

Medicare Plus... or Minus

This was the Doctors Reform Society submission of December 2003 to the Senate Select Committee examining the Federal Government's latest Medicare changes.

The following submission firstly addresses the three specific items referred to in the terms of reference and then adds further comments and alternative proposals.

1. Increase in the rebate of \$5 if bulk billed for pensioners, health care card holders, and children under 16 years

This proposal goes to the heart of destroying the universality of Medicare. It very clearly differentiates these people from the rest of the patients who can expect to be charged a copayment. Already there are well-publicised examples of doctors treating bulk billed patients as second class citizens. 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.

Doctors who currently bulk bill patients in the eligible category may feel they can continue to bulk bill such patients, but they will also see that the absence of any increase in the rebate for other patients is a clear indication from the Government that they should not be bulk billing those other patients, even when they know that they are struggling financially. The working poor who cannot get on a health card will be even more likely to find their doctor stops bulk billing them.

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 copayment.

The net effect of this change for patients will be that more patients who currently struggle to afford medical bills, will be faced by bigger bills, will fail to seek medical care when they need it, and will end up sicker because of it.

The effect on the system will be a further undermining of the principle that timely access to quality health care is a right not a privilege. It is an attempt to destroy the belief that a system which attempts to uphold that principle is a public good.

2. Expansion of 'safety net'.

This will fail to address the needs of most patients who are struggling with health costs, will almost certainly be inflation-

ary, and will be an advantage only to a small number of patients, and even then, will only help them later in the year when they finally reach the 'safety net' threshold.

The current 'safety net' covers costs up to the scheduled fee for all visits to doctors (including radiology and pathology), with a threshold of \$319.70. It does not include any copayments above the scheduled fee. Most doctors would not be aware of whether their patients have reached the threshold. Many patients are not aware of its existence.

The proposed 'safety net' covers all costs above the bulk billing rebate. At the moment doctors are constrained in their billing patterns partly by their perception of how much the patient can afford.

This proposal makes it simpler for the doctor who can now look at the \$500 or \$1000 threshold and decide that the patient should be able to afford that in a year. They will thus feel less constrained to hold down his/her own prices.

This will be especially apparent in situations where the current copayments are \$50 – 200 e.g. for specialist and x-ray services. For some of these doctors the 'safety net' will be a license to print money. Although it is predicted to cost only \$266 million over 3-4 years, it will almost certainly increase substantially as doctors feel more comfortable with charging more above the scheduled fee because the 'safety net' is there.

Some patients who quickly run up medical bill of hundreds of dollars because they need a lot of expensive tests and specialist visits, will reach the threshold and benefit in the short term as their out of pocket costs drop to 20% of the copayment. However, over time many of these people will miss out because doctors will charge more, knowing that most of the payment is covered by the 'safety net'.

Most patients will not reach the 'safety net' threshold and will simply be faced by ever increasing copayments. This will include pensioners, health care card holders, and children, who are currently charged over \$5 copayment and whose GP will not forgo that copayment for the smaller \$5 rebate increase the Government proposes.

Even for those 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 trou-

ble budgeting for a week, let alone a year, and will be little helped by this proposal.

But the very concept of an improved 'safety net' is also inherently flawed unless one believes that the basic problems with the current system cannot be improved. The perceived need for an expanded 'safety net' arises from an acceptance that patient copayments are too high.

The most direct and efficient way to address this problem is to reduce those copayments. A healthy Medicare would require progressively less reliance on 'safety net's. Proposals to improve Medicare and reduce copayments are addressed below.

3. Workforce Issues

The recognition that there are significant workforce issues which have their greatest impact in certain geographical areas is to be commended.

i. Bonded medical school places.

Proposals to increase the number of medical school places only as bonded positions appears inherently flawed. Entry to medical school places should be on the basis of merit. However, bonded scholarships offered after merit based medical school entry has been achieved, would be a viable alternative to achieving the same aim.

In addition the already agreed to proposal of an increase in the number of full fee paying medical student places possible is a disturbing trend which also ignores the principle of entry to medical school based on merit. It should be opposed.

ii. Attracting overseas doctors.

Many of the suggestions regarding this issue have already been tried with limited success. It is unclear whether this initiative has any basis in practicality in terms of achieving its stated objectives. In addition, there is a concern that if suitably qualified overseas graduates are working in their own developing country, then we are depriving such countries of much more desperately needed medical resources in our attempt to solve our workforce shortages.

iii. Nurse Practitioners.

Increased involvement of nurses in primary health care is to be commended. However the scope of this proposal is very limited and the concept of introducing it as a fee for service construct has the potential to lead to the same problems as the over emphasis on fee for service has in relation to doctors services.

4. General Comments

The essential problem with Medicare Plus is that it is part of a strategy to gradually transform Medicare (access to doctors, hospitals, and pharmaceuticals) from a system which aimed to provide equal access independent of means, into a system constructed so that those who can afford any kind of health care continue to get it, those who cannot afford much health care are given access to a 'safety net', and those who can

afford reasonable access some of the time will have the opportunity to access any kind of health care they want but if it is too expensive they may be able to fall back into the 'safety net'.

It is likely that even in the short term, the introduction of a two tiered system of rebate payments, combined with the very inadequate 'safety net', would lead to more patients missing out on timely access to quality health care. In the long term it will lead to even greater disparities in access as standards in the 'safety net' slip and the population increasingly believes that the only way they can have quality health care is with money in the pocket, so the advocacy for the public system declines.

This is a return to private affluence and public squalor as existed before Medicare and Medibank, when GPs' charity was the only way many patients received any treatment, and when the commonest reason for imprisonment for debt in South Australia was failure to pay medical bills.

This is the situation in the United States where 'safety nets' exist and 40 million people are under- or uninsured and don't qualify for the 'safety nets', and where the commonest cause of personal bankruptcy is failure to pay medical bills. This proposal takes us that bit closer to a US style system where twice as much per person is spent on health care than in Australia yet they die younger.

Suggestions from the ALP and the Democrats that any increase in the rebate should be directed, not to a particular type of patient, but to encouraging a general increase in bulk billing rates, are to be commended. Either of the proposals clearly supports the principle of universal access to quality health care. In contrast the Medicare Plus proposal supports universal access to an inadequate rebate.

Suggestions that a better 'safety net' than the one proposed would make patients better off are, however, taking a very short term view both of what patients need and of how the development of a 'safety net' further erodes the universality of the system. An expanded 'safety net' with a lower threshold would be even more inflationary, and would then set the scene for further cost cutting to pay for it.

Eventually, private health insurance would be brought in to 'improve' the situation (as was proposed in the 'A Fairer Medicare' package). As costs rise, no matter what level the 'safety net' is set at, patients would increasingly struggle to afford care before reaching the threshold, and many would never reach that threshold.

Reliance on a greatly improved 'safety net' would set in place another step on the path away from a universal health care system.

What is required is a bulk billing strategy which aims to increase general bulk billing rates as suggested by the ALP and the Democrats. However, much more is needed to make Medi-

care fairer.

The emphasis on improving primary health care in the general sense (i.e. not just GP access but also allied health services) in the Democrats policy is to be commended. The provision of practice nurses and the Medicare Plus proposal of nurse practitioners assists primary health care in a small way. Much more needs to be done.

We suggest a reassessment of primary health care centres (community health centres) which function very well in Victoria despite many inefficiencies related to disparate funding sources. These could be expanded and greatly increased in number to form the basis for a more gradual change to how primary health care is funded and organised.

In addition however, one of the concerns raised regarding copayments and affordability is that bulk billing rates for specialists remain very low and none of the proposals address that issue except through the 'safety net'.

We propose that Federal funding of public hospitals require a specified minimum level of specialist outpatient services across the specialties, with such services being without copayments.

In our previous submission to this Committee, we provided an indication of how to reallocate the Private Health Insurance rebate. This has been updated (below) and includes the details on primary health care centres.

It does not require any extra funding apart from that suggested to fund the ALP bulk billing proposal. It thus leaves open the possibility of using funds the Government has found to pay for Medicare Plus to expand this proposal. This proposal could also be expanded using the \$4.6 billion surplus or by increase in the Medicare levy, especially given that surveys indicate the Australian public are willing to pay more taxes for a better health service if they know the extra taxes will be spent on health

Proposal to Improve Medicare, the Public Hospital System, and the PBS, and to decrease the need for a "safety net"

1. Remove immediately the Medicare levy surcharge exemption \$ 1.1 billion. (introduced in 1997, along with the surcharge itself, the removal of the exemption simply makes the Medicare levy a more progressive tax).

This will only affect those on > \$50,000 single, > \$100,000 family income. It will mainly affect those who would have continued with PHI even without the subsidy.

A. Allocate \$ 500 million/ year immediately to public hospitals

B. Allocate \$ 300 million/ year to immediate changes to GP funding.

- \$ 300 million for practices which bulk bill all patients. Incentive programme eg cash bonus, practice nurse, medi-

cal indemnity, capital costs, simplified practice incentive payments.

- use current ALP bulk billing strategy (funding already detailed) to increase the rebate for bulk billed services.

This leaves \$300 million for 3 (below).

2. Remove support for ancillary benefits \$ 600 million.

C. Allocate this to Government funded primary health care centres

- Providing range of ancillary services (physiotherapy, nursing, occupational therapy, podiatry, drug and alcohol workers, counselling, etc.)
- Cost \$ 2 million per centre per year
- With or without GPs
- If GP services present, they would be bulk billing, and financially self supporting through rebate (increased), and package (B).
- If all cost from Federal Government, this would allow the formation of 300 such centres over time, 1 for every 80,000 population. Initially directed to areas of greatest need, with aim of expanding model to all areas.
- All costs would not be from Federal Government as many of these services are currently funded by State and Local Government. Thus, suggest funds pooling with Federal Government providing three quarters, i.e. \$ 450 million, and States providing one quarter (from money already allocated to primary health care.)

This should all be done in the context of a National Primary Health Care Framework and Policy as suggested in the PHAA submission to the Canberra Health Care Summit.

D. Allocate \$ 150 million to after hours GP services working out of these primary health care centres. Cost, \$ 0.5 million per centre for one GP (includes security and reception) until midnight.

This needs to be done in the context of renegotiating of the Australian Health Care Agreement to ensure accountability and transparency of how money is spent, and a process of matched funding from State and Federal sources. A Health Reform Commission, as suggested by the recent Canberra Health Summit, could facilitate this.

An alternative is to expand the capacity of the Australian Institute of Health and Welfare to enable it to look at all health funding from all sectors of government and from the private sector, and report every 2 years on health financing, with particular attention to detailing all cost shifting, so that transparency of health funding is assured, and accountability is possible.

Although not as far reaching as the proposed Health Reform Commission, the many reforms suggested both at the summit and from the committees for the AHCA, could then be considered, unencumbered by claim and counter claim about funding. It is also much less likely to become a bureaucratized

ineffective under-resourced white elephant (a potential fate of the Health Reform Commission).

Within the renegotiation of the AHCA would be the proposal that a minimum level of specialist services be provided by public hospitals with no out of pocket expenses incurred.

3. The remaining \$ 300 million from the Medicare levy surcharge exemption, combined with increasing yearly amounts from the gradual reduction in the PHI rebate percentage (\$1.6 billion ie \$2.2 - \$0.6 for ancillaries) to be spent on:

- E. Increase in the Aged Care budget \$ 550 million
- F. Funding for a dental health scheme \$ 750 million

- G. Funding for fundamental changes to the provision of drug information for doctors so as to control PBS costs. \$100million
- H. Increased funding for Aboriginal Health \$ \$500 million

This is a cost neutral proposal apart from using the ALP bulk billing proposal. This can be funded as the ALP has suggested or out of the \$4.6 billion budget surplus.

		Savings (items) *	Expenditure (items)	Savings millions	Expenditure millions
Stage 1		Medicare Levy Surcharge Exemption 1,100 – 300 for Stage 4		800	
	A		Public Hospitals		500
	B		Package for Bulk Billing GPs		300
Stage 2		Ancillary Benefits Cover		600	
	C		Primary Health Care Centres		450
	D		After Hours GP Services		150
Stage 3		Medicare Levy Surcharge Exemption		300	
		PHI Rebate		1,600	
	E		Dental Health		750
	F		Aboriginal Health		500
	G		Aged Care		550
	H		PBS Education		100
Total				3,300	3,300

*These figures for savings (\$1.1 billion for Medicare levy surcharge exemption, \$2.2 billion for PHI rebate) are based on figures from Why Support Private Health Insurance in Australia? *New Doctor* 79, L Segal, Health Economics Unit, Monash University.



Video Review

Breath of Fresh Air

Video \$104.50 incl GST (add \$10 postage and handling). Conscious Productions, 2002. Orders ph 03 9537 2590 consciousprod@yahoo.com.au

I haven't seen him before but I recognise the young man in this short documentary. Jamie wasn't born with the best hand of cards and, at 22, would appear not to be doing particularly well in life. His brother, however, did worse - he died sniffing paint.

Paint sniffing, or chroming, has become ubiquitous among marginalised youth over recent years but few documentaries relating to the issue have been made. This one does provide a bit of insight into why some people are so desperate to numb their brains. If Australia was a better place, it would be prime time TV. It's not, so maybe ask a library to get a copy. Both depressing and hopeful, it is worth a view.

Andrew Gunn