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Queensland Government

Premier of Queensland
and Minister for Trade

Please quote: AM/14/Social Policy

13 JUN 2003

Senator Jan McLucas
Chairperson
Senate Inquiry on Medicare
The Senate
Parliament House
CANBERRA ACT 2600

Dear Senator McLucas

Please find attached the Queensland Government's submission to the Senate Inquiry on Medicare. My Government welcomes this opportunity as it is an issue of vital interest to states and territories, health consumers, professionals and workers in the health care system.

My Government has recently released its Health 2020 Strategic Directions policy which sets out the key health issues and priorities which need to be addressed by governments and the community if improved health outcomes are to be realised in the future. A major challenge will be ensuring sustainability and equitable access to a quality health care system.

As you would be aware, states and territories are in the process of considering the Commonwealth's offer in relation to the Australian Health Care Agreement. In addition, the Fairer Medicare package recently announced by the Commonwealth has significant implications for Queensland's public hospital and primary health care system.

I look forward to the Committee's report on this important issue.

Yours sincerely

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SENATE SELECT COMMITTEE ON MEDICARE

Introduction

Medicare has been the mainstay of Australia's public hospital and health system for many years. It is a system that has served all Australians well through the fundamental principle of universality. Relative to other western countries, it is a cost efficient system that, in the main, ensures access to all those in medical need.

While the Medicare system can boast a sound record, it is not to say that our public health system cannot be improved. To that end, Commonwealth and State Health Ministers have been working on a policy reform agenda for over 12 months in the lead up to the renegotiation of the Australian Health Care Agreements. One of these important areas is that of the interface between the provision of primary health care services, a responsibility of the Commonwealth, and public hospital services, the responsibility of the States.

The fundamental issue in this context is that public hospital emergency departments are under increasing pressure principally because of the failure of the Commonwealth Government to address the decline in bulk billing arrangements. Evidence of this is presented in the body of this submission. What the Commonwealth has proposed in its recent announcements on this topic is a fiscal response without reference to the health policy agenda.

Similar to its negotiations with States and Territories on housing and disability, the Commonwealth is attempting through this package to shift responsibility and risk to the public and State and Territory Governments.

In fact, the Commonwealth has in effect ignored the reform agenda that all Health Ministers, including the Commonwealth Minister, have been party to - a reform agenda that seeks to respond to the challenges confronting our public health system and ensure its sustainability for Australia's health consumers.

Role of Medicare and the Future

In 2002, the Queensland Government released the Smart State: Health 2020 Directions Statement which emphasises the importance of maintaining and strengthening primary health care services to meet the future needs of the Queensland population.

The burden of disease has shifted in recent decades from communicable diseases caused by infection to non-communicable diseases influenced by lifestyle including diet, smoking, physical inactivity and alcohol. The World Health Organisation (WHO) estimates that by 2020 chronic disease will account for 60% of the burden of disease in the western world (WHO – Innovative Care for Chronic Conditions, Meeting Report, May 2001). Heart disease, chronic depression, stroke and chronic obstructive lung diseases are likely to be amongst the top five contributors to the disease burden.

The ageing population and increasing number of people living with a chronic condition will require a major change to the way future health services are delivered. The WHO notes:

> "Chronic conditions require an evolution of health care from an acute "find it and fix it" model towards a coordinated, comprehensive system of care ... Effective chronic illnesses care requires more than simply adding additional interventions to an existing system focused on acute care. Rather, it necessitates basic changes in delivery system design." (WHO, Innovative Care for Chronic Conditions, Meeting Report, May 2001)

For this reason, health systems around the world are attempting to shift their emphasis from an acute care system centred around hospitals to primary care emphasising health promotion and prevention, increasing medical and allied health professionals working in the local communities and greater home based care.

In 2002, the United Kingdom (UK) Treasury completed a long-term exercise to determine what the health costs for the National Health Service (NHS) might look like over the coming twenty years (UK Treasury Securing Our Future Health – Taking a Long Term View, March 2002). The UK Treasury estimated that by 2022-23, the potential saving in total health spending could be as much as £30 billion per year (10.6% of GDP compared to 12.5% of GDP) if every individual payed at least one more visit to the GP per year, there was increased management of chronic diseases by GPs and individuals in community rather than hospital settings and risk factors such as smoking and obesity reduced compared to the levels experienced in 2002.

A strong Medicare system which provides quality, responsive primary health care services must continue to be a platform for health care provision if Australia is to meet the challenge of ageing and chronic disease management while ensuring a sustainable and affordable health care system.

Queensland Context

In considering the terms of reference of the Inquiry, there are a number of Queensland specific issues that should be highlighted. Several of these issues are unique to Queensland and are germane to people accessing health services through general practitioners.

- Queensland is the fastest growing State in Australia and any changes to Medicare impacting negatively on individuals or the public hospital system will therefore be significant.

- Because of the wide geographic spread of the State, many communities in rural and remote parts do not have access to primary health care services.

- Access to primary health care services by Indigenous communities in rural areas is also particularly poor because of a lack of general practitioner services.

- As a result of Queensland's traditional free public hospital system, there is a culture of people "drifting" to the public hospital system; and

- Because of a higher than otherwise take up rate of private health insurance policies with front end deductibles, more Queenslanders are likely to rely on the public hospital system.

The access to and affordability of general practice under Medicare, with particular regard to:

(a) the impact of the current rate of the Medicare Benefits Schedule and Practice Incentive Payments on practitioner incomes and the viability of bulk-billing practices;

While there are several factors that are likely to impact on the viability of bulk billing practices, the current rate of the Medicare Benefits Schedule (MBS) is probably the most significant. There have been repeated concerns by the medical profession in particular about the inadequacy of the level of the current rebate. The rebate simply does not reflect the costs of operating a general practice.

In 1995 the Commonwealth Department of Health and Ageing together with the Australian Medical Association undertook a Relative Value Study, the most comprehensive review of the Medicare Benefits Schedule since its inception. This study sought to identify general practice costs and in so doing, clearly showed the present MBS fee structure to be inadequate. In fact, the study concluded the schedule fee for a Level B Consultation should be around $44, almost twice the present level.

The introduction of the Practice Incentives Program has provided some buffer to practitioner incomes although this has been very much at the margin. In any event, the scope for this to continue is becoming less. While this program has worked well in some instances such as the immunisation, there are other areas including asthma and mental health where the program has not operated optimally. In fact many practitioners are of the view that the Practice Incentives Program is increasingly being hamstrung by red tape. In this regard there is a view that rather than focus on meeting agreed outcomes, practitioners spend much of their time dealing with cumbersome administrative arrangements.

In essence, practitioners gain little net benefit from the Program. Moreover, funding from this Program only represents a small proportion of the total operating revenue for most practices and therefore adds almost nothing in terms of maintaining a viable general practice. The March 2003 Productivity Commission report "*General Practice Administrative and Compliance Costs*" found that in 2001/02 (using base case assumptions):

- the estimated administrative costs for general practitioners and general practice resulting from Commonwealth policies and programs were about $228M or 5% or GPs estimated total income; and

- nearly 39% or $75M of the $193M outlay on the Practice Incentive Program (PIP) were accounted for by administration and compliance costs.

The consequence of these circumstances is that some general practitioners are leaving the profession while in other cases, practices that once operated through the evenings and at weekends are no longer doing so.

(b) the impact of general practitioner shortages on patients' ability to access appropriate care in a timely manner,

There is no question that a patient's ability to access and receive timely and appropriate care is inextricably linked to the number of general practitioners providing primary health care services. This problem is certainly exacerbated in outer metropolitan, rural and remote areas. These points were among the conclusions drawn from a study undertaken by Access Economics in 2001 on behalf of the Australian Medical Association. Overall the study found that the shortfall of general practitioners across Australia was between 1200 and 2000. The rural/urban split was 700 and 500 respectively with most of the shortfall in rural areas being in NSW and Queensland.

In this regard moves in the recent budget by the Commonwealth Government to increase training places are to be supported. Without sufficient numbers of practitioners, increasing pressures are placed on emergency departments of public hospitals. This in turn means resources are tied up undertaking work that should rightly be done in a community setting.

More needs to be done however, than just increasing the number of training places available and one must question the strategy of "bonding" students such that they must then spend a predetermined amount of time practicing in specified locations after graduating. There is a view that adopting this strategy alone will not necessarily attract high quality students and neither does it actively promote the benefits of entering general practice as a profession. While Queensland has had a degree of success with this strategy, it carries some risk. Students may "pay out" their contract or simply refuse to relocate to their designated location.

There are other factors that also contribute to shortages in general practice. Aside from remuneration these include, working long hours, medical indemnity, lack of professional and social support and a lack of integration with other health service providers. As a result, more needs to be done to alleviate these issues in order to provide for a more positive working environment for practitioners. Other measures that should also be pursued include an expansion of the practice nurse workforce scheme and continuing consumer education. In the case of the former, this scheme is currently only available in outer metropolitan and rural areas should be extended across all States and Territories. Insofar as the latter is concerned, consumers need to be increasingly educated in a range of areas including the definition of medical need, timing associated with the need for medical expertise and self management for certain conditions. Consideration should also be given to evidence based consumer information available on the internet / phone line.

In a State such as Queensland, the lack of primary care services is of particular concern especially for those living in rural and remote areas. The impact of this is

also evident in relation to Indigenous Australians who suffer from high morbidity and mortality rates. As a result, there is low usage of the Medicare Benefits Schedule and a heavy reliance on public hospitals. In addition, in order to overcome some of the problems caused by the absence of primary health care practitioners, the Royal Flying Doctor Service provides some level of service. This however, is not a sustainable model for quality primary services and may impact on its capacity to delivery on its valuable role as a retrieval and emergency service.

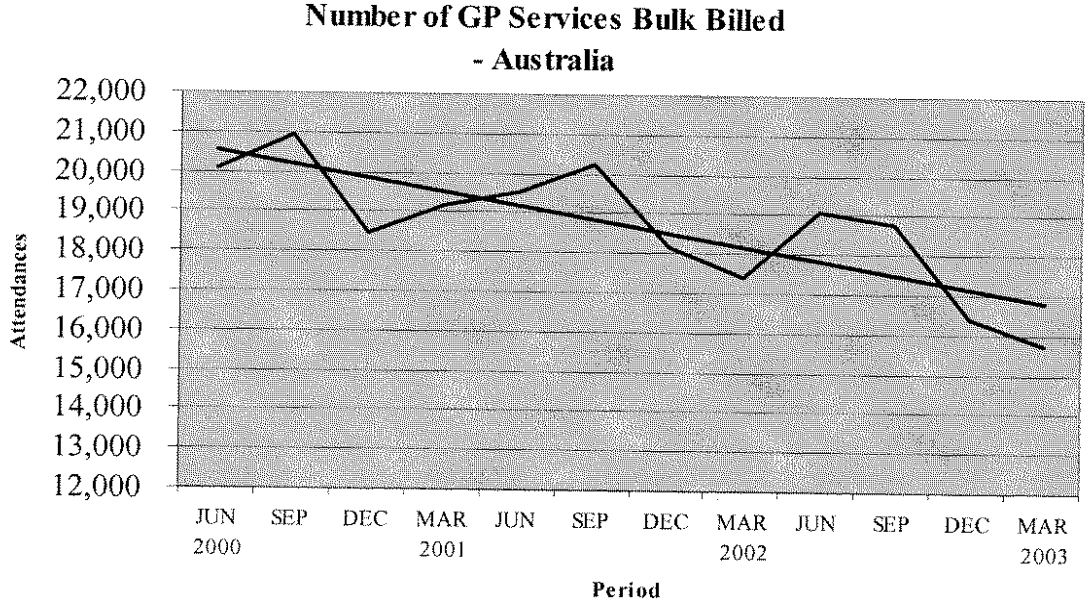
(c) the likely impact on access, affordability and quality services for individuals, in the short- and longer-term, of the following Government-announced proposals:

(i) incentives for free care from general practitioners limited to health care card holders or those beneath an income threshold,

The impact of the new measures offering incentives for free care to cardholders or those beneath an income threshold is likely to be minimal. This is for two reasons. Firstly, it is likely that many pensioners and cardholders are already bulk billed for services and there is no reason to think this will not continue. Therefore there will be little difference in the way these groups receive and pay for their services. Secondly, but perhaps more importantly, the majority of practitioners are indicating they do not support the new package and will therefore not participate in the proposed scheme.

There are strong indications from the Queensland Division of General Practice that many of its members are not supportive of the new arrangements. As an example, 31 practices in one metropolitan Division of General Practice responded to a questionnaire regarding the perception of the new arrangements. Of this number, only 3 practices supported the package while the remaining 28 did not. Among the comments received, many practitioners saw the package as an attempt by government to gain more control, believed the rebate was manifestly inadequate, thought their practice would be worse off financially and believed patients would also be worse off.

The net result of the Government's proposals is that little is likely to change. This holds true particularly for general practitioners and as a result, they will continue to operate under undue cost pressures. Bulk billing is therefore likely to continue to fall, as evident from the following graph, and non-cardholders will experience further increases in out of pocket expenses when visiting a general practitioner. These patients will in effect be cross subsidising the cost of services to pensioners and cardholders. Under these circumstances, public hospital emergency departments will continue to experience increased workloads as a result of the inability of patients to afford general practitioner visits.

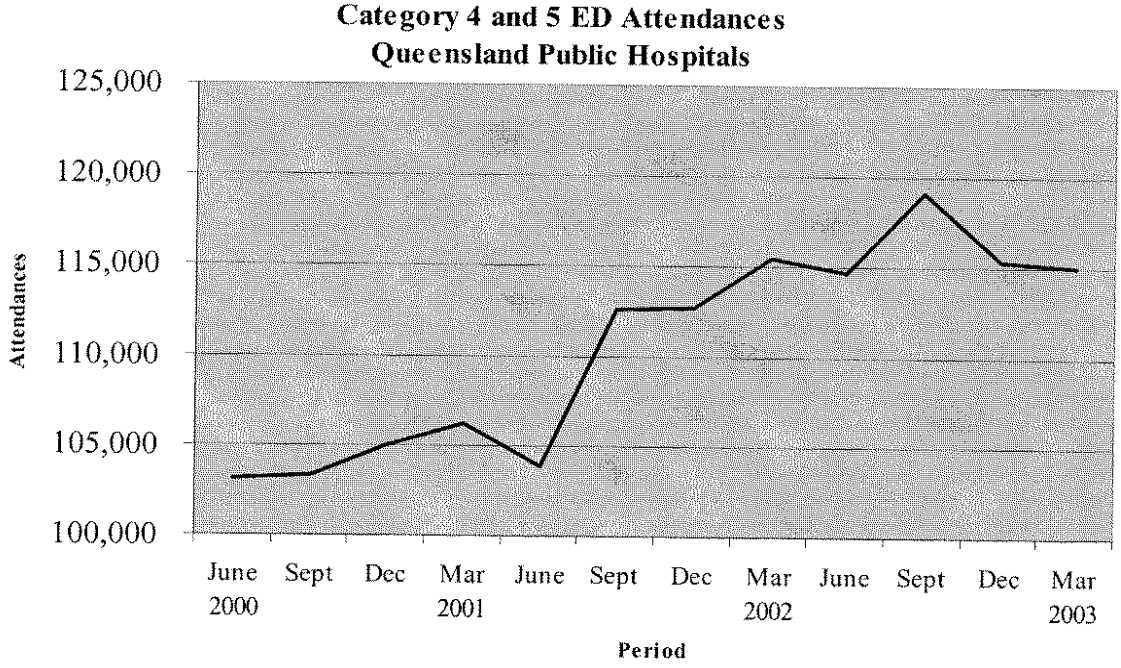


Source: Department Of Health and Ageing. Medicare Statistics - Table B8 (March 2003 Quarter Report)

(ii) a change to bulk-billing arrangements to allow patient co-payment at point of services co-incidental with direct rebate reimbursement,

A policy of allowing a co-payment at point of service delivery is likely to substantially effect doctors' fees for all patients, but particularly low income earners. Assuming most cardholders will be bulk billed, doctors are likely to charge all other patients a co-payment that, on average, could be $20 to $25. This is consistent with the marked drop-off in bulk billing generally seen over the last few years. While this may not be a heavy impost on some patients, say those earning $50,000 plus, it will severely hit those low income earners.

The net effect of these arrangements is likely to be that this group particularly will think twice about visiting their general practitioner. Instead, they will ultimately attend the emergency department at the nearest public hospital. However, it is also likely they will present "sicker" having put off attending their general practitioner because of the cost. The graph below shows a steady increase in emergency department workloads for Queensland public hospitals over the last 3 years. From the data available for the corresponding period, there is a clear inverse relationship between the reduction in bulk billing and the substantial increase in public hospital emergency department activity.



Source: Attendances Data Source: Queensland Health Emergency Data Collection.

Queensland Health has estimated the likely impact of these arrangements on the workload of public hospital emergency departments. The methodology is premised on taking the total Queensland population and subtracting the number of pensioners and cardholders, children 19 years and under and low income earners defined as those earning $28,000 or less. It is assumed these groups will be covered by the bulk billing arrangements. It is further assumed that those persons earning $52,000 per year will continue to see their general practitioner and bear whatever co-payment may be involved in a consultation. This leaves a relatively large group of Queenslanders on low incomes defined as those earning between $28,000 and $52,000 who are likely to transfer to the public hospital system.

Based on these parameters and assuming people visit their general practitioner about four times a year which is the relevant average for Queensland, a demand transfer of 10% from this group will lead to an activity level for Category 4 (semi urgent) and 5 (non-urgent) patients of about 835,907 in emergency departments. This represents a doubling in activity, currently at about 412,613 presentations. While there are two methods by which this additional activity can be costed, this fundamentally represents a significant cost shift from the Commonwealth to the State.

Using the Medical Benefits Schedule, the estimate for these presentations is an additional $10.4m, while using the National Hospital Cost Data Collection the estimated additional cost is $55.9m. The difference in these figures highlights the fact that the provision of primary medical services in a hospital setting are not cost effective. In addition to the cost of these consultations, there are other significant flow on costs that are incurred by the State including radiology and pathology. In other words, it makes much more economic sense for these services to be provided by general practitioners and to allow hospitals to deal with the more complex medical and surgical cases.

(iii) a new safety net for concession cardholders only and its interaction with existing safety nets, and

Under the existing arrangements the safety net is relatively simple covering all patients not just cardholders. The scheme provides for Medicare to pay the difference between the rebate and the scheduled fee once a patient has reached a threshold of $319.70 out of pocket expenses in any one calendar year.

As part of the new arrangements, the Commonwealth Government is now proposing a second scheme for cardholders only. Under this scheme, cardholders will have to reach a threshold of $500 per calendar year but thereafter, will be entitled to receive a benefit equivalent to 80 cents in every dollar for the difference between the Medicare rebate and the entire fee charged by the practitioner.

If nothing else, the additional safety net arrangements fail the test of administrative simplicity. Furthermore, the separate safety nets will lead to inequitable outcomes and a two tiered system. Depending on what level of fee a particular doctor charges, a cardholder may receive a benefit from one or other of the schemes. In the event the patient exceeds the current arrangements and reaches the criteria for the new safety net they will receive a different benefit from the existing scheme. Aside from being confusing and in all likelihood not well understood by the general public, a more equitable approach would be to have the one scheme for all patients.

(iv) private health insurance for out-of-hospital out-of-pocket medical expenses; and

The proposed new arrangements to allow private health funds to insure for out of hospital out of pocket expenses will do little to improve access, affordability and quality of services for individuals.

Under the proposed scheme, patients will not qualify for benefits until they incur costs of $1000 or more. Given most people only attend a general practitioner on average five times a year, they would have to incur out of pocket expenses of $200 per visit. This is clearly not realistic. On the other hand, if it is assumed that patients incur an out of pocket expense on average of $20 per visit, this would equate to 50 general practitioner consultations in any one year. However, this is also unrealistic and as a result, by far the majority of patients will not get the benefit of the proposed arrangements.

The only group who might benefit from these arrangements are those suffering from chronic conditions. However, it is hard to see how even this group of patients will benefit as it would mean them visiting their doctor at least once a week.

(d) alternatives in the Australian context that could improve the Medicare principles of access and affordability, within an economically sustainable system of primary care, in particular:

(i) whether the extension of federal funding to allied and dental health services could provide a more cost-effective health care system,

There is now ample evidence to support the notion that dental health and an individuals general health are clearly linked. In a paper prepared on behalf of the Australian Health Policy Institute by John Spencer entitled "What Options do we have for Organising, Providing and Funding Better Public Dental Care?" he notes this point.

"Medically necessary dental care has been suggested to be integral to comprehensive treatment to ensure optimum health outcomes for patients undergoing chemotherapy; having heart valve and other heart surgery; transplantation; suffering from diabetes; hepatitis C and HIV infection; and living with long term renal dialysis and haemophilia." He goes on to say that "..oral health should be seen as an integral aspect of general health and dental care as a component of health care."

In a similar vein, allied health professionals can also play an important role in the determination of a person's general health. This is particularly the case with older more frail patients where they suffer from debilitating chronic illnesses. The provision of allied health services for people in the community not only has a direct impact on their immediate condition but also on their broader health and well being including their mental health.

Access to dental and allied health services in the community will clearly alleviate pressure on the public hospital system by, in some cases, avoiding the need for hospitalisation either through remedying the problem altogether or through better ongoing management of the condition. As a result of this strategy, many patients would be able to be treated in their preferred environment (in the community or their home) and it should also lead to cost savings to the health system.

Extending federal funding to allied health and dental health services could be achieved either through an extension of the Medicare Benefits Schedule or through program funding, although the costs and benefits as well as the impacts on existing jurisdictional responsibilities would need to be carefully examined. Utilising the Schedule would, in all likelihood, be resisted by the Commonwealth Government as it would involve extending an already uncapped program. However, the introduction of specific program funding not unlike the former Commonwealth Dental Program which operated in the mid 1990's could be contemplated. In this way the government could place certain caveats on eligibility and benefits as it saw fit. Given the growing burden of chronic disease and cohort of older people, serious consideration needs to be given to whether more flexible models of allied health and general practice service delivery are required.

(ii) the implications of reallocating expenditure from changes to the private health insurance rebate, and

Access for individuals to health services could be improved by redirecting Commonwealth funding from the private health insurance rebate to the public health sector. In a report by Professor John Deeble, entitled "The Private Health Insurance Rebate"(January 2003) commissioned by State and Territory Health Ministers, he argues, among other things, that the rebate has failed on both economic and health service criteria. In addition, Deeble says that lifetime health cover, the other major government reform, has had a far more dramatic affect on private health insurance membership.

Furthermore, he quotes work undertaken by Duckett and Jackson (2000), in which they conclude for a similar casemix overall costs are about 10% higher in private hospitals than public ones. This implies that for the cost of the rebate, public hospitals could not only eliminate undue waiting times, but also treat nearly 60% of all patients now treated in the private system. Deeble says, if used in this way, funding would not "leak" into administration, ancillaries and measures that simply improve the insurance industry's products. Because admission would depend on medical need rather than insurance status, it would also be more equitable.

It is true that private hospital activity has increased substantially as a result of the introduction of the 30% rebate. However, it is also clear that this has been a consequence of additional demand. That is to say, there has been no demand transfer from the public sector to the private sector. Public sector activity has remained steady and waiting times in public hospitals have not changed.

Over and above these issues, funding from the rebate could be redirected in a number of other ways to support primary care services. In particular, it could go towards the establishment of community health centres as well as multi purpose centres especially in rural and remote areas. Furthermore, it could be used to increase Medicare rebates, particularly for services provided by general practitioners.

The overriding conclusion however is access to health services could be improved by redirecting the rebate funding into either public sector or private sector services. The question remains however as to what impact this would have on private health insurance levels if this were the case. As Deeble points out it was lifetime health cover that has had the major effect on the take up rate for private health insurance. In these circumstances, while premiums for private health insurance would likely rise, if all else remained unchanged it might be assumed the number participating would largely remain the same.

(iii) alternative remuneration models that would satisfy medical practitioners but would not compromise the principle of universality which underlies Medicare.

Present remuneration arrangements work within the principle of universality and centre around a fee for service model. It is fair to say this is the preferred model of the medical profession and moving away from this basis is therefore likely to be difficult.

The major problem with the current system however is that the Medicare Benefits Schedule, the rebates for which are time based, are not sufficient to sustain a viable

general practice sector. Access to private medical services continues to be a function of the general practitioner workforce and the extent of bulk billing throughout Australia.

The clearest alternative to present remuneration arrangements involves increasing the current rebate levels such that they more closely resemble the costs of operating in private practice. In this way, bulk billing is more likely to be sustained at high levels and patient out of pocket expenses will be ameliorated. Importantly, all patients will be treated equally and the principle of universality will be maintained.

An alternative to the fee for service approach is the capitation model similar to that in use in the United Kingdom. Under this option, doctors would be paid a fixed amount for services provided to a population within a specified geographic area. Furthermore, an adaptation of both the models referred to here would involve a blended approach in which doctors would be reimbursed for services both on a fee for service basis as well as population basis. In recent years the Commonwealth has funded general practice through a greater proportion of blended payments such as the Practice Incentive Program. Whilst the concept of a population based approach to delivering services to general practice patients has received some support from the profession, finding an acceptable model of payment which does not compromise the fee for service model has proved difficult.