EXECUTIVE SUMMARY

Overview

The terms of reference for the Senate Select Committee on Medicare contained three broad tasks: to examine the current health of Medicare; to assess the Government's *A Fairer Medicare* package; and look at other options and proposals, including the ALP policy on Medicare.

To fulfil this task, the Committee took evidence around the country from government agencies, doctors and, most importantly, the people around Australia who expect and rely on quality delivery of medical services.

The health of Medicare in Australia – key findings

The viability of General Practice

General practice across Australia is so varied that any generalisations about its viability are difficult. It is clear that GPs still earn a considerable income in comparison to measures such as Average Weekly Ordinary Time Earnings (AWOTE). What stood out though is that real incomes for GPs who exclusively bulk-bill, relative to AWOTE, have fallen in the past ten years.

Historical changes in real terms to the income of doctors who charge an additional out-of-pocket payment to at least some of their patients, are harder to ascertain. However, there is clear evidence that out-of-pocket charges to patients have been rising quite markedly, suggesting that the majority of GPs have been receiving income growth at a rate closer to AWOTE than those GPs relying solely on Commonwealth payments.

It is also apparent that there is a strongly held perception in the GP community that incomes have fallen relative to both medical specialists and other professionals. It is likely that it is this perception, combined with a shortage of GPs nationally, that is driving the falling rates of bulk-billing and the rising out-of-pocket costs.

The other major factor in the viability equation is, of course, practice costs. The Committee received evidence that the cost of running a general practice is approximately 50% of gross income, and that the proportion of income swallowed up by running expenses had increased over recent years. However, the Committee heard no compelling evidence that GP running costs had outgrown the CPI.

It is certainly possible that the costs of rural practices are greater than the average, however, the Committee also received evidence to suggest that this is balanced by higher than average incomes for rural GPs.

Two issues seem to have the greatest impact for many GPs: the time and cost of administering blended payments such as the Practice Incentive Payments (PIP), and

the Enhanced Primary Care schemes (EPC); and the unsustainably high workloads, especially for GPs working in the many areas of workforce shortage around Australia.

The Committee concludes that while general practice remains financially viable in most parts of Australia, practitioners who exclusively bulk-bill are relatively worse off now than they were a decade ago, while workloads and administration for all doctors has increased.

The Committee supports the establishment of the 'Red Tape Taskforce' and recommends a similar review of the PIP program, to complement the work already undertaken on the usefulness of EPC. These analyses should form the basis of a further examination of the optimal role of blended payments in remunerating doctors.

Recommendation 3.1

The Committee recommends that the Commonwealth Government undertake a review of the Practice Incentive Program (PIP) with a view to assessing it's effectiveness in meeting its policy objectives.

Access to general practice

Access to affordable, effective and timely primary care is fundamental to Australia's continued health and prosperity. General Practice plays a pivotal role in this, and must be accessible when and where it is needed, regardless of patients' economic or geographic situation.

From the Committee's analysis, it is clear that the problems in accessing doctors around Australia is significant. The Committee found a range of causative factors. These included an increase in GP attendances over time, which had not been matched by new entrants to the profession; a move away from hospital-based care; and the increasing health care needs of an ageing population with a corresponding growth in chronic illnesses.

On the supply front, the Australian GP workforce is suffering from the restrictions and reductions placed on medical school places and provider numbers during the mid-1990s. The average age of GPs is increasing and many are close to retirement. There is an overall decrease in the participation rate of GPs, as more practitioners structure their working lives to meet the demands of family and lifestyle with a corresponding decrease in the hours worked.

Perhaps the most concerning aspect of GP shortages is the evidence the Committee received in many places of the very low numbers of medical graduates choosing a career in general practice.

Declining doctor numbers have critical implications for current and future access to primary health care, both from outright shortages and the increasing pressure on prices caused by short supply and high demand. These factors are both evident in the falling bulk-billing rates.

A Fairer Medicare?

The Committee's second task was to examine in detail the measures contained in the Government's 'A Fairer Medicare' package.

The proposed billing arrangements

The government package proposes changes to the current system of billing, that on the surface do not appear particularly radical, but will fundamentally change the way Medicare works and its role in Australian health care.

The key elements of the government's proposals are a system of incentive payments for practices that agree to bulk-bill all concession card holding patients and the capacity for participating practices to receive rebates for all their patients directly from the HIC.

At a philosophical level, the government package amounts to a decisive step away from the principle of universality that has underpinned Medicare since its inception. The Committee does not accept the government's argument that, because everyone continues to be eligible to be bulk-billed and receives the same rebate, universality is preserved. This argument is disingenuous and ignores the reality of the incentive system the government seeks to put in place. In practice, a GP will receive more public money to treat a concession card holder than they will for treating a non-concessional patient. The fact that the incentive payment has a different label to the rebate payment is of minimal practical significance, particularly given the direct rebate of funds to the practice. A Fairer Medicare is about a return to a welfare system.

At a practical level, the policy is focused on 'guaranteeing' bulk-billing of concessional patients in a way that is quite simply unnecessary, since the majority of these people are in all likelihood already bulk-billed. The Committee is inclined to agree that the package essentially focuses on a solution to a problem that does not exist.

Far more serious though, are the practical ramifications of the proposals. If put into effect, the scheme will trigger a fall in bulk-billing for all those who are not concession cardholders. Inevitable problems arise at the boundaries of entitlement, and many Australians in genuine need of bulk-billing will fall just outside the threshold of concessional status – including many working families and those with chronic illnesses. These people will face both more gap payments, and overall, a rise in the level of such payments.

The Committee commissioned the Australian Institute of Primary Care (AIPC) to analyse the potential inflationary effects of the Government's package. They reported that bulk-billing levels would fall to approximately 50% of all GP services and that out-of-pocket costs would rise by 56%.

The proposals to enable direct payment at the point of service will have an important impact on these outcomes. The Committee acknowledges there are inefficiencies inherent in requiring patients to pay the whole consultation amount up-front and subsequently gain reimbursement from a Medicare office. However, as the evidence shows, this system plays an important part in maintaining price control. Creating a separate rebate and copayment would in all likelihood open the door to considerable price rises.

The effect of the government package is the emergence of different categories of patients. As one doctor explained:

> By only focussing on Medicare as a safety net for Health Care Card holders the government will set up a three tier health system: those who are recognised as 'poor' and needy, those who are the unacknowledged 'poor' who will miss out the most and those who can afford to pay for what they want.[1]

The remedies for the current problems in Medicare do not lie in refocusing the system on concessional patients, nor in tinkering with the criteria for the granting of those concession cards, but rather in a reorientation towards the role of Medicare as a universal insurer, with equal benefits for everyone.

Recommendation 6.1

The Committee recommends that the General Practice Access Scheme not be adopted.

Safety nets

The Committee recognises that there are gaps in the existing safety net arrangements, which potentially leave some people with no choice but to pay significant out-of-pocket costs. However, creating two additional layers of safety net is inefficient and likely to increase the overall administrative costs and cause further confusion to the intended beneficiaries of the scheme – particularly when the very people who most need the safety nets are also the ones whose access is most compromised by administrative complexities.

The problems faced by people who do not qualify for a health concession card arise again in relation to safety nets that attach to concessional status and are inherent in any differentiated system that steps away from the principles of universality. As Mr Goddard of the Australian Consumers' Association told the Committee:

> The role of safety nets is inextricably linked to copayments and a lack of access and a lack of equality of access. The more satisfactory access is, the less need there is for a safety net. However, safety nets become essential if

1 Dr Tait, Submission 121, p. 1: see also Dr Costa, *Proof Committee Hansard*, Sydney, 22 July 2003, p. 62

> there is going to be a significant level of copayment or out-of-pocket expenses.[2]

Further, a system focusing on welfare safety nets implicitly serves to separate the wealthier part of society from the benefits of a system they continue to pay for.

The provision of a private health insurance safety net reflects the government's agenda of moving responsibility for funding health care from Medicare to the individual.

The Committee is also sceptical of the effectiveness over time of any reliance on private health insurance safety nets. Experience has shown that rapid rises in private health insurance premiums are likely to erode the affordability of the proposed net for many families and, again, it is those on the boundary – the working poor – who are likely to miss out.

Overall, the Committee believes that any consideration of the issue of safety nets must be underpinned by a commitment to the principle of universality and the role of Medicare as a properly funded public insurer. Put into practice, this commitment removes much of the need for safety nets in the first place.

Recommendation 7.1

The Committee recommends the Senate reject the proposal for an additional safety net that differentiates concessional and non-concessional patients.

Recommendation 7.2

The Committee recommends the expansion of the existing Medicare Safety Net to provide for all out-of-pocket costs in excess of a set amount.

Recommendation 7.3

The Committee recommends that this amount be indexed annually to ensure that the safety net reflects the real costs of health care.

Were this proposal implemented, it would render the second proposed private health insurance safety net unnecessary.

Workforce and technology measures

The government package provides for additional bonded medical school places and practice nurses.

There is a clear need for additional medical school places, and the Committee fully supports the extra 234 positions proposed by the government. In the context of the maldistribution of doctors in Australia, it is reasonable to place some bonding

2 Mr Goddard, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 55

requirements on these places. On the evidence presented to the Committee, there also seems little doubt that the additional bonded places will be filled. The Committee is of the view that it will be more effective to allow the bond to be served during training.

It must also be noted that on early indications, the system by which the government is distributing the bonded places to various universities appears to be having inequitable results, with some universities actually *losing* non-bonded HECS places. According to the Department of Health and Ageing, the University of Sydney will offer 27 bonded places in 2004, but will lose 23 standard HECS places, over its 2002 enrolment while Monash University which enrolled 138 standard places in 2002 will only offer 128 in 2004.[3]

Recommendation 8.1

The Committee supports the proposal for 234 new bonded medical school places, but recommends amending the proposal to enable students to begin working off the bond period during postgraduate vocational training as Registrars.

The Committee supports the government proposal for additional practice nurses. Wider use of practice nurses has the potential to significantly reduce the burden on GPs, particularly in rural areas where the workloads are high. However, the Committee also strongly supports the view that the nurse initiative should not be limited to those practices that decide to sign on to the government's package.

In the wider context of a national shortage of nurses, it is also critical that initiatives for general practice do not draw nurses out of public hospitals. The Commonwealth government must therefore provide leadership in developing national nursing policies to ensure that governments do not work at cross-purposes with each and thereby exacerbate existing pressures on the nursing workforce.

Recommendation 8.2

The Committee recommends that the government expand the existing program for the provision of nurses, allocating assistance on the basis of need rather than limiting it to 'participating practices' in the Government's 'A Fairer Medicare' package.

In general, the Committee supports the policy to provide assistance to practices to get access to online services. In the short term it offers important efficiencies for general practice operations, and in the longer term represents a fundamental stepping stone to the adoption of higher technology practices, information sharing, electronic patient records and online education.

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3 Department of Health and Ageing, Submission 138B, Question 11. See also *Government 'playing tricks' as medical schools lose out,* Sydney Morning Herald, 8 October 2003, p. 4

For these reasons, the Committee does not agree with the government policy to limit these assistance measures to 'participating practices'. Wide-scale national adoption of best practice information technology is in the national interest and should be encouraged for all practices.

Recommendation 8.3

The Committee recommends that the government provide support to all general practices to assist with the costs of adopting information technology and accessing HealthConnect online. Access to the program should not be limited to 'participating practices' in the Government's 'A Fairer Medicare' package.

Alternatives in the Australian context

The Committee's third task was to examine alternatives in the Australian context that would improve Medicare's delivery of affordable access to primary care.

The ALP Policy

The Committee received limited evidence on the ALP policy's reception to provide a definitive response. It is clear, however, that where opinions or comparisons were offered, Labor's proposal was, with rare exception, preferred over that of the coalition. Respondents focussed favourably on the ALP policy's emphasis on retaining bulk-billing as a central tenet of health care policy, and on increasing its rates. Increasing the rebate was popular with some, while others saw it as a short-term response to a complex and long-term problem. Workforce measures, which the Labor and government packages share, enjoyed some support, although were criticised as being 'too little, too late'.

From the AIPC Report, it is also apparent that the Labor proposal will result in an overall decrease in out-of-pocket costs and it is probable that bulk-billing rates would increase to 77%, auguring well for the ongoing universality of Medicare.

Allied and dental

Dental health plays a crucial role in overall health and the Committee is concerned at the evidence that many Australians are experiencing increasing problems in accessing timely and effective dental care. This will have unfortunate consequences for the individuals concerned, and implications for society as a whole, with flow-on effects of declining population health, increased chronic illness, and resulting pressures on public hospitals.

For these reasons, the Committee does not accept the government mantra that dental care is a state and territory responsibility. Adequate access to dental care is too interrelated to other aspects of Commonwealth health care for such neat jurisdictional lines to be drawn. As well, the social justice implications of the current problems are too great for the Commonwealth to ignore.

The Committee sees public dental care as a responsibility that is shared with the states and territories, and one in which the Commonwealth should take an active leadership role – a role that is clearly within the Commonwealth's constitutional powers. The key question is what form this role should take.

Currently, the principle form of Commonwealth involvement in dental care is via the private health insurance rebate. In practice this means that Commonwealth spending is directed primarily to a wealthier group in society, while providing no targeted assistance to those most in need. If the Commonwealth's involvement is to be limited, it should at least be limited to measures that target those groups that have the greatest need.

The Committee believes the evidence points overwhelmingly to the restoration of the earlier, and successful, Commonwealth Dental Health Scheme. This represents a targeted measure of limited cost that has already been shown to achieve significant increases in access to dental care among those most in need.

Recommendation 10.1

The Committee recommends that the Commonwealth immediately recommit to a Commonwealth contribution towards public dental health services and negotiate targets with the states and territories, particularly for high need groups.

In relation to allied health care – such as physiotherapy, occupational therapy, psychiatry, speech therapy, nutritionists, and podiatry – the Committee has received considerable evidence supporting the funding of health promotion, other preventative health strategies and the treatment of chronic illness through complementary allied health services under Medicare.

While the Committee agrees with this evidence, there are considerable complications associated with any extension of the MBS to cover allied health services.

Firstly, the cost implications are very large, requiring an increase of Commonwealth funding of potentially $3-4 billion, while the savings generated via improved access to primary care and allied health professions, could emerge in areas of health care currently funded by the states and territories, which may necessitate renegotiation of funding and the allocation of roles.

Secondly, the inclusion of an extensive range of allied health services on the MBS may trigger an explosion of supply-induced demand, with resulting blow-outs in Medicare funding.

Thirdly, extending allied health on the MBS also raises the issue of which services would receive priority for Medicare funding and which would miss out.

For these reasons, the Committee does not advocate any broadening of the scope of services covered by the MBS. While there is a legitimate need to enhance access to allied health, the Committee considers there are more targeted and effective mechanisms for addressing the issue. These include enhancing successful aspects of

current initiatives, such as the More Allied Health Services program, the funding of primary health care teams, or providing funding for shared access to resources via groups such as the Divisions of General Practice.

Private Health Insurance rebate

The Committee was asked to consider the implications of reallocating the funding for the PHI rebate.

Determining whether the rebate is equitable and has met its objectives is an immensely complex task. Given that the rebate only came into force in January 1999 and Lifetime Health Cover in July 2000, the limited data on both the equity of the measures and their effectiveness makes it difficult to make unequivocal determinations.

Nevertheless, the Committee does consider that enough evidence has already been presented to at least cast doubt on the overall effectiveness of the PHI rebate in contributing to the improvement of Australia's health system. Given the enormous amount of money involved in the subsidy, and the alternate uses to which it could be put (discussed above), these criticisms must be taken seriously.

In this context, it is premature to form any conclusions on alternative allocation of the resources. However, as Professor Sainsbury framed the question:

> The issue is: how can we most effectively spend taxpayers' money to protect and promote the health of the poorest in society – and the middle and the richest? Is subsidising those people who earn under $20,000 a year to allow them to purchase private health insurance the most cost-effective way of improving their health and treating them when they are sick?[4]

What can be concluded is that any removal or alteration to the allocation of the rebate must not occur without a commensurate reallocation of the resources to ensure that at the very least, equitable access to the health system is maintained. At no time during the transition phase must the overall health system become less efficient or effective; and the people's confidence in the capacity of publicly funded health system including the public hospital system must be restored.

Recommendation 11.1

The Committee recommends that an independent inquiry be established to assess the equity and effectiveness of the 30% private health insurance rebate, and the integral Lifetime Health Cover policy.

Other options

4 Prof Sainsbury, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 85

The Committee heard from many people of the need to increase the MBS rebate. The central question is whether it should be raised, and if so, to what level?

The Committee is not convinced of the need to substantially increase the level of the MBS rebate, and has reservations as to whether doing so would, of itself, improve levels of bulk billing. It is clear that other incentives are also required.

In a wider analysis, it is evident that there is a need to change the focus of medical practice towards more integrated primary care. However, it is also clear that in some respects the current fee-for-service model is acting as a roadblock to progress.

As various successful trial programs have demonstrated, there are practical and successful alternatives, and the Committee was particularly impressed with the initiatives in the Hunter Region in this respect. There is now sufficient evidence in place to move beyond trials. The emphasis must now be on implementing a more flexible system that enables other methods of primary care to operate.

One option is to make greater use of salaried doctors and community health care centres. However, three things must be remembered:

- this model has been used in the past, and found to be successful, notably in remote area practice in areas such as the Northern Territory;
- this model is not proposed as a replacement for private practices around the country, but an alternative in areas where private practices may not be viable due to a small and/or poor patient base; and
- no single model is likely to meet the particular needs of all areas, so any adoption of this approach must embed sufficient flexibility to adapt the model to these needs.

Therefore, while supporting the concept of this model, the Committee recognises that two important questions still need to be resolved: to establish circumstances in which it is useful and appropriate to move to a community medical centre model and to identify who the employer should be.

Recommendation 12.1

The Committee recommends that the Commonwealth Government consider the use of Medicare grants to enable Community Health Centres to be provided in areas of identified need.

Recommendation 12.2

The Committee recommends that the Commonwealth Government commence negotiations with State and Territory governments to put in place arrangements which permit bulk-billing general practice clinics to operate either co-located or closely located to public hospitals in areas of low bulk-billing.

In relation to funding of the Medicare system, the Committee considers that with the current budget surplus, raising additional revenue through means such as increasing the Medicare levy is not necessary at this time.

However, as shown above, there is scope to improve current funding arrangements. The Australian Health Care Summit called for the creation of a National Health Reform Council, in part to address these issues.

The Committee concludes that workable solutions are already available for many of the problems outlined here. The key ingredients are the political will at both Commonwealth and state/territory levels to adopt flexible funding models to encourage adaptive responses to the particular needs of different regions, together with an informed community encouraged to actively engage in finding solutions both locally and nationally.

The Committee sees an ongoing need for enhancing Australia's commitment to research and analysis of health data. The Committee experienced for itself the limits of data collection and analysis that is available in the field of health policy and funding. Both the inherent complexity of the subject matter and its enormous social significance suggest that these limitations be addressed.

At the same time, the Committee is aware that the needs of researchers and policy makers should not translate into requirements for busy doctors to provide more statistics and data, in an environment where 'red-tape' is already a burden. On the evidence, the Committee agrees that there is considerable potential to make better use of the existing pool of data through better analysis and research, which would ultimately assist in a better informed and more targeted use of health funding.

Recommendation 12.3

The Committee recommends the expansion of research funding to allow for a more comprehensive analysis of health data.

The Committee is concerned at the evidence given in relation to overseas trained doctors. It is disturbing that Australia's medical workforce has become so dependent on medical professionals trained overseas, particularly when there are so many Australians wanting to enter medical courses. As a matter of principle, the Committee takes the view that Australia, as a wealthy developed nation, should not be taking doctors away from nations where the need for qualified doctors may be even greater than our own.

The Committee is concerned over the apparent lack of supervision of, and support for, some OTDs practising medicine in Australia without full accreditation. This situation places both the doctors concerned, and the communities they serve, in potentially dangerous situations. Part of the problem may be an imbalance between the onerous requirements for doctors to enter Australia as skilled migrants and gain accreditation and other much easier means whereby they can enter and practice in areas of medical workforce shortage.

However, in the light of the important role many of these OTDs are playing in rural and remote areas, the solution is not to restrict their practice. In the Committee's view, the better response is to put in place measures to enhance the management of OTDs in a clear and transparent manner. This would involve:

- checks on qualifications prior to commencing practice;
- the identification and provision of bridging training where necessary; and
- ongoing supervision and mentoring to OTDs during the early period of practice in Australia.

Recommendation 12.4

The Committee recommends that the Commonwealth government urgently examine the current use of overseas trained doctors in Australia and consider ways to address the current difficulties of training and support.

Australia has yet to develop a clear national consensus on what it wants from its health system who will provide it, and how it will be paid for. This process is critical to resolve the current public policy debate. The broad ranging inquiry into the Canadian health system by the Romanow Commission provides a clear precedent for this type of debate.

Recommendation 12.5

The Committee recommends that a proposed new national health reform body be established and tasked to conduct a comprehensive process of engagement with the community that will provide a forum for a well-informed discussion on the values, outcomes and costs of Medicare and the Australian health system.