SUBMISSION TO SENATE SELECT COMMITTEE ON MEDICARE

Prepared by Wagga Wagga City Council

This submission addresses the following terms of reference:

The access to and affordability of General Practice under Medicare, with particular regard to:

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

(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

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

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

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

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

ACCESS TO AND AFFORDABILITY OF MEDICARE IN RURAL, REGIONAL AND OUTER METROPOLITAN AREAS OF AUSTRALIA

It is obvious to everyone in rural, regional and outer metropolitan Australia that access to medical services has become more difficult and is relatively more expensive than in the past.

Medical Services are a public service to which all Australians are entitled to equitable access. Clearly there is not equitable access to these services, and this is starkly evidenced by the AMWAC and AMA reports into the number of medical practitioners in metropolitan and non-metropolitan areas.[1]

Medical services are a public service that the Government has a responsibility to provide equitably for all Australians

There are a range of difficulties being experienced in the different areas, but across the board, the lack of available medical resources is the fundamental underlying problem.

The following indicators most clearly describe the problem.

Indicator 1 – Number of doctors per capita[2]

Metropolitan Areas:	306 medical practitioners per 100,000 patients
Other areas:	143 medical practitioners per 100,000 patients

The first and overriding concern is the lack of medical practitioners available to service patients in non-metropolitan areas. The figures are readily available which show the critical shortage of doctors and allied health workers outside of the metropolitan areas.

The concentration of medical practitioners in metropolitan areas results in inequitable access to services elsewhere and consequently, the medicare rebate that is repatriated to non-metropolitan areas is significantly less than metropolitan areas.

(b) continued

Indicator 2 – Medicare rebate repatriated per capita[3]

Metropolitan areas:	$125.59 per capita
Other areas:	$84.91 per capita

Rural and regional taxpayers pay the same medicare levy as their city counterparts but their recovery of the medicare rebate per capita is significantly lower than in metro areas. This is of course due mainly to the fact that there are insufficient doctors to provide services in non-metro areas and accordingly to bill Medicare. The repatriation of the medicare rebate is skewed toward metropolitan areas, with, in our estimation, approximately $220 million per annum being repatriated to metropolitan areas over and above what would be an equitable distribution based on population density.

Indicator 3 – Bulk Billing accessibility[4]

The third concern is that it costs more for medical services in non-metropolitan centres, due primarily to the lack of bulk billing. Recent figures published in the Sydney Morning Herald from a survey by NSW Health indicated that bulk billing rate in our area (Greater Murray Area Health Service) was in the order of 4% compared with 48% in South Sydney, 33% in Western Sydney and 28% on the Central Coast. The submission by the Alliance of NSW Divisions of General Practice clearly states that the financial incentive offered under the current proposal is 'totally inadequate' to reverse the 'deterioration and potential disintegration of Medicare in Australia.'

Where is the incentive for rural and regional practitioners to take on yet more patients at reduced rates in practices that are increasingly unprofitable and clearly underfunded compared to other professional entities?

Clearly the service is not being provided equitably, in fact there has been a failure of both the current policy settings and the market to provide equitable access to medical services

The medicare levy that is collected from all Australians equally regardless of where they live is not repatriated to all Australians equally

(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

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

SYSTEMIC MARKET FAILURE

At present, rural and regional communities are:

- effectively subsidising medical services in metropolitan centres through the medicare rebate scheme to an amount of $220 million per annum;
- enduring waiting periods on average of 6-8 weeks or are unable to gain access to a general practitioner at all; and
- when they do gain access are unfairly burdened with higher fees (regardless of whether or not they are entitled to bulk billing rates) because of the lack of competition in the market

The suggested policy changes are likely to exacerbate the current problem. We anticipate that doctors are more likely to practice in areas where they are able to maximise their revenue from the additional payment that they are now able to charge non-concessional patients over and above the bulk billing limit.

There is no incentive to practitioners to encourage them to consider relocation to areas of under-supply. In addition, where general practitioners already practice in an area of under-supply, bulk billing arrangements are often rare or non-existent. Hence there will be no competitive market forces to entice them to offer free care to Health Care Cardholder's because these patients do not have the option of choosing an alternative provider.

The suggested policy changes are likely to exacerbate the current problem

Our argument is that there is a market failure in the provision of medical services in Australia. The free market has failed to provide adequate accessible equitable services outside of metropolitan areas. The provision of medical services is a public service, which from a public policy point of view necessitates equitable access for all Australians. In economic terms there should be neutral resource allocation. In the absence of equitable access (where there is a gross distortion in the market, as in this case) there is an argument that Government should intervene in the market and regulate the supply of services to ensure (as far as practicable) the equitable access to those services.

The 1998 AMWAC Discussion Paper 'Medical Workforce Supply and Demand' has articulated this argument:

To a large extent these tensions are a function of the health care financing system which does not provide the price signals which would facilitate remedial action in many other market settings. For example, in an over-supplied GP market in a capital city, the current Medicare rebate stops the price of consultations dropping to the point where practices become uneconomic and some practitioners are forced out to less competitive and more remunerative locations. The universality of the rebate across Australia provides no financial weighting for the additional financial and social costs of practice in many geographic or socioeconomically disadvantaged locations, or for higher skill levels and longer consultations which may be necessary.[5]

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

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

EFFORTS AND OUTCOMES

For years, a range of initiatives have been implemented to try and redress the problem of inadequate medical services. The Department of Health, the Rural Doctors Association, the Australian Medical Association, the State Area Health Services, Universities, the various medical specialist colleges and individual doctors have all been actively pursuing various actions with the best intentions. Many of the initiatives relating to training of new doctors in rural and regional areas and some of the other initiatives have had limited success in attracting doctors.

The absence of appropriate price signals has resulted in a market failure in terms of distribution of medical services

We would argue however that these initiatives either have a generational lead time and will not have practical benefits for at least 10 to 15 years, or are essentially band-aid solutions which do not address the immediate crisis which is evident in medical services. Notwithstanding all of the effort made over the last 5 or so years, there is very little evidence that access to services has improved appreciably.

We propose that it is necessary to pursue a strategy that applies short-term economic stimuli until the longer-term strategies come into effect. This does not necessarily mean a permanent policy, but one for a defined period to enable a correction in the market until there is evidence of change in the distribution of medical resources.

We advocate that the government should implement short-term economic stimuli to restore the market to equilibrium

Australian Governments have a history of applying 'equalisation measures' to enable equity and access in resource allocation. The fundamental outcome of such a strategy would be to ensure that there is (as far as practicable) equitable access to medical services for all Australians, and consequently, there is an equitable distribution of medicare rebates.

(d) continued

AN ALTERNATIVE REMUNERATION MODEL

The primary idea which we propose is the implementation of a differential medicare rebate, with substantially higher rebates being provided in areas of greatest need (possibly on a sliding scale to reflect the extent of the problem being experienced). This idea is not new, and there are instances of this mechanism working around the world, for example in Quebec in Canada.

A differential medicare rebate is proposed between those areas that are adequately serviced and those that are unable to attract and retain medical practitioners. The quantum of the differential is a matter for determination but it needs to be sufficient to achieve two objectives:

(i) To provide a realistic incentive which is sufficiently attractive to medical practitioners to consider practising outside of metropolitan areas.

(ii) To redress the inequitable distribution of the medicare rebate within Australia.

While a substantial differential rebate of the scale proposed in Appendix 1 (Scenario 3) would have a short-term fiscal impact there would be significant long-term benefits in terms of moving General Practitioners to areas of greater need that would outweigh the costs.

(This impact assumes that it would not be possible to reduce metropolitan rebates accordingly given the strong evidence of declining incomes and increased expenditure for General Practitioners across Australia.)

One such stimulus would be the introduction of a substantial differential rebate

Government has a responsibility to stimulate or regulate the market to ensure access and equity

SUMMARY

Put simply we argue that:

(i) Medical services are a public service which the Government has a responsibility to provide equitably for all Australians

(ii) Clearly the service is not being provided equitably, in fact there has been a failure of both the current policy settings and the market to provide equitable access to medical services. In short, the Medicare Levy that is collected from all Australians equally regardless of where they live is not repatriated to all Australians equally.

(iii) The suggested policy changes are likely to exacerbate the current problem. In short, we anticipate that doctors are more likely to practice in areas where they are able to maximise their revenue from the additional payment that they are now able to charge non-concessional patients over and above the bulk billing limit.

(iv) There has been a market failure in terms of distribution of medical services in the absence of appropriate price signals to regulate supply. Under these circumstances we advocate that the government should implement short-term economic stimuli to restore balance in the market for medical services until long-term measures take effect.

(v) If the short-term economic stimulus such as a substantial differential rebate should fail to correct the market after the defined period, we would argue that, despite the implications of implementing such a scheme, geographic provider numbers would be an option to guarantee equitable access.

Assumption

We have used the data available through Health Insurance Commission & the Australian Tax Office and simply compared metro versus non-metro to present our arguments. However we are aware that outer-metropolitan areas and remote communities also experience significant and unique disadvantages and our arguments could easily be expanded to allow for their case given more detailed information. One approach would be to create a tiered differential rebate based on relative distance & remoteness from inner-metropolitan areas or based on GP: Population ratios.

Endnotes:

[1] Access Economics. *An Analysis of the Widening Gap between Community Need and the Availability of GP Services.* A report to the Australian Medical Association by Access Economics Pty Ltd. Canberra, ACT: February 2002. &
AMWAC (Australian Medical Workforce Advisory Committee), AIHW (Australian Institute of Health and Welfare). *Medical Workforce Supply and Demand in Australia: A Discussion Paper.* AMWAC Report 1998.8. AIHW Catalogue Number HWL 12. October 1998

[2] *Finding a Cure: NSW Summit on Rural Doctors Shortage*. Tamworth, 17-19 April 2002. Conference Papers. www.tamworth.nsw.gov.au

[3] Appendix One
(a) The Department of Primary Industries and Energy & the Department of Human Services and Health 1994. (PIE & HSH 1994). Population as at 30 June 2000. Source: ABS 2000. Excludes external territories.
(b) Data Request from the Health Insurance Commission (HIC)
Information Management Division Medicare benefits Report – In Confidence.
Report period 01/07/1999 – 30/06/2000. Date of service by provider postcode.
(c) Taxation Statistics 1999–2000 (Table 3: Personal taxpayers. Selected items by state and postcode)

[4] Sydney Morning Herald. *Bulk-billing rates are collapsing, says poll* By Ruth Pollard and Mark Metherell. February 12, 2003.

[5] AMWAC (Australian Medical Workforce Advisory Committee), AIHW (Australian Institute of Health and Welfare). *Medical Workforce Supply and Demand in Australia: A Discussion Paper.* AMWAC Report 1998.8. AIHW Catalogue Number HWL 12. October 1998.