

95 Mr McAuley, Submission 96, p. 1

96 Mr McAuley, *Proof Committee Hansard*, 19 January 2004, pp. 11-12

> do to them if they did not bulk-bill and a set of expectations about what the patients expected.
>
> The rise in bulk-billing up to 1996-97 was not associated with a rise in coverage and it was not associated with a rise in doctor numbers particularly. The drop after that has not been associated with those things either. It was a perception that the doctors had, which was also endorsed by the relative values study, that they were underpaid. Whether or not they were underpaid did not matter – they thought they were.[97]

3.113 The difficulty in predicting what effect changes in GP supply and income levels will have on overall bulk billing rates makes the process of policy formulation problematic and is of great relevance to the discussion of alternatives in the following section. It is clear that bulk billing rates are dependent on a complex mix of factors including: doctor numbers in a particular area; MBS rebate levels; the income of the people in an area; doctor's earning expectations; and the somewhat intangible impact of government policy expectations on the role and extent of bulk billing.

3.114 Deducing which of these are the most important causal relationships is further complicated by the fact that different factors are likely to have different degrees of importance at various points of the decision making spectrum. Thus for example, government and societal expectations of doctors to bulk bill are unlikely to greatly influence bulk billing levels in a situation where the MBS rebates are substantially below real costs. Conversely though, these expectations may be crucial to preventing or limiting high gap fees if the rebate is relatively generous.

Perverse incentive towards shorter consultations

3.115 A final, structural, issue is the concern that a single flat rate $5 payment for any item, however long, short, or costly it may be to deliver, effectively provides an incentive towards short consultations. Dr Lim, a GP from Western Sydney explained that:

> as the incentive would appear to be a fixed amount regardless of the duration of each consultation, it would appear to reward mostly shorter visits. It actually does nothing to reward longer or more comprehensive consultations. Therefore, it does not encourage quality or preventative care.[98]

3.116 Thus, for example, a doctor who sees:

> 10 patients an hour is therefore going to be significantly ahead of someone who sees four patients an hour or a doctor who spends more time on

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97 Prof Deeble, *Proof Committee Hansard*, 19 January 2004, p. 5

98 Dr Lim, *Proof Committee Hansard*, 19 January 2004, p. 58

> comprehensive consultations and therefore spends half an hour with each patient. The latter doctor would be rewarded the least by this system.[99]

3.117 This could potentially exacerbate an existing tendency of the Medicare system to encourage a 'churning' or high through-put of patients. The Royal Australian College of General Practitioners consider the $5.00 payment to be:

> extremely regressive as an incentive, since shorter consultations receive a higher percentage increase on the MBS, than longer consultations. Despite the College's faith in GPs providing adequate consultation times to meet their patients' needs, the College is concerned from a policy viewpoint that the incentive will reward shorter consultations.[100]

3.118 The importance of longer consultations in high quality primary care and in addressing lifestyle issues is well known, as Professor Dwyer from the Australian Healthcare Reform Alliance explained:

> Longer consultations cost more per patient visit but produce far better outcomes and in the long-term are extremely cost effective. A ten-minute consultation with someone about whom a doctor knows little is unlikely to alter a dangerous lifestyle. All experienced physicians will tell you that they need time to 'listen between the lines' and let the real problems that a patient wishes to discuss come to the surface.[101]

3.119 Departmental officers commented in response that this tendency is corrected in part by the higher rebates payable for long consultations. Secondly, on practical grounds, rectification of the problem would essentially require a sliding percentage based rebate:

> We are constantly aware of the desire not impose additional administrative burdens on GPs. … To set it as a percentage would have required essentially a new item to twin with every MBS item.[102]

Conclusion – effective reforms

3.120 The Committee concludes that the proposed measures are likely to maintain if not marginally increase the levels of bulk billing for those in the two target categories – concessional patients and children under 16. However, the package is likely to see a slide in the overall levels of bulk billing to the wider population to around 60%, as

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99 Dr Lim, *Proof Committee Hansard*, 19 January 2004, p. 63

100 RACGP, Submission 67, p. 6. This problem also noted by Catholic Health Australia, Submission 48, pp. 1-2; Australian Healthcare Association, Submission 56, p. 6; Dr Alexander, Submission 26, p. 1; Rural Doctors' Association, Submission 87, p. 8

101 AHRA, Submission 94, p. 7

102 Mr Davies, *Proof Committee Hansard*, 20 January 2004, p. 68

bulk billing becomes generally available *only* to those in the target categories. The bottom line is Medicare Plus neither restores wide scale bulk billing, nor intends to.

3.121 Given the complexity of predicting bulk billing rates and gap payments, it remains unclear whether this move would also drive a rise in gap payments for general GP consultations, as practices cross-subsidise to take advantage of the rebate incentives. For this reason, the Committee agrees that there are legitimate grounds for linking higher payments to incentives to bulk bill.

3.122 Perhaps the greatest paradox in the government proposal is that it focuses on providing bulk billing to categories of people who already enjoy the highest rates of bulk billing in Australia. To a large extent, the policy puts forward a solution to a non-existent problem, while overlooking – if not worsening – the more pressing issue of declining access to bulk billing for everyone else.

3.123 The Committee also finds that the proposal does not address the underlying structural inequities that currently plague the operation of Medicare: the low levels of bulk billing in regional areas, and the problems in accessing many specialists and diagnostic services due to low bulk billing rates and high gap payments.

Alternatives

3.124 The Committee heard various alternatives to the government's proposals which, it could be argued, better address the existing problems with access to Medicare health services. Three principal alternatives were suggested:

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

A $5 incentive for all bulk billed services

3.125 Based on the underlying importance of bulk billing and the pitfalls of selecting certain categories of people to the exclusion of others, both discussed above, a number of submissions considered that the government's proposals would be improved by extending the $5 incentive payment to any service that is bulk billed, irrespective of the recipient.[103] In this way the principle of universality would be maintained. As the Preston Reservoir Progress Association submission argued:

103 Advocated by a number of submissions, including: AHA, Submission 56, p. 6; Humanist Society of Victoria, Submission 23, p. 2; Combined Pensioners and Superannuants Association of NSW, Submission 28, p. 4; Dr Lambie, Submission 34, p. 1; TasMAG, Submission 22, p. 4. VMAG, Submission 27, p. 4 (the latter two also recommend the use of bulk billing targets.)

> If the government believes that the $5 incentive will be sufficient to ensure continued bulk billing, then why not extend it to the other 40% of the population.[104]

3.126 This view accepts a legitimate role for targeted incentives aimed specifically at raising the level of bulk billing. Mr Goddard of the Australian Consumer's Association stated:

> I think there is certainly a good case for rewarding bulk-billing, for saying that we value doctors who bulk-bill and that there be something extra in it for them.[105]

3.127 A significant advantage of this approach is that it would limit the extent to which increases in the rebate would be simply swallowed up by the medical profession – at great public expense – with no impact on bulk billing rates. This problem was discussed in detail in the Committee's first report[106] and remains a concern of the government.

3.128 However, such a solution does not address the underlying problems with the rebate levels, and as such, would not do anything to restore doctor confidence in the fundamentals of the system. Further, as noted above, such a payment would not have any influence on the currently low levels of bulk billing for most specialist and diagnostic services.

Raising the rebate

3.129 Many submissions consider that the key shortcoming of the Medicare Plus proposals is its failure to come to terms with the fundamental issue of setting and maintaining a realistic level for the MBS rebate.[107] Thus, for example, the Tasmanian Medicare Action Group argued:

> The fact that the government has allowed Medicare rebates to fall so far behind … actual fees charged by GPs is evidence of its lack of commitment to a universal and equitable national health insurance scheme.[108]

3.130 In general, the doctors' groups share this view and see a general reassessment and raising of the rebate as the central solution to current levels of bulk billing.[109]

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104 PRPA & DDEMG, Submission 85, p. 4

105 Mr Goddard, *Proof Committee Hansard*, January 2004, p. 46

106 Senate Select Committee on Medicare, *Medicare – Healthcare or Welfare?*, p. 180

107 Australian Pensioners' and Superannuants' league Qld., Submission 3, p. 3; Mr Winterton, Submission 10, p. 1; NSW Retired Teachers Association, Submission 21, p. 1; UnitingCare, Submission 55, p. 7; City of Darebin, Submission 42, p. 3; Mr Boyle, Submission 47, p. 1

108 TasMAG, Submission 22, p. 4

3.131 Evidence received by the Committee's first inquiry showed that although rebates have been increased in line with inflation, based on a government wage cost index (WCI5), there has been a genuine decline in that part of a doctor's Medicare income relative to average weekly earnings. This, in combination with higher-than-indexed costs of medical practice, were said to be the principle drivers of falling bulk billing and rising gap fees.[110]

3.132 The report by the Australian Institute of Primary Care, commissioned by the Committee for the first inquiry, found that when comparing doctors' incomes from the MBS with average weekly ordinary time earning (AWOTE), Commonwealth expenditure on GPs in 1992-93 was about 5.2 times AWOTE, falling to 4.7 times AWOTE in 2002-03.[111]

3.133 However, as the discussion in the previous section of this report illustrates, it is far from clear whether increases to the MBS can guarantee any significant rise in bulk billing rates. This was the Committee's conclusion in the first report.

3.134 Mr Davies of the Department of Health and Ageing admitted that even the extra income generated by doctors from the current proposals will not necessarily increase the current levels of bulk billing for either the target groups or the wider population.[112]

3.135 Even where the need for a general increase in the MBS is accepted, it still leaves the vexed question of how much it should be increased by. This issue has already been discussed in some detail in the Committee's first report, examining the claims of the doctors' groups and the outcomes of the Relative Values Study.[113] During this inquiry the St Vincent de Paul society recommend raising the rebate for all GP services by $10 and indexed,[114] while Mr Goddard told the Committee:

> there is a reasonable prima facie case to say that there should be comparative wage justice for doctors as well as for everybody else; we should restore the level to where it was when the Medicare rebate was actually pretty generous, and it was comparatively at its most generous right at the beginning and again at the beginning of the nineties – and tak[ing] that as the measure of real value you would need to increase the rebate for

109 AMA, Submission 9, pp. 1 & 2; RACGP, Submission 67, p. 6

110 Senate Select Committee on Medicare, *Medicare: Healthcare or Welfare?*, p. 17

111 Senate Select Committee on Medicare, *Medicare: Healthcare or Welfare?*, p. 17

112 Mr Davies, *Proof Committee Hansard*, 19 January 2004, p. 45

113 Senate Select Committee on Medicare, *Medicare: Healthcare or Welfare?*, p. 169

114 SVDP, Submission 58, p. 8. See also Mr Winterton, Submission , p. 10; Geelong West Branch of the ALP, Submission 41, p. 3; Catholic Health Australia, Submission 48, p. 6

> basically every service by between $5 and $7, on average. On top of that, the profession talks about a lot of costs which are specific to general practice. I do not think we have the research really to know what those are. Our feeling is that the case for that has not been proven. That is not to say that there is not a case there; the case has not been demonstrated.[115]

3.136 Catholic Health Australia compared the cost implications of the various proposed MBS increases for GP consultations:[116]

- Extending the $5 increase to all bulkbilled services will cost $326.6 million (ie $5 x 96.9m services x 67.4% bulkbilled), or $59.3 million additional per year than in the Government package. This assumes the bulkbilling rate stabilises at 67 percent and the number of services does not decline further.

- Extending the $5 increase to all GP services whether or not they are bulkbilled will cost $484.6 million (ie $5 x 96.9m services), or $217.3 million more per year than in the Government package. Again this assumes the number of services does not decline further.

- To provide a $10 increase for all GP consultations would cost around $969 million, or $701.7 million more per year than the Government's current package.

3.137 However, the Committee also notes the cautionary comments of Professor Deeble, that raising the rebate does not mean matching the prevailing level of average gap payments, currently at $12.77:

> The submissions say that, if the amount of payment that the government offers is less than the gap that we can get by charging patients what we think they can pay, then the logical extension of that is that the government has to match whatever the doctors decide to charge. That is not necessarily true. But if they will only bulk-bill if they get the same amount that they think they could get from patients then you might as well give up Medicare, because it is completely untenable to go chasing any level of fee that a doctor thinks they can get.[117]

3.138 The Department of Health and Ageing also pointed to the fact that although remuneration to GPs for consultations was under-funded 'to a small degree', other government initiatives – such as the Practice Incentives Program (PIP) – has delivered increases in practice income that 'more than offset this under-funding'.[118]

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115 Mr Goddard, *Proof Committee Hansard*, 19 January 2004, pp. 45-46

116 Catholic Health Australia, Submission 48, pp. 6-7

117 Prof Deeble, *Proof Committee Hansard*, 19 January 2004, p. 5

118 DHA, Submission 54, pp. 7-8. Note also Table 5

3.139 In relation to specialists, the ACA also saw little benefit in raising the schedule fee due to the already low rate of bulk-billing:

> This is not to sweep the problem under the carpet; there are clear inequities in a system which allows specialists to charge virtually open-ended fees. The problem needs to be taken up on the supply side, particularly restrictions on entry to certain specializations. The best approach may be on a profession-by-profession basis, for there is no single pattern of shortage.[119]

3.140 A second issue, that in the longer term underpins the question of increasing the MBS benefits, is reform to the indexing system by which the MBS is adjusted.

3.141 The Schedule is currently determined by the Medical Services Advisory Committee, administered by the Department of Health and Ageing. According to the Department, it is a historical schedule which is indexed annually and occasionally adjusted for new technologies or new forms of treatment.[120] Again, this issue was addressed in the Committee's first report, which explained the current indexation method.[121]

3.142 The key to the importance of this issue is the strongly held view within the medical profession that the current system has failed to deliver realistic payments and has been discredited.[122] The Medical Benefits Schedule forms the central structural backbone of the Medicare system, and as such, is the foundation of bulk billing. As long as the schedule remains discredited, efforts to restore bulk billing are likely to enjoy limited success. It is arguable therefore that a reformed method, preferably with greater transparency, is needed to restore doctors' commitment to the Medicare system. Mr Goddard told the Committee:

> I think the important thing is indexation … a number of GPs have told me they do not want this situation to arise again – if they are going to get back into bulk-billing, they want to make sure that they are not in the same situation again in another five or 10 years – and realistic indexation, based on an objective measurement of genuine costs, would I think provide them with the assurance that it would be worth getting back in. Getting them back in is going to be a problem.[123]

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119 ACA, Submission 36, p. 14

120 Mr Davies, *Proof Committee Hansard*, 20 January 2004, p. 50

121 Senate Select Committee on Medicare, *Medicare: Healthcare or Welfare?*, p. 179

122 RDAA, Submission 87, p. 15

123 Mr Goddard, *Proof Committee Hansard*, 19 January 2004, p. 46

3.143 These sentiments are reflected in the comments of a number of submitters.[124]

Additional targeted measures

3.144 Other groups recommended that if the proposals were to proceed in their current form, affordability and access for those groups in identified need would be improved by special additional measures not contained in this package.

3.145 The National Association of People Living with HIV/AIDS (NAPWA) put forward one such suggestion, arguing for the creation of a chronic illness card. This card would entitle holders to the benefit of the bulk billing incentives and lower safety net thresholds in the package, thereby helping to mitigate the impacts of chronic illness, which require 'a complex matrix of clinical management, and often, additional allied health support', particularly in relation to the cost of accessing pharmaceuticals.[125]

3.146 As Mr Goddard explained, the GPs who treat chronic illness specifically are required, sometimes by regulation, to have a higher level of qualification and skill than many generalist doctors – their general knowledge plus the specialised knowledge of the illness:

> But not only is there no benefit to them for that; there is a disincentive. For example, when I go to my doctor to talk about HIV, I am never out in less than half an hour. But there is no way that the doctor, who sees a lot of us – and we do tend to congregate – can claim for all of that. In the present situation, without recognising that looking after chronic illness is different, we are actually financially penalising some of our best doctors.[126]

3.147 Representatives of the Consumers Health Forum of Australia, the Public Hospitals, Health and Medicare Alliance of Queensland and ACOSS all supported the need to better address the needs of this group.[127]

3.148 The Committee also received evidence from the National Association of Developmental Disability Medicine. They point to health outcomes significantly below average for the group they represent, which includes those with intellectual disability, cerebral palsy, and autistic spectrum disorders, and show that people in these groups typically die twenty years younger than the general population. The Association considers one of the principle barriers to be the inadequacy of the MBS

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124 Dr Matthews, Submission 05, p. 1-2; Mrs Scholem, Submission 7; Dr Alexander, Submission 26, p. 3; SVDP, Submission 58, p. 8

125 NAPWA, Submission 44, p. 10; Mr Menadue, *Proof Committee Hansard*, 19 January 2004, p. 41

126 Mr Goddard, *Proof Committee Hansard*, 19 January 2004, p. 40

127 Ms Hokins, Ms Mohle and Mr Harvey, *Proof Committee Hansard*, 19 January 2004, pp. 40-41

rebate relative to the amount of additional time needed to properly assess and manage the health problems associated with these conditions.

3.149 They recommend, among a number of measures, the provision of specific funding for health assessments for people with developmental disability, similar to those already provided for the aged and indigenous population under the Enhanced Primary Care initiatives.[128]

3.150 Finally, the Rural Doctor's Association of Australia renewed its calls for special recognition of the higher costs of providing medical services in regional and remote areas, by means of a rural loading for MBS or separate consultation item numbers for these services.[129] This suggestion was discussed in the Committee's first report.[130] Since that time, the RDAA has released the findings of their recent study, conducted in conjunction with Monash University: *Sustaining Medical Practice in Rural and Remote Australia: a summary of the viable models of rural and remote practice project*,[131] which found that one in five medical practices in rural and remote Australia are not viable.[132]

Specialists costs

3.151 As the discussion above demonstrated, the government package does nothing to address the issue of low bulk billing rates and high gap fees for specialists and some diagnostic services. The Committee strongly believes that no meaningful improvements to access and affordability under the Medicare system can be achieved without addressing specialist costs.

3.152 Several alternatives to the proposed safety nets are worth broadly canvassing.

3.153 First, measures could be taken to increase the number of specialists providing services in public hospitals, potentially through flexible funding arrangements enabling bulk billing by specialists in public hospitals or expanded outpatient clinics. Second, funding could also be provided to incorporate specialist and diagnostic services into Community Health Centres (discussed in greater detail in Chapter 5). Third, the government could move to a system of bulk purchasing for selected services. For example, regional tenders could be offered for the provision of a specified number of services in a particular region. This may prove an effective means

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128 National Association of Developmental Disability Medicine, Submission 17

129 RDAA, Submission 87, p. 16

130 Senate Select Committee on Medicare, *Medicare: Healthcare or Welfare?*, p. 185

131 RDAA, Submission 87, Attachment 1

132 RDAA, Submission 87, p. 8. See also RDAA, Submission 87A, Attachments 1 & 2

of price control particularly in relation to largely uniform, undifferentiated services, but is less relevant for more variable services.

3.154 The Committee also notes the example offered by the long-standing government agreements with pathologists and optometrists, which have seen capped funding and high bulk billing rates in both areas, amounting to 84.1% for pathology services and 96.5% in optometry.[133]

Conclusion – alternatives

3.155 The Committee sees considerable merit in some of these alternatives. In particular, the Committee considers that these $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.

3.156 It is clear though, that 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 must be addressed for both general practitioners and specialists.

3.157 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 true practice costs and 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 bulk billing system and if it is perceived to have become irrelevant, the viability of Medicare as a universal health insurer is undermined.

3.158 The Committee concludes that the only solution to this problem is to reform the current system for determining the MBS and introducing a more transparent manner 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.

3.159 Only this type of reform can deliver an outcome that has the necessary legitimacy with both the medical profession and the general population. This legitimacy is needed both to entice the medical profession to recommit to the bulk billing system, and to sustain the confidence of the Australian public who pay for Medicare.

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133 Department of Health and Ageing, Medicare Statistics 1984/85 to June Quarter 2003, p. 11

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.

3.160 Finally in relation to specialist costs, the Committee considers that given the scope of the terms 'specialist and diagnostic services', it is necessary to be circumspect about advocating any particular solutions to this problem. Also, as noted above, raising rebate levels for specialists may have little or no effect on their billing practices and as such, it should be acknowledged that fee for service is not necessarily the best model for purchasing specialist and diagnostic services.

3.161 The Committee concludes that a three-fold approach is necessary to address the issue of specialist costs.

3.162 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, minimising gap payments, and maximising adherence to the schedule fee.

3.163 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.

3.164 Second, and in recognition of the limits of the above approach, the government should explore alternative models of providing specialist and diagnostic services, such as those outlined in paragraphs 3.150 above.

3.165 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 observance of 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.

Chapter 4

Workforce measures

Introduction

4.1 Term of reference (b)(iii) requires the Committee to consider:

> the Government's proposed workforce measures including the recruitment of overseas doctors;

4.2 The Medicare Plus package introduces a number of workforce measures that are additional to those contained in *A Fairer Medicare* Package.

4.3 *A Fairer Medicare* provided for: 234 new medical school places, bonded to areas of workforce shortage; 150 new GP Registrar training places, plus funding for 457 full time equivalent practice nurses.

4.4 Medicare Plus now adds:

- Funding for an additional 1500 full time equivalent doctors and 1600 full time equivalent nurses in the period 2003 – 2007.
- The creation of a new Medicare Item Number to enable a rebate of $8.50 to practice nurses undertaking immunisation and wound management. This will be in addition to a grant of $8,000 per Full Time Equivalent GP in a practice to assist in employing practice nurses in urban areas of workforce shortage.[1]
- The introduction of short term placements for trainee medical practitioners in outer metropolitan, regional and rural/remote areas in an attempt to address the current supply shortage.
- Incentives for Non-Vocationally Registered (NVR) doctors to practice in areas of medical shortage for a period of five years.
- Funding to increase the number of overseas-trained doctors (OTDs), directed to areas of workforce need.

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1 Practice nurse incentives will also be available to practices that participate in the PIP, and which are located in these urban areas of workforce shortage.

- Measures, as yet unspecified, to encourage the continued practice of doctors in areas of workforce need, and to bring doctors who have ceased practice back into the system.[2]

4.5 The bonded medical school places remain from the previous package, but as recommended by the Committee, Medicare Plus will enable students willing to undertake postgraduate vocational training in rural areas to attribute the period spent (up to three years) against their bond term. Otherwise, the additional under- and post-graduate training places for GPs, as well as training places for nurses and allied health workers, remain from the original package.

4.6 According to the Hon Tony Abbott MP, Minister for Health:

> A key factor in maintaining the affordability of medical services is having an adequate supply of doctors and nurses. Medicare Plus is Australia's most extensive effort ever to attract and retain a larger medical work force. It makes an immediate and sustained investment in supporting the equivalent of about 1,500 more doctors and 1,600 more practice nurses by 2007. More than $1 billion supports these initiatives to 2006-07.
>
> More doctors will be trained, and more will be encouraged to work in areas of shortage.[3]

Reactions to the proposals

4.7 Although reactions to the proposal were mixed, most respondents welcomed the workforce component of the package as a move in the right direction, and considered it an improvement on the measures contained in *A Fairer Medicare*.[4] Uncontroversial elements of the package include: the concept of training more doctors and nurses in Australia, increasing access to care in aged care facilities; assisting ex-doctors to return to the medical workforce, and various measures to assist overseas-trained doctors (OTDs) to assimilate smoothly and productively into the Australian workforce.

4.8 However, many respondents were also dubious about the likelihood of achieving the stated objectives, particularly those relating to recruitment of 1,500 extra doctors

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2 This proposal attracted little comment, but respondents were generally supportive of it. See, for example, Rural Doctors' Association of Australia, Submission 87, p. 29; Australian Medical Association, Submission 9, p. 3

3 The Hon Tony Abbott MP, Minister for Health, Second Reading Speech, *Health Legislation Amendment (Medicare)* Bill 2003, House of Representatives Hansard, 4 December 2003, p. 23331

4 See, for example, Australian Divisions of General Practice, Submission 91, p. 1; City of Darebin, Submission 42, p. 3; Australian Consumers' Association, Submission 36, p. 10; Catholic Health Australia, Submission 48, p. 10

and 1,600 more practice nurses.[5] Respondents question how such significant numbers can realistically be delivered, and suggest that government objectives are overly optimistic. The Australian Health Care Reform Alliance had this to say:

> It is totally unrealistic to suggest that an immediate increase of 1,500 in the number of full time equivalent doctors available to the system is achievable. Totally inadequate numbers of additional places for medical students and nurses in Universities and Colleges will not see us adequately address our long-term need for more professionals from these health disciplines.[6]

4.9 Uniting Care put it this way:

> The announcement of additional short term supervised placements in regional and rural areas for junior doctors is positive, however it will result in only an additional 70 full-time doctors every year, when it has been estimated that a total of 2,000 are needed.[7]

4.10 St. Vincent de Paul saw this problem in the wider context of a continuing inadequate investment in medical workforce training, coupled with disincentives and debt, and continuing large numbers of students who do not receive an offer of a place in university in medical courses.[8]

4.11 The Australian Health Care Reform Alliance pointed out that the provision of more training places alone would not necessarily result in more graduates, and that it was a matter of transforming the perception of general practice among potential medical students:

> [More training places for general practitioners] is indeed a hollow initiative given that the places currently available are not being filled so unattractive is the prospect of entering general practice for many young doctors. The funding of [additional] training places will be a good idea and indeed essential once the basic underlying problems that are deterring doctors from entering general practice have been solved.[9]

4.12 The Committee notes that the provision of funding for extra doctors and nurses does not constitute a guarantee of their delivery. Indeed, the Department of Health and Ageing emphasised that the funding related to full-time equivalent (FTE) positions,

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5 See, for example, Public Hospitals Health and Medicare Alliance of Queensland, Submission 51, p. 3; Australian Consumers' Association, Submission 36, p. 10

6 Australian Health Care Reform Alliance, Submission 94, p. 19

7 UnitingCare, Submission 55, p. 8

8 SVDP, Submission 58, p. 10

9 Australian Health Care Reform Alliance, Submission 94, p. 19

and not necessarily to that many new workers.[10] In terms of new FTE positions which are filled by new entrants, many of the doctors will be drawn from overseas, and OTD entry targets were set through consultation with medical bodies such as the Australian Medical Council, rather than through specific modelling.[11]

4.13 The remainder of chapter four provides more specific commentary on those proposals which garnered most interest.

Implications for public hospitals

4.14 Concern was expressed at the prospect that the package might drain both doctors and nurses from the already stretched public hospital system. The Australian Healthcare Association expressed the following misgivings with regard to doctors:

> The AHA is concerned about the MedicarePlus proposal to release graduate doctors from hospital placements and put these doctors in general practice placements. The proposal does not offer any way for the public hospital system to recruit more doctors to replace the graduates, and the AHA fears that removing them from public hospitals will simply result in further doctor shortages. The Federal Government cannot remove doctors from under-staffed public hospitals without replacing them.[12]

4.15 Similarly, some believed the incentives to nurses in general practice would draw already scarce staff away from other areas of need, such as hospitals.[13]

4.16 The Department of Health and Ageing contends that the workforce initiatives aim to add to the pool of staff rather than re-distribute it between sectors. The Department argues that, alongside an increase in the number of people registering as nurses in recent years, the measure will encourage those who have left the profession to return, citing the provision for refresher courses as a facilitator in this regard.[14] With respect to doctors, initiatives such as more training places, increased use of overseas-trained doctors, and re-entry to the workforce by doctors who have left it, aim to bring about 'new' full-time equivalent practitioners to the system.

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10 Mr Davies, *Proof Committee Hansard*, Canberra, 20 January 2004, p. 49

11 Mr Wells, *Proof Committee Hansard*, Canberra, 20 January 2004, p. 50

12 AHA, Submission 56, p. 3. See also Queensland Nurses Union, Submission 62, p. 6

13 See, for example, Moreland City Council, Submission 81, p. 3; National Rural Health Alliance, Submission 65, p. 9; Catholic Health Australia, Submission 48, p. 10

14 Department of Health and Ageing, Submission 54, p. 25

Overseas trained doctors

4.17 The most consistent criticism of the workforce proposals was related to the increasing use of OTDs, who form an integral part in the government's proposed solution to the current shortage, particularly in the short term. The effective and efficient utilisation of OTDs can be complicated because of the mechanics of migration, cultural differences, additional training requirements, and the associated need to evaluate foreign qualifications. The Committee became aware of such difficulties during the first inquiry, when it found:

> The Committee is concerned over the apparent lack of supervision over, and support for, some OTDs practising medicine in Australia without full accreditation. This situation places both the doctors concerned, and the communities they serve, in potentially dangerous situations. Part of the problem may be an imbalance between the onerous requirements for doctors to enter Australia as skilled migrants and gain accreditation, and other easier means by which they can enter and practice in areas of medical workforce shortage.[15]

4.18 Many respondents consider Australia's reliance on OTDs to be morally questionable, and argue that the nation has sufficient resources to train all necessary medical staff without resorting to encouraging practitioners from less fortunate areas to practice here.[16] The Australian Divisions of General Practice pointed to Australia's international obligations:

> Australia also has an obligation to observe the tenets of the Melbourne Manifesto endorsed by WONCA 2002[17]. The Melbourne Manifesto presents a code of practice for the international recruitment of health care professions, and has put the onus on every country to train enough health professionals to meet its own needs.[18]

4.19 Putting it somewhat more strongly, Mr Gregory submitted that:

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15 Senate Select Committee on Medicare, *Medicare – healthcare or welfare?*, p. 204

16 See, for example, Australian Medical Association, Submission 9, p. 3; UnitingCare, Submission 55, p. 8; Australian Divisions of General Practice, Submission 91, p. 2; Queensland Nurses' Union, Submission 62, p. 6; Victorian Medicare Action Group, Submission 27, p. 5; Australian College of Non VR GPs, Submission 35, p. 3; Australian Nursing Federation, Submission 64, p. 5; Doctors Reform Society, Submission 16, p. 3

17 The Fifth World Organisation of Family Doctors World Conference on Rural Health, Melbourne, 30 April-3 May 2002.

18 Australian Divisions of General Practice, Submission 91, p. 2

> It is absolutely shameful that a country like this is in that situation and having a net impost on the world supply of doctors.[19]

4.20 During the first inquiry, the Committee found that:

> It is disturbing that Australia's medical workforce has become so dependent on imported medical professionals, particularly when there are so many Australians wanting to enter medical courses. As a matter or principle, the Committee takes the view that Australia, as a wealthy developed nation, should not be taking doctors away from nations where the need for qualified doctors may be even greater than our own.[20]

4.21 There was a perception among some that the use of OTDs was a 'bandaid' solution, failing to address underlying problems:

> It is a short term measure that does nothing to alleviate the chronic issues domestically that have resulted in our own workforce crisis. Improving pay and conditions, offering incentives to work in difficult to recruit areas, and encouraging and support[ing] undergraduate enrolment are all vital issues that need to be undertaken from a central, well planned perspective.[21]

4.22 The RDAA agreed, submitting that the use of OTDs:

> … must be recognised as a short-term measure – a stop-gap until Australia produces sufficient medical graduates to provide its own medical workforce adequate to meet the needs of all parts of the country.[22]

4.23 The RDAA also pointed out that reliance on OTDs left Australia vulnerable to competition in the international labour market, which is already experiencing a shortage, a factor not lost on Doctors Stewart and Brown, who noted that:

> EEC work practice legislation limiting hours of work and on call for doctors in Europe will lead to a huge demand for more medical practitioners in Europe. Australia will be competing for medical graduates in a world environment deficient in doctors.[23]

4.24 In its Submission the Department of Health and Ageing outlines a broad recruitment strategy for attracting overseas-based practitioners, anticipating the use of

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19 Mr Gregory, *Proof Committee Hansard*, Canberra, Monday 19 January 2004, p. 92

20 Senate Select Committee on Medicare, *Medicare – healthcare or welfare?*, p. 204

21 Australian Nursing Federation, Submission 64, p. 5

22 Rural Doctors' Association of Australia, Submission 87, p. 26

23 Drs Stewart and Brown, Submission 40, p. 1

direct marketing activities, as well as internet based methods. A target of 725 doctors over four years has been set, and the Department indicated that it would not target developing countries in its campaign.[24]

4.25 Others saw the issue as less of a moral issue, and more of a practical one, questioning the medium- to long-term effectiveness of using OTDs, and the implications of patchy examination requirements, as well as lack of support, for quality of care delivered by OTDs.

4.26 A number of respondents commented on the low examination pass rates achieved by many OTDs. The point was made by a number of respondents that OTDs who are placed in rural and remote areas, where the need for their services is greatest, face an uphill battle because the professional and social support infrastructure is smallest. Accordingly, there needs to be a commitment to support programs.[25]

4.27 Associate Professor Hawthorne provided the Committee with the most comprehensive analysis of the issue, based on her extensive research and publication on issues surrounding the use of OTDs, particularly in Australia. Associate Professor Hawthorne stressed the important role of OTDs in the current Australian medical landscape, and detailed a number of problems which present themselves for efficient utilisation of OTDs in Australia.[26]

4.28 Professor Hawthorne reports that OTDs, particularly those seeking permanent residentcy, are having significant problems qualifying for work in Australia, primarily because of a ban *against* OTDs applying under the skilled migrant program. As a result, a decidedly different cohort of entrants arrive, with applicants entering Australia through generalised, non-profession based criteria (such as general migration), often without proven competency in either English or in medicine. These doctors can find exams such as those from the Australian Medical Council (AMC) a great challenge, and failure rates are high. The Australian Healthcare Association added that:

> While the recruitment of overseas doctors is a good notion in principle, in practice Australia has encountered major problems … includ[ing] the high rate of failure for the AMC test. Part 1 of the AMC is an English comprehension and multiple choices and Part 2 is a practical oral examination of patients and conditions. At present, 2,000 doctors have passed Part 1 of the AMC but have not completed Part 2. Another 3,000 doctors have expressed interest in sitting Part 1 but have not yet felt

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24 Department of Health and Ageing, Submission 54, p. 28; See also Mr Wells, *Proof Committee Hansard*, Canberra, January 20 January 2004, p. 51

25 Drs Stewart and Brown, Submission 40, p. 1; Rural Workforce Agency (Victoria), Submission 90, p. 6

26 Associate Professor Hawthorne, Submission 88, pp. 3-8

> confident to sit the exam. The AHA has said that overseas students may need extra assistance and training before sitting the exam, including spoken English practice …
>
> [T]he government acknowledged the problems with the low pass rate for the exam and as part of Medicare Plus has said it will change the system to increase the pass rate. This raises issues of concern for the AHA, as the test is based on final year medical student tests and therefore meets Australian standards. If the AMC is changed and made 'easier' the AHA is worried that quality will be compromised. Quality should be a key factor in recruiting doctors from overseas and the government must ensure that testing is maintained at the Australian standard, regardless of the low pass rate[27]

4.29 However, this does not preclude many of these applicants for *permanent* residency from practicing without relevant testing. Associate Professor Hawthorne submits that:

> Due to demand-driven processes, substantial numbers of these OTDs have entered Australian practice prior to passing one or both of the AMC exams.[28]

4.30 Obversely, Professor Hawthorne reports that *temporary* resident OTDs are able to by-pass the Occupational English Test and AMC exams at point of entry, proceeding immediately to medical practice. In this context, she argues for the reform of OTD entry requirements through, among other things:

- the lifting of the ban relating to medically trained applicants within the skilled migration program; and
- the adequate resourcing of professional transition training for both temporary and permanent OTDs, particularly pertaining to appropriate and accessible preparatory bridging programs for the purposes of professional competency.[29]

4.31 However, Professor Hawthorne stopped short of endorsing full equity in qualification requirements between temporary and permanent OTDs, saying:

> On equity grounds there seems a clear case for extending the administration of the Occupational English Test and AMC exams to temporary entrant OTDs. However this is a complex decision which would require careful government consideration for several reasons.

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27 Australian Healthcare Association, Submission 56, p. 9

28 Associate Professor Hawthorne, Submission 88, p. 3

29 Associate Professor Hawthorne, Submission 88, pp. 3-5

> Firstly, the introduction of these measures would almost certainly reduce the attractiveness of Australia as a medical destination to prospective temporary resident OTDs—not an outcome desirable in the current shortfall situation. Secondly, the application and assessment process of temporary entrant OTDs would be significantly delayed. Thirdly, substantial numbers of current applicants would be likely to fail, if we extrapolate AMC and OET pass rates by country of origin to temporary resident OTDs (eg from India). Fourthly, as we have seen, demand-driven processes have ensured that substantial numbers of permanent resident OTDs lacking AMC [accreditation] are currently engaged in 'area of need' practice, despite the fact that they are theoretically required to sit these exams and secure passes.
>
> For all these reasons I make no simple recommendation to the Senate regarding this issue - rather identifying it as one meriting very careful consideration.[30]

4.32 Professor Hawthorne also suggested requiring permanent resident OTDs to serve in areas of need for a defined period, as is currently the case with temporary applicants.[31]

4.33 Putting aside morality and numerical effectiveness, the ACA did not see how recruitment of OTDs would necessarily ease the burden caused by the current maldistribution, and commented that doctors:

> …[C]an be expected to have the same geographic preferences as their established colleagues. Many are likely to wish to practice in areas where there is already adequate GP supply and, given the profession's history of ignoring blandishments to move to areas of need in which they do not want to live, this problem will continue to be extraordinarily difficult to solve.[32]

Expanding the role of nurses

4.34 A key new plank of the package is the expansion in the role of nursing staff within the general practice setting, as recommended by government Senators in the first inquiry. This would be partly achieved through the creation of a new MBS number for nurses to carry out prescribed procedures relating to immunisation and wound management, which would attract a rebate of $8.50.[33] To complement this, the practice grants program from *A Fairer Medicare* will be carried over to Medicare Plus.

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30 Associate Professor Hawthorne, Submission 88A, p. 1

31 Associate Professor Hawthorne, Submission 88, p. 4

32 Australian Consumers' Association, Submission 36, p. 10

33 This rebate will increase by $5.00 where the service is bulk billed and performed on a concession card holder or child under 16 yrs.

4.35 The proposal is generally supported, with comments focusing on the potential for widening its scope.[34] The Australian Divisions of General Practice would expand the list of claimable items to include:

- monitoring and clinical management (such as reviewing blood pressure after alteration in treatment);
- providing early disease detection services (such as diabetes screening in high risk groups);
- input to chronic disease management (such as providing asthma education);
- home visits, including protocol-driven health assessments under the supervision of a GP; and
- conducting Pap smears.[35]

4.36 The Department of Health and Ageing does not rule out the expansion of the list of rebateable items for nurses in the future, but points to the fact that practice nurses have never attracted a rebate before, and that a measured approach needs to be taken in the introduction of the initiative.[36]

4.37 The ADGP also pointed out the need for clear definition of what the package intends by 'broad supervision', where the doctor is required to monitor a nurse's activities.[37] While the ADGP broadly supports the initiative, it considered that the proposed rebate of $8.50 'demeans' the level of knowledge and expertise required by nurses, and should be increased.

Bonding of Medical School Graduates

4.38 This measure was carried over from the *A Fairer Medicare* package, and much of the evidence received by the Committee in the first Inquiry was mirrored in the second. In its first report, the Committee acknowledged the difficulties likely to be encountered with the scheme, but expressed support for the bonded places under the proviso that students be allowed to begin working off their bond during postgraduate

34 See, for example, Rural Doctors' Association of Australia, Submission 87, p. 27; Doctors Reform Society, Submission 16, p. 3

35 Australian Divisions of General Practice, Submission 91, p. 6

36 Mr Davies, *Proof Committee Hansard*, Canberra, 20 January 2004, p. 48

37 Australian Divisions of General Practice, Submission 91, p. 6

vocational training as Registrars.[38] The Committee's findings in this regard are set out in more detail in its first report.[39]

4.39 In Medicare Plus, the government acceded to this recommendation. However, the Committee again received some evidence critical to the measure.

4.40 Some respondents saw bonding as a short-term solution, and foresaw negative consequences further down the line, as bonded doctors grew to resent the compulsion to remain in areas of need, and deserted them at the conclusion of their term.[40] The Royal Australian College of General practitioners put it this way:

> The future of General Practice requires that our recent medical graduates see General Practice as an exciting career choice. The bonding of medical graduates and changes to the higher education sector are likely to dissuade some of our potential doctors from this career path which is likely to impact on the future numbers of GPs. The RACGP calls on the Government again to remove the bonding of medical student places and to support the long term viability of Australian general practice.[41]

4.41 However, some respondents favoured bonded *scholarships*, and the Rural Doctors Association of Australia sets out a number of options for these arrangements in some detail.[42] The National Rural Health Alliance offered 'conditional support' for the concept of bonded scholarships, where:

> … students receive substantial funds to assist them to undertake a medical degree in exchange for a commitment to practice in specified areas in the future. With the right details in place and full disclosure by both parties these may be seen as fair contracts in which a genuine benefit is provided by one party in return for services made available by the other.[43]

4.42 Alternatively, the Australian Health Care Reform Alliance promoted the expansion of an existing program:

> Far better [than creating bonded places] is the program already provided by the Federal Government which sees affirmative action programs find

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38 Senate Select Committee on Medicare, *Medicare – healthcare or welfare?*, p. 107

39 Senate Select Committee on Medicare, *Medicare – healthcare or welfare?*, pp. 97-111

40 See, for example, Rural Doctors' Association of Australia, Submission 87, p. 24

41 Royal Australian College of General Practitioners, Submission 67, p. 4

42 See, for example, the National Rural Health Alliance, Submission 65, p. 11; Rural Doctors Association of Australia, Submission 87, p. 3; Australian Medical Association, Submission 9, p. 3

43 National Rural Health Alliance, Submission 65, p. 11

> additional places for medical students from country areas in our medical schools with a significant amount of their training carried out in country clinical schools.[44]

4.43 The RDAA agrees, suggesting the enhancement of the existing Medical Rural Bonded Scholarship introduced in the 2000-01 Budget. Each of 100 Scholarships is worth around $21,000 per annum, and they are offered to students contracted to complete six years of rural practice on completion of their training. The RDAA also points out that initiatives aimed at encouraging post-graduate doctors to rural areas may be leaving things too late:

> …[C]onsiderable research now indicates that influencing people toward rural medicine should begin much earlier than post-graduate training. One Australian study reported that 'interest in rural practice wanes as medical education progresses'.[45]

Funding for rural GPs doing procedural work

4.44 The importance of having GPs capable of conducting procedural work in rural regions was espoused by the Rural Workforce Agency, Victoria:

> The importance of rural GPs to community and hospital services is a critical issue, particularly the maintenance of GP proceduralists … [m]any Victorian rural communities are not large enough to support their own specialist services. In these communities, GPs provide much of the procedural work to their local hospitals and communities including emergency services, obstetric, anaesthetic and surgery services … [o]ur data shows that the 2nd biggest rural specialist deficit is surgeons. The need for rural GP proceduralists to continue to be able to deliver these services in a supported clinical environment is clear.[46]

4.45 The RDAA agreed, reporting that only about 24% of rural doctors practice obstetrics, and 16% anaesthetics. The Association points out that:

> While the decline in each area is problematic in itself, a loss or deficiency in one area of procedural practice inevitably leads to losses in the others, as for example, surgeons are unable to practice when there is no anaesthetist.[47]

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44 Australian Health Care Reform Alliance, Submission 94, p. 21

45 Rural Doctors' Association of Australia, Submission 87, p. 25. Study cited is Laurence *et al*, Increasing rural activity and curriculum content in the Adelaide University Medical School, *Australian Journal of Rural Health*, 2002

46 Rural Workforce Agency (Victoria), Submission 90, p. 10

47 Rural Doctors' Association of Australia, Submission 87, p. 28

4.46 The government's proposal to support procedural GPs through extra payments available through the Practice Incentive Payment (PIP) program was welcomed by most respondents who commented on it. Catholic Health Australia:

> The Government's proposal … will go some way toward assisting GPs who have retained more than 10 percent of their practice as procedural. The proposal will assist in the retention and continuing comprehensiveness of practice of some rural GPs. The quantum of funding is unlikely to attract additional procedural GPs back to areas where they have left.[48]

4.47 The Australian Healthcare Association echoed these remarks:

> The AHA is pleased to observe the new MedicarePlus package deals with workforce issues, including additional funding for rural GPs with a minimum of 10% MBS procedural practices. This will relieve some of the pressure on rural healthcare. The emphasis on retraining and refresher courses in the package is a positive initiative by the Government, as it will encourage a higher level of quality in the sector.[49]

4.48 However, the RDAA points to the need for further consultation and refinement in the implementation of the initiative, so that the chance of achieving objectives is maximised. An example is the provision of up to $10,000 per year for locum services to enable procedural upskilling. The RDAA supports the measure, but calls for flexibility in implementation, as the availability of locum services in rural areas, and hence the time a doctor can be absent from their practice, is severely restricted.[50]

Enhanced rebate for Non-VR GPs in areas of shortage

4.49 This proposal attracted little comment. Notably, supporters of this initiative include the Australian College of Non-VR GPs.[51] The College pointed out, however, that areas of need were defined by Statistical Local Area (SLA). It was argued that SLA was an inappropriate unit of measurement, and that assessment should occur by individual suburb.[52]

Conclusion

4.50 This package is not a panacea for workforce problems, particularly in rural areas. There are also severe doubts in the opinion of the Committee that the overall number

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48 Catholic Health Australia, Submission 48, p. 11

49 AHA, Submission 56, p. 8

50 Rural Doctors' Association of Australia, Submission 87, p. 29; Australian Medical Association, Submission 9, p. 3

51 Australian College of Non-VR GPs, Submission 35, p. 1-2

52 Australian College of Non-VR GPs, Submission 35, p. 1-2

of ‘new’ practitioners and nurses which the Government anticipates will come online, is actually achievable.

4.51 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, then, as an overall package of initiatives and assuming a substantial increase in the number of new practitioners and nurses can be achieved, it is commendable.

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

4.53 However, training new doctors does take many years and Australia continues to suffer a doctor shortage. OTDs represent 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.

4.54 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.

4.55 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.

4.56 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.

4.57 The Committee supports the proposals.

Chapter 5

Other issues

Introduction

5.1 This chapter addresses four additional matters raised during the inquiry. These include two measures that are contained in the government package:

- the proposed billing measures to enable the direct online claiming of the Medicare rebate from the doctor's surgery; and
- the proposed aged care measures.

5.2 The chapter also considers two that are not:

- access to dental care; and
- addressing the need for deeper system reform to the Medicare system.

HIC Online and direct lodgement of Medicare claims

5.3 In cases where a patient is not bulk billed, the government proposes to change current arrangements to enable MBS claims to be lodged electronically at the point of service (ie. at the doctor's surgery), with the payment made directly to patient's bank accounts within about two working days. Where a patient is privately billed, they must still pay the full amount up-front.[1]

5.4 This differs from the existing system which requires the rebate claim to be lodged at a Medicare office, although 'pay Doctor' cheques will remain available. The new proposal differs from *A Fairer Medicare* package, in that the government has decided not to proceed with the proposal to pay the rebate amount directly to the doctor.[2]

5.5 In order to provide this service, practitioners must participate in HIC Online. Under MedicarePlus, the Government offers a grant to all medical practices to assist in accessing the HIC Online, amounting to $750 for metropolitan practices and $1,000 for rural, regional and remote practices. Although the system can operate on normal 'dial-up' connections, $9.2 million has been allocated to assist practices establish broadband access.

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1 Assuming the practitioner does not offer a 'pay doctor cheque' option, which will still be catered for under the revised package but is usually not offered by practitioners.

2 DHA, Submission 54, p. 16

5.6 The Department of Health and Ageing submission also points out that, since 1999, practices have benefited from around $430 million to assist in computerisation of their practices, through the Practice Incentives Program.[3]

5.7 It should be noted that the current proposal accords with the first inquiry's Recommendation 8.3 to expand the existing program in order to provide assistance to all general practices with the costs of adopting information technology and accessing HIC Online.

5.8 The Committee received relatively little comment on this issue, but notes the concern raised by both the Southern Tasmanian Division of General Practice and Dr Alexander over the logistics of administering this system and their fear that 'practices will become quasi Medicare offices'.[4]

5.9 The Australian Divisions of General Practice and the Osborne Division of General Practice also argued that the level of support is not adequate relative to the costs of implementing and maintaining HIC on line. ADGP argue:

> If the Government wishes to maximise the impact and realise the full efficiencies possible through the HIC Online initiative, it is imperative that Divisions of General Practice are funded to support its implementation. Such support will entail:
>
> - providing general practices with support for upgrading/making compatible their existing IMIT systems;
>
> - providing advice in business systems alignment resulting from the adoption of a new billing mechanism;
>
> - providing advice, training and information sharing to maximise the patient outcomes and clinical benefits possible from the concomitant availability of broadband internet resources.
>
> … Further, it will be critical that the process to interact with HIC Online be fully automated and integrated into GPs' desktop software packages. Work must be undertaken as a matter of urgency with the software providers to integrate this function into their accounting modules. Broadband access may assist connectivity, but without seamless integration with standard software used by general practices, the initiative will struggle to succeed.[5]

5.10 While noting these comments, the Committee reiterates the conclusion of the first report on this issue:

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3 DHA, Submission 54, p. 17

4 Southern Tasmanian Division of General Practice, Submission 57, p. 2; Dr Alexander, Submission 26, p. 3

5 ADGP, Submission 91, p. 8. See also ODGP, Submission 24, p. 2

> In general terms, the Committee accepts that the costs associated with getting online are likely to be quite high, but at the same time, the incentives are not designed to meet the whole of the cost, but rather to make a contribution. This is appropriate given that, notwithstanding its wider significance to best practice health care, information technology is a business cost that must be met by all businesses and one that offers a general practice significant financial dividends through increased efficiencies.[6]

Aged Care proposals

5.11 A final and important aspect of the Government's proposals are the measures designed to improve access to health care for those in aged care facilities. There are two principal aspects to these proposals.

5.12 First, the government package proposes a new MBS item to undertake comprehensive medical assessments of new and existing residents of aged care homes. These assessments will attract a Medicare rebate of about $140, and it is expected that in 2006/07, about 90,000 residents will receive an assessment.[7]

5.13 Second, up to $8,000 will be provided each year to GPs who participate in partnership arrangements with aged care providers. Divisions of General Practice will establish panels of GPs in regions across Australia whose purpose will be to identify and implement action to improve the health of aged care residents. The Department of Health and Ageing submission explained that:

> While still able to access the comprehensive medical assessment item, GPs on these panels will also undertake additional activity, including perhaps being rostered for after hours work and working on health improvement strategies with aged care providers.[8]

5.14 Together, these measures aim to provide more comprehensive and better planned health care for residents of aged care homes, as well as better access to a GP, either on a regular basis if that is what is required, or in an emergency.

5.15 These proposals have received wide support.[9] According to UnitingCare, for example:

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6 Senate Select Committee on Medicare, *Medicare: Healthcare or Welfare?*, p. 113

7 DHA, Submission 54, p. 25

8 DHA, Submission 54, p. 25

9 Including: Australian Pensioners and Superannuants League Qld, Submission 3, p. 6; Catholic Health Australia, Submission 48, p. 12; Osborne Division of general Practice, Submission 24, p. 2; Dr Gault, Submission 26, p. 2; Australian College of Non-VR GPs, Submission 35, p. 3; Australian Healthcare Association, Submission 56, p. 1; Queensland Nurses Union, Submission 62, p. 6; COTA National Seniors Partnership, Submission 73, p. 3; Australian Divisions of General Practice, Submission 91, p. 8

> Uniting*Care*'s Ageing and Disability Service, who run facilities for the aged such as nursing homes and hostels, report that GP visits to residents can be rushed and that the new Medicare item announced in MedicarePlus will hopefully facilitate longer visits by GPs. It was also thought that this would result in staff being more confident in calling upon GPs to visit more regularly.
>
> The additional funding to address the problem of GPs not being available after hours or for emergencies was considered positive, and it was thought that this might avoid the need to send some residents to hospital.[10]

5.16 The only cautionary note came from the Australian Consumers' Association, who warned that 'like many such measures, it is likely to be of limited effect where the lack of access is caused by a doctor shortage.'[11]

5.17 Both the Royal Australian College of General Practitioners and the National Council on Intellectual Disability suggested slight modifications to the proposal, seeking provision of health assessments for younger and disabled people. This could apply to those who are resident in nursing homes,[12] or to all such people.[13]

Improving access to primary health care

Dental care

5.18 An issue continuing to attract comment in this second inquiry, and an area not addressed in the government's proposals, is access to dental health care.

5.19 The Committee's first report, *Medicare: Healthcare or Welfare?*, contained considerable discussion of the problems in accessing dental care and recommended the Commonwealth government take a more active leadership role by reinstating the former Commonwealth Dental Health Program.[14] Much of this discussion remains relevant now and this report will not re-examine the issue in any detail, save for a couple of comments.

5.20 In general, the Committee notes continuing evidence of inadequate access to dental health care across Australia for people on low incomes.[15] From both a practical

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10 UnitingCare, Submission 55, p. 9

11 ACA, Submission 36, p. 11

12 RACGP, Submission 67, p. 8

13 NSW & National Councils on Intellectual Disability, Submission 39, p. 3

14 See Chapter 10 and Recommendation 10.1

15 Illawarra Dental Health Action Group, Submission 19, p. 1; National Advisory Committee on Oral Health, Submission 14, p. 2; Tasmanian Government, Submission 64, pp. 3-4

and conceptual level, it remains curious that Australia continues to separate jurisdictional responsibility for dental care from that of the rest of the body. The Committee reiterates its view that the Commonwealth government can and should take a greater leadership role in national dental health. As Mr Gregory of the National Rural Health Alliance told the Committee:

> As if national leadership on something so important as this were not enough, there are some other reasons why the Commonwealth has a quite legitimate involvement in dental health. Firstly, the Commonwealth is responsible for higher education and therefore has controls over the leavers of dentistry schools and funding thereof, how many we are training and so on. Secondly, the Commonwealth is responsible for aged care. It is amongst the elderly in our population that some of the worst oral health and dental health exist. Thirdly, the Commonwealth is responsible for social security. It is among the people of lower incomes, as you well know, that the worst problems exist.[16]

5.21 As the Australian Dental Association suggests, there are three principle actions the Commonwealth should take. The first is to reintroduce the Commonwealth Dental Health Scheme, subject to modifications to ensure that earlier problems associated with inadequate targeting of measures and anomalies in service provision are not replicated.[17]

5.22 The second is to take immediate action to rectify the existing and worsening dental workforce shortages in Australia. The Australian Dental Association estimating that Australia is going to suffer a shortfall of between 700 and 2000 dentists by 2010.[18] During public hearings Dr O'Reilly explained to the Committee that:

> there is going to be about $25 million in Commonwealth funding needed across the four dental schools to increase the infrastructure, to physically be able to accommodate the increase in the number of students. Our modelling has shown that we will have a net increase of approximately $1 million a year in tuition costs for those extra places. It would cost the Commonwealth approximately $3 million a year in fee subsidies.[19]

5.23 The third is to develop a range of incentive measures that address the particularly acute dental workforce needs of rural and regional areas. These measures include rural

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16 Mr Gregory, *Proof Committee Hansard*, 19 January 2004, p. 110

17 ADA, Submission 79, p. 2 & 4. The proposal received support from NSW Retired Teachers Association, Submission 21, p. 2; St Vincent DePaul, Submission 58, p. 12. For further discussion of the problems associated with the Commonwealth Dental Health Scheme, see Dr O'Reilly, *Proof Committee Hansard*, 19 January 2004, p. 107

18 Dr O'Reilly, *Proof Committee Hansard*, 19 January 2004, p. 97

19 Dr O'Reilly, *Proof Committee Hansard*, 19 January 2004, p. 99

scholarships, and HECS forgiveness for dental graduates agreeing to work in areas of shortage.[20]

5.24 These programs should be guided by the findings of the National Oral Health Survey, which is due to report in July 2004.[21]

5.25 The Committee, noting again the importance of oral health to general health, as well as the almost totally preventable nature of dental disease,[22] 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.

Australian Democrats – additional comments on dental care

The Australian Democrats consider that reinstating the Commonwealth dental program is not a sufficient response to the poor dental health services provided in Australia. There is very uneven access to dental services across Australia, with some States, notably Queensland, providing well-resourced services, while Victorians have in recent years experienced long waiting lists and a shrinking per capita dental services budget.

As long as there is no formal purchasing arrangement with the States to ensure that the States take their responsibility seriously, then it is unlikely that a Commonwealth program can be anything other than a stop-gap measure.

Indeed, the 1997 evaluation of the Commonwealth dental program found that the scheme was unable to meet its objective of providing preventive and maintenance dental care, because of the large unmet demand for emergency intervention for serious oral problems.

20 ADA, Submission 79, p. 7. See also Dr O'Reilly, *Proof Committee Hansard*, 19 January 2004, p. 99

21 Dr O'Reilly, *Proof Committee Hansard*, 19 January 2004, p. 83. National Advisory Committee on Oral Health, Submission 14, p. 2

22 Dr O'Reilly, *Proof Committee Hansard*, 19 January 2004, p. 83

The Australia Institute of Health and Welfare has found that where the Commonwealth has increased its funding to the States for public hospitals, the States have taken this as an opportunity to contribute less themselves. The effect of this is that services to patients are not improved, despite higher federal funding.

Just as the Commonwealth has insisted in the last round of Australian Health Care Agreements to a formal commitment by the States as to their financial contribution, the States must be made accountable for their responsibility in dental health service provision.

The Commonwealth does have a clear responsibility to ensure a national oral health program, and one that is properly funded. However, this requires careful consideration of how resources can best be used across States and Commonwealth to ensure that the goal of improved oral health is maximised.

Recommendation: *The Commonwealth develop a national dental health policy, with funding to the States conditional upon State resources and service delivery performance.*

Allied health

5.26 A second issue, not addressed in the government's current proposals, is improving access to allied health professionals such as occupational therapists, physiotherapists, speech therapists, chiropractors, dieticians or psychologists.

5.27 As the first report showed,[23] these services form an important part of the total primary health care framework, and the specialist services of this group also offer methods for preventive and rehabilitative care that can do much to relieve the load on other parts of the health system.

5.28 However, these services are not currently covered by the Medicare system, which limits the capacity for doctors to refer patients to the most appropriate professional and undermines the effectiveness of other government initiatives such as the Enhanced Primary Care items that promote a multi-disciplinary approach to health care.

5.29 The Committee's conclusions in the first report remain relevant and the Committee does not recommend any broad introduction of new MBS items to cover allied health professions. However, there are examples of services provided by allied health professionals which offer compelling arguments to support their inclusion on the MBS – even if only for limited and defined items. Examples include counselling

23 Senate Select Committee on Medicare, *Medicare: healthcare or welfare?*, p. 133

services offered by psychologists, and the management of incontinence and knee joint osteoarthritis by physiotherapists.[24]

5.30 In the Committee's view, such new MBS items should only be created in the context of agreements with the relevant professional bodies that support high levels of bulk billing.

Community health care centres

5.31 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 problems can be triggered by either a shortage of health care professionals or the commercial non-viability of practise in some areas – particularly in rural and regional areas.

5.32 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. An added advantage of this approach is the capacity to co-locate limited facilities and equipment, and meet the preferences of many doctors for salaried, flexible and part time work.

5.33 The exact form of these centres will vary according to the particular needs of each area. In this respect, the Committee sees an important role for both the local Division of General Practice and local governments in planning and administering health centres that best meet the needs of the local population.

5.34 A useful basis for the funding of these centres can be the calculation of the difference between the national average Medicare benefits paid per capita and the benefits paid in a particular region. 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 underfunded in this way, the difference in funding should be allocated to that area and invested in community health care facilities.

5.35 Existing programs have also demonstrated that this model provides a flexible basis for pooled funding arrangements between the Commonwealth and the states.

5.36 The Committee again notes the importance of linking these centres to the local public hospitals in order to maximise the efficient sharing of facilities and expertise,

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24 Australian Physiotherapy Association, Submission 32, p. 12. Note also the Psychootherapy and Counselling Federation of Australia, Submission 71, p. 2

and the capacity of the centres to provide bulk billed general practice services that take the pressure from the hospitals emergency departments.

5.37 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.

System reform

5.38 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, costs shifting and blaming that seems to inhibit solutions to many problems plaguing health care in Australia.

5.39 Country Women's Association have 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.[25]

5.40 The Australian Health Care Reform Alliance sees the need for fundamental reform to the Australian health care system. Professor Dwyer, spokesperson for the Alliance, told the Committee that the health care system is at a crossroads:

> One of the paths that we could take, which I am absolutely convinced that Australians want … involves a sweeping reform of our health care system. We are all sick to death of the fighting between federal and state politicians about health. We are sick of reading about hospital crises in the paper every morning and hearing about the Medicare crisis, not having enough doctors and work force issues. The Australian public want the problems solved.

5.41 According to the Alliance, the major barrier to health care reform in Australia is the jurisdictional inefficiency associated with the division of responsibility for various parts of our health care system between Federal and State Governments:

> Nowhere is this more obvious than in examining the struggle health professionals are having to properly integrate, in a horizontal fashion, primary and community care with hospital care. For this reason the Alliance has been calling for the formation of a Health Care Reform Commission; a State/Federal co-operative bureaucracy involving senior health professionals

25 CWA, Submission 70, p. 2

> and consumers to look at redesigning the way we prevent illness and deliver health care in Australia.

5.42 As their submission argued:

> Medicare, and in particular the general practitioner services that it supports, should not operate as an island in an ocean of health care but rather a vital link in an integrated, networked, patient-focussed system.

5.43 The primary objectives of this reform are to enable better horizontal integration of health services that would improve the capacity of general practitioners to head up a team of health professionals and enable doctors to care for sicker patients in their homes, aged care facilities or hostels rather than sending them to hospital.

5.44 The Australian Council of Social Services conclude that:

> The Federal Government should commit to establishing a National Health Reform Council as proposed by the Australian Health Reform Alliance. The Council would oversee a full public review of the health care system aimed at developing broad consensus on the future shape of the system – including the way in which medical and other health care professionals are paid and supported.[26]

5.45 The Committee agrees and reiterates its earlier call[27] for the establishment of a National Health Reform Council.

Recommendation 5.3

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

26 ACOSS, Submission 45, p. 4. See also Doctors Stewart and Brown, Submission 40, p. 1; and Queensland Nurses Union, Submission 62, p. 1

27 Senate Select Committee on Medicare, *Medicare: Healthcare or Welfare?*, Recommendation 12.5

Signed by:

Senator Jan McLucas
Chair

Senator Michael Forshaw

Senator Ursula Stephens

Senator Lyn Allison

Senator Meg Lees

Government Senators' Report

Quite predictably, the Government Senators cannot support the Labor Party's response to Medicare Plus as their report is naïve at best and loose with the truth at worst. It also rejects an important policy initiative that would see $266.4 million go to Australians to assist in the payment of their out-of pocket expenses incurred for out-of-hospital Medicare services.

The Bill currently before the Senate deals only with the issue of safety nets for such expenses and yet the Labor Party, for purely political reasons, will not agree to granting Australians such assistance.

The Labor Party report distorts the intent of the legislation and its outcomes. For the record, it is worth stating clearly the intention of the Bill.

The measures in the Health Legislation Amendment (Medicare) Bill 2003 make medical services more affordable. They do this by introducing three new safety-nets to cover 80% of the out-of-pocket costs incurred for out-of hospital Medicare services above a specified threshold in a calendar year:

- The concessional safety-net – for holders of certain concession cards, with a threshold of $500 per family;
- The FTB(A) safety-net – for families in receipt of Family Tax Benefit (A), with a threshold of $500; and
- The extended general safety-net – for all other families and individuals, with a threshold of $1000.

The measures in the Bill, as proposed by these amendments, will have a total cost over 2003-04 and the following three years of $266.4 million. This includes payments to patients and administrative costs.

Out-of-pocket expenses incurred for out-of-hospital services can be financially crippling, especially when the services required are extensive, on-going and intense. Often they are unforeseen, due to accidents or the sudden onset of serious illness.

The measure not only includes medical expenses of GPs and specialists but diagnostic expenses such as pathology, radiology, psychiatry, tissue biopsy, radiotherapy and pap smears. The expenses associated with these services have, by far, been responsible for the largest increase in costs to patients since 1984-85. Someone who is in need of such extensive services could find they reach the threshold very quickly. The government therefore considered it important to assist with these expenses.

Labor rejects such assistance. Its near-obsessive concern with the bulk-billing rate overlooks the fact that even if 100% of General Practitioners bulk-billed all their patients, those with chronic conditions or severe episodes of sickness would still be faced with high out-of-pocket costs, which the Government package is designed to address.

Contrary to Labor Party claims, the underlying principles of Medicare, as framed by Labor at Medicare's inception, remain key features of the Medicare policy development. In summary these principles are:

A universal Medicare, where all Australians:

- Can access affordable health care, no matter where they live or how much they earn;
- Are eligible for a universal rebate for the services they receive;
- Are able to benefit from free care in public hospitals; and
- Are able to receive subsidised medicines through the PBS.

The Medicare Plus measures add $1.5 BILLION to the previously announced $917 MILLION committed in A Fairer Medicare.

The Labor Party has, not surprisingly, disagreed with virtually all the measures in both packages.

They have criticised the targeting of the assistance. However, linking a payment to a bulk billed service provided to patients in greatest need is an effective means of targeting this investment to maintaining affordable services for those patients where the impact will be greatest. It is worth noting that the medical profession supports the Government's safety net legislation and the targeting in the Bill for such people, but the Labor Party doesn't. The medical profession's support for the Government's proposal is understandable given that if they subscribe to all the measures in the package, they will receive between $35,000 and $43,000 (maximum) extra per year.

It is also worth noting that there is nothing in this Bill, or any previous Bill, that will prevent **any** patient being bulk billed. It is quite dishonest to suggest otherwise.

We recommend the government examine Professor Deeble's evidence to the Committee and whether there would be a community benefit to his proposal.

For the reasons outlined above, the Government Senators strongly support the Bill before the Senate and urge all Senators to support its passage as soon as possible to ensure that Australians quickly receive the benefits of the proposed safety nets.

The Government Senators do, however, recommend that the Minister consider expanding the number of services undertaken by practice nurses which would attract a rebate. Currently, the services eligible for the rebate would be immunisation and wound management. We would suggest that a number of other services, such as dietary advice for those in need, quit smoking advice, breast examination and pap smears to name but a few, should attract the rebate. The Australian Division of General Practice made similar recommendations in its submission. The nurse undertaking the advice role, after diagnosis by a doctor, would free the doctor's time to see other patients.

There is also a suggestion that many doctors simply do not have the time to assist some patients with lengthy lifestyle advice, and resort to prescribing medication instead. We believe that where the clinical diagnosis warrants it, all other avenues should be explored prior to drug therapy.

As most nurses are female the performance of pap smears by the nurse could be attractive to women generally and, more specifically, to women from some cultures who simply do not have a pap smear if it is to be performed by a male doctor.

While we recognise there is no prohibition of doctors using practice nurses under their supervision for a multitude of roles currently, their work outside immunisation and wound management will not attract the MBS rebate. As the rebate for a nurse doing such work would be $8.50 as opposed to a doctor at $25, the cost saving would be substantial and the amount of time which doctors could spend with other patients would help meet the demand.

Finally, Government Senators also recommend consideration be given to a specific review of the merits of increasing the Medicare rebate for longer consultations. If it was found to be justified, better health outcomes for patients are likely to ensue.

Senator Sue Knowles
(Deputy Chair)

Senator Guy Barnett

Senator Gary Humphries

Appendix 1

List Of Public Submissions, Tabled Documents, Supplementary Information And Other Written Material Authorised For Publication By The Committee

1	Mt Druitt Medical Practitioners Association	NSW
2	Dr Thomas Lyons	QLD
3	Australian Pensioners' and Superannuants' League Qld Inc	QLD
4	Ms Loris Erik Kent Hemlof	SA
5	Dr Ian Matthews	QLD
6	Dr Pat Cranley	WA
7	Mrs Deborah Scholem	NSW
8	Mr Ange Kenos	VIC
9	Australian Medical Association Limited	ACT
	Tabled at Canberra Public Hearing 19.1.04	
	• Opening statement by Dr Mukesh C Haikerwal	
10	Mr Peter Winterton	
11	Defend and Extend Medicare – Australia	VIC
12	Ms Andrea McRae	NSW
13	Mr Denise Lawungkurr Goodfellow	NT
14	National Advisory Committee on Oral Health	SA
15	Nimbin Community Economic Development Officer	NSW
16	Doctors Reform Society	NSW
17	Australian Association of Developmental Disability Medicine	VIC
18	Mr Tomas Nilsson	TAS
19	The Illawarra Dental Health Action Group	NSW
20	Association of Independent Retirees (A.I.R.) Ltd	ACT
21	NSW Retired Teachers Association	NSW
22	Tasmanian Medicare Action Group (TasMAG)	TAS
23	Humanist Society of Victoria Inc	VIC
24	Osborne Division of General Practice	WA
25	Dr Andrew Gault	VIC
26	Dr Graeme Alexander	TAS

27	Victorian Medicare Action Group	VIC
28	Combined Pensioners and Superannuants Association of New South Wales Inc	NSW
29	Australian Pensioners & Superannuants Federation Inc	NSW
30	State Retired Mineworkers	NSW
31	Mr E D Webber	NSW
32	Australian Physiotherapy Association	VIC
33	Macarthur Greens	NSW
34	Dr John Lambie	QLD
35	The Australian College of Non VR GP's Inc	SA
36	Australian Consumers' Association	TAS
37	The Australasian Faculty of Musculoskeletal Medicine	VIC
38	Women's Action Alliance (Aust) Inc	SA
39	NSW & National Councils on Intellectual Disability	NSW
40	Dr Ruth Stewart and Dr Anthony Brown	VIC
41	Geelong West Branch of the Australian Labor Party	VIC
42	Darebin City Council	VIC
43	Lismore City Council	NSW
44	National Association of People Living with HIV/AIDS	NSW
45	Australian Council of Social Services	NSW
45a	Australian Council of Social Services	NSW
46	Geelong Medicare Action Group	VIC
47	Mr Chris Boyle	NSW
48	Catholic Health Australia	ACT
49	Mr Claude Phillips	NSW
50	Nimbin Still Needs Doctors rural Action Group	NSW
51	Public Hospitals, Health and Medicare Alliance of Queensland	QLD
	Tabled at Canberra Public Hearing 19.1.04 • "Health Consumers Network" information which is now Submission No 99.	
52	National Centre for Social and Economic Modelling (NATSEM), University of Canberra	ACT
53	The Australian Greens	VIC
54	Department of Health and Ageing	ACT

Tabled at Canberra Public Hearing 20.1.04

- Graphs: comparison of Standard GP Rebate (Item 23) with GP Bulk Billing rates—Increase in patient contributions per capita since Introduction of Medicare—Corrigendum to Submission (now submission 54a)

54a	Department of Health and Ageing	ACT
54b	Department of Health and Ageing	ACT
55	UnitingCare NSW.ACT	NSW
56	Australian Healthcare Association	ACT
57	Southern Tasmanian Division of General Practice	TAS
58	National Council of the St Vincent de Paul Society	NSW
59	Queensland Government	QLD
60	Professor John Deeble	ACT
60a	Professor John Deeble	ACT
61	Tasmanian Government	TAS
62	Queensland Nurses Union	QLD
63	NSW Nurses' Association	NSW
64	Australian Nursing Federation	VIC
65	National Rural Health Alliance Inc	ACT
66	Consumers' Health Forum of Australia	ACT
67	The Royal Australian College of General Practitioners	VIC
67a	The Royal Australian College of General Practitioners	VIC
68	Liquor Hospitality and Miscellaneous Union	NSW
69	Dr Michael Pietryk	VIC
70	Country Women's Association of New South Wales	NSW
71	The Psychotherapy and Counselling Federation of Australia	VIC
72	The Australian Association of Pathology Practices	ACT
73	COTA National Seniors Partnership	VIC
74	Australian Diagnostic Imaging Association	ACT
75	Australian Federation of Aids Organisations Inc	NSW
76	HIV/AIDS Legal Centre Inc	NSW
77	Ms Jean Giese	VIC
78	Ms Loretta Vieceli	NSW
79	Australian Dental Association Inc	NSW

80	Victorian Council of Social Service	VIC
81	Moreland City Council	VIC
82	Blue Mountains Division of General Practice Inc	NSW
83	Geelong and Region Trades and Labour Council	VIC
84	Ms Judy Thallur	SA
85	Preston-Reservoir Progress Association and Darebin Defend and Extend Medicare Group	VIC
86	City of Whittlesea	VIC
87	Rural Doctors Association of Australia	ACT
87a	Rural Doctors Association of Australia	ACT
88	Associate Professor Lesleyanne Hawthorne	VIC
88a	Associate Professor Lesleyanne Hawthorne	VIC
89	Dr E Durham Smith	VIC
90	Rural Workforce Agency Victoria	VIC
90a	Rural Workforce Agency Victoria	VIC
91	Australian Divisions of General Practice	ACT
92	Dr Ed Boyapati	VIC
93	Mr Sam Bobb	VIC
94	Australian Health Care Reform Alliance	NSW
95	Australian Local Government Association	ACT
96	Mr Ian McAuley	ACT
97	National Tax & Accountants' Association Ltd	VIC
98	Mr Murali Thalluri	SA
99	Health Consumers Network	QLD
100	The Northern Territory Government	NT

Appendix 2

Witnesses Who Appeared Before The Committee At Public Hearings.

Monday, 19 January 2004, Public Hearing, Parliament House, Canberra

University of Canberra

Mr Ian McAuley,

Centre for Health Economics Research and Evaluation

Professor Jane Hall,

Professor John Deeble

Prince of Wales Hospital, Sydney

Professor John Dwyer,

National Centre for Social & Economic Modelling (NATSEM)

Ms Agnes Walker,

Australian Consumers Association

Mr Martyn Goddard, Health Policy Officer,

Australian Council of Social Services

Associate Professor Roy Harvey, Health Policy Advisor,

COTA National Seniors Partnership

Ms Ann Wentworth, Co-chair of the COTA National Seniors ACT Policy Council,

Consumers Health Forum of Australia

Ms Helen Hopkins, Executive Director,

National Association of People Living with HIV/AIDS

Mr David Menadue, National President,

Public Hospitals, Health and Medicare Alliance of Queensland

Ms Beth Mohle, Policy Officer,

Australian Medical Association

Dr Mukesh Haikerwal, Vice President,

Royal Australian College of General Practitioners

Professor Michael Kidd, President,

Australian Divisions of General Practice

Dr Robert Walters, Chairman,

Rural Doctors Association

Dr Graham Slaney, Industrial Vice President,

The Australian College of Non-VR GPs

Dr James Moxham, President,

Dr Kean-Seng Lim

Catholic Health Australia

Mr Francis Sullivan, Chief Executive Officer,

UnitingCare NSW/ACT

Rev. Dr. Anne Wansbrough, Senior Policy Advisor,

National Rural Health Alliance

Mr Gordon Gregory, Executive Director,

Australian Nursing Federation,

Ms Jill Iliffe, Federal Secretary,

Rural Workforce Agency Victoria

Dr Jane Greacen, Chief Executive Officer,

St Vincent de Paul Society

Mr Terry McCarthy, Chair, Social Justice Committee,

Australian Dental Association

Dr Bill O'Reilly,

Tuesday, 20 January 2004, Parliament House, Canberra

Family and Community Services

Mr David Kalisch, Executive Director

Ms Lynne Curran, Assistant Secretary

National Welfare Rights Network Inc

Ms Genevieve Bolton, National Liaison Officer

University of NSW – Social Policy Research Centre

Ms Julia Perry, Honorary Fellow

Commonwealth Ombudsman

Professor John McMillan, Commonwealth Ombudsman.

Mrs Helen Fleming, Senior Assistant Ombudsman, Social Support

Ms Tammy Wolffs, Director of Investigations, Social Support Team

Department of Health and Ageing

Mr Philip Davies, Deputy Secretary

Ms Judy Blazow, First Assistant Secretary

Mr David Learmonth, First Assistant Secretary

Mr Robert Wells, First Assistant Secretary

Mr Rob Wooding, First Assistant Secretary

Ms Rosemary Huxtable, Assistant Secretary

Ms Leonie Smith, Assistant Secretary

Mr Geoff Leeper, Deputy Managing Director – Operations, Health Insurance Commission