Chapter 5

Other issues

Introduction

5.1 This chapter addresses four additional matters raised during the inquiry. These include two measures that are contained in the government package:

- the proposed billing measures to enable the direct online claiming of the Medicare rebate from the doctor's surgery; and
- the proposed aged care measures.

5.2 The chapter also considers two that are not:

- access to dental care; and
- addressing the need for deeper system reform to the Medicare system.

HIC Online and direct lodgement of Medicare claims

5.3 In cases where a patient is not bulk billed, the government proposes to change current arrangements to enable MBS claims to be lodged electronically at the point of service (ie. at the doctor's surgery), with the payment made directly to patient's bank accounts within about two working days. Where a patient is privately billed, they must still pay the full amount up-front.[1]

5.4 This differs from the existing system which requires the rebate claim to be lodged at a Medicare office, although 'pay Doctor' cheques will remain available. The new proposal differs from *A Fairer Medicare* package, in that the government has decided not to proceed with the proposal to pay the rebate amount directly to the doctor.[2]

5.5 In order to provide this service, practitioners must participate in HIC Online. Under MedicarePlus, the Government offers a grant to all medical practices to assist in accessing the HIC Online, amounting to $750 for metropolitan practices and $1,000 for rural, regional and remote practices. Although the system can operate on normal 'dial-up' connections, $9.2 million has been allocated to assist practices establish broadband access.

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1 Assuming the practitioner does not offer a 'pay doctor cheque' option, which will still be catered for under the revised package but is usually not offered by practitioners.

2 DHA, Submission 54, p. 16

5.6 The Department of Health and Ageing submission also points out that, since 1999, practices have benefited from around $430 million to assist in computerisation of their practices, through the Practice Incentives Program.[3]

5.7 It should be noted that the current proposal accords with the first inquiry's Recommendation 8.3 to expand the existing program in order to provide assistance to all general practices with the costs of adopting information technology and accessing HIC Online.

5.8 The Committee received relatively little comment on this issue, but notes the concern raised by both the Southern Tasmanian Division of General Practice and Dr Alexander over the logistics of administering this system and their fear that 'practices will become quasi Medicare offices'.[4]

5.9 The Australian Divisions of General Practice and the Osborne Division of General Practice also argued that the level of support is not adequate relative to the costs of implementing and maintaining HIC on line. ADGP argue:

> If the Government wishes to maximise the impact and realise the full efficiencies possible through the HIC Online initiative, it is imperative that Divisions of General Practice are funded to support its implementation. Such support will entail:
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> - providing general practices with support for upgrading/making compatible their existing IMIT systems;
> - providing advice in business systems alignment resulting from the adoption of a new billing mechanism;
> - providing advice, training and information sharing to maximise the patient outcomes and clinical benefits possible from the concomitant availability of broadband internet resources.
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> … Further, it will be critical that the process to interact with HIC Online be fully automated and integrated into GPs' desktop software packages. Work must be undertaken as a matter of urgency with the software providers to integrate this function into their accounting modules. Broadband access may assist connectivity, but without seamless integration with standard software used by general practices, the initiative will struggle to succeed.[5]

5.10 While noting these comments, the Committee reiterates the conclusion of the first report on this issue:

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3 DHA, Submission 54, p. 17

4 Southern Tasmanian Division of General Practice, Submission 57, p. 2; Dr Alexander, Submission 26, p. 3

5 ADGP, Submission 91, p. 8. See also ODGP, Submission 24, p. 2

> In general terms, the Committee accepts that the costs associated with getting online are likely to be quite high, but at the same time, the incentives are not designed to meet the whole of the cost, but rather to make a contribution. This is appropriate given that, notwithstanding its wider significance to best practice health care, information technology is a business cost that must be met by all businesses and one that offers a general practice significant financial dividends through increased efficiencies.[6]

Aged Care proposals

5.11 A final and important aspect of the Government's proposals are the measures designed to improve access to health care for those in aged care facilities. There are two principal aspects to these proposals.

5.12 First, the government package proposes a new MBS item to undertake comprehensive medical assessments of new and existing residents of aged care homes. These assessments will attract a Medicare rebate of about $140, and it is expected that in 2006/07, about 90,000 residents will receive an assessment.[7]

5.13 Second, up to $8,000 will be provided each year to GPs who participate in partnership arrangements with aged care providers. Divisions of General Practice will establish panels of GPs in regions across Australia whose purpose will be to identify and implement action to improve the health of aged care residents. The Department of Health and Ageing submission explained that:

> While still able to access the comprehensive medical assessment item, GPs on these panels will also undertake additional activity, including perhaps being rostered for after hours work and working on health improvement strategies with aged care providers.[8]

5.14 Together, these measures aim to provide more comprehensive and better planned health care for residents of aged care homes, as well as better access to a GP, either on a regular basis if that is what is required, or in an emergency.

5.15 These proposals have received wide support.[9] According to UnitingCare, for example:

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6 Senate Select Committee on Medicare, *Medicare: Healthcare or Welfare?*, p. 113

7 DHA, Submission 54, p. 25

8 DHA, Submission 54, p. 25

9 Including: Australian Pensioners and Superannuants League Qld, Submission 3, p. 6; Catholic Health Australia, Submission 48, p. 12; Osborne Division of general Practice, Submission 24, p. 2; Dr Gault, Submission 26, p. 2; Australian College of Non-VR GPs, Submission 35, p. 3; Australian Healthcare Association, Submission 56, p. 1; Queensland Nurses Union, Submission 62, p. 6; COTA National Seniors Partnership, Submission 73, p. 3; Australian Divisions of General Practice, Submission 91, p. 8

> Uniting*Care*'s Ageing and Disability Service, who run facilities for the aged such as nursing homes and hostels, report that GP visits to residents can be rushed and that the new Medicare item announced in MedicarePlus will hopefully facilitate longer visits by GPs. It was also thought that this would result in staff being more confident in calling upon GPs to visit more regularly.
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> The additional funding to address the problem of GPs not being available after hours or for emergencies was considered positive, and it was thought that this might avoid the need to send some residents to hospital.[10]

5.16 The only cautionary note came from the Australian Consumers' Association, who warned that 'like many such measures, it is likely to be of limited effect where the lack of access is caused by a doctor shortage.'[11]

5.17 Both the Royal Australian College of General Practitioners and the National Council on Intellectual Disability suggested slight modifications to the proposal, seeking provision of health assessments for younger and disabled people. This could apply to those who are resident in nursing homes,[12] or to all such people.[13]

Improving access to primary health care

Dental care

5.18 An issue continuing to attract comment in this second inquiry, and an area not addressed in the government's proposals, is access to dental health care.

5.19 The Committee's first report, *Medicare: Healthcare or Welfare?*, contained considerable discussion of the problems in accessing dental care and recommended the Commonwealth government take a more active leadership role by reinstating the former Commonwealth Dental Health Program.[14] Much of this discussion remains relevant now and this report will not re-examine the issue in any detail, save for a couple of comments.

5.20 In general, the Committee notes continuing evidence of inadequate access to dental health care across Australia for people on low incomes.[15] From both a practical

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10 UnitingCare, Submission 55, p. 9

11 ACA, Submission 36, p. 11

12 RACGP, Submission 67, p. 8

13 NSW & National Councils on Intellectual Disability, Submission 39, p. 3

14 See Chapter 10 and Recommendation 10.1

15 Illawarra Dental Health Action Group, Submission 19, p. 1; National Advisory Committee on Oral Health, Submission 14, p. 2; Tasmanian Government, Submission 64, pp. 3-4

and conceptual level, it remains curious that Australia continues to separate jurisdictional responsibility for dental care from that of the rest of the body. The Committee reiterates its view that the Commonwealth government can and should take a greater leadership role in national dental health. As Mr Gregory of the National Rural Health Alliance told the Committee:

> As if national leadership on something so important as this were not enough, there are some other reasons why the Commonwealth has a quite legitimate involvement in dental health. Firstly, the Commonwealth is responsible for higher education and therefore has controls over the leavers of dentistry schools and funding thereof, how many we are training and so on. Secondly, the Commonwealth is responsible for aged care. It is amongst the elderly in our population that some of the worst oral health and dental health exist. Thirdly, the Commonwealth is responsible for social security. It is among the people of lower incomes, as you well know, that the worst problems exist.[16]

5.21 As the Australian Dental Association suggests, there are three principle actions the Commonwealth should take. The first is to reintroduce the Commonwealth Dental Health Scheme, subject to modifications to ensure that earlier problems associated with inadequate targeting of measures and anomalies in service provision are not replicated.[17]

5.22 The second is to take immediate action to rectify the existing and worsening dental workforce shortages in Australia. The Australian Dental Association estimating that Australia is going to suffer a shortfall of between 700 and 2000 dentists by 2010.[18] During public hearings Dr O'Reilly explained to the Committee that:

> there is going to be about $25 million in Commonwealth funding needed across the four dental schools to increase the infrastructure, to physically be able to accommodate the increase in the number of students. Our modelling has shown that we will have a net increase of approximately $1 million a year in tuition costs for those extra places. It would cost the Commonwealth approximately $3 million a year in fee subsidies.[19]

5.23 The third is to develop a range of incentive measures that address the particularly acute dental workforce needs of rural and regional areas. These measures include rural

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16 Mr Gregory, *Proof Committee Hansard*, 19 January 2004, p. 110

17 ADA, Submission 79, p. 2 & 4. The proposal received support from NSW Retired Teachers Association, Submission 21, p. 2; St Vincent DePaul, Submission 58, p. 12. For further discussion of the problems associated with the Commonwealth Dental Health Scheme, see Dr O'Reilly, *Proof Committee Hansard*, 19 January 2004, p. 107

18 Dr O'Reilly, *Proof Committee Hansard*, 19 January 2004, p. 97

19 Dr O'Reilly, *Proof Committee Hansard*, 19 January 2004, p. 99

scholarships, and HECS forgiveness for dental graduates agreeing to work in areas of shortage.[20]

5.24 These programs should be guided by the findings of the National Oral Health Survey, which is due to report in July 2004.[21]

5.25 The Committee, noting again the importance of oral health to general health, as well as the almost totally preventable nature of dental disease,[22] reiterates its recommendation to implement a new Commonwealth Dental Health Program, and to actively consider these proposals to expand the size and distribution of the dental workforce.

Recommendation 5.1

The Committee again recommends the creation of a new Commonwealth Dental Health Program and the active consideration of measures to address workforce shortages in dentistry.

Australian Democrats – additional comments on dental care

The Australian Democrats consider that reinstating the Commonwealth dental program is not a sufficient response to the poor dental health services provided in Australia. There is very uneven access to dental services across Australia, with some States, notably Queensland, providing well-resourced services, while Victorians have in recent years experienced long waiting lists and a shrinking per capita dental services budget.

As long as there is no formal purchasing arrangement with the States to ensure that the States take their responsibility seriously, then it is unlikely that a Commonwealth program can be anything other than a stop-gap measure.

Indeed, the 1997 evaluation of the Commonwealth dental program found that the scheme was unable to meet its objective of providing preventive and maintenance dental care, because of the large unmet demand for emergency intervention for serious oral problems.

20 ADA, Submission 79, p. 7. See also Dr O'Reilly, *Proof Committee Hansard*, 19 January 2004, p. 99

21 Dr O'Reilly, *Proof Committee Hansard*, 19 January 2004, p. 83. National Advisory Committee on Oral Health, Submission 14, p. 2

22 Dr O'Reilly, *Proof Committee Hansard*, 19 January 2004, p. 83

The Australia Institute of Health and Welfare has found that where the Commonwealth has increased its funding to the States for public hospitals, the States have taken this as an opportunity to contribute less themselves. The effect of this is that services to patients are not improved, despite higher federal funding.

Just as the Commonwealth has insisted in the last round of Australian Health Care Agreements to a formal commitment by the States as to their financial contribution, the States must be made accountable for their responsibility in dental health service provision.

The Commonwealth does have a clear responsibility to ensure a national oral health program, and one that is properly funded. However, this requires careful consideration of how resources can best be used across States and Commonwealth to ensure that the goal of improved oral health is maximised.

Recommendation: *The Commonwealth develop a national dental health policy, with funding to the States conditional upon State resources and service delivery performance.*

Allied health

5.26 A second issue, not addressed in the government's current proposals, is improving access to allied health professionals such as occupational therapists, physiotherapists, speech therapists, chiropractors, dieticians or psychologists.

5.27 As the first report showed,[23] these services form an important part of the total primary health care framework, and the specialist services of this group also offer methods for preventive and rehabilitative care that can do much to relieve the load on other parts of the health system.

5.28 However, these services are not currently covered by the Medicare system, which limits the capacity for doctors to refer patients to the most appropriate professional and undermines the effectiveness of other government initiatives such as the Enhanced Primary Care items that promote a multi-disciplinary approach to health care.

5.29 The Committee's conclusions in the first report remain relevant and the Committee does not recommend any broad introduction of new MBS items to cover allied health professions. However, there are examples of services provided by allied health professionals which offer compelling arguments to support their inclusion on the MBS – even if only for limited and defined items. Examples include counselling

23 Senate Select Committee on Medicare, *Medicare: healthcare or welfare?*, p. 133

services offered by psychologists, and the management of incontinence and knee joint osteoarthritis by physiotherapists.[24]

5.30 In the Committee's view, such new MBS items should only be created in the context of agreements with the relevant professional bodies that support high levels of bulk billing.

Community health care centres

5.31 The Committee's first report recommended the use of community health care centres as a means of improving access to primary health care in areas in which there are identified problems in accessing health services. These problems can be triggered by either a shortage of health care professionals or the commercial non-viability of practise in some areas – particularly in rural and regional areas.

5.32 These community health centres, using salaried health professionals including GPs, practice nurses, and other health professionals such as pharmacists, health educators, midwives or dieticians, can provide a single source of high quality integrated primary care in areas where mixed private practices could not survive. An added advantage of this approach is the capacity to co-locate limited facilities and equipment, and meet the preferences of many doctors for salaried, flexible and part time work.

5.33 The exact form of these centres will vary according to the particular needs of each area. In this respect, the Committee sees an important role for both the local Division of General Practice and local governments in planning and administering health centres that best meet the needs of the local population.

5.34 A useful basis for the funding of these centres can be the calculation of the difference between the national average Medicare benefits paid per capita and the benefits paid in a particular region. The Committee has already observed the significant inequities that exist between the benefits from the Medicare system received by a person in a rural town compared to inner city Sydney, and in simple terms, this means that people in the rural town are not getting the health care resources they are entitled to. Where the calculations reveal that an area is underfunded in this way, the difference in funding should be allocated to that area and invested in community health care facilities.

5.35 Existing programs have also demonstrated that this model provides a flexible basis for pooled funding arrangements between the Commonwealth and the states.

5.36 The Committee again notes the importance of linking these centres to the local public hospitals in order to maximise the efficient sharing of facilities and expertise,

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24 Australian Physiotherapy Association, Submission 32, p. 12. Note also the Psychootherapy and Counselling Federation of Australia, Submission 71, p. 2

and the capacity of the centres to provide bulk billed general practice services that take the pressure from the hospitals emergency departments.

5.37 For these reasons, the Committee reiterates its earlier recommendation:

Recommendation 5.2

The Committee again recommends that the Commonwealth government promote the use of Medicare grants to enable Community Health Centres to be provides in areas of identified need.

System reform

5.38 Finally, some evidence to the inquiry expressed disappointment that the revised package still fails to tackle the big issues in Australian health care: in particular, the ongoing problems with health funding arrangements between states and the associated jurisdictional conflicts, costs shifting and blaming that seems to inhibit solutions to many problems plaguing health care in Australia.

5.39 Country Women's Association have the view that:

> While ever the Government fiddles with the peripherals and fails to come to grips with the need to completely overhaul the whole question of Health Care in Australia, any proposals come across largely as policy being made on the run, band aids being applied to carry through to the next election.[25]

5.40 The Australian Health Care Reform Alliance sees the need for fundamental reform to the Australian health care system. Professor Dwyer, spokesperson for the Alliance, told the Committee that the health care system is at a crossroads:

> One of the paths that we could take, which I am absolutely convinced that Australians want … involves a sweeping reform of our health care system. We are all sick to death of the fighting between federal and state politicians about health. We are sick of reading about hospital crises in the paper every morning and hearing about the Medicare crisis, not having enough doctors and work force issues. The Australian public want the problems solved.

5.41 According to the Alliance, the major barrier to health care reform in Australia is the jurisdictional inefficiency associated with the division of responsibility for various parts of our health care system between Federal and State Governments:

> Nowhere is this more obvious than in examining the struggle health professionals are having to properly integrate, in a horizontal fashion, primary and community care with hospital care. For this reason the Alliance has been calling for the formation of a Health Care Reform Commission; a State/Federal co-operative bureaucracy involving senior health professionals

25 CWA, Submission 70, p. 2

> and consumers to look at redesigning the way we prevent illness and deliver health care in Australia.

5.42 As their submission argued:

> Medicare, and in particular the general practitioner services that it supports, should not operate as an island in an ocean of health care but rather a vital link in an integrated, networked, patient-focussed system.

5.43 The primary objectives of this reform are to enable better horizontal integration of health services that would improve the capacity of general practitioners to head up a team of health professionals and enable doctors to care for sicker patients in their homes, aged care facilities or hostels rather than sending them to hospital.

5.44 The Australian Council of Social Services conclude that:

> The Federal Government should commit to establishing a National Health Reform Council as proposed by the Australian Health Reform Alliance. The Council would oversee a full public review of the health care system aimed at developing broad consensus on the future shape of the system – including the way in which medical and other health care professionals are paid and supported.[26]

5.45 The Committee agrees and reiterates its earlier call[27] for the establishment of a National Health Reform Council.

Recommendation 5.3

The Committee again recommends the establishment of a National Health Reform Council.

26 ACOSS, Submission 45, p. 4. See also Doctors Stewart and Brown, Submission 40, p. 1; and Queensland Nurses Union, Submission 62, p. 1

27 Senate Select Committee on Medicare, *Medicare: Healthcare or Welfare?*, Recommendation 12.5

Signed by:

Senator Jan McLucas
Chair

Senator Michael Forshaw

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