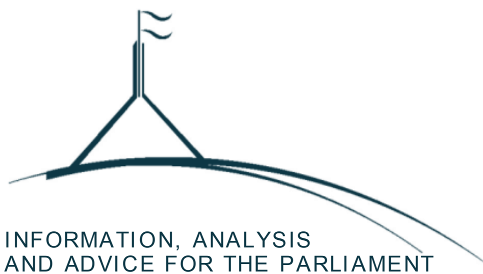

INFORMATION, ANALYSIS
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Bills Digest
No. 176 2002–03

Health Legislation Amendment (Medicare and Private Health Insurance) Bill 2003

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Health Legislation Amendment (Medicare and Private Health Insurance) Bill 2003

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Social Policy and the Law and Bills Digest Groups
19 June 2003

Contents

Purpose 1

Background 1

- What is Medicare? 1
- Context of the proposed changes 2
- 'A Fairer Medicare' 4
- Out-of-Hospital Insurance Plans 5
- Concessional Safety Net 8
- General Practice Access Scheme 9
- The ALP's Proposal 11

Main Provisions 12

- Schedule 1: 'Out-of-hospital insurance plans' 12
- Schedule 2: 'Concessional Safety-Net' 14
- Schedule 3: 'General Practice Access Scheme' 16

Concluding Comments 16

- Will Doctors sign on to GPAS? 16
- Inflationary Pressures? 17
- Concession Card Holders 18
- The Broader Context 21
- Final Comments 21

Endnotes 22

Health Legislation Amendment (Medicare and Private Health Insurance) Bill 2003

Date Introduced: 28 May 2003

House: House of Representatives

Portfolio: Health and Ageing

Commencement: Generally, Royal Assent except items 9-12 of Schedule 1 which may commence immediately after relevant provisions of the proposed *Health Legislation Amendment (Private Health Insurance Reform) Act 2003*.

Purpose

To:

- permit insurance companies to provide 'out-of-hospital insurance plans' covering the 'gap charge' between the Medicare rebate and out-of-pocket costs for general practitioners (GPs);
- establish a concessional safety-net for out-of-pocket costs for 'out-of-hospital' services;
- permit GPs working in practices participating in the General Practice Access Scheme (GPAS) to directly bill the Health Insurance Commission (HIC) while charging non-concessional patients a 'gap amount'.

Background

What is Medicare?

Medicare is the Commonwealth funded health insurance scheme that provides free or subsidised health care services to the Australian population. It covers both in-hospital services for public patients in public hospitals, through Australian Health Care Agreements with the States and Territories, and provides subsidised or free access to doctor's services.

Free or subsidised treatment by medical practitioners is one of the cornerstones of Medicare. Medical services available under Medicare are listed in the Medicare Benefits

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Schedule (MBS). The Commonwealth, in consultation with various stakeholders, sets the Schedule fee for these services. Under existing arrangements doctors are paid 85 percent of the Schedule fee for out-of-hospital services and 75 percent for services provided in private hospitals.

There are currently three ways of billing under Medicare.

1. *Patient Billing*: Patients themselves may claim Medicare benefits by paying the doctor's account and then claiming the benefit from Medicare.

2. *Pay Cheque to Doctor*: Patients can obtain a cheque from Medicare, payable to the doctor. This cheque along with any balance is then given to the doctor.

3. *Bulk Billing*: Medical practitioners can directly bill Medicare, accepting the Medicare rebate as full payment for the service.

Under the bulk-billing arrangements no additional charges relating to a bulk-billed service may be made, consequently there are no out-of-pocket expenses incurred by the patient. Generally, when a Medicare service is not bulk billed, it is because the practitioner is charging more than the Medicare rebate.

Further detail about the operation of Medicare can be found in the Parliamentary Library publication Medicare - Background Brief.[1] A brief discussion of the universality of Medicare can be found in the Parliamentary Library Publication: Is Medicare Universal?.[2]

Context of the proposed changes

Over the past two years there have been numerous claims by commentators, medical practitioners, lobby groups and politicians that Medicare and in particular bulk billing is in crisis.[3] As an important component of Medicare, the decline in bulk billing rates, particularly among GPs, has been the cause of significant controversy.

Since peaking at 80.6 percent in 1999–2000, the overall proportion of GP Medicare services bulk billed has fallen by about 12 percent. In the quarter ending March 2003, Department of Health and Ageing figures show that the percentage of GP Medicare services bulk billed had dropped to 68.5 percent.[4] The first of the graphs below clearly shows the increase, plateau and then decrease in the proportion of services bulk billed between 1984-1985 and 2001-02.

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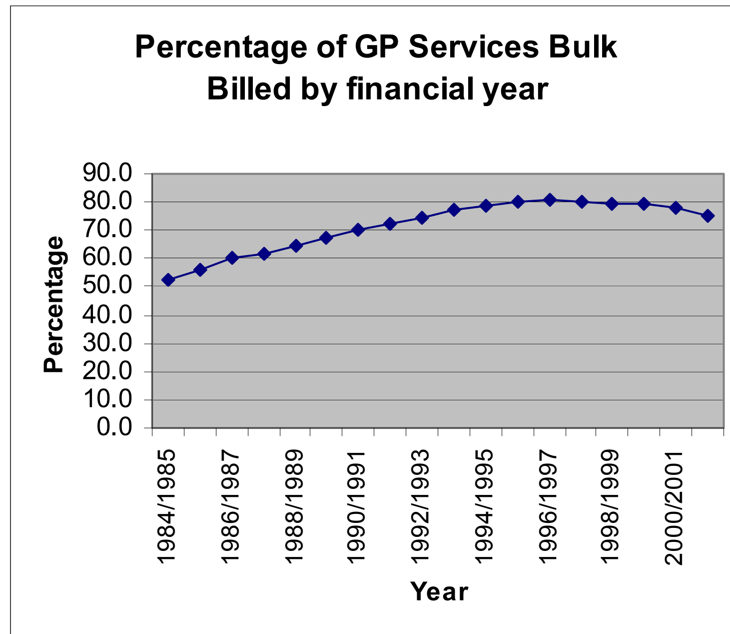
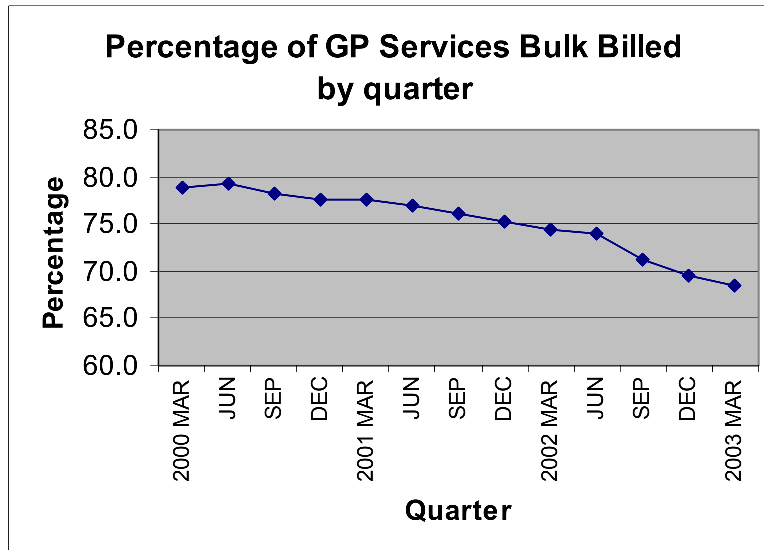


A more detailed picture of the decline in bulk billing since March 2000 is provided below. As the graph makes clear, the decline in the proportion of GP Medicare services being bulk billed is gathering momentum.



Implicated in this decline in bulk billing is a significant maldistribution of GPs. According to the Australian Institute of Health and Welfare there are significant differences in the number of doctors per 100 000 of the population by geographic area. As the table below makes clear, the more remote an area is the lower the number of GPs per 100 000 of the population.

Primary Care Practitioners per 100 000 of the population by geographical area

Geographic Area	No.	Rate[5]
Capital City	14 697	121
Other Metro. Centre	1 526	105
Large Rural centre	1 188	105
Small Rural Centre	1 167	95
Other Rural Centre	1 967	79
Remote Area	421	75
Total	20 966	110

Source: AIHW, Medical Labor Force, 1999

The Commonwealth has argued that the supply of doctors in an area has a significant impact on the proportion of services bulk billed. They argue that below average bulk billing rates are an indicator of an under supply of doctors in a geographical area and there is some evidence to suggest that this is the case.[6] An oversupply of practitioners can drive prices down to the Medicare rebate, increasing bulk billing rates.[7] The Parliamentary Library publication: The Decline in Bulk Billing: explanations and implications provides further analysis of the interaction between the number of GPs and the rate of bulk billing, and canvasses some of the other explanations for the recent decline in bulk billing.[8]

'A Fairer Medicare'

It is within the context of the decline in bulk billing of primary care services that debate about the future of Medicare first arose and it was with the stated aim of fixing this problem that the Coalition Government launched its '*A Fairer Medicare*' package. The key components of this package are:

- The introduction of the General Practice Access Scheme (GPAS) which is intended to guarantee that Commonwealth concession card holders attending participating general practices will be bulk billed.
- Participation in GPAS will be available to all general practices with participating practices receiving monthly incentive payments that are linked to their number of concessional patient visits. The level of incentive payment will differ depending on the geographic location of a practice: $1.00 in capital cities, $2.95 in other metropolitan

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areas, \$5.30 in rural centres and \$6.30 in other rural and remote areas. For a full-time equivalent GP seeing an average number of patients with a concession card (estimated by the Department of Health and Ageing to be approximately 3,500 per year) the value of the incentive each year will be around \$3,500 in capital cities, \$10,250 in non-metropolitan cities, \$18,500 in rural centres and \$22,050 in outer rural and remote areas.

- In those practices participating in GPAS, doctors will be able to claim the Medicare rebate directly from the HIC while issuing an additional charge to patients. They will also have streamlined direct billing arrangements and rapid payment of rebate claims, down from 8 days to 2 days.[9] The intended effect of this part of the scheme is to reduce up-front out-of-pocket expenses for patients and alleviate the necessity for patients who are not bulk billed to go to a Medicare office.

- For concessional patients unable to access a bulk billing GP, the establishment of a concessional safety net that will meet 80 percent of concessional patients' out-of-pocket costs for all out-of-hospital Medicare services over a \$500 threshold in a calendar year.

- The lifting of the prohibition on private health insurance for out-of-hospital Medicare services. The '*A Fairer Medicare*' package proposes to allow private health insurers to offer insurance coverage for the cost of out-of-hospital Medicare funded services over a \$1,000 threshold in a calendar year. This includes costs above the schedule fee in general practice, specialist and diagnostic services. According to the Department of Health and Ageing fact sheets, the cost of this new product will be approximately \$1 per week for family cover.

- For practices participating in GPAS there will be financial incentives for 'broadband connectivity', or greater support for broadband computer access for practitioners in rural and remote communities.

- The creation of an additional 234 new medical school places each year and 150 new GP Registrar positions each year are also proposed in the package. These places are expected to be available in the 2004 calendar year.

- Funding to participating practices in areas of workforce shortage will be provided to employ up to 457 full-time equivalent nurses.

The three legislative components of the *A Fairer Medicare* package contained in this Bill are discussed below.

Out-of-Hospital Insurance Plans

Amendments to the *National Health Act 1953* to permit insurance for out-of-hospital out-of-pocket expenses is one of the key proposals of this Bill.

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The *National Health Act 1953* was introduced by the Menzies Government and has for over fifty years, albeit with substantial amendments, governed the operation and regulation of the private health insurance industry.

The introduction of Medicare in 1984 by the Hawke Labor Government led to the most significant changes to private health insurance since the commencement of the *National Health Act 1953*. Under the *Health Legislation Amendment Act 1983* the private health insurance industry was prohibited from offering insurance for out-of-hospital Medicare costs (including the gap between the Medicare Rebate and Schedule Fee).[10]

The primary rationale for this prohibition was that 'gap insurance' was thought to encourage the practice of fixing charges above the schedule fee. That is, if gap insurance is offered it assumes that charges above the Schedule Fee will be made and provides a basis to do so.[11] Some commentators have argued that the Government's claim that there is nothing in their '*A Fairer Medicare*' package that would cause doctors to increase fees, is undermined by the proposal to introduce private health insurance for out-of-pocket expenses.[12]

The Bill proposes amendments that will allow Registered Health Benefits Organisations to offer insurance for out-of-hospital out-of-pocket expenses for the first time since 1983. The passage of this Bill will end Medicare's monopoly on out-of-hospital insurance and lead to a significant structural alteration to the Australian health system.

Medicare services covered by the new arrangements will include:

- out-of-hospital GP services
- diagnostic tests (eg: x-rays, ultrasounds, biopsies, and radiation oncology)
- out-of-hospital consultations with specialists

The peak body of the private health funds, the Australian Health Insurance Association (AHIA), considers the new insurance product not so much as 'gap insurance' but rather 'catastrophe insurance'.[13] The AHIA argues that the new product will insure people for those instances where they are diagnosed with, or have, a chronic illness or who have an acute attack, and consequently have considerable numbers of visits to specialists, etc.[14]

Ultimately, the insurance cover may only be viable for very few patients. Ordinarily, as the AHIA has acknowledged, few people will incur $1000 of out-of-pocket expenses and thereby reach the out-of-hospital insurance threshold.[15] The Government has noted that approximately 30 000 families (without concession cards) per year are expected to reach the proposed $1000 threshold for out-of-pocket expenses for out-of-hospital services. As many as five million people are expected to be potentially covered by the proposed insurance. Similar to the AHIA, the Department has noted that the proposed out-of-hospital insurance is expected to be similar to the large take up of ambulance cover which

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is a product with '… a relatively low premium against an unlikely but potentially catastrophic cost'. [16]

There may be a need to support high out-of-pocket expenses incurred by certain patients. The AHIA points out that currently there are few provisions made for those whose out-of-hospital medical expenses are high. However, there are existing arrangements for those with medical expenses above $1200 a year through the taxation system.

Inflationary Pressures?

Perhaps the real issue is whether the changes will have any effect on the price of medical services. The President of the AHIA has acknowledged very few people will reach the out-of-hospital insurance threshold by going to GPs 'unless the GPs make incredible changes to their business practices'.[17] One change may be in the prices set for medical services.

Some commentators have argued that the proposed out-of-hospital insurance product will provide an incentive to the medical profession to reach the $1000 threshold.[18] Paradoxically, while an increase in prices and/or number of consultations will impose a larger burden on patients it will also bring forward the threshold for out-of-hospital insurance cover.

Importantly, it has been suggested that there will be a reduction in bulk billing amongst specialists. Specialists have not been included in the proposed GPAS and consequently, are not provided with monthly incentive payments to bulk bill concession card holders. However, they will be included under the proposed out-of-hospital insurance products. Ironically, a fall in bulk billing among specialists, and an increase in price to concessional card holders, may have its own effect on bringing forward the out-of-hospital insurance threshold to some consumers. In other words, for a given rate of access to specialist services, a patient will reach the out-of-hospital insurance threshold sooner.

Other Issues

The proposed introduction of out-of-hospital insurance plans has also led to a broader discussion about structural changes to Medicare, the establishment of a precedent for insurance for out-of-hospital co-payments and a significant transfer of responsibility from the public sector to the private sector. The introduction of insurance for out-of-hospital expenses paves the way, it has been argued, for greater divergence between the Medicare Rebate and actual costs, where in the future pressure to reduce the cost of health care can legitimately be directed by the medical services market towards the coverage of private health insurance rather than the level of the rebate or more broadly towards the operation of Medicare.[19] If the gap between the Medicare rebate and actual costs continues to increase then it is foreseeable that there will be pressure for the role of out-of-hospital insurance to be expanded, for instance, by reducing the threshold from $1000 to $500, or allowing insurance for all out-of-hospital expenses. Such a situation would diminish the importance of Medicare and take pressure off the government for increases in the

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Medicare rebate (as private health insurance would be available to cover the gap between the rebate and the actual cost of out-of-hospital medical services).

Concessional Safety Net

Another key aspect of this Bill is the introduction of a new safety-net under the *Health Insurance Act 1973*.

One of the characteristics of the Australian Health System is that the Commonwealth Government cannot, under the Constitution, overtly control the fees that doctors charge, nor can it make particular forms of billing compulsory for some or all groups of patients. The 'civil conscription' clause in the Constitution prevents a national government from coercing or conscripting medical doctors; in lay terms, the Government cannot force doctors to bulk bill.[20] With the focus of the Government's Medicare package on the provision of incentives to GPs to bulk bill concessional patients, the establishment of a concessional safety net is intended to provide an additional safeguard against excessive out-of-pocket expenses for concessional patients.

As with the out-of-hospital insurance cover, the concessional safety-net may only apply to very few patients. It might be argued that few concessional patients will incur $500 of out-of-pocket expenses using GPs and thereby reach the safety-net threshold unless, to borrow the opinion expressed above, 'GPs make incredible changes to their business practices'.

Inflationary Pressures?

The establishment of a new concessional safety net that includes all out-of-pocket expenses for out-of-hospital Medicare services has led to extensive discussion of whether the existence of such a safety net will have some impact on the fees that doctors charge.

It became clear during the Senate Budget Estimates that the Department of Health and Ageing has done no modelling on the potential impact of the Safety Net on fees, because its costings assumed there would be no increase.[21]

The Secretary of the Department and the Minister for Health and Ageing both argued in Estimates that it was unlikely that GPs or other doctors would be aware that a patient has reached the safety net. However, it is worth noting that GPs play an important role in managing chronic disease and are an important source of referrals to specialists. Consequently, it is likely that a GP, providing care to a patient with a chronic disease, will be aware of their patients' use of the health system and other Medicare services. Indeed, enhancing the role of GPs in managing chronic disease has been a focus of other programs instigated by the current government. While no modelling has apparently been done, the HIC would (in a continuation of its current practices) be responsible for monitoring fees.

The concessional safety net is estimated to cost the Commonwealth $67.1 million over the forward estimates.[22] Evidence provided in Senate Budget Estimates indicates that approximately $20 million of this amount is for administration.[23] The government has

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estimated that approximately 50 000 families will reach the concessional safety net each calendar year. [24]

While the numbers affected may be small, the inflationary effects may be significant because there may be more scope to increase the price of medical services from a bulk-billed rate ($25.05 for GPs) than from a patient-billed rate (average $38).

General Practice Access Scheme

As noted above GPAS is intended to encourage GPs to bulk bill Commonwealth concession card holders. The scheme will provide monthly incentive payments to GPs on the basis that they bulk bill *all* concession card holders. As well as these incentive payments, those practices participating in GPAS will be able to claim the Medicare rebate directly from the HIC (that is, bulk bill) while issuing an additional charge to patients.

The capacity to charge patients an additional payment while directly claiming the Medicare rebate from the HIC has long been considered by GPs as a panacea.[25] However, as with other components of the Government's *A Fairer Medicare* package, GPAS has generated significant controversy. The disputes about GPAS are discussed below.

Does GPAS introduce a co-payment?

There is some debate about whether GPAS introduces a 'co-payment'. The Prime Minister and Minister for Health and Ageing have consistently argued that the *A Fairer Medicare* package does not introduce a co-payment. Others have challenged this claim. The ALP and various commentators have argued that the package does introduce a co-payment.[26]

The issue of a co-payment under Medicare has generally been considered in relation to bulk billing. As noted above a doctor is currently prohibited from charging any amount above the Medicare rebate if they bulk bill. This has been the situation since Medicare was introduced in 1984, with a brief exception in late 1991 and early 1992.

In November 1991 the ALP introduced a '*prescribed* co-payment' for bulk billed services. For a brief period doctors could bulk bill a patient and charge a small fee above the Medicare rebate.[27] The co-payment was abolished after only 3 months of operation, when Paul Keating became Prime Minister. Clearly GPAS does not *prescribe* a co-payment, however it does facilitate charging patients while allowing doctors to bulk bill. Consequently, the questions about the definition of this additional charge remain.

The key issue appears to be the definition of 'co-payment'. A 1999 Productivity Commission report on Private Hospitals offers the following definition:

> The portion of the cost of an insured health service met by the user[29]

If such a definition of co-payment is accepted, then the term 'co-payment' could feasibly be applied to the additional charges while bulk billing that will be available under GPAS. Medicare is arguably an insurance system. Doctors can currently charge an additional fee

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on top of that covered by the insurance (i.e. the Medicare rebate) under the patient-billing arrangements. In fact the AMA refers to this as charging a co-payment.[30] However, as noted, doctors cannot charge the patient an additional fee under bulk-billing arrangements.

The proposed GPAS would lift this prohibition and enable doctors to bulk bill (that is get the Medicare rebate directly from the HIC) and charge the patient an additional fee. According to the Productivity Commission definition, and, arguably, the approach taken by the AMA, this 'additional payment' could be considered a co-payment.

Unlike the brief introduction of the 'prescribed co-payment' introduced briefly by the Labor Government in 1991, and also unlike the co-payments for PBS listed drugs, the proposed additional charge available under GPAS will not be prescribed.

Inflationary Pressures?

Despite the Government's repeated claims that there is no reason for doctors to increase their fees, various commentators and lobby groups have argued that there will in fact be a substantial increase in GP fees arising directly out of the '*A Fairer Medicare*' package. Anecdotal evidence from doctors and practice managers cited in industry journals such as *Australian Doctor* indicate that there is some evidence to suggest that doctors will take advantage of the opportunity to charge non-concessional patients an additional fee (while also bulk billing them) and some suggestion that this gap amount will be higher than the 'out-of-pocket' expenses under existing arrangements.[31] The editorial in a recent issue of *Healthcover* offers a particularly pessimistic view of the inflationary pressures of GPAS, arguing that the scheme is the equivalent of a 'big Easter Egg giveaway'. It argued that:

> … patients who have been paying $50 up front for a visit to the GP (GP fees are limited only by what the market can bear) and then claiming back the $25 Medicare benefit (so they are ultimately only $25 out of pocket), can expect their GP to continue to charge the $50 up front (the market-tested limit) and pocket the $25 benefit.[32]

So, GPs (and specialists) may be encouraged at least to stay at the market tested limit. Moreover, some who are charging below that limit may be encouraged to move toward it and others may even be encouraged to move beyond that limit. The suggestion seems to be based on the possibility that, under the GPAS scheme, the additional payment for non-concessional patients may distort the price signals in the market for patient billed services.

So, in the hypothetical example above, price signals *at the surgery* are distorted. While the upfront price to the patient remains the same, the total cost charged by the doctor would increase from $50 to $75, with the Medicare effectively paying $50 instead of $25.

It is, however, difficult to predict how doctors participating in GPAS will alter their billing practices other than that they will be required to bulk bill concessional patients.

As noted above, the Department of Health and Ageing has conducted no modelling on potential inflationary effects of the '*A Fairer Medicare*' package, including the capacity of

participating GPs to charge an additional payment while bulk billing non-concessional patients.[33] The reason for this is that, according to the Minister of Health and Ageing, Senator Patterson, 'there is nothing in the package which should cause doctors to increase their fees. This issue was explicitly agreed with by the Department of Finance and Administration in formulating the estimates.'[34]

The ALP's Proposal

As readers will be aware, the ALP has provided details of its own plan for Medicare. In his 2003 budget response, the Leader of the Opposition outlined the key components of this plan which include:

- Lifting the Medicare rebate from 85 percent of the Schedule Fee to 95 percent of the scheduled fee, with the intention, at some time in the future, of increasing the rebate to 100 percent of the Schedule Fee. (If implemented now it would have the effect of increasing the Medicare rebate from $25.05 to $29.45.)

- The introduction of incentive payments to doctors who meet the following bulk billing targets:

  – Doctors in metropolitan areas who bulk bill 80 percent of services will receive an additional $7,500 a year.

  – Doctors in outer metropolitan areas who bulk bill 75 percent of services will receive an additional $15,000.

  – And doctors in rural and regional areas who bulk bill 70 percent of services will receive an additional $22,500.

- As with the *A Fairer Medicare* package, the ALP has promised to increase the number of doctors in rural areas and make more nurses available to doctors who meet the bulk billing targets outlined above.

The contrast between the ALP and the Government's plans is interesting. While the Government has proposed significant changes to the basic operation of Medicare, (the introduction of private health insurance, a patient charge while allowing direct claiming of the Medicare rebate from the HIC, increasing the level of the rebate for concessional patients) the ALP has retained a commitment to the basic structure of Medicare and its original principles (maintenance of a universal rebate; no distinction between concessional and non-concessional access).

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Main Provisions

Schedule 1: 'Out-of-hospital insurance plans'

Schedule 1 amends the *Health Insurance Act 1973* and *National Health Act 1953* to permit insurance companies to provide 'out-of-hospital insurance plans' to consumers.

Health Insurance Act

The *Health Insurance Act 1973* prohibits certain forms of medical insurance. Basically, insurance companies cannot offer policies covering professional services that are wholly or partly covered by Medicare benefits. Exceptions were introduced in 1985, dealing with 'applicable benefits arrangements',[39] and in 1998, dealing with overseas visitors.[40] These 'applicable benefits arrangements' are policies with 'registered organizations' covering fees and charges for hospital treatment,[41] or professional services, given to people in hospital.[42] Effectively, an 'applicable benefits arrangement' means that a person has 'hospital cover'.

Item 1 introduces a new exception in relation to 'out-of-hospital insurance plans'.

National Health Act

The *National Health Act 1953* contains a large part of federal control over health services, including regulation of nursing homes, pharmaceutical benefits and private health insurers.

Regulation of private insurers, or 'health benefits organizations', focuses on registration, solvency and agreements with hospitals and doctors or 'purchaser-provider agreements'. An insurer may register as an 'open-membership organisation' or a 'restricted membership organisation' (eg, limited to an employment group, professional association or union).

The 'purchaser-provider' agreements allow insurers to deal directly with service providers and thereby offer limited or no out-of-pocket costs for policy holders or contributors, who have 'hospital cover' under the corresponding 'applicable benefits arrangements' above.

Limitations in these agreements, including perceptions that insurers could interfere in the doctor-patient relationship, led to amendments in 2000 dealing with 'gap cover schemes'.[43] 'Gap cover schemes' cover the difference between hospital costs and Medicare benefits. In theory, they allow greater choice among consumers and greater freedom among doctors, given that there are no requirements for 'purchaser-provider' agreements with insurers.

Gap Charges and Out-of-Hospital Services

Item 13 introduces **New Division 4B** which provides for 'out-of-hospital insurance plans'.

If passed, the provisions would allow these plans to commence from **1 January 2004: new paragraph 73BDEC(3)**.

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'Out-of-hospital insurance plans' are polices with 'registered organizations' covering 'gap charges', or the difference between 'out-of-hospital service' costs and Medicare benefits.

An 'out-of-hospital service' is any professional service *excluding*:

- professional services given by medical practitioners to people in hospital, and
- any professional services that are declared by the regulations to be excluded.

An insurer may only indemnify a patient beyond a 'gap charge threshold' of $1 000.[44] That is, the plans would only apply where the 'gap charges' incurred by the individual policy holder, or their dependents,[45] reach a total of $1 000 in a calendar year. The 'gap charges' are covered whether they are incurred in the waiting period or term of the plan.[46]

An 'out-of-hospital' policy:

- must be 'distinct' from any other policy offered by the insurer,
- cannot limit the range of 'out-of-hospital' services covered, and
- cannot deny access to persons (unless the insurer has restricted membership).[47]

The effect of the second limitation and the regulation making power above is that the range of 'out-of-hospital' services covered is controlled by Government, not the insurers.

Waiting Periods (new section 73BDEE)

An insurer may specify a maximum waiting period of 6 months.

An insurer may not specify *any* waiting period in respect of a person who has hospital cover, ie a member in relation to an applicable benefits arrangement, before 1 July 2003.

Information Sharing (new sections 73BDEF & 73BDEG)

A prospective subscriber must provide the insurer with information regarding the identity of the persons to be covered by the plan along with their Medicare number and expiry date. Also, a subscriber must notify the insurer of any changes 'as soon as practicable'.

This requirement is to allow insurers to provide information to the Health Insurance Commission for the purpose of 'tracking amounts towards the gap charge threshold'.[48] The information is 'for the purpose of use' by these bodies 'in relation solely to the operation of' insurance plans and thereby the *Health Insurance Act 1973* and *National Health Act 1953*.

Similarly, an insurer must pass this information, along with other information to the HIC. This may include 'other matters … necessary for the [HIC] to undertake its functions in relation to plans' determined by the head of the HIC in a disallowable instrument.

The insurer may pass on a person's Tax File Number or information about their health.

The HIC is obliged to notify insurers when a subscriber reaches the gap charge threshold and it must state which services were wholly or partly counted to achieve that threshold.

Claims (new section 73BDEI)

Insurers are obliged to pay any gap charges, or part thereof, incurred beyond the threshold.

Incidental Amendments

Items 14 to **35** amend provisions which currently deal with 'applicable benefits arrangements', etc. to include references to 'out-of-hospital insurance plans' and associated provisions above (where relevant).

Private Health Insurance Incentives Act

The *Private Health Insurance Incentives Act 1998* introduced an incentives scheme, in the form of direct payments or reduced premiums, equal to 30 percent private health insurance costs. It replaced the Private Health Insurance Incentives Scheme of 1997.

Items 36 to **39** amend provisions to incorporate 'out-of-hospital services cover'.

Schedule 2: 'Concessional Safety-Net'

Schedule 2 amends the *Health Insurance Act 1973* to introduce a new concessional safety-net to cover certain 'out-of-pocket costs' for 'out-of-hospital' services.

The *Health Insurance Act 1973* currently provides safety-net arrangements in relation to 'out-of-pocket' costs for 'out-of-hospital' services and pharmaceutical benefits.

Readers will be aware that attempts were made to change the safety-net arrangements for pharmaceutical benefits in the 2002-03 Budget. These changes were expressed in the National Health Amendment (Pharmaceutical Benefits – Budget Measures) Bill 2002. That Bill has been rejected twice by the Senate thus creating a double dissolution trigger.

Generally, Medicare benefits are a proportion of a government approved schedule of fees. The Medicare benefit for 'out-of-hospital' services is set at 85 percent of the Schedule Fee, which may be more or less than the fee actually charged by a given general practitioner. Effectively, any practitioner wishing to charge the Schedule Fee cannot offer bulk billing. Moreover, the schedule of fees implies a minimum 'patient contribution' for these services.

The present safety-net subsidises the gap between the Medicare Benefit and the Schedule Fee for 'out-of-hospital' services where the 'patient contribution' exceeds $319.70 a year.[49]

(The '*patient contribution*' is the gap between Medicare benefits and Schedule Fees.)

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The proposed safety-net would subsidise 80 percent of the gap between the Medicare Benefit and actual expenses where the 'out-of-pocket' expenses exceed $500 a year.

(The '*out-of-pocket*' expense is the gap between Medicare benefits and actual expenses).

It applies to 'concessional beneficiaries' under Part VII of the *National Health Act 1953*.

Generally

Where the 'out-of-pocket' expenses for a claim, when added to the 'out-of-pocket' expenses for all other claims in that year, exceeds the 'concessional safety-net amount' ($500), an 80 percent subsidy for those expenses is payable on top of the ordinary medicare benefit.

At the margin, where the 'out-of-pocket' expenses for a claim, when added to the 'out-of-pocket' expenses for the other claims, only *just* exceeds the 'concessional safety-net amount' the 80 percent subsidy applies to the excess expenses beyond $500.

Perhaps significantly, a patient does not need to have paid 'out-of-pocket' expenses in full. The concessional safety-net arrangements may commence where the claimant has paid at least 20 percent of the 'out-of-pocket' expenses. In effect, this allows a claimant for the concessional safety-net to have an outstanding account with their GP and/or specialist.

Families with Concessional Members (**new section 10ACA**)

The concessional safety-net applies in relation to services for concessional beneficiaries where the 'out-of-pocket' expenses for all other claims, *whether for the concessional beneficiary or other family members*, exceeds the 'concessional safety-net amount' ($500).

Individuals (**new section 10ADA**)

The concessional safety-net arrangements are largely the same as above, with the obvious fact that the claimant will themselves be a concessional beneficiary.

Consequent Reductions in the Ordinary Safety-Net (**new subsections 10AC(2A)** and **10AD(3A)**)

As noted above, the usual safety-net arrangements apply when the 'patient contribution', or the gap between Medicare benefits and Schedule Fees, exceeds $319.70 a year.

The ordinary safety-net needs to take account of amounts that have been paid as 'out-of-pocket' expenses, but have then been subsidised under the concessional safety-net.

The mechanism is a formula which reduces the amount of 'patient contribution' that is deemed to have been paid where a person is covered by the concessional safety-net:

> An amount of patient contribution is taken to have been paid … to the extent that the amount of the increase in the benefit payable ... exceeds the difference between the total medical expenses incurred … and the Schedule Fee for the relevant service.[50]

This formula means that if a patient pays more for a medical service, they will:

- incur more 'out-pocket-expenses' and reach the concessional safety net faster, and
- make more 'patient contributions' and reach the ordinary safety-net faster.[51]

However, there seems to be a point, around the $50 mark, where a patient will:

- make no 'patient contributions' and will not reach the ordinary safety-net.[52]

Schedule 3: 'General Practice Access Scheme'

Schedule 3 amends the *Health Insurance Act 1973* to permit patients to assign rights to Medicare benefits to general practitioners under a 'General Practice Access Scheme'.

Where a GP is covered by an 'arrangement' with the Head of the HIC, his or her patients may enter into an agreement that assigns their right to a Medicare benefit (**proposed subsection 20A(1A)**). This right then allows the GP to directly bill the HIC and charge a patient a 'gap amount'. This arrangement would only apply to non-concessional patients, as doctors participating in GPAS must guarantee bulk billing to concessional patients.

Ordinarily, claims for assigned Medicare benefits would be sent electronically to the HIC within 6 months, or such longer period as is approved in writing by the Minister (**proposed subsection 20B(2B)**).

This arrangement would apply to expenses incurred on or after 1 February 2004 or a period not later than 1 July 2004 nominated by the Minister in a disallowable instrument (**item 10**).

Concluding Comments

The changes to the operation of Medicare and private health insurance proposed in this Bill have generated significant public debate and comment. The content of some of this debate has been raised in the background and main provision sections of this digest. This section further expands on these issues.

Will Doctors sign on to GPAS?

Setting aside the issue of the Bill's passage through the parliament, the success of the *A Fairer Medicare* package in meeting the Government's aims rests largely on whether GPs decide to participate in GPAS. As noted above the scheme is voluntary and general practices must make their own decisions about whether to participate. The Government has predicted that signing on to GPAS will make financial sense for approximately 75 percent of general practices.[53] However, there has been some contention that the actual sign on rate will be much lower. A recent survey of 700 GPs found that 83 percent would

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not participate in GPAS.[54] The findings of this survey reflect a generally negative view of the *A Fairer Medicare* package by GPs and industry peak bodies such as the AMA.[55]

It seems likely that the decision by general practices to sign on to GPAS will rest on a number of factors. These include:

- the mix of concessional and non-concessional patients in the practice,
- the current billing practices and the fee schedule of the practice,
- their geographical location, and
- the decision of other general practices in their area to join or not join GPAS.

Whether eventually a significant enough number of general practices sign on to GPAS to have a positive impact on bulk billing of concessional patients and reduce the out of pocket expenses at the point of service for non-concessional patients is, at this stage, unanswerable.

Inflationary Pressures?

As noted above, no modelling has been conducted by the Department on potential inflationary pressures contained in the *A Fairer Medicare* package. The Government and Department of Health and Ageing have argued that the package contains nothing that will lead doctors to increase their fees. Other commentators have argued that the *A Fairer Medicare* package could, potentially, lead to increases in the cost of doctor's visits for non-concessional patients. These two positions are underpinned by different premises or assumptions about doctors' behaviour and their decision making about their billing arrangements. The two sets of assumptions are outlined in the box below.

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No Inflationary Impact	Inflationary Impact
GPs will base their decision to sign onto GPAS *on the basis of the financial advantage accruing to them from the incentive payments for bulk billing concessional patients*	GPs will base their decision to sign onto GPAS *on the basis of the opportunity to charge an additional fee to non-concessional patients while directly billing the HIC for the Medicare rebate*
Changes to the current billing arrangements will make the *out-of-pocket expenses at the point of service cheaper for non-concessional patients*.	The capacity to charge some patients an additional fee while directly billing HIC for the Medicare rebate *removes the downward pressure on prices that bulk billing has provided*
The introduction of out-of-pocket out-of-hospital private health insurance *will provide cover to those with chronic and severe conditions but will not encourage doctors to meet the $1000 threshold*	The introduction of private health insurance *will encourage doctors (in particular specialists) to meet the threshold*
The concessional safety net *will not be manipulated to protect concessional patients from high out-of-pocket costs while maintaining high incomes for doctors*.	*The concessional safety net is open to manipulation*

The actual impact of the *A Fairer Medicare* package will largely depend how practices make their decision to join or not join GPAS and how the new private health insurance product and concessional safety net are considered by doctors.

Concession Card Holders

Eligibility for Concession Cards

As noted above the operation of the *A Fairer Medicare* arrangements is likely to be heavily affected by the proportion of concessional and non-concessional patients seen by a medical practitioner. According to the Government's own figures there were approximately 7 million concession card holders in 2001/02.[56] It has been estimated that half of all GP attendances are for people with a concession card. A full time attendance workload for a GP is approximately 6,500. As noted above, to reach the maximum monthly incentive payments under GPAS, a GP in a metropolitan area would need to have 3,500 concessional attendances per year.[57]

Already the AMA has begun to urge the Federal Government to consider tightening up eligibility for concession cards.[58] It has been suggested that the higher the numbers of people covered by concession cards, the less likely it is that those GPs who have dropped bulk billing will return to it because of the incentive payments.

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GPAS and Patient Mix

While the package includes incentive payments for doctors to bulk bill, the extra payment will still be less than what a doctor could receive as a private fee if they were to patient bill (as opposed to bulk bill) concessional patients. It could be argued that another significant incentive in the package is the GPAS scheme which allows GPs to charge non-concessional patient a gap on top of bulk billing. However, even this incentive only makes real financial sense if a practice has relatively few concessional patients. The more concessional patients a practice has the fewer patients can be charged a co-payment.

As the recently retired AMA president Dr Kerryn Phelps stated:

> They [practices] have to do their own sums. I mean, if they only have 5% or 10% of patients who are health care cardholders, they may be able to afford to do this. If they have 90% of the patients in their practice who are health care cardholders then one dollar extra for a consultation is really not going to help them out very much.[59]

The concerns expressed by the industry raise the spectre of participating GPs wishing to keep the number of their patients with concession cards contained to a certain percentage of all patients. A situation where participation in GPAS is only financially sensible for doctors who maintain a certain mix of patients raises important questions about access to GP services for concession card holders. Significantly, there is, as yet, little detail about how GPAS will operate and a primary question must be, what mechanisms will be in place to ensure that doctors do not turn away concession card holders?

Equity

The *A Fairer Medicare* package has been promoted as providing greater equity than current arrangements because it provides incentives, for the first time, for GPs to bulk bill concession card holders. The targeting of benefits to low income earners is in fact widely used within the Australian welfare system. Indeed Medicare, as a universal health insurance system with no targeting arrangements, has been the exception rather than the rule in Australia.

The Government has expressed some concern that concession card holders currently have no guarantee that they will be bulk billed and the package has been designed to ensure that those who are considered to be on low incomes will become the least likely to have out-of-pocket expense for Medicare services.

Debate about whether universal or targeted services and benefits are more equitable has a long and complex history; suffice to say here that there are well developed arguments on both sides of the debate. The Parliamentary Library Publication: Is Medicare Universal? considers these debates in further detail.

It is, however, important to note that the argument that bulk billing will be specifically targeted at those with low incomes is itself open to challenge. Significant numbers of self funded retirees have access to concession cards through the Commonwealth Seniors

Health Card (CSCH). The CSCH is available to those retired people who have reached age pension age but do not qualify for the Age Pension and have an annual income of less than $50 000 (singles), $80 000 (couples combined); or $100 000 (couples combined who are separated due to ill health). Any working family of two adults and two dependent children that earns over $32, 292 per annum will not be eligible for the proposed incentive payments to doctors for bulk billing them. The ALP and other groups have questioned the equity of a scheme that allows a couple earning $80 000 per year access to 'targeted' benefits while a working family of four earning $33 000 per annum will not have access.

Administrative Costs

When Medicare was first introduced the 'bureaucratic maze of cross-checking' for eligibility under Medibank was cited by Dr Neal Blewett, Minister for Health as a significant problem. He was confident that Medicare would provide relief from the complexity of a means tested and multi-tiered system of medical benefits because:

> … Medicare provides the same rate of benefit to all Australians and therefore removes the need for eligibility checking … the delay between lodgement of direct bill claims and receiving payment will be reduced.[60]

Indeed the administrative savings associated with Medicare were one of the primary reasons that the government expected doctors to:

> … take advantage of the direct billing system. The greater the use of direct billing the lower the administrative cost will become for doctors and the Government and the lower the cost of seeking treatment will become for the patient.[61]

It is important to note that the administrative expenses associated with billing patients (for example, handling bad debts and the issuing of bills) are much lower in 2003 that they were in 1983. However, there will be administrative costs associated with the *A Fairer Medicare* package.

According to the budget papers associated with this measure the incentives for bulk billing concession card holders will place no added burden on GPs. The incentive payments will be automatically generated from information held by the HIC. Despite these assurances some questions about the administrative costs of GPAS remain. These include:

- Whether people will have to show concession cards at the point of service
- If so, what do doctors have to do with that information?
- Other concerns include who is liable when cross matching shows that someone who claimed to be a concession card holder is not. Doctors will be expecting to receive an incentive payment where there may be no entitlement. Conversely, and perhaps less likely, what will happen if a patient does not disclose their concessional status and is not bulk billed by a participating GP.

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Prior to the introduction of Medicare, the double handling of bills was a significant administrative burden for doctors. For instance, there were numerous situations where a GP bulk billed a patient because they believed that patient to be eligible for bulk billing and then it was discovered by the HIC that this was not the case. Where this occurred doctors were responsible for pursuing payment from the patient. The proposed system differs from that which existed under the final years of Medibank because bulk billing will continue to be available to all who are eligible for Medicare. That said, it seems likely that doctors will have to bear any loss associated with confusion over individual patients' eligibility for the incentive payment for bulk billing.

The Broader Context

Since coming to power in 1996 the Howard government has initiated a series of changes to the operation of the Australian health system. Health care in Australia has been a mix of public and private provision. Despite this 'mixed economy', by the mid-1990s the private health insurance industry was arguably facing a crisis. A significant decline in membership as well as a skewed risk profile amongst those who maintained health insurance membership, amongst other factors, had seen private health insurance premiums increase rapidly, these increases in turn contributing to the decline in membership. Soon after their election, the Howard government began to introduce a series of reforms to private health insurance, designed to increase the membership of funds. Outlined below is a brief summary of some of the significant changes in private health insurance introduced since 1996:

- gap cover
- private health insurance incentives scheme (PHIIS)
- the Medicare Levy Surcharge
- Life Time Health Cover
- the 30 percent private health insurance rebate (replacing PHIIS)

More recently, there has been a move to deregulate the products offered by the funds and there have been changes to the way in which funds are able to seek premium increases.[62] The changes in private health insurance and the proposed changes to Medicare are arguably part of a broader project of reintroducing substantial private responsibility for the costs associated with health and illness for those the government argues are able to afford it and shoring up the safety net for those who cannot.

Final Comments

The Explanatory Memorandum to this Bill argues that the proposed changes to Medicare and private health insurance will make medical services more affordable. However it could be argued that questions about the potential inflationary effects of the different

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components of the *A Fairer Medicare* package combined with the apparent disinterest of general practitioners in participating in GPAS raise uncertainty about the accuracy of this claim. Moreover, while it may be the case that, at the point of service, the cost of non-concessional patient billed GP services may decrease (because such patients will only be paying the gap between the Medicare rebate and the fee charged by the doctor), there is nothing in this package that will make the *overall* cost of GP services cheaper for these patients. Indeed, as noted above, many commentators have argued that there will be an incentive for participating GPs to either increase their fees and/or to cease bulk billing non-concessional patients.

Endnotes

1 Amanda Biggs, 'Medicare – Background Brief', *Parliamentary Library E-Brief*, at http://www.aph.gov.au/library/intguide/SP/medicare.htm.

2 Amanda Elliot, 'Is Medicare Universal?', *Research Note No. 37 2002-03*.

3 John Loizou, 'Our doctors too poor to bulk bill', *Northern Territory News*, 30 August 2002. Stephen Smith, MP, 'Biggest yearly decline ever in GP bulk billing', *Media Release*, 30 August 2002.

4 Medicare Statistics, March Quarter 2003, released 16 May 2003.

5 Per 100 000 population, based on ABS estimated resident population figures at 31 December 1999.

6 Australian Medical Workforce Advisory Committee, Australian Medical Workforce Benchmarks, AMWAC, North Sydney, 1996; Monica Pflaum, 'The Australian Medical Workforce', Department of Health and Aged Care, *Occasional Paper No. 12*, August 2001.

7 Pflaum, op. cit., p. 57, see also AMWAC, op. cit.

8 Amanda Elliot, 'Decline in Bulk Billing: Explanations and Implications', *Current Issues Brief No. 3 2001-02*.

9 Participation in HIC On-line will also reduce the time-lag between submitting billing and payments from 8-2 days. The reason it is not limited to GPAS participating doctors is because it would be too administratively difficult to distinguish between participating and non-participating GPs: Community Affairs Legislation Committee, Consideration of Budget Estimates, 3 June 2003, p. 20.

10 Generally, medicare benefits are a proportion of a government approved schedule of fees. The medicare benefit for 'out-of-hospital' services is set at 85 percent of the Schedule Fee, which may be more or less than the fee actually charged by a given general practitioner. Effectively, any practitioner wishing to charge the Schedule Fee cannot offer bulk billling. Moreover, the schedule of fees implies a minimum 'patient contribution' for these services.

11 Dr Neal Blewett, Minister for Health, Second Reading Speech, Health Legislation Amendment Bill 1983, House of Representatives, *Debates*, 6 September 1983, p. 402.

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12 *Australian Doctor*, Medicare Reform, 9 May 2003, pp. 21-25

13 Russell Schneider, Chief Executive AHIA, 'The future of Medicare', Health Report, *Radio National*, 5 May 2003.

14 Russell Schneider, 'Medicare reforms are sensible', *Canberra Times*, 12 May 2003.

15 While details about the new insurance plans have not been provided the AHIA and the Health Minister have indicated that the plan is likely to cost about $1 per week, or $52 a year. This does not include the 30 percent rebate.

16 Community Affairs Legislation Committee, Consideration of Budget Estimates, 3 June 2003, p. 44.

17 Russell Schneider, Chief Executive AHIA, 'The future of Medicare', Health Report, *Radio National*, 5 May 2003.

18 Editorial, *Healthcover*, June-July 2003, pp. 11-15.

19 Professor Jeff Richardson and Dr John Deeble, 'The future of Medicare', Health Report, *Radio National*, 5 May 2003.

20 The 'civil conscription' clause is contained in s. 51(xxiiiA) of the Constitution.

21 Senate Community Affairs Legislation Committee Consideration of Budget Estimates Monday, 2 June 2003, p. 26.

22 Explanatory Memorandum, p. 1.

23 Senate Community Affairs Legislation Committee Consideration of Budget Estimates Monday, 2 June 2003, p. 26.

24 Senate Community Affairs Legislation Committee Consideration of Budget Estimates Monday, 2 June 2003, p. 29.

25 *Australian Doctor*, Medicare Reform, 9 May 2003, p. 22.

26 For example, Simon Crean, Transcript of Doorstop – Woolongong, 10 April 2003; Stephen Smith, 'Medicare: Bulk-Billing', MPI, House of Representatives, *Debates*, 15 May 2003, p. 14729; Maria Vamvakinou, Health Legislation Amendment (Medicare and Private Health Insurance) Bill 2003, Second Reading Debate, House of Representatives, *Debates*, 5 June 2003, p. 15515; Julie-Ann Davies, 'Just how sick is Medicare?', *The Age*, 10 April 2003.

27 The co-payment was $2.50 for all direct billed consultations, except concession card holders, and included a reduction of rebate by $3.50 for non-bulk billing GPs.

29 Productivity Commission, *Private Hospitals in Australia*, Commission Research Paper, 1999, Canberra, p. VIII.

30 See for instance: Joint Statement - Australian Medical Association (AMA); Australian Divisions of General Practice (ADGP); Royal Australian College of General Practitioners (RACGP); Rural Doctors Association of Australia (RDAA) - Government's Medicare Package, 1 May 2003; Dr Kerryn Phelps, 'Health Policy - Here, There and Medicare', Speech to 2003 AMA Parliamentary Breakfast, Parliament House, Canberra, 6 March 2003; Dr

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Kerryn Phelps, AMA President, 'The Future of Medicare', Speech to the National Press Club, Canberra, 7 May 2003.

31 Mark Lipscombe, 'At the coalface', *Australian Doctor*, 9 May, 2003, p. 24.

32 'Government's juicy offer would have patients (the sick) funding pay rises for GPs', *Healthcover*, June-July 2003, p. 11.

33 Significant discussion of the assumptions that the 'Fairer Medicare' package was built on, including the assumption that there would be no inflationary impact from the package is contained in Senate Community Affairs Legislation Committee Consideration of Budget Estimates Monday, 2 June 2003, see pp. 39-42 and p. 96.

34 Senate Community Affairs Legislation Committee Consideration of Budget Estimates Monday, 2 June 2003, p. 96.

39 *Health Insurance Act 1973*, subsection 126(6), inserted by section 9 of the *Health Legislation Amendment Act 1985*.

40 *Health Insurance Act 1973*, subsection 126(6), inserted by Schedule 8 to the *Health Legislation Amendment Act (No. 2) 1998*.

41 Provided that treatment is covered by a 'purchaser-provider agreement'.

42 See the definition of 'applicable benefits arrangement' in section 5A of the *National Health Act 1953*.

43 *Health Legislation Amendment (Gap Cover Schemes) Act 2000*.

44 This is the effect of the combined operation of the definition of 'gap charge threshold' (**item 3**) and 'reimbursable gap charge' (**item 7**).

45 A plan may only cover a contributor or their dependents: new section 73BDED.

46 See the definition of 'gap charge threshold' in Schedule 1, item 3.

47 The *National Health Act 1953* provides for the registration of 'restricted membership organizations' or insurers that are based, for example, on membership of a profession: see the definition of 'restricted membership organizations' in section 4(1).

48 *Explanatory Memorandum*, p. 10.

49 The 'safety net amount' is set in the *Health Insurance Act 1973* at $246 (section 8(1A)) and is indexed annually. It was set at $319.70 in the March 2003 Quarter: Department of Health and Ageing, Medicare Statistics March Quarter 2003.

50 This may be translated as the following:

'contribution' = [0.80 x (expenses - Medicare Benefit)] - (expenses - Schedule Fee)

51 For example, a concessional patient who pays $40 for an ordinary consultation with a general practitioner will be covered by a $25 Medicare benefit against a $29 Schedule Fee:

'contribution' = [0.80 x ($40 -$25)] - ($40 - $29)

= $12 - $11

= $1

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Similarly, for a concessional patient who pays $35 for an ordinary consultation:

'contribution' = [0.80 x ($35 -$25)] - ($35 - $29)

= $8 - $6

= $2

52 For a concessional patient who pays $50 for an ordinary consultation:

'contribution' = [0.80 x ($50 - $25)] - ($50 - $29)

= $20 - $21

= $-1

53 Senate Community Affairs Legislation Committee Consideration of Budget Estimates Monday, 2 June 2003,

54 Brad McLean, 'Huge rejection of government Medicare plans', *Australian Doctor*, 23 May 2003, p. 5.

55 See for instance Adam Cresswell, 'Government incentives "miserly": AMA', *Australian Doctor*, 23 May 2003, p. 4; George Liondis, 'Medicare: most unlikely to opt in', *Australian Doctor*, 9 May 2003, pp. 1-2.

56 A Fairer Medicare - Fact Sheet 1 Addressing affordability for Commonwealth concession card holders.

57 Senate Community Affairs Legislation Committee Consideration of Budget Estimates Monday, 2 June 2003.

58 *Australian Doctor*, Medicare Reform, 9 May, 2003, pp. 21-25.

59 Dr Kerryn Phelps, AMA President, Sydney. AMA's response to the Government's Medicare reforms, 28 April 2003.

60 Dr Neal Blewett, Minister for Health, Second Reading Speech, Health Legislation Amendment Bill 1983, House of Representatives, *Debates*, 6 September 1983, p. 402.

61 Dr Neal Blewett, Minister for Health, Second Reading Speech, Health Legislation Amendment Bill 1983, House of Representatives, *Debates*, 6 September 1983, p. 402.

62 These more recent changes are discussed within the Parliamentary Library publication: The regulation of private health insurance premiums

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