Queensland Government

Premier of Queensland
and Minister for Trade

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Select Committee on Medicare

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

Dear Senator McLucas

Please find attached the Queensland Government submission to the reconstituted Select Committee on Medicare. As you are aware, the Queensland Government provided a submission to the Inquiry and the Honourable Wendy Edmond MP, the Minister for Health and Minister Assisting the Premier on Women's Policy, appeared at the public hearings in Brisbane in August 2003.

The Queensland Government submission responds to the key elements of the Government's revised Medicare package, 'MedicarePlus'.

If you require further information regarding this submission, please do not hesitate to contact Ms Norelle Deeth, Deputy Director-General, Policy and Outcomes Division, Queensland Health, GPO Box 48, Brisbane, Queensland, 4001. Ms Deeth may be contacted by phone 07 3234 0837, fax 07 3234 0270 or by email at: Norelle_Deeth@health.qld.gov.au.

Yours sincerely

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Queensland Government Submission to the
Senate Select Committee on Medicare – Reappointment
18 December 2003

Introduction

A key consideration of any changes to Medicare is the effect on accessibility by Australians to primary care. For most people, primary health care services are the first point of contact with the health system. Evidence exists both nationally and internationally to support the importance of providing appropriate and adequate access to quality primary care services. Countries with accessible primary care access have reduced demand for more expensive care, including hospital services. Primary health care also enhances quality of life and wellbeing. Primary care has a vital role in supporting and maintaining the health of the community, particularly in light of Australia's ageing population and increasing levels of chronic illness.

Medicare, via bulkbilling, has supported access to free General Practitioner (GP) services, a central plank of primary care health services in Australia, since its introduction almost twenty years ago. Rates of bulkbilling for GP services peaked in 1996/97, with over 80% of all GP attendances bulkbilled. However, access to free GP services is gradually being eroded:

- The proportion of GP attendances bulkbilled in Australia fell from 79.4% in 1998-99 to 69.5% in 2002-03. Over the same period, the total number of GP attendances nationally reduced by 1.3 million. The average number of GP attendances per person is now 4.8, down from 5.4 over the same period.

- Over 30% of all Australians live in rural and remote locations. The supply of doctors impacts significantly on levels of bulkbilling (for example, in metropolitan areas there are more GPs and higher levels of bulkbilling). There are few, if any, rural doctors currently bulkbilling patients, except for concession cardholders.

- Queensland has consistently attracted lower per capita Medicare benefits for GP services than the national average. The reduced Medicare benefits paid to Queensland largely results from the high degree of population dispersion. Difficulties in attracting and retaining GPs and other Medicare funded medical professionals to rural areas, continues to place additional pressure on State-funded services.

- In addition, while Medicare benefits per person for GP services have risen by 9.7% nationally over the last five years, Queensland's benefits per person have only increased 6.7%. This trend has further disadvantaged Queensland in relation to relative Medicare benefits accruing to the State.

- The Medicare benefits rebate for a standard consultation has increased by an average annual rate of 4.4% over the last five years. The current schedule fee for a standard consultation (Item B) is $30.20, attracting a Medicare benefit (85%) of $25.70. The average co-payment for patient billed GP services has risen by 30%

over the last five years from $9.88 to $13.61 in 2002-03 (nationally). Some GPs charge a co-payment of as much as $25 per visit.

These factors highlight the current crisis in bulkbilling and diminishing access to GP services. From a Queensland perspective, the decreasing number of bulkbilling GPs is having a significant impact on State-funded public hospital emergency departments. Patients who would normally have gone to their GP are now accessing services through the emergency department of their local public hospital, where they can obtain treatment free of charge.

For example, in Queensland, the federal electorate of Dickson has seen bulkbilling rates fall from 79.6% in March 2000 to 49.7% in March 2003. The principal hospital in this electorate, Caboolture Hospital, has seen emergency department semi-urgent and non-urgent presentations increase by 49% from 1999-00 to 2002-03. In particular, non-urgent presentations grew by 174% over that four-year period and 40.8% in 2002-03 alone. There is clearly a strong relationship between declining access to bulkbilling GPs and increasing demand for care in emergency departments.

Comments on the *MedicarePlus* Package

(i) The Government's proposed amendments to the Health Legislation Amendment (Medicare and Private Health Insurance) Bill 2003

MedicarePlus proposes to reimburse 80% of out-of-pocket costs incurred on medical costs for out of hospital services. This safety net would come into effect after an annual threshold of $500 is reached for low and middle-income earners and over $1000 for all others. GP and specialist consultations, blood tests, psychiatry, X-rays, CT scans, tissue biopsy, radiotherapy and pap smears would be included in the safety net arrangements.

A safety net is likely to encourage doctors to set higher medical fees if it is perceived that the safety net will offset higher prices. The need for a safety net would suggest a risk of spiralling out of pocket costs and that co-payments are likely to continue to increase. This would further compromise access to services and the universal nature of Medicare would continue to be undermined.

While the proposed threshold applies to a range of services, GP attendances accounted for 44% of all Medicare funded services in 2002-03. Based on the average co-payment for GP services of $13.61, the $500 safety net proposed for low and middle income families, would only apply after 38 visits to a GP and or 76 visits or more for the $1000 safety net. In 2002-03, Queenslanders visited a GP an average of four times. Therefore, very few people are likely to benefit from the safety net, but will be affected by the higher fees charged by doctors.

As safety net arrangements already exist (relating to both pharmaceutical and medical costs – see http://www.hic.gov.au/yourhealth/our_services/suhc.htm#a), the introduction of another layer of safety nets will increase administrative costs, will be inefficient and difficult for both service providers and the general public to understand. The idea of the *MedicarePlus* safety net is deceptive and it would be

more sensible to lower the threshold of the existing safety net rather than introduce another layer of bureaucracy.

The need to introduce new safety nets would largely be negated if the Federal Government demonstrated a genuine level of commitment to ensuring universal access to Medicare for all Australians.

(ii) The Government's proposed increase to the Medicare rebate for concession cardholders and children under 16 years of age

MedicarePlus proposes an additional $5 payment to GPs for each bulkbilled service provided to a concession cardholder or child under 16 years. This proposal provides an incentive to GPs to bulkbill one group of patients over another and is a move away from Medicare's underlying principle of universality. Australia would have a two tiered health system.

In addition, concession cardholders are far more likely than other patients to be bulkbilled under current arrangements, this proposal is focused on fixing a problem that does not exist.

MedicarePlus proposes an increase in the Medicare rebate of only $5 and would do little to restore GP incomes or increase patient access to free GP services.

In order to maintain the universal nature of Medicare, any increase in the rebate should apply to consultations provided to all Australians, not only concession cardholders and children under 16 years.

An increase in the Medicare rebate of $10 for Level B Consultations, which form over three-quarters of GP attendances, would cost an achievable $680M per annum (based on 2002-03 activity levels). Proportional increases could be applied to the Schedule Fee for Levels A, C and D consultations.

(iii) The Governments proposed workforce measures including the recruitment of overseas doctors

The workforce initiatives included in the *MedicarePlus* package appear to be useful. However, many of the initiatives are dependent on availability of sufficient nurses and GPs. For example, a new demand for GP practice nurses and GP services for residents of aged care facilities would exceed supply. In addition, the initiative to increase access to GP services in residential aged care facilities will require substantial auditing to ensure value for money and compliance.

There has been an inadequate supply of GPs in Australia since the Australian Government commenced capping of GP training positions in 1997, with many practices unable to recruit Australian graduates to replace retiring/departing staff. Due to the delayed impact of many initiatives, such as providing 450 additional GP training places, Australia will remain heavily dependent upon supply of international medical graduates until at least 2007.

The additional 450 accredited training positions may prove difficult to achieve as training providers are already struggling to obtain sufficient accredited training positions. This is particularly the case in rural areas where practices are heavily burdened by participation in undergraduate and vocational doctor training. The increased number of training positions may not increase the supply of doctors in rural areas.

The initiative which is designed to supply more graduate doctors to outer metropolitan, regional, rural and remote areas appears to be attractive. There are currently limited opportunities for junior doctors to gain practical experience in early postgraduate years. However, while it is noted that the State will be funded to release junior doctors from hospitals, it is not clear how 70 full time equivalent junior doctors may be removed from hospitals without compromising hospital service levels and patient care. Queensland is currently experiencing a significant under-supply of junior doctors due to a number of factors, including imposed limitations on university and training positions. This situation is not expected to improve until the first output of graduates from James Cook University in 2006. *MedicarePlus* has not addressed this.

In relation to recruitment of qualified health professionals from overseas, *MedicarePlus* proposes to employ international recruitment strategies; reduce red tape in approval processes; provide assistance for employers and international medical graduates in arranging placements; and opportunities for doctors to stay longer or obtain permanent residency through changes to immigration arrangements. These initiatives will have a significant lead-time. No details have been provided on the marketing strategy and how Australian jurisdictions would collaborate on this. In addition, it is not clear how red tape would be reduced in the approval process for doctors. The development of appropriate regulation and assessment processes will also be resource intensive. This is not acknowledged in the proposal.