SA Divisions of General Practice Inc

17 June 2003

Ms Ellen Humphrey
Senate Select Committee on Medicare
Parliament House
Canberra, ACT 2600

Dear Ms Humphrey

Please find attached the submission from SA Divisions of General Practice Inc (SADI) to the Senate Select Committee Inquiry on Medicare.

Contact details for further information are at the end of our submission.

Yours sincerely

VR Williams

Ms Valerie Williams
Executive Officer

SA Divisions of General Practice Inc. First Floor, 66 Greenhill Road, Wayville SA 5034
Phone (08) 8271 8988 Facsimile (08) 8271 8344 Email: sadi@sadi.org.au Website: www.sadi.org.au
ACN A0023905K

SA Divisions of General Practice Inc

Submission to Senate Select Committee Inquiry into Medicare

Response to individual Terms of Reference

(1) That a Select Committee, to be known as the Select Committee on Medicare, be appointed to inquire into and report by 12 August 2003 on the following matters,

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;

SADI response:

- Bulk billing must remain a choice of the practice, with this choice based on its patient demographics, practice philosophy and individual business analysis
- It is important to have financial incentives which recognise the level to which GPs subsidise health care costs for patients who have difficulty affording care
- Growth in practice costs substantially exceeds rebate increases, resulting in a real decrease in GP incomes. The decreasing ratio of rebates to practice costs puts pressure on practices to increase patient through-put. The proposed incentives do not adequately compensate for this
- The substantial administrative burden involved in incentives such as Practice Incentive Payments has resulted in many practices not taking up such incentives. It is essential to simplify incentive mechanisms so that the administrative costs of receiving the incentive do not outweigh the benefit to the practice and its patients
- Improved practice business and clinical systems are essential for practice viability. The Divisions of General Practice network (Divisions, State-based organisations (e.g. SADI) and ADGP) plays a vital role in providing support for practice computerisation and clinical process automation to assist greater practice efficiency. This role has been hampered by the cessation in December 2001 of specific Federal funding to the Divisions network for supporting the implementation of information technology/information management within general practice.

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

SADI response:

- GP shortages in both rural and urban areas are exacerbated by current shortages of supporting professionals such as nurses and allied health providers. In urban areas this is particularly impacting in the outer urban regions which in Adelaide are the outer southern and outer northern areas, both of which have significant lower socio-demographic populations
- Many practices are closing their books to new patients as the current workload is unsustainable

- Extension of the practice nurse subsidy to support the employment of practice nurses in all practices (rural and urban) will facilitate greater access to general practice services. This will assist practices to adopt a team approach and delegate work to the most appropriate professional, increasing practice efficiency and effectiveness
- Extension of the More Allied Health Services funding to urban areas would go a significant way to improving patient care and alleviating some of the workforce pressures on GPs
- New approaches such as peer supported learning for all practice staff may help to alleviate pressure and rationalise workloads. The Divisions network will play a key role in implementing this approach. SADI has already supported the establishment of practice nurse networks across SA and has trained GP Peer Support facilitators. Most Divisions in SA support practice managers networks
- The high workload impacts on the ability of GPs to take up new activities including those focused on quality improvement. Quality incentives should be better structured and targeted to encourage whole-of-practice involvement. When we ask GPs who have either temporarily or permanently left clinical practice, we find that one of the major reasons cited is difficulties in conducting a quality practice, in which the necessary time can be spent with patients with chronic and complex problems. Those that are left in the workforce report feeling that they are more and more on an unrewarding treadmill. Another response by some GPs to this pressure is to limit their practice to particular areas, such as sports medicine or mental health
- The current high workload of GPs also effects patient continuity as it is more difficult for patients to book into the GP of their choice. When waiting times for an appointment increase, patients who need urgent, or even non-urgent attention, must see whichever GP in the practice has a free appointment, rather than being able to access their usual or preferred GP. From the GP's point of view this also decreases their satisfaction with the quality of their work, because of the reduction in personal continuity and follow up of the patient
- Both immediate and long term strategies are needed to address GP workforce shortages across both rural and urban Australia. These include reconsidering entry requirements to particular medical schools and raising the prestige of general practice as a profession.

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,

SADI response:

- Concession cards e.g. health care cards are not a good indicator of whether a patient can afford health care. There needs to be a clearer, more appropriate definition of disadvantage with regard to accessing health services
- Need is not necessarily defined by income level. People on moderate incomes who have chronic illness, with a number of family members with health problems or who experience a sudden health crisis may also have difficulty affording care
- GPs wish to retain discretion to offer subsidised care to their patients based on their longitudinal knowledge of the patient's circumstances and health needs

- The proposed incentives appear very unlikely to change practice among GPs who do not currently bulk bill. The majority of GPs who are currently bulk billing tell us that they are planning to cease bulk billing within the next 6 to 12 months, and that the introduction of the proposed changes to Medicare will not alter their plans
- The Attendance Item Restructure Working Group funded by the Government in 2002 (but still not released) conducted a comprehensive analysis of current rebate levels and determined that the MBS should be restructured so that financial incentives encourage longer consultations to support quality practice.

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

SADI response:

- Online billing should be made available to all practices as it is convenient for patients and efficient for practices and the HIC. This excellent initiative should not be linked to preparedness to take up other parts of the Medicare Package
- This facility may assist patients with cash flow issues and improve access in the short term. However the impact on patients facing a major health issue which requires substantial upfront costs over a short period will need to be closely monitored and may need to be alleviated e.g. by enabling the GP to initiate subsidised care for that patient
- There are real concerns about the availability/reliability of connectivity in rural and remote areas, which may discriminate against patients in these areas, where Medicare facilities are also less accessible. Additional funding should be available to ensure equity for rural/remote patients
- The ongoing maintenance costs associated with online billing also need to be assessed
- The Divisions network has previously demonstrated its capability in assisting general practice to computerise, but will need adequate resourcing to support general practice to take up online billing.

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

SADI response:

- The survey conducted by ADGP indicated that a majority of GPs supported the safety net
- The contribution of general practice fees to the safety net limit is likely to be small; however, it may partially assist in alleviating financial pressure from other specialists' fees on patients who have high health care needs
- The safety net makes an important recognition of total out of pocket medical expenses, which is particularly important where charges for services greatly exceed the schedule fee
- The affordability and accessibility of referred services need serious consideration
- Concession cards are a poor delineator of need, and the safety net needs to be extended to cover all families who may experience difficulty affording health services.

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

SADI response:

- There is concern that extending private health insurance coverage to the primary care sector will lead to an increase in premiums due to the broader risk base
- The potential for the private health insurance industry to increasingly attempt to influence clinical practice and referrals (eg. through preferred provider networks as in the US) as they seek to manage this risk is an area of concern
- GPs and practice staff will face greater administration and red tape in dealing with 43 health funds rather than a single insurer, e.g. Medicare
- There are concerns that this will increase the divide between private and public patients and create differential access to health services.

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,

SADI response:

- The proposed extension of funding to groups of providers will create more silos within health care further fragmenting and complicating the system for patients and providers
- International evidence has proven that the most effective delivery of health services is through an integrated system, where providers work as a team centred on the patient's needs
- Better outcomes are achieved by shifting the balance of the health system to the delivery of primary care
- There needs to be increased public investment in the entire primary care sector, including dental and allied health services, with a focus on generalist, comprehensive, longitudinal care with integration of services through automated health records and support for a team approach.

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

SADI response:

- The Divisions network has achieved substantial success in delivering integrated patient care through a number of initiatives including the More Allied Health Services program. Funding from the private health insurance rebate could be redirected to expand this program so that patients in both rural and urban areas have better access to coordinated general practice and allied health services
- A portion of the $2.3 billion p.a. private health insurance rebate could also be used to bring rebates to a level that is reasonable and in line with actual practice cost increases

- Medical indemnity support could also be provided for practitioners in areas of need to ensure ongoing access to services e.g. GP obstetrics in rural communities.

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

SADI response:

- With ADGP, SADI supports the availability of flexible funding options that recognise the diversity of GPs, practice size and structure, practice styles, practice demographics and locations
- Funding mechanisms should support quality care including easing workload pressures on GPs enabling them to take up quality improvement activities. One strategy to ease workload pressures is to ensure adequate practice staff
- Funding should build the capacity of practices e.g. by replacing fragmented and unwieldy Practice Incentive Payments with an infrastructure grant that enables efficient automated clinical and business systems
- Funding should support practice population health approaches that allow practices to apportion work to the most appropriate person to deliver the care and enable a team approach. This is particularly important to appropriately and effectively manage the increasing prevalence of chronic diseases
- Funding should follow the patient and be targeted at achieving health outcomes
- Mechanisms to reward quality prescribing and diagnostic use should continue to be pursued through the Divisions of General Practice Network, with savings realised channelled back into supporting primary care service provision eg. through peer support networks, practice staff education and training, protected time for Continuing Professional Development, etc.

For further information please contact
Ms Valerie Williams, Executive Officer
or Dr Tori Wade, Medical Director of
SA Divisions of General Practice Inc
Ph: 08 8271 8988
valerie.williams@sadi.org.au
tori.wade@sadi.org.au