Attachment 2.

SUMMARY

NEW MEDICARE Building on Medicare

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The objectives of Medicare are admirable – universal coverage for basic medical care and "free" care and access for all citizens in the public hospital system.

Since its introduction, however, serious flaws have gradually eroded the system and have substantially reduced the equity of Medicare's objectives. Some of these are: the lack of universality in cover for medical benefits, where, for patients on low incomes who are not bulk-billed the co-payment is a burden; the widening gap of patient co-payments for services charged above the Schedule fee; the inequity of hospital access through the development of a two-tier system, Public and Private; and the unaffordability (even with the 30% Rebate), and therefore the unavailability of private insurance for low and middle income families, producing a disproportional advantage for those who can afford it. The problem is that the suggestions for reform being presented by the major parties concentrate only with one or two of these problems in isolation, such as the 30% Rebate for private insurance, $5 incentives to bulk-bill, other cash incentives to bulk-bill, safety net cover, 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 scheme is flawed because of unnecessary complexity in having three different systems of funding (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.* 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. Unfortunately, restructuring the scheme is seen as political and electoral suicide. 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.

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.**

A New Insurance Vehicle

New Medicare amalgamates the current triple system of medical benefits from Medicare, Private Insurance and direct Government grants to Public Hospitals, into one National system of insurance, mandated to cover every citizen equally, drawing upon a National Health Insurance Fund. It has one "premium" of payment by the consumers (an amended Medicare Levy, proportional to income) paid into the National Fund. This Fund will be financed from four existing sources. Currently, Government is committed to money paid as Public Hospital grants ($15Bil.), money currently paid by Medicare for medical benefits ($8 Bil.), and money currently paid as a 30% rebate on private insurance ($2.4

Bil.), a total of $25.4Bil. – offset by $4.5Bil. received from the current Medicare Levy – leaving a net outlay of $20.9Bil. from general revenue. New Medicare re-allocates this $20.9Bil. into the National Fund, plus the new amended Levy of an expected $7Bil., generating a total of $27.9Bil. In New Medicare Public Hospitals will be financed by the insurance system rather than by direct Government grants. This large Fund is the source to distribute standard benefits, in one Standard Table, to all citizens.

By amalgamating the funding systems confusion can be reduced to one system of insurance covering medical benefits and all hospital accommodation; one method of payment, an amended Medicare Levy,; and one complete Standard Table of insurance in which benefits can be assured to cover all that is necessary for good standard medical care outside hospitals and in either Public or Private hospitals. The single insurance system means that every citizen will be effectively covered for what, at present, requires both Medicare and Private Insurance. This system is cost-neutral to Governments as it can be financed entirely out of current Government commitments. The plan described offers three models of organisation:

Model A: A single, central, National Health Insurance Fund, (on a base of $27.9 Bil., as described), as the single recipient of "premiums" (which will be the Levy), and the dispersal of the Standard Table of benefits, (and of any Supplementary Insurance), with deletion of the Private Funds entirely. A simple system but the deletion of the Private Insurance industry is probably unrealistic.

Model B: A single, central, National Health Insurance Fund, (on a base of $27.9 Bil., as described), as the single recipient of "premiums" (the Levy), with no premium payable to Private Funds. This Fund then distributes its income to the existing Private Funds on a formula, who then disperse the benefits of the Standard Table when a claim is made. The Funds can also offer Supplementary benefits. This is the preferred choice as it recognises the reality of the existing Private Insurance system. A formula has to be provided to determine how the central pool is to be disbursed to the Private Funds. It must be recognized that different demographic and aged groups consume different levels of health services. To meet the expected risks, the "real" premiums to pay for medical services actually would currently need to be of the following order:

16 - 25 years of age	$600
26 - 45 "	$900
46 - 60 "	$1,200
61 -70 "	$2,000
70+ "	$2,500

This gives a basis for the calculation of the amount of money to be disbursed from the central pool to each individual Private Fund. A Fund would submit an annual profile of its members graded into the five age groups; reimbursement to the Funds would then be at the above levels in accordance with the numbers of members in each group. Such a mechanism preserves the equity of "premiums" (the Levy) being paid by the citizen in proportion to income, yet provides the Funds with realistic budgetary figures for the actual expected costs of outlays for medical services.

Model C: A system using the Private Funds entirely, with no Government involvement. This is the poorest of the choices and is not recommended. However, in the full paper it is described in full.

The Levy

The current flat rate (1.5%) of the Levy actually discriminates against low income families. This "hurts" the low income family more than a high income family - $375 out of $25,000 is harder to meet than $1125 out of $75000. In New Medicare, the Levy will be payable in a variable rate in proportion to income, (with maximum capping), ensuring equity of contributions for all. Such a system is not possible with private insurance premiums. Health Card recipients will pay no Levy.

The Levy will be collected, as at present, through Income Tax Returns.

For a single taxpayer Levy rates would be:

Taxable Income up to $20,000	Levy 1.0%
" $20,000 - $50,000	Levy 1.5%
" $50,000 - $60,000	Levy 2.0%
" Over $60,000	Levy 2.5%

with a maximum cap of $2,000 for a single contributor.

Family cover = double the single rate, with a maximum cap of $2,500.

The following chart for a single taxpayer illustrates the equity of the formula; similar savings apply to the family rate.

Examples for Single Persons

	Current			New Medicare Levy for full insurance
	Levy	Private ins. (after 30% rebate)	**Total**	
Tax. Inc. $18,000	270	850	**1120**	**180**
" $35,000	525	850	**1375**	**525**
" $55,000	825	850	**1675**	**1100**
" $80,000	1200	850	**2050**	**2000 (cap commences)**

It can be seen that:

- the cost of insurance for taxable incomes up to $50,000 is the same as *currently paid in the Medicare Levy alone*, and *for low incomes considerably less so*, and yet these figures include full insurance cover comparable to person who currently pays both the Levy and a high rate of Private insurance premium.

- at all levels of income the cost of insurance is far lower than is currently paid by a person who pays the Levy and a Private insurance premium, even for incomes up to $70,000.

- at $80,000 the cap on the Levy commences for all higher incomes, and is still cheaper than a current Levy plus Private insurance premium.

Integration of Hospitals

Currently, an undesirable two-tier system has developed. There is no question that access to hospital is easier and quicker for the better off who can afford private insurance, and who accordingly have access to a Private hospital. While the Public hospitals are over-burdened there is unused capacity in many Private hospitals. **The facilities of both should be integrated by assuring access to either for "standard" care.**

This is achieved, not by subsidizing Private hospitals to accommodate public patients, but by **structuring the Standard benefits of Medicare to apply equally to either type of hospital**. This can be done when Public Hospitals are financed by the

same mechanism as are Private Hospitals i.e. by drawing upon the insurance system (rather than by direct Govt. grants). The fees charged by the Public hospital for accommodation, theatre and other ancillary services will be at the same rate as in a shared ward in a Private hospital, and the benefits paid out will be identical. For both public patients in Public hospitals and private patients in Private hospitals, (including Health Card recipients in either), recovery will be 100% for "standard" accommodation (shared ward), thus ensuring "free" hospital care for public patients in Public hospitals as well as for all patients (at the shared ward level) in Private hospitals. Similarly, professional medical services in the Public hospitals will be on a fee-for-service basis at the *Rebate* level, and refunded from the insurance pool at 100% level, thus ensuring "free" medical care in a Public hospital. In the Public hospitals all services for public patients, both hospital charges and medical services, will be bulk-billed, so the public patient is free of all claim procedures. Health Card recipients will have access to either type of hospital at no cost. **This mechanism allows the Public and Private hospitals to be integrated, and provides equal access for standard care to either system for all citizens.**

The Standard Table of Benefits of New Medicare.

The "Standard Table" is very extensive, much more so than provided by any current Tables. The standard level will be known as "New Medicare Standard"; there will be one scale only, simply understood, easily identified, and completely adequate in itself for essential medical care. As an example, the benefits outside hospital will as follows:

(a) 100% cover of medical fees(General and Specialist) and of essential allied professional fees (Physiotherapy, etc.) for Health Card recipients and many other defined patients, who can be bulk-billed at either the Schedule or Rebate fee level, depending on the nature of the medical service. (See Bulk-billing in the next Section)

(b) 90% cover of medical fees (General and Specialist) and of essential allied professional fees (as above) at Schedule fee level for others, with maximum gap of $15 for each consultative service, $150 for a procedural service and $1000 for all services in one calendar year.

Similar 100% cover is provided for standard ward accommodation, theatre and labour ward fees, ICU, Emergency, etc., in Public *and* Private hospitals, medical cover of 100% for all public patients, 100% cover for defined patients in Private Hospitals and 90 % for other private patients.

Under the Standard Table additional supplemental insurance is not necessary for adequate medical and hospital cover for essential health care but could be available for "gap" cover up to the Schedule fee and for preferred type of hospital accommodation, and/or for "Extras" (Dental, Optical etc).

Bulk-billing

Bulk-billing has become a litmus test of the social philosophy of political parties in their attitude to Medicare. No other feature divides them as much. Nor is any subject filled with so many myths and misunderstandings. The full paper provides a full analysis. Herewith is a summary of the conclusions.

There is no logic that bulk-billing necessarily be fixed at the Rebate level. This discount limits its use and makes all sorts of incentive schemes necessary. *Bulk-billing should be at the rate proportional to the medical service* - a service of greater complexity (such as for many elderly or disabled Health Card recipients) to be at the Schedule fee level, other shorter or minor services at the Rebate level. *In this way no*

additional cash or other incentives are necessary. The fees charged would only be what they would be without bulk-billing.

For those who believe there should be total universality, with every patient and every service being bulk-billed, that is a political decision. It will be very popular with consumers, and certainly achieves universality, but the costs must be accepted– the risks of over-servicing, over-utilisation, lower standards, and the necessity of legislation to make it mandatory or else a complicated set of cash incentives; if it is decided to bulk-bill at the Schedule fee rate for every patient, it will be very expensive; if at the Rebate level for every patient, it underestimates the value of some consultations.

For those who want some limitation on bulk-billing, but more generous than the philosophic approach of the current Government, there is the difficulty of defining who exactly should benefit, and at what level of re-imbursement.

A compromise for bulk-billing is suggested as follows:

- all services in Public Hospitals for public patients, medical services at the Rebate level, and accommodation and other ancillary serves at 100% recovery rate.
- accommodation and ancillary services for private patients in shared wards in either Public or Private Hospitals at 100% recovery rate.
- medical services both outside and inside hospitals for the following identified groups – Health Card recipients, Children under 16 years of age, Unemployed and underemployed, Patients in Nursing Homes and Institutions of care, Self-supporting students, Pastors, Clergy, and religious Orders.
- medical services to other groups where additional information is required, such as financially disadvantaged low income families not on Health Card concessions, families in a period of financial or emotional distress, elderly and others without family support when even the paper work is difficult, nurses and professional colleagues in the health field. These groups are no less important than the identified groups but the information involves privacy issues, e.g. the income level of a family. On this account the inside knowledge, sensitivity and empathy of the attending practitioner is the only realistic guide. I do not think it can be legislated for, as much as some ideologues would wish for it to be written in stone, without breaching privacy.

Apart from these categories, it remains an option for a doctor to bulk-bill any or all patients at his/her discretion.

Other aspects of Medicare

Any reforms to Medicare need to consider a whole range of issues and delivery systems. They are all very important but are actually secondary to getting the basic structure of Medicare right in the first place – which is the object of this paper. They are beyond the scope of this paper and are only listed here as examples for development:-

Health Education and Prevention, The role of Community Health Centres, Primary Health Care strategy and new models, New models of General Practice, Rural Health services, Workforce distribution and shortages, Nursing Homes, Domiciliary nursing, Rehabilitation services, Aged Care facilities, Psychiatric services, Medical immigration, Rights of choice, Responsibility and Accountability, Resource allocation of expensive modalities, Hospital admission rates, Management issues, Coordination of services, and the role of Government.