Attachment 3

NEW MEDICARE

BUILDING ON MEDICARE

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NEW MEDICARE - Building on Medicare

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New Medicare in Outline

New Medicare amalgamates the current triple system of medical benefits of Medicare, Private Insurance and direct Government grants to Public Hospitals into one National system of insurance, mandated to cover every citizen equally for all benefits. It has one "premium" of payment by the consumers (an amended Medicare Levy, proportional to income) paid into a National Health Insurance Fund. This Fund is financed from four existing sources. Currently Government is committed to money paid as Public Hospital grants ($15 Bil.), money currently paid by Medicare for medical benefits ($8 Bil.), and money currently paid as a 30% rebate on private insurance ($2.4 Bil.), a total of $25.4 Bil. – offset by $4.5Bil. received from the current Medicare Levy - leaving a net outlay of $20.9Bil. from Government General Revenue. New Medicare will re-allocate this $20.9Bil. into the National Fund, plus the new amended Levy, expected to raise $7Bil., generating a total Fund of $27.9Bil. In New Medicare Public Hospitals will be financed by drawing on the insurance system rather than by direct Government grants. This large Fund is the source to distribute standard benefits, in one Standard Table, to all citizens, either directly through a single National Health Insurance Commission, or dispersed under a formula to the existing Private Health Funds, using them as agents – the choice is a political option. In the latter case there is no separate premium paid to the Private Funds. This system results in premium payments by consumers *substantially lower* than currently for all income groups but especially for low and middle income families, provides equity in payment of medical benefits, rationalizes the problem of bulk-billing, simplifies the Table of benefits into one Table, and guarantees equity of access for hospital care by integrating the over-burdened Public Hospitals with the unused capacity of Private Hospitals, with equal benefits payable in both for standard care. With Public Hospitals financed by the insurance system, as are Private Hospitals, integration and increased budgets result.

New Medicare is an expansion of Medicare in which, by virtue of citizenship, every citizen is insured in one system, without means test, for considerably increased coverage of medical services outside hospitals, for "free" medical care, accommodation and ancillary charges for public patients in Public hospitals (as recovery of all fees will be 100% from the insurance system), and "free" accommodation and ancillary charges in standard wards in Private Hospitals and for private patients in Public Hospitals.

This system is cost-neutral to Governments as it can be financed entirely out of current Government commitments.

Preamble

The objectives of Medicare are admirable – universal coverage for basic medical care and "free" care and access for all citizens in the public hospital system.

The "universality" of Medicare gave the promise of an equitable and fair provision of health services, and in the first few years this was almost so, all be it with co-existence of private insurance. In the late 1970's some 70% of the community held

private insurance and the capacities of private hospitals were fully utilized. There was therefore a balance in the availability of hospital services, with ready access to the public hospitals. Public hospital waiting lists were small and of almost equal length to those in the private system. The initial level of General and Specialist Schedule fees were based upon the concept of "the common fee" i.e. the usual fees most commonly accepted as fair and reasonable, and few patients were charged above the Schedule fee. For patients not bulk-billed the gap over the Medicare rebate was not excessive for most patients (and nil in hospital for those with insurance), although the first glimmerings of discrimination in consultations were already apparent for the marginal group of low income earners who did not qualify for a Health Card concession and who were not bulk-billed. Universality was never quite complete and such that did exist required the continuance of the expense of private insurance.

Since that time serious flaws have gradually eroded the system and have substantially reduced the equity of Medicare's objectives. Private insurance became progressively more expensive until by the mid-1990's enrollment dropped to just over 30%, with a consequent huge diversion of patients into the public system. At the same time no Government on either side of political ideology faced the reality of the need to concurrently increase the facilities and resources of public hospitals to restore the balance. Huge waiting lists in the public hospitals have resulted and an undesirable two-tiered system has developed; those who can afford private insurance have ready access to private hospitals while those without private insurance, including many low and middle income families for whom it is simply too expensive, queue for public hospital services. At the same time, the lack of universality in cover for medical benefits has worsened, with the decline in bulk-billing rates. There are more citizens in the low band of incomes for whom, if they are not bulk-billed the co-payment is a burden. Bulk-billing remains controversial and Medicare never quite defined its role. For the consultative services by doctors to be truly universally available, bulk-billing would need to apply to every service for every patient, as some would claim Medicare was meant to be; others would claim that it was only meant to be applied to those in special need, such as Health Card recipients. There is a political divide on this issue and much misinformation. A rational approach to bulk-billing is fully discussed in the text below. There has also developed a widening gap of patient co-payments for services charged above the Schedule fee, as the Schedule fee has not kept pace with the ever increasing costs of medical practice, nor even with the CPI.

These various deficiencies are recognized by Health Economists, Social planners, the Medical profession and political Parties but the suggestions for reform being presented so far by the major parties concentrate only with one or two of these problems in isolation, such as the 30% Rebate for private insurance, $5 incentives to bulk-bill, other cash incentives to bulk-bill to an agreed percentage of patients, safety net cover over a certain limit, etc. *Nowhere is there a serious attempt to recognize the basic deficiencies in the structure of Medicare itself which underlie all the flaws in the system;* within a short time all the temporary nibbles being suggested will prove to be inadequate and more fiddling will again be required. The scheme is flawed because of unnecessary complexity in having three different systems of funding and service providers (Medicare benefits, Private Insurance and direct grants to public hospitals), two different "premiums" (the Medicare Levy and Private Insurance), lack of integration of the

capacities of two hospital systems (Public and Private), and multiple, confusing and inadequate Tables of benefits. *The basic problem with Medicare is that it never went far enough to construct one complete system,* but remained constrained by existing patterns of practice and funding. It retained the double system of funding - "public services by Government" and "private insurance", setting up an ideological conflict of priorities in policy making, and inevitably leading to the current discriminatory two-tier system. Although it would be quite unrealistic to think that we could now eliminate the established private insurance system, it is still possible to have one complete system of a central fund of insurance, one "premium" only, and one comprehensive Table of benefits, incorporating the private system as agents, as will be described. Unfortunately, restructuring the scheme is seen as political and electoral suicide if any suggestion is made to the public that major changes are being considered. Medicare is such a "holy cow" for all political Parties that none have been prepared to make the serious changes that are required, yet *solutions to the flaws are available*; and ironically serious changes are the only way to achieve the true objectives of Medicare They are described herein and are certainly achievable if a Party will only grasp the nettle. Hopefully decisions can be made that are bipartisan, as Health should be.

The scheme described is not a replacement of Medicare; indeed, it is an *expansion* of Medicare to produce **one system which adequately covers medical services outside hospitals and both medical costs and accommodation for every citizen in both Public and Private Hospitals.**

The philosophy underlying the scheme is that access to *health is a social right*, and should be equally available to all citizens irrespective of means. Health must be taken right out from the present philosophy of control by "market forces". However much these forces do or do not apply in other areas they do not apply to health and will never achieve equity. Health is a *service,* resting on human need, and in which fairness, compassion and empathy are essential, and it is not quantifiable by a financial balance sheet. The undue influence delegated to Private Funds, especially concepts of Managed Care – perpetuating the very worst aspects of American health policy – in determining policy and cost-control, and the 30% Rebate, are but two examples of when economic considerations override the "social good". Neither addresses the social need of equity of access and equal availability of services. Good health services are a rightful expectation of every citizen. This is not just a pious motherhood platitude – it must underlie all Government planning. Clearly, polices must be economically responsible and financially viable, but *quality* and *need* must be the starting points in determining policy, not cost-control alone.

Further, it is appreciated that "Medicare" involves wider ramifications than just direct patient care, e.g. Public Health, Pharmaceutical services, Health education and prevention, the role of Community Health Centres, Primary Health Care strategy, Restructuring of General Practice, Holistic Care, Workforce distribution, Rural Health Services, Nursing Homes, Domiciliary nursing, Rehabilitation, Special facilities in Geriatrics and Psychiatric services, Special services in Infant and Maternity Health, AIDS clinics, Child Abuse, Drugs, Medical Registration, Medical Immigration, etc., etc. Many of these services are shared between Commonwealth and States and are part of the Medicare Agreement; they require innovative thinking and consultation with a number of other bodies. *They are all very important aspects of a complete Health system, and*

certainly need to be part of any reform process. But none of these can be addressed until we provide a comprehensive scheme of funding and restructuring of the patient care aspects of Medicare itself. *This paper is specifically addressed to the more usually perceived concept of Medicare, the area of direct patient care by doctors and associated professions for services outside hospitals, and the care and accommodation of patients in both Public and Private hospitals.*

NEW MEDICARE IN DETAIL

1. Universality

New Medicare mandates that the health benefits of the scheme will be equally and equitably available for every citizen by a single insurance system – unlike current Medicare in which universality does not equally apply to medical benefits, nor to access to Public hospitals, nor to accommodation in Private hospitals; and membership of Private Funds for that accommodation only applies to 43% of the population. The single insurance system means that every citizen will be effectively covered for what, at present, requires both Medicare and Private Insurance.

2. One System

The current system is flawed by complexity. One system (Medicare) covers medical benefits; another system (private insurance) covers private hospital accommodation, and may make another addition to medical benefits. Another system funds public hospitals by Government grants.

Further confusion is added by there being both a Medicare Levy and private insurance premiums. The Levy is often mistakenly seen as a premium to cover all the costs of health care and personal health needs, including belief by some to cover accommodation in private hospitals (a confusion commonly experienced in consultant practice). In fact, the Levy contributes less than 30% of the health budget. For this reason it also does not allow the consumer to identify health costs. While we have had both a Levy and private insurance as an option there is a financial and psychological disincentive to taking out the additional private insurance premium. Two systems of payment are unnecessary.

Finally, the wide plethora of options available in the private insurance Tables is thoroughly confusing, - as any consultant knows in practice in discussing hospital admission with patients; few patients really know what they are covered for. The so-called Basic Table in particular proves, to patients' surprise, to be totally inadequate.

This confusion can be reduced to one system of insurance covering medical benefits and all hospital accommodation; one method of payment, an amended Medicare Levy (which is the "premium"), deleting payment of individual private insurance premiums; and one complete Standard Table of insurance in which benefits can be assured to cover all that is necessary for good standard medical care outside hospitals and in either Public or Private hospitals.

3. Equity of Payment With respect to medical services, the claim to provide "universal coverage of basic medical care" is not equitable for all citizens. The problem is about the

15% out-of-pocket expense of the gap between the Rebate fee recovered from Medicare and the Schedule fee. Bulk-billing eliminates that gap for some, but for patients on low incomes who are not bulk-billed the patient co-payment is more of a burden for them than for those on high incomes. That burden may be considerable for the large fees of investigations, procedures and operations; added to which is a widening gap in patient co-payment for services as the fees commonly charged now considerably exceed the Schedule fees.

Private insurance affords greater benefits to those who can afford it, but it is simply too expensive for a majority of low and middle income families even with the 30% Rebate. Further, the current Government's 30% Rebate only adds to the discrimination – the cost of $2.4 Bill. is contributed by all taxpayers, yet only those who can afford private insurance receive the benefit. The remainder legitimately ask why their share of the contribution is not returned to the Public system.

These anomalies are addressed in subsequent sections – bulk-billing (Section 11), the Schedule fee (Section 12), and the cost of insurance (see below in this Section)

Finally, the flat rate (1.5%) of the Levy discriminates against low income families. This "hurts" the low income family more than a high income family - $375 out of $25,000 is harder to meet than $1125 out of $75000.

In New Medicare, the one premium of insurance, the Levy, will be payable <u>in a variable rate</u> <u>in proportion to income,</u> (with maximum capping), **ensuring equity of contributions for all. Such a system is not possible with private insurance premiums. Health Card recipients will pay no Levy.** (In this paper "Health Card recipients" refer to "Pensioners" of all types – Aged, Disability, Widows, etc., and including Gold Card Veterans).

The Levy will be collected, as at present, through Income Tax Returns.

To structure the Levy in proportion to income a simple formula is to relate the rate of the Levy to the current levels of Income Tax for a single taxpayer:

Taxable Income		
Taxable Income	up to $20,000	Levy 1.0%
"	$20,000 - $50,000	Levy 1.5%
"	$50,000 - $60,000	Levy 2.0%
"	Over $60,000	Levy 2.5%

with a maximum cap of $2,000 for a single contributor.

Family cover = double the single rate, with a maximum cap of $2,500 for a single income family breadwinner, i.e. for a family breadwinner whose spouse and children do not work, there will be only one Levy at the family cover rate. In a two income family without children each will pay the single rate; with children, one will pay the family rate and the other half the single rate.

Health Card recipients will pay no Levy, but have full participation in the scheme.

The following charts illustrate the equity of the formula, which indicate that:

- the cost of insurance for taxable incomes up to $50,000 is the same as *currently paid in the Medicare Levy alone*, and *for low incomes considerably less so*, and yet these figures include full insurance cover comparable to person who currently pays both the Levy and a high rate of Private insurance premium.

- at all levels of income the cost of insurance is far lower than is currently paid by a person who pays the Levy and a Private insurance premium, even for incomes up to $70,000.

- at $80,000 the cap on the Levy commences for all higher incomes, and is still cheaper than a current Levy plus Private insurance premium.

Example for Single Persons

	At present			New Medicare Levy for full insurance
	Levy	Private ins. (after 30% rebate)	**Total**	
Tax. Inc. $18,000	270	850	**1120**	**180**
" $35,000	525	850	**1375**	**525**
" $55,000	825	850	**1675**	**1100**
" $80,000	1200	850	**2050**	**2000 (cap commences)**

Family cover

For the same levels of taxable income, current Levy and a current Private Insurance family rate premium of $1,700 (after 30% rebate), for a single breadwinner with a family, the comparison of totals is:

	At present	New Medicare Levy for full insurance
	Total	
Tax, Inc. $18,000	1970	**360**
" $35,000	**2225**	**1050**
" $55,000	**2525**	**2200**
" $80,000	**2900**	**2500 (cap)**

Again, it can be seen that the new levels of payment for complete cover of all benefits are *substantially* less than currently paid out for the Levy and a Private insurance premium, especially in incomes up to $50,000. At both the single rate and the family rate, the burden of costs is largely removed from low and middle income families to an affordable level, and equity is brought into the system.

The new Levy levels will bring in more revenue than the present Levy, not only because the rates are higher for higher incomes, but because it includes what would normally be paid as a Private insurance premium – and whereas the latter is currently only paid by 43% of taxpayers it will now be paid by all taxpayers, (except Health Card recipients), thus extending the base by several millions.

The money collected by the Levy will be paid into a central National Insurance Fund, together with other moieties to be described, for the dispersal of the benefits of the Standard Table.

4. Integration of Hospitals

Currently, an undesirable two-tier system has developed. There is no question that access to hospital is easier and quicker for the better off who can afford private insurance, and who accordingly have access to a Private hospital. The economically disadvantaged have access only to an over-burdened public system where there are large waiting lists for elective conditions, diminished access for semi-urgent conditions, and repeated crises in intensive care and emergency departments. While the Public hospitals are over-burdened there is unused capacity in many Private hospitals. **The facilities of both should be integrated by assuring access to either for "standard" care.**

This is achieved, not by subsidizing Private hospitals to accommodate public patients, but by **structuring the Standard benefits of Medicare to apply equally to either type of hospital.** To do this requires a different method of funding of Public hospitals. Currently, a Private hospital meets its costs for services by rendering accommodation and ancillary charges (theatre, etc) set at a particular level for standard services, the source of this money ultimately being the insurance Fund to which the patient belongs. **It is proposed that, instead of funding being from Government grants, Public hospitals be funded precisely and predominately by the same mechanism as in Private hospitals – the hospital will charge full fees in the name of the patient for accommodation and ancillary services, and recover them from the central insurance vehicle.** Private hospitals will continue to be financed from the same insurance pool. (The nature of this insurance vehicle is described below). Appendix 1 details the effect of this method of funding, which will exceed that currently received by Public hospitals by direct Government grants.

The fees charged by the Public hospital for accommodation, theatre and other ancillary services will be at the same rate as in a shared ward in a Private hospital, and the benefits paid out will be identical. For both public patients in Public hospitals and private patients in Private hospitals, (including Health Card recipients in either), recovery will be 100% for "standard" accommodation (shared ward), thus ensuring "free" hospital care for public patients in Public hospitals as well as for all patients (at the shared ward level) in Private hospitals. Similarly, professional medical services in the Public hospitals will be on a fee-for-service basis at the *Rebate* level, and refunded from the insurance pool at 100% level, thus ensuring "free" medical care in a Public hospital. In the Public hospitals all services for public patients, both hospital charges and medical services, will be bulk-billed, so the public patient is free of all claim procedures. Health Card recipients will have access to either type of hospital at no cost.

This mechanism allows the Public and Private hospitals to be integrated, fully utilizing the capacities of both and, because the expensive modalities of hospital care (accommodation, theatre and ancillary charges) are covered by the Standard Table of benefits to an identical degree in both Public and Private hospitals it provides equal access for standard care to either system for all citizens.

Apart from the major advantages of utilizing the full capacities of both systems and providing equity of access, these changes assure the Public hospitals of more certain income and a more efficient method of budgeting; it introduces an element of competition between the hospitals which may contribute to keeping costs down; it ends the constant arguments between Commonwealth and States about the funding of Public hospitals (still a fact in August 2003); and importantly releases a large amount of money for the insurance pool, as described below.

5. The National Insurance Fund

Under these arrangements Government grants to Public Hospitals will cease (except for a 20% moiety for certain services of a non-fee-for-service nature – see Section 9) thus allowing the many billions of dollars (currently at least $15Bill.) currently paid to Public hospitals by Commonwealth and States, to be applied to the insurance pool for payment of the standard benefits. This National Fund will have three other sources of income. As described, the Medicare Levy will be paid into this pool. Currently, the Levy raises about $4.5Bill. but under the suggested sliding scale of Levy rating this will increase to at least **$7Bill.**, a gain in revenue of $2.5Bill. Secondly, currently (2002-3), Government expenditure on Medicare benefits is **$8Bill.**, and this will also be available to the insurance pool. Thirdly, the current Government budgets for **$2.4Bill**. in the 30% Rebate. The combination of re-allocated Government grants to Public hospitals, increased revenue from the Levy, current expenditure on Medicare benefits, and money budgeted for the Rebate, will provide a very significant source of funds (about **$27.9Bill.**), at no additional cost to Government (!), to finance all the extensive benefits of the "Standard" Table of New Medicare. (As a guide, the entire income to Private Insurance Funds is currently about $4.5Bill. and this finances all services in Private hospitals, Gap insurance and prostheses, so that nearly $28Bill. should provide the necessary income for the extended benefits of New Medicare).

How these benefits are disbursed from the Fund is described below in Section 10, in a choice of three models.

6. The Standard Table of Benefits of New Medicare.

The "Standard Table" is very extensive, much more so than provided by any current Tables, and certainly much more than the current Basic Table. The standard level will be known as **"New Medicare Standard"; there will be one scale only, simply understood, easily identified, and completely adequate in itself for essential medical care.**

It will provide benefits as follows:

Outside Hospitals (a) 100% cover of medical fees(General and Specialist) and of essential allied professional fees (Physiotherapy, Occupational Therapy and Speech Therapy) for Health Card recipients and other defined patients, who can be bulk-billed at either the Schedule or Rebate fee level, depending on the nature of the medical service. (See Bulk-billing in Section 11)

(b) 90% cover of medical fees (General and Specialist) and of essential allied professional fees (as above) at Schedule fee level for others, with maximum gap of $15 for each consultative service, $150 for a procedural service and $1000 for all services in one calendar year.

(c) re-imbursement of the fee of a Nurse Practitioner to be negotiated with that profession.

Public Hospitals (a) 100% cover of medical fees (General and Specialist) and of essential allied professional fees (as above) for all public patients, with no means test, including Health Card recipients, mandated at Rebate level.

(b) 90% cover of medical fees (General and Specialist) and of essential allied professional fees (as above) at Schedule Fee level for private patients, with safety gap provisions as above.

(c) 100% cover for accommodation for public patients (and private patients in shared ward), set at the level of a shared ward in an advanced Private hospital, including care in Accident and Emergency Departments, Intensive Care Units, Special Care Nurseries, Day Procedure Units and Dialysis Units.

(d) 100% cover for Theatre fees and Labour wards for all patients, at rates related to the surgery or delivery.

(e) 100% cover for prostheses and pharmaceuticals for public patients, and 90% cover for private patients.

These arrangements assure free care for all citizens as public patients in Public Hospitals, without means test.

Private Hospitals (a) 100% cover for medical fees (General and Specialist) and of essential allied professional fees (as above) for Health card recipients and other defined patients, who may be bulk-billed at Schedule fee level.

(b) 90% cover of medical fees (General and Specialist) and of essential allied professional fees (as above) at Schedule fee level for other private patients, with safety gap provisions as above.

(c) 100% cover for accommodation for all patients in a shared ward, (including Health card recipients), including in the special departments as above in a Public hospital.

(d) 100% cover for Theatre fees and Labour wards for all patients, at rates related to the surgery or delivery.

(e) 100% cover for prostheses and pharmaceuticals for Health Card recipients, and 90% cover for other patients.

7. Supplementary Benefits

Under the Standard Table supplemental insurance is not necessary for adequate medical and hospital cover for essential health care. However, additional supplementary cover may be purchased as an option in two forms. (a) "**Medicare Add-on**" for "gap" cover for the 10% of the Schedule fee not covered, plus for upgraded accommodation, private en-suite rooms, etc., and usable in both Public and Private Hospitals. (b) "**Medicare Extras**" for Health Care Extras, such as Dental, Optical, Pharmaceutical, Other Therapies, Audiometry, Appliances, etc., as currently offered.

Such Tables must be marketed separately and not allied to confusing packages containing New Medicare Standard; nor should they be marketed on the implication that they are essential for adequate care. They should only be for a limited number of levels at the discretion of the Insurer. It is essential that all insurance arrangements are kept simple and easily understood by consumers - no variables, such as Health Maintenance Organisations (HMOs), Preferred Provider Options (PPOs), pre-paid plans, front-end deductibles, etc. We must avoid the nightmare of the multiple systems of the USA.

8. Public and Private Hospitals

The Public Hospital system will be open to all citizens without means test, and all patients will be billed for medical care on the fee-for-service principle at Rebate level, and for the full realistic cost of accommodation and ancillary charges; these costs will be recoverable in full for all public patients through the insurance system, thus ensuring the objective of "free care" being available in Public Hospitals for all citizens. Recovery will be by bulk-billing to simplify the procedures. Public Hospitals must therefore pay for themselves (with some exceptions described below), in competition with Private Hospitals, from the fees they generate. Apart from the exceptions, there will be no Government grants to maintain the Public Hospital system.

All patients in a Public Hospital will be deemed to be of equal status whether "public" or "private" with respect to essential or emergency services, resident medical staff, teaching or research. The election to be a private patient may be on the basis of preferred choice of doctor and/or level of accommodation. The degree of cover in the Public hospitals will be that as set out in New Medicare Standard conferring total coverage of *all* costs for all public patients, total coverage of accommodation and theatre costs for private patients in a shared ward, and major coverage (90%) of medical fees for those patients who elect to be private. There will be no particular advantage for hospital managers in Public hospitals to discriminate in favour of private patients to obtain more income as at present - full accommodation fees are charged to all patients. The playing field is made level between Public and Private Hospitals and equity of access to either is achieved for all patients.

In the Private Hospital system, the level of cover in New Medicare Standard is 100% of theatre fees and accommodation if in a *shared* ward, for *all* patients, thus increasing the availability of these private beds to all citizens at no cost. Health Card recipients and other defined patients may also elect to go to a Private hospital at no cost, with cover provided at the Standard level, i.e. 100% of accommodation in a shared ward and 100% of medical fees at Schedule level. Patients who elect to be private will be billed for medical fees at 90% of the Schedule fee, and those with supplementary insurance may choose upgraded accommodation, etc.

The differences for a patient to choose to be private are the right of choice of doctor, the fewer attendants involved in management, and the options available in choice of accommodation through Supplementary insurance at a higher cost. (For public patients in Public Hospitals, right of choice should be respected wherever possible, but cannot be guaranteed because of the more complex shared responsibility in management between a larger number of attendants of senior and junior Consultants and resident staff, necessitated by the large volume of patients, the training programs, and the complexity of rostering of staff to provide 24 hour cover).

9. Additional Grants to Public Hospitals

Public Hospitals will be funded predominantly by the fees generated for accommodation, theatre and ancillary services, as are Private hospitals. However, some continuing direct Commonwealth/State funding to Public Hospitals will be necessary, estimated at about 20% of current Government grants.:

- For teaching in its widest context in the Teaching Hospitals and some other Major Hospitals, including the training of under-graduates and post-graduates of medical, nursing, and many professional groups. However, some of this is the responsibility of Universities and other Institutions and therefore some costs may come out of other portfolios; but much teaching is done by Consultants and others outside the University system.

- For the evaluation of new technologies, for clinical trials, and for clinical research, as these hospitals must extend the frontiers of knowledge and the setting of standards. Much of this is also done outside University Departments.

- For major capital development.

- For the funding of out-patient services involving multi-disciplinary clinics and clinics for the multi-handicapped for complex problems, for interpreters, dietitians, ancillary helpers, etc., all of which are difficult to fund on a fee-for-service basis.

- For services of a supportive nature; e.g. medical social workers, child abuse clinics, pastoral care, which also cannot attract fees.

- For educational and prevention programs, for outreach programs, after care, rehabilitation and hospice care under control of the hospital.

- For that moiety of the salaries of full-time and part-time Hospital staff not funded by medical fees.

- For some hospitals in rural areas with small populations.

10. The Vehicle for Insurance

In considering the reforms necessary, Health economists tend to polarise around one of two extremes - either a system of total Government monopoly of services;

or a system of total private enterprise where it is assumed that market forces will control delivery and financing. But neither system alone can guarantee social equity and responsible financing. Government monopoly may provide for simplicity, finite control, and can be seen as promoting the "social good", but may suffer from lack of incentives for performance. Market forces invite competition which may promote efficiency, but often results in inequity due to economic rationale as the dominant determinant of policy or from the dominance of unreasonable profitability.

Whatever is decided the important thing is that there should be only one system. We do not want to perpetuate the cumbersome double system of part Medicare and part private insurance which we currently endure. To some extent the choice is a political decision and, like the Health economists, there will be polarised views on either side of politics. **But it comes down to what is the most practical and achievable**. On the one hand, we already have a Medicare structure in place and it would be a relatively simple exercise to expand its insurance role from medical benefits to the complete range of medical and hospital benefits. To have one national insurer is certainly easily understandable by the community and takes all the complexity out of the present double system, the plethora of dozens of separate Funds, different Tables from which to choose, and even which hospital is best supported by a particular Fund. The objection is obviously that this creates a monopoly of insurance in Government hands, which is anathema to some people. It could be feared that a Government monopoly would apply undue pressure on providers in controlling utilisation and servicing levels, on medical fees, on admission practices, length of stay, efficient management, accountability, etc. But lest it be thought that the private insurance industry is totally independent and avoids this Government control, the facts are otherwise. Government already tightly controls private insurance in determining premium rises, obligatory requirements of basic benefits, registration of Funds and amount of reserve funds to be held. And Private Funds apply equal pressure on providers on servicing levels, on fees, length of stay, etc, etc., by reason of the very competition between Funds so lauded as a benefit, in their efforts to reduce their costs and remain profitable, and by the same demands for accountability. That is precisely what the "contracting" system and "managed care" is meant to achieve in the private insurance industry. If the one vehicle for insurance is delegated to the Private Funds then competition between Funds *may* reduce health costs through efficiency gains, but frankly this thesis of economic rationalism in the Health field has yet to be proved. So far, the obsession with privatisation on both sides of politics has, in some privatisation experiments, led to poorer service and limitation of choice, and no-one can claim that the present private insurance industry is a model of cooperation, innovation and efficiency! The more serious danger of the private system is that policy can unduly be determined by the economic bottom line, and not by quality and social need.

In truth, there is not much difference in the end result. There must necessarily be control and some regulatory burden in either system. In an ideal world the simplicity of having a single National system is more practical and achievable. In fact, because negotiation between a number of parties will be an essential component of on-going polices, this would be easier to manage with one National body than a host of separate insurance Funds. A single National Health Insurance Fund, with a clear role and focus,

could be a more efficient administrative structure than a plethora of separate companies. This is Model A described below.

However, the reality is that we do have Private Insurance Funds in existence and it may be quite unrealistic to imagine they can be just deleted from the system. In Model B described below it is possible to construct a scheme which has many features of one National scheme – the "premium" being the Levy to a central National Fund, which is then disbursed to the existing Private Funds, under a formula, to act as agents to dispense the benefits. This is the preferred arrangement.

Model C uses the Private Insurance industry as the sole vehicle, with premiums collected as at present, with no Government involvement. This is not recommended.

Overriding and supervising the whole health care system there will need to be a controlling National Health Commission, and considerable thought needs to be given to the composition and terms of reference of this Commission. The Commission should be an independent statutory body, appointed at arms length from the Government Departments of Community Services and Health (or whatever name), with continuity beyond a Government's term and beyond the whims of any particular Party. It needs representation at least from Government, Hospital Administrators, Medical Professionals and Consumers.

Should the Private Insurance Industry be chosen as the sole vehicle for the insurance arrangements as Model C there will still be a need for the Commission, to determine over-all policy of health care.

It must be stressed that the choice of insurance vehicle is not vital to the implementation of the New Medicare scheme. It can work with either vehicle. The choice is a political one. My choice is for a single National funder using the Private funds as agents (Model B), because it faces the existing reality of Private Funds; but reference is made in appropriate sections as to how it would apply if the system is based on a single National Insurer (Model A) or entirely on the Private Insurance industry (Model C).

What is emphasised is that one single, easily understood insurance system is required for all the patients needs, that claims are made to one system only; that the one system covers all basic costs of both medical care and hospital accommodation in both public and private hospitals, and that it is equally available to every citizen.

The plan described below offers three models of funding:

Model A: A single, central, National Health Insurance Fund, as the single recipient of "premiums" (which will be the Levy), and the dispersal of the Standard Table of benefits, (and of any Supplementary Insurance), with deletion of the Private Funds entirely.

Model B: A single, central, National Health Insurance Fund, as the single recipient of "premiums" (the Levy), paid out to the Private Funds under a formula, and using the Private Funds as agents for the dispersal of the Standard Table of benefits. The Funds can also offer Supplementary benefits.

Model C: A system of Private Funds to which individual premiums are paid as at present, and which disperse the Standard Table of benefits, with no Government involvement.

Model A:

In Model A there will be one, central National Health Insurance Fund under the National Health Insurance Commission, financed from four sources – the Medicare Levy (at the new rating estimated to raise about **$7Bill.**), plus the moiety of money currently given by Commonwealth and States as grants to Public hospitals (currently **$15Bill**), plus that already budgeted in Commonwealth outlays for the payment of Medicare benefits (**$8Bill.**), plus the current budget for **$2.4Bill.** for the 30% Rebate out of general revenue, (and therefore can be legitimately added without an increase in total Government outlays), - less the $4.5Bill. currently received from the Medicare Levy – making a combined total of **$27.9Bill.** for the Fund. This is a very substantial figure, and as discussed in Appendix 1 should be sufficient to adequately fund all the benefits of the New Medicare Standard table. There will be no Private Insurance Funds in Model A.

The Fund will pay for all claims under the parameters of the New Medicare Standard Table through existing and expanded Medicare offices.. The Fund can also offer Supplementary benefits.

The "premium" for the Fund is the Medicare Levy, collected annually as at present through the Income Tax Return. The new Levy will be indexed in proportion to income, as described in Section 3.

Model B:

This model faces the reality of the existence of a Private Insurance industry. Although there is much in favour of the simplicity of a single National insurer as in Model A, the political realities of removing the private industry are profound. The Private Funds can be utilized as follows: instead of the complexity of collecting separate premiums by separate Funds, the "premium" will be the Levy, indexed against income (which is not possible with the premiums at present collected by separate Funds), collected annually with the Income Tax Return, and paid into a single, central National Insurance Fund as in Model A. This Fund is augmented by the three other sources of money, as in Model A, to provide a pool of **$27.9Bill.**

From this central pool, the funds will be disbursed to the Private Funds in proportion to the number of members in each Fund, to act as agents to meet the claims submitted to them mandated under the Standard Table of benefits. From the citizen's point of view the premium is collected automatically in the Income Tax return, and from the patient's point of view, there is only one source from which to claim payment, viz. his/her Private Fund of choice (thus avoiding the need for double claims from Medicare and Private Funds as at present). The Funds can also offer Supplementary benefits.

A formula has to be provided to determine how the central pool is to be disbursed to the Private Funds. Disbursement purely in proportion to the number of members in the Fund is not adequate. An innovation is introduced to refine the formula which more rationally faces the real costs of care in different age groups, and guarantees viability of the Funds. Under the current system of "community rating" (all members pay the same premium) the problem is that different demographic groups of citizens consume different degrees of medical services, e.g. a healthy 20-year old paying $800 as premium may only utilize $600 worth of services (making them reluctant to join a Fund), but a 75-year old, paying the same $800 premium may consume $3,000 in services. It underlies the problem the Funds have in accurate budgeting, or even remaining viable. Thus, in Model B, a fixed equal amount of repayment per member from the central pool to the

Private Funds might not address the demographic spread of members in a particular Fund. Nor would a system of simply returning the Levy which each member pays, (and, in any case to do so would be an invasion of privacy as it would reveal to the Private Fund the income level to which the member belongs). In another context, McKay in 1988 suggested five demographic levels each with its own expectation of medical risk. I have modified this, and have deleted children less than 16 years of age, who will be covered by a family enrollment. To meet the expected risks, the "real" premiums to pay for medical services actually would currently need to be of the following order:

16 - 25 years of age	$600
26 - 45 "	$900
46 - 60 "	$1,200
61 -70 "	$2,000
70+ "	$2,500

This gives a basis for the calculation of the amount of money to be disbursed from the central pool to each individual Private Fund. A Fund would submit an annual profile of its members graded into the five age groups; reimbursement to the Funds would then be at the above levels in accordance with the numbers of members in each group. Such a mechanism preserves the equity of "premiums" (the Levy) being paid by the citizen in proportion to income, yet provides the Funds with realistic budgetary figures for the actual expected costs of outlays for medical services. It also assures the viability of the Funds.

Model B thus accommodates all the features and benefits of New Medicare, using the Private Insurance Industry as agent.

Model C

I include this Model only for completeness. It is not recommended as it inadequately deals with some of the key elements of New Medicare. This model preserves the current Private Insurance system as the *sole agent* for the collection of premiums and the disbursal of benefits. Membership of a Fund will be mandatory for all citizens. Some features of New Medicare will apply – one source to which premiums are paid, i.e. to the Private Fund (as in this Model there will be no Medicare levy); one comprehensive Table of benefits (the "Standard Table" of New Medicare) which the Funds are mandated to supply; one source to which claims are made; and the same arrangements in the funding of Public and Private hospitals, the former being funded on the insurance system for recovery of full costs. Otherwise, there is no direct Government involvement (apart from the 20% moiety for supportive services as previously described). Separate from the private insurance premiums being paid directly to the Private funds from the individual Fund member, there will still be the source of funds collected from the other moieties as in Models A and B - the money currently paid by Commonwealth and States to fund Public hospitals, and the budgeted amounts allotted to Medicare benefits and to the 30% Rebate, a total of **$20.9Bill**. **This pool will be used to heavily subsidise the private premiums to make them affordable**. To employ a subsidy scheme in this way is not discriminatory because every person is mandated to be insured

and so all receive the benefit of the subsidy, and because the Standard table assures equity of access for all citizens to both Public and Private hospitals.

There is no doubt that such a system could be structured. However, it suffers from two serious faults. Firstly, premiums cannot be struck in proportion to income, as the Funds will have no access to the incomes of their members (correctly so). This has always resulted in unaffordable levels of premiums for low and middle income families; and under community rating with everyone paying the same premium those on high incomes pay a disproportionally low premium, both factors thus perpetuating inequity and discrimination. Nor can premiums be struck in proportion to medical risk in each demographic group, as this would severely discriminate against the elderly who would have to pay a huge premium. Consequently Funds have to set premium rates at a relatively high rate to cover the high risk groups and remain viable.

Secondly, a purely private system places undue control under the thesis of "market forces" and a danger that quality and need become secondary to financial cost control, as discussed in earlier sections. It invites the worst aspects of Managed Care, in which quality and accountability are largely defined in financial terms.

However, it may be possible to address both these concerns.

With regard to premiums, the cost of premiums can be made more universally affordable by a system of heavy subsidization, but not by a fixed rate like the current 30% Rebate which is still insufficient to make the premium affordable to low and middle income families. Under New Medicare there is a much larger source of funds available to *substantially* subsidise the premiums to a more affordable level – $20.9Bill. as described above, – much more than the $2.4Bill. currently being paid out of general revenue for the 30% Rebate.. Further, by applying the principles described in Model B, the **subsidies can be weighted to take account of the different levels of demographic risk, and yet preserve the principle of community rating.** Thus, the premium could be set at, say, **$600** for all single taxpayers, (other than Health Card recipients who will pay no premium, the Funds receiving 100% of their premium from the central fund subsidy), a figure perhaps just acceptable to low income families. However, the subsidies paid directly *to the Private Insurance Fund*, not to the individual member of the Fund, from the central pool would be in accordance with the demographic profile of the numbers of members in each category of risk, as in Model B,- the greater the risk the greater the subsidy. E.g. a 16 – 25 year old pays a premium of $600, and the Private Fund receives no subsidy, but a 75 year old also pays a premium of $600 but the Fund receives a subsidy from the central pool on his behalf of $2,500. **This achieves risk rating for calculation of real costs but community rating for the patient.**

Attractive as this idea is in achieving relatively low premiums, I personally doubt that it is sufficiently generous to the marginal families on incomes up to, say, $35,000 – especially when family cover is required for a single breadwinner, who then is required to pay double the single rate i.e.$1,200 in a premium. **However, there may be a way of effectively indexing the premium for low income families through a special offset in the Income Tax Return. That area will need exploring if Model C is adopted. This could effectively bring the cost of the premium for these families down to levels comparable to those of Models A and B.**

But it still does not address the fact that very high income taxpayers (under community rating) still only pay $600 in premium for full insurance cover. The effect of Tax offsets (reducing Government revenue) and the low contributions ($600) from all taxpayers will also reduce the overall revenue from premiums, compared with that from the Levy in Models A and B – see Appendix 1.

With regard to the fears about the undue influence of market control in an entirely private system, community and professional input and Government oversight is essential. As has already been discussed above, even when the Private Insurance system is utilized, there will still be a need for overall supervision and power to act from a National Health Insurance Commission (see page 13), which, by its composition and terms of reference will receive advice and direction from consumers, medical and ancillary professionals, hospitals, and Government Departments.

Given these provisos, an entirely private system of insurance could be the vehicle for New Medicare, but at the risk of some degree of inequity and some decrease in overall income.

11. Bulk-billing

Bulk-billing has become a litmus test of the social philosophy of political parties in their attitude to Medicare. No other feature divides them as much. Nor is any subject filled with so many myths and misunderstandings.

Bulk-billing (i.e. direct billing to the Insurance Fund for medical services) is designed to leave the patient with no co-payment and is understandably widely supported by the community. The fee paid to the doctor is currently set at the Rebate fee level, i.e. 15% less than the Schedule fee. The argument is all about the 15% out-of-pocket expense of that gap, and whether its presence for patients who are not bulk-billed is a denial of the Medicare claim to provide "universal coverage of basic medical care".

The current Coalition Government views bulk-billing as a safety net only for certain patients (Health Card recipients, and now additionally children), a concept equating to the "sick poor". This limited policy is inequitable because the 15% gap for low income families who do not qualify for the concession is much more of a financial burden than to those on high incomes. The Government's response is to offer $5 to the doctors above the Rebate to encourage a greater participation rate in bulk-billing. In designing this flat rate bonus the planners seem to be unaware that there a whole range of General Practitioner fees (and Specialist fees) depending on the length and complexity of the consultation – in some the $5 is adequate, in others quite inadequate. For example, General Practice consultations at the Surgery are in four levels with the gap between Rebate and Schedule fees being, respectively, $2.05, $4.50, $8.60, $12.65. There are several other categories (Home visits, hospital visits, etc) with wider gaps than $5. Similarly, the gaps for Specialist consultations vary from $10.65 to $22.80, and even more so for prolonged attendances. It is therefore extremely doubtful if the offer of $5 will provide any incentive for more doctors who currently do not bulk-bill to begin doing so only to be out-of pocket.

On the other hand, there are those who believe *every* service on *every* patient should be bulk-billed. There is no doubt that this truly would achieve "universality". No patient is left out-of-pocket and every citizen is covered equally. Attractive as this concept is in political terms it comes at considerable cost. Firstly, it is

very doubtful if Medicare was designed on the assumption that all or even most medical services were "meant" to be bulk-billed. In fact, Medicare never defined who should or should not be bulk-billed. The scheme was designed with both a Rebate fee *and* a Schedule fee, indicating that the normal expectation under usual circumstances was a "fair and reasonable" Schedule fee. If all services were meant to be bulk-billed we would have only required one fee. In fact, historically, bulk-billing was not mandated but "encouraged" on the argument that billing at the lower Rebate level (15% below the Schedule fee) would "save" the practice the administrative costs of collecting fees from individual patients by 15%. This has proved to be a myth, as practice costs are scarcely diminished at all by the bulk-billing process, especially if the practitioner still provides an itemized copy of the account to the patient of the services, to inform the patient of real costs, as should occur as the ethical demands of a good practice require. Unless the patient is given a copy of an itemized account it hides the true costs of service. The reality is that bulk-billing is a *significant discount* for services. Secondly, because the fee is a discount there is a temptation to push through the maximum number of patients in the shortest time in order to keep up a viable income, which has spawned a growth in "Bulk-billing Clinics" – and even some of these are now abandoning the practice as being uneconomical, as shown by recent decline in the rate of bulk-billing. Competitive pressures between practices to bulk-bill is a most potent risk of over-servicing by medical entrepreneurs. Thirdly, with no built-in check on free visits there is the danger of over-utilisation by consumers. It may be difficult to substantiate, but I over-servicing and over-utilisation may be costing Medicare millions of dollars in unnecessary or inadequate services. Fourthly, rapid throughput in bulk-billing clinics has been substantiated to lead to lower standards of medical care (note the comments in the Health Service Commissioners Report in 1992, Victoria, that those clinics were the major source of complaints by patients). Finally, some would argue that wealthy persons should make some contribution to health costs, and not receive free treatment when they could afford to pay for it. Advocates of universal bulk-billing have to address these difficulties.

A further misunderstanding is to confuse the desire to relieve the patient of a co-payment with the level of the fee paid. Currently, bulk-billing assumes payment at the Rebate level, i.e. a discounted fee. Because the fee is discounted (and it is additionally claimed that the level of the Rebate has not kept pace with practice costs nor even with CPI), doctors claim it is uneconomic and bulk-billing rates are accordingly falling. But there is no reason why the bulk-billing fee should necessarily be pegged to the Rebate level. It could be struck at any level, e.g. the Schedule fee, and still leave the patient with no co-payment. Indeed, this is proposed by the Labour Party as an alternative to encourage a greater participation rate, but it is unclear whether this is for *every* service and for *every* patient. Clearly, if every patient is bulk-billed at Schedule rate there is no need for any cash incentives to be offered to doctors to encourage participation rates and no need for two fees in the Medical Benefits Schedule Book; yet cash incentives are being offered, suggesting that only *some* patients will be bulk-billed at the Schedule rate, but which ones are not defined.

These dilemmas underlie the failure to understand the basis of a fee. A fee charged should be *in relation to the quality of the service rendered* and has little to do with either the mechanism of payment of the fee, or the financial state of the patient. (for example, in the latter case I have never charged a known wealthy patient a higher fee

than the Schedule fee just because they are wealthy). Where bulk-billing is applied, the logic should be that if the service rendered is significant the re-imbursement should be at the Schedule fee level; if for a minor or less demanding service, at the Rebate level. For example, for many Health Card recipients (elderly, disability pensioners, etc.,) by their nature often have complex problems and much co-morbidity, demanding more care and longer commitment than other patients, the bulk-billed fee should be at the Schedule fee level. Why is the medical service to such patients deemed to be of lesser value (by the Rebate fee of current Medicare) than the same service to a person who pays the full fee? On the other hand, logic would decree that services of a more minor nature should be bulk-billed at the Rebate level. It is for this reason that in the Standard Table of benefits in New Medicare (Section 6) bulk-billing is "at either the Schedule or Rebate fee level, depending on the nature of the medical service". In either case the patient is not out-of-pocket and the objective of bulk-billing is still achieved. On that principle, practices can remain viable with no necessity for the complication of cash bonuses.

Finally we now come to a political decision. Planners of policy simply have to come to terms with reality.

For those who want to have total universality, with every patient and every service being bulk-billed, that is a political decision. It will be very popular with consumers, and certainly achieves universality, but the costs must be accepted as set out above – the risks of over-servicing, over-utilisation, lower standards, and the necessity of legislation to make it mandatory or else a complicated set of cash incentives; if it is decided to bulk-bill at the Schedule fee rate for every patient, it will be very expensive; if at the Rebate level for every patient, it underestimates the value of some consultations.

For those who want some limitation on bulk-billing, but more generous than the philosophic approach of the current Government, there is the difficulty of defining who exactly should benefit, and at what level of re-imbursement.

Frankly, there may be no complete solution, and a compromise will be necessary, but it is possible to identify some major groups who should benefit, and protect their interests; however, there will remain an optional group where the judgment, insight and integrity of the attending practitioner is the nearest we will get to a fair scheme without invading privacy by legislative intrusion. A compromise for bulk-billing is suggested as follows:

- all services in Public Hospitals for public patients, medical services at the Rebate level, and accommodation and other ancillary serves at 100% recovery rate.
- accommodation and ancillary services for private patients in shared wards in either Public or Private Hospitals at 100% recovery rate.
- medical services both outside and inside hospitals for the following identified groups – Health Card recipients (see definition in text)
  Children under 16 years of age
  Unemployed and underemployed
  Patients in Nursing Homes and Institutions of care
  Self-supporting students, Pastors, Clergy, and religious Orders.

- medical services to other groups where additional information is required. These groups are no less important than the identified groups but the information involves privacy issues, e.g. the income level of a family. On this account the inside knowledge, sensitivity and empathy of the attending practitioner is the only realistic guide. I do not think it can be legislated for, as much as some ideologues would wish for it to be written in stone, without breaching privacy. These include – financially disadvantaged low income families not on Health card concessions, families in a period of financial or emotional distress, elderly and others without family support when even the paper work is difficult, nurses and professional colleagues in the health field.

Apart from these categories, it remains an option for a doctor to bulk-bill any or all patients at his/her discretion.

Finally, the fee level of bulk-billing should be determined by the nature of the medical service, either at the Schedule or the Rebate fee level, as described above. *In this way no additional cash or other incentives are necessary.* The fees charged would only be what they would be without bulk-billing.

12. Schedule of fees

Fundamentally, the medical fee is part of the contract between doctor (or other professional) and patient, and either party has right of choice in decisions to agree on a fee that is "fair and reasonable". It is not controllable directly by Government as it is unconstitutional in Federal law to do so. However, any insurance scheme requires a Schedule for the insurer to compute both the premium and benefit, and so *a Schedule is unavoidable*. The present system of determination of Schedule fees has clearly failed. It is not "reasonable" that the Schedule has not even kept pace with inflation, and certainly not with increases in practice costs, including the greatly increased costs of medical indemnity; the undesirable consequence is that we now have an *ever widening gap between the Schedule fee and the actual fee commonly charged*, often a difference of hundreds of dollars – *which defeats the whole structure of Medicare*. The present failure is because the determination of a particular fee is not based upon an informed analysis of real practice costs and relativities among the different disciplines, without which the determination is largely guess work. It is often based upon the advice of each specialist group with its own wish list, or simply upon an arbitrary financial figure as a compromise between the money that is available and the strength of argument put up by a particular group. Despite the prejudice held by some in the community, the Australian Medical Association Fees Bureau is a reputable body which genuinely does calculate real practice costs and relativities. Unfortunately, the Government has refused to endorse the Relative Value Study which would have put some rationality into the determination. The Association's Fee Bureau assessment of real practice costs and relativities should be the starting basis for the Schedule determination. Facts must overcome prejudice and a determination worked out that is sufficiently realistic to eliminate these huge gap demands. On the other hand, the medical profession cannot be the sole determinant of

the fees for a service which is community owned. The Schedule should be drawn up by a professional group, including Government, Insurer, Profession, Consumer, and the Australian Medical Association Fees Bureau, to determine "fair and reasonable" fees, which should consider actual practice costs, and which at the very least should parallel the inflation rate.

Clearly, the Insurer must be part of this process so that a fee is negotiated for the determination of the benefit and premium, but it is not the role of the Insurer alone to dictate the fee. Its role is to adjust the benefit and premium to meet the costs determined by the representative group. There must be no "contracts" with this single player.

While recognising that, technically, such a Schedule is a recommendation only, the various features of the New Medicare scheme will apply considerable pressure on professionals to charge the Schedule fee. The fee is an agreed and negotiated one in which the profession plays a major role in its determination, and therefore *carries an obligation on professionals to stick by an agreement*. The fee is direct to the patient (apart from bulk-billing) and a direct contract is established, with right of choice and agreement for both parties; the consumer is better informed and involved; and there are the requirements of accountability. The degree of compliance with the Schedule is likely to be very high, as it should be, and desirably will make it unnecessary to impose restrictive regulatory and bureaucratic controls. *There is no doubt that any marked divergence from the Schedule, with an unacceptably large patient co-payment will destroy the scheme itself, and bring on the bureaucratic controls that are in no-one's interest.* This is a reality with which the professions must come to grips.

The Schedule must include mechanisms for review, revision, appeals and arbitration.

OTHER ASPECTS OF NEW MEDICARE

12. Rights of Choice

A citizen's right of choice is:

- For choice of hospital, public or private.

- For doctor of choice outside hospitals (General and Specialist), and for doctor of choice as a private patient in hospitals. For *public* patients in Public Hospitals, this right of choice should be respected wherever possible, but cannot be guaranteed because of the complexity of shared responsibility in management between a larger number of attendants of senior, junior and resident staff, necessitated by the large volume of patients, and the complexity of rostering of staff to provide 24 hour cover. However, all patients whether public or private, are deemed to be of the same status with respect to the teaching, research, and training responsibilities in Teaching Hospitals, in emergency situations, and the involvement with resident staff.

- For choice of private insurance fund, if it is decided that Private Insurance is to be the vehicle for insurance in Model C in the New Medicare scheme.

- For choice of supplementary insurance.

13. Responsibility, Competition, Incentives and Cost Control

Essential to the plan are the concepts of shared responsibility, competition in the hospital system to facilitate innovation and performance based incentives, accountability in all players, cost control, value for money, and quality of service.

With respect to hospitals, public hospitals will have to compete with private hospitals; with both being funded from the same source on equal terms, each will have the incentive to provide the best quality services for the least cost, with priorities directed to better patient care, which will be the criterion of the effectiveness of the management system.

With respect to Insurers, if it decided to use Private Funds as the insurance vehicle, Funds will need to compete with one another to remain viable. Their viability will rest on administrative efficiency and on innovation to supply supplementary benefits, but particularly on their interplay with providers (medical and hospitals) to control costs, through pressure on utilisation and servicing levels, on medical fees, on admission polices, length of stay, etc. These same pressures will be applied by a single National Insurer as well. The points have been expanded earlier.

With respect to Governments, they enter the equation by determining the level of subsidisation, the regulation of the system, the allocation of funding for other parts of the health budget, and the degree to which they respond to public demands for equity in the system and viewing health as a service.

With respect to Medical and other Health Professionals, the community expects accountability. To a large extent the professions have already responded, and there has been much progress to quality assurance, peer review, audit of outcomes, utilisation reviews and delineation of responsibilities. They direct attention at quality of care, and not just costs. The Medical Colleges have strongly supported these measures. For example, the Royal Australasian College of Surgeons has in place time-limited Recertification to maintain continued competence, based on mandatory Continuing Medical Education, obligatory keeping of an audit of outcomes, and peer review of performance. It defines the delineation of responsibilities in clinical practice, has checks on health factors affecting performance, has defined standards for surgical departments (complications review, for example), and has strict disciplinary measures. Other Colleges have similar procedures.

With respect to consumers, there has been an increasing role in demanding information, informed choices and evidence of accountability; they interplay with

providers in assessing the reasonableness of costs (with the Insurer in premium costs, with professionals in the degree of co-payment, etc); with the part they should play in decisions about resource allocation; and through the ballot box in support or otherwise of Government policies of priorities. The simpler the Health scheme, the more readily will it be understood, the more realistic will be the public's expectation of what is possible, and the more effective and responsible will be the input.

14. Resource Allocation

All parties should play a part in resource allocation of priorities, especially for new or expensive high technology, and for the serious ethical questions of life support in special circumstances (e.g. for severe congenital anomalies, for the very elderly, in Intensive Care Units, etc). New Medicare involves this shared responsibility; it is not just a medical responsibility:

- of doctors, to advise on the basis of genuine medical advances, predictability of outcomes, effectiveness of treatment options, audits, cost-benefit.

- of ethicists and pastors.

- of hospitals, on what they can afford to pay.

- of Insurers, on what they can afford to pay as benefits.

- of consumers, on their stance on the ethical questions, on their conception of the cost priorities, on what they are prepared for the community or themselves to pay, on the strength and influence of pressure and lobby groups.

- of Government, on what it is prepared to pay as the subsidy to insurance, on funding of special services for complex treatments and for the consequences of long-term survival.

- of Area Boards, on the strategic planning and distribution of special units, hospitals and services.

Resource allocation is a total community responsibility, and it is the interplay of all groups that should determine what is realistically possible. No-one denies the difficulty.

15. Hospital Admission Rates

Admission rates and length of stay should be minimised by:

- Analysis of the audit of outcomes of alternate methods of treatment. This is an ongoing process, not definable by a one-off set of "practice guidelines" as advocated by some non-clinically trained Health economists, but always evolving, and continually coming under review by the quality assurance committees of hospitals.

- The encouragement of Day Procedures.

- The provision of hostel-type accommodation for country patients for pre-admission investigations.

- Maximum pre-operative work-up outside hospitals and minimum stay before surgery.

- The provision of better after-care facilities, such as purpose-built centres, nursing home accommodation, better use of out-patient departments, and closer liaison with general practitioners.

16. Management Issues

1. - Co-ordination of Community Health Centres, Primary Care concepts, and General Practice.

2. The development of strategic plans for hospital development and supply of services, to reduce duplication in areas or regions including:

- Co-ordination of special units (cardiac, transplantation, etc).

- Co-ordination of diagnostics (CT, MRI, etc).

- Co-ordination between Public and Private Hospitals.

- Co-ordination with outreach services such as Nursing homes, after care, hospices, geriatric services, services for chronically handicapped.

- Co-ordination beyond the Teaching Hospitals.

- Co- ordination of capital expenditure.

Some of these ventures are currently under way.

3. All grants and budgeting should be on the basis of equity, efficiency incentives and rewards, quality of care, and be population based.

4. Improved management information systems, training and techniques, including for clinical professionals:

- Decisions based on accurate data.

- Budgeting techniques, DRG and Casemix and perhaps other systems.

- Regular consultation with clinical staff in all areas concerning patient care, before decisions are made.

- Flexible staffing, multi-skilling.

- Smaller semi-autonomous units in large hospitals, with delegation of authority.

5. Networking of services - laundry, catering, cleaning, maintenance companies.

6. Improved work environment

   - Conditions of service

   - Morale

7. Focus on quality assurance practices.

17. Rural Services

The Royal Australasian College of Surgeons is only one body trying to address the problems in rural areas. But, as an example, it has set up a special Division of Rural Surgery which recommends pre- and post-graduate vocational training for rural General Surgeons, including in this training, specialty training where areas are not yet serviced by specialists (Orthopaedic surgery, Urology, etc); increased training positions in specialties where there is a shortage; assisted training in surgery to General Practitioners in isolated areas; pre-Fellowship rotations of training to country hospitals; and supports other recommendations currently being considered by Federal Cabinet.

In addition, some direct funding may be necessary in rural areas with small populations, as the fees generated may be too small to supply adequate services, including professional salaries, hospital running costs, and transport assistance.

Consultation between Health Departments, Area Boards and Colleges is required to determine areas of need, shortages and maldistribution.

Bonding of medical students and perhaps postgraduates for rural service, in lieu of financial help during training is also being trialed.

Separate submissions should be sought from general practitioner organisations and other professional groups with services in rural areas.

18. Role of Government

With the redirection of medical and hospital services to either a single statutory National Health Insurance Fund or to the Private Funds under a National Health Insurance Commission, it is appropriate to suggest some new or altered roles for Government and Health Departments. The Health portfolio covers many areas outside direct medical care (the specific area of Medicare), so other established functions will continue. Although not a complete list, the important roles include:

- The determination and distribution of the subsidies to the Insurer to reduce the cost of premiums to consumers.

- Social polices which ensure that citizens have a *right* to health, and that Government priorities ensure that citizens have the capacity to pay for the services. This is not just "motherhood" platitude - Government philosophy must be convinced of the principle, otherwise no effective action will follow.

- Regulation of the Health Insurance industry to ensure adherence to the criteria of New Medicare Standard, agreement to the fees and rebates contracted in the Schedule, accurate information for consumers, and, if Private Funds are chosen as the insuring vehicle, that there is fair competition. The regulations will include prohibition of any arrangement by which the Insurer contracts exclusively with only a few nominated hospitals, to the extent of limiting the patient's right of choice of hospital; or interfere in clinical decision-making.

- Public health and quarantine services.

- Pharmaceutical services.

- Health Education, Promotion, and monitoring of health access.

- Community Health Centres, Primary Care Facilities, etc.

- Special services e.g. - Ancillary grants to Teaching and some Public Hospitals (see text, Section 9)

  - Supportive services (social work, infant and maternity centres, child abuse clinics, domiciliary nursing, etc)

  - Special services (STD clinics, AIDS, drug dependency, chronic disablement services, rehabilitation, nursing homes).

  - Geriatric services

  - Psychiatric services

  - Special support for rural areas.

  - Registration of professions through Professional Boards.

- Polices on workforce, medical immigration and distribution of services in consultation with professional bodies.

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APPENDICES

APPENDIX 1.

Where will the money come from?

The details of every State budget and Commonwealth outlays are extremely complicated, and every effort has been made to break these down into accurate figures, such as outlays for the Public Hospital system, the numbers of citizens receiving pensioner benefits, the age brackets of the population (with the number of pensioners, privately insured, and income levels, etc, in each bracket). The author has consulted widely on Government documents and Annual Reports in the portfolios of Consumer Affairs, Health, and Social Security, and on Tables published by the Australian Bureau of Statistics. Never-the-less the author concedes that there are some gaps and probable inaccuracies, simply because he lacks the facilities to research all the material. However, it is a firm belief that the overall thrust of the calculations is not far from the true situation and that the scheme is economically sound.

Income

In Models A and B, the "Insurer" - The National Health Insurance Fund – will be funded by: (a) The Medicare Levy = $7Bill.

(b) The money currently paid by Commonwealth and States as grants to Public Hospitals = $15Bill

(c) The money currently paid by Commonwealth to fund Medicare benefits = $8Bill.

(d) The money currently paid by Commonwealth to fund the 30% Private Insurance rebate = $2.4Bill.

Total = $32.4Bill. However, the current Levy raises $4.5Bill. so the total net outlay by Government is reduced by this amount. **Thus the total money available to the Insurer is $27.9Bill. and none of this is at any additional cost to government over present outlays**. It is a very substantial amount, sufficient to cover the extensive range of benefits of the New Medicare scheme.

In the New Medicare scheme the additional outlay for the Insurer over the current role of Medicare in paying medical benefits, is to pay for medical benefits *and* accommodation charges in Public Hospitals under the new arrangements for financing these Hospitals, and for accommodation in Private Hospitals - the latter currently covered by the Private Funds. The major sources to meet these additional costs will come from the above list of sources of funds. The Levy income is larger because the Levy rates are higher (apart from those on low incomes), and, because it includes the "insurance premium" equivalent to the premium currently paid by members to a Private Insurance fund, the consumer base will be 100% of contributors (less Health Card recipients), not just 40%+ as at present, the scheme being mandatory for all citizens.

Some saving to Government may come from some reduction in the bureaucracy of Commonwealth and State Health Departments, which will have less to do in administering Public Hospitals. On the other hand, there will be some increased costs in the expansion of Medicare offices to New Medicare Insurance offices to handle the

increased insurance arrangements, if Model A is chosen, partly offset by the deletion of all costs of the Private Insurance industry (at least a saving overall to the community), if the National Health Insurance Fund is the single insurance vehicle in Model A.

In Model B, where claims are made to the Private funds as agents, there is substantial saving by the deletion of all Medicare offices.

In Model C, there is no Medicare Levy so the total source of funds for the central pool is **$20.9Bill.** (see above figures for Models A and B) available for subsidies as described on page 14. In addition, in this Model, assuming the community rated private insurance premium to each Private Fund is held at $600 per member, the Funds have a collected *potential* income from premiums of **$6Bill.** (calculated as 10 million single members paying the premiums – 4.31 million Health Card recipients and 5 million children paying no premiums). However, as discussed on page 14, if tax offsets are introduced to lower the costs of premiums to low income families, this "potential" income will be reduced to about **$5.0Bill**. The total funds are therefore **$25.9Bill.**., slightly less than in Models A and B.

Hospitals

In 2002, there were 1051 hospitals in Australia, of which 62% were Public, i.e. approx. 650. To support these Public Hospitals, the Commonwealth contributed approx. $6.5Bill. in grants to the States for this purpose. (In 2003, the Commonwealth has made an offer to increase this to over $8Bill. annually). The States and Territories contributed an additional $9Bill. The current total combined figure is at least $15Bill. Obviously, some of these hospitals are small, with annual budgets costing less than $2Mil., others are huge, costing well in excess of $150Mil. annually, and this money currently finances the accommodation charges of public patients, the medical, managerial, lay, and other professional salaries, the costs of many diagnostic, therapeutic and non-medical services, and a host of other costs. It is proposed that the bulk of these costs will be covered by the charging of full realistic fees by the hospital for accommodation, theatre, and other service fees, (as is done in Private hospitals), and charged against the patients' insurance. In addition, the medical and other professional costs, salaries, entitlements, etc, will no longer be the hospitals' responsibility, but paid directly by the provider from fees collected on a fee-for-service basis. However, as discussed in the main text, Sections 9 and 18, there are some costs which cannot be collected on a fee-for-service principle in many public hospitals, and a moiety of direct funding by Government will be required for these. I assess that this moiety is about 20% of total hospital costs.

Thus, as an example, take a 450-bed major Public Hospital, currently costing a State Government a budget of about **$170Mil**.annually. The maximum income **under an insurance system** at full occupancy can be expected to be as follows:

450 beds at $650 per day = $107Mil.annually
theatre and other charges = $50Mil.annually
direct moiety from Govt. = $35Mil. annually (i.e. 20% of total costs)

Total = $192Mil.

Hospitals seldom run at full occupancy, but this calculation certainly suggests that an insurance system would more than cover current running costs with a positive balance of up to $22Mil over the present system. It could enable this hospital to restore and expand a number of services denied in the present system.

Medical Benefits and Hospital charges

In Models A & B, these will be billed against the insurance vehicle, the National Health Insurance fund, the latter having a projected income of **$27.9Bill.** This a very significant amount, considered sufficient to meet all the claims for the Standard Table as defined for New Medicare, even allowing total insurance cover for the 4.31 million Health Card recipients who pay no Levy, and even after deducting 20% ($3Bill. from the current $15Bill. of Government grants) as continued grants to Public hospitals for specific purposes as in Sections 9 & 18. (The current Private Insurance income is only about $4.5Bill., and yet it meets the major costs of claims in private hospitals). The net income available for the Fund to meet all Standard claims is therefore **$24.9Bill.**, which works out that every one of 14.31 million individual members of the Fund (i.e.10 million non-Health Card paying contributors, plus 4.31 non-paying Health card recipients; 5 million children under 16 are covered by one or other contributor) are each effectively insured for a "premium" of **$1,740** each, assuming that all contributors were single, *more than double the premium currently collected by a Private Fund in a top Table for a single contributor.* This figure should be sufficient to fund all the extensive benefits of New Medicare.

In Model C, which uses Private Insurance Funds exclusively, and there is no Levy, the figures are slightly less satisfactory. As discussed above, the income to the Funds will be **25.9Bill.**, less $3Bill. reserved for the direct moiety to Public hospitals (the 20% for non-fee-for-service costs), leaving a balance available of **$22.9Bill.**

Each member of 14.31 million members of the Funds is therefore effectively insured for a "premium" of **$1,600,** assuming that all contributors were single – not quite as much as in Models A and B, but *still almost double the premium currently collected by a Private Fund in a top Table for a single person.* In this Model, the 10 million contributors are each paying an actual premium of **$600,** and 4.31 Health Card recipients are paying **nil**. The Funds, however, are being subsidized by an *average* additional $1,000 per member from the central pool, providing the $1,600 in toto per person to meet the insurance claims. Compared with the figure in Models A and B ($1,740) there is slightly less of a margin to meet all the extensive benefits of New Medicare.

(These figures compare with the present arrangement, in which the Private Funds receive about $4.5Bil. annually – approx. 4 million single contributor units, paying on average about $1125 each in premiums. There is substantially more money available in the New Medicare scheme, but this is necessary to provide the much more extensive benefits in the scheme.)

The scheme is therefore cost-neutral to the Governments' present commitments, yet provides greatly increased cover in medical services and in both Public and Private hospitals.

APPENDIX 2

Medical Billing Procedures

The arrangements for medical billing involve several concepts of shared responsibility. Billing must be such that both provider and consumer are made conscious of the real costs of health care.

1. Fee-for services will apply for all medical services, both within and outside hospitals, and for accommodation in hospitals, and the accounts will document these costs, so that real costs are identified and understood by patients.

2. Billing is direct to the patient, re-affirming that the *correct relationship of the contract is between doctor and patient*, not between doctor and a third party. The recovery of costs is between patient and third party. Even when a patient is bulk-billed, a full account of the services rendered should be provided to the patient.

3. There should be a small co-payment patient moiety to pay, except for those defined for bulk-billing (see Section 11) and for patients in Public Hospitals, to discourage over-servicing and over-utilisation of services, and to inform the patient of real costs. Hence, New Medicare Standard pays only a 90% benefit for medical benefits outside hospitals, and for private patients in hospitals. Supplementary insurance is an option to meet this gap.

4. Bulk-billing will apply to several services and are fully described in Section 11.

5. In some rural areas, especially with small populations, some funding by Commonwealth/State over and above the fees generated may need to be provided to pay for the services necessary, including professional salaries, running costs of hospitals, and special services.

Public Hospital billing procedures

(a) Accommodation charges. For patients in *shared* wards, both public and private patients, where accommodation costs are 100% recoverable on insurance, it would seem an unnecessary step to bill the patient, who then claims on insurance, and then pays the bill. The hospital should simply bill the Insurer direct, i.e. *bulk billing, with a copy to the patient to inform of the costs of care.* This is probably not possible with private patients in *single* hospital rooms, etc., as this would require a knowledge of the supplementary insurance held by the patient, without which there would be constant confusion.

(b) Medical services. With the fee-for-service principle, billing procedures are more complicated in the public hospital system than in private practice, because of the large number of individuals involved in patient care, and the involvement of resident medical staff. It is important that ethical principles are maintained in that a relationship is established with the patient, a direct service is rendered and identified, and because the patient receives a copy of the account, the names of attending professionals must appear to whom the patient can refer. Public patients have the same rights as private patients. The following suggestions are made:

1. Deletion of the requirement of Notice of Referral or Letter to a Specialist. Most staff are Specialists, and *many patients will be admitted without referral.* That a Letter of Referral could be written by the Casualty staff is quite spurious.

2. Doctors and other professionals may bill as individuals, or where the services are provided on a "unit" or team basis, it will be appropriate to bill in the name of the unit, provided the names of the attendants are nominated.

3. As set out in "New Medicare Standard", the medical fees charged to public patients are mandated at the rebate level (90% of the Schedule). This is because the service is necessarily less personal (because of the many staff), and the patients are not referred personally. *For public patients, all medical services should be bulk billed at the rebate level* to lesson the burden of paper work for them; however, it is important that *the patients are sent a copy of the account for services* to allow them to be aware of the costs involved and to maintain the correct relationship between patient and attending staff.

The relation with private patients is more direct and personal and the Schedule fee is more appropriate, sent directly to the patient.

4. On receipt of the fee, it is an internal matter for the consultant staff to decide how it will be distributed. It may be to an individual, case by case for services rendered, or as a pooled fund to supply salaries, sessions, on-call, recall, leave, long-service, superannuation, sick leave, secretarial services and research. *Remember that, in the New Medicare system, neither the hospital nor the Government are responsible for salaries or other perquisites of employment, and, as in private practice, these and perquisites must be supplied from income received from fees.*

5. Similarly, the actual billing and secretarial services may have optional mechanisms, done through private rooms or set up within the hospital.

6. Full-time staff will be paid by the hospitals (under Award conditions) (See Item 9 in the main text - Government role in providing funding); but as some of these will also be billing on a fee-for-service, part or all of the fees received will be applied to make up part of the salary on an agreed formula.

7. RMOs have a dual function partly in providing, as an employee of the hospital, a service for the hospital, and partly as a direct participant in providing a

medical service (e.g. admission, discharge, procedures, night cover, etc). The salary should be made up as a hospital moiety and contribution from fees collected by medical staff. RMOs should not be able to bill themselves, but identifiable and individually rendered services should be billed in the name of the unit.

8. Out-patient, Accident and Emergency, and ICU services should attract fees for services rendered, and be fully recoverable for all patients.

9. Certain services may be excluded from attracting fees (see Item 9 in the main text), and will require separate funding direct from Commonwealth/State grants.

APPENDIX 3.

The Origins of the New Medicare Scheme

In 1987, while supporting the principles of Medicare, the Royal Australasian College of Surgeons proposed to Government and Opposition in written and oral submissions to Health Ministers, a number of suggestions to redress the imbalance between public and private sectors, restore equity, provide competition, and make private insurance affordable by Government subsidisation of insurance premiums. It expanded these principles in a Submission to the Senate Inquiry in 1989.

Independently, Bernie McKay & Associates had also suggested a subsidisation model (6) and a method of financing it. In addition, McKay in the same paper developed an innovative concept of competition in the funders as a major stimulus to reform, called "The Australian Competitive Health Plan", a plan which has not received due recognition. Acknowledgment is made to this author for this major contribution. In a second important analysis (5), for the Australian Health Ministers' Advisory Council and the Macklin Review in March 1991, Bernie KcKay & Associates deal with management issues.

The initial drafts of the following New Medicare scheme (I originally called it "Medishare" to emphasise that Health involves a shared responsibility amongst a number of players, and later it was called "Extended Medicare") were developed and written by the author, (E Durham Smith), while President of the Royal Australasian College of Surgeons (1987 - 1989), and Executive Director of the College (1989 - 1992), on behalf of the other Medical Colleges, for a combined Submission to the Macklin National Health Strategy Review in 1991. It drew partly on McKay's ideas of weighted subsidies, although covered a much wider spectrum, and was supported by a number of position papers solicited from individuals in the Royal Australasian College of Physicians , the Faculty of Anaesthetists, and several other Medical Colleges. These position papers were a major a source of background information, emanating as they did from eminent and experienced medical professionals.

Since then many changes have taken place in Medicare and in society and those early submissions now do not apply. The present paper, **upgraded to November 2003**, has changed in many details from those earlier drafts and must be considered a

completely new document. It is a personal document, not related in any way to the views of any of the current Medical Colleges, nor to the Australian Medical Association, nor to any Political Party, and does not purport to represent these views in any way. The author is retired from practice and holds no office in any of these bodies.

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