Australia: “MedicarePlus” aims to kill off Medicare

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With the help of four so-called “independent” senators, the Howard government finally got its “MedicarePlus” plan through parliament last week, nearly a year after the release of its original “Fairer Medicare” package. Health Minister Tony Abbott triumphantly declared it a “watershed moment for Medicare.”

His comments betray the fact that, despite agreeing to spend an additional $427 million on the plan over the next four years, the government’s purpose remains the same: to speed up the demolition of the present Medicare health insurance system. Above all, it seeks to kill off the last remnants of Medicare’s most important feature for ordinary working people—their ability to see a doctor without charge.

Abbott’s package was the government’s third attempt in a year to push its measures through parliament. That the government and its Senate partners felt compelled to triple the original budget allocated to the package—from $917 million last April, to $2.4 billion last November to $2.85 billion now—is a measure of their concerns about the public’s response.

Years of chronic under-funding by successive governments, combined with the deliberate running down of the levels of Medicare rebates paid to doctors, have already devastated the health system. In many regions of Australia, especially in rural and outer-suburban areas, it has become almost impossible for working people to find a GP who still “bulk-bills,” that is, bills the government for consultations instead of charging patients a fee. Those seeking free treatment in public hospitals face long waiting lists, while conditions inside the cash-starved hospitals have deteriorated, producing a wave of avoidable patient deaths.

This disastrous decline has generated deep popular outrage toward those responsible—federal and state governments, both Liberal-National Party and Labor. The Howard government is scheduled to call an election this year. Hence, Abbott’s desperation to stitch up an agreement that Prime Minister John Howard’s administration could cynically present as an “improvement.”

Medicare and its predecessor, Medibank, introduced in 1975, have never provided a free, universal health care system. Medicare is a government-run insurance scheme, partly funded by income tax levies, that covers treatment in public hospitals and 85 percent of “schedule fees” charged by GPs and a limited range of other treatments, including X-rays, pathology and eye-tests. Those doctors and services that “bulk-bill” the government accept the 85 percent fee as payment in full.

MedicarePlus’s centrepiece consists of a minimal “safety net” for families and individuals. They will be reimbursed for 80 percent of their out-of-pocket medical expenses, once these have reached $300 ($700 for middle and higher-income families) in a year. These thresholds have been lowered marginally from $500 and $1,000 respectively from last November’s package.

By the government’s own calculations, only five percent of the population will benefit from this “safety net” once their medical expenses reach these amounts. These patients—typically the elderly or chronically-ill—will be left bearing 20 percent of their costs, which may be massive.

More fundamentally, the very notion of a safety net demonstrates the underlying thrust of the scheme: to eliminate what is left of general access to free doctor’s visits. Nationally, the proportion of GPs bulk-billing has already fallen from 80.6 percent to 65.7 percent since 1996, mainly because the government’s bulk-billing “schedule fee” paid to doctors has been frozen at around $25. This fee is just over half the government’s own Relative Work Study estimate that a 15-minute GP consultation is worth $48.50.

GPs who nevertheless have kept bulk-billing, usually out of a sense of professional responsibility or sympathy for their patients, have been forced increasingly to abandon the practice for economic reasons. Bulk-billing rates in Adelaide, for example, plummetted from 78 percent to 62.3 percent between 2000 and 2003. In country areas, rates have fallen to as low as 30 percent.

Where doctors do not bulk bill, patients can face upfront fees of more than $50 for a standard GP’s consultation, and more than $150 for a specialist. They can later claim reimbursement from Medicare, but only for 85 percent of the “schedule fee”. For a specialist, the “gap” can exceed $50.

As a result, people are avoiding or delaying visits to doctors—at the risk of incalculable long-term health damage—or turning to over-stretched public hospital emergency departments. The total number of GP visits declined by 1.3 percent from December 2002 to December 2003. State governments have reported increases of up to 14 percent in the number of non-urgent or semi-urgent cases presenting to emergency wards over the past three years.

The so-called safety net will only accelerate these trends, by encouraging doctors to give up bulk-billing, comforted by the conception that their patients will be protected somewhat from high medical costs. Health economists have predicted that the bulk-billing rate will drop to 40 percent.

MedicarePlus is specifically designed to end general access to

bulk-billing. The package lifts the bulk-billing fee offered to doctors by $5 in major cities and $7.50 elsewhere, but only for Health Concession Card holders and children under 16. Health care cards are restricted to welfare recipients and workers earning 25 percent less than the minimum wage. Anyone earning more than $340 a week, which is far below the poverty line, does not qualify.

Bulk-billing will increasingly be regarded as a second or third-rate service, confined to the most impoverished layers of society. With fees set far below market rates, there is no guarantee that doctors will keep providing the service, even for children and concession card holders. Where they do, they will be under financial pressure to shunt patients through quickly.

The results will be catastrophic for working class people. The "gap" between doctors' fees and Medicare reimbursements could quickly soar from $50 to $150, the Doctors Reform Society (DRS) has warned. For families with children, many of whom regularly need medical attention, the costs could easily run into thousands of dollars a year.

"Most of our patients will not be bulk-billed because they are not pensioners and card holders," DRS president Tim Woodruff commented in a media release. "It means that many pensioners and health care card holders will not be bulk-billed. And for those who are bulk billed it means that they will be seen as second class citizens, unable to pay their way to decent health care, relying on doctors' charity."

The government boasted that the final package extended Medicare to some health services not previously covered. Chronically ill patients—those whose illnesses are expected to last more than six months—can be referred by their GPs to allied health specialists such as psychologists, physiotherapists, podiatrists and dieticians. But patients will be covered for a maximum of five visits a year, and only refunded $80 for the first visit and $35 for subsequent visits. These rebates will be well below the usual fees of up to $150. Annual bills for these services often exceed $1,000.

Patients whose chronic conditions are exacerbated by dental problems can have three dental consultations per year and collect a total rebate of $220. Given the high cost of dental treatment, this is little comfort. One media report, for example, noted the plight of a woman who needed $5,000 in dental work to repair the impact of bowel surgery on her broken and brittle teeth.

These extremely limited provisions only highlight Medicare's general lack of coverage of these essential health services. The "chronically-ill" test means that the dental program is expected to cover only 23,000 patients over four years, while the other specialist services are predicted to assist 150,000 patients—less than 1 percent of the population—over the same period.

Most of the extra $427 million pledged in order to secure the senators' votes was clawed back from public hospital salaries budgets. On the same day that the MedicarePlus deal was signed, the federal government cut its funding to the states to run public hospitals by $400 million. Under last year's federal-state hospital funding agreement, Canberra can vary its payments according to a wages cost index.

This robbing of public hospitals is on top of the $3.7 billion a year that the Howard government already diverts from the public health system to subsidise private health insurance premiums to the tune of 30 percent. Assisted by this handout, the private health funds have raised their premiums by some 20 percent over the past three years. Just a month ago, the government approved fee increases averaging 7.5 percent.

Now the "safety net" will give private medical clinics, hospitals and specialists a blank cheque to raise their fees more quickly. Facing mounting GP bills, and fearing second-rate treatment under what remains of Medicare, increasing numbers of people will feel obliged to purchase private health insurance. Since the subsidy was introduced in 1999, the proportion of people privately insured has risen from around 30 percent to over 40 percent. A further influx will, in turn, fatten the profits of private hospitals and other medical entrepreneurs. Market forces will be let loose, pricing high-quality health care further out of reach for most people.

Media outlets generally hailed the outcome, while insisting that the process of dismantling Medicare had to continue. "MedicarePlus ends the fantasy of unlimited, free universal health care regardless of the cost which Labor remains committed to—while in opposition, at any rate," an *Australian Financial Review* editorial stated.

Health Minister Abbott declared that his negotiations with the four senators displayed "democracy at its best." He claimed that what had been a good package had become even better, thanks to the "insights and persistence of the senators."

In fact, the deal demonstrates the worthlessness of the so-called independents, and the entire parliamentary establishment, in halting the decimation of public health. The four senators—ex-Labor representative Shayne Murphy, right-winger Brian Harradine, One Nation's Len Harris and former Australian Democrats leader Meg Lees—have assisted the government to cobble together a package that will accelerate Medicare's creeping death.

None of the parliamentary parties proposed any return to Medicare's original promise of universal health coverage, let alone any guarantee of access to free, high quality health care as a basic social right. The Australian Democrats expressed their dismay that Abbott had walked away at the last minute from striking a deal with them, which offered a similar $5 rise in the bulk-billing fee.

Likewise, the Labor Party proposed only marginal increases in bulk-billing fees, claiming, without any evidence, that this would raise the proportion of GPs bulk-billing to 80 percent. At the same time, Labor pledged to maintain the multi-billion dollar private insurance subsidy, rather than re-direct the funds into bulk-billing and public hospitals.