Policy Document

Universal Health Coverage for Australian Citizens and Permanent Residents

Background

The Australian Medical Students' Association (AMSA) is the peak representative body of Australia's 17,000 medical students. AMSA is committed to ensuring and advocating for the right to equitable opportunity. All Australians should be able to achieve their full professional and personal potential, including access to the best attainable health.

Health care systems seek to provide timely, quality services to populations. Whilst health care systems vary in structure from country to country, a robust health care system is characterised by sustainable financing mechanisms, reliable research, up-to-date facilities and a well-trained workforce. Primary health care is the first level of contact between service users and the health system, ensuring full coverage and equity of basic health care needs. Effective first point care results in equity of accessibility to secondary and tertiary care, preventing overuse or strain on such services.

The World Health Organisation (WHO) endorsed Universal Health Coverage (UHC) to allow all people to obtain the health promotion, prevention and treatment services they require without suffering financial hardship. UHC is assessed across 2 key components:

1. The proportion of the population with access to essential, quality health services
2. The proportion of the population that directs a significant portion of their household income towards health

Multiple countries, including Australia, are addressing UHC to meet increasing health demands and service costs. The social determinants of health (SDH) are the conditions of an individual’s life, location, age or environment which dictate their health status. SDH can interfere with an individual or population’s access to or calibre of UHC, compromising both health and the health care system.

Our Current Australian Healthcare System

Australia has a mixed public-private healthcare system that is subject to a range of funding and regulatory mechanisms. Affordable access to healthcare for all Australian residents is provided under the Health Insurance Act of 1973, while substantial private sector involvement enables a degree of individual choice. The Australian Federal, State/Territory and local governments share responsibility for health by acting as funders, policy developers, regulators and service deliverers.

Government Roles in Funding

The Commonwealth government is responsible for funding Medicare, Pharmaceutical Benefits Scheme (PBS), national immunisation programs, subsidies for aged care and private health insurance rebates. Meanwhile, State governments are responsible for managing public hospitals, funding of community and mental health services, ambulance and emergency services and patient transport schemes. Both the Commonwealth and State governments share funding for public hospitals and palliative care. Local governments play a role in providing environmental health services (e.g. sanitation) and community-based health and home-care services.
Instituted in 1984, the Medicare Benefits Schedule (MBS) universally subsidizes payments for hospital and medical services. The Medicare levy (the ‘Levy’) was introduced to enable the Australian Government to meet the costs for the universal national healthcare system.

The Levy is a progressive tax; the highest income bracket contributes 2% of their taxable income while the lowest income bracket is exempt. Some higher income individuals are required to pay an additional surcharge if they do not have an appropriate level of hospital cover from private health insurance. In May 2017, it was announced that the levy will increase from 2 to 2.5% from 1 July 2019, with the additional 0.5% being used to fund the National Disability Insurance Scheme (NDIS).

This income contribution guarantees public patients in public hospitals free treatment, whilst private patients treated in a public or private hospital can claim back 75% of the MBS fee. For out of hospital care, Medicare will cover 100% of the MBS fee for a general practitioner and 85% of the MBS fee for a specialist. However, doctors can charge above the MBS fee, and in those circumstances the patient will be required to pay the additional amount. As of 2017, threshold is $2056.30 for general patients, or $656.30 for concession card holders.

Pharmaceutical Benefits Scheme (PBS)

The PBS universally subsidizes payments for a high proportion of prescription medicines. A general patient pays a standard co-payment, while concessional patients pay a lower co-payment. These co-payment amounts are annually indexed to the Consumer Price Index. Additionally, different safety net thresholds exist to keep costs affordable for general and concession patients who purchase a significant amount of medications per calendar year. When the specific threshold is reached, general patients pay a concession rate, while concession patients receive the rest of their medications free of charge. As of 2017, the threshold is $1,521.80 for general patients and $384 for concession cardholders.

Australia compared to the rest of the world

From 2015-2016, the total health expenditure in Australia was 10.3% of gross domestic product (GDP), which is above the 2016 OECD average of 9.0% of GDP.

In 2017, the Commonwealth Fund healthcare system report saw Australia rank second overall out of eleven high income countries. The countries’ systems were measured on the basis of care process, access, administrative efficiency, equity, and health care outcomes. Australia is ranked first in administrative efficiency and health care outcomes.

Barriers to the Australian Healthcare System

Aboriginal and/or Torres Strait Islander peoples (ATSI)

Cultural barriers are one of the most significant obstacles to obtaining universal health care amongst the ATSI population. The ATSI population face several barriers to accessing quality health care. Remote and rural conditions, as well as socioeconomic disadvantage and cultural hindrances all play a part in reducing the accessibility of healthcare. These barriers produce across the board inequities between the ATSI population such as higher rates of child mortality, chronic diseases and lower life expectancy.

Cultural barriers encompass everything from conceptions of sexuality to differing understandings of health. The resulting miscommunication quickly leads to disengagement with the health system and reduced access to health care. Harmful assumptions about choices of care, attitudes towards health and racial prejudice all play a role in building these cultural barriers. Having a practitioner who does not share one’s background, upbringing or values, which is a common occurrence, further reduces feeling of cultural safety, especially with ‘white doctors’. 
Furthermore, lack of personnel hamper universal health access to the ATSI population: the ratio of Nurses to population in remote areas is half that of metropolitan areas.

Medicare Rebate Freeze

In the past, governments have introduced various ill-fated schemes attempting to reduce health expenditure, most notably the GP co-payment under the Abbott Coalition government. The proposed policy would add a $7 surcharge on all GP consultations, pathology tests and X-rays. The intended effect was to discourage patients from seeking unnecessary visits to the GP, thereby alleviating the burden from healthcare providers and restoring the health budget bottom line.

In 2013, the then Labor government introduced a temporary pause on MBS rebate indexation as part of a $664 million budget saving measure. This was reimposed by the Coalition government, with successive budgets extending the freeze until July 2020 in order to achieve $3.9 billion in savings. Following sustained pressure from the Australian Medical Association (AMA), Royal Australian College of General Practitioners (RACGP) and other medical lobby groups, the Coalition government announced the gradual reintroduction of MBS rebate indexation in the 2017-2018 Budget at a cost of $1.0 billion over four years; GP bulk billing incentives were to be indexed from July 2017, GP and specialist consultations from July 2018, specialist procedures and allied health items from July 2019 and targeted diagnostic imaging from July 2020.

Prior to the commencement of the freeze, MBS items were indexed annually in accordance with the Wage Cost Index and Consumer Price Index. This measure recognised and responded to increases in practice costs due to inflation. Such costs include personal income, wages for practice staff, medical equipment/supplies, utility expenses, continuing professional development, accreditation and insurance. MBS indexation, however, rarely covered the entirety of practice costs, accounting for the out-of-pocket expenses incurred by non-bulk billed patients. The pause on indexation froze the MBS rebate at $37.05 for standard GP consultations until 2020, exacerbating the financial strain already imposed by inadequate indexation.

As a result of the freeze, there are concerns that healthcare providers such as GPs would be forced to absorb the cost personally or pass it on to their patients. A 2015 RACGP survey found 57% of its members would increase out-of-pocket expenses for patients through either the curtailment of bulk billing and introduction of a co-payment (30%) or increasing out-of-pocket expenses for non-concessional card holders (27%). The freeze was therefore predicted to impact practices servicing lower socioeconomic communities most severely, as those with high bulk billed populations would be unable to transfer the excess cost onto non-bulk billed patients. As Professor Brian Owler, former president of the AMA, notes, "The Medicare patient rebate freeze extension means that health is going to cost more for all Australians, but particularly the poorest, the sickest, the vulnerable and the disadvantaged." Indeed, since the introduction of the freeze, out-of-pocket expenses for standard GP consultations have increased from $30.27 in the 2014 September quarter to $35.34 in the 2017 September quarter. This is concerning in light of government statistics showing 12% of Australians did not seek GP or specialist care because of costs, leading to poorer outcomes and increasing strain on secondary and tertiary healthcare systems.

Although bulk billing rates did experience an increase from 82.7% in the 2014 September quarter to 84.6% in the 2017 September quarter, this is likely a reflection of GP practices absorbing excess costs internally and/or increasing out-of-pocket expenses for non-bulk billed patients. It is unclear whether this upward trend would have continued over the period 2018-2020 had indexation not been reintroduced, or whether healthcare providers would have been forced to introduce co-payments for previously bulk billed patients in order to ensure sustained economic viability.

Position Statement

AMSA believes that:

1. Access to health services is a right of all Australians, regardless of financial, social or other circumstances;
2. UHC is an essential requirement for all people to achieve their universal human right to health and wellbeing;

3. UHC should be evidence-based, timely, and consistent in its high quality of service, regardless of financial, social or other circumstances

4. UHC should aim to be equitable, financially sustainable, proactive and subject to regular review

Policy

AMSA believes that:

1. Access to healthcare should be “universal”. All people should have equitable access to a high quality system because:
   a. The social determinants of health are often beyond the control, responsibility or blame of the individual;
   b. The economic and social prosperity of a nation and society relies on the good health of its population;

2. Health systems and health policy should be designed around patients’ needs;

3. Health systems should be seamless and simple to access;

4. Flexibility in health systems is consistent with patient autonomy and should be protected and respected. Individual choice about health services should be driven by the appropriateness of services to meet the individual’s needs. The ownership of services (ie. Public or private) alone should have minimal influence on individual choice;

5. Resources should be allocated efficiently in an evidence-based manner to maximise fairness and therapeutic good;

6. UHC is the most equitable system for healthcare delivery, as well as the most affordable system in terms of total health costs as a percentage of GDP where private and public spending is balanced, as justified by extensive international research [12];

7. There are many methods of funding to achieve an equitable health system, and these funding methods should not leave one patient cohort at a greater relative disadvantage than another group, nor should they result in any form of financial barrier to healthcare access;

8. The Medicare rebate freeze is a poorly justified and harmful regression away from UHC and that it will:
   a. Reduce necessary use of healthcare services that safeguard the current and future health of the community;
   b. Unfairly burden people with lower incomes, who are already the most vulnerable to poorer health, and the most likely to defer GP visits;
   c. Exacerbate inequalities and reinforce disadvantage;
   d. Have minimal, if any, contribution to the construction of a sustainable and equitable health system;
   e. be logistically impracticable for primary health services.

AMSA calls upon:

1. The Australian Commonwealth, State and Territory Governments to:
   a. Prioritise a health system that delivers UHC as an essential requirement for all peoples through their undeniable human right to health and wellbeing;
   b. Ensure that all people have access to the minimum acceptable (as advised by WHO) quality of evidence-based healthcare that is required to maintain their health and wellbeing;
   c. Carefully develop the health system to ensure its long-term sustainability with consideration to the inevitable increases for healthcare demands, while maintaining UHC for all peoples;
   d. Carefully develop the health system to ensure it is proactive and adaptable in its approach to the future health needs of the Australian people, including the development of medical technology;
   e. Hasten the reintroduction of indexation for MBS rebate items.

2. Medical Schools to:
a. Incorporate content into the medical curriculum, which adequately equips medical graduates with the necessary skills and understanding to work efficiently in the Australian health system;
b. Provide opportunities for students to acquire a contextual understanding of the social determinants of health;
c. Recognise that effective advocacy is a requirement of the medical profession and to provide opportunities that encourage, nurture and train medical students to be effective advocates in all spheres;

3. Australian medical students, health students and health professionals to:
   a. Recall the values that underpin our professional practice, including social accountability, social justice and the human right to accessible healthcare;
   b. Proactively seek opportunities to improve the equitable access and sustainability of the health system; and
   c. Remain informed of current policy and literature that concerns the Australian health system
   d. Actively advocate for and safeguard the right to universal, equitable access to a minimally acceptable standard (as advised by WHO) of healthcare.

References


5. Health Insurance Act 1973 (Cth)


15. Jie-Li Li, Cultural barriers lead to inequitable healthcare access for aboriginal Australians and Torres Strait Islanders, Chinese Nursing Research, Volume 4, Issue 4, 2017


Policy Details

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<tr>
<th>Name:</th>
<th>Universal Health Coverage for Australian Citizens and Permanent Residents</th>
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