MINISTER FOR HEALTH AND COMMUNITY SERVICES

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Senator Jan McLucas
Chair
Senate Select Committee on Medicare
Parliament House
CANBERRA ACT 2600

Dear Senator McLucas

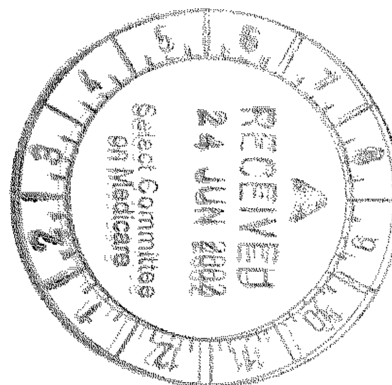
Thank you for your invitation to provide a written submission addressing issues which are of relevance to our Government.

Please find attached the Northern Territory's submission.

Yours sincerely

JANE AAGAARD

19 JUN 2003



SENATE SELECT COMMITTEE ON MEDICARE

ACCESS TO AND AFFORDABILITY OF GENERAL PRACTICE UNDER MEDICARE

SUBMISSION FROM THE NORTHERN TERRITORY GOVERNMENT

INTRODUCTION

The principle of universal access to health insurance and a guaranteed rebate based on a standard schedule of payments is a sound one. It is this approach which has contributed to a cost-effective system in Australia relative to that in other western countries.

However, general practice under Medicare has not served the people of the Northern Territory well despite the best efforts of Governments and the medical profession. The formal division of responsibilities between Commonwealth and State and Territory Governments with respect to primary health services has never reflected reality, especially in the NT, where there has always been a shortage of GPs. The Productivity Commission's publication *Report on Government Services, 2003*, confirms that the Commonwealth's investment in general practice in the NT is far below that of other States and Territories at $89.10 per person per annum compared with a national average of $158.50. The NT Government had been required to make up the deficit and provide substitute services in an area of Commonwealth responsibility in order to address the primary health care needs of a population with high rates of chronic illness and mortality.

NORTHERN TERRITORY CONTEXT

The NT has a small, highly dispersed population, a large proportion of which is Aboriginal (28 per cent). In general, Territorians are younger than other Australians. Within a total population of 199,900 (ERP December 2001), only 3 per cent are aged over 65 years compared to 12 per cent of the total Australian population. The Aboriginal population is particularly young with 38 per cent being aged under 15 years compared to 22 per cent of the NT non-Aboriginal population.

Most people (70 per cent) are resident in the five urban centres, all of which are remote from the rest of Australia. The two largest residential areas are Alice Springs and Darwin with populations of approximately 28,000 and 109,000 respectively. Of the Aboriginal population, most (70 per cent) are resident in remote communities although Darwin itself has an Aboriginal population of around 11,000. There is also growing demand for services in the rural community outside Darwin.

While the Aboriginal population is very stable, there is a component of the non-Aboriginal population which is very mobile, with a high proportion having moved from interstate and a high turnover of people each year as people move in and out of the NT. There has also been a large increase in the military population in the past 10 years affecting Darwin and Katherine. This 'migrant worker' population is characterised by a population of younger adults with young children.

Overall the health status of the non-Aboriginal population is similar to that of other Australians. However, most of the Aboriginal people in the NT have much worse social and economic circumstances, and worse living conditions and health status than other residents. NT Aboriginal

death rates are over three times higher than Australian national rates, and life expectancy is approximately 20 years less than that of other Australians. The severe disadvantages suffered by Aboriginal people in many aspects of their lives and their resultant serious health problems have a large impact on the services provided in the NT.

Alice Springs and Darwin are similar to other Australian cities in that they have a primary care service that is provided primarily by General Practitioners. However, even in these centres, a significant proportion of the population accesses health care through community health centres operated either by the Department of Health and Community Services or Aboriginal community-controlled health services. In addition, there are no GP clinics in the five major centres operating after 10pm. Because there are few private doctors and no private pharmacies outside the five main centres, NT residents in remote areas access health services from one of approximately 97 community health centres, the majority of which are funded and operated by DHCS.

The remainder are health services funded by the NT but operated by local Councils or Health Boards and Aboriginal community controlled services that receive Commonwealth funding or a mix of NT and Commonwealth funds. Around 20 health centres have a GP, but by far the majority are operated by Nurses and Aboriginal Health Workers supported by visiting District Medical Officers and Allied Health Professionals.

There are also five public hospitals in the NT, in Darwin, Alice Springs, Katherine, Tennant Creek and Nhulunbuy, and one private hospital in Darwin.

THE ACCESS AND AFFORDABILITY OF GENERAL PRACTICE UNDER MEDICARE

(a) Impact of the current rate of the Medicare Benefits Schedule and Practice Incentive Payments on practitioner incomes and the viability of bulk-billing services.

The general practice community has increasing expressed concern about its viability under Medicare. A high level of dissatisfaction within the profession is widely reported. As evidence of this, bulk-billing rates in the NT continue to fall in line with the national trend (Table 1) and those patients who do pay extra, pay more than most people in Australia (Table 2).

Table 1

Medicare - % of unreferred attendances (GP) bulk-billed*
12 months to December 2000, 2001, 2002

	2000	2001	2002
Solomon *(Darwin and Palmerston)*	59.0%	59.2%	57.2%
Lingiari *(other NT)*	71.6%	70.3%	71.8%
Total NT	63.9%	63.3%	63.3%
Total Australia	77.6%	75.2%	69.6%

*Based on enrolment postcode
Source: Senate Community Affairs Legislative Committee, Answers to Estimates Questions on Notice 13 February 2003

Billing practices in Darwin and Palmerston are more akin to RRMA 3-6 patterns (Attachment 1) than to capital city and other metropolitan centres. The rest of the NT has the expected billing practices of RRMA 7. In the NT, the only GP practices which bulk-bill all patients are those that target Aboriginal people.

Table 2

Medicare – Average patient contribution[#] per service* 12 months to December 2000, 2001, 2002			
	2000	**2001**	**2002**
Solomon *(Darwin and Palmerston)*	$16.85	$17.94	$19.42
Lingiari *(other NT)*	$15.33	$15.72	$16.97
Total NT	$16.37	$17.20	$18.61
Total Australia	$10.95	$11.50	$12.77

*Based on enrolment postcode
[#]Patient contribution is calculated as the difference between the fees charged and benefits paid. It is in relation to patient-billed, non hospital GP services only.
Source: Senate Community Affairs Legislative Committee, Answers to Estimates Questions on Notice 13 February 2003

The average patient contribution for Darwin and Palmerston is the highest in Australia, except for Sydney – an average of $19.42 per service on top of the Medicare benefit (Table 2). Those residents of Lingiari who are not bulk-billed, on average, pay an extra $16.97 every time they see a GP. The average Australian pays only $12.77 extra.

For whatever reason, GPs in the NT have indicated the need to have high fee-for-service rates. Additional income from the Practice Incentives Program is accessible only to accredited practices, and because there are significant barriers to accreditation in our remote communities, uptake of PIP has been low in the NT.

Although the Relative Value Study has not resulted in a final agreed result, it has indicated that the present MBS fee structure is inadequate to cover general practice costs. Clearly this needs to be addressed.

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

The high rates of morbidity in the NT require significant investment in primary health care services. The costs of delayed diagnosis and resulting chronic disease are high. Regional Planning studies conducted under the Primary Health Care Access Program used ideal staff / population ratios which reflect the health needs of Aboriginal people. The GP ratio is 1:400 for a small community with modifications in larger communities to acknowledge economies of scale.

Clearly these rates are not being attained and the NT Government has maintained the system of community-based nurses and Aboriginal Health Workers supported by visiting District Medical Officers and allied health professionals.

The shortage of GPs in the NT not only exists in remote areas but also in Darwin, Palmerston and Alice Springs. Last year, the NT Remote Health Workforce Agency conducted a survey of GP to population ratios of GP services. The results were found to be well below any agreed national benchmark. The NT wide ratio is 1 GP: 1,601 people, Darwin has 1:1,660, Alice Springs 1:1,647 and Palmerston and rural areas, 1: 2,949. This is well below any agreed national benchmarks.

(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

Currently many more people than Commonwealth concession card holders are bulk-billed. For general practices in Darwin and Palmerston, who currently bulk-bill at least one in every two patients, the incentive of $1 per service bulk-billed to Health Care Cardholders is unlikely to effect access to services. These GPs already charge their other patients an average of $19.42 extra.

For Palmerston and rural areas where there are significant workforce shortages, the incentive is even less likely to be effective if they are related to RRMA classifications. The NT Government and GP organisations in the NT argue that Palmerston and rural areas should be treated as RRMA 3 for the purposes of practice incentives because of their workforce issues.

However, this initiative indicates to the public (and doctors) that bulk-billing is only expected to apply to Health Care Card holders. This is contrary to the view of many in the community. It may mean that that low-income people without a Commonwealth Concession Card, who had previously been bulk-billed, will now be charged for services as the doctors attempt to transfer the financial risk to other patients. These people should not be tempted to wait until they are really sick before they go to see the doctor, or find they must turn to our hospital Emergency Departments for help. This could result in increased usage of hospital Emergency Departments with resulting flow-on of costs to States and Territories.

It is acknowledged that this aspect of the package will provide assistance to those GPs who already bulk-bill all their patients, for example, in Aboriginal Medical Services. In particular, the increased incentives for remote areas will be welcome in the NT.

An ADGP survey of GPs indicates that they do not support the new package. The requirement to opt in before receiving any aspects of the package is one to which GP are likely to find most objectionable.

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

This aspect of the package seems attractive at first glance. It is likely to be well received by patients who have only to outlay the 'patient contribution' instead of the full fee. However, this may result in an attempt by doctors to increase fees by what seems, to the patient, to be a small amount.

This will result in a structural change in the way in which increases in costs are paid for – from public means to private.

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

This safety net is welcome although its interaction with the existing scheme for all patients will cause confusion. For simplicity, it would be best to have the scheme cut in at the same threshold level.

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

This element of the proposal is not likely to improve access or affordability. It is most likely to increase the fee charged by doctors to patients with insurance. This is a practice with which we are already familiar in relation to workers compensation and other insurance schemes.

(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

Any changes to Medicare needs to address under performance of the scheme in the NT. As stated previously, the Commonwealth's investment in general practice in the NT is almost half of that in the other States and Territories.

Oral / dental health is a component of general health. There is evidence of a strong association between poor oral health (in particular periodontal disease) and prematurity, low birth weight, cardiovascular disease and diabetes. Good oral health is preventative health care as well as being medically necessary in preventing complications in procedures such as cardiac surgery, renal transplantation and conditions such as hepatitis C. It should be part of any preventable chronic disease program and a component of the overall health management plan in the management of diabetes and renal failure.

Oral health is particularly important in Aboriginal health because of the extremely high prevalence of chronic disease. In their strategic framework, the National Aboriginal and Torres Strait Islander Health Council has identified oral health as one of the 10 priority areas requiring urgent Government attention.

In the same way, certain allied health services are essential components of health care for many health conditions. At the very least, they minimise impairment and disability and prevent high cost long-term care. The availability of allied health services in the public hospital system is one of the reasons why people choose to attend Emergency Departments and hospital outpatient services.

The recommended approach is to extend Commonwealth funding to oral health and allied health in specifically funded programs that target health problems in an evidence-based fashion.

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

Figures for the NT population indicate that the number of people with health insurance is around 8 to 10 per cent below the national average. There is only one private hospital in the NT so options for utilisation of private hospital insurance are limited. Since the significant increase in the uptake of private health insurance with the introduction of lifetime cover in 1999, the NT has experienced a small but consistent decrease in the level of coverage over the past 3 years. Non declaration of private insurance status in public hospitals is also an issue.

There are no indications in the NT that the increase in private health insurance has had any effect on the public hospital system.

Funding from the rebate should be more appropriately and more effectively directed to primary health care and the management of chronic disease.

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

Medicare may not guarantee universal access to GPs but it does guarantee universal access to the Medicare rebate. This is the fundamental component that must be retained and adequately funded. The decline in bulk-billing has contributed to the creation and widening of health inequalities. Clearly the rebate must be increased in keeping with increased practice costs.

Attachment 1

Bulk-billing rates and patient contribution for unreferred services by RRMA – Dec Qtr 2002

	Bulk-billed	Ave Contribution*
	%	$
Sydney	85.08	14.98
Rest of RRMA 1	69.39	13.25
Total RRMA 1	75.08	13.63
RRMA 2	67.91	13.06
RRMA 1 & 2	74.36	13.56
RRMA 3	53.38	12.03
RRMA 4	53.74	11.45
RRMA 5	52.96	11.18
RRMA 6	57.66	15.51
RRMA 7	70.71	13.76
RRMA 3-7	54.15	11.64
TOTAL	**69.58**	**12.87**

* for patient billed services

Source: Senate Community Affairs Legislative Committee, Answers to Estimates Questions on Notice 13 February 2003