BH:AG

10 July 2003

Mr Elton Humphery, Secretary
Senate Select Committee on Medicare
Suite S1 59
Parliament House
CANBERRA ACT 2600

Dear Mr Humphery,

Thank you for the opportunity to contribute to this Inquiry. The New South Wales Nurses' Association (NSWNA) is the industrial and professional body that represents over 48,000 nurses in NSW and is also the NSW Branch of the Australian Nursing Federation. The membership of the Association comprises all those who perform nursing work, from assistants in nursing who are unregulated, to enrolled and registered nurses at all levels including management, education and in the academic area.

The Association is of the view that this Inquiry has the potential to highlight the fact that Australia's system of health care is affordable, equitable and of high quality, largely due to the system of universal access operating over the last quarter of a century.

Health care is financed in Australia in a manner that reflects our commitment to a just and humane society and our recognition of the shared benefits of a high standard of health and well-being in the community. Investment in primary health care is the key to achieving a high quality and efficient health system and is essential for the wider social and economic development of the nation.

The inverse relationship between health status and socioeconomic status, the rising costs of medical technology, increasing income disparities and the ageing population are all factors that demand government intervention to redistribute health resources to ensure efficient outcomes.

Rationing of health resources along the lines of capacity to pay is inconsistent with the goal of affordable access to high quality health care for every Australian. It is clear from international experience that market forces are neither efficient or effective mechanisms to ensure the shared social benefits of a healthy population.

NSWNA is fundamentally opposed to the introduction of uncapped co-payments, incentives to restrict bulk-billing to healthcare card holders and a payment system that creates the illusion of reducing upfront costs by disguising growth in co-payments.

The Government's proposed changes to Medicare, if implemented, will have the effect of creating a two-tier system of health care, where poorer and more vulnerable Australians will face real financial barriers to accessing essential primary health care.

Yours sincerely

BRETT HOLMES
General Secretary

Sumission to the Senate Select Committee on Medicare

July 2003

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;*

Bulk-billing by General Practitioners (GPs) is a key mechanism that ensures equity of access to primary health care on the basis of need rather than capacity to pay. The continuing fall in rates of bulk-billing and concomitant rising level and incidence of co-payment indicate that adjustments are necessary to maintain the high quality and low cost health care that is available to every Australian through Medicare.

It is clear that an increasing number of GPs have reached the conclusion that the Medicare rebate is insufficient to meet their business objectives and that the imposition of a co-payment is necessary to ensure the viability of their practice. This trend has a number of implications for access, affordability and quality of care.

The decision to bulk-bill services is at the discretion of the GP. If the rebate is maintained at a level that is competitive in terms of the market for general practice services, then bulk-billing will remain a viable option that has advantages for both providers and consumers. More importantly, widespread participation in bulk-billing has a strong cost-containment effect on the aggregate costs of health care, which has enormous benefits shared by the whole community.

Practices that do provide universal access through bulk-billing have been forced to develop business processes that maximise the cost-effectiveness and efficiency of their service. Consultations are only as time consuming as is absolutely necessary, assessments are less than comprehensive and quality care is compromised.

GPs electing to bulk-bill some patients, whilst charging co-payments for others have acknowledged that co-payment rates reflect the need to subsidise the services provided to bulk-billed patients. This two-tier pricing arrangement has the effect of creating two types of patient. The logical consequence is an inflationary pressure on the level of co-payment to subsidise the cost of bulk-billing, as well as resource constraints on bulk-billed consultations.

Further, as bulk-billing becomes increasingly peripheral to the market and and the practice of imposing upfront fees becomes more widespread, the cost containment effect of Medicare is lost. The inflationary effect of these market forces will be particularly evident in areas of GP shortage where demand surpasses supply and competitive pressures are absent.

Ample evidence is available to support the contention that access to general practice is already restricted and less affordable. A number of studies have provided evidence that upfront costs represent significant barriers to access:

- Consultations tend to be shorter for lower socio-economic groups, which may undermine the quality of the care provided.[1]
- Patients indicate that financial barriers prevent them from adhering to the advice of their doctor.[2]
- Patients indicate that cost has a direct influence on their decision to seek timely primary health care, fill prescriptions and seek recommended diagnostic tests and follow up.[3]

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

The increasing pressures associated with general practice, the diminution of the intrinsic rewards of the work and the failure of funding arrangements to satisfactorily compensate GPs has had the inevitable effect of reducing the attractiveness of general practice as a career and the predictable workforce shortage has developed.

The decrease in supply of GPs[4] has impacted on patients' ability to access appropriate care in a timely manner in a number of ways. Community demand is not reflected in the supply and distribution of general practice with serious implications for equity and affordability.

In some of the most affluent metropolitan areas where GPs are in plentiful supply, the heightened competition has contained the growth of co-payments and rates of bulk-billing remain high.

Conversely, in rural and remote areas where the general practice workforce is in chronic shortage, many areas do not have access to a GP that bulk-bills and where bulk-billing is available, waiting times are often excessive. Patients from rural and remote areas are also subject to the necessity to travel long distances, which has serious effects, not only in terms of affordability and timeliness of access, but also outcomes.

These anomalies are more significant when one considers the well-documented link between socio-economic status and health[5]. The shortage and maldistribution of GPs has given rise to a situation where those most able to pay but with least need have access to an oversupply of bulk-billed services and those with the greatest need and least capacity to pay are subject to severe scarcity, long waiting times and in some cases, prohibitive costs. It is a situation that is strikingly inconsistent with the principle of access priority based on clinical need rather than capacity to pay.

In the context of severe GP shortages, the centrality of general practice to primary health care and the role of GPs as gatekeepers to the rest of the health care system means that a significant portion of the community will have delayed or limited access to appropriate and timely care, with serious implications for population health outcomes generally.

(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,*

There are numerous concerns and problems raised by this proposal. In responding to this issue, the NSWNA would first like to emphasise that access to bulk-billing is not free care: Australians pay for bulk-billed services through the taxation system.

It is clear that entitlement to a health care card is not a reliable indicator of need. For example, a 1996 survey[6] examined the issues related to access and affordability of health care for patients with chronic illness who are ineligible for Health Care Cards due to their level of income. The findings of this study underscore the catastophic effect that the Government's proposal could have on the health of this group. Even at existing levels of access and affordability, the expense of medications and other needs for the effective management of chronic illness are resulting in hardship, regardless of income.

In some circumstances, individuals spend a large proportion of their income on the medicines and other services necessary to manage their health needs and remain independent and productive. In doing so, they retain their capacity to contribute to the community through taxes (including the Medicare levy), they prevent relapse or deterioration of their condition, thereby containing the cost to the community of their health needs, but all at great financial hardship to themselves.

Respondents to the survey also indicated that the financial pressures associated with their illness contributed to *"a downward spiral of ill-health and poverty"*[7]. The allocation of concessions for health care on the basis of income thresholds demonstrates a flawed understanding of the needs of health care consumers, the value of unfettered access to primary health care and the cost-effectiveness of early diagnosis and treatment intervention before more expensive therapies are necessary.

The expansion over recent years of access to concession cards for particular groups also invites comment with regard to the fair, accessable and affordable distribution of health care services. For example, a retired couple who are too wealthy to qualify for the Age Pension but who have an annual income less than $80 000 are eligible for the Seniors Health Care Card, and under the Government's proposals, incentives will be provided to GPs to bulk-bill this group.

No incentives will be provided however, to enhance the access of families with considerably lower incomes to bulk-billing. In fact, with the inflation of upfront costs associated with the absence of the cost-containment effect of the MBS, middle-income families will face financial barriers to accessing general practice.

The reality of general practice is that GPs are operating a small business in an increasingly pressured environment that demands tight fiscal management. The number of GPs willing to settle for the MBS rebate is diminishing and there is clear evidence of the economic imperatives influencing the decision to bulk-bill. A proposal that reinforces the notion that free access to health care is necessary only for the most disadvantaged in society, as opposed to strengthening the

community's commitment to and support of universal access, will inevitably result in many members of the community unable to afford upfront fees or insurance having limited access to health care.

Limiting incentives to bulk-bill to healthcare cardholders or those beneath an income threshold will entrench a two-tiered system of health care, with second-class care available to second-class citizens while high quality services become increasingly the preserve of the wealthy.

The Minister for Health's repeated claim that this proposal will not contribute to a reduction in the availability or quality of bulk-billed services to non-healthcare cardholders defies reason and logic. Further, the NSWNA objects to the Government's deflection of the responsibility for ensuring access to bulk-billing GPs. The NSWNA believes that it is the responsibility of Government to set the Medicare rebate at a level that maintains bulk-billing as a viable option for the business of general practice.

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

Under current arrangements, the requirement for the bulk-billing doctor to accept the Medicare benefit as full payment for a service has an important cost-containment affect.

If a co-payment is charged, then the patient must be presented with the full account and claim the Medicare rebate separately[8]. Allowing co-payment at the point of service co-incidental with direct rebate reimbursement would disguise inflating co-payments.

While in the short-term it may lower the upfront payment, it would not make the actual service more affordable. In fact, it would foster the growth of co-payments and exacerbate the difficulties faced by many Australians attempting to access affordable primary health care.

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

The NSWNA is firmly of the opinion that the value of universal access to health care for every citizen is underpinned by sound economic as well as social rationales. For reasons outlined previously, any proposal to undermine universal access would result in a two-tier system of health care with substantial long-term costs to the community.

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

The NSWNA is opposed to an expansion of the role of private health insurance in the funding of primary care in Australia for reasons related to efficiency and equity.

Many Australians not entitled to healthcare cards already have difficulty paying private health insurance premiums, and it is clear that the 30% Private Health Insurance Rebate favours high-income earners rather than low-income earners.

Extending private health insurance to cover out-of-hospital out-of-pocket medical expenses would facilitate the inflation of co-payments and insurance premiums. Further, it is reasonable to expect that those who opt for such insurance will seek to withdraw from contributing to the publicly funded scheme through the Medicare levy.

Australian policy-makers have the advantage of examining other systems that have opted to rely on private health insurance and it is outrageous, given the bleak outcomes that have accompanied the American experience, that an Australian government would pursue an arrangement with such clear implications for the cost and just distribution of healthcare resources.

(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,

NSWNA urges the Government to recognise the critical importance of a robust primary care sector and the inherent advantages, both in terms of costs and outcomes, of high quality preventative care, early intervention and effective management of chronic conditions.

Extension of federal funding to cover the services of nurse practitioners, practice nurses and other disciplines would allow a range of expertise to participate in and strengthen the role of the primary health care sector.

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

The NSWNA is opposed to public subsidy of private health insurance for a proportion of wealthy Australians. The $2.3 billion this subsidy costs[9] should be immediately redirected to the public system which benefits every Australian.

The Private Health Insurance Administrative Council[10] indicates that the introduction of this expensive rebate did not promote uptake of private health insurance by Australians and that it was only with the introduction of Lifetime Health Cover, a measure that extorted the public into opting out of the public

system, that the proportion of Australians privately insured increased signifacantly[11].

Again, the Government has failed to consider the implications for equity and fairness of this measure. It is an un-means tested benefit that offers substantial benefits to those on higher incomes, but which poses a real problem for those on lower incomes who would struggle to take out private health insurance.

Further, the public subsidisation of Extras cover, for health 'accessories' such as sports shoes, gym memberships and golf-clubs, at the expense of universal access to primary health care is irrational and unacceptable to any fair-minded Australian.

In view of the 30% Private Health Insurance Rebate's failure to reduce the burden on public hospitals[12] and failure to distribute resources fairly or equitably[13], it should be scrapped immediately and the billions saved should be rightfully returned to the public system that benefits every Australian.

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

Maintenance of the principle of universality in our health care system is not difficult. The NSWNA supports a MBS rebate set at a level that retains the cost-containment competitive pressure on the primary health care market.

NSWNA also calls for a model of remuneration that provides real incentives to GPs to bulk-bill 100% of consultations as well as significant incentives to ensure that the maldistribution of services is corrected.

[1] Furler, Harris, Chondros, Powell Davies, Harris and Young (2002) The inverse care law revisited: impact of disadvantaged location on accessing longer GP consultation times, *Medical Journal of Australia,* 177 (2): 80-83.

[2] Blendon, Schoen, DesRoches, Osborn, Scoles and Zapert (2002) Inequities in Health Care: A Five Country Survey. *Health Affairs,* 21: 182-191

[3] Blendon, Schoen, DesRoches, Osborn, Scoles and Zapert (2002) Inequities in Health Care: A Five Country Survey. *Health Affairs,* 21: 182-191

[4] General Practice in Australia: 2000, Department of Health and Ageing, Accessed from http://www.health.gov.au/gpconnections/gpinoz.htm July 2003.

[5] Walker, A.-- Health Inequalities and Income Distribution, Australia: 1977 to 1995 --Paper prepared for the 7th Annual National Health Outcomes Conference. Canberra, Australia. 27-28 June 2001. Accessed from http://www.natsem.canberra.edu.au/pubs/cp01/2001_002/cp2001_002.pdf, July 2003.

[6] *"Some Illnesses Are More Expensive To Live With Than Others:* A survey of costs to people with chronic illness who do not have a health care card", 1996, Chronic Illness Alliance, Melbourne, Accessed from http://www.chronicillness.org.au/healthcard.htm, July 2003

[7] ibid

[8] Health Insurance Commission, http://www.hic.gov.au/yourhealth/our_services/am.htm#f, accessed July 2003

[9] Commonwealth Department of Health and Ageing (2003) *Portfolio Budget Statements 2003-2004 – Outcome 8: Choice Through Private Health,* Accessed from www.health.gov.au/budget2003/pdf/out8.pdf July 2003.

[10] Source: Private Health Insurance Administrative Council (PHIAC), *Membership and Coverage*, Accessed from www.phiac.gov.au/statistics/membershipcoverage/hosquar.htm July 2003.

[11] Source: Private Health Insurance Administrative Council (PHIAC), *Membership and Coverage*, Accessed from www.phiac.gov.au/statistics/membershipcoverage/hosquar.htm on 29 May 2003.

[12] Duckett, S. and Jackson, T. (2000) 'The new health insurance rebate: an inefficient way of assisting public hospitals', *Medical Journal of Australia,* Vol. 172, pp. 439-442.

[13] Smith, J. (2001) *How fair is health spending? The distribution of tax subsidies for health in Australia,* The Australia Institute, Discussion Paper No. 43.