COMMONWEALTH OF AUSTRALIA

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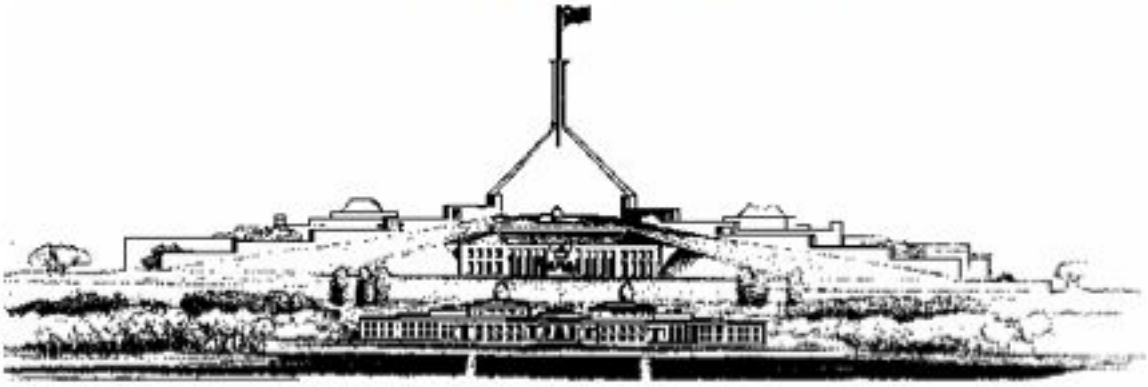

THE SENATE

COMMITTEES

Medicare Committee

Report

SPEECH

Wednesday, 11 February 2004

BY AUTHORITY OF THE SENATE

SPEECH

Date	Wednesday, 11 February 2004	**Source**	Senate
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Questioner		**Responder**	
Speaker	McLucas, Sen Jan	**Question No.**	

Senator McLUCAS (Queensland) (10.08 am)—I present the second report of the Select Committee on Medicare entitled *MedicarePlus: the future for Medicare*, together with the *Hansard* record of proceedings and documents presented to the committee.

Ordered that the report be printed.

Senator McLUCAS—I seek leave to move a motion in relation to the report and also seek leave to allow debate on the report to exceed 30 minutes.

Leave granted.

The DEPUTY PRESIDENT—I understand that informal arrangements have been made to allocate specific times to each of the speakers in today's debate. With the concurrence of the Senate, I shall ask the Clerk to set the clock accordingly.

Senator McLUCAS—I move:

That the Senate take note of the report.

It is with much pleasure that I present the second report of the Select Committee on Medicare with an erratum picking up on two amendments that were made in the drafting of the report. Late last year the Senate reinstituted the Senate Select Committee on Medicare and asked us to inquire into the government's new proposals for changes to Medicare. Some Liberal senators have suggested that there was no need for the inquiry. The fact that 100 submissions were received over the Christmas period, when people are by and large taking leave, tells me not only that Australians agreed that it was important to scrutinise the government's proposals but that they were prepared to give up time during a busy time of the year to engage in the debate about the funding of our health system.

Overall, there were mixed reactions from the community to the package, but widespread concern remains about the underlying policy direction of the government. The set of proposals from the government include: the introduction of two safety nets, a $5 incentive to doctors to bulk-bill, a series of work force measures and measures to increase access to GPs for those in aged care facilities. The work force measures and the proposal to increase access to GPs for people in aged care facilities are generally welcomed, although the committee did express some reservation about the availability of doctors and nurses to fill the places identified. These matters are covered in chapters 4 and 5 of the report.

The two elements of the package that we spent the most time considering were the proposal for a series of safety nets and the $5 incentive to bulk-bill concession card holders and children under 16. It is important to assess these two components as related elements and to look behind them to the philosophical basis on which they are made. Whilst it is recognised that health costs for a growing number of Australians are increasing, it is the view of the committee that the government's proposal for a safety net is flawed for both philosophical and practical reasons. Firstly, it moves Medicare away from its first principle of universality—that is, health care should be available to all on the basis of health need not capacity to pay. The safety net proposal creates two classes of people on the basis of income. There will be those who are eligible for an 80 per cent rebate of all out-of-hospital out-of-pocket expenses after they have spent $500 and then there will be another group who gain eligibility for the rebate after they have spent $1,000.

These classifications of people bear no relation to the health needs of those individuals and families and would undermine the simplicity and fairness of Medicare. Many of the submissions identified this fundamental shift in the way Medicare is administered. The Queensland Nurses Union expressed it in this way:

... the overall thrust of the package is towards a residual rather than universal model of health care with a greater emphasis on individual (financial) responsibility through co payments rather than a societal or collective responsibility for the health of a nation through our taxation system.

Along with these philosophical problems, there are significant practical problems inherent in the proposals for the safety nets. It is evident that the proposed thresholds are too high to deliver real benefits to many Australians. The government's figures identify that barely 200,000 families and individuals will be covered by the safety net. Mr Abbott will say that 12 million families will be eligible for the safety net, but I say, to quote the government senators' report, he is being `loose with the truth'. Australians will not be duped by his language.

The government senators' report makes much of the cost of this proposal. I agree with them that $266.4 million over four years is a lot of money, but it is not well targeted. It assists only a small number of families and individuals with the very highest of health costs. Further, it is very expensive administratively. Some $71.5 million or 26.85 per cent of the program will be spent on administration—not on improving Australia's health but on forms, computer programs and the like. These costs will be largely ongoing. It is a clumsy, poorly designed program reflecting the haste in which it was developed. A further problem is the proposed link to the family tax benefit A. The government proposes that recipients of family tax benefit A be eligible to access an 80 per cent rebate after the family has spent $500.

The Commonwealth Ombudsman recently undertook an inquiry into the operations of family tax benefit A following an extraordinarily high number of complaints about its operation. The Ombudsman appeared before the inquiry and raised two areas of significant concern. Firstly, family tax benefit A's inherent reliance on income estimation by families has led many families into debt with the Australian Taxation Office. Linking fair and simple Medicare to this complex and confusing tax benefit system is simply not good public policy. Secondly, and importantly, there is the discrimination against those without children that is inherent in the policy.

As I said earlier, the government's proposal provides no measure of health need in order to deliver health services. This is extremely evident when you look closely at who will be caught in the safety net and who will not. A family with one child, earning $84,500, will be eligible for the $500 safety net, but a single person—potentially a single person with a chronic illness—earning under $20,000 has to spend over $1,000 in order to receive assistance. A family of three which is eligible for family tax benefit A in the same circumstances, whose child turns 16 and moves to youth allowance, moves on the child's birthday from a threshold of $500 to $1,500.

Many witnesses and submitters spoke of the potential inflationary effects of the safety net proposal. Their concerns were shared by the committee. The proposed safety net sends no signal to the medical profession, notably specialists, to contain fees. In fact, the departmental representative appearing before the committee made it very clear—he said that the signal to specialists was `business as usual'. The system proposed includes the uncapping of out-of-pocket costs incurred by patients. That is, irrespective of the gap charged by specialists especially, 80 per cent will be covered by the safety net. The government has shown no leadership in trying to contain specialist costs. Rather than send a message that is essentially `charge what you want, we'll pick up the bill', wouldn't it make more sense to begin to negotiate with specialists groups to honestly and openly come to an understanding about real costs of practice and, as a result, sensible remuneration levels? The committee makes a series of recommendations to that effect at paragraph 3.3.

GPs have been pressured, through the focus on their billing arrangements, to keep costs down. But this pressure has not been applied in any way at all to sections of the specialist sector. The committee therefore recommends that the proposed safety net contained in the Health Legislation Amendment (Medicare and Private Health Insurance) Bill 2003 be rejected in its current form. We are rejecting it not only because the safety net is clumsy in design, not only because it is complex for consumers, not only because the safety nets are poorly targeted—missing many who need assistance and collecting some who do not—but because it is based on the wrong principles. It is based on the government's view that there can be two types of access to health services and the principle that health care can be treated as a welfare program.

That is not Medicare. That is not the fair, simple and universal Medicare that all of us in this chamber know that Australians understand and value. I urge senators who are contemplating negotiations with the government at the moment to take extreme care. Australians know that the Howard government has always wanted to dismantle Medicare. Independent and minor party senators need to ensure that the first principle of Medicare—that is, its universality—is preserved.

My colleagues Senator Forshaw and Senator Stephens, whom I wish to thank for their participation in the inquiry, will address other elements in the package later in this debate. Again, I thank other members of the committee—Senator Knowles, Senator Barnett, Senator Humphries, Senator Lees and Senator Allison—for giving up a lot of their Christmas holidays to participate in the inquiry. Finally, I thank the secretariat for the

work that they have done, probably when they were wanting to have a Christmas holiday—Jonathan Curtis, Tim Watling and Hanna Allison—and for their hard work, cheerfulness and great advice.