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No. 85 2003–04

Health Legislation Amendment (Medicare) Bill 2003

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Bills Digest
No. 85 2003–04

Health Legislation Amendment (Medicare) Bill 2003

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Social Policy Group
13 February 2004

Contents

Purpose.....	1
Background.....	1
Medicare.....	1
Bulk-billing and patient payments	2
Declining Bulk-billing Rates	2
Bulk-billing and Concessional Patients.....	4
Increasing Out-of-Pocket Expenses.....	4
Addressing the Decline in Bulk-billing.....	5
‘Medicare Plus’	6
Medicare Safety Nets	8
The Existing Medicare Safety Net.....	8
The Extended General Safety Net	8
The Concessional Safety Net.....	9
Main Provisions	10
Schedule 1 – Extended safety-net.....	10
Concluding Comments.....	14
Inflationary Effects?	15
Where to Set the Safety Nets?	15
Are Concessional Patients at Higher Risk?	15
Comparing Concessional and General Patients	16
Bulk Billing Rates:	16
The Number of Medical Services Accessed.....	17
Lower Capacity to Pay?.....	17
Concluding Comments	17
Endnotes.....	18

Health Legislation Amendment (Medicare) Bill 2003

Date Introduced: 4 December , 2003

House: House

Portfolio: Health and Ageing

Commencement: The day of Royal assent

Purpose

To:

- establish a concessional safety-net for out-of-pocket costs for 'out-of-hospital' medical services;
- establish a family tax benefit (A) safety-net for out-of-pocket costs for 'out-of-hospital' medical services;
- establish an extended general safety-net for out-of-pocket costs for 'out-of-hospital' medical services.

Background

Medicare

Medicare is the Commonwealth funded health insurance scheme that provides free or subsidised health care services to the Australian population. It covers medical and diagnostic services supplied outside public hospitals by general practitioners and a range of specialists. Under Medicare arrangements,¹ free services are also provided in public hospitals to people who choose to be treated as public patients.

The subsidy or “rebate” paid for a service under Medicare is based on the Schedule fee that the Commonwealth sets for that type of service. Under existing arrangements, doctors are paid a rebate of 85 percent of the Schedule fee for an out-of-hospital service and 75 percent for a service provided in private hospitals.

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There are currently three ways of billing under Medicare.

1. *Patient Billing*: Patients can pay the doctor's account for the service and then claim reimbursement from Medicare at the amount of 85 per cent of the Scheduled fee for that service (ie., claim the 'Medicare benefit'). Any amount paid by the patient above 85 per cent of the Scheduled fee will be an out-of-pocket expense for the patient.
2. *Pay Cheque to Doctor*: Patients can obtain a cheque from Medicare, payable to the doctor, for the rebate amount appropriate for the service provided (85 per cent or 75 per cent of its Scheduled fee). If the price charged by the doctor for the service is higher than this amount, the patient must pay the balance as an out-of-pocket expense.
3. *Bulk Billing*: Medical practitioners can directly bill Medicare for a service, 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.²

Bulk-billing and patient payments

The purpose of a health insurance scheme like Medicare is to ensure as much as possible that a person's access to medical care does not depend on his or her capacity to pay.³ The availability of bulk-billing plays an important role in Medicare achieving this purpose. In recent years, however, there has been a consistent decline in the rate at which services have been bulk-billed, particularly among GPs. Correspondingly, there has been an increase in patient-billed services, where patients have been asked to contribute a payment for their medical services. The following outlines these recent trends in bulk-billing and patient payments.

Declining Bulk-billing Rates

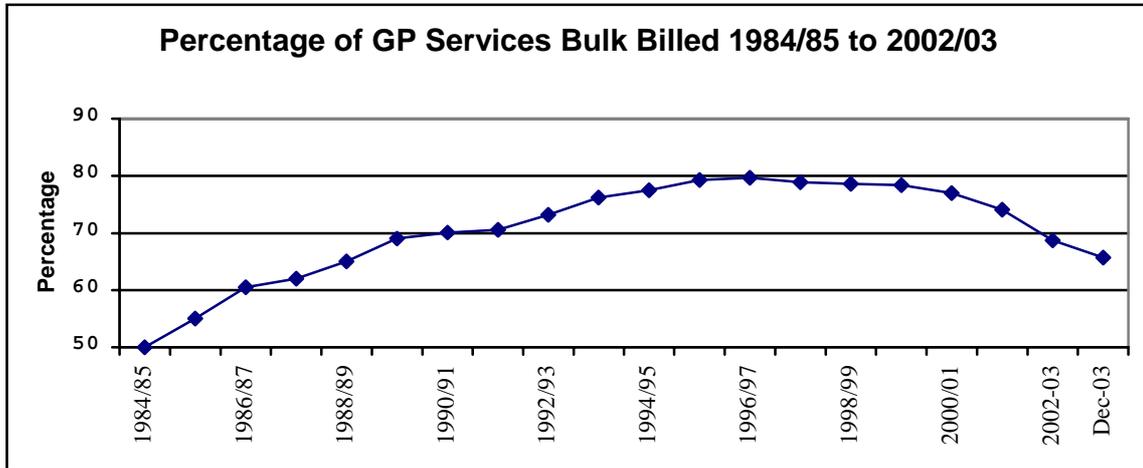
Figure 1 below shows the increase, plateau and then decrease in the proportion of GP services bulk billed between 1984-1985 and September 2003. The decrease has been occurring since 1996-97, but has become steeper since 2000. Between June 2000 and September 2003, there has been a 10 per cent drop in the proportion of GP services bulk billed.⁴ This suggests that the decline is gaining momentum.

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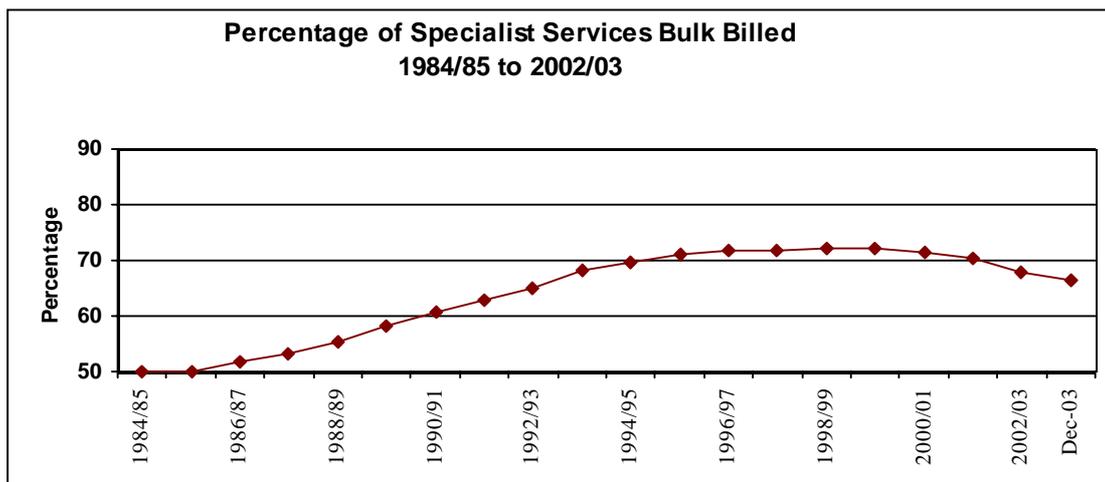
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Figure 1



There has also been a recent decline in the overall proportion of specialist and diagnostic services that have been bulk-billed. As Figure 2 below indicates, the rates of bulk-billing for such services were generally never as high as for GP services, and the decline (which only began after 1999-00) has been less pronounced. There is also considerable variation between non-GP services. While the bulk-billing rate for pathology services, for instance, has increased 10 per cent since 1994-95, the rate for obstetrics has almost halved.

Figure 2



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Bulk-billing and Concessional Patients

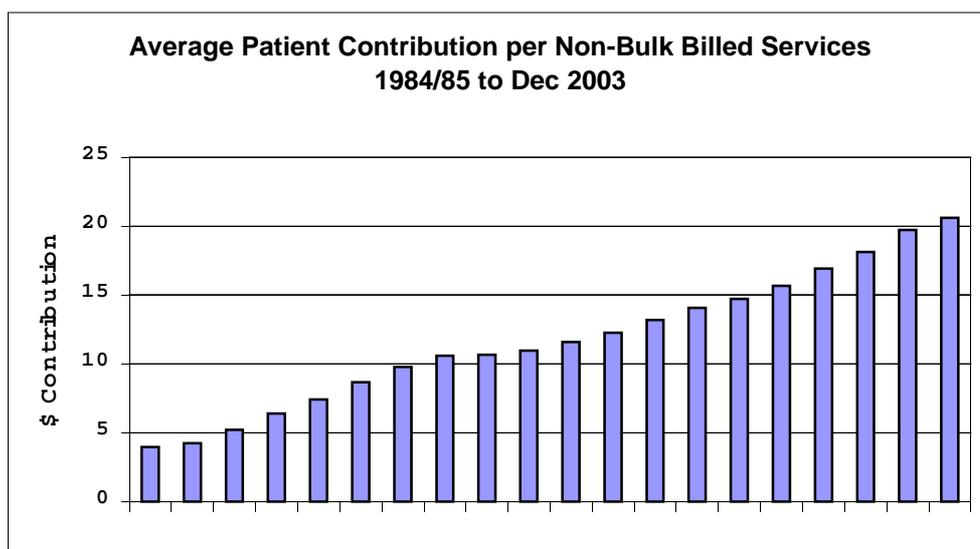
The limited data available indicates that there have been decreases in the rates at which concessional patients (holders of a Health Care Cards, Pensioner Concession Cards, or Commonwealth Seniors Health Card) have been bulk-billed for the GP services they access. Between the 2001 and 2002 calendar years, there was a 5.7 per cent decrease in the proportion of GP services bulk billed for concessional patients, with a slightly greater decrease in metropolitan areas (-5.7 per cent) compared to rural (-5.2 per cent).⁵ Bulk billing rates were, nonetheless, relatively high for concessional patients for both years (86.4 per cent and 80.7 per cent respectively).

Longer term data specific to concessional patients is not readily available. However, the percentage of GP services bulk-billed for patients aged over 65 years has dropped 8.3 per cent from 86.9 per cent in 1996-97 to 78.6 per cent in 2002-03 (to March).⁶ This compares with a decrease of 10.4 per cent in the same period for the rest of the population (from 78.9 per cent to 68.5 per cent).

Increasing Out-of-Pocket Expenses

Clearly, a decrease in bulk-billed services will mean an increase in the proportion of services where patients incur out of pocket costs (through being charged more than the Medicare rebate for the service). But there has also been a steady increase in the average amounts that patients have paid for non-bulk-billed services. Figure 3 shows the rate of increase in average patient payments for non-bulk-billed services since 1984/85.⁷

Figure 3



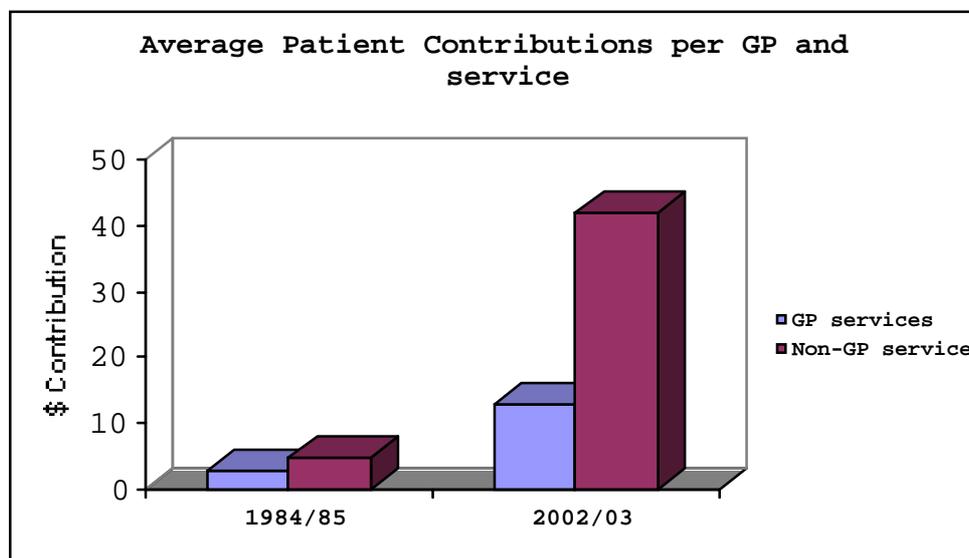
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For GP services, patients contributed an average \$2.86 per service in 1984/85, compared to \$12.90 in 2002-03. For specialist and diagnostic medical services the average out of pocket expenses have been greater, as has the rate of increase. Department of Health and Ageing figures indicate that in 1984/85, patients contributed an average \$5.03 to non-GP services, and by 2002/03 the contribution had increased 310 per cent (in real terms) to \$41.82.⁸ Figure 4 represents the difference in average patient contribution between GP and non-GP specialist and diagnostic services (out of hospital). It is likely that the increase in average patient costs for specialist and diagnostic services is due to the greater provision outside the hospital setting of complex procedures which increasingly use advanced and expensive technologies.

Figure 4



These trends in patient contributions suggest that patients are at increasing risk of incurring out-of-pocket expenses for their visits to the GP and to specialists, and at risk of those expenses becoming increasingly high. Given the lower bulk-billing rate and higher average patient contributions for specialist and diagnostic services, people accessing these non-GP services are at particular risk of incurring high out of pocket expenses.

Addressing the Decline in Bulk-billing

It is within the context of this decline in bulk billing that a debate about the future of Medicare has arisen, and it is with the stated aim of fixing this problem that the Coalition Government has presented its '*MedicarePlus*' package. There has been considerable debate, however, as to how the problem might best be fixed, and what the factors are that lie behind the decline in bulk-billing, particularly in relation to GPs. Explanations of this

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have tended to centre around two views. One focuses on the level of the Medicare rebate to doctors, and the other focuses on the geographical distribution of GPs.

Medical practitioners have argued, particularly through the AMA, that GPs are increasingly charging patients more than the Medicare rebate for consultations because the Schedule fees against which that rebate is set, does not provide sufficient recompense for providing those consultations.⁹ The Federal Government, however, argues that a decline in bulk-billing rates in an area is a consequence of an under-supply of medical practitioners in that area. Underlying this is the view that competition between GPs providing services is a major influence on the number of services that they bulk bill.¹⁰ 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.¹¹

Whichever of these views is more accurate, the Commonwealth Government is limited in the ways it can go about addressing the bulk-billing problem. 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. Nor, arguably, can it force doctors to work in certain geographical areas. 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.¹² At best, the Government can provide incentive measures to encourage doctors to bulk-bill, and measures that lessen the cost impacts on patients when doctors don't bulk-bill. This is what the Coalition Government's *Medicare Plus* package of measures (and the *A Fairer Medicare* package that preceded it) seeks to provide. The proposals of this Bill are part of the *Medicare Plus* package.

'Medicare Plus'

Medicare Plus was announced on 18 November 2003, and provides \$2.4 billion between now and 2006/07, with an additional \$1 billion each year thereafter. It retains or expands on some of the measures of *A Fairer Medicare*, and adds further ones.

The affordability and workforce measures in the *Medicare Plus* package are:

- For patients who are concession card holders, or members of families in receipt of Family Tax Benefit (A), the introduction of a concessional safety-net that will meet 80 per cent of out of pocket medical expenses over \$500 per individual or family in a calendar year.
- For general patients and families, the introduction of an extended general safety-net that will meet 80 per cent of out of pocket medical expenses over \$1000 per individual or family in a calendar year.

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- The provision of an additional \$5 incentive payment to GPs for every concessional patient, and patient under 16 years of age bulk-billed.
- The provision of grants to GPs and specialists to encourage electronic lodgement of Medicare claims via HIC Online. Patients can then have their Medicare benefits paid directly into their bank accounts, when the consultation takes place.
- The provision of funding to improve broadband internet access for GPs in rural and remote areas.
- The provision of further funding to assist GPs assess their current business practices and practice scheduling.
- For practices in urban areas of workforce shortage, the provision of grants for the employment of 457 additional full-time practice nurses.
- In order to free up GP time, the creation of two new Medicare Benefits Schedule (MBS) items for specified services provided by a practice nurse without a GP being present.
- The funding of an additional 150 GP training places each year for outer-metropolitan and rural areas, and the funding of 280 short-term placements for graduate doctors in practices in outer metropolitan, rural and remote areas.
- The development of an international recruitment strategy to coordinate current state and territory arrangements for recruiting overseas trained doctors.
- For procedural GPs in rural and remote areas, the provision of financial support to attend up-skilling courses.
- For GPs and specialists no longer practising medicine, the provision of refresher training courses and other support to encourage their return to the medical workforce.
- Funding of an additional 234 rural bonded medical school places, with up to three years of post-graduate vocational training undertaken in rural areas to count toward the six year bonding period that applies to these places.

The safety-net measures, which are the components of the *MedicarePlus* package contained in this Bill, are discussed below.

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Medicare Safety Nets

The Existing Medicare Safety Net

There has always been a safety net arrangement relating to patient-billed services with Medicare. This safety net arrangement, which applies in the same manner for all patients, is defined in terms of “gap” amounts paid for medical services. The gap amount paid for a service is the difference between the Medicare rebate for that service and its Medicare scheduled fee. The gap amount for a service is not always equal to the total amount that the patient may pay out-of-pocket for the service. Doctors and specialists can, and do, charge patients more than the Medicare scheduled fee. In such cases, the patient will have to pay the gap amount, and the remainder of the fee charged. Under the existing safety net, when the gap amounts that a patient has paid within a calendar year reach \$328 (the safety net threshold), Medicare will pay 100 per cent of the gap amount that the patient is charged for any subsequent medical services in that year. The same thresholds and safety net coverage apply to families, as to individuals.

It has been estimated that an average of 43, 404 people per year reached the existing safety net threshold between 1998 and 2002, and 154, 680 different people reached it at some time in that five year period.¹³ The total safety-net benefits Medicare paid has risen from nearly \$8 million in 2000, to nearly \$8.8 million in 2002.¹⁴ The existing safety net costs the Health Insurance Commission \$6.30 per service to manage and administer. This compares with an average management cost of \$1.43 per service for all services in 2002/03.¹⁵

The Bill leaves the existing safety-net arrangement in place, and proposes the addition of two new safety net arrangements.¹⁶

The Extended General Safety Net

The establishment of an extended general safety net is intended to provide an additional safeguard against patients facing high out-of-pocket expenses as a result of doctors charging more than the Medicare scheduled fee for services. Under the proposed arrangement, once a patient’s cumulative out of pocket costs for medical services in a calendar year exceeds \$1000, Medicare would pay 80 percent of the patient’s out-of-pocket-costs for any subsequent medical service in that year. Unlike the existing arrangement, the proposed safety net includes amounts the doctor charges above the scheduled fee, as well as the gap amount. In other words, it includes the difference between the Medicare rebate for the service and the fee that the doctor charges for the service. The same thresholds and safety net coverage apply to families, as to individuals.

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The Concessional Safety Net

A similar safety net arrangement will apply for concession card holders and families receiving Family Tax Benefit A (FTB (A)),¹⁷ but with a lower safety-net threshold amount of \$500 per calendar year in recognition of the generally lower capacity of these groups to pay out of pocket medical expenses. Under the safety-net arrangements, benefits covering 80% of the out-of-pocket costs for subsequent services will be paid to families and individuals who have concessional beneficiary status, or are registered members of a family in receipt of Family Tax Benefit (A). The relevant concession cards and income limits are indicated in Figure 5.

Figure 5

<i>CARD</i>	<i>INCOME LIMIT</i>
Health Care Card (<i>eg., people on Newstart, Youth Allowance, Parenting Payment</i>)	\$17, 472 pa (single) \$29, 068 pa (couples) \$30, 836 pa (single/couple with one child) + \$1768 pa (for each extra child)
Health Care Card (through FTB (A))	\$31,755 pa (families on full rate Family Tax Benefit Part A)
Pensioner Concession Card (<i>Age pensioners, Disability support pensioners</i>)	\$32, 929 pa (single) \$33, 569 pa (single with one child) \$55, 029 pa (couples) + \$640 pa (for each extra child)
Commonwealth Seniors Health Card (<i>Self Funded retirees</i>)	\$50, 000 pa (single) \$80, 000 pa (couples) \$100, 000 pa (couple if separated by illness, care or gaol)

The Department of Health and Ageing has estimated that approximately 200, 000 families and individuals each year would access safety net benefits under the proposed arrangements. Just over 80 percent of these (165,000) would be concessional beneficiaries, and around 15 or 20 percent (35, 000) would be general beneficiaries.¹⁸ The proposed safety net measures are estimated to cost \$266.3 million over four years, with around \$15 million of this being devoted to the costs of managing and administering the safety net.¹⁹

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Main Provisions ²⁰

Schedule 1 – Extended safety-net

Schedule 1 amends the *Health Insurance Act 1973* (the Act) to establish the new safety-nets for expenses incurred in a calendar year for out-of-hospital Medicare services.

Items 1 to 29 make amendments to Part II of the Act, which provides for the payment of Medicare benefits.

Item 30 provides for the date of application of the extended general safety-net.

Item 1: Subsection 8(1A)

Item 1 inserts a definition for *concessional person* in section 8 of the Act. This definition is based on the definition for concessional beneficiary for the purposes of the Pharmaceutical Benefits Scheme, as set out in Part VII of the *National Health Act 1953*. This will mean that those people who are eligible for concessions under the Pharmaceutical Benefits Scheme will also be eligible for the new concessional safety-net.

A person, who, at any time in a calendar year, becomes a concessional beneficiary under the Pharmaceutical Benefits Scheme, will also become eligible for additional benefits under the Medicare concessional safety-net for that year.

Item 2: Subsection 8(1A)

Item 2 provides for the threshold amount for the concessional safety-net. The threshold amount will be set at \$500 and will be indexed annually under section 10A.

Item 3: Subsection 8(1A)

Item 3 provides for the threshold amount for the extended general safety-net. The threshold amount will be set at \$1000 and will be indexed annually under section 10A.

Item 4: Subsection 8(1A)

Item 4 defines a Family Tax Benefit (A) (FTB(A)) family for the purpose of the Medicare FTB(A) safety-net as a family in receipt of family tax benefit under sections 23 or 24 of the *A New Tax System (Family Assistance)(Administration) Act 1999*.

Item 5: Subsection 8(1A)

Item 5 provides for the threshold amount for the FTB(A) safety-net. The threshold amount will be set at \$500 and will be indexed annually under section 10A.

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Item 6: Subsection 8(1A)

Item 6 makes a minor amendment to the definition of patient contribution in subsection 8(1A) to exclude payments made in respect of a safety-net from the patient contribution.

Item 7: Subsection 8(1A)

Item 7 adds a note for the reader pointing out that the safety-net amount is indexed under section 10A.

Item 8: Section 9

The effect of item 8 is to recognise that the calculation of Medicare benefits for the purposes of the new safety-nets will be in accordance with the relevant safety-net provisions.

Items 9, 10, 11, 12, 13 and 14: Section 10AB

Items 9 to 14 make minor consequential amendments to include references in section 10AB to the safety-nets established in new sections 10ACA and 10ADA (being introduced by items 17 and 20 respectively).

Item 15: After subsection 10AC(2)

It will be possible for a family to qualify for the existing safety-net in section 10AC and/or the new safety-nets to be established under new section 10ACA. There is no requirement to qualify for one safety-net before the other. Item 15 amends the existing safety-net for families in section 10AC to deal with the scenario where a family qualifies for any of the new safety-nets before the existing safety-net.

Item 15 inserts new subsection 10AC(2A) to provide for the calculation of the patient contribution for the existing safety-net to include the relevant gap after a payment is made under one of the new extended safety-nets. This amount is the amount that the patient is actually out-of-pocket after receipt of a benefit paid in accordance with one of the new safety-nets, up to the amount of the gap between the rebate and the schedule fee.

Item 16: Paragraph 10AC(6)(a)

Item 16 amends paragraph 10AC(6)(a) to include a reference to take account of the new subsection 20(2A) proposed by item 26.

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Item 17: After subsection 10AC**10ACA Extended safety-net – families**

Item 17 inserts new section 10ACA to establish the new safety-net for families. New subsection 10ACA(1) establishes some new definitions for the purposes of the extended safety-net for families, including *relevant services*, being out-of-hospital medical services attracting a Medicare benefit. In-hospital services are not covered.

New subsection 10ACA(2) provides that where a family qualifies for a new safety-net, Medicare benefits will be increased by 80% of the out-of-pocket expense for the claim.

New subsection 10ACA(3) defines an out-of-pocket expense for the purposes of the extended safety-net.

New subsection 10ACA(4) sets out the circumstances which must apply for the extended safety-net to be accessed. These include that the:

- service was rendered to the claimant or a member of a registered family unit
- expense was incurred in the calendar year
- claimant has paid at least 20% of the out-of-pocket cost
- Health Insurance Commission has accepted the claim, and
- concessional safety-net, the FTB(A) safety-net or the extended general safety-net applies to the claim.

New subsection 10ACA(5) provides that a safety-net will apply to a claim when that claim and all relevant prior claims exceed the applicable safety-net amount.

New subsection 10ACA(6) defines a relevant prior claim.

New subsection 10ACA(7) deals with how a benefit under a safety-net will be calculated when a portion of a claim enables a person to be eligible for a safety-net. Benefits under a safety-net will only be payable on the portion of the claim by which the patient's out-of-pocket expenses exceed the applicable safety-net threshold.

New subsection 10ACA(8) provides that a safety-net benefit becomes payable only after a family becomes registered. However, expenses incurred by the family before registration will be taken into account in calculating whether the family is eligible for safety-net benefits in that calendar year.

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New subsection 10ACA(9) provides that a person who is paid a Medicare benefit by means of a pay doctor via claimant cheque is deemed to have paid that portion of the medical expense as represented by the amount of the pay doctor via claimant cheque.

New subsection 10ACA(10) provides that the question of when the medical expenses are incurred is determined under the regulations.

Item 18: After subsection 10AD(3)

This item adds an identical provision to the existing safety-net for individuals in section 10AD to the provision added to 10AC by item 15.

Item 19: Paragraph 10AD(4)(a)

Item 19 amends paragraph 10AD(4)(a) to include a reference to take account of the new subsection 20(2A) proposed by item 26.

Item 20: After section 10AD

10ADA Extended safety-net - individuals

This item inserts a new section 10ADA into the Act. New section 10ADA is the equivalent of the new section 10ACA introduced by item 17, except that it applies to individuals.

Items 21 and 22: Section 10AE

Items 21 and 22 make minor consequential amendments to include references in section 10AE to the extended safety-net established in new section 10ACA (being introduced by item 17).

Item 23: Subsection 10A(1)

Item 23 inserts a new paragraph 10A(1)(d). This amendment provides for the indexation of the concessional safety-net amount, the FTB(A) safety-net amount and the extended general safety-net amount to be indexed on a calendar year basis in the same way as the existing safety-net. The first indexation for these safety-net amounts is set to occur in January 2005.

Item 24: Subsection 10A(2)

Item 24 provides for the indexation day and the reference quarter for the concessional safety-net amount, the FTB(A) safety-net amount and the extended general safety-net amount by their inclusion in the CPI Indexation table in subsection 10A(2).

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Item 25: Subsection 20(1A)

Item 25 amends subsection 20(1A) by including a reference to new subsection 20(2A) being introduced by Item 26.

Item 26 inserts new subsection 20(2A). New subsection 20(2A) will provide that where a claim for a safety-net benefit is only partly paid, the benefit for the unpaid part of the account can only be paid by means of a cheque drawn in favour of the doctor, and that the claimant may also be paid part of the benefit if the full benefit is not paid to the doctor.

Items 27, 28 and 29

Items 27, 28 and 29 amend paragraphs 20(3)(a), 20(4)(a) and 20(4)(b) respectively, to include references to new subsection 20(2A), inserted by Item 26.

Item 30: Application

Subitem 30(1) provides that the Minister must, within six months of Royal Assent publish a notice specifying the date of commencement of the new extended safety-net, which must itself be within six months of Royal Assent. This will enable the Minister to set the commencement date for an earlier time if the systems required to administer the extended safety-net are in place earlier than expected.

Subitem 30(2) specifies that if the Minister does not publish a notice, the new extended safety-net commencement day is taken to commence on the day after the end of the six months of the date of Royal Assent.

Subitem 30(3) specifies these amendments apply to expenses incurred after the commencement date for the extended safety-net. Expenses incurred before the commencement date may be taken into account in determining whether a safety-net applies, ie in calculating whether the applicable safety-net out-of-pocket amount (\$500 or \$1000) has been reached.

Concluding Comments

Three issues have become prominent in the public debate about the proposed safety net changes: (i) whether safety net coverage of uncapped out of pocket costs will lead to increased doctors' fees, or over-accessing of doctors by patients; (ii) whether the safety net thresholds are set at appropriate levels; and (iii) whether there should be a separate concessional safety net. The following comments briefly address these issues.

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Inflationary Effects?

Will the proposed safety nets provide an incentive, or at least make it easier, for doctors to charge higher fees to patients once they reach the safety net threshold, because Medicare, rather than patients, will pay most of the doctors' fees? The likelihood of this is unclear. Doctors may not always know when a patient has reached the threshold, particularly when the costs that contribute to the threshold may come from a range of GP, specialist and diagnostic services delivered by different practitioners. However, it is worth noting that GPs do 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. Nonetheless, testimony provided to the Senate Select Committee on Medicare indicates that the Health Insurance Commission has the information that would enable them to detect variations in doctors' fee levels for patients before and after they reach the safety net threshold.²¹ To a minor extent also, the remaining 20 per cent of the fee that the patient must pay might contribute to some downward pressure on the fees the doctor charges.

Where to Set the Safety Nets?

Some of the debate surrounding the proposed safety nets has centred on what the appropriate level of annual out of pocket costs should be, for patients to qualify for safety net coverage.²² However, there has been little discussion around the factors and considerations that might be relevant to setting those levels. The Department of Health and Ageing has stated that the \$1000 threshold amount in the previously proposed private insurance "safety net" of *A Fairer Medicare* was chosen largely as a trade-off between costs and benefits.²³ Clearly, though, the point of a safety net is to protect against patients being faced with excessive or unaffordable medical costs. Little has been said, however, about what constitutes "excessive" costs, or what makes medical costs up to a certain point ones that the *patient* should bear, but costs after that point ones which should be borne through state based insurance. Without some criteria or account of these things it is not clear how the issue of where to set the safety net thresholds can be systematically debated or credibly resolved.

Are Concessional Patients at Higher Risk?

The existing Medicare safety net applies to individuals and families regardless of their income or concessional status. Proposing a separate concessional safety net with a lower threshold than for general patients presumably reflects a view that concessional patients are at a higher risk of being faced with unaffordable medical costs than general patients. There are three possible ways in which this risk might be higher:

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- concessional patients are more likely than general patients to access services which are not bulk billed (and which, consequently, involve an out of pocket expense), or
- concessional patients access a higher number of medical services than general patients, and even if they access patient billed services at the same *rate* as general patients, they will access more of them, or
- the same level of out of pocket costs will be less affordable for concessional patients than for non concessional patients.

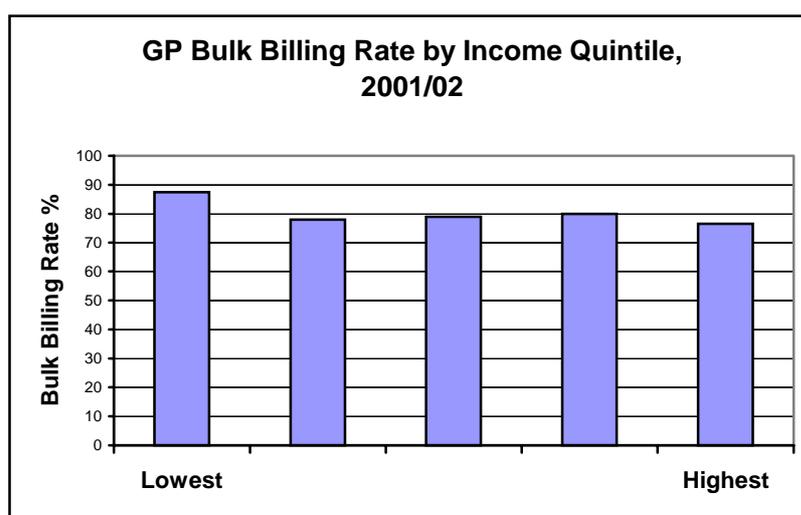
As was indicated earlier, there is very little Medicare data available that is specific to concession card holders. However, the data that there is does not always support the view that concessional patients are at a higher risk of unaffordable medical costs than general patients in the three ways above.

Comparing Concessional and General Patients

Bulk Billing Rates:

Over 70 per cent of full-time equivalent GPs bulk-billed at least 80 per cent of their services for concessional patients in 2002. Over one-third of those doctors bulk-billed all of their services for concessional patients.²⁴ There is evidence also that GP bulk billing rates do not vary greatly between different income groups. Figure 6 below indicates the low level of variation for 2001/02.²⁵

Figure 6



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An independent analysis of the relationship between bulk billing rates and income levels does suggest a weak correlation between the two, but suggest that this is just as likely explained by regional differences.²⁶ It was noted above also that the GP bulk billing rates for concessional patients in 2001 and 2002 were 86.4 per cent and 80.7 per cent respectively. This compares with 75.7 per cent and 71.5 per cent for the whole population for those respective years.²⁷

The Number of Medical Services Accessed

There is little data on the number of services that concessional patients access compared to non-concessional patients, particularly over time. However, figures for patients over 65 years compared to those under that age range might provide a rough picture of relative usage. According to Health Department Medicare statistics, over 65s accessed, on average, 25.3% of all the Medicare medical services each year between 1996/97 and 2002/03. It is true that the number of services accessed by over 65s has increased at a higher annual rate than that for under 65s in that six year period (an average annual rate of 4.3% compared to 1% respectively).²⁸ But, it still remains that only around a quarter of all medical services are accessed by that older age group. Bearing in mind that these figures only give a rough idea of concessional usage, they do not support the contention that concessional patients access a higher total number Medicare services than non-concessional.

Lower Capacity to Pay?

The income limits on eligibility for most concession cards do suggest that the same medical expense is likely to constitute a higher proportion of the income of concessional patients than non-concessional patients. However, it is arguable that this would not necessarily be true for holders of Commonwealth Seniors Health Cards, where the income limit for singles is \$50, 000. There is also the related question as to whether concessional patients are on average charged more or less for medical services than general patients. Information from the Department of Health and Ageing indicates that the average payments per GP service made by patients over 65 years have been consistently less than the rest of the population between 1996/97 and 2002/03 (to March). Moreover, even though the average payments paid by both cohorts has increased over that period, the increase has been less for over 65s. (33.8 per cent increase for over 65 years, and 47 per cent increase for the rest of the population).²⁹

Concluding Comments

These observations are by no means conclusive, and the data available is very limited. However, the available evidence does suggest that concessional patients may not be at as high a risk of unaffordable medical costs as the establishment of a separate and more protective safety-net arrangement might suggest. At the very least, there seems to be little in the way of publicly available data to support the view that a concessional safety net is strongly warranted.

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Endnotes

- 1 Through the Australian Health Care Agreements with the States and Territories.
- 2 Amanda Biggs, 'Medicare – Background Brief', *Parliamentary Library E-Brief*, at <http://www.aph.gov.au/library/intguide/SP/Medicare.htm>.
- 3 A brief discussion of the universality of Medicare can be found in the Parliamentary Library Publication: Is Medicare Universal? Amanda Elliot, *Research Note No. 37 2002-03*.
- 4 Medicare Statistics, September Quarter 2003.
- 5 Senate Community Affairs Legislation Committee, Examination of Budget Estimates, Additional Information Received, Vol. 4, November 2003, p. 2. “Metropolitan” consists of RRMA 1 & 2 classified areas, and “rural” consists of RRMA 3–7.
- 6 Senate Community Affairs Legislation Committee Examination of Budget Estimates 2003-04, Additional Information Received, Vol. 4, November 2003, p. 86.
- 7 Medicare Statistics, September Quarter 2003.
- 8 Department of Health and Ageing, Supplementary Submission to the Select Committee on Medicare, December 2003, p. 4.
- 9 Kerryn Phelps, “GP Bulk-billing rates dive again”, AMA Press Release, 30 August 2002.
- 10 Department of Health and Ageing, Supplementary Submission to the Senate Select Committee on Medicare, December 2003, p. 3.
- 11 Amanda Elliot, 'Decline in Bulk Billing: Explanations and Implications', *Current Issues Brief No. 3 2001-02*.
- 12 The 'civil conscription' clause is contained in s. 51(xxiiiA) of the Constitution.
- 13 Department of Health and Ageing, Supplementary Submission to the Senate Select Committee on Medicare, December 2003, p. 18.
- 14 Senate Select Committee on Medicare *Hansard* 28/08/03, p. 86
- 15 Estimate supplied by the Health Insurance Commission, Tuesday November 25, 2003.
- 16 There is also another “safety net” arrangement that operates through the tax system. Section 159P of the *Income Tax Assessment Act 1936* provides for a 20% rebate on medical expenses incurred in a financial year over \$1500. This, however, is only payable against income that is taxable for the financial year.
- 17 The purpose of FTB part A is to help families with the cost of raising children. To be eligible for FTB part A an individual must have a dependent child under 21 or a dependent full-time student aged 21 to 24, be an Australian resident and meet the income test. Over 1.8 million families with over 3.4 million children are currently receiving the payment on a fortnightly basis. Around 100,000 people claim FTB through the tax system
- 18 Senate Select Committee on Medicare *Hansard* 20/01/04, p. 57

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- 19 Department of Health and Ageing, Supplementary Submission to the Senate Select Committee on Medicare, December 2003, p. 21.
- 20 This section is based on the Explanatory Memorandum.
- 21 Senate Select Committee on Medicare, 2003, *Medicare – healthcare or welfare?*, p. 90. The relevant information is not currently used for this checking purpose, however.
- 22 This has been reported as one of the “sticking points” between the Democrats and Coalition Government in negotiating passage of this Bill through the Senate. See “Democrats stall on Abbott’s Medicare changes”. *The Age*, 4 December 2003.
- 23 Mr Davies, Department of Health and Ageing, *Proof Committee Hansard*, Canberra 28 August 2003, p. 89
- 24 Department of Health and Ageing, Supplementary Submission to the Senate Select Committee on Medicare, December 2003, p. 12.
- 25 Department of Health and Ageing, Supplementary Submission to the Senate Select Committee on Medicare, December 2003, p. 4.
- 26 Ian McAuley, 2003, “Bulk billing by Income/Electorate”, submission to the Senate Select Committee on Medicare, January 2004.
- 27 Medicare Statistics, September Quarter 2003.
- 28 Medicare Statistics, September Quarter 2003. Table D1.
- 29 Senate Community Affairs Legislation Committee, Examination of Budget Estimates, Additional Information Received, Vol. 4, November 2003, p. 86.

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