

Background to the Synod 2003 resolution on Medicare

This proposal applies *Directions for Health Policy*, adopted by the 2002 synod, to current debates about Medicare in response to the budget proposals announced by the Government in May, and issues being raised in the inquiry of the Senate Select Committee on Medicare. UnitingCare has already made submissions on these matters to the Senate Inquiry into Medicare, and this proposal is intended to both support that work and to alert the wider church to the issues.

The government's proposed changes further shift the burden of payment onto individual patients through co-payments and private health insurance premiums.

While the government argues that the current rebate for private health insurance for hospital treatment provides people with choice, the fact is that many families on low incomes feel compelled to have private health insurance as they no longer trust the public system to deliver the care that they need when they need it. A million people on incomes of less than \$20,000 per annum have private health insurance. Medicare was intended to cover the needs of these people. It should do so.

The Australian Government in the 2003 budget announced the following proposed changes to Medicare:

1. Incentive payments to doctors to encourage bulk-billing. Problem: for many doctors, the incentive payments will be small, and the doctors will be better off charging a co-payment, ie charge patients a fee in addition to the Medicare payment.
2. Doctors will now be able to claim Medicare rebates directly, whether or not they bulk bill. This is a change in policy and reduces the incentive to bulkbill – there will now be no disadvantage to doctors who charge patients an additional fee.
3. People with health concession cards will now have to pay the first \$500 in fees above Medicare rebate and then will receive 80% of the gap between Medicare and the fee doctors charge. This reduces the incentive on doctors to bulkbill or charge only the scheduled fee. They can charge above the scheduled fee, knowing the cost to the patient is capped.
4. There will be no incentive payment for doctors to bulkbill people who do not have health concession cards. Those without concession cards will have to pay the first \$1000 above the rebate, after which they will be able to obtain rebates IF they have taken out the new health insurance to cover doctors charges. Doctors will have direct access to Medicare rebates, even if they do not bulkbill, thus removing a disincentive to doctors to charge additional fees. As at present, families also have to pay the first \$708 for PBS medicines, before they get them at the concessional rate.

The level of bulk billing has dropped significantly in the last few years, although it still averages 69%. In some areas, such as Parramatta, there is a very high level of bulkbilling. In other areas, especially in some country towns, there is no doctor who bulkbills. This means that access to a

doctor depends on having the money available “upfront” to pay the fee, thus discouraging many people from going to the doctor, which can result in health problems worsening.

There is substantial evidence that doctors feel underpaid and will respond to the removal of constraints by increasing fees.

Only about 30000 families have levels of health care which would take them through the \$1000 “safety net” so that they can claim from private health insurance. The rest will pay health insurance as an additional “levy” and carry the cost of copayments themselves. UnitingCare has explored the budgets of people on low incomes from Centrelink payments or wages. Such families struggle to find money for expenses beyond housing and food. They simply cannot afford to pay private health insurance or direct fees to doctors. Many struggle to pay for prescribed medicines. When they take out private health insurance, they have to give up some other essential part of their budget.

Health care needs are not evenly spread through the population. Families with high health care needs are severely disadvantaged by any additional payments beyond the Medicare levy. They need a universal system that does not require private health insurance premiums or payment of doctors fees. The proposed system is inequitable.

The issue for synod is not whether or not its members can afford to pay private health insurance. It is what system best provides people on low incomes with access to quality care. It is also how do we constrain doctors’ fees so that the total health care cost is kept at an affordable proportion of the economy as a whole.

The Public Health Association comments on the proposed changes to Medicare as follows: “The title 'a fairer Medicare' for the changes being proposed for Medicare is nothing but misleading claptrap. The changes will destroy Medicare and the PHAA will continue to work with our colleagues in the National Medicare Alliance and others to do all we can to oppose those that will increase 'co-payments' and/or create a two-tier health care system.”

Dental health has a significant impact on general health, and *Directions for health* mentioned it in the principles that should underlie the public health system. It is one of the matters being considered by the Senate Select Committee into Medicare.