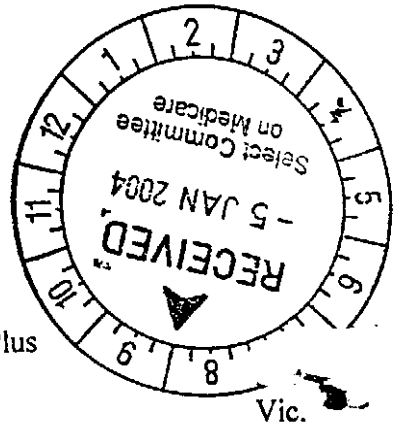

The Secretary
Senate Select Committee on MedicarePlus
Suite S1 30
Parliament House
Canberra, ACT 2600

Vic.

27th December 2003

Dear Sir/Madam,

Re: Submission to the Senate Select Committee on MedicarePlus

As a concerned consumer and Medical practitioner, I wish to make three points:

1. The $5 Incentive for bulk-billing This must be seen in the context of the philosophy of bulk-billing. The current Coalition Government views bulk-billing as a safety net only for certain patients (Health Card recipients, and now additionally children. This limited policy is inequitable because the 15% gap for low income families who do not qualify for the concession is much more of a financial burden than to those on high incomes. The Government's response is to offer $5 to the doctors above the Rebate to encourage a greater participation rate in bulk-billing. In designing this flat rate bonus the planners seem to be unaware that there a whole range of General Practitioner fees (and Specialist fees) depending on the length and complexity of the consultation – in some the $5 is adequate, in others quite inadequate. For example, in the Medical Benefits Schedule Book of November 2003, General Practice consultations at the Surgery are in four levels with the gap between Rebate and Schedule fees being, respectively, $2.05, $4.50, $8.60, $12.65. There are several other categories (Home visits, hospital visits, etc) with wider gaps than $5. Similarly, the gaps for Specialist consultations vary from $10.65 to $22.80, and even more so for prolonged attendances. It is therefore extremely doubtful if the offer of $5 will provide any incentive for more doctors who currently do not bulk-bill to begin doing so only to be out-of pocket. It is therefore inadequate and wrongly based.

I submit as an attachment an analysis of the concepts of bulk-billing, of which there is much misunderstanding by all parties.

2. Workforce shortages The Coalition suggests importing numbers of overseas trained doctors, as well as increasing places in Australian Medical Schools. I have no objection to accommodating more overseas doctors, except it is illogical to do this when a number of overseas students willing to pay full fees to enter our Medical Schools take up places that could be filled by Australian students, and then many of these oversea students will not eventually practice in Australia. I believe the number of

overseas students should be reduced, and their places filled by Australian students who will stay in Australia. Further, I believe the Medical School intake could be increased overall by 10%, without reducing standards.

3. Reform of Medicare Deficiencies in Medicare are recognized by Health Economists, Social planners, the Medical profession and political Parties but the *suggestions for reform being presented so far by the major parties concentrate only with one or two of these problems in isolation, such as $5 incentives to bulk-bill, other cash incentives to bulk-bill to an agreed percentage of patients, safety net cover over a certain limit, etc. Nowhere is there a serious attempt to recognize the basic deficiencies in the structure of Medicare itself which underlie all the flaws in the system;* within a short time all the temporary nibbles being suggested will prove to be inadequate and more fiddling will again be required. The MedicarePlus scheme fails to recognize the need for basic reform, which ought to be its priority. The current Medicare scheme is flawed because of unnecessary complexity in having three different systems of funding and service providers (Medicare benefits, Private Insurance and direct grants to public hospitals), two different "premiums" (the Medicare Levy and Private Insurance), lack of integration of the capacities of two hospital systems (Public and Private), and multiple, confusing and inadequate Tables of benefits. *The basic problem with Medicare is that it never went far enough to construct one complete system,* but remained constrained by existing patterns of practice and funding. It retained the double system of funding - "public services by Government" and "private insurance", setting up an ideological conflict of priorities in policy making, and inevitably leading to the current discriminatory two-tier system. Although it would be quite unrealistic to think that we could now eliminate the established private insurance system, it is still possible to have one complete system of a central fund of insurance, one "premium" only, and one comprehensive Table of benefits, incorporating the private insurance Funds as agents, as will be described. Unfortunately, restructuring the scheme is seen as political and electoral suicide if any suggestion is made to the public that major changes are being considered. Medicare is such a "holy cow" for all political Parties that none have been prepared to make the serious changes that are required, yet *solutions to the flaws are available*; and ironically serious changes are the only way to achieve the true objectives of Medicare. They are described in my attachment and are certainly achievable if a Party will only grasp the nettle. Hopefully decisions can be made that are bipartisan, as Health should be.

The scheme described is not a replacement of Medicare; indeed, it is an *expansion* of Medicare to produce **one system which adequately covers medical services outside hospitals and both medical costs and accommodation for every citizen in both Public and Private Hospitals.**

I commend the enclosed New Medicare scheme to the Committee – there is a full version and a Summary version of 5 pages.

Yours sincerely

E Durham Smith AO,MD,MS,FRACS,FACS