Presentation to the Senate Select Committee on Medicare



Why Victoria opposes the proposed changes to Medicare

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Victoria
The Place To Be

The basis of Medicare

In 1984 the Commonwealth and States agreed that under Medicare there would be:

- Universal access to medical and hospital care for all Australians

- Funding for Public Hospital services shared between State and Commonwealth Governments

- Medical care in general practice funded by the Commonwealth with the States providing free services at Public Hospital Emergency Departments

After 20 years, we find

- Public hospitals continue to provide universal access but the State and Commonwealth share of funding is no longer equal
  - Victoria's share of public hospital funding is now over 50% and the Commonwealth only 40%
- A declining proportion of people can access GPs
  - Too few doctors in outer suburban, rural regions
  - Decrease in bulk billing & after hours availability
- Public hospital emergency departments are under increasing pressure
  - At 8% per annum growth, emergency departments are facing the fastest growing demand for hospital services

The number and rate of bulk billed GP services is dropping

- Two million fewer bulk billed GP services in Victoria in the last two years

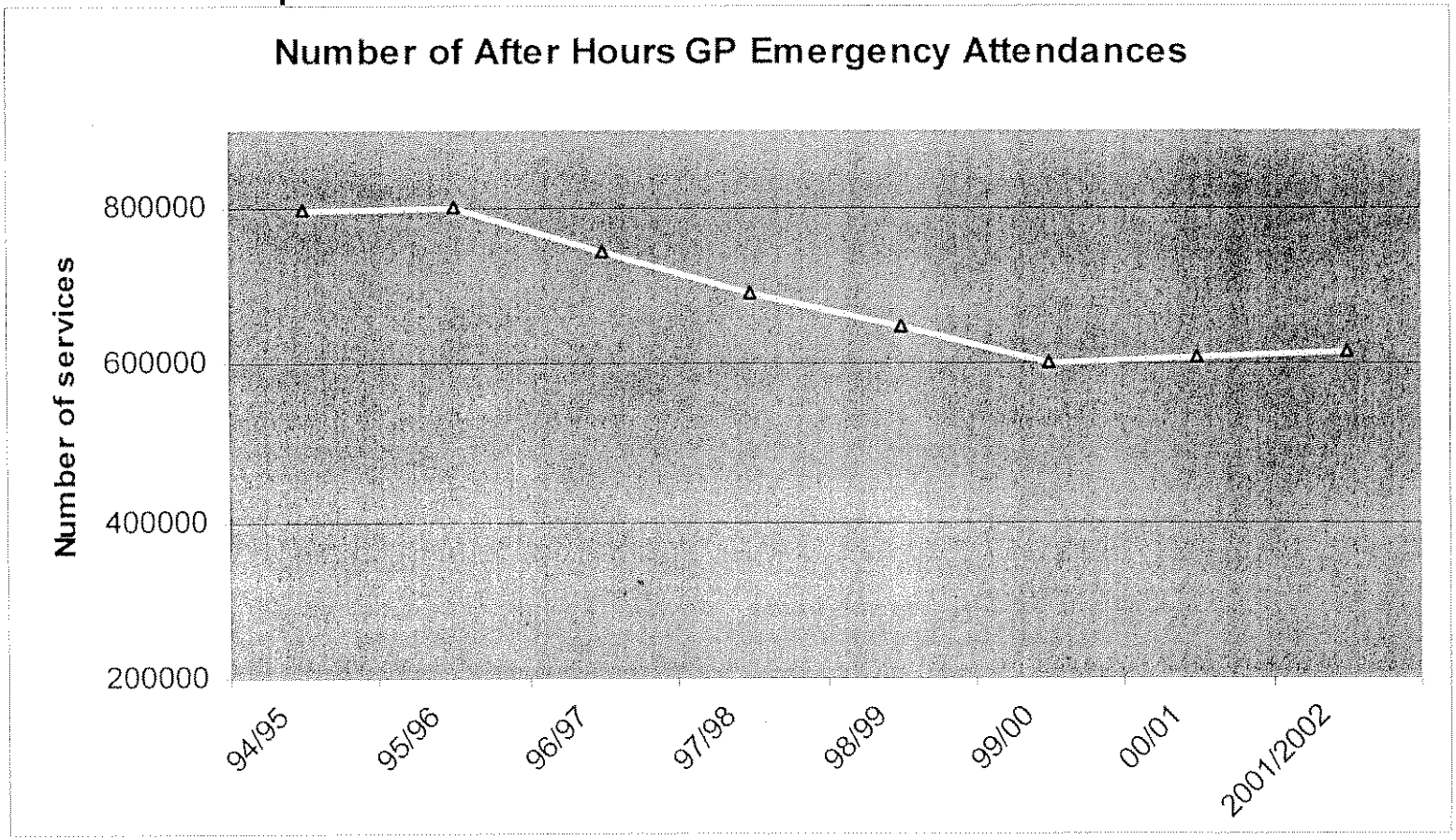
No.of GP attendances bulk billed (by broad service type)

	Million		Percentage	
	Victoria	Australia	Victoria	Australia
1997-98	20.3	82.3	79.1%	79.8%
1998-99	20.3	81.5	79.0%	79.4%
1999-00	20.1	80.3	78.6%	79.1%
2000-01	19.3	78.1	76.7%	77.6%
2001-02	18.3	74.9	73.4%	74.9%
Mar-03	n/a		n/a	68.5%

HIC Annual Reports (Unreferred attendances- Table 9A and 9B)

After hours GP access is not improving

- Down by 25% over four years to 1999/00
- Little improvement from recent incentives



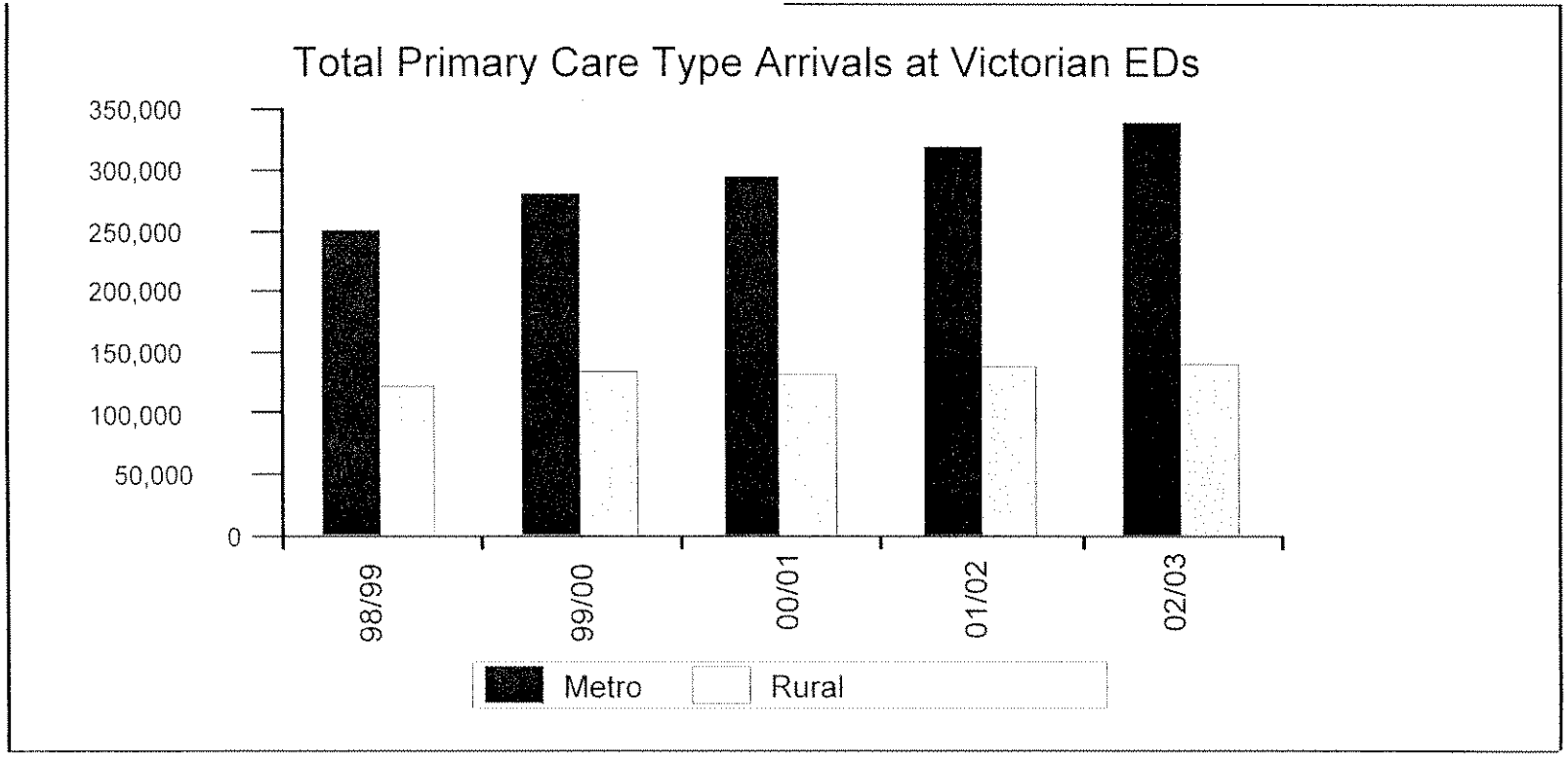
Who are Primary care Type patients?

- Do not arrive by ambulance
- Are not referred by a GP
- Are triage Category 4 or 5
- Are not admitted
- Have a total ED length of stay of less than 12 hours

GPDV, Policy Issues paper No 16. April 2002

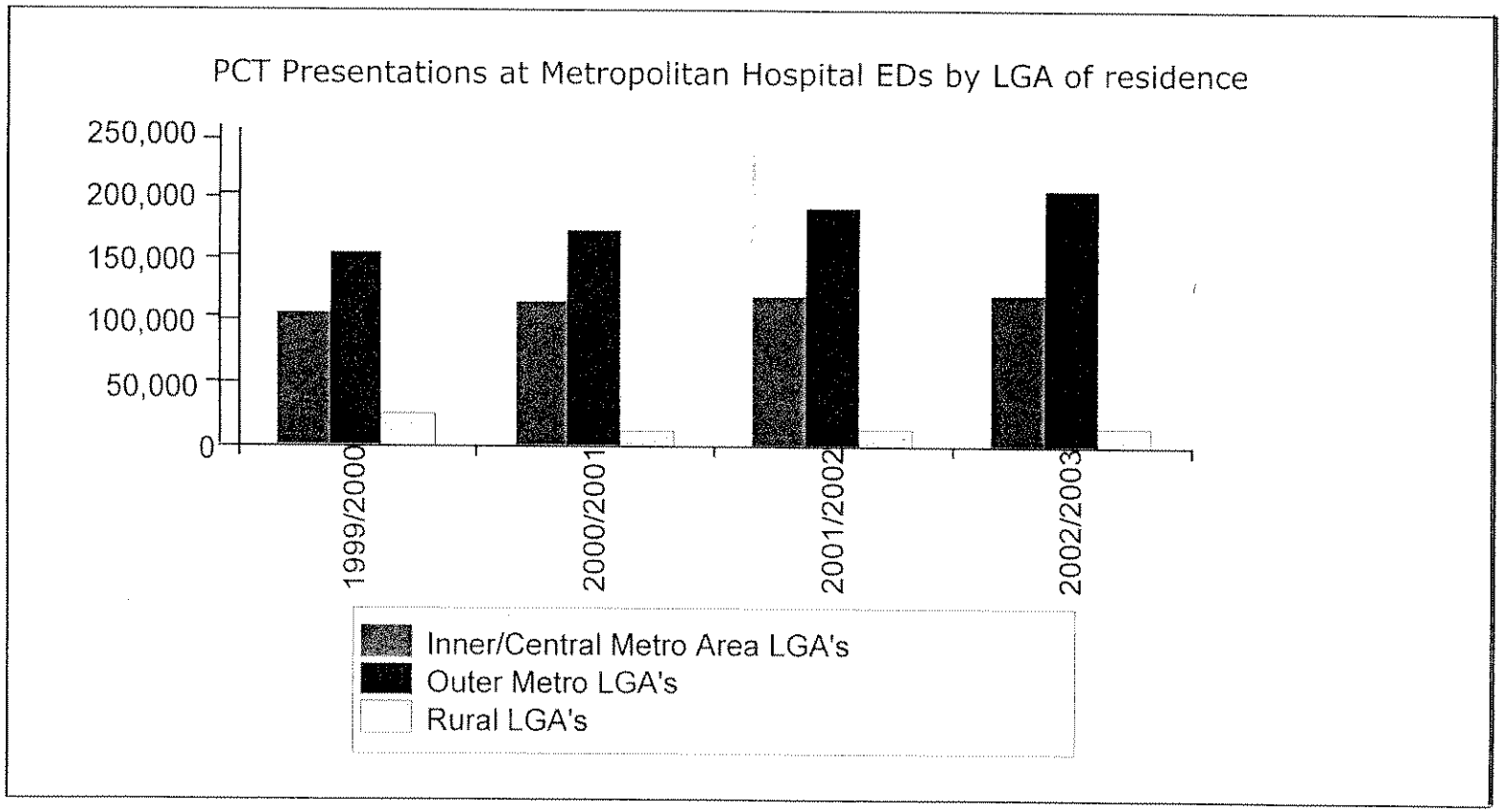
Rapid growth in Primary Care type patients presenting to Emergency departments

- Growing at an average 6.5% or 25,000 patients per year



Increased demand is greatest on outer suburban hospitals

- The growth in Primary Care Type patients at hospitals is closely linked to areas of GP shortage



In addition, out-of-pocket costs to patients are increasing

- Co-payments increased more than CPI in 32 out of 37 Victorian Federal electorate, *(Sept 2001 - Sept 2002)*
  - Calwell 22.0%,
  - Mallee 18.2% and
  - La Trobe 17.6% increase.

- Proposed changes are an invitation to doctors to continue increasing co-payments and demanding them from more patients

- The recent introduction by one practice of a three tier scale to enable people to "jump the queue" sets another bad precedent which will be encouraged by the proposed changes.

Needs of vulnerable members of the community will not be met

- Only an estimated 16% of GPs provide services in residential aged care facilities:
  - Levels of remuneration perceived to be poor - $1.45 per patient after the 7th patient seen in the facility
  - The level of paperwork GP must complete for the facility to fulfil accreditation requirements viewed as too onerous
  - The lack of appropriate consultation facilities and basic equipment for simple procedures undermines quality of care
- Higher co-payments mean many poor people will avoid going to the doctor.
- Prevention and screening programs will miss those who are in the greatest need.

High level of GP dissatisfaction

- Failure of Medicare rebates for GP 'bread-and butter' services to keep up with CPI
- Increasing practice costs
  - High wages cost for locums and sessional doctors
  - Rising Medical indemnity costs
- Perceived poor remuneration, particularly compared to other medical specialties
- Increasing red tape
- Compliance and administrative costs resulting from Commonwealth policies and programs
  - Estimated at $13 100 per GP or $228 million a year

Proposed changes to Medicare create a two tier system

- Undermines universal access to health care;
- Entrenches discrimination against low income families, with access to GPs on 'ability-to-pay';
- Effectively means bulk billing will only be available to concession card holders in well off areas where doctors can charge high fees to others;
- In poor areas the incentives are insufficient for GPs with high levels of patients on concession cards;
- These GPs will choose not to participate and will charge a universal co-payment

Measures to address workforce shortages, too little, too late

- Only 10 of the promised 234 additional medical places per year are for Victoria and it takes 12 years to fully train a vocationally registered GP
- The 38 additional Victorian GP training places are also welcome but won't have an impact until 2008
- The State needs over 60 extra doctors urgently
- The $64.2m for nurses and allied health in general practice is welcome but amounts to a little over 0.5 EFT per practice - estimated at 65 EFT for whole of Victoria.

Doctors get the major benefits

- $346.2m for small additional amounts for each concession card holder bulk billed
  - $1 each for city doctors, $2.95 each in outer metropolitan areas, $5.30 in rural centres, $6.30 in remote areas
- The right to charge substantial co-payments to all other patients, including low income families
- $35.3m to encourage GPs to take up new business arrangements
  - $11m for direct claiming arrangements
  - $24.3m to encourage uptake of HIC Online

Consumers face increased co-payments and insurance costs

- $67.1m to extend the MBS safety net for concession card holders. Most will pay more.
  - $500 threshold and 80% out-of-pocket costs over the threshold
- $89.6m to subsidise Health funds to offer medical gap insurance for non concession card holders
  - $1000 threshold
- No guarantee the premiums for Medical gaps cover will be kept to $1 per week.
- Both are expensive to administer and assume patients will be paying more

Proposed changes to Medicare will aggravate current trends

- Promote the rapid decline of bulk billing to all but concession-card holders
- Even less access to After hours GP services
- Introduce new barriers and reduce access, particularly for chronically under serviced members of the community
- Increase the disincentives for GPs to under service vulnerable groups such as residents of aged care homes
- Unlikely to attract sufficient GPs to geographical areas of GP shortage such as rural and regional areas and the outer suburbs

...and further increase pressure on hospitals

- Further increase in demand for public hospital services through Primary Care Type patients presenting to Hospital Emergency Departments.
- Undermining prevention and increasing acuity through deferral of treatment
- Public hospitals will become an overstretched "safety net" providing free Primary Care Type services for those unable to find a GP willing to bulk bill.
- Yet, funding for the Medicare changes has been cut from Commonwealth grants to the States for public hospitals

The Commonwealth funding offer for public hospitals is inadequate

- $918m has been cut from the Commonwealth forward estimates for public hospital funding ($350m less for Victoria over next five years)
  - This is equivalent to the loss of funding for an entire public hospital such as Maroondah Hospital ($70m a year)
- Funding has also been cut through:
  - Reduced adjustment for utilisation growth – 1.7% vs 2.1% pa in current AHCA
  - Utilisation growth applies to smaller share of grant
  - Lower starting point for quality funding

Public hospital is capped, private hospitals get full increases

- The overall real increase for public hospitals is capped around 3% pa for the next five years
- Yet, the Commonwealth has recognised medical costs are rising faster than this through the increases granted to private health funds:
  - 8.5% increase between 2001 and 2002
  - 6.3% proposed increase between 2003 and 2004
- And this unfair advantage will continue as private health insurance premiums rise above CPI and GP services come under Private Insurance

Why Victoria opposes the proposed changes to Medicare

GUIDING PRINCIPLES OF THE CURRENT MEDICARE	GUIDING PRINCIPLES OF THE PROPOSED MEDICARE
Universal coverage	2 tier Medicare
Equitable access to doctors	Access based on ability to pay
Fairness	Inherently unfair
Sustainability (of the system)	Undermines the system (especially public hospital EDs)
Simplicity for doctors and patients	Multiple payment arrangements and systems
Adherence to current fee setting parameters	Incentives to charge larger co-payments destroy bulk-billing for all but concession card holders

In summary, what Victoria would like

- Commonwealth to restore access to general practice through:
  - Increasing MBS rebates
  - Providing incentive payment to GPs (rural, outer metro and undersupplied areas) if they meet bulk billing targets
- $918 m for improving Medicare to come from additional funds – not funds taken from the AHCA funding for public hospitals.
- A re-commitment to the reform agenda of improving the interface between hospitals and primary and aged care services.