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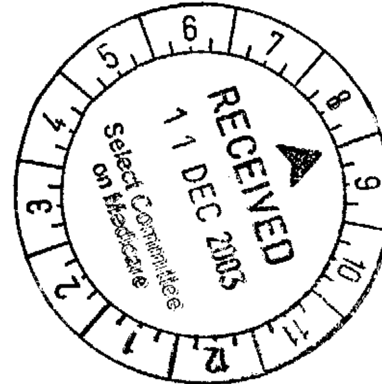
AMA



03/428

Mr Jonathan Curtis
Secretary
Senate Select Committee on Medicare
Parliament House
CANBERRA ACT 2600

Dear Mr Curtis

Please find attached the Australian Medical Association's submission in response to matters referred to the Select Committee on Medicare by the Senate on 25 November 2003.

Should you have any queries or require further information please contact Ms Julia Nesbitt on (02) 6270 5462.

Yours sincerely

Dr Robert Bain
Secretary General

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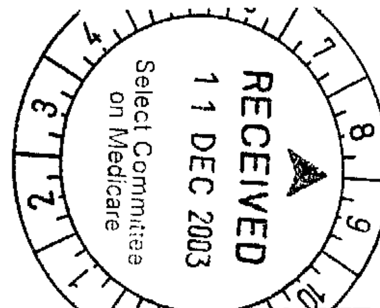

AMA RESPONSE TO MATTERS REFERRED BY THE SENATE TO THE MEDICARE SELECT COMMITTEE ON 25 NOVEMBER 2003

(b) (i) The Government's Proposed Amendments to the Health Legislation Amendment (Medicare and Private Health Insurance) Bill 2003

The AMA is of the view that two huge, and sometimes conflicting, issues shape health financing system design:

- a fundamental objective of any health insurance system is to allow the population to share the financial risk of poor health; while
- a fundamental issue for public health financing is to ensure that all citizens have reasonable access to health care regardless of their means.

Australians in the lower socio economic groups tend to have relatively worse health than the rest of the community, particularly if they live in rural areas. On average they require more GP services than higher income groups. Lifestyle issues such as diet, alcohol and tobacco consumption, lack of preventative treatment through regular checkups and the sheer impact of poverty all contribute to poor health and the need for increased GP attention.

In its supplementary submission to the Senate's Medicare inquiry the AMA stated that there are three major steps that are required to ensure access and affordability of GP care for this group:

- ***An adequate number of available GPs***

  As the Department of Health and Ageing submission to the Senate Select Committee inquiry into Medicare shows the number of GPs per 100,000 people is very inadequate in some regions. This is echoed in Access Economics studies that indicate low GP numbers in low socio economic areas.

  Rural areas tend to have low levels of bulkbilling and this is clearly linked to different cost structures and the shortage of GPs in many of these areas.
  Outer urban areas have high levels of bulk billing driven by the needs of low socio economic status patient populations. The dominance of bulk billing makes general practice non viable and thus contributes to the current and increasing workforce shortage.

- ***Rebates from Medicare must enable the patient to pay the doctor a fee that at least covers costs***

  Doctors will cross subsidise their fees and assist their lower income and chronically ill patients but as the rebate falls further and further behind the real costs of providing GP services, practices with a high level of bulkbilling become increasingly uneconomic.

  General practitioners are intimately connected to the communities they serve and in which their patient population resides. They have an intimate understanding of the circumstances of individuals and families within that community.

- ***There must be an effective safety net for those affected by significant bouts of ill health***

  All Australians should be eligible for additional assistance when medical costs exceed what is judged to be a reasonable level for such persons or individuals to afford.

  The provision of strengthened safety nets by Government for needy patients who strike barriers to access arising from the failure of the MBS fee schedule to reflect practice costs is welcomed. AMA advocates a safety net scheme which approaches from the patient's point of view and which provides support to those with poor health status (more often than not, those with a poor socio-economic status). AMA continues to support a single safety net that combines both PBS and MBS expenditure as the triggers and that have lower thresholds than currently proposed. Access to the safety net should be at three levels: pensioner, health-care-card holder and non-concessional.

  AMA notes that the changes in the safety net proposed by Government do little to support single people on low incomes with high healthcare needs.

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

The AMA welcomes the removal of the compulsory bulk billing of concession cardholders that was a key feature of the original Fairer Medicare Package. The proposal to increase the rebate by $5 where the doctor bulk bills a concession cardholder or child under 16 is welcomed.

This measure will allow general practice to continue to establish its own billing practices and to make decisions on bulk billing based on socio economic need or chronic illness.

It will not do anything, however, for those people who cannot find a GP to treat them within a reasonable time. This measure will have little or no workforce impact and is unlikely to impact on the overall bulk billing rate as the community's medical insurer (Medicare) continues to fail to keep up with the costs of providing basic primary health care services.

The measure does not address the growing gap between the patient rebate and the true value of general practice service – the lynch pin of affordability.

While AMA welcomes additional funding to improve access to high quality healthcare for cardholders and children, this is not a long-term solution. The long-term solution is a Medicare Benefits Schedule (MBS) that also recognises and rewards high quality longer consultations when they are appropriate. The AMA maintains its support for the 7-tier MBS structure proposed by the Attendance Item Restructure Working Group (AIRWG) with proper funding on the basis that it improves quality, patient equity and safety.

(b) (iii) The Government's proposed workforce measures including the recruitment of overseas doctors.

More graduate doctors to outer metro, rural and remote areas
AMA welcomes pre vocational terms for junior doctors in general practice (under supervision). This scheme will allow more graduates to experience general practice and will promote choosing general practice as a career. Placing these graduates in outer metropolitan, rural or remote areas will not only provide more services to these regions, but also have an impact on long-term GP numbers in these areas.

It is important that these places meet Royal Australian College of General Practice (RACGP) standards of supervision. The level of supervision required by these junior doctors will place significant demands on participating general practices and adequate funding and support will be required.

More overseas trained doctors
MedicarePlus recognises the Government's commitment to ensuring that Overseas Trained Doctors meet appropriate Australian standards before they are able to practise medicine in Australia. The AMA supports measures that will reduce the bureaucratic red tape that is preventing or delaying doctors who meet the standards and quality required from practising in Australia. However, AMA sees this as only a short-term solution. Government needs to recognise that Australia has a moral responsibility to train enough medical practitioners to meet this country's own medical workforce needs, rather than rely on medical schools in other countries to provide for its own medical workforce needs.

Supporting rural and remote GPs, especially procedural
This measure is consistent with the AMA proposal contained in its GP Vision: "Implementation of a sabbatical system for rural and remote GPs whereby every few years they are granted fully paid study leave to allow them to pursue study and training to upgrade skills. Currently, rural doctors are disadvantaged because of isolation and inability to easily access latest developments in medicine."

The success of this initiative will depend on a well supported and highly skilled locum workforce This may be achieved through enhancing the recognition and support for locum general practitioners and the adoption of a simple and affordable national medical registration process.

Helping GPs and specialists re-enter the workforce
AMA supports any plans to help GPs and specialists re-enter the workforce. With the workforce shortage growing any deterrents to doctors rejoining the workforce must be removed. The range of equivalent measures for specialists should be extended to GPs and all measures should be delivered through the relevant Colleges.

Bonded medical school places
AMA remains very disappointed to see that the bonding of students remains a feature of the Government's package. The AMA believes that training measures are part of a good long term workforce strategy but overseas evidence supports AMA's long held view that bonding will not deliver the workforce redistribution the Government hopes to achieve. Scholarship and/or debt relief measures are the ones that have been shown to work.

Non VRs
Keeping non VR GPs in the workforce is essential. The restriction of this measure to non VRs who choose to practice in specific geographic areas fails to recognise that this large section of the GP workforce is under threat. The patients of non VR GPs who do not choose to relocate to specified areas will continue to experience the discrimination of significantly lower rebates. Non VR GPs will continue to be lost from the medical workforce as they become increasingly unemployable due to this discrimination imposed on patients by Government and as their practice of quality medicine becomes increasingly non viable.

The AMA strongly supports a final round of grandfathering to vocational recognition of all eligible non VR GPs as both a patient centred response and a measure to improve retention of general practitioners within the declining general practice workforce across Australia.