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Tasmania

PREMIER

24 DEC 2003

Senator Jan McLucas
Chair
Senate Select Committee on Medicare
Suite S1 30
Parliament House
CANBERRA ACT 2600

Dear Senator McLucas

I am writing in response to your invitation to make a submission to the Inquiry being undertaken by the Senate Select Committee on Medicare into the Commonwealth Government's *MedicarePlus* package.

The Tasmanian Government provided a submission on 11 July 2003 to the Select Committee's Inquiry into the *A Fairer Medicare – Better Access, More Affordable* package. While welcoming the increased funding for the *MedicarePlus* proposals, the Government's fundamental concerns about the impact of the package on the public health system and access to health services remain.

I enclose a brief submission to the Inquiry in response to the *MedicarePlus* package.

Thank you for providing the Tasmanian Government with the opportunity to provide comment to this Inquiry. I look forward to the Committee's report on this important issue.

Yours sincerely

Jim Bacon MHA
Premier

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TASMANIAN GOVERNMENT SUBMISSION TO THE SENATE SELECT COMMITTEE ON MEDICARE INTO THE *MEDICARE PLUS'* PACKAGE

Tasmania welcomes the opportunity provided by the Senate Select Committee Inquiry into Medicare to provide comment on the *MedicarePlus* package. While the Tasmanian Government acknowledges the expanded funding for *MedicarePlus*, many of the concerns with the previous package remain. Tasmania is concerned that the package will:

- Fail to restore bulk billing levels that have fallen dramatically in recent years;
- Effectively destroy universal Medicare coverage and create a two-tier system in its place;
- Hit the working poor, with particular impacts on regional areas including Tasmania that have a comparatively low socio-economic profile;
- Fail to address the ineffectiveness of the Private Health Insurance rebate;
- Fail to provide the increased support needed to attract GPs to rural and regional areas; and
- Fail to address the need for the current Commonwealth Government to reverse its 1996 decision to stop funding of oral health services.

Funding Public Health Services

Tasmania is concerned that the Medicare package has in effect been partly funded by shifting funds previously allocated for public hospitals. The Commonwealth's funding commitment for public hospitals through the 2003-08 Australian Health Care Agreements (AHCAs) has been reduced by $918 million over four years compared to the forward estimates for the roll over of the 1998-2003 AHCA arrangements. Under the new Commonwealth AHCA, the indexation provisions have been significantly reduced to achieve the budget saving that the Commonwealth has used to redirect funds from public hospitals to partly fund the Medicare package.

The growth in Commonwealth funding for public hospitals has been reduced at a time when public hospitals are under immense pressure due to the ageing of the population, the Commonwealth's failure to provide adequately for aged care beds and other demand growth factors.

Despite the GST arrangements, the Commonwealth revenue base is growing much more rapidly than that of the States and Territories. As a result, the Commonwealth has a responsibility to ensure that States and Territories are adequately resourced to provide free public hospital care. The Commonwealth is reneging on its long standing and accepted obligation in this regard.

Tasmania is of the view that the Medicare package money would be far better spent in funding public hospitals than in financing a program that is unlikely to achieve its aim of preventing a further decline in bulk billing.

Our concern is largely for people who are not concession card holders, and who do not have private health insurance. The new *MedicarePlus* package is still based on a two-tiered system, that only envisages bulk billing applying to children under 16 and

concession card holders. Other low income earners will not be bulk billed and are likely to face increased out of pocket costs. These low income earners may either forgo treatment due to the cost or seek free treatment through public hospitals. The implications of this are that further pressure will be placed on public hospital outpatient services. For some patients, chronic conditions may be left untreated until they have progressed to a point where high-cost services in the public hospital sector are required.

States and Territories will yet again carry the burden of extra demand on public hospital services, which are provided free of charge to all eligible persons who wish to receive them.

The pressure placed on public hospitals as a result of the Commonwealth health policy is compounded by the failure of Commonwealth aged care policies. Not enough aged care beds are available to cope with the ageing of the population. While the Australian Government's new 'Pathways Home' program is acknowledged, it is in fact no more than a re-badging of the funding included in the previous AHCA as the National Health Development Program – there are no additional funds.

In practical terms this means that a significant number of hospital beds across the country are occupied by people who are in hospital only because there are no aged care beds available. In Tasmania's case, the latest available figures show that this month we have 79 hospital beds occupied by people waiting placements in residential aged care facilities.

Effectiveness of new General Practice arrangements

The current GP consultation rebate of $25.05 is only just over half the AMA recommended fee and has not kept pace with inflation since its introduction. It is therefore not surprising that many General Practitioners consider this payment inadequate and have stopped bulk billing.

The new incentive payment of an extra $5 per patient to General Practitioners (GPs) who bulk bill children under 16 and health concession card holders may be too low to ensure continued bulk billing by GPs, which may decline further. Higher fees to non-concession cardholders over 16 years old may result if GPs are to agree to bulk bill concession cardholders and children under 16. Also this reform only applies to those GPs who agree to bulk bill concession cardholders, so that if the take up of bulk billing is low then the benefits of these arrangements will only apply to a small number of consumers.

The extension of the Medicare safety net to all Australians is welcomed.

Tasmania had the second lowest level of GP attendance bulk billing of any jurisdiction (after the ACT) at 58.5 % in 2001-02. This compares with the national average of 74.9%. Tasmania also had the third lowest level of scheduled fee observance in 2001-02 (after the ACT and the NT) at 68.5% compared with a national average of 78.5%. The lower levels of bulk billing and schedule fee observance indicate a less affordable general practice situation already exists in Tasmania and Tasmanians therefore already contribute a greater amount towards their own health

care than most other jurisdictions. At the same time as having amongst the lowest bulk billing levels, a far greater proportion of Tasmanians are in the lowest annual income brackets, compared to most other jurisdictions.

According to the Productivity Commission Report on General Practice administrative and Compliance Costs (31 March 2003), Practice Incentive Payments, Vocational Registration and Enhanced Primary Care payments all have high administrative and compliance costs at respectively 38.6%, 15.0% and 53.9% of total funding received and also involve large amounts of time consuming paperwork. Due to the high administrative and compliance costs these programs are not popular with GPs and this also explains the relatively low take up rate of programs such as Enhanced Primary Care.

Tasmania like other States has experienced difficulties in attracting General Practitioners, both to rural areas and in large regional metropolitan centres (e.g.. Launceston). Tasmania has a relatively high number of rural practices filled by overseas trained doctors with conditional registration due to the unavailability of local graduates to fill these positions. Not only may conditional registration limit the scope of practice, but it also places a burden on the health system in relation to supervision and education. In addition, when full registration is achieved, many practitioners move on, creating a lack of continuity and certainty.

There are many GP practices in Tasmania that have closed their books to new patients and so timely access to GP services is a significant issue in the State.

The new GP places are welcomed but the bonded nature of the places could be a disincentive to students. Classifications of rural and remote areas also work against Tasmania as some areas of high need do not meet the national criteria for rural and/or remote areas.

The additional support for training and supervision is also welcomed. However, supporting the volume of placements required in a small health system such as Tasmania's is an issue with only a limited number of medical staff but growing student numbers. The teaching role for medical staff cannot be expanded at the expense of clinical practice.

The limited access of practice nurses to Medicare items is a sensible reform and long overdue. However, there is potential for improving access and affordability if allied health and dental care was to be covered, at least to some degree, through Medicare. A redirection of the private insurance rebate could be one way to fund this. This could create a system that improves access to a more diverse workforce and reduce the pressure on GPs.

De-funding of dental services

The Commonwealth Government withdrew Dental Scheme funds from the States and Territories in 1996, resulting in a loss to Tasmania of over $3 million per year (a total of over $18 million to date).

Since that time the State has had to reconfigure service delivery and reassess priorities in order to maintain a dental service to eligible adults and children. The previously well funded children's service has had to have funds redirected to enable the adult service to continue.

Dentists who had been funded through the Commonwealth Dental Scheme were unable to have their contracts renewed, and the workforce has continued to dwindle to the current level of 9.5 FTE.

As the other States are experiencing similar difficulties, but in many instances have a greater funding base from which to draw to replace the Commonwealth funds, competition for staff has further reduced Tasmania's capacity to recruit and retain staff.

Tasmania's relative isolation and its inability to offer dental training has raised further barriers to recruitment.

The waiting lists that were introduced under the Commonwealth Dental scheme have now increased to the point where adult patients have little opportunity to receive general care. The adult service provides an emergency service for the most part, and despite prioritising of service delivery, there are many patients who are unable to access the service in a timely manner.

The State is not able to offer specific and appropriate services from within a hospital setting, and many of the patients seen in the community are placed at significant risk of complications because of the lack of access to the hospital system. Patients with significant co-morbidities such as drug and alcohol conditions, mental health issues, cardiovascular disease or cancers who in other states would receive their dental care in a hospital are unable to obtain any treatment at all, seriously reducing their possibility of a positive prognosis.

Effectiveness of the Private Health Insurance Rebate in reducing demand on public health services

The private health insurance rebate is very poor value for money. The purported goal of this policy is to relieve pressure on the public hospital system. This has not been achieved. There have been no significant reductions in waiting lists for elective surgery and the demand for public hospital services continues to grow. While demand has increased in the private sector, there has been no associated reduction in the public sector. The increased uptake in private health insurance appears therefore to stimulated additional demand.

As observed in the report by Professor John Deeble, *The Private Health Insurance Rebate* (January 2003), the rebate has only made a small contribution to the increased uptake in private health insurance as the majority of the increase was due to the introduction of lifetime health cover. The rebate would be far better spent on public hospitals or to boost MBS payments to GPs. Professor Deeble's report demonstrates that the rebate has not been effective in relieving pressure on public hospitals.

Other Comments

The Commonwealth package does not address the central issue - which is that the Medicare rebate is too low. If the rebate is increased sufficiently to **all** patients almost all doctors would bulk bill.

Additionally, it is well worth mentioning that the issue of General Practice as a key, but not exclusive, element of primary health care needs a broader policy approach than just price signals.

We need to understand why people see a GP, to ensure that the range of skills and aptitudes match what is required, and that GP care is in fact the most appropriate treatment.

Working life decisions of young doctors are being influenced by much more than income alone, and a holistic approach is required to resolve the primary care needs of the Australian population.