Australian government moves to dismantle Medicare bulk-billing

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Under the guise of safeguarding the present Medicare health system, the Australian government has unveiled a plan that takes another substantial step toward dismantling it. Prime Minister John Howard's cynically named "MedicarePlus" package, announced on November 18, is designed to rapidly accelerate the destruction of the scheme's primary feature: the ability of ordinary people to see a doctor without charge.

At the centre of the government's claims is that MedicarePlus will provide families with a "safety net" by eventually reimbursing them for 80 percent of their out-of-pocket expenses for medical services outside hospital, once they have already spent $500 ($1,000 for higher-income families) in a year. But apart from the extremely limited nature of the supposed safety net, the very concept underlines the essential aim of the government's scheme: to eliminate what remains of universal access to free doctor's visits.

Millions of working people, already financially squeezed dry, will be forced to pay upfront for basic medical care. Medicare "bulk-billing," a system whereby doctors and medical clinics could send their patients' bills direct to the government, will be reduced to a residual system catering only for Health Concession Card holders, the very poorest members of society.

At the same time, the scheme will further undermine the foundations of the public health system by boosting the coffers of the already highly-subsidised private health insurance funds, pharmaceutical giants and private medical operators. Faced with the prospect of mounting medical bills, more and more people will feel compelled to take out expensive private health insurance.

Every opinion poll and other measure of popular sentiment shows the disastrous state of the health system, followed by the deteriorating state of public education, to be one of the major concerns of ordinary people. After years of deliberate government under-funding of public health, access to free care has been increasingly constricted. By eroding the level of fees paid for bulk-billing, growing numbers of doctors have been driven to charge full, up-front fees. Because public hospitals have been starved of adequate funds, their wards are hopelessly over-crowded and waiting lists have grown longer and longer, so that patients who are not privately insured must wait months for basic surgery.

Fearing an electoral backlash in next year's scheduled federal election, Howard and his newly-appointed Health Minister Tony Abbott have gone to great lengths to portray MedicarePlus as an improvement on the government's previous "Fairer Medicare" scheme, released in April. That package provoked such deep opposition that Abbott's predecessor Kay Patterson proved incapable of pushing it through the Senate, where the government does not have a majority.

However the fundamental purpose of Abbott's revamped plan remains exactly the same: to bring to an end the past period of almost three decades in which working people, for the first time, had some guarantee of access to medical care, free of crippling financial burdens.

Medicare is basically a government-run insurance scheme, partly funded by income tax levies, that covers the cost of treatment in public hospitals, as well as 85 percent of an "arbitrated schedule fee" for visits to GPs and 75 percent for in-patient services in private hospitals. It also covers a limited range of other essential medical treatment, notably eye-tests, X-rays and blood tests. Patients are universally entitled to reimbursement of these fees. But for ordinary people, Medicare's most important feature is that they can effectively obtain free treatment from those doctors who opt to "bulk-bill" the government and accept the 85 percent Medicare fee as payment in full.

The adoption of Medibank, Medicare's predecessor, by the Whitlam Labor government in 1975 marked the highpoint of social reformism in Australia. Under the system of private health insurance that prevailed until then, 17 percent of people had no health cover at all. In some Australian states, the most common reason for going to jail for debt was failure to pay medical bills.

Universal health coverage was one of the central pledges made by Whitlam's government, elected in 1972 after 23 years of Liberal-National Party rule. In reality, Medibank fell far short of that. It amounted to a subsidy for private fee-for-service medicine, whether provided by individual GPs, group practices or high-volume medical clinics.

Whitlam claimed it was impossible to adopt a British-style system of salaried medical services because of a constitutional prohibition on "civil conscription" for doctors. That ban was inserted in the Constitution by a 1946 referendum, in which voters gave the federal government power to provide welfare payments, pharmaceutical benefits and medical and dental services. But, in a deal with the Liberals and the medical establishment, the Chifley Labor government agreed to include the proviso against "civil conscription".

Despite its restricted character, Whitlam's plan was fiercely opposed by the Australian Medical Association (AMA)—the main doctors' body—sections of business and the Coalition parties, which blocked it in the Senate. Labor was forced to call a double dissolution election in 1974 and then convene the only joint sitting of parliament in history in order to have the legislation passed.

It was the last major social reform covering the entire population to be enacted in Australia. After the ousting of the Whitlam government in the governor-general's Canberra Coup of 1975, the Fraser Liberal government quickly moved to abolish Medibank, provoking the first, and only, official one-day general strike ever called by the Australian Council of Trade Unions in 1976. Initially, the Liberals retained a watered-down Medibank Mark II, which went through several phases, involving a special income levy, reduced rebates for doctors and up-front fees. Finally in 1981, the scheme was restricted to pensioners, sickness beneficiaries and people meeting stringent means tests.

The resulting public hostility was a key factor in the election of the Hawke Labor government in 1983, which promised to restore Medibank. Labor's Medicare scheme, however, imposed a 1.35 percent levy on income and before long the government attempted to axe bulk-billing,

which grew rapidly from less than 45 percent of medical services in 1984-85 to more than 60 percent in 1990-91. The 1991 budget reintroduced co-payments for patients, but health minister Brian Howe was forced to reverse the measure in the face of widespread opposition.

The Labor government then effectively froze the level of fees paid to doctors, placing them under increasing financial pressure to abandon bulk-billing. Between 1991 and 1996, the "schedule fees" declined by about 10 percent compared to the consumer price index. Yet, many doctors did not impose additional fees and the bulk-billing rate continued to rise, from 65 percent in 1992 to over 70 percent in 1996.

When the Howard government took office in 1996, it continued Labor's freeze on schedule fees, which fell far below doctor's costs, intensifying the pressure to abandon bulk-billing. In 1999, the Liberals went further, introducing a 30 percent subsidy—costing an estimated $3.7 billion a year—for those purchasing private health insurance. With public hospitals chronically under-funded, thousands of ordinary people were pressured into joining private health funds in the hope of avoiding both doctor's bills and lengthening hospital queues. The proportion of people privately insured rose from around 30 percent to nearly 45 percent, but it has since fallen back to 43 percent as premiums have soared despite the subsidy.

Over the past four years, the proportion of GPs bulk-billing has fallen from 73 percent to 67 percent nationally. Bulk-billing rates remain higher in the inner suburbs of major cities, primarily because super-clinics push patients through consultations in as little as five minutes. In many rural and outer suburban areas, bulk-billing doctors have become almost impossible to find. Victoria's Goulburn Valley is officially the lowest bulk-billion region, with a rate of just 30.2 percent.

There is ample evidence that, as a result, out-of-pocket medical expenses—which rose by more than 40 percent on average in the six years to March last year—are discouraging some sick people from seeing a doctor. A Commonwealth Fund survey in 2002 found that 16 percent of sick adults said they did not receive medical care because of its cost and 23 percent did not fill a pharmaceutical prescription for the same reason.

Health economists have predicted that MedicarePlus will swiftly cut the bulk-billing rate to as low as 40 percent. It will do this in several ways. First, the government has lifted the bulk-billing fee paid to doctors by $5, but only for Health Concession Card holders and children under 16. Only welfare recipients and workers earning about 25 percent less than the minimum wage have health care cards. Even shop assistants and hospitality workers, Australia's lowest-paid workers—on $684 a week before tax—no longer qualify because the government's means test has fallen far behind the cost of living.

Second, the increase in the doctor's fee from some $27 to $32 is far too small to encourage doctors to keep bulk-billing, even for the poor. The government's own Relative Value Study, conducted jointly over five years with the AMA, assessed a 15-minute GP consultation to be worth $48.50. Studies have shown that the average co-payment ("gap") fee being charged by doctors who have ceased bulk-billing is over $13, more than twice the $5 rise. Many doctors who have retained bulk-billing up until now, out of loyalty or sympathy for their patients and in the hope that the government would restore rebates to financially viable levels, are likely to start charging up-front fees.

Third, doctors may be enticed to abandon bulk-billing, and raise their fees, by the knowledge that the government has established a so-called safety net for patients. This "safety net" is largely a mirage, because few families will see a doctor the estimated 30 or more times a year needed to reach the $500 threshold. In fact, the government's own estimates are that only 200,000 people—about 1 percent of the population—will pass the limits in 2006-07. Even so, doctors will feel justified and able to lift their fees, given that the government will ultimately reimburse patients with large bills.

Those who do benefit from the 80 percent reimbursement of high medical bills will tend to be wealthier patients who can afford high-priced treatments. The underlying requirement to pay the remaining 20 percent of bills will remain a heavy burden on low and middle-income earners.

Expensive specialists and private clinics are particularly expected to profit from this scheme. This will, in turn, help speed up the privatisation of the health industry. Private health funds and hospitals will also have their revenues boosted by the accelerated decline of general bulk-billing, as more people feel obliged to privately insure themselves to cover expenses. Those who do so are exempted from an additional Medicare levy on higher income earners, further draining funds away from the public system.

MedicarePlus will intensify the strain on the public hospital system. Already, unable to find bulk-billing doctors, tens of thousands of people have been compelled to turn to public hospital emergency departments, where treatment is still free. This trend has been worsened by a 28 percent decline in after-hours GP services and home visits since 1997—another impact of the freeze on bulk-billing fees.

According to Tony O'Connell, chairman of the New South Wales Critical Care Committee, emergency departments in NSW alone have experienced an annual increase of 40,000 "purely GP-type attendances," with more than 15,000 patients a year simply requesting medical certificates and repeat prescriptions. NSW health officials told a Senate inquiry that one in five patients visiting public emergency departments had minor complaints that should be treated by GPs. In NSW rural towns where there was no bulk-billing, people accessed emergency departments 60 percent more than in towns that had bulk-billing.

MedicarePlus will create a three-tier medical system, with treatment determined primarily by wealth, not health. At the bottom will be society's poorest and most vulnerable people, dependent on over-stretched public hospitals and whatever bulk-billing services remain. In the middle will be working families trying to find the money to pay medical bills. At the top will be those with ample resources to buy comprehensive private insurance.

The Howard government's plan will progressively undermine what is left of Medicare by letting loose market forces that will inevitably drive up medical costs. Increasingly, the health system will resemble that of the United States, where the private and corporate practice of medicine has sent health care costs soaring to some 15 percent of gross domestic product, compared to about 9 percent in Australia (already up from 8 percent over the past seven years because of creeping privatisation).

Before long, the government will insist that further the gutting of public health is needed in order to "save" Medicare. As the *Australian*'s Paul Kelly noted: "The health package is a short-term fix. There is one certainty: two or three years down the track, the system will demand its next fix."

The Howard government has only been able to make these attacks on the public health system because of Labor's complicity. Howard and Abbott are cynically exploiting the inroads into bulk-billing and public health services already made under Labor. They are simply taking to its logical end the process commenced by the Hawke and Keating governments—slashing public health care and handing it over to profit-making concerns.

If Labor were in office, it would do little differently. Conscious of the popular hostility to the devastation of public health, Labor claims to oppose the government's measures. But it has proposed only marginal increases in bulk-billing fees, which would ensure Medicare's continued creeping death. To appease the private health industry lobby, Labor has pledged to maintain the private insurance subsidy, rather than re-direct the funds to public hospitals.

Together with the minor parties in the Senate, Labor has sought to refer the MedicarePlus plan to a Senate inquiry, which may delay the scheme but do no more than make minor alterations. This can be seen from

proposals of the Australian Democrats. They are seeking to rescue the government's package by lowering the "safety net" threshold to $300 and extending the $5 bulk-billing incentive to all patients. These amendments would do nothing to alter the plan's thrust, or its human cost.

Not one of the parliamentary parties proposes a return to Medicare's promise of universal health coverage, let alone any extension to the array of essential services that were never covered by Medicare, such as dentistry, physiotherapy, podiatry, occupational therapy and counselling. None will challenge the profit system, which has proven incapable of providing for the needs of the vast majority of the population.

What is required is an independent political movement of the working class based on an alternative socialist program that rejects the subordination of every aspect of economic and social life, even the most basic necessity of decent health care, to the dictates of corporate profit.

Free, high quality health care must be a fundamental social right. For that to happen, it must be taken out of the hands of the profiteers, health care monopolies, insurance houses and drug companies and placed under social ownership and the democratic control of the working people.