Social Security Abroad

Amendments to Australia's National Health Act*

In 1970 Australia amended its National Health Act on the basis of recommendations from the Nimmo Committee of Enquiry into Health Insurance, a panel created especially to review the country's hospital and medical insurance systems. Although they are within the framework of a national scheme, medical insurance and hospital insurance are administered as separate and self-contained systems within each State. Most insurance agencies sell both types of insurance, and persons may purchase one type, both types, or neither.

The amendments (1) realigned the relationship between physicians' fees, medical benefits, and cost-sharing by patients, effective July 1, 1970; (2) provided Government assistance to low-income families in obtaining medical and hospital insurance; and (3) introduced, effective January 1, 1971, new administrative requirements for organizations providing private insurance under the national health insurance systems.

MEDICAL INSURANCE

Australia's voluntary medical insurance program, introduced in 1953, combines private insurance, Government benefits, and patient cost-sharing. Persons who purchase medical insurance from private, nonprofit insurance organizations (called medical benefit funds) registered under the National Health Act are then entitled to receive supplementary cash benefits from the Commonwealth Government to help defray the cost of physicians' services. In all cases the patient must also pay a portion of the cost of the medical services he receives.

The medical benefits system stresses the following features: (a) receipt of Government benefits contingent on the purchase of private insurance and (b) cost-sharing, designed to discourage overutilization of services. The traditional doctor-patient relationship is maintained: there is freedom of choice of doctor by patient and of patient by doctor. The doctor may charge on a fee-for-service basis and be paid his full fee directly by the patient. Thus, no third party intervenes between the patient and the doctor, nor is there a direct payment by the Government to the patient; the insurance organization pays the patient a cash refund that covers both the private insurance benefit and the Government benefit for the particular service.

Factors Leading to 1970 Changes

According to critics, the medical insurance system before the 1970 amendments did not offer adequate protection to its participants. Since the program began, there had been a wide spread between the fees that patients paid for physicians' services and the benefits they received from the Government and from private insurance. Combined benefits by law could not exceed 90 percent of medical costs, so that persons were legally required to pay at least 10 percent of the costs. In practice, however, the average share paid by patients had never been less than 30.4 percent (fiscal year 1966) and had reached a high of 37.8 percent (fiscal year 1958). In fiscal year 1970, participants in the program paid 35.5 percent of their medical costs; insurance organizations and the Commonwealth paid 35.6 percent and 28.9 percent, respectively.

The Government had increased medical benefits once since the start of the program, and the insurance organizations had increased benefits from time to time. The effect of the higher benefits was wiped out by rising physicians' fees, however. Some persons, in an effort to secure better protection, purchased medical insurance from more than one fund, but they could collect only one Government benefit for a single medical service.

Another problem leading to the 1970 amendments was the large number of medical benefit tables—benefit-premium combinations—that the insurance organizations offered the public. This situation caused confusion and dissatisfaction and tended to reinforce the underinsurance, because participants failed to maintain adequate levels of protection as medical costs rose. In addition, since all insurers were required to charge the same premium for a given package of benefits, the more efficient organizations could accumulate

* Prepared by Evelyn Peel, Division of Health Insurance Studies.

large reserves. The uniform premium also was said to contribute to high administrative costs because organizations resorted to nonprice methods of competition to attract customers.

Benefit Changes

Benefit-fee relationship.—The 1970 amendments created a new system of medical benefits linked to the "most common fee"—the fee most frequently charged for a particular medical service—and to a related fixed copayment—a fixed dollar, out-of-pocket amount paid by the patient for the service when the charge is at the common fee rate.

The common fees that went into effect in July 1970 were based on two surveys conducted by the Australian Medical Association. The first was a study of the doctors' bills submitted to the medical insurance organizations over a 2-month period in each State. In the second survey, specialists were questioned directly about the fees they actually charged during a given period. (See technical note on page 31 for method of determining fees.)

Physicians are not bound to charge the common fee. They must, however, inform patients of the common fee for the service if they wish to participate in the program.

For each particular service the combined Commonwealth benefit and private insurance benefit must equal the common fee less the copayment for that service. The maximum copayment was set at $5 (Australian)[1] and applies to services with a common fee of $40 or more. The Government pays an additional benefit when the cost of an operation and the services directly associated with it would result in a copayment of more than $5 at the common fee rates.

The Commonwealth schedule of benefits for a service is the same throughout the country. The private insurance benefit, however, varies from State to State. Each State has its own schedule of benefits that lists for each service the private insurance benefit and the amount of the fee to be paid by the patient when doctors charge the common fees applicable in that State. Separate fee schedules are established for specialists and general practitioners.

[1] One Australian dollar equals 89 U.S. cents.

TABLE 1.—Schedule for consultation with general practitioners, July 1, 1970

[In Australian currency]

State	Office, hospital, and nursing-home visits				Home visits			
	Most common fee	Government and private benefit	Copayment		Most common fee	Government and private benefit	Copayment	
			Amount	Percent of fee			Amount	Percent of fee
New South Wales	$3.50	$2.70	$0.80	22.9	$5.00	$3.80	$1.20	24.0
Victoria	3.20	2.40	.80	25.0	4.50	3.30	1.20	26.7
Queensland	2.85	2.05	.80	28.1	4.25	3.05	1.20	28.2
South Australia	2.80	2.00	.80	28.6	4.20	3.00	1.20	28.6
Western Australia	2.80	2.00	.80	28.6	4.20	3.00	1.20	28.6
Tasmania	3.00	2.20	.80	26.7	4.00	2.80	1.20	30.0

Source: *Journal of the Commonwealth Department of Health, Vol. 20, No. 1,* March 1970.

The copayment is the same in all the States for many items, including consultation with general practitioners, as table 1 shows, but this is not always the case. Although the patient's out-of-pocket payment for a service may be the same in all the States, the proportion of the fee covered by the patient may differ among the States.

For more than 300 medical services customarily performed by either a general practitioner or a specialist, the patient receives a higher benefit if he has been referred to a specialist by a general practitioner than if a general practitioner performs the service. In this way, the copayment for the service is kept within the maximum regardless of who performs the service. (Before July 1970 higher benefit rates for services of specialists were limited to consultations.) Table 2 shows the different reimbursement rates used by Government and private insurance companies for

TABLE 2.—Benefits for removal of tonsils and adenoids, for patients under age 12, July 1, 1970

[In Australian currency]

State	General practitioner		Specialist	
	Common fee	Combined Government and private benefits	Common fee	Combined Government and private benefits
New South Wales	$23.00	$20.00	$55.00	$50.00
Victoria	25.00	22.00	50.00	45.00
Queensland	23.00	20.00	35.00	31.00
South Australia	23.00	20.00	40.00	35.00
Western Australia	20.00	17.00	35.00	31.00
Tasmania	23.00	20.00	31.50	27.50

Source: Charles D. Spencer Associates, *Employee Benefit Plan Review,* November 1970, pp. 22–23.

the same operation—removal of tonsils and adenoids in a patient under age 12—depending on whether a general practitioner or a specialist performs the operation.

Other changes.—The 1970 reform introduced a single table of medical benefits for each State with all insurance organizations in the State paying benefits at the same rate. This step eliminates purchasers' choice but assures them of substantially adequate coverage against the cost of medical treatment provided at common fee levels. Three months, starting July 1, 1970, were allowed for transfer from the old benefit tables to the single table.

Now persons may purchase insurance from only one insurance organization. If they are entitled to workmen's compensation or to a similar third-party payment, the Commonwealth medical benefit is reduced by the amount of the third-party payment.

Medical insurance organizations can no longer provide smaller benefits to persons they classify as "special account" contributors because of preexisting conditions or chronic illnesses. Presumably, the Commonwealth Government continues to underwrite special account deficits. Certain services of dental oral surgeons, as prescribed by regulations, were to be brought under the medical benefits scheme.

SUBSIDIZED HEALTH INSURANCE

Before 1969, low-income persons unable to afford the private hospital and medical insurance prerequisite for receipt of Commonwealth benefits were automatically excluded from the Nation's health insurance programs. As a consequence, 21 percent of the population was not covered for hospital insurance benefits and 25 percent was not covered for medical benefits in fiscal year 1970, according to statistics of the registered insurance organizations. Some of the noninsured, of course, were eligible for benefits under other Government programs, such as the Pensioner Medical Service, a plan that provides Government benefits to certain categories of persons meeting a means test. Other persons had elected not to participate. Nonetheless, there was a correlation between membership in the health insurance schemes and income.

In October 1969 the National Health Act was amended to provide free health insurance to persons receiving unemployment or sickness benefits, to immigrants during the first 2 months in Australia, and to families with incomes not over the legal weekly minimum wage. The 1970 amendments provide assistance to families with incomes somewhat above the minimum wage in obtaining health insurance, as shown below.

Weekly family income (in Australian currency)	Percent of premium paid by Government
Under $42.50	100
42.50–45.49	66⅔
45.50–48.50	33⅓
More than $48.50	0

Subsidized families are entitled to full medical benefits and to hospital benefits equal to the cost of public ward accommodations. They may pay the difference in cost to purchase more expensive hospital benefits.

HEALTH INSURANCE ORGANIZATIONS

The 1970 amendments relating to health insurance organizations are concerned primarily with their expenditures, especially the expenditures of the funds with membership open to the public (in contrast to funds restricted to a particular association or employer). The provisions apply both to organizations writing hospital insurance and to those writing medical insurance, functions often performed by the same organization.

All organizations had to apply to the Department of Health for re-registration by October 1, 1970, so that the 1970 amendment requirements for participation in the program could go into effect on January 1, 1971. The new law requires all organizations to file an annual financial statement using a standard accounting year. The statements will be reported to both Houses of Parliament. Organizations open to the public must establish a separate fund for each State in which they are registered and must submit a separate financial statement for each fund.

Limits on the management expenses of the health insurance organizations are prescribed by regulation, and Commonwealth benefits are reduced to the extent a fund's management expenses exceed these limits.

Although all medical insurance organizations in a State now must offer the same benefits, premiums can vary if they are approved by the Minister of Health. Weekly premium charges for medical insurance of the major open funds are listed below.

[In Australian currency]

State	Weekly family rate	Weekly individual rate
New South Wales	$0.75	$0.38
Victoria	.60	.30
Queensland	.64	.32
South Australia	.60	.30
Western Australia	.50	.25
Tasmania	.55	.28

Source: Australian Department of Health, *The New Health Benefit Plan.*

The amendments included a provision designed to restrain the accumulation of reserves. Beyond amounts held against unfiled claims and prepaid premiums, the larger funds are to gradually limit reserves to the equivalent of 3 months' premium income.

EFFECTS OF 1970 AMENDMENTS

Information on the operation and effect of the 1970 amendments is as yet sketchy. The new "most common fee" system clearly is an attempt to stabilize the relationship between medical fees and medical benefits. Stabilization has been an objective of the medical benefits scheme from the beginning, but several features in the new system should increase chances of success toward attaining this goal. First, by standardizing the out-of-pocket fee that is paid by the patient and substituting this fixed amount for the formerly unlimited patient payment, medical fees will become more set. Second, since participating physicians must tell their patients the most common fees for each medical service, patients can theoretically refuse treatment from a doctor whose fees are higher than the most common fee. In addition, there has been a nationwide educational campaign on the new system. Literature has been distributed that explains the amendments and lists the common fees in each State for the most frequently used services.

The agreement between the Government and the Australian Medical Association for a coordinated review of fees and benefits every 2 years is still in effect. The relationship and coordination of this procedure with the new system is not entirely clear. The increases recommended by the Australian Medical Association in February 1971 to be effective in July were not based on the new common fee schedules put into effect July 1970 but on the fees commonly charged as of July 1, 1969, the last date of a general fee increase under the agreement. The Government was critical of the large increases recommended. It claimed that the updating of fees according to movements in economic indicators—the usual method—did not take into account the favorable changes in physicians' income since July 1970 as a result of the new medical benefits system and the subsidized health insurance program. There is no information yet on the July 1971 fee increase and its effect on benefits and out-of-pocket payments.

With respect to other innovations in 1970, persons eligible for subsidized health insurance reportedly are not aware of their right to participate and those that do participate do not understand the necessary administrative procedure. It is believed, however, that these difficulties will be overcome in time. For purposes of the different benefits paid to patients if a general practitioner performs a service or if he refers the patient to a specialist for the service, there has been some problem in defining "specialist" and in determining acceptable circumstances for referral.

TECHNICAL NOTE

The criteria the Australian Medical Association used to obtain a statistically significant "most common fee" for each service were:

(1) There must be a prime modal point that is clearly greater than any other modal point;
(2) there must be more than 60 incidences analyzed for each item of service;
(3) the exact fee must be known in more than 50 percent of the incidences analyzed (where several items of services are included in a doctor's bill, it is at times not possible to state definitely the specific fee for each item of service);
(4) the prime mode must include more than 15 percent of the total incidences analyzed, for which the fee is known;

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TABLE M-2.—Public income-maintenance programs: Hospital and medical care payments, 1940–71

[In millions]

Period	Total	OASDHI (health insurance for the aged)[1]			Other programs			
		Total	Hospital insurance[2]	Medical insurance	Veterans	Temporary disability[3]	Workmen's compensation[4]	Public assistance[5]
1940	$165				$70		$95	
1945	222				97		125	
1950	832				573	$7	200	$52
1955	1,265				688	20	325	232
1960	1,846				848	41	435	522
1961	2,093				899	46	460	688
1962	2,406				940	46	495	925
1963	2,611				971	50	525	1,065
1964	2,890				1,019	51	565	1,255
1965	3,204				1,072	52	600	1,480
1966	4,898	$1,019	$891	$128	1,137	54	680	2,008
1967	9,554	4,549	3,353	1,197	1,328	53	750	2,873
1968	12,107	5,697	4,179	1,518	1,429	55	830	4,096
1969	13,836	6,603	4,739	1,865	1,573	59	920	4,681
1970	15,568	7,099	5,124	1,975	1,793	61	1,010	5,606
1970								
August		591	418	173	150			444
September		588	423	165	154			465
October		609	438	171	155			488
November		588	417	171	150			490
December		631	457	174	162			530
1971								
January		591	451	140	156			510
February		601	436	165	152			503
March		736	536	199	172			566
April		668	497	171	166			565
May		635	459	176	163			592
June		659	480	179	176			576
July		647	477	170	184			596
August		644	462	182	181			574

[1] Benefit expenditures from the Federal hospital insurance and supplementary medical insurance trust funds as reported by the U.S. Treasury.

[2] Represents payments in behalf of all persons aged 65 and over, including those not insured for cash benefits under OASDHI and railroad retirement. Excludes payments by Railroad Retirement Board for beneficiaries in Canadian hospitals.

[3] Benefits in California and New York (from 1950), including payments under private plans. Monthly data not available.

[4] Benefits under Federal workmen's compensation laws and under State laws paid by private insurance carriers, State funds, and self-insurers. Beginning 1959, includes data for Alaska and Hawaii. Monthly data not available.

[5] Federal matching for medical vendor payments under public assistance began October 1950.

Source: U.S. Treasury and unpublished data from administrative agencies.

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(5) the prime mode plus all the cases below it for which the fee is known must be greater in number than all the cases above the prime mode for which the fee is known.

By these standards, a prime mode would not qualify as a common fee unless it, together with the frequencies of the fees below it, were greater than the number of frequencies above it. When no single, clearly-defined mode emerged or when a service was so rare that there was insufficient information, the "most common fee" was decided on the basis of reasonability, taking into account the frequency distribution and the common fee for similar services.