COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Reference: Health Insurance Amendment (Medicare Safety-nets) Bill 2005

THURSDAY, 18 AUGUST 2005

CANBERRA

BY AUTHORITY OF THE SENATE

INTERNET

The Proof and Official Hansard transcripts of Senate committee hearings, some House of Representatives committee hearings and some joint committee hearings are available on the Internet. Some House of Representatives committees and some joint committees make available only Official Hansard transcripts.

The Internet address is: **http://www.aph.gov.au/hansard**

To search the parliamentary database, go to:
http://parlinfoweb.aph.gov.au

SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Thursday, 18 August 2005

Members: Senator Humphries *(Chair)*, Senator Moore*(Deputy Chair)*, Senators Adams, Barnett, Fielding and Polley

Participating members: Senators Abetz, Allison, Mark Bishop, Boswell, Brown, George Campbell, Carr, Chapman, Colbeck, Coonan, Crossin, Eggleston, Chris Evans, Faulkner, Ferguson, Ferris, Forshaw, Hogg, Hurley, Lightfoot, Ludwig, Lundy, McEwen, McGauran, McLucas, Nettle, O'Brien, Payne, Robert Ray, Watson, Webber and Wong

Senators in attendance: Senators Adams, Allison, Fielding, Humphries and Moore

Terms of reference for the inquiry:

Health Insurance Amendment (Medicare Safety-nets) Bill 2005

WITNESSES

Committee met at 4.01 pm

HAIKERWAL, Dr Mukesh Chandra, President, Australian Medical Association

O'DEA, Mr John, Director, Australian Medical Association

YONG, Dr Choong Siew, Vice-President, Australian Medical Association

CHAIR (Senator Humphries)—I declare open the hearings of the Community Affairs Legislation Committee inquiry into the Health Insurance Amendment (Medicare Safety-nets) Bill 2005. Witnesses are reminded that the evidence given to the committee is protected by parliamentary privilege. I also remind you that the giving of false or misleading evidence to the committee may constitute a contempt of the Senate. The committee have before us your submission. We thank you very much for that. We realise that there was not much time provided to make submissions, but we appreciate the information that has been provided to the committee in the submission. I invite you now to make an opening statement. After that we will direct some questions to you.

Dr Haikerwal—The AMA are grateful for the opportunity to speak to the committee. We believe that the legislation around the safety net is a very important issue and that the implementation of the new Medicare safety net was a significant improvement on the safety net provisions that pre-existed this current change. The original safety net had thresholds at $300 and $700. That increased the availability of safety net benefits to individual patients when they reached these thresholds and afforded medical treatment to those with chronic illness and those with significant health care needs with the knowledge that there was a lid on their expected out-of-pocket costs.

When the changes were mooted to increase these thresholds, that caused us significant anxiety, because the move from the benefit that would have come through the original process of having a decent safety net which meant something—and I will explain that in a moment—to a decent safety net that still meant something but was harder to access was a step in the wrong direction. The reason I say 'a safety net that means something' is that the previously existing safety net allowed only 15 per cent of the rebate to go towards the safety net, so if a fee of $100 was paid and the rebate was $85 the amount that would go towards the safety net was only $15. When you have $15 to access the safety net, which in GP consultation terms was around 80 consults, the benefit you got was only that $15, in effect.

The new safety net kicks in at around 13 GP consults if you are on a health care card and accessing at $300. Increasing that safety net to $500 means that you would have to have 22 GP consults to get to the safety net. If we go on to the full safety net it is 31 consults and 44 consults for the $1,000 threshold. However, when you access that new safety net it is a significant benefit on the previous safety net, because the original Medicare rebate of 85 per cent is payable, together with 80 per cent of the balance. That means that the out-of-pockets for individuals is quite significantly reduced once they reach that safety net.

We believe that the introduction of the higher rebates is therefore something that negates the benefits that were first envisaged when Strengthening Medicare, as it is now called, came into being. When the announcement was made we thought it was excellent. We believe that the amount set aside for this was probably underfunded. The amount of money that Medicare had been underfunded over the last 20 years had capitalised, and the safety net was one way

of addressing that underfunding of the Medicare system. The idea was either to increase rebates so that patients would therefore get the benefits at the user end or, at the other end, that they would get the benefits after reaching a certain threshold, such as after a certain number of visits. We were quite comfortable with the safety net being the manner of administering this program rather than by necessarily increasing wholesale the rebates. Although, obviously we believe the rebates need to be addressed in a different forum.

So, in summary, we believe that the safety net is a very good improvement on the original Medicare safety net, we thought the original thresholds were set quite fairly, we still support the safety net quite strongly and we are concerned about the new thresholds that are currently proposed.

CHAIR—You have emphasised that the new arrangements are less extensive than the originally announced safety net. Would you still regard the new version of the safety net as being a better arrangement than the absence of a safety net altogether?

Dr Haikerwal—Absolutely. The Medicare safety net as it is in the legislation has diminished in value because Medicare rebates have become less and less important as the Medicare benefits schedule that we use has become outmoded. The new safety net uses real fee as opposed to scheduled fee as its basis. That is significant. It emphasises that the safety net is catching up with real life.

CHAIR—I see. Your submission states:

AMA is of the view that the whole matter should be allowed to settle down now and that any future refinements should be made on the basis of evidence and consultation.

When you say, 'should be allowed to settle down', do you mean the arrangements as announced in Strengthening Medicare or the arrangements in this bill?

Dr Haikerwal—The arrangements in the original Strengthening Medicare package which set the thresholds at $300 and $700.

CHAIR—Would you accept that the reason there is no need to allow those arrangements to settle down is that the government has made it clear that it was trying to rein in the cost of the scheme? It is already clear that the cost of the scheme is going to be quite large, or larger than originally estimated in the government figures. Leaving arrangements to settle down will not change that basic fact, and that is the fact on which these major changes have been erected.

Dr Haikerwal—It is probably a year and a bit since this original change was made and it is hard to know what the usage has been in that time between enactment on 1 January and now. The figures to date have shown that the usage of the safety net has been reasonably consistent and that there has been no gaming, which was always a concern. People always thought the fees would go up because of people being on the safety net and that has not been proven to be the case. I am really proud that the profession has been very honest through this whole process. Fees have gone up once in November, as they have always done in bygone years. Obviously government needs to look at costs and this is a method of reining in some of those costs. At the inception of Strengthening Medicare, we stated that the amount set aside was probably too small because Medicare was already quite large and, therefore, the pent-up need would certainly emerge, and that is what is emerging. So it is not a failure of policy; I think it is a failure of budgeting and not allowing enough money, in that case.

Senator ALLISON—The Rural Doctors Association suggests that a preferable proposal would be to cap the safety net payments for every individual Medicare item. Does your organisation support that as an alternative?

Dr Haikerwal—No. It is counterintuitive to do that because you do not know which items you will and will not require in the course of an illness. I think that the Medicare system is one of open access for the people that need it. When they need it they get the benefits; if they do not need it there is no need for the benefit.

Mr O'Dea—It changes the nature of the scheme away from being a safety net as soon as you do something like that.

Senator ALLISON—You would still have the safety net but, rather than capping the amount that you accrue, you would cap the payment which would comply.

Mr O'Dea—Yes, but you take my point that then means that you diminish the safety net that you have announced. It is no longer 80 per cent of what is charged; it is 60 per cent or 50 per cent or whatever.

Senator ALLISON—Correct. One of the reasons for suggesting this is the obvious point made—I think it was made in the ACA submission to this inquiry—which is that the people hardest hit by the threshold increase will be those with chronic illness, who tend to accrue medical costs slowly throughout the year. They would have to visit a general practitioner many times to qualify for the safety net, whereas those perhaps on the north shore of Sydney might quickly meet their threshold by virtue of the fees paid to specialists—private obstetricians is given as an example of that. Does that not make some sense?

Dr Haikerwal—I do not believe so. People who live in rural areas are able to access the same specialists on the north shore if they want to.

Senator ALLISON—If they go to the north shore?

Dr Haikerwal—Yes. I understand that is a weird concept. Obviously people like to have services near to where they live. But it is about access to services wherever people want to have them delivered. I think to limit access to by item number would make a reasonably complex system even more complex. In many ways, it would limit the access to safety net benefits further rather than increase access to benefits.

Senator ALLISON—What do you say about the suggestion from the Rural Doctors Association that 30 per cent of the population accesses only 21 per cent of Medicare funded GP services? As throughout the Medicare debate, it draws attention to what I call the Medicare deficit for people in rural areas. You are not seriously suggesting we could fix that deficit by getting people to come to the city?

Dr Haikerwal—Obviously that is not the answer, but it is a possibility if people want to do that. That is the point I am making. What is important is that people get access to services and that those services are properly rebated, and if they are paying out-of-pockets those out-of-pockets are diminished. If the out-of-pocket payments in that rural area are less, then the rebate is obviously going to be less because they are paying less.

Mr O'Dea—The other point is that you do not really need a safety net for $20 gaps.

Senator ALLISON—You do if you are very sick and you go to the doctor a lot.

Mr O'Dea—That is true. But you do not need an elaborate safety net for very small gaps. You do need a safety net for very large gaps. You can turn it round the other way if you want to and make that case.

Senator ALLISON—So you do not have any other suggestions to make about how we might contain the costs of the safety net.

Mr O'Dea—I think that the change that has been made is the least intervention that could have been made. To that extent, we would prefer what was there before, but if there has to be a change, if the government says it has to have savings, this change is the next best change.

Dr Haikerwal—This change, although we do not support it because it does reduce the access, still maintains the integrity of the scheme, which is to give a reasonable out-of-pocket rebate on the real fee, when it is charged, so that the out-of-pocket expense that people are going to encounter during the year is limited. If they are going several times a year or if they have families that are sick, they will get access to a decent rebate and therefore their out-of-pocket expenses will be limited.

Dr Yong—With the experience of the safety net so far, it has not tended to be inflationary, which was something that people were concerned about. The question before the government and the parliament is really whether having the utilisation safety net is reflecting what people need in health care and whether they are able to access it. That has been more than what was initially estimated, which is why the cost of the safety net overall is higher than what was expected. We believed that was the case at the time. I guess it would be remiss of an organisation like the AMA not to point out the health consequences of rationing care, in whichever way you choose to ration it, whether that is by changing the thresholds of the safety net or by doing it some other way. But we see a demand from the public for medical services, and they are using the services. We supported the safety net because it does help to reflect the cost of medical practitioners providing the services more realistically than an artificially capped Medicare card system does.

Senator ALLISON—Are you suggesting that the measure was not inflationary—if I can just get this right—and that more people have used services and that is why it is much higher than anticipated?

Dr Yong—We thought that would be the case because it has allowed some people to access services more easily than they would have done otherwise.

Senator ALLISON—Is that borne out by the figures? We will check that with the department, but it was not my understanding that there were more consults than before, following the safety net.

Mr O'Dea—I think there has been a rise. We do not have detailed figures. We do not have access to the figures, actually. The raw consultation data shows quite a rise from the December quarter 2003, for example, to the December quarter 2004. But you should ask the department about that.

Senator ALLISON—Is that with no increase in the number of doctors or not a substantial increase in the number of doctors?

Mr O'Dea—There must be. Someone is supplying the services.

Dr Haikerwal—There was a trend when there was a drop in the number of GP consults. Part of the Strengthening Medicare package was to try to address the fact that we have more people in the population, more older people, more chronic illness and fewer services being provided. But we have seen that the Strengthening Medicare package has kept more people practising within the system. Therefore, the number of consults is probably reflected in those numbers.

Senator ALLISON—We will follow that up with the department and hope that they have some useful figures for us.

Dr Yong—We have not seen fees rise dramatically, as Dr Haikerwal said. One of the other things we would be looking at is the health consequences of, hopefully, better care for people with chronic conditions. Certainly in my discipline, psychiatry, there has been some anecdotal feedback at least that that is happening. People are more able to access continuing care, from both specialists and GPs, and I think that we should see some improved health outcomes down the line from that. We should see people being able to participate for longer and more easily in the work force, high productivity and that kind of thing.

Senator ALLISON—Would you anticipate that this lifting of the threshold would then have the result of fewer people accessing services that they need? Is that the logical conclusion you draw?

Dr Yong—That is the outcome that we fear may happen. It is difficult to quantify, because we do not have access to data that allows for that kind of modelling, as we pointed out in the submission. That is the kind of fear that we have. If it is harder for people to reach the safety net, more people may drop out of seeking the sort of care that they need.

Senator MOORE—Dr Haikerwal, in the beginning of our evidence, I was having difficulty working out what was the original and what was not. I think I have got it down—and Senator Humphries clarified that as well.

Dr Haikerwal—It is nice simple system, Senator.

Senator MOORE—It is not a simple system.

Mr O'Dea—I actually think that the safety net that is based on the difference between the schedule fee and the rebate is still there. Not many people are using that one, because the new one is much better.

Senator MOORE—That is when we get caught up between originals and all that kind of stuff. In your submission you say that, on evidence available, there is no indication that doctors' fee increases have had an impact. Further on, you also make a point about a lack of information on which to make arguments and build cases. There is an oft stated view that there have been significant increases in health costs over the last few years. There have been various figures bandied around about the cost of health going up. We have had this in a number of inquiries. For the record, can you let us know on what evidence you have been able to make the assertion that it has not been an increase in doctors' fees—and it has been said that there has been a blow-out in cost.

Also, to follow up on that point, what information do you think you need? You are regular lobbyists in the industry. A couple of times, even today, you have said that you did not have access to information or data. What information do you think you ought to have in order to make a clear assessment when you are involved in this discussion so often?

Mr O'Dea—The information we base it on is the department's Medicare statistics publications. You have not got a full year yet, but as I remember I used the December 2003 to December 2004 quarters.

Senator MOORE—Which are the latest—

Mr O'Dea—There is an increase in the aggregate fees charged, and some part of that is explained by services. The number of services goes up so the total fees go up. The charges go up, so the total fees go up. And the complexity of items drifts up. So there are three things in there. When you took out the amount for volume growth and schedule fee growth—which is just the indexation of the schedule—there was not a lot left. There was a very small amount left. So 90 per cent, or more than 90 per cent, of the increase in aggregate fees charged was explained by volume and schedule fee increases. What that is saying, I think, is that the doctors are charging more—but about the same as the schedule is indexed. And the bundle of items that they are using is also shifting up in complexity. Not a lot of it was because of runaway charges, if you like. Before we make absolutely dogmatic statements, we want to look at a year's worth of data.

Senator MOORE—Would one year be enough to look at?

Mr O'Dea—It would be close to being conclusive.

Dr Haikerwal—One of the times that we did have a chance to look at the figures was when the new item was introduced for obstetric care, which is obviously something that will come to your attention as well. That showed very clearly that, apart from the normal annual indexation, there has been no increase in other services. The obstetrics service use—apart from an initial build-up, because of the number becoming newly available—has also been very flat. So there has not been any increase in fees or anything inflationary from that point of view, apart from normal annual adjustments that are made.

Senator MOORE—The other issue that is raised in regard to the difference between the general fee charged by GPs as opposed to the specialist fee is increases. Do you have any comment on the allegation that has been made that there has been a significant rise in specialist costs—not just in obstetrics, which has been the subject of quite a lot of debate, but generally? It has been mentioned that there is a crisis in the number of specialists that are available, the need for their services and also, as you said, the complexity of services as people are accessing different levels of care. Do you have any indication whether there has been a rise in specialist charges or not?

Mr O'Dea—We meet with the department on a regular basis. We have said all along that we want to make sure that this works. If there is a problem, we want to intervene before it becomes a matter of public derision or whatever. So we have said all along that we want to work with them and they have showed us the figures all the way through. They look at key item numbers—the ones that are very highly used—and at the charging behaviour at the mean, the median and the 99 percentile and so on. We cannot see that there is anything bad

going on across the board. You have a few outliers, but that is not where the story is. The story is where the averages are. As Mukesh says, I think it is a good message for doctors as a result. We all know that there are issues in obstetrics. There were things that were not on the schedule and that came on and so on which looked like increases, but they were not. But it has been a pretty good message, I think.

Senator MOORE—With regard to the statement about lack of information, is there any information that you require that would make it easier for you to have up-to-date information about your industry so that you can be involved in the debate even more than you are now?

Mr O'Dea—I have not given that a lot of thought. We do not even know what is spent in total on the safety net. It is buried in the total figures. It is hard for us to make too many comments. To do any sensible modelling you have to have the whole HIC database, the Centrelink database and a few others. We are never going to be given access to it and I do not think we want it. But we would like some more information out there—as much as the government and the department can make available.

Dr Haikerwal—We feel it is important to make sure this area is not abused. We want to work closely with the department in this instance. We can set them certain requests that will help to identify whether there is a problem with fee-setting or not. To have that relationship is important. To actually get those requests furnished is important. To date they have been very good around the safety net arrangements because I think it is also in their interests to make sure that we help should there be a problem. So a collaborative approach is actually quite good. As to whether we want access to the whole database to manipulate, I do not think we do. There is so much information there and it gets very difficult. The HIC online data is quite useful. But, again, it is just trends—it does not give us specifics. We do rely on HIC and the department should the need arise.

Mr O'Dea—It would be useful to know how many people are accessing it in a yearly cycle, at what time and in what month. There is a cyclical pattern to the expenditure. It goes up as people become eligible during the year and in May or June it really starts to hit. It rises right through to December and then goes back down to almost nothing in the first six months of the year and so on. So there is a cycle. We would be interested to know how many people are getting in there, when they are getting in there and what services are contributing. We would be interested to know which bundles of services are contributing mainly to accessing the safety net, whether it is GPs, specialists or obstetrics et cetera. We would be very interested to know that. But we have not sat down and thought about it carefully enough to give you an answer.

Senator ADAMS—Dr Haikerwal, at the end of your submission you say that, in the future, the AMA would see merit in amalgamating the MBS and PBS. Would you like to expand on that? I am very interested in what you think about that.

Dr Haikerwal—The Medicare safety net is obviously the medical fee aspect. People who are unwell or have multiple illnesses or have members of the family with multiple problems have jumped a certain number of hurdles. Under the old safety net it was $300 and 13 consults and it went up to 22 under the new safety net when you have a health care card. Then they have another set of hurdles to jump in terms of medication. The concern is that, with the

increased copayment that people are making for their medications, which went up substantially just before the election, the contribution they are making has been raised quite significantly. That is yet another set of hurdles they have to jump before they get a further subsidy on their medications. We think they are being hit twice before they can actually get an affordable level of care.

With prescription medication, the concerns are much more about people who are not cardholders and are paying nearly $30 a prescription. Nowadays, if they have a condition like blood pressure, for instance, they will often need two or three agents, perhaps they have cholesterol too, and they may be asked to pay $120 a month on prescriptions, or up to a certain level, before they can access that safety net. There is some merit in having one hurdle with one set of amounts to jump over before full benefits apply. I think the point is to try and streamline the situation so that there is better access once you have reached a certain amount of out-of-pocket expenditure.

Mr O'Dea—It would make it a lot simpler and clearer for people if they knew the amount they could spend on their health, doctor or pharmacist and, after they get to that level, they would have to spend 20 per cent or whatever of the rest of the bill. It would be clear, equitable and simple for people. I think it would take a lot of work, but it is something we should keep in mind.

Senator ADAMS—That is what I was wondering about. Thank you.

Senator FIELDING—I appreciate hearing your thoughts, particularly that you would like to have a little more information. I am keen to find out whether we can provide you with that, if it is not confidential, and I would be keen to hear your views and any other alternatives once you have seen that information. I would like to find out what can be provided. I assume the committee would also like to see that you got that information, as long as it is not obviously confidential and per patient. Broadly speaking, I think it should be provided to you, but I do not know how quickly the committee can arrange it.

CHAIR—We will be asking the department shortly if they can provide information to us.

Senator ALLISON—You mentioned earlier that the behaviour of doctors was moderate and there was no evidence that doctors were ripping off the system, as it were. Professor Leeder's submission cites a couple of examples where procedures have been folded into consultations. He cites IVF as an example whereby the benefit is about $1,000 and the procedure costs $3,000. However, before the safety net, two accounts would be rendered to the patient: one for the submission to Medicare and the other paid out of pocket. Now they are put together which is a part explanation for the blow-out, as it were. Have you had a chance to look at those kinds of behaviours? Where else would we expect to see them? Are they confined to specialist services or do you deny that this is happening?

Dr Haikerwal—It was certainly a concern for us that people were rolling into a consultation things like consumable items that normally would have been billed for separately. It therefore made the fee for that consult increase.

Senator MOORE—Can you give us an example of a consumable item?

Dr Haikerwal—Somebody having a procedure done which requires a steroid injection or something. The cost of the injection, which may or may not be a PBS item, is rolled in. We asked for that sort of information because that was our real concern. On Tuesday, we looked through those figures in quite some detail and really there is no evidence of any real change. There are outlays and we want to find out if they are there for some particular reason or if this is a practice that is going on. If it is a practice, it is certainly not wholesale and, even if it is not, we still want to make sure that people understand the claims that are legitimate and the claims that are not legitimate. For a claim to be legitimate, it has to be a fee that is reproducible and justifiable. We would be concerned if they could not justify the fee. Botox is another procedure that comes to mind. The use of Botox is a consumable item. They have looked at dermatology items and plastic surgery items and that has not been shown to be the case.

Mr O'Dea—There were a few occasions right at the beginning when some weird things were going on. A clarification and an opinion were needed. We worked with the department to get some advice out there to everybody that the charge had to relate to the service that is provided, not to some other service, and so on. That was all clarified. A lot of these other things are not increases in charges but charged differently. The total amount paid to the doctor is the same, but Medicare is picking up a bit of it on the safety net.

Senator ALLISON—That is the example that Professor Leeder gives us.

Mr O'Dea—Yes.

Senator ALLISON—But you do not have any information on the practice?

Mr O'Dea—We do have some information, but the department would probably be able to talk to you about that. The department has an ongoing interest in some of that, and to the extent that we can we will sort some of it out. But it is a big benefit to the people who are using the service.

Senator ALLISON—It may be a big benefit to private health insurance as well.

Mr O'Dea—They probably need all the help they can get.

Senator MOORE—Just following up on Lyn's question, that was the data that you were looking at. You said earlier in your response that you had trawled over the data and could not find it. That was the same data that you were talking about?

Mr O'Dea—Yes.

Senator MOORE—Dr Haikerwal, can we get some more information for the record—and could you send it to us because it is not particularly relevant to this inquiry—in relation to the response that you gave to Senator Adams about the change in the way the PBS is done. I was following that through in my mind, about how you would do that. I have not heard you give evidence like that before. Could we get an explanation about how that could possibly work, and if you could send that to us on notice that would be really useful.

Dr Haikerwal—I am happy to do that.

Senator MOORE—It will come up in some inquiry in the future for sure.

CHAIR—Thank you very much for your evidence this afternoon and for coming in at fairly short notice.

Dr Haikerwal—Thank you for the opportunity.

[4.37 pm]

GREGORY, Mr Gordon, Executive Director, National Rural Health Alliance

CHAIR—Welcome, Mr Gregory. The committee has your submission before it. Thank you for submitting that to us at fairly short notice. I invite you to make an opening statement and then we will ask you questions in the usual fashion.

Mr Gregory—Thank you for inviting the National Rural Health Alliance to appear before the committee. It is a challenge for the alliance to report with confidence on quantitative elements of the committee's terms of reference. It is clear that increases in the safety net thresholds will transfer some additional health care costs to patients from government. People in rural and remote areas are likely to be affected to a greater extent than those in the major cities for three reasons. First, they face higher average out-of-pocket costs so that, proportionately, they will bear more of the burden of the costs shifted to patients. Secondly, families in rural and remote areas can less well afford such costs because, in aggregate, they have lower incomes than their metropolitan counterparts. Finally, because accessing out-of-hospital care is more expensive for a number of reasons, people in country areas will find themselves paying the residual 20 per cent more frequently and with greater difficulty. This is especially the case given the higher incidence of some illnesses in country areas, especially injury but also circulatory disease, some cancers and respiratory disease.

The second term of reference talks about the extent of the higher out-of-pocket expenses. For its submission on Medicare in February 2003, the alliance estimated that in 1996-97 people in rural and remote areas had $43 million more in out-of-pocket expenses than people in the major cities. This was an estimate by a consultant to the alliance who is of very good repute but who emphasised the difficulty of making the estimate. Whatever the aggregate differential figure for that year, it is likely to be higher today. It has been asserted that average national out-of-pocket costs have risen from $8.89 per visit in 1996 to $14.85 this year. And out-of-pocket costs are still higher in rural areas because rates of bulk-billing there are still lower, despite increases over the past 12 months due to 100 per cent Medicare and the differential incentives for card holders and children.

The third term of reference relates to the implications for access and equity in health care. Access and equity are the central pillars of much of the Alliance's work. In our brief submission to you we make the case that Medicare's universality is its most important principle and that in more remote areas it is more principle than reality. Where there is no doctor there is no access to Medicare. In such places there is therefore no value in the safety net. This is not an argument against Medicare but rather justification for two other things. First, for reshaping Medicare so that it better covers people in more remote areas, and second, it is the central argument for continuing the special work force and other health programs for rural and remote areas in recognition of the Medicare deficit and the higher out-of-pocket costs incurred.

It is perhaps hard to argue unequivocally against the very existence of the Medicare safety net because, apart from anything else and as you have just been reminded, there always was one—albeit less comprehensive and less well-known—but it is not impossible to so argue. A

single low-level threshold was rejected initially as being too costly—meaning that it was regarded as inappropriate for all taxpayers, whether frequent users of out-of-hospital care or not, to share the costs of the cover and despite the fact that through the tax system it would have been progressive. It is strange then and certainly less equitable, despite the two thresholds, to have a major part of the costs borne only by those who are heavy users of the services, including those on low incomes. There is a fear that a greater emphasis on a safety net at all is evidence of an official or planned unwillingness to control or minimise out-of-pocket costs and that having two levels increases the trend towards a two-tier system. Both of these fuel suspicions that one day Medicare will be a welfare program rather than a universal health insurance system to which all contribute and by which all are covered.

There can be no doubt that the safety net is based on acceptance of the fact that health care costs have been shifted to patients and that its higher thresholds shift more costs again. There can be no doubt either that it is regressive despite the two tiers. People with a sense of history may regard these current developments as symbolic of the way Australia's health care system is going. For this reason they, and the National Rural Health Alliance, have a strong interest in the current round of health reform being led by COAG and the Productivity Commission and in where this reform may take us.

The final point to be made is that there is a close but complex relationship between Medicare and its safety net, the structure and financing of the health care system, and health work force issues which as a nation we are finding so troubling at present. As the system is reformed we must be aware that its structure will determine how health care costs are distributed between governments and patients and what sort of health work force we will require in the future. We encourage the Senate to continue its role as the house of review so that the voices of people in more remote circumstances will continue to be heard in the work of parliament.

CHAIR—Thank you, Mr Gregory. I just have one question. You point out that there is a shortage of doctors in rural areas. This is a point you have made very well on previous occasions. You also point out that the rate of bulk-billing is considerably lower in rural and regional areas than in the rest of Australia. Given the lack of bulk-billing is it reasonable to suppose that it is more likely in a given year that people in rural and remote areas would access or qualify for the safety net, even with the raised thresholds, than a person living in an urban area?

Mr Gregory—In aggregate, yes.

Senator ALLISON—I am interested in your suggestion about changing the services—recommendation 2, I think it is. Can I invite you to expand on what you would like to see with regard to that recommendation:

> that the current safety net should be replaced with an alternative means of protecting people with ongoing medical needs ...

Mr Gregory—Is that recommendation 2 in our submission?

Senator ALLISON—I beg your pardon—it is the submission of the Consumers Association. I will ask you the same question: do you think there are better ways of protecting rural people in particular and can you make some suggestions about what that might be?

Mr Gregory—As I hope was clear both from our written submission and the statement I have just made, Medicare is just as important for rural and remote people as for anyone else. We have argued for years that its universality should be retained. The provision which we are here discussing takes away from that universality so that is something that the alliance regrets. What we want, if you like—and this phrase has been coined before in our submission to the Senate on Medicare—is universality plus. This was coined at the stage when the government was talking about Medicare plus—that is, we want universality but we want changes to be made in such a way that people in areas where there are no or few doctors can still have the benefits of that notional contract which exists between the government of Australia and its people: that they will all have access to no cost or low-cost primary care wherever they live. So what that means, among other things, is greater attention to the alternative, some innovative means by which primary care is delivered in more remote areas where doctors are not available. Of course, the corollary of that has to be that whatever those alternative means are, they should be subject to the public purse. They should be paid for in the same way as Medicare is. So we therefore welcome and celebrate some of the programs like the Primary Health Care Access Program, which is done well and of which greater things are expected.

We welcome the moves towards salaried positions where it seems that fee-for-service private practice is not going to be viable or sustainable. We would welcome moves which are less unequivocally supported by all parties for Medicare item numbers to be extended to, for instance, nurse practitioners. I have to say quickly that this is not yet a proposal that the alliance for which I work has formally endorsed but it clearly is the sort of innovation which would (a) be amenable to support from the public purse and (b) provide primary care at no or low cost to people where there is no doctor.

It is an absolute certainty that remote people currently miss out. People in country towns where there are insufficient numbers of doctors miss out. We know that the doctors' books in quite large sized towns—20,000 or 30,000 people—are closed to some people, so they miss out. If you cannot see a doctor, you cannot engage in that contract with the government. You cannot access Medicare, and the safety net, frankly, is irrelevant. What is not irrelevant is the fact that you do not have access to primary care in a timely and affordable fashion which is going to make or keep you healthy.

Senator ALLISON—The question I meant to ask you was about capping the safety nets because that was what your recommendation was. We have just heard the AMA say that they did not think that would work. Can you explain how you think it would work?

Mr Gregory—When I was sitting in the back row listening to you, I noted that you said that was from RDAA. RDAA is a member of the alliance, but I have got to say that I am not familiar with that recommendation and it does not form part of our submission to you. I think I am correct in that.

Senator ALLISON—It was the Rural Doctors Association; you are correct. I am sorry—I cannot win a trick today.

Mr Gregory—Let me be quite clear. RDAA is one of the 24 member bodies which comprise the alliance for which I work, but that recommendation has not yet found its way

into our corporate governance and, indeed, into our corporate memories, some of which resides up here.

Senator ALLISON—I understand. Thank you.

Senator ADAMS—I note your submission says:

… out-of-pockets costs are both higher and more up-front in rural areas than in the cities.

And there is a footnote with a reference to the Patient Assisted Travel Scheme. Would you like to elaborate on that for me, please.

Mr Gregory—Again, it was interesting sitting in the back row, as I was, when the suggestion was made by the AMA—and, I think, not tongue-in-cheek—that everybody in rural and remote areas could access their specialist care on the North Shore. It sounds pretty dopey; nevertheless, it reminds us of the need for a good, comprehensive, fair system for PATS or IPTAS or whatever it is called in the various jurisdictions, and this is something which certainly the alliance believe strongly. In fact we are currently working on a new paper to make the point that one of the options where you do not have access to local medical specialists or any other services is to provide subsidised transport to the regional centre or the nearest capital city. So that reference from the AMA is not one we would support, but it reminded me and it should remind all of us of the importance of PATS and its equivalent in all jurisdictions.

Senator ADAMS—Thanks.

Senator FIELDING—For you to make any further recommendations, would you like any other information or data of any sort, just while we are on that topic? Or are you reasonably happy that you have—

Mr Gregory—I think it is obvious, isn't it, from what we have written and what I have said that we believe out-of-pocket costs are the real issue. I think we sometimes make the mistake of believing that bulk-billing per se is the issue. It is not, of course. Bulk-billing is a means to an end, and that is to provide care at affordable prices. So we would very much like to have more information, better information, about out-of-pocket costs as they vary from region to region. We would also like information—since you ask!—about the relationship between levels of bulk-billing and other procedures requested, meaning: where there is more bulk-billing, is it possible that there is also a greater volume of script writing and referrals to specialists? So there is a possibility that there is a relationship between rates of bulk-billing and rates of other ancillary interventions sought by the GP, some of which have costs and therefore entail further costs to the health consumer.

Senator FIELDING—Thank you.

CHAIR—Mr Gregory, thank you very much for your appearance here today, at short notice.

Mr Gregory—Thank you, senators.

[4.55 pm]

DAVIES, Mr Philip Keech, Deputy Secretary, Department of Health and Ageing

ROBERTSON, Ms Samantha, Acting Assistant Secretary, Medicare Benefits Branch, Department of Health and Ageing

CHAIR—I welcome representatives of the Department of Health and Ageing. You are reminded that the giving of evidence to the committee is protected by parliamentary privilege and that the giving of false or misleading evidence to the committee may constitute a contempt of the parliament. You will not be required to answer questions on advice that you may have given in the formulation of policy or to express a personal opinion on matters of policy. We have your submission. Thank you very much for producing it in short order. I now invite you to make an opening statement of a brief duration. We will then ask you some questions.

Mr Davies—In the interests of brevity we will let our submission stand as our opening statement. I do not see any need to read that into the record, if you are happy with that.

CHAIR—There is just one question from me. There was speculation about the concept of a safety net generating inflation in doctors' fees and doctors upping their fees in order to capture the extra capacity that was in the system to pay fees. Has any evidence been produced to the department of that occurring as a result of the early stages of the safety net?

Mr Davies—No, there has been no such evidence. As I think previous witnesses may have already said this afternoon, we keep quite a close eye on trends in total fees. With the exception of the initial phenomenon around obstetric items coming within the scope of the safety net, which evidenced itself as an increase in fees but was actually a widening of the scope of Medicare, there has been nothing of great concern. We have also looked at IVF as another area where there has been some growth but, other than those two, we have seen no systematic evidence of anything other than normal inflationary increases in fees—normal secular trends in fee growth.

Senator ALLISON—How do you explain the blow-out in demand on the safety net?

Mr Davies—There are really three arguments. When you say 'blow-out', I assume you are referring to the need about a year ago to adjust the estimates. From our investigations we believe there are three factors driving that. The first was the higher than expected number of families who registered for the safety net. The second was the fact that the original costings had been carried out using fee statistics back to 2001, so they did not take into account the fact that fees themselves had risen in the intervening two or three years. The third was the issue of families who—what do we call it?

Ms Robertson—Increased registrations and substantiation.

Mr Davies—Substantiation. That is the other point. We assumed people were going to be slightly less assiduous than they turned out to be in the end in terms of accessing their entitlements under the safety net.

Senator ALLISON—How do you know that?

Mr Davies—We assumed a certain percentage and, once the safety net started running, it turned out our assumption had been lower than the reality.

Senator ALLISON—What is the percentage you are referring to?

Mr Davies—Sorry?

Senator ALLISON—You assumed a certain percentage. What is that percentage you were assuming?

Mr Davies—In terms of substantiation, I do not have the figures on the assumed and the eventual substantiation rates, but we can certainly take that on notice and get back to you quickly.

Senator MOORE—So, once people registered, it was the number of people who built up the number of visits that it took to reach the point, so that is the substantiation.

Mr Davies—My understanding, and I stand to be corrected by my colleague, is that substantiation refers to the number of people who, once each individual in the family has crossed the safety net, actually choose to avail themselves of that benefit. Some people who are eligible for Medicare benefits do not actually claim them. What we were observing was that more people were likely to do so.

Ms Robertson—Once a person has reached the safety net threshold, they then have to substantiate that they have actually incurred the out-of-pocket costs that are recorded on the HIC systems. If their doctor's accounts have been paid using a pay doctor cheque, they have to show the Health Insurance Commission that they have paid the difference between the Medicare rebate and what the charge is that is recorded on the system. That is what we call substantiation.

Senator MOORE—So quite a separate group.

Mr Davies—Yes.

Senator ALLISON—It would be good to have the actual figures on the percentage, but are you able to precisely indicate which families were entitled to the safety net but who either were not able to substantiate it or chose not to substantiate it? Do you have precise figures on that, and for which year do you have the figures?

Mr Davies—We would not have it pre safety net because it was not an issue pre safety net. The need to substantiate only arose as an issue when the safety net was introduced. As for what we assumed and what it actually turned out to be, and whether we could actually impute anything from the original Medicare safety net, I do not know. Those figures would be way back. I will certainly see if we can find those for you, Senator, and give them to you on notice.

Senator ALLISON—Thank you.

Ms Robertson—Under the old safety net people did have to register as a family and we do still require that now because the Health Insurance Commission has a lot of individual people on their database and without somebody nominating as a composition, as the family, we have no way of knowing whether or not they are part of one and the same family. So you have to actually register as a family unit, because sometimes people would be on different Medicare cards.

Senator ALLISON—What were the figures there? How many families did you anticipate would register and how many eventually did?

Mr Davies—Again we do not have those data with us but we can find those for you.

Senator ALLISON—And how do you explain that difference? Was it just an error or were there different family groupings going on that you could not know about?

Mr Davies—You are asking us to speculate—

Senator ALLISON—No. Mr Davies, you made an estimate and it is your job to do that sort of work, and what we are interested in is why that estimate is wrong.

Mr Davies—I was going to say that I would imagine that one explanation may be that the new safety net is a better deal, if you like, than the original safety net. It offers people who have health care costs a higher level of benefit.

Senator ALLISON—What are you referring to with original and new?

Mr Davies—There has always been a safety net in Medicare.

Senator ALLISON—The original proposal?

Mr Davies—No, the traditional safety net, the initial safety net.

Senator ALLISON—The old safety net.

Mr Davies—Yes. Let us go for old/original and new. The extended safety net gives people more benefit and therefore they have a higher incentive to do whatever is necessary to access that benefit.

Senator ALLISON—You mean families have come together in order to qualify for the safety net; individuals have formed themselves into families for this purpose?

Mr Davies—I do not know what the domestic arrangements are but they form themselves into families in the eyes of the HIC.

Senator ALLISON—What does that mean?

Mr Davies—They have told the HIC they are a family.

Senator ALLISON—Do you have reason to doubt that?

Mr Davies—They have actually said to the HIC, 'There were these five Medicare cards. We are a family.' They always were a family but there was never any real incentive for them to do so. With the publicity surrounding the safety net and the increased benefits that the safety net offers, I emphasise that I am hypothesising or speculating but certainly in my family the prospect of accessing the higher safety net benefits gave us the incentive to tell the HIC we were a family.

Senator ALLISON—Does that mean you surrender your old Medicare card in order to get the one that indicates you are a family?

Mr Davies—No. The linking between the Medicare cards is purely a virtual thing on the HIC database. It knows to keep a tally of the totals on a collection of Medicare numbers, which constitute the family's numbers.

Senator ALLISON—And you will provide the committee with the figures on that?

Mr Davies—We will certainly try to dig those out.

Senator ALLISON—Can we go the second reason you cite. The original costings used fee statistics from 2001. Was it an error that you used 2001 statistics for 2004?

Mr Davies—It certainly was not an error, no. At the time we started the policy development and the costings, that was the only full year of data that we had.

Senator ALLISON—You were not able to add some level of normal inflation to those figures to figure out what 2004-05 would be?

Mr Davies—I think that would be hazardous, because the only way you could do that would be an across-the-board figure and we are talking about the consolidation of theoretically 20 million people's different claiming patterns. There is seasonality, which is why we had to get the full year.

Senator ALLISON—So you are not talking about doctors' fees and out-of-pocket costs in this original costing in which you used fee statistics from 2001. What exactly are you referring to?

Mr Davies—It was fees as evidenced by claims, I think I am right in saying. Yes.

Senator ALLISON—I do not understand why you were not able to apply an inflationary figure to those fees to come up with what might happen in 2004.

Mr Davies—I was not party to the detail modelling but I would imagine we would have done this exercise on the actual data. But as I think about it, and about some of the papers that I saw at the time, I think we did put in an inflation allowance. I think you are triggering memories that we did put it in, which suggests that we underestimated the amount of inflation rather than failed to take it into account.

Senator ALLISON—What is the inflation rate now? I am not sure what figures we are talking about: whether it is 2004-05 or a calendar year.

Mr Davies—For the safety net we always work on a calendar year basis.

Senator ALLISON—Are we talking about 2004 figures?

Mr Davies—We now have full year data on the 2004 calendar year.

Senator ALLISON—How does the 2004 calendar year compare with the 2001 calendar year for doctors' fees? What is the rate of inflation?

Mr Davies—We have total fees, which are not per capita.

Senator ALLISON—You must be able to give fees per consult.

Mr Davies—We would probably need to do some division, but total fees charged for the calendar year 2003 were $10.3 billion. For the calendar year 2004 they were about $11.4 billion.

Senator ALLISON—And for 2001?

Mr Davies—This table which I have in front of me—which I am happy to hand to you—covers the 2001-02 financial year, where the total was $9.6 billion.

Senator MOORE—What table is that?

Mr Davies—It is our regular publication on Medicare statistics.

Senator MOORE—It is the regular one that we get?

Mr Davies—Yes. I can give you the document, if you like. That is total fees across the country, across all services.

Senator ALLISON—But do you have a table that shows the total number of consultations—that we can calculate or that you may have calculated—which will tell us whether the increase is due to the number of consultations being increased or the fees being increased? The AMA suggests that there were more consultations and that that was the reason that the fee increases were not out of line with normal inflation over that period.

Mr Davies—There is certainly a growth in both. I understand that, following the June estimates, we have an outstanding question on notice that goes to that issue in a little more detail. There is another table here, which gives you the average patient contribution per service for patients billed out of hospital, so we have taken out all the bulk-billed services. That tells us that the average patient contribution in the 2001-02 financial year was $18.12 and, in the first quarter of 2004, it was $22.20.

Senator ALLISON—Would you regard that as being a high rate of increase?

Mr Davies—I am trying to calculate an annual percentage. It is about 20 per cent over three years, so it is about six per cent per year.

Senator ALLISON—That is higher than the CPI.

Mr Davies—Yes.

Senator ALLISON—Is it possible for you to give the committee the basis on which you calculated the figures that you have put in your submission—for instance, the 1,070,000 million fewer people who will now qualify in 2006? Is it possible to have the calculations that give rise to that?

Ms Robertson—I do not understand what data you are after. We have provided the total number of claiming units—families and singles that we expected to qualify in 2005 under the current thresholds. Then we have another figure for units that we expect to qualify, as the thresholds change for 2006.

Senator ALLISON—Is that just on the basis of the 2005 figures?

Mr Davies—The 2.57 million was the projected number in 2006, with the lower thresholds.

Senator ALLISON—But how did you project them? You must have taken some figures. Do you have the figures for 2005?

Mr Davies—The projected number for 2005?

Senator ALLISON—Or did you project them from 2004?

Mr Davies—I think we have a number for the 2005 calendar year. It is, effectively, 2.3 million in the current year.

Senator ALLISON—I am just asking how you moved from 2004-05—whenever it was—to 2006 on the assumptions you make in that calculation.

Mr Davies—That is just a costing essentially for the forward estimates.

Senator ALLISON—But you must have based them on something?

Mr Davies—We do not have that detail. It is the detailed modelling of future Medicare costs.

Senator ALLISON—A number of submissions have said that the difficulty in understanding the need for increasing the threshold has been the lack of data. Is it possible to get a breakdown of the figures for 2004-05 between rural and metropolitan; specialists and GPs; age groups, if that is a possibility; family circumstances; out-of-pocket costs and consultations—

CHAIR—What do you mean by family circumstances?

Senator ALLISON—The size of families that are more likely to qualify—what sort of people are qualifying for the safety net.

Mr Davies—Who are qualifying in the current year or who qualified in the—

Senator ALLISON—The current year and projected. In understanding the impact of that, we would like to know if it is mostly families with lots of children who are less likely to qualify, if it is singles or people who have high specialist out-of-pocket costs or if it is those who have chronic illness that gives them the need for regular GP consultations, for instance.

Mr Davies—Generally, because of the change that is now proposed for the next calendar year, it will be, for want of a better word, a representative sample in the sense that it was a group of people who faced costs of more than $300 and now it is a group of people who face costs of more than $500. So who is not accessing the safety net is, if you like, just a slice of the spectrum of people who would previously have accessed it. Because it is essentially a financial measure, the design does not favour or disfavour any particular group; it is just people who have high costs.

Senator ALLISON—But that is at odds with some of the submissions we have received. The ACA, for instance, says:

> Hardest hit by the threshold increase will be people with chronic illnesses. These people tend to accrue medical costs slowly throughout the year. They would have to visit a general practitioner many times to qualify ...

How do we know if this is the case or not if you are not able to give us that data?

Mr Davies—One fundamental point about that is that we do not know from Medicare data what people's medical condition that is causing them to use services is.

Senator ALLISON—But you do know if someone is having a regular visit with a GP and you do know if someone is paying for an obstetrician and that that is the cause of their getting over the threshold.

Mr Davies—What we do know is that previous concession card holders and family tax benefit A individuals and families who previously spent between $300 and $500 in out-of-pocket, out-of-hospital costs will be the ones who will no longer access the safety net. I would imagine that in that cohort you would have some people with chronic disease and you would

have some people who were using maybe out-of-hospital diagnostic services. It would be a fairly representative sample.

Senator ALLISON—But how do you know that? What work have you done to establish that it is a representative sample and it does not just catch those people with chronic illness who have got relatively low costs compared with—

Mr Davies—It does not differentiate what the costs are attributed to.

Senator ALLISON—I realise that.

Mr Davies—It is the fact that it used to be $300 and it is going to be $500, subject to the legislation. So, regardless of whether you used to get to $300 by lots of GP visits and now you will not get to $500, I do not see any systematic relationship between disease conditions, family structure and your likelihood of reaching the safety net.

Senator ALLISON—So you would not agree with the statement:

Hardest hit by the threshold increase will be people with chronic illnesses.

You disagree with that, and you can demonstrate that?

Mr Davies—As I sit here, I cannot see a chain of logic that would take me to that conclusion.

Ms Robertson—In terms of looking at how this is expected to impact on services, we look at the proportion of broad types of service that get people towards the threshold. That is how we have calculated the numbers that will be affected by the changes to the thresholds. As to whether we have the hard evidence here to lead you to the conclusion now, no, we do not.

Mr Davies—In previous discussions we have said that the people who benefit from the safety net are not likely to be people who only use GP services.

Senator ALLISON—No, not at all.

Mr Davies—You need to be a heavy user of GP services to access the safety net. Typically, it will be diagnostic services—services like radiotherapy—that will take you over. We also do not understand people's motivations for using services, Senator.

Senator ALLISON—Or doctor's motivations in sending them there.

Mr Davies—People self-refer to GPs.

Senator ALLISON—The AMA said there was a higher number of consultations. I think you said there were but that you would come back with the figures on that, so that we can compare the increases with—

Mr Davies—I do not think we have talked you through data on total volume of services. Again, I can read the figures out, if you want, or I can give you the book, in order to see the trends in total service volumes.

CHAIR—Perhaps provide them on notice.

Mr Davies—We can give you that table on notice, certainly.

Senator ALLISON—Out-of-pocket expenses by region: is that also in the HIC data?

Mr Davies—It is done by state and territory.

Senator ALLISON—It is not available by region?

Mr Davies—It is certainly done by state and territory within here.

Senator ALLISON—So that lumps rural in with metro?

Mr Davies—Yes. To do it by rural and metro would take quite a substantial bit of analysis.

Senator ALLISON—Do we have bulk-billing by region?

CHAIR—We have it by electorate, don't we?

Mr Davies—Not routinely. Again, I have seen—it is fairly old now—one-off analyses of bulk-billing rates by RAMA, which is the measure of regional, but I don't know—

Senator ALLISON—When do we expect to produce those figures next?

Mr Davies—I don't think they are produced routinely. As I recall, when we were looking at the Strengthening Medicare package we looked at bulk-billing rates by RRMA. I think that is information that we have previously provided.

Senator ALLISON—Do you have any data on the specialist fees and the suggestion that there is a procedural element of the fee which is now being lumped in under Medicare and was either previously dealt with through in-patient services like obstetrics—the cost of the delivery was put onto the consultation for obstetrics—or through cost shifting by way of private health insurance coverage?

Mr Davies—As I said earlier, we have no evidence of anything systematic in that area, with the notable exception of obstetrics, which we have already addressed. In the latest version of the Medicare schedule book—and I think the AMA have put out a similar reminder—we extended the rubric at the front of the publication, reminding doctors using Medicare that the fee charged should only cover the medical service delivered. We have also taken steps of a reasonably technical nature as there were a number of items in the schedule that could have been claimed as an out-of-hospital item but which, according to the best clinical advice, should never have been delivered outside a hospital setting. We have taken steps so that they can only be claimed as an in-hospital item and therefore cannot be brought into the scope of the safety net. That was an adjustment we made in the November schedule last year which significantly reduces the risk of what you just described.

CHAIR—I ask you to take one question on notice, please: Professor Stephen Leeder gives an example, in the last paragraph of his submission, of what I think he implies is a bit of manipulation of billing arrangements in order to exploit the safety net. I am not sure I actually understand how this works—it is not particularly clear to me—but perhaps you might like to look at that and pass any comments to the committee on whether you consider that there is a genuine loophole or potential for manipulation.

Senator ALLISON—Is that IVF treatment?

CHAIR—He gives the example of IVF but says it could happen elsewhere.

Senator ALLISON—That is what we just talked about.

Mr Davies—It is actually the point we were just talking about with Senator Allison. I assume, when he says, 'Before the safety net, two accounts would be rendered to the patient,

one for submission to Medicare and the other to be paid out of pocket,' one was for the Medicare-eligible service and the out-of-pocket expense was for the items not covered by Medicare. If a provider now put both of those onto one bill and told the patient to put it all through Medicare, they would be guilty of exactly the behaviour I have just been describing, which is quite clearly illegal and has been brought to their attention as being so. The same applies to wheelchairs, I assure you.

CHAIR—That sounds logical. In that case, I think you have covered that point. I thank you both for your appearance here today. I thank the witnesses, my colleagues, Hansard and the staff of the committee for their assistance in this hearing.

Committee adjourned at 5.26 pm