



QNU Submission to the Senate Select Committee on Medicare 18 June 2003

Mr Elton Humphrey
The Secretary
Select Committee on Medicare
Suite S1 30
Parliament House
Canberra ACT 2600

Dear Mr Humphrey,

Re: Submission to the Senate Select Committee on Medicare

The Queensland Nurses' Union (QNU) appreciates the opportunity to make a submission to the Senate Select Committee Inquiry into Medicare.

This submission will be brief due to the short time frame allowed for submissions. The QNU would normally encourage individual members and local branches to make submissions but the short time frame has prevented us from following our normal practice. We wish to place on record that because of this we are concerned that our members have been denied the opportunity to express their views and concerns and the QNU has been prevented from consulting members in a comprehensive manner on this critically important issue.

Before addressing each of the terms of reference some background information is provided about the QNU.

Background information

The QNU is the principal health union registered in Queensland. In addition the QNU operates as the state branch of the federally registered Australian Nursing Federation (ANF). It represents the largest number of women members of any union in Queensland.

The QNU covers all categories of workers that make up the nursing workforce in Queensland. This includes registered nurses, enrolled nurses and assistants in nursing, be they employed in the public sector or the private for-profit and not-for-profit health sectors. Our members work across a variety of settings from single person operations to large health and non-health institutions, and classifications from entry level trainees to senior management.

Membership of the QNU has grown steadily since its formation in 1982 and as at June 2003 was in excess of 31,600 and still growing. Like the nursing profession as a whole, the overwhelming majority of our members are female (93%).

The QNU has a democratic structure based on workplace or geographical branches. Approximately 250 delegates are elected from the branches to attend the annual QNU conference which is the principal policy making body of the union. On a number of occasions in recent years delegates to our conference has passed resolutions supporting the maintenance and extension of Medicare and charging the QNU to campaign in the defence of Medicare. In addition to the annual conference the QNU has an elected council and an elected executive, which in turn have decision-making responsibilities between conferences. Council is the governing body of the union.

Predominantly, QNU members in the public sector are employed under federal awards and agreements and in the private sector are employed under state awards and agreements. In addition, since 1994 when no enterprise agreements were in place covering nursing workers, the QNU has become party to over 200 enterprise agreements which cover a diverse range of health facilities and other non-health establishments where nursing services are provided (eg, schools, prisons and factories). We therefore have a clear and comprehensive understanding of

the complexity and inter-relationships of contemporary health service delivery as well as the diversity of locations where health services are delivered.

The QNU is affiliated with the Queensland Council of Unions and is represented on the Australian Council of Trade Unions via its membership of the Australian Nursing Federation. We belong to a number of community groups/alliances, the most relevant to this inquiry being our role as Secretariat for the Public Hospitals Health and Medicare Alliance of Queensland (PHHAMAQ). We endorse PHHAMAQ's submission to this inquiry.

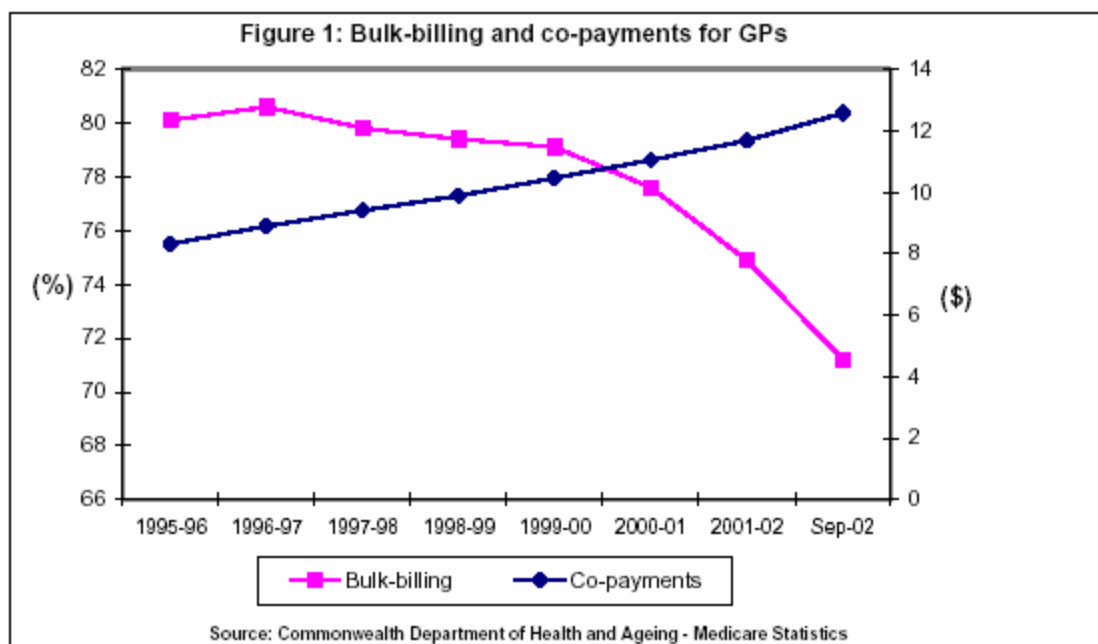
Over the years the QNU has made numerous submissions to inquiries that are of relevance to this select committee. For example, we made a number of submissions to the Senate Inquiry into Public Hospital Funding as well as other Senate and non-parliamentary inquiries on health related matters. Like PHHAMAQ we provided a submission to the Queensland Minister for Health earlier this year on the re-negotiation of the Australian Healthcare Agreement. (A copy of this submission is enclosed for your information.) We believe it is essential that a broad view of the various components of our universal health system is taken when examining the future of Medicare. The institutional silos that have developed in our health system must be broken down if we are to improve on the current system to better meet the health needs of the community.

TERMS OF REFERENCE

The access to and affordability of general practice under Medicare, with particular regard to:

(a) the impact of the current rate of the Medicare Benefits Schedule and Practice Incentive Payments on practitioner incomes and the viability of bulk-billing practices;

The QNU supports calls by the National Medicare Alliance (NMA) for an immediate increase in Medicare rebates to offset inflation. (Members of the National Medicare Alliance include the Australian Consumers' Association, Australian Council of Social Service, Australian Nursing Federation, Doctors' Reform Society, Health Issues Centre, Public Health Association of Australia and The Australian Women's Health Network.) The NMA released a series of short and medium to long term recommendations to address the decline in bulk billing in Australia in their paper *A plan to end the bulk billing crisis* (March 2003). The QNU supports the recommendations contained in that report and notes with alarm its prediction that if bulk billing rates continue to fall at the present rate then by September 2016 the rate of bulk billing will fall to nil. The decline in bulk billing in recent years is highlighted graphically in that report (at page 3) by the table reproduced below:



Although the QNU supports the recommendations in *A plan to end the bulk billing crisis* report we believe that a close examination of the success of current incentive measures provided to doctors from government needs to be undertaken as a matter of urgency. For example, in recent years past federal budgets have contained a number of initiatives for doctors in general practice settings (for IT support/infrastructure, to provide wage subsidies to employ practice nurses in rural settings etc) but to our knowledge the effectiveness and take up of these initiatives have not been analysed. Before embarking on a series of new initiatives the magnitude, appropriateness and effectiveness of existing incentives for doctors must be reviewed.

The QNU believes that bulk billing rates have been undermined by stealth in recent years because the federal government has failed to adequately index these to take account of inflation. Although we support increases to Medicare rebates to ensure the inflationary effect of recent years is accounted for, we strongly believe that this must occur in the context of an open and accountable framework for establishing and reviewing the level of rebates and other forms of remuneration/support by government. The QNU supports fair compensation for the work performed by doctors. Our members have their wages negotiated through a transparent industrial relations framework. If agreement cannot be reached then there is recourse to an independent umpire – the Australian Industrial Relations Commission or the Queensland Industrial Relations Commission. We believe that a similar open and transparent mechanism must be established for the setting and review of remuneration of medical officers, especially given that a significant component of their remuneration is funded by the taxpayer.

It is also the case that the issue of remuneration should not be viewed in isolation. For example, the recent medical indemnity insurance crisis (a crisis which extends beyond doctors to other health professionals) highlights that it is planned to use taxpayer funding to address this issue for doctors. The QNU supports government intervention in addressing this issue but believes this needs to be considered in an overall examination of how the practice of doctors is financed by government. Why is it not possible, for example, to link provision of indemnification of medical officers by government to a commitment to bulk billing all patients? The community would support the appropriate indemnification of doctors by government from taxpayer funding but surely has the right to ask what does it get in return?

The issues of remuneration of doctors and medical indemnity are complex ones. However they must be considered by this Senate Select committee. We again place on record that we believe that the timeframe allocated for the inquiry is too short to enable this to be done appropriately. The views of the community should inform these discussions. In recent years the community has become more aware of their rights in health care and are better able to articulate their needs and expectations. In our view the community must be given the opportunity to have input into the debate on the critically important issue of health financing, especially given the current levels of inflation in health care (and the drivers of this inflation) and the possible “blow out” in health expenditure that could result from the ageing of our population.

(b) the impact of general practitioner shortages on patients’ ability to access appropriate care in a timely manner,

There are shortages of general practitioners in remote areas and in some outer metropolitan and some regional areas. This relates more to the distribution of general practitioners rather than an actual profound shortage. According to Australian Institute of Health and Welfare (AIHW) data (sourced from *Australia’s Health 2002* and AIHW website), in 1999 there was a higher percentage of medical practitioners in metropolitan (76.8%) and large rural centres (6.2%) than the percentage of population residing in those areas (63.9% and 6.0% respectively). On the other hand, in rural areas where 13.2% of Australia’s population reside, 4.6% of medical practitioners had their practice. (*Australia’s Health 2002*, p 270-271) In 1999 there were 264.2 medical practitioners per 100,000 of population in Australia, but there was great variance in numbers between states, with the ACT having the highest rate per 100,000 of population (333.1) and Queensland the lowest (232.9). (AIHW website). According to OECD selected data (Australia, New Zealand, Canada, USA and UK), numbers of medical practitioners per 1,000 population increased in all countries between 1981 and 1998, with Australia having the second highest rate behind the USA in 1998. (*Australia’s Health 2002*, p 278) We are unaware of the existence of agreed international or national benchmarks for medical practitioner numbers per general population, and this issue should be further investigated when examining this particular question posed by the inquiry.

Shortages of general practitioners must be examined in the context of geographical distribution and the relationship with other health professionals. Rather than there being shortages of medical practitioners the QNU believes that there is a maldistribution of medical practitioners and therefore effort should be concentrated on addressing the maldistribution. In many remote areas in Queensland for example there is a chronic inability to recruit (let alone retain) medical practitioners. Nurses usually fill the void in such circumstances, with their scope of practice being expanded accordingly. With the acute on chronic and worsening shortage of nurses in Australia this solution to the lack of medical practitioners will be compromised.

Medical workforce shortages may exist in some discrete areas of specialty (where we recommend that the medical college's controls on supply be closely examined) and geographical areas. These are however insignificant when compared to the depth and breadth of nursing shortages in Australia. According to AIHW data the number of full time equivalent nurses per 100,000 of population in Australia has been steadily declining since 1994, reported at 1,018 per 100,000 in 1999 (*Nursing labour force 2001*, p 5). The national review of nursing education that was jointly conducted by the Commonwealth Departments of Health and Education (final report released in September 2002 *Our Duty of Care*) concluded that in the period 2001-2006 there will be 31,000 nursing vacancies will be created in Australia, almost three quarters of these vacancies created by nurses leaving the profession. Despite recent concurrent reviews (the national review of nursing education and a Senate Inquiry into Nursing) and the numerous comprehensive recommendations arising from these reviews we currently appear no closer to implementing a national strategy to address the nursing shortage crisis.

Nursing shortages must also be seen in a context of the broader health workforce, its composition, skills and numbers. (Our fear is that the reluctance to address nursing shortages will lead to the substitution of nurses with unqualified or less qualified personnel and this will have adverse consequences on quality of care.) In some areas the crisis may have been engineered to achieve budget savings. Certainly a reluctance to accept and act on the findings of two national inquiries amounts to dereliction of duty in our view. Until such time that wider nursing shortages are addressed one strategy announced in the Howard government's "reform" of Medicare, the wage subsidy to general practitioners to employ practice nurses, is highly unlikely to be successful. It is likely that such subsidies will be claimed to offset the cost of employing existing nurses employed in general practice and not those to undertake an expanded practice nurse role.

(c) the likely impact on access, affordability and quality services for individuals, in the short- and longer-term, of the following Government-announced proposals:

(i) incentives for free care from general practitioners limited to health care card holders or those beneath an income threshold,

The QNU believes that any incentives for medical practitioners should be aimed at ensuring bulk billing for all Australians, not merely concession card holders or those below a certain income. To differentiate between Medicare card holders in this manner is a fundamental attack on the universality of the scheme and will be vehemently opposed by the QNU.

Various recent opinion polls have shown that the vast majority of Australians support the maintenance of bulk billing for all Australians. For example:

Nine MSN poll conducted on Friday 16 May, which asked "Do you believe all Aussies should have access to bulk-billing?", resulted in a respondents yes vote of 22079 (78%) and no of 6276 (22%)

A Choice poll conducted on-line that is still to be conducted showed that as at 17 June 2003 87.63% believed that bulk billing by GPs should be available to all Australians as opposed to 12.37% who responded that bulk billing should be restricted to concession card holders.

On the broader issue of the package of changes to Medicare a **Newspoll survey** conducted nationally among 1200 respondents aged 18 years or over between 28 April and 1 May had the following results:

The question was asked "Are you personally in favour or against this proposed change to the Medicare system?"

1200 Respondents	Total	Male	Female
In Favour	22%	21%	23%
Against	60%	59%	61%
Neither/Don't Know	18%	20%	16%
TOTAL	100%	100%	100%

(ii) a change to bulk-billing arrangements to allow patient co-payment at point of services co-incident with direct rebate reimbursement,

The QNU totally rejects the introduction of co-payments at point of service. Members of the QNU are currently reporting that they and patients they care for are experiencing difficulties meeting the current gap they are expected to pay (between the Medicare schedule fee and the actual fee that doctors charge) when visiting the GP. It is not uncommon for people to delay accessing health services (or not seek them at all) because of financial embarrassment. There has been a shift to a "user pays" system in health over recent years that has meant that out of pocket expenses by patients is growing. According to AIHW and ABS data:

"Most non-government funding for health goods and services in Australia comes from out-of-pocket expenditure by individuals. This includes both expenditure when the individual meets the full cost of care and where the individual and third-party payers (for example, private health insurance funds or the Commonwealth Government) share the funding. Expenditure by individuals accounted for 57.8% (\$10.5 billion) of estimated non-government funding of health goods and services during 2000–01 ... and rose by almost 8 percentage points over the decade to 2000–01. Private health insurance funds provided 23.7% (\$4.3 billion) down from 34.7% in 1990–91. The remaining 18.5% (\$3.4 billion) came from other non-government sources (mainly compulsory motor vehicle injury insurers and workers' compensation insurers), which experienced a rise in its share of funding of health, by 3.1 percentage points, over the decade." (Health Expenditure Australia 2000 – 01 (AIHW), p 30)

According to the National Medicare Alliance, the out of pocket expense of visiting a non-bulk billing doctor has increased by 16.6% over the last two years (to December 2002) with the average patient contribution rising to \$12.78 per GP visit. Already many Australians aren't seeking medical advice when it is required, or are thinking twice before they go to a doctor because of increasing medical and drug costs.

The ACTU has calculated that the Howard government's proposed changes to Medicare would mean that a working family of four with an average number of GP visits would have to pay around \$500 extra per year for formerly bulk-billed GP visits and pathology tests. They believe that the changes will mean that doctor's fees will increase like never before and that bulk billing will be restricted mainly to pensioners and health cardholders. The Howard government's existing health policies have already resulted in alarming increases in out-of-pocket health care costs and a collapse in bulk billing by GPs and the ACTU expects this trend to get worse if the proposed changes are implemented.

In our view once co-payments are entrenched they will continue to grow and will be unpredictable, forcing up health care inflation. To quote Professor John Deeble, one of the architects of Medicare, the changes will have far reaching consequences:

"Whatever the Government says, full insurance will be means tested from now on and there will be GP co-payments for most people. These would be uncapped and unpredictable, and only a fool would believe that they will not rise or eventually extend to other services."

(iii) a new safety net for concession cardholders only and its interaction with existing safety nets, and

The QNU does not support differentials in safety net arrangements for categories of patients. In our view this will create a two tiered system within Medicare that strikes at the core of one of its fundamental principles – that of universality.

(iv) private health insurance for out-of-hospital out-of-pocket medical expenses; and

In our view allowing private health insurance for out of pocket medical expenses will merely serve to increase health care costs. We predict that medical fees charged for all will rise

significantly given that the “gap” will be covered by a third payer (insurance companies) for those who have health private insurance.

Whilst on the issue of private health insurance, the QNU believes that the 30% rebate for private health insurance should be scrapped. The tax payer funding that goes to this incentive for the minority of Australians with private health insurance is significant. (This currently stands in excess of \$2.2 billion per annum) The majority of Australians (56%) don't have private health insurance and yet their taxes are going towards providing incentives for those who do rather than funding health services for all Australians through Medicare and public health services.

(d) alternatives in the Australian context that could improve the Medicare principles of access and affordability, within an economically sustainable system of primary care, in particular:

(i) whether the extension of federal funding to allied and dental health services could provide a more cost-effective health care system,

The QNU believes that federal government funding must be extended to non-medical health care such as nursing, allied health and dental services. We believe that any changes that extend services funded under Medicare must not be done in a piecemeal fashion and should be focused on ensuring quality health care in an economically sustainable manner. This requires a fundamental shift in focus beyond a “medical model” of health care and must be based upon community health needs and expectations. Again we believe this inquiry cannot achieve a proper examination of these issues in the time frame allocated. Rather it is our strong view that this inquiry should recommend a national independent commission inquiry into the future of health care in Australia to fully investigate options for achieving this objective.

(v) the implications of reallocating expenditure from changes to the private health insurance rebate, and

The QNU supports reallocating expenditure for our universal health care system from the funding currently provided for private health insurance rebate. We have never supported this rebate because it is our belief that it results in inequity and promotes queue jumping. It is fundamentally an unjust arrangement in our view – it is fairer that this be spent on services that are provided to all Australians such as ensuring bulk billing is available to all. The wealthy or better off in society will always be able to obtain preferential access to services by virtue of the fact that they can afford to pay to have a service provided in the private sector. This reality should not be compounded by tax payer funding supporting and promoting this inequity. The private health sector plays an important role in the Australian health system, but this should only be seen as complementary to our universal system.

Since the introduction of the private health insurance rebate there has been repeated evidence that this has not achieved one of its stated policy objectives – to relieve pressure from the public hospital system. The issue of appropriateness of services being provided under this scheme has also been called into question and needs further close examination. There is strong anecdotal evidence that people who have felt forced into taking out private health insurance are seeking to achieve “value for money” by accessing services that may not be necessary. We believe the system is currently promoting over-servicing.

(vi) alternative remuneration models that would satisfy medical practitioners but would not compromise the principle of universality which underlies Medicare.

Earlier in our submission we stated that the system for remuneration for medical services must be more closely examined. This must not be done in a knee jerk fashion but rather a comprehensive review is required. A system is required that is fair, transparent and accountable. Issues such as medical indemnity insurance must also be considered when looking at alternative models. Certainly many options are available, including one potential option favoured by the QNU of government funded multi-disciplinary primary health care clinics. Such decisions to change health financing/remuneration models must be based on community health needs and expectations, bringing us again to our call for a national independent commission of inquiry into the future of health services in Australia.

Summary

In summary the QNU is extremely concerned about the Howard government's proposed policy changes to our universal health system. We fear that such changes will take us further down the track of a US style health system, a system that Australia should not emulate. Australians reject a US style health system as the "fend for yourself" approach does not sit well with our commitment to a "fair go". The vast majority see Medicare as more than a universal health insurance scheme, rather it symbolises the type of society we want Australia to be. It is a concrete demonstration of mutual support and concern for fellow citizens when they are at their most vulnerable – when they are sick.

The QNU has made a number of recommendations throughout this submission. As some of these are preliminary in nature we will not draw the recommendations out to form a specific section on recommendations. Rather we would prefer to make a number of broad recommendations to this inquiry.

Namely that the QNU calls upon this Senate inquiry to:

- Oppose all Howard Government policy initiatives that will undermine the integrity, universality and ongoing viability of Medicare;
- Support bulk billing for all Australians as a fundamental cornerstone of our health system;
- Instigate an independent national inquiry into the future of the Australian health system, so the community determines the type of health system that meets its needs; and
- Ensure no changes to Medicare until this national independent inquiry is finalised.

Thank you for the opportunity to provide a submission to this inquiry. We apologise for the brevity of our submission, but the timeframe for submissions has not allowed us to provide more detail nor consult fully with our members on these matters.

Please do not hesitate to contact me (or in my absence QNU Project Officer Beth Mohle) on 07 3840 1444 should you wish to discuss our submission further or if you require any additional information.

Yours sincerely,

Gay Hawksworth

SECRETARY