The Senate

Select Committee on Medicare

Medicare – healthcare or welfare?

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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

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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

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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.

CHAPTER 1

Introduction

Medicare is not a discretionary Government handout. Nor is it a welfare scheme. It is an insurance system to which everyone contributes according to their income. They then have a universal right to coverage. That solves all the problems of protecting pensioners, the unemployed, other low-income earners, large families and the chronically ill with equity, dignity and less intrusion into their affairs than any alternative.[1]

Background to the Inquiry

1.1 On 14 May 2003, the Government announced in its Budget a number of significant changes to the existing Medicare scheme, titled '*A Fairer Medicare – Better Access, More Affordable'*. The Senate subsequently agreed, on 15 May 2003, to the appointment of the Select Committee on Medicare, to inquire into and report by 12 August 2003, on the following matters:

> 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;
>
> (b) the impact of general practitioner shortages on patients' ability to access appropriate care in a timely manner,
>
> (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,
> >
> > (ii) a change to bulk-billing arrangements to allow patient co-payment at point of services co-incidental with direct rebate reimbursement,
> >
> > (iii) a new safety net for concession cardholders only and its interaction with existing safety nets, and

1 Professor John Deeble, *Not ailing, but in need of a check-up*, Sydney Morning Herald, 10 March 2003, p. 15

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

(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,

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

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

1.2 On 19 June 2003, the Senate referred to the Select Committee the Health Legislation Amendment (Medicare and Private Health Insurance) Bill 2003 which was the legislative enactment of the budget announcements. With the reference of this bill, and the time pressures associated with the Committee's hearings program, the reporting date was extended initially until 9 September 2003, and then until 30 October 2003.

Conduct of the Inquiry

1.3 The Inquiry was advertised in *The Australian* on 21 May 2003 and then on a number of further occasions. The Committee also wrote to a wide range of individuals and organisations, including all State and Territory governments, inviting submissions and posted information concerning the Inquiry on the internet. The initial closing date for submissions was 18 June. This was extended to 10 July following the reference of the bill. The Committee continued to receive submissions through the course of the Inquiry.

1.4 The Committee received 226 submissions as well as seven confidential submissions. A list of all submissions and other documents authorised for publication that were received during the inquiry is at Appendix 1. The Committee Chair, Senator McLucas, presented to the Senate a petition with over 11 000 signatures that strongly supported Medicare and a universal public health system. The petition had been circulated by the Public Hospitals Health and Medicare Alliance of Queensland. The terms of the petition are reproduced in Appendix 1.

1.5 The Committee commenced its hearing program by convening an expert roundtable discussion in Canberra on 21 July. This was followed by public hearings in Sydney, Newcastle, Melbourne (twice), Perth, Adelaide, Hobart, Bundaberg, Brisbane and Canberra. A full listing of the Committee's public hearings, and the witnesses who appeared, is at Appendix 2. Transcripts of the public hearings and roundtable discussion may be accessed through the Internet at
http://www.aph.gov.au/hansard/index.htm

Commissioned research

1.6 An important issue emerged early in the Inquiry, namely the extent to which the Government's 'A Fairer Medicare' package contained measures that could have an inflationary effect on the cost of health care. This view had been articulated in a number of submissions received by the Committee.[2] However the Department of Health and Ageing maintained that there were no elements in the package that would tend to create this effect, and as such, no modeling of the cost effects of the package was necessary.[3]

1.7 A majority of the Committee believed the issue should be independently assessed. Given the implications of higher costs for access to health care, and the number of submissions that raised the issue of possible inflationary effects, it was necessary to settle the issue (to the extent possible) by some definitive analysis. Consequently, and in the absence of any departmental modeling, the Committee commissioned the Australian Institute for Primary Care (AIPC) at LaTrobe University, headed by Professor Hal Swerissen, to conduct this research. The President of the Senate approved the commissioning of the research.

1.8 The AIPC was asked what, if any, inflationary effects on health care costs for consumers are likely to emerge from the:

- **Government's 'A Fairer Medicare' package**, including incentives to practices that agree to bulk-bill all concession card holders, the capacity for non-concessional patients to pay only the gap at the point of service, the introduction of a new $500 safety net for concession card holders, and the creation of a category of private health insurance for out of hospital costs where they exceed $1000; and
- **Opposition proposal**, including measures to increase the patient rebate to 95% of the scheduled fee for bulk-billed services, and the introduction of incentive payments to encourage bulk-billing target rates in metropolitan, outer-metropolitan and rural and regional areas.

1.9 The AIPC presented its report to the Committee on 19 September 2003, and the research team then met with the Committee in Canberra on 23 September. The briefing by AIPC on the conduct and outcomes of their research, as well as the subsequent discussion with the Committee were held in public and the transcript is accessible from the Internet at http://www.aph.gov.au/hansard/index.htm. The AIPC report is included as Attachment 1.

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2 For example Professor Wilson, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 30; Professor Deeble, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 46; Professor Richardson, Submission 52.

3 See for example: Mr Stuart, *Community Affairs Legislation Committee Hansard*, Consideration of Budget Estimates, 2 June 2003, p. 41; Mr Davies, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 37. see also Mr Davies, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 69. This issue is discussed in detail in Chapter 8 – Bulk billing under the government package.

Structure of the report

1.10 The report deals with the terms of reference and the Health Legislation Amendment (Medicare and Private Health Insurance) Bill 2003 simultaneously, and comprises three parts.

1.11 Part 1 contains an overview of Medicare, its history and objectives, including the concepts of bulk-billing and universality. Addressing terms of reference (a) and (b), chapters 3 and 4 consider the viability of general practice in Australia, and current problems in access to medical services.

1.12 Part 2 addresses term of reference (c), and assesses the government's 'A Fairer Medicare' package, considering measures relating to: bulk-billing; direct payment of the Medicare rebate at the point of service; additional safety nets; and workforce measures in chapters 5 to 8 respectively.

1.13 Part 3 then considers term of reference (d), and alternative options to improve access and affordability in Australian health care. Chapter 9 considers the ALP policy, and chapter 10 examines the potential to extend Medicare funding to allied and dental health services. Chapter 11 assesses the benefits and costs of reallocating the Private Health Insurance rebate to other health programs. Chapter 12 then addresses a range of other options including reformed funding arrangements, and moves to a more integrated primary care model.

Assistance with the Inquiry

1.14 In the course of the Inquiry, the Committee received a large number of submissions from a range of organisations and private individuals, together with a wealth of supporting documents, reports, and other references. Others gave freely of their time in appearing before the Committee at its public hearings, and in many cases, undertook additional work to provide follow up information to the Committee in response to questions raised during the discussions.

1.15 The Committee would like to record its appreciation to all of these people for the time taken in preparing their evidence to the Inquiry, all of which contributed greatly to the Committee's consideration of these complex issues.

1.16 Recognition is also due to the research team from the Australian Institute of Primary Care at Latrobe University who, at the request of the Committee, undertook the detailed modeling of the cost and inflationary implications of the government and opposition proposals. This commissioned research was undertaken with tight time limitations, and the Committee appreciates the expertise of the Institute in completing the research within the Committee's timetable.

1.17 Finally, the Committee thanks the officers of the Secretariat team who administered the Inquiry, and assisted with the research and drafting of the report.

CHAPTER 2

The Medicare System

To most Australians, good insurance means no out-of-pocket costs. Bulk-billing provides that. It is the only device that has. How much was expected or wanted? One of the great advantages of a universal system, if it is truly universal, is that you do not have do worry that the people within it are being treated fairly. You do not have to make special provision for the underprivileged…[1]

Introduction

2.1 This chapter lays out in broad terms the overall terrain of the Australian health system and general practice, by outlining the basis for the Medicare system, the main elements of its operation, and key participants in the health debate.

Australia's Constitution and a shared responsibility for Health[2]

2.2 The axiom of the Australian federal system is that the Commonwealth can exercise only those powers conferred on it by the Constitution, and that the States and Territories have carriage of all residual unspecified matters. There is no specific Commonwealth power with respect to health, though many heads of power will support laws that touch on different aspects of health policy. The range of the references in the Constitution defines a scope of Commonwealth responsibility that has, through creative adaptation, been expanded gradually.

2.3 In defining and expanding its role in health, the Commonwealth has also made use of the Executive power contained in section 61, which empowers the administration to undertake many administrative activities without prior authorisation from an Act of Parliament.

2.4 The social services powers of the Commonwealth inserted into section 51 of the Constitution by the 1946 referendum contain a prohibition on civil conscription with respect to medical and dental services. Civil conscription has been interpreted quite broadly, referring not only to actual compulsion to perform services, but also to indirect or practical measures which may constitute it.[3]

2.5 In practical terms, the Commonwealth provides direct financial support for both the Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme

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1 Prof Deeble, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 10

2 Discussion of the constitutional basis to Australia's health system is drawn from John McMillan, *Commonwealth Constitutional Power over Health,* ISBN 0646110128.

3 Ibid. See also *General Practitioners Society v Commonwealth* (1980) 31 ALR 369

(PBS), while also undertaking a leadership role in issues of national policy significance.

2.6 States and Territories provide public hospital infrastructure and services, and the majority of community health programs. Traditionally, allied and public dental health have been driven primarily though State and Territory Governments. In addition, there is a broad range of health services provided on a cooperative basis between the federal and state jurisdictions.

Australian Health Care Agreements (AHCAs)

2.7 In order to determine the respective responsibilities of the Commonwealth and the States and Territories, all parties enter a five yearly bilateral agreement, called an Australian Health Care Agreement (AHCA), and previously known as Medicare Agreements. Under the AHCAs, the Commonwealth provides financial assistance to the States and Territories to meet part of the cost of providing public hospital services (and comprising approximately 48 percent of total recurrent funding).

2.8 The Agreements contain certain principles by which the recipient states agree to abide, including that hospital services must be provided free of charge to public patients on the basis of clinical need and within a clinically appropriate period, regardless of geographic location.

2.9 The 2003-2008 Australian Health Care Agreements provides State and Territory Governments with a total of $42 billion from the Commonwealth.

History and purpose of Medicare[4]

2.10 Medicare is the Commonwealth funded health insurance scheme that provides free or subsidised health care services to the Australian population. It covers both in-hospital services for public patients in public hospitals, through Australian Health Care agreements with the States, and provides subsidised or free (bulk-billed) access to doctors' services, plus certain pathology, psychiatry and optometry services.

2.11 Medicare's predecessor, Medibank, was introduced by the newly elected Whitlam Labor Government, and commenced on 1 July 1975 after the passing of the Medibank legislation by a joint sitting of Parliament on 7 August 1974. The Health Insurance Bill 1973 was the main bill establishing Medibank, together with several accompanying bills, including the Health Insurance Commission Bill 1973.

Original Purpose

2.12 According to the Second Reading Speech of the Health Insurance Bill 1973 delivered by the Hon. Bill Hayden on 29 November 1973, the purpose of Medibank

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4 The following description of Medicare's history and operation is exerted with minor changes from Amanda Biggs, *Medicare – Background Brief*, Parliamentary Library, 14 May 03

was to provide the ‘most equitable and efficient means of providing health insurance coverage for all Australians’, based on underlying principles of universal coverage, equitable distribution of costs, and administrative simplicity.

Financing and Cost

2.13 The original legislation proposed financing the program through a taxpayer levy of 1.35 per cent on taxable income, with exemptions for low income earners. However the Senate rejected the bills dealing with financing of the program in August 1974 and again in December 1974. Consequently, the final program was funded entirely from general revenue.

2.14 The hospital component of Medibank entailed free treatment for public patients in public hospitals, and subsidies to private hospitals to enable them to reduce their fees. Benefits for public hospitals were provided through hospital agreements with state governments, under which the federal government allocated grants equal to 50 per cent of net operating public hospital costs.

Changes under the Fraser Government

2.15 The Medibank program had only a few months of operation before the dismissal of the Whitlam Government on 11 November 1975, and the subsequent election of the Fraser Liberal-National Coalition Government in December 1975. Following the election, a new program was announced in a Ministerial Statement to Parliament on 20 May 1976. ‘Medibank Mark II’ was launched on 1 October 1976 and included a 2.5 per cent levy on income, with the option of taking out private health insurance instead of paying the levy.

2.16 Other significant changes in 1976 included the federal government declaring the hospital agreements with the states invalid, and the subsequent introduction of new hospital agreements where the federal government provided 50 per cent funding for *approved* net operating costs. Also in 1976, legislation was passed allowing the Health Insurance Commission (HIC) to enter the private health insurance business. This led to the establishment of Medibank Private on 1 October 1976.

2.17 In 1978, medical benefits were reduced to 75 per cent of the Schedule fee and bulk-billing was restricted to holders of Pensioner Health Benefits cards and those deemed by the doctor to be, in the Minister's words, ‘socially disadvantaged’. The health insurance levy and the compulsion to insure were abolished in 1978.

2.18 In 1979, Medicare benefits were limited to the difference between $20 and the scheduled fee. In 1981 access to free hospital and medical care was restricted to pensioners with health care cards, sickness beneficiaries, and those meeting stringent means tests. An income tax rebate of 32 per cent was introduced for those with private health insurance.

Medicare from 1984

2.19 The major changes introduced by the Fraser Government were largely rejected by the Hawke Labor Government, who returned to the original Medibank model. Although the financing arrangements were different and there was a name change from Medibank to Medicare, little else differed from the original. Medicare, as it now exists, came into operation on 1 October 1984 following the passage in September 1983 of the *Health Legislation Amendment Act 1983*, including amendments to the *Health Insurance Act 1973,* the *National Health Act 1953* and the *Health Insurance Commission Act 1973.* It differed from the original Medibank program only in matters of detail.

2.20 In his Second Reading Speech in September 1983, Dr Blewett described the legislation as 'a major social reform' that would 'embody a health insurance system that is simple, fair and affordable'. He also emphasised the 'universality of cover' as being 'desirable from an equity point of view' and 'in terms of efficiency and reduced administrative costs'.

Medicare cost and financing

2.21 Funding for Medicare was to be 'offset' by a Medicare levy, originally set at 1 per cent of taxable income, with a low income cut-off point of $7110 per year for a single person and $11,803 for married couples and sole parents. Below these income levels no levy was payable. More details are provided in the Second Reading Speech made by The Hon Chris Hurford when he introduced the Medicare levy bill in September 1983.

2.22 The Medicare levy is currently set at 1.5 per cent of taxable income. In 2000/2001, the levy raised $4.58 billion. This equates to 15.9% of the total Commonwealth expenditure on health for that year of $28.845 billion.[5]

The operation of Medicare – an overview

2.23 Medicare is a universal insurance scheme which provides financial assistance to Australians who incur medical expenses in respect of professional services rendered by eligible qualified medical practitioners, participating optometrists, pathologists and psychiatrists. Medicare also provides free in-hospital services in public hospitals for patients who choose to be treated as public patients. Funding for these services is shared between the Federal and State and Territory Governments under the Australian Health Care Agreements.

2.24 When an eligible patient presents at an eligible medical practitioner, a consultation takes place, and the practitioner provides the consultation for no more than the rebate available from Medicare (85% of the Schedule Fee), the patient signs

5 The Committee notes that the Medicare Levy was never intended to fully cover Commonwealth expenditure on health care.

the Medicare claim form at the point of service. This allows the practitioner to directly bill the Health Insurance Commission along with other similar patients ('bulk-billing').

2.25 In the event that the practitioner charges more than the Rebate for the consultation, the patient is charged for the entire cost of the consultation. The patient then presents their receipt and Medicare Card at a Medicare office and a rebate is issued for 85% of the Schedule Fee. Alternatively, the patient may take an unpaid account from the practitioner to a Medicare office, in response to which a cheque is drawn for 85% of the Schedule Fee. This cheque, along with any difference between the amount rebated and the amount owing is then issued to the practitioner by the patient.

2.26 At this point, it is also worth making a brief comment on terminology. During the inquiry, the terms 'gap' and 'copayment' were often used interchangeably, and both terms were also frequently taken the mean difference between the rebate and the actual fee charged by the GP. This is likely to add to existing confusion over the operation of Medicare.

2.27 The term 'gap' has been historically used to refer to the difference between the rebate and the Medicare schedule fee. The term 'copayment' technically refers to a dual billing arrangement whereby GPs claim the rebate directly from Medicare, as ordinarily occurs where a patient is bulk-billed, but also receive an additional payment from the patient. It is important to note that 'copayments' are technically illegal under current Medicare rules.

2.28 In this report, the Committee has endeavored to use the terms with their correct meaning, and the difference between the rebate and the actual fee charged is referred to as an 'out-of-pocket cost'. However, in many cases, quotes from witnesses have been reproduced containing terms that are, from a technical perspective, incorrect.

Eligibility

2.29 Medicare eligibility largely rests on Australian residency, except for foreign diplomats and their dependants. People who reside in Australia are eligible if they meet any of the following criteria:

- they hold Australian citizenship;
- they have been issued with a permanent visa;
- they hold New Zealand citizenship; or
- they have applied for a permanent visa (in most cases).

2.30 As of 29 August 2000, holders of Temporary Protection Visas have access to Medicare. Asylum seekers have access if they have an unfinalised application for a permanent residence visa (either for migration or asylum) and hold a valid visa with work rights in force. Some asylum seekers without work rights are eligible for

Medicare if they are the spouse, child or parent of an Australian citizen or permanent resident.

Safety Net Arrangements

2.31 Under Medicare, Safety Net Arrangements apply which protect patients from significant out-of-pocket costs for GP services.

2.32 Once payments up to the level of the Schedule Fee for an individual or family exceed a total of $319.70 (indexed annually) in a calendar year, Medicare benefits increase from 85% to 100% of the Schedule Fee for any further non-inpatient costs incurred in that year.

2.33 A Medical Expenses Tax Offset is also available where out-of-pocket medical expenses exceed $1,500 in one calendar year. Eligible expenses include those incurred through the services of doctors, nurses, chemists or hospitals. Where net expenses exceed the threshold, claimants may receive a 20% tax offset on the balance after $1,500.[6] For further discussion about safety net arrangements see chapter 7.

Blended payments [7]

2.34 The Medicare framework also encompasses two additional payments schemes - the Enhanced Primary Care (EPC) scheme, and the Practice Incentive Payments scheme (PIP). EPC provides a framework for a multidisciplinary approach to health care and the 28 EPC Items on the Medicare Benefits Schedule (MBS) include health assessments for people aged 75 and over (or 55 and over for Aboriginal and Torres Strait Islander people), and multidisciplinary care planning.

2.35 PIP aim to recognise general practices that provide comprehensive, quality care, and which are either accredited or working towards accreditation against the Royal Australian College of General Practitioners' (RACGP) *Standards for General Practices*. Payments focus on aspects of general practice that contribute to quality care, such as provision of after hours care, student teaching and better prescribing, with a loading paid to practices in rural and remote locations.

2.36 The PIP scheme grew out of the Better Practice Program in response to a series of recommendations made by the General Practice Strategy Review Group (GPSRG) that reported to the Government in March 1998.

Consumer organisations

2.37 There are a number of organisations that play an important role in lobbying on behalf of consumers in relation to health issues. In acknowledging the valuable work of these groups, the Committee is also mindful of the difficulties they face in

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6 Australian Taxation Office website – (www.ato.gov.au) – accessed on 3 September 2003.

7 Department of Health and Ageing website (www.health.gov.au) accessed on 4 September 2003

performing their task given the limited resources available to them. Key challenges in this respect are finding the time and resources to widely consult their 'constituency', as well as getting across the technical and statistical complexity inherent in many aspects of public health policy issues.

2.38 These groups include but are not limited to:

Australian Consumers' Association

2.39 The Australian Consumers' Association is an independent advocacy and information organisation. It promotes consumer rights through its publications, including Choice magazine, and through policy advocacy. Specialist policy officers are employed in the areas of health, financial services, communications and IT, and food. The ACA is not funded by industry or government, and is a not-for-profit company limited by guarantee.[8]

Consumers' Health Forum of Australia

2.40 The Consumers' Health Forum of Australia Inc (CHF), established in 1987, is a peak non-government organisation representing consumers on national health care issues. CHF establishes policy in consultation with members, comprised of over one hundred health consumer organisations. CHF states that they 'provide a national consumer voice to balance the views of government, industry, service providers and health professionals'.[9]

State Based Health Consumers' Organisations

2.41 The Health Consumers' Council (WA) is an independent community based organisation, representing the consumers' 'voice' in health policy, planning, research and service delivery. The Council advocates on behalf of consumers to government, doctors, other health professionals, hospitals and the wider health system and is funded by the Western Australian Department of Health. The Council has 600 members across Western Australia, including remote, rural and metropolitan consumers.[10]

2.42 Health Issues Centre (Victoria) is an independent not-for-profit organisation promoting consumer perspectives in the Australian health system. The Centre states that 'particular areas of interest include health financing, quality in health services, consumer protection and complaints mechanisms, community development and

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8 Martyn Goddard, Australian Consumers Association, Additional information, 15 September 2003.

9 Consumers' Health Forum of Australia, Submission 102, p. 1.

10 Health Consumers' Council (WA), Submission 62, p. 1.

evaluation'. The organisation also claims a strong reputation for public interest research and health system analysis.[11]

2.43 There are also a number of other state based state based organisations including the Public Hospitals and Medicare Alliance of Queensland.

General Practice in Australia

2.44 The Royal Australian College of General Practitioners[12] defines general practice as part of the Australian health care system, operating predominantly through private medical practices, and providing universal unreferred access to whole person medical care for individuals, families and communities.

2.45 To be a general practitioner, a person must be a registered medical practitioner in Australia under the rules of the RACGP.[13]

2.46 For the purposes of Medicare, a 'recognised' GP is one who is vocationally registered under Section 3F of the *Health Insurance Act 1973* (Cth), holds fellowship of the RACGP or equivalent, or holds a recognised training placement.[14] In national terms, the proportion of GPs who are vocationally registered is increasing, though not across all jurisdictions.[15]

2.47 In 2001/02 there were approximately 24,000 GPs and other medical practitioners in Australia, representing about 123.3 medical practitioners per 100,000 population. Of these, there were 84.9 full-time equivalent GPs per 100,000 population on average nationally.[16]

Vocationally registered and non-vocationally registered practitioners

2.48 A general practitioner may or may not be vocationally registered (VR). Approximately 90% of GPs in Australia are VR, meaning that they have either completed the Royal Australian College of General Practitioners' Fellowship Examination or are fellows of the College by virtue of their year of graduation from Medicine.[17] The major practical significance of the distinction is that the service

11 Health Issues Centre, Submission 63, p. 2.

12 Royal Australian College of General Practitioners website (www.racgp.org.au) 2 July 2003

13 Royal Australian College of General Practitioners website (www.racgp.org.au) 2 July 2003

14 Royal Australian College of General Practitioners website (www.racgp.org.au) 2 July 2003

15 Report on Government Services 2003, page 10.35, Productivity Commission, February 2002, available at www.pc.gov.au/gsp/2003. See also below *Vocationally registered and non-vocationally registered practitioners*

16 Report on Government Services 2003, page 10.5, Productivity Commission, February 2002, available at www.pc.gov.au/gsp/2003.

17 Dr Moxham, Submission 48, p. 6

provided by a non-VR GP attracts a lower Medicare rebate of $17.85,[18] compared with around $25 for those who are registered.

Professional Organisations

2.49 Doctors are represented through a number of professional organisations. These include:

The Royal Australian College of General Practitioners

2.50 The College is a representative body and plays a central role in setting and maintaining the standards for quality practice, education and training for general practice in Australia. The RACGP also acts as advocate for Australian GPs on issues affecting the profession and its ability to provide quality primary health care to health consumers.[19]

The Australian Medical Association

2.51 The AMA represents 27,000 doctors, of which about one-third, or approximately 8,500, are general practitioners.[20] The AMA aims to promote and advance public health, medical standards, ethical behaviour, and the independence of the medical profession, as well as protecting its political, legal and industrial interests.[21]

Divisions of General Practice

2.52 The Divisions of General Practice began as part of the Commonwealth Government's 1991-2 major reforms and budget initiatives. As a component of the Demonstration Practice Grants Program ten Divisions were originally piloted and by 1993 there were 100 Divisions in place across most of Australia.[22] Following the Report of the General Practice Strategy Review in 1998, the national and state Divisions were formed. Today, there are 120 Divisions covering all of Australia, with 94 per cent of GPs being members of their local Division.[23]

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18 Dr Moxham, Submission 48, p. 1

19 Royal Australian College of General Practitioners website (www.racgp.org.au) accessed on 4 August 2003

20 Which would amount to around one-third of overall GP numbers, or half based on full-time workload equivalents. See chapter 4, paragraph 4.19 for a discussion of GP numbers in Australia.

21 Australian Medical Association website (www.ama.com.au) accessed on 4 August 2003.

22 Department of Health and Ageing, *General Practice in Australia: 2000*, p210, available at http://www.health.gov.au/gpconnections/pdf/chpsix.pdf

23 Australian Divisions of General practice website (www.adgp.com.au) accessed on 14 October 2003

2.53 The Australian Divisions of General Practice (ADGP) is the peak national body representing these local Divisions of general practice across Australia. The primary objectives of the ADGP are to facilitate communication between Divisions as well as to support and represent their interests to the Commonwealth Government. The ADGP plays an important role in marshalling local Divisions, State-based organisations and other medical and consumer bodies in providing national programs over a broad range of primary care issues.[24]

2.54 The role of the Divisions that make up the organisation varies somewhat in focus across the nation, but generally centres on programs to support general practice, including:

- organising education programs;
- supporting practices in adopting information management and information technology;
- helping practices implement population health programs including programs in relation to chronic disease management, and
- providing advice about practice management issues.[25]

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24 Australian Divisions of General practice website (www.adgp.com.au) accessed on 5 August 2003

25 Department of Health and Ageing, *The future role of the divisions network*, June 2003, p. 6.

CHAPTER 3

General Practice Incomes and the viability of Practice in Australia

Abandonment of bulk billing is a huge step for GPs and their patients ... but it reached the point where we had to either start charging or close down.[1]

Introduction

3.1 Term of Reference (a) requires the Committee to examine:

> [T]he impact of the current rate of the Medicare Benefits Schedule and Practice Incentive Payments on practitioner incomes and the viability of bulk billing practices; …

3.2 The extent to which general practice is viable at the current level of Government subsidy of primary health care is a central question when addressing this Term of Reference. The Committee received considerable evidence that practice income was inadequate to both meet practice costs and provide a reasonable income for practitioners. Many witnesses believed that bulk-billing all patients was financially unsustainable, because increases in the Medicare rebate had failed to keep pace with the rise in the costs of running a GP service.

3.3 This chapter looks at the various models of payment used to remunerate doctors, the quantum of that income, the costs of running a practice, the outcomes of the Relative Value Study, and the viability of general practice in Australia.

Viability

3.4 It is important to note at the outset that viability is an inherently subjective concept, as it incorporates not only a recognition that income must exceed costs, but that profit must be sufficient to meet the highly variable needs and wants of the individual practitioner. Like any group of professionals there are differences of opinion amongst GPs about what constitutes a reasonable net income. In other words, what remuneration is sufficient for a GP to feel it is worth his or her while to continue in practice, and under what conditions s/he will choose to bulk-bill, are infinitely variable.

The viability of General Practice

3.5 The average full-time GP income and practice costs in Australia vary widely depending on location, patient profile, local market conditions, individual practice

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1 Dr Matthews, Submission 110, p. 3

costs, and clinical style. At the roundtable hearing, Dr Bain of the AMA commented that due to this disparity, net GP incomes were:

> …extremely variable across the board. When we did a survey of GPs we found a range of net hourly incomes between $30 and $60. That would encompass most GPs — there would be some above that and a few below it.[2]

3.6 Current net (post-expenses, but pre-income tax) FTE GP incomes are estimated by the AIPC at between $91,000 for a metropolitan doctor, and around $111,000 for a rural doctor. Differences across geographic settings are largely attributable to variations in bulk-billing rates.[3]

The viability of exclusively bulk-billing General Practice

3.7 Throughout the Inquiry, the Committee heard from practitioners and others reporting the diminished viability of general practice in Australia, and the near impossibility of running one as a bulk-billing operation.[4]

3.8 One doctor captured the tension between his commitment to bulk-billing as an important component of universal health insurance system, and the pressure to charge patients in order to compensate for the longer working hours required due to failure of Government policy to maintain some parity between GP supply and demand. He expressed the quandary in these terms:

> I am a bulk-billing GP, and there are four or five of us. We are barely surviving on bulk-billing, but we are determined to keep doing it because it is the only way we can be doctors, if you like. One doctor is threatening to leave. He is non-VR. He gets $18 fully bulk-billed. That will never increase, because he is a non-VR doctor. We cannot get locums, because the number of doctors in training has been reduced – until the recent initiative. So there are no doctors out there; all of them have been soaked up by the entrepreneurs. We are stuck there with no relief.[5]

3.9 However, there were other views. A number of economists gave evidence that the opportunity cost of bulk-billing has been over-estimated by many practitioners, because they do not fully realise the cost savings of billing through that system. The fact that there are fewer debts and lower administration costs associated with bulk-billing in high numbers was put by Professor Marley of Newcastle University, for instance:

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2 Dr Bain, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 17

3 AIPC Report to Select Committee on Medicare, p.20. Dr Mackey of the RDAA, while pointing out the higher costs associated with rural practice, accepted that higher incomes are earned. See *Proof Committee Hansard*, Canberra, 28 August 2003, p. 115

4 See, for example, Darebin Community Health Service Inc, Submission 40, p. 1

5 Dr Costa, *Proof Committee Hansard*, Sydney, 22 July 2003, p. 52

> If GPs stopped listening to the rhetoric, they would see that they actually make more money by bulk-billing, and we have clear evidence that that is the case. That happens because people who do not bulk-bill usually discount for pensioners and disadvantaged people anyway. There will be a proportion that they do bulk-bill, and they are overrepresented in people attending practices. They have to employ more staff, they have bad debts and there is evidence that doctors do not use the higher consultation levels, which they could legitimately charge — the levels C and D advanced consultations — if they are giving a bill to the patient, whereas if they bulk-bill they do. If you bulk-bill you do not have any cash flow problems—the government always pays.[6]

3.10 The AIPC Report compared doctors' incomes from the MBS with average weekly ordinary time earnings (AWOTE), both now and in the past. Average Commonwealth expenditure on GPs in 1992-93 was about 5.2 times AWOTE. Subsequently, this ratio fell to 4.7 times AWOTE in 2002-03. From 1993 to 2003, AWOTE increased by 10.6 percent more than Commonwealth expenditure on GPs.[7] This analysis is particularly relevant to viability of bulk-billing, as the Commonwealth provides the sole means of income for those practitioners. Where doctors charge above the level of the rebate, income is supplemented by the patient. Therefore, AWOTE provides a useful point of comparison between increases in medical incomes as opposed to increases in overall earnings.

3.11 The critical issue for most medical witnesses was the diminished value of the MBS rebate. Many doctors illustrated the degree to which they considered the rebate fell short of requirements by analysing the number of patients seen in a given hour to derive sufficient income. For example, Dr Alexander, a Tasmanian GP, currently consults on average four to five patients per hour. He commented that:

> In our practice, for me to generate the same amount of money through bulk-billing [as is earned currently with a co-payment], I need to see nine patients per hour.[8]

3.12 Rising relative costs were also a primary complaint:

> Bulk-billing rates do not reflect the growing costs of running a practice, including the financial burden of increasing administrative and bureaucratic responsibilities. Practices are being forced to increase income through various strategies including increasing patient throughput and charging the patient a gap amount above the rebate.[9]

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6 Professor Marley, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 30

7 AIPC Report to Select Committee on Medicare, p. 11

8 Dr Alexander, *Proof Committee Hansard*, Hobart, 31 July 2003, p. 39

9 Queensland Divisions of General Practice, Submission 146, p. 2

3.13 Dr Powell illustrated the tension between financial necessity and optimal patient care:

> There is a point in the consultation process where bulk-billing is sustainable; that is, at about eight minutes. The further that you move away from that eight-minute time frame the more disparate the income versus looking after the population with charity and compassion equation becomes.[10]

3.14 Practice viability is also threatened by the doctor shortage which is discussed in chapter 4. Where they are unable to attract sufficient medical staff, practices face fixed costs while practice income and the number of consultations decline.[11]

Models of Payment

Fee-for-Service

3.15 The fee-for-service model is the basis of the current Australian system, which operates on a payment made in return for each specific medical service rendered by a practitioner. The payment may be derived from more than one source, as is the case when GPs are remunerated through out-of-pocket charges as a supplement to the Medicare rebate.

3.16 Support for this model is widespread among health professionals, although Evidence was presented that many younger doctors find other models more attractive due to the flexibility they provide.[12]

Capitation

3.17 The capitation model remunerates practitioners with a uniform payment for the number of patients on their books, regardless of the number of consultations required by the group. The remuneration may also be geographically determined, whereby practitioners are responsible for delivering the health services required by all patients within a given boundary.

3.18 Capitation payments have characterised GP remuneration in the United Kingdom under the National Health System (NHS).

Salaried Doctors

3.19 General practitioners may also choose to work in salaried positions for a variety of reasons including not wishing to be involved with the business aspect of private practice, preferring to limit their work hours for personal or lifestyle reasons, or desiring flexibility in their future employment options. In Australia GPs are

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10 Dr Powell, Proof Committee Hansard, Bundaberg, 25 August 2003, p. 19

11 Dr Powell, Proof Committee Hansard, Bundaberg, 25 August 2003, p. 19

12 Professor Andrew Wilson, Proof Committee Hansard, Canberra, Monday 21 July 2003, p. 19

employed on negotiated salaries in community health centres or with large corporate primary care providers.

3.20 There are reports of growing support for this model by GPs, particularly among the younger and recently graduated doctors:

> The young graduate is much more interested in lifestyle than income. They are not interested in owning practices and buildings. They want to walk into a well-managed environment, do the job and go home. They would work in a salaried environment; many of them choose to do just that—work on salaries in general practices and so on. So the nature and shape of the work force is really changing quite dramatically.[13]

Blended payments

3.21 Blended payments comprise a mixture of these models, but may also reflect complementary incentive payments targeted at improving health outcomes.

3.22 The Practice Incentives Program described in chapter 2 is a good example of a blended payment, whereby practitioners are rewarded with incentive payments for improving their practices through modernisation of technique and infrastructure, as opposed to servicing more patients.

General Practice incomes

3.23 Critical to the issue of viability is the income of individual GPs and practices, about which the Committee heard a range of views in evidence. It should be noted that this section deals simply with gross income to GPs, not the remuneration that flows to them after costs, tax and other expenses have been paid.

3.24 GPs receive remuneration not just from the MBS through the Health Insurance Commission, but also from patients (through out-of-pocket costs), the Department of Health and Ageing (through blended payments), the Department of Veterans Affairs and other sources.

3.25 The Australian Institute for Primary Care (AIPC) in research commissioned by the Committee estimated gross annualised incomes per full-time equivalent (FTE) GP to range between $221,676 in a metropolitan area or capital city, and $241,196 in a rural region. The variation in these estimates is due to different relative proportions of bulk-billed services and is exclusive of income received from Worker's Compensation claims, insurance claims, payments through public hospitals, and payments from the Department of Veteran's Affairs.[14]

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13 Professor Marley, Proof Committee Hansard, Newcastle, 23 July 2003, p. 30

14 AIPC Report to Select Committee on Medicare, pp. 20-21 (see Appendix 3).

3.26 Using similar parameters, a figure of $242,000 was provided by the Department of Health and Ageing, comprising of:

- $196,000 (81%) derived from MBS payments;
- $24,000 (10%) derived from patient contributions; and
- $22,000 (9%) derived from blended payments such as PIP.[15]

3.27 The Committee heard from various witnesses that rural GPs often earn more than their city counterparts.

> Rural doctors are split. There are a lot of rural doctors who are ideologically committed to the private practice model … some of Australia's richest GPs are rural GPs ... [s]o it is not true that all rural doctors are poor. Unfortunately, where there are so few doctors and there is so little competition, they can charge a lot, and they do.[16]

3.28 This is acknowledged by the Rural Doctors' Association, although it is argued that the extra income is earned through longer hours, and is offset by extra costs (see 'Practice costs', below).

> Sure, the doctors may earn more, but they are doing a lot more work in the rural areas. They are called on, they are doing a lot more of the after-hours work and they do a lot more of the hospital work. Income is up, but they are working a hell of a lot more as well.[17]

Practice costs

3.29 The Department provided modeling of average practice costs, based on the Relative Value Study (RVS).[18] One of the important components of the RVS was to develop fair and reasonable estimates of practice costs for each of the medical specialist groups that participated in the review. The estimates differ markedly depending on the specialty and number of practitioners operating within a practice.

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15 Department of Health and Ageing, *GP Income – Australian Government and patients*, tabled documents, roundtable hearing, Canberra, 21 July 2003

16 Dr Boffa, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 50.

17 Dr Mackey, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 115

18 The RVS is a review of the General Medical Services Table of the MBS. The guiding principles of the review include introducing equity into the MBS, providing common structure across professional groups, and promoting and appropriately rewarding good clinical practice. 27 specialty groups participated in the conduct of the RVS. The review resulted in the development of a revised core consultation item structure and the completion of three studies: Practice Costs Study, Professional Relativities Study and Remuneration Rates Study. For further information see www.heath.gov.au/rvs/index.htm and discussion in chapter 12.

For general practice the estimated costs of practice vary from $127,330 in a sole doctor practice, to $111,007 per doctor where four doctors practice together.[19]

3.30 These findings created substantial controversy at the time they were released.[20] The methodology of the study and many of its assumptions were widely criticised within the medical profession. The Australian Medical Association (AMA) argued that the costings in the RVS Practice Costs Study underestimate the actual costs of running a practice. According to the AMA the study is:

> … based on unreasonable working hours and lack of provision for sick, long service or study leave … the study also failed to allocate funds for locum provision … [and] recommended costs to buy practice equipment were also inadequate to meet accreditation standards.[21]

3.31 The RVS Study figures form the basis of analysis on practice costs by the Australian Institute for Primary Care, which estimates that a practitioner in a three doctor surgery would incur costs inflated by CPI of $130,676 in 2002/03.[22]

3.32 However, a study conducted by the AMA and Access Economics in 2001 puts costs significantly lower, at approximately $115,000 and $75,000 for a one and three doctor practice, respectively. This study found that practice costs fell 'significantly from a solo practice to a two-doctor practice, and continued to diminish with increased practice size, although after six FTE GPs the data limitations made the relationship unstable'.[23]

3.33 If an average gross income of around $230,000 and practice costs of around $130,000 are accepted, this represents costs running at around 56 percent for a three doctor practice. The Committee heard that it is not uncommon for practice costs to be as low as 15 percent of total revenue, where minimal extra services are added in the delivery of care.[24]

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19 Department of Health and Ageing, Costs of General Practice, tabled documents, roundtable hearing, Canberra, 21 July 2003, sourced from the RVS study *A resource based model of private medical practice in Australia – final report, Volumes 1 and 2* (Price Waterhouse Coopers December 2000). All costs have been adjusted to values current as at 31 December 1999.

20 See also chapter 12, where the contentious assumptions are elaborated on.

21 Cathy Saunders 'GPs seething at faults in practice cost study', *Australian Doctor* 30 April 1999

22 AIPC Report to Select Committee on Medicare, p. 20

23 AMA, *Primary Health Care for All Australians; An Analysis of the Widening Gap between Community Need and the Availability of GP Services* (Access Economics February 2002), p.16. See also Department of Health and Ageing, Costs of General Practice, tabled documents, roundtable hearing, Canberra, 21 July 2003.

24 Dr Djakic, *Proof Committee Hansard,* Hobart, 21 July 2003, p. 70

Costs of rural practice

3.34 A number of rural-based practitioners contend that their practices are more expensive to operate than those in metropolitan areas, a fact that should be taken into account for statistical analysis of incomes and viability. Dr Mackey, a doctor from South-Western NSW, and speaking for the Rural Doctors Association of Australia (RDAA) told the Committee that:

> RDAA research which is soon to be published indicates that the cost of providing medical services is considerably higher in rural and remote Australia. The Medicare rebate is based on urban cost structures. It is indexed … to the generic formula of WCI5[25] and does not take into account specific costs, for example, equipment, continuing medical education, accreditation, the rural industrial awards of employing staff and, of course, indemnity insurance.[26]

3.35 Some of these costs were elaborated on by Dr Slaney of the RDAA:

> If we take a rural doctor who provides a range of specialist services, including obstetrics, anaesthetics and radiology, all those skills need to be maintained within the requirements of the relevant colleges. That costs a lot more money for a rural doctor, compared with your average urban general practitioner who does not need to access those skills. The cost structures in running any business in a rural environment are higher than in an urban environment. You have increased telephone costs – most of the calls made to specialists are long distance. You have costs in visiting people at home, costs of transport are higher, and costs of computer software support are extremely expensive because in most cases you need to pay people fees to come out and visit your practice. All those costs are significantly higher than in an urban environment.[27]

3.36 The equipment costs can be significant. Some rural practices requiring equipment more usually found in a small casualty department, including for example a defibrillator, an ECG, a dynomap, an oximeter, and an X-ray machine (worth around $50,000):[28]

> In an urban environment, a lot of serious issues can be immediately flicked to a nearby casualty department or a specialist, whereas in a rural environment they are our problem and we have to deal with them.[29]

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25 For a discussion on WC15, see chapter 12

26 Dr Mackey, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 107

27 Dr Slaney, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 114

28 Dr Slaney, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 114

29 Dr Maxwell, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 115

3.37 Information technology costs are a significant burden for rural and regional practices, and the elevated price of facilities such as broadband access in remote rural locations. As Dr Mackey explained:

> It is fairly disgusting that for three days there is no access in or out – you can ring around town because you use the local exchange. We will not say whose fault that is. The situation is that to have something reasonable, you need ADSL or some other fast mode of access. Really, what we are saying [is] that that should be put onto every rural practice and onto every rural community of substantial size.[30]

The cost of accessing blended payments

3.38 The high costs of administration and access to the series of blended payment schemes was a recurrent theme among medical witnesses who indicated that this has a direct impact on both practice costs and practice income, and also on viability. The prevailing view was that most of the income sources were viably accessed only by larger practices with sufficient IT and staff resources to handle the heavy administrative demands of the programs.

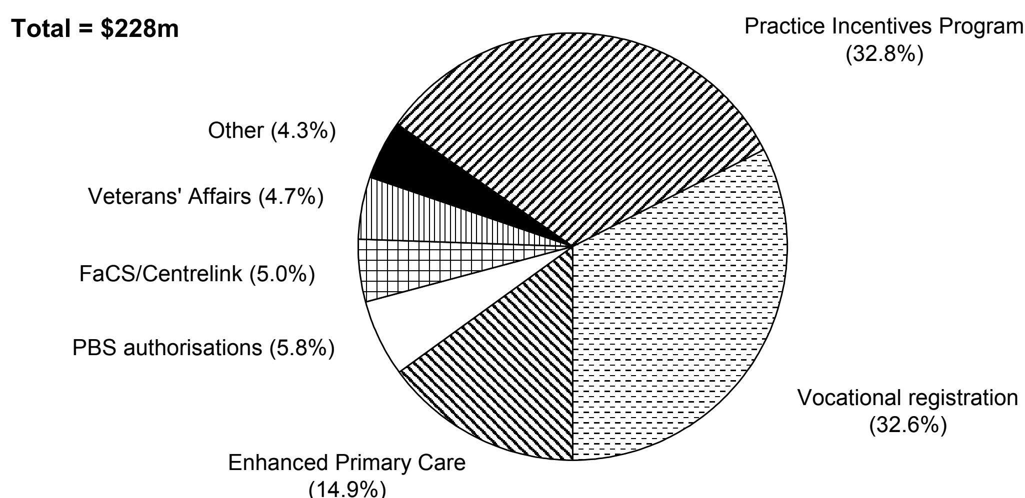
3.39 The Committee accepts that this is true: in other words that the principle of economy of scale applies to GPs as it applies to other professional groups and industries. Rural GPs, GPs in outer metropolitan areas, and those in towns and cities who practice by themselves or with a small number of other doctors are at a comparative disadvantage when it comes to accessing Government subsidy and incentive programs.

3.40 The March 2003 Productivity Commission Report *General Practice Administrative and Compliance Costs* found that the total administrative and related costs for all GPs associated with accessing Commonwealth policies and programs was approximately $228 million in 2001/02, which is 5 percent of total GP income, or about $13,100 per year per GP.[31]

30 Dr Mackey, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 117

31 Productivity Commission, *General Practice Administrative and Compliance Costs*, 31 March 2003, p. 57

3.41 **Table 3.1 - Estimated GP Administrative Costs 2001/02**[32]



3.42 Table 3.1 demonstrates that under the base case examined by the Productivity Commission, the Practice Incentives Program, Enhanced Primary Care and Vocational Registration accounted for over 75 percent of administrative costs. About 39 percent of the Commonwealth outlay on PIP was accounted for by costs associated with administration.

3.43 The other primary complaint from practitioners, which was also supported by the Commission's findings, was the 'fragmentation' of payments from various sources, including the Department of Health and Ageing and the Health Insurance Commission. This 'silo' approach added further layers of administration and increased practitioner frustration.[33]

3.44 In contrast, Dr Moxham does not consider this to be a major issue:

> It is about 15 minutes a day, and I think it is part of the consultation. If I see a patient and do a blood test, part of that consultation is looking at the result of that blood test when it comes in the next day and making a decision about what to do about it. I do not think you can then complain that that is non-billable; it was billable, it was part of the original consultation. It is the same as filling in forms for Centrelink – it is all part of a consultation.[34]

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32 Productivity Commission, *General Practice Administrative and Compliance Costs*, 31 March 2003, p. xxi

33 Productivity Commission, *General Practice Administrative and Compliance Costs*, 31 March 2003, pp. xxiii and xxx

34 Dr Moxham, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 10

Practice Incentives Program

3.45 The primary aims of PIP were described in chapter 2, and broadly include enhancing the delivery of medical services through changes to practice and approaches to patient care.[35]

3.46 The majority of general practices in Australia participate in PIP.[36] In May 2001, there were 5,260 practices participating in the program, covering 80 per cent of patients. Following the introduction of accreditation requirements on 1 January 2002, by May 2002 there were 4,482 PIP practices covering 76 per cent of patients, of which 4,189 had achieved full accreditation. Therefore, PIP practices continue to cover the majority of patients attending general practice in Australia.[37]

3.47 The effectiveness of the PIP scheme as it currently operates was questioned by a number of witnesses who cited excessive 'red tape' as a severe limitation on a practitioner's ability to access the payments. The view was expressed that PIP discriminated in favour of larger practices that could devote the necessary resources required to make claims under the scheme.[38] While criticism of the program was mainly directed to administrative costs, there were expressions of support for the rationale behind PIP and the potential benefits stemming from it.[39]

3.48 However, there was also doubt that the program was worth the effort for the outcomes it achieved. Dr Gault articulated this view:

> For all its stated aims, this scheme has in my mind, and I guess in the minds of many other GPs, functioned in main as a bribe to continue bulk-billing. Without P.I.P, the current crisis would have occurred five years ago. We are therefore very wary of extensions to P.I.P. given its ever-increasing red tape and the fact that it aims to avoid the thorny issue of co-payments.[40]

Enhanced Primary Care

3.49 The Enhanced Primary Care (EPC) scheme as outlined in chapter 2 provides a framework for a multidisciplinary approach to health care through a more flexible, efficient and responsive match between care recipients' needs and services.[41] However, some concerns were expressed in relation to EPC. For example the South

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35 Refer to 2.32

36 For information on PIP see http://www.hic.gov.au/providers/incentives_allowances/pip.htm

37 Department of Health and Ageing, Annual Report 2002, Outcome 2, p. 7

38 See, for example, Dr Matthews, Submission 110, p. 6

39 See, for example, Australian Council of Social Services, Submission 106, p. 4

40 Dr Gault, Submission 6, p. 1

41 Enhanced Primary Care information sheet, www.health.gov.au/epc. Accessed on 16 September 2003.

Kingsville Health Cooperative noted the time constraints associated with accessing supplementary incentive payments:

> For an under-funded, over-worked practice, the notion of moving towards new types of payments seems an uncertain and difficult luxury, and does not seem appropriate in the light of the immediate medical needs that will not be met as a result of this type of organisational change.[42]

3.50 The Department of Health and Ageing commissioned an evaluation of the effectiveness of the EPC program in achieving its policy objectives, and this was conducted through the course of 2002.[43] The Report concluded that the EPC program had made a significant contribution to improving management of patients with chronic illness and complex care needs. However, it also found that many of the practical requirements of claiming EPC items under the MBS were difficult to achieve in the clinical setting. Some of these difficulties included the complexity of paperwork, the disallowance of delegating to a practice nurse, and the logistics of co-locating health professionals for a case conference.[44]

3.51 Costly administrative procedures act as a disincentive. The Productivity Commission Report calculated that, in order to receive EPC payments of $63 million in 2001-02, participating GPs had to outlay $34 million in administrative costs.[45] The Report noted that case conferences were particularly underutilised, with 3,121 participating GP's claiming for just 10,727 services in the year 2001-02.[46] The fragmented nature of the EPC items and the complex claiming requirements were illustrated by Dr Carter:

> If I vaccinate a child I get a vaccination incentive. If I check a diabetic's health in a particular way I get another payment, case conferences within specific guidelines earn a little more, and dozens of other schemes from asthma to pap smears earn little bits of cash, but all these bits must be chased and paperwork rears its ugly head and reduces the effective benefit to the point that many GPs just don't bother.[47]

3.52 The sheer volume of paperwork required was a source of constant criticism in evidence. The Committee notes that the Government has established a 'Red Tape'

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42 South Kingsville Health Cooperative, Submission 80, pp. 1-2

43 Professor David Wilkinson *et al*, *Evaluation of the Enhanced Primary Care (EPC) Medicare Benefits Schedule (MBS) Items and the General Practice Education, Support and Community Linkages Program (GPESCL) Final Report*, July 2003, Department of Health and Ageing

44 Ibid, pp. 3 - 4

45 Productivity Commission, *General Practice Administrative and Compliance Costs*, 31 March 2003, p. 60.

46 Productivity Commission, *General Practice Administrative and Compliance Costs*, 31 March 2003, p. 24.

47 Dr Carter, Submission 19, p. 2

taskforce in response to recommendations made by the Productivity Commission, and this taskforce is due to report in November 2003.[48]

Conclusion

3.53 The evidence indicates that real incomes for GPs who exclusively bulk-bill, relative to average weekly ordinary time earnings, have fallen in the past ten years, and that an increase in net earnings of about 10.6% would be required to retain relative parity.[49]

3.54 It is more difficult to ascertain historical changes in real terms to the income of doctors who do charge at least some of their patients above the rebate level. However, the clear evidence that out-of-pocket charges to patients have been rising quite markedly (see chapter 4) suggests that the majority of GPs have been receiving income growth at a rate closer to AWOTE than those GPs relying solely on Commonwealth payments.

3.55 While knowledge of historical changes in GP income is important, it is not possible to externally regulate GP remuneration. As a result, the extent to which GPs *perceive* their income to be sufficient or otherwise at any given time is important. The vast majority of practitioners and associated organisations who submitted to the Inquiry expressed the view that incomes for GPs had fallen substantially over recent years. This decline, coupled with a shortage of doctors, caused an increase in the number and quantum of out-of-pocket charges and a decrease in bulk-billing.

3.56 The Committee received evidence that the cost of running a general practice ran at approximately 50% of GP gross income, and that the proportion of income absorbed by running expenses had increased over recent years. However, the Committee heard no compelling evidence that GP running costs had outgrown the CPI, and the question of viability has been determined with reference to the most conservative cost figures available.[50] The Committee acknowledges that costs of rural practices are higher than average, but notes the solid evidence that practice incomes in rural areas outstripped those in more populated areas.[51] There is no evidence that rural practices' extra costs exceed their extra income.

3.57 With respect to the effectiveness of blended payments such as PIP and EPC, the Committee is mindful of the many benefits which can be obtained through their

48 See http://www.health.gov.au/redtape/index.htm for further information on the Taskforce.

49 As outlined at 3.10.

50 Australian Institute for Primary Care, *An analysis of potential Inflationary effects on health care costs for consumers associated with the Government's 'A Fairer Medicare', and the Opposition proposal*, September 2003, La Trobe University, p. 20

51 The Committee notes the evidence provided by the Department of Health and Ageing relating to income earned by FTE GPs by RRMA, but is swayed by the extent and consistency of evidence to the contrary.

use. The Committee supports an examination of the effectiveness 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. Pending the outcome of such a study, the Committee believes that the role of the 'Red Tape Taskforce' is critical in laying the foundations for an analysis of what part blended payments should play in the future. The bulk of complaints to the Committee related to unwieldy and unreasonable administrative requirements. The Committee therefore recommends that the Taskforce addresses the procedural as well as the structural components of the system and recommends substantive reforms.

3.58 It is the view of the Committee that practitioners who exclusively bulk-bill are clearly relatively worse off now than they were a decade ago. This decline in remuneration in real terms for GPs who bulk-bill around 80% of their patients is of serious concern, and the Committee concludes that the relative under-remuneration is a primary factor, along with practitioner shortage, in the falling rates of bulk-billing in Australia.

Recommendation 3.1

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

CHAPTER 4

Access to General Practice in Australia

> *Our service bulk-bills patients. Our patients often indicate that bulk-billing is crucial to them, that because of their family commitments or their income levels they would not be able to see a doctor without that. Because we have waiting lists, sometimes patients elect to go elsewhere, but they are finding it increasingly difficult ... to find a bulk-billing practice. Those that do bulk-bill are fairly heavily booked. In fact one of the ones that we constantly refer people to has just closed its books in the last few weeks because it was overwhelmed.*[1]

4.1 This Inquiry's Terms of Reference require an examination of the access to and affordability of general practice under Medicare, with particular regard to the impact of general practitioner shortages on patients' ability to access appropriate care in a timely fashion. Discussion of access to services can be analysed in terms of two primary and interdependent factors - the physical availability of doctors, and the costs of access to doctors' services.

4.2 In the context of a market for medical services, the factors are closely linked. For instance, a decline in the number of doctors graduating from medical school as GPs has an effect on the medical workforce, therefore affecting patients access to medical services. However, such a change in workforce also has profound effects on the level of competition between practitioners as market forces act to set pricing to the patient. This has direct implications for financial availability of services.

4.3 Obversely, a trend by doctors in a given region away from bulk-billing, toward higher out-of-pocket patient contributions, or increased direct government funding, will not simply have ramifications for financial availability of services, but may also cause general practice to appear more attractive to medical graduates, as rates of remuneration are seen to grow.

4.4 As a result of this relationship, questions of access to services must be addressed with reference to both workforce supply and cost to patients as tandem factors in achieving the desired outcome.

4.5 This chapter examines a number of indicators to assess the level of access to GPs, the causes of lack of access, and the impact of reduced access.

4.6 It must also be acknowledged that current supply problems may be substantially due to earlier government policies designed to limit GP numbers. These included:

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1 Ms Joan Barry, *Proof Committee Hansard*, Hobart, 31 July 2003, p. 21

- measures to restrict the number of funded university medical school places and training places;
- tighter restrictions on the entry of overseas trained doctors; and
- the introduction of provider number legislation in 1996, which prevented newly qualified doctors from accessing Medicare until the completion of vocational registration training.[2]

Current GP services

4.7 A number of indicators can be used to assess the level of access to GPs. These include the number and location of GPs, rates of bulk-billing, the level of average out-of-pocket expense, and the decline in out-of-hours services and services to nursing homes.

GP numbers and their location

4.8 In 2001/02 there were approximately 24,300 GPs and non-Vocationally Registered (non-VR) medical practitioners in Australia, which is slightly fewer than six years ago. Full-time workload equivalent GPs have increased from 16,316 to 16,736 since 1996-97, which represents an increase in the average workload per practitioner. The figure of 16,736 represents a ratio of 84.9 full-time equivalent doctors per 100,000 population, a decrease from 88 per 100,000 in 1996-97.[3]

4.9 On a comparison by state and territory, the Northern Territory fares worst, with nearly half the average number of full-time equivalent GPs per 100,000 population, at 46.1. Much better off is the ACT with 65.5 per 100,000, followed by Western Australia at 74.7. The highest ratio of doctors occurs in South Australia, which enjoys 88.8 practitioners per 100,000, with NSW a close second at 88.4.

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2 AMA, Submission 38A, p. 2: see also DOHA, Submission 138, p. 10

3 Report on Government Services 2003, page 10.5, Productivity Commission, February 2002, available at www.pc.gov.au/gsp/2003.

Table 4.1 Medical practitioners billing Medicare and full time workload equivalent GPs.[4]

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
GP numbers									
1996-97	8 229	6 064	4 471	2 386	2 060	659	417	240	24 526
1997-98	8 107	5 952	4 438	2 363	2 032	667	414	257	24 230
1998-99	8 029	5 917	4 556	2 327	2 020	655	413	259	24 176
1999-2000	8 011	5 906	4 655	2 334	1 999	647	418	264	24 234
2000-01	7 983	5 881	4 681	2 365	2 016	643	421	278	24 268
2001-02	7 991	5 887	4 713	2 353	2 023	653	406	281	24 307
Full time workload equivalent GPs									
1996-97	5 796	4 088	3 031	1 403	1 308	374	230	86	16 316
1997-98	5 870	4 031	3 108	1 416	1 319	366	233	90	16 432
1998-99	5 797	4 060	3 128	1 405	1 319	361	230	89	16 389
1999-2000	5 803	4 117	3 138	1 412	1 289	364	222	88	16 433
2000-01	5 770	4 098	3 177	1 424	1 345	366	219	94	16 493
2001-02	5 898	4 144	3 212	1 443	1 351	382	212	93	16 736
GPs per 100 000 people									
1996-97	130.9	131.8	131.6	132.8	139.0	139.1	134.7	128.1	132.3
1997-98	127.5	128.0	128.5	129.3	136.3	141.2	133.1	134.6	129.2
1998-99	124.7	125.9	129.9	125.5	134.7	138.8	131.6	133.4	127.3
1999-2000	122.9	124.1	130.4	124.2	132.7	137.1	131.9	133.7	126.1
2000-01	120.8	121.9	128.8	124.1	133.1	136.0	130.9	139.0	124.5
2001-02	119.7	120.6	127.3	121.8	132.9	137.9	125.3	140.1	123.3
Full time workload equivalent per 100 000 people									
1996-97	92.2	88.8	89.2	78.1	88.2	79.0	74.2	46.1	88.0
1997-98	92.3	86.7	90.0	77.5	88.5	77.4	74.9	47.1	87.6
1998-99	90.0	86.4	89.1	75.8	88.0	76.6	73.2	45.9	86.3
1999-2000	89.0	86.5	87.9	75.1	85.6	77.1	70.1	44.5	85.5
2000-01	87.3	85.0	87.4	74.7	88.8	77.5	68.1	46.9	84.7
2001-02	88.4	84.9	86.8	74.7	88.8	80.7	65.5	46.1	84.9

4 Full time workload equivalents (FWEs) are calculated for each practitioner by dividing the practitioner's Medicare billing by the mean billing of full-time practitioners for that reference period. For example, an FWE value of two indicates that the practitioner's total billing is twice that of the mean billing of a full time practitioner.
GP and FWE numbers include GPs and Other Medical Practitioners (non-VR GPs).
GP numbers are based on the doctors' major practice postcode as at the last quarter of the reference period. The major practice postcode is the location at which the doctor rendered the most services. FWE numbers are based on the doctors' practice location postcodes at which services were rendered within the reference period.
Population data – Estimated resident population was based on the 2001 Census Benchmark. The 2001/02 projections were calculated by taking the average of the preliminary estimated resident population at 31 December 2001 and the projected population (produced for Commonwealth Treasury in June 2002) at 31 December 2002. External territories are excluded from state/territory totals, but included in the totals for Australia consistent with the ABS publication 3101.0.
Source: Report on Government Services 2003, Productivity Commission, February 2002, Table 10A.9, available at www.pc.gov.au/gsp/2003.

Practitioner shortages

4.10 The Committee is persuaded by the evidence presented by various health workforce observers that for the last few years there has been an undersupply of GPs in Australia, not merely a distortion in their distribution, as was argued by the Department. Evidence from Monash University put it like this:

> The prevailing view in medical policy circles [in the early- to mid-1990s] was one not of supply but of maldistribution of the medical workforce. But this case has foundered in the face of evidence of fundamental structurally based shortages of doctors in Australia … [t]he problem is clear at the level of first and second year interns. They provide the core of junior doctors in the public hospitals, but in recent years there have not been enough to fill requirements … [t]hese shortages cannot be reduced to problems of maldistribution. Rather, they are a consequence of there being too few graduates from medical schools in Australia.[5]

4.11 In terms of outright shortage, the Australian Medical Workforce Advisory Committee (AMWAC) reported in 2000 that, in 1998, there was a shortage of about 1,240 GPs in rural and remote areas, but a surplus of some 2,300 in metropolitan areas, resulting in a net surplus nationally.[6] In a report commissioned by the AMA delivered in February 2002, Access Economics considers the findings technically correct, but AMWACs assumptions about them misleading. The Access Economic report alleges an overall shortage of between 1,200 and 2,000.[7] Their main point of disagreement is the level of AMWAC's 'lean benchmark' to establish GP necessity to area. The number of GPs required in any area is calculated on the average number of GP consultations per capita. Access Economics claims that the 'average' number used by AMWAC is inaccurate, and because it is set too low, the estimate of how many doctors are required to meet demand is correspondingly too low.[8]

4.12 Looking behind the statistics, the Committee heard about the real effects of practitioner shortages on people's lives. According to the Queensland Minister for Health, the Hon. Wendy Edmond:

> A lot of elderly people, in particular, if they cannot get a GP appointment go to the hospital. And many of the people who are waiting in our clinics have tried to get a GP appointment and they all say they either could not get in to

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5 Bob Birrell *et al*, *The Outlook for Surgical Services in Australasia*, Centre for Population and Urban Research, Monash University, June 2003, p. 6

6 *The General Practice Workforce in Australia; Supply and Requirements 1999 to 2010*, Australian Medical Workforce Advisory Committee, August 2000, p. 2

7 *Primary Health Care for All Australians: An Analysis of the Widening Gap between Community Need and the Availability of GP Services*, a report to the Australian Medical Association from Access Economics Pty Ltd, February 2002, p. 9. It should be remembered that the AMWAC report was prepared a number of years before that of the AMA, and may well have reflected reality in 1998

8 ibid, p. 8

> see a GP because they have closed their books and are not taking any new patients or they cannot get an appointment for a week, and, if you are elderly and sick, that is a long time to wait.[9]

4.13 The Committee heard from a number of practitioners who would like to retire, or have more than enough patients to maintain a full time practice, but who are overwhelmed by the demand for their services:

> [G]eneral practitioners cannot close their books; they are the only game in town in some instances. The pressure is such that patients are appearing, whether or not they have an appointment, with urgent situations.[10]

4.14 The situation is not confined to general practitioners. Other primary care practitioners, as well as specialist physicians, are clearly maintaining long waiting lists:

> This morning I received two letters advising of orthopaedic outpatient appointments at my local hospital. The advice was: ‘We’ve written to your patient; they can expect an appointment in 26 weeks.’ I thought, ‘Well, 26 weeks is not too bad,’ but then I re-read the letters and both letters actually said 26 months, and I thought, ‘That’s probably not quite as good.’ … I have to ring those people and say, ‘Can you put up with your shoulder pain and hip pain for another two years until you get your appointment in outpatients — not your operation; your appointment in outpatients? We need to manage what we can do.’ The frequency with which that occurs is distressing and puts enormous pressure on our staff who manage the patient’s distress and on the GPs with whom I work. I find it more and more difficult to do this job — and I love doing this job.[11]

Regional distribution of GPs

4.15 In addition to a numerical shortage, the majority of respondents report a coincident severe maldistribution within the practitioner workforce.[12] Many also foresee a worsening in this situation in the future.

4.16 The latter analysis is supported by the States and Territories, who all report shortages, a maldistribution, or both.[13] It is argued strongly that, in a demographic that suffers higher levels of mortality, disease incidence and hospitalisation, people in rural

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9 The Hon Ms Edmond, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 23

10 Dr Walters, *Proof Committee Hansard* , Brisbane, 26 August 2003, p. 67

11 Dr Kastrissios, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 96

12 See, for instance, Department of Health and Ageing, Submission 138, p. 17

13 See, for example, NSW Government, Submission 154, p. 8; Tasmanian Government, Submission 147, p. 4; Northern Territory Government, Submission 82 p. 3 and Queensland Government, Submission 32, p. 4.

and remote areas are further disadvantaged by a relative lack of access to primary care.[14] The table below illustrates the change in GP location over recent history.[15]

Table 4.2 Full time workload equivalent GPs by region [16]

	Capital city	Other Metro centre	Large Rural centre	Small Rural centre	Other Rural area	Remote centre	Other Remote area	Aust.
1996-97								
Total GPs	17 169	1 768	1 362	1 306	2 301	246	374	24 526
FWE	11 445	1 274	924	923	1 504	120	125	16 316
FWE per 100 000	96.8	89.9	80.9	74.8	63.1	53.8	40.2	88.0
1997-98								
Total GPs	16 787	1 737	1 349	1 323	2 325	257	452	24 230
FWE	11502	1 288	941	934	1 510	122	134	16 432
FWE per 100 000	96.0	89.5	81.5	75.0	63.0	54.1	42.9	87.6
1998-99								
Total GPs	16 495	1 713	1 377	1 375	2 435	296	485	24 176
FWE	11 472	1 283	936	926	1 513	119	142	16 389
FWE per 100 000	94.5	87.5	80.3	73.7	62.7	52.4	45.3	86.3
1999-2000								
Total GPs	16 305	1 719	1 390	1 474	2 542	309	495	24 234
FWE	11 475	1 286	935	951	1 526	118	142	16 433
FWE per 100 000	93.2	86.1	79.4	75.0	62.9	51.6	45.2	85.5
2000-01								
Total GPs	16 165	1 740	1 435	1 493	2 629	311	495	24 268
FWE	11 383	1 285	953	996	1 601	124	150	16 493
FWE per 100 000	91.5	83.5	78.4	77.5	65.0	55.3	48.0	84.7
2001-02								
Total GPs	16 007	1 712	1 449	1 571	2 747	310	511	24 307
FWE	11 433	1 298	982	1 043	1 700	124	155	16 736
FWE per 100 000	90.8	83.3	79.7	80.2	68.3	54.5	49.0	84.9

4.17 In 2001/02, in capital city and other metropolitan areas, there was an average of more than 90 FTE GPs per 100,000 population, whereas in rural and remote

14 See Australian Hospital Statistics 2001-02, Australian Institute of Health and Welfare, Health Services Series number 20, June 2003, p. xi

15 Report on Government Services 2003, Productivity Commission, February 2002, Table 10A.37, available at www.pc.gov.au/gsp/2003.

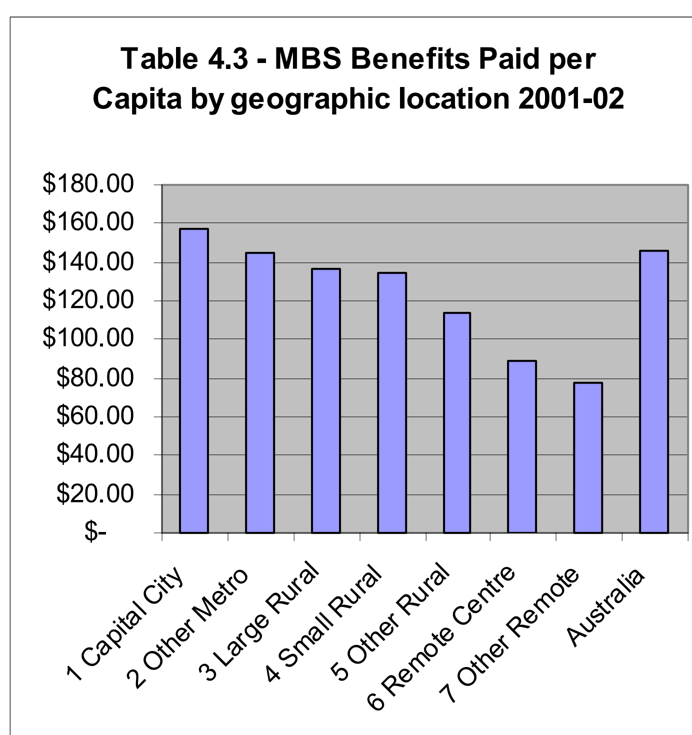
16 Report on Government Services 2003, Productivity Commission, February 2002, Table 10A.37, available at www.pc.gov.au/gsp/2003. Includes Other Medical Practitioners, such as non-VR GPs. Capital city = State and Territory capital city statistical divisions; other metropolitan centre = one or more statistical subdivisions that have an urban centre with a population of 100 000 or more; Large rural centre = SLAs where most of the population resides in urban centres with a population of 25 000 or more; Small rural centre = SLAs in rural zones containing urban centres with populations between 10 000 and 24 999; Other rural area = all remaining SLAs in the rural zone; Remote centre = SLAs in the remote zone containing populations of 5000 or more; other remote area = all remaining SLAs in the remote zone.

regions, the average fell to 49 per 100,000. Even so, this figure represents a substantial increase over previous years.

4.18 It should be noted that not all major centres are well serviced by practitioners. The Australian Capital Territory reported an undersupply, even compared to rural and remote communities, and pointed to the relative success of Commonwealth policies to redistribute doctors to smaller communities, not including the ACT. It was noted that the decline in ACT practitioners was substantially greater than in other capital cities.[17]

Regional distribution of benefits

4.19 Department of Health and Ageing figures for 2001/02 show a decline in MBS expenditure per capita as areas become more remote.[18]



(Dept Health and Ageing, Submission 138, p. 21)

4.20 As Table 4.3 indicates, people in small rural and remote areas receive MBS funding at a level of between $78 and $134 per capita per annum, while large metropolitan and capital city areas receive funding at between $144 and $157. This clear disparity has grave equity implications, as those in less populated areas enjoy less and less MBS funding per capita yet suffer relatively more exposure to risk factors such as smoking, obesity, inactivity, high blood pressure, and excessive consumption of alcohol.[19] While a 'chicken and egg' argument could easily be applied

17 ACT Government, Submission 171, p. 4

18 Department of Health and Ageing, Submission 138, p. 21

19 Australian Institute of Health and Welfare, Australia's Health 2002, p. 215

here, the disparity in relative population health is indisputable, and will only improve with an increase in the per capita expenditure in rural and remote areas.

4.21 PolMin expressed strong concerns about inequity:

> PolMin submits that Medicare's principle of universality has failed to provide equitable access for all to good quality health care, and that [this] failure is profoundly evident in Australians living in regional and rural regions.[20]

4.22 The AMSANT illustrated the point dramatically:

> The average Medicare access for a person living in Double Bay is about $1,000 per year. They have an oversupply of GPs and they have supply-induced demand, so a lot of that is wasted money. The average Medicare expenditure of a patient living in remote parts of the Kimberley's is about $100 a year, so there is gross inequity in access to Medicare because there is gross inequity in access to GPs, and that is what primarily determines the inequity in the bulk-billing rate.[21]

4.23 Unequal distribution of MBS benefits is an issue in less remote regions than the Kimberley. The Committee heard from Dr Sprogis, based in the Hunter region of NSW:

> I happen to know that in Western Sydney the average consultation rate to population is eight per year. In this town it is about four. The disparity in funding on a per head of population basis just on rebates alone is $200 in Sydney per head per year — including in some of the richest parts — but $100 per year per person in one of the poorest regions of our state. It is worse if you go west. It gets down to two consultations per year per person west of the mountains in some parts of New South Wales.[22]

Declining Rates of Bulk-billing

4.24 Bulk-billing is a cornerstone of access to primary care in Australia, playing an indispensable day-to-day role not just for disadvantaged people, but for all Australians. Affordability of access is critical.

4.25 At present, doctors who do not bulk-bill (ie. do not charge any more than the rebate for their services, and subsequently bill the HIC directly for that amount) normally charge the patient the full amount of their fee, which is then partially reimbursed (by the amount of the Medicare rebate) when the patient presents their receipt at a Medicare office.

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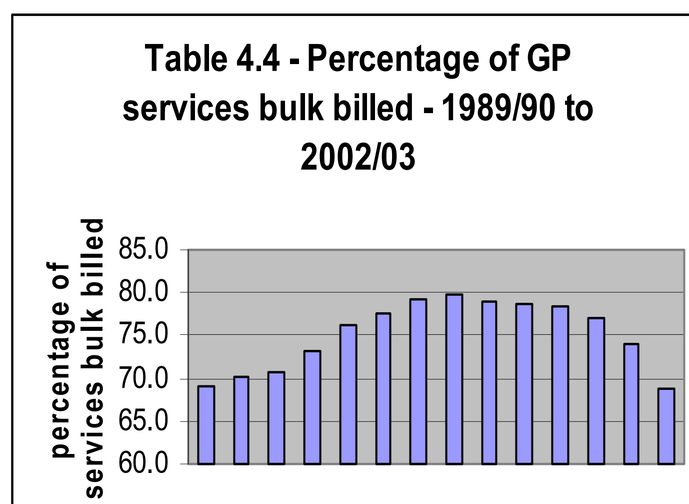
20 Australian Political Ministry Network (PolMin), Submission 35, p. 1

21 Dr Boffa, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 43

22 Dr Sprogis, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 2

4.26 Recent history has seen a decline in rates of bulk-billing of GP visits. The graph below illustrates the trend.[23]



4.27 The imposition of an out-of-pocket contribution has obvious and profound implications for many patients and their families. In the event that money is 'found' to pay the doctor, other areas of the household budget may be undermined. If patients choose not to see the doctor or cannot assemble the necessary out-of-pocket contibution, they may suffer considerable adverse health consequences:

> Much evidence exists that patient payments at point of service such as copayments affect access to health care adversely for the less well-off while improving access for the wealthy. This is for both 'necessary' and 'unnecessary' visits. There are often underlying factors creating these visits, and patients do not have the medical skills to make this distinction. After copayments were introduced for optometrists visits in the UK it was found that cases of undiagnosed glaucoma (a treatable form of blindness) increased.[24]

4.28 As recently as 2002, reports indicate that 16 percent of non-institutionalised adults with health problems surveyed had not seen a doctor when sick in the past two years due to cost, while 23 percent had not filled a prescription due to cost:[25]

> A visit to our family doctor is something that we must budget for and a family sickness is something that we cannot afford as a visit for the four of us costs almost $100 even before we purchase any pharmaceutical items … there are times when we have no option but to use a bulk-billing centre and

23 Medicare Statistics 1984/85 to June quarter 2003, Department of Health and Ageing, p. 43

24 Doctors Reform Society, Submission 25, P. 3. See also Professor Andrew Wilson, Canberra, *Proof Committee Hansard*, Monday 21 July 2003, p. 30

25 The Commonwealth Fund, 2002 International Health Policy Survey

> if we are denied access to this medical service we will be forced to use a public hospital or just go without.[26]

4.29 There has also been a drop in the number of services rendered by GPs in the June quarter of 2003, compared with the same period in 2002. Attendances fell by 4.4% to 22,356,000.[27] While many prospective attendees may have demurred from consulting their GP due to broader access issues such as waiting times, it is important to note that unavailability of bulk-billing played a substantial role in the decline. This trend has alarming consequences for population health, as strong evidence exists as to the primary role which GPs play in preventive health care.[28]

The geographic distribution of bulk-billing

4.30 In addition to noting an overall drop in the proportion of bulk-billed out-of-hospital services, the Committee was struck by the geographic disparity in access to bulk-billed services, particularly in the context of GP services. Bulk-billing rates for general practice vary widely between regions.

Table 4.5 - Proportion of non-referred attendances to GPs that were bulk-billed, by region[29]

	1996-97	1997-98	1998-99	1999-2000	2000-01	2001-02
Capital city	85.9	85.6	85.4	85.2	83.8	80.8
Other metro centre	81.3	80.1	79.5	78.6	76.2	72.3
Large rural centre	65.7	63.7	61.7	60.8	59.8	59.0
Small rural centre	64.8	63.1	61.7	61.7	60.9	59.3
Other rural area	62.1	59.6	59.1	58.6	57.7	56.6
Remote centre	56.0	56.7	57.6	59.0	60.0	58.9
Other remote area	70.1	69.6	70.1	70.1	69.5	70.0
Unknown	68.8	70.3	71.4	73.4	72.7	71.5
Australia	80.6	79.8	79.4	79.1	77.6	74.9

26 Ms Hamill, Submission 41, p. 1

27 Medicare Statistics 1984/85 to June quarter 2003, Department of Health and Ageing, p. 8

28 Department of Health and Ageing, Submission 138, p. 40

29 Capital city = State and Territory capital city statistical divisions; other metropolitan centre = one or more statistical subdivisions that have an urban centre with a population of 100 000 or more; Large rural centre = SLAs where most of the population resides in urban centres with a population of 25 000 or more; Small rural centre = SLAs in rural zones containing urban centres with populations between 10 000 and 24 999; Other rural area = all remaining SLAs in the rural zone; Remote centre = SLAs in the remote zone containing populations of 5000 or more; other remote area = all remaining SLAs in the remote zone. Report on Government Services 2003, Productivity Commission, February 2002, Table 10A.36, available at www.pc.gov.au/gsp/2003. .

4.31 As a general rule, people in capital cities are much more likely to be bulk-billed than those outside cities. In 2002, some 80.8 percent of GP services delivered in capital cities were bulk-billed, compared to 56.6 percent in other rural and remote areas.[30] This reflects a strong link between the supply of GPs and the availability of bulk-billing services:

> [I]n rural and remote areas, where the general practice workforce is in chronic shortage, many areas do not have access to a GP that bulk bills, and where bulk-billing is available, waiting times are often excessive. Patients from rural and remote areas are also subject to the necessity to travel long distances, which has serious effects, not only in terms of affordability and timeliness of access, but also outcomes.[31]

Declining out-of-hours and nursing home services

4.32 Another indicator of access to GP services is out-of-hours and nursing home services. There has been a decline in the number of home and nursing home visits by GPs, and a parallel increase in the cost of such services. Whether GP services provided after hours have decreased is difficult to establish, but many respondents point to increased utilisation of Accident and Emergency Departments as a sure indicator that they have.[32] The possible causes of such a decline are discussed later in this chapter.

4.33 The impact of the shortage in out-of-hours services can be severe:

> Parents with a child with a severe mental illness require a GP visit in the middle of the night. Locum is unable to attend for several hours and if they do attend will cost $140. Only alternative is to visit the emergency department of a hospital.
>
> A daughter desperately tries to arrange a GP visit for her father in a Victorian outer urban aged care facility. After ringing 25 GPs, one finally agrees to visit at a cost of $160.[33]

4.34 The unpredictability of pricing adds another element to the problems in accessing the services. Mr Mehan of Newcastle described the inconsistency in fee structure for out-of-hours services:

> At Woy Woy, in the southern part of the Central Coast, the hospital has no outpatient facility. Doctors there are on a roster. They are allowed to use the public facility but they are allowed to charge whatever they feel is appropriate, and that will vary from doctor to doctor. Last night, the charge before 11 p.m. was $40. The night before, Monday night, it was $120. My

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30 Department of Health and Ageing, Submission 138, p. 25

31 NSW Nurses' Association, Submission 140, p. 3

32 See, for example, NSW Government, Submission 154, p. 9

33 Victorian Medicare Action Group, Submission 64, p. 3

> affiliates tell me that their members have been asked to pay $100 or $110 for seeing the outpatient service at Woy Woy Hospital, a public facility on the Central Coast.[34]

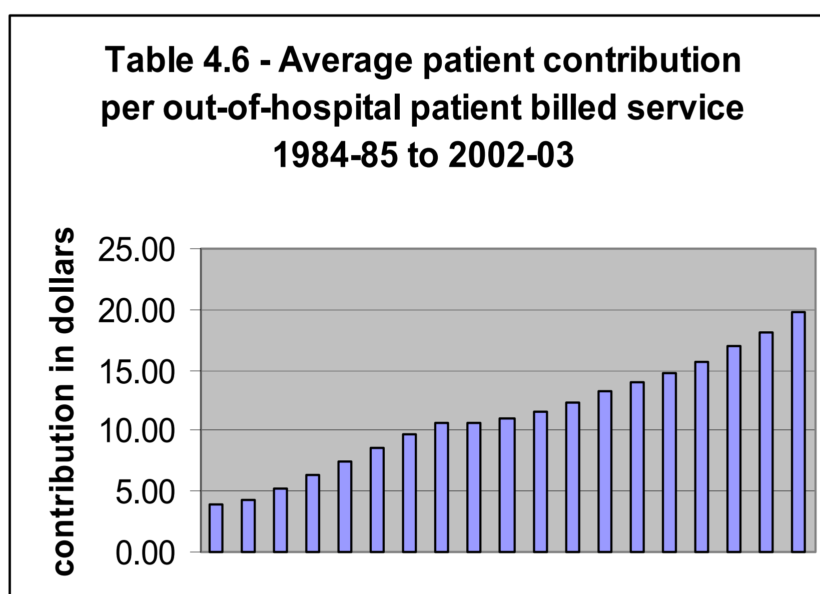
4.35 The dramatic impact that a lack of out-of-hours services has on the very vulnerable was never clearer than in the context of domestic violence:

> Women and children who have been subjected to domestic violence and/or who have insufficient economic means to access private hospital treatment have to go to the Base hospital and wait their turn in Emergency…[m]any women leave without accessing the medical service they need or refuse to attend because of the long wait. Private hospitals offer an after hours service but if you do not have private health coverage it is not accessible. In the last year we have not had a single client with private health insurance.[35]

4.36 This decline acts to feed hospital overflows and other shortage-induced phenomena, such as access to timely medical care.

Increasing out-of-pocket costs

4.37 The out-of-pocket contribution made by patients increased from an average of $3.95 to $19.72 over the 1984/85 to 2002/03 period, as illustrated in Table 4.6, below.[36]



4.38 GP services, when viewed alone, also show an increase in patient contributions over the period 1989/90 to 2002/03 as Table 4.7 illustrates.[37]

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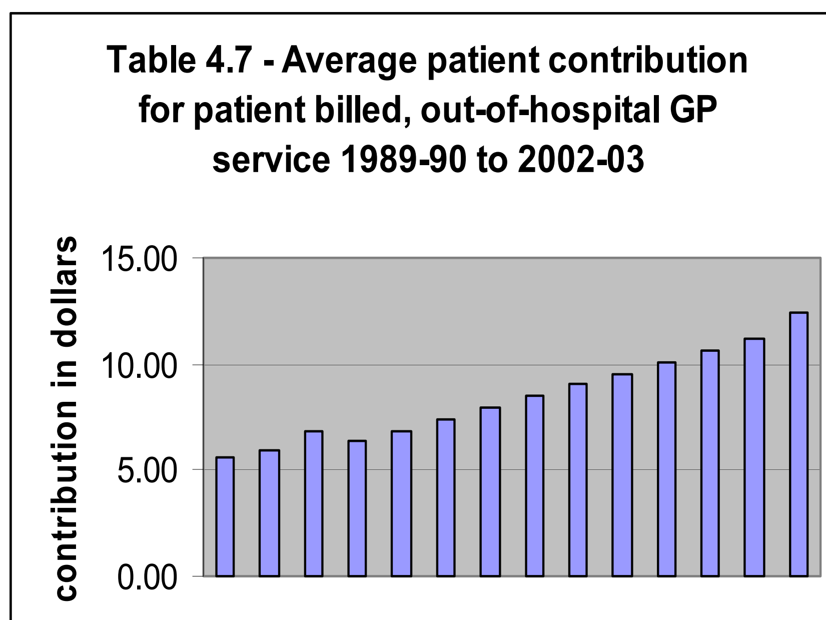
34 Mr Mehan, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 51

35 Bundaberg and District Women's Domestic Violence Service Inc, Submission 145, p. 2

36 Medicare Statistics, 1984-85 to June Quarter 2003, Department of Health and Ageing, Table A5.



4.39 The declining rate of bulk-billing, particularly for those without a health care card has led to increasing numbers of patients being required to pay the full fee 'up front'. This was noted as problematic in many submissions:

> I can't afford to go to the doctor and if I do go I can't afford the medicine. Both my daughter and I need to go but we can't. There's no money until next Thursday. I owe [the medical centre] $9 for the last bill and I haven't got it.[38]

4.40 The point was also made that out-of-pocket costs are not simply a phenomena experienced in the GP context. Many patients, especially those with more complex needs (who tend also to be poorer) encounter these costs with ancillary and allied health services. The cumulative effect of out-of-pocket costs, which individually may seem small, could test the finances of even those not normally considered as socio-economically disadvantaged.

4.41 Dr Woodruff stated that:

> As we know, it is not only GP services that they have to potentially pay copayments for – there are pharmaceutical bills, specialist services and ancillary services. Those people on $40,000 or $50,000 will not be able to afford and cannot currently afford private health insurance, which is rising at seven per cent per year, well above inflation.[39]

4.42 A participant in an Anglicare survey expressed similar frustration:

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37 Medicare Statistics, 1984-85 to June Quarter 2003, Department of Health and Ageing, Table B5. Pre 1989 data unavailable for comparison.

38 Anglicare Tasmania, Submission 142, case study on page 7.

39 Dr Woodruff, *Proof Committee Hansard*, Sydney, 22 July 2003, p. 53

> If you go to the doctors you have got to pay a gap which can be up to $10, depending on who you see. It's $50 to $100 for a specialist. All doctors should bulk people on low incomes. We don't go to doctors and our kids don't because we can't afford it. Doctors bills have gone up but the Medicare subsidy hasn't. What are they doing?[40]

4.43 Some GPs exercise discretion when charging out-of-pocket expenses,[41] reducing or waiving them if they deem their patients unable to pay. This has been described as 'compassionate discounting'. Many submissions note that doctors still bulk-bill patients considered to be disadvantaged or particularly needy, but that bulk-billing of most or all of their patients, at the same time providing a quality level of service, would drive the practice bankrupt.[42]

4.44 The practice of discretionary discounting was a cause of concern to the Committee. Many doctors defended the practice by claiming that they gained a comprehensive knowledge of their patients' financial situation through their clinical relationship, and that they doubted the integrity of the health care card system[43], results in support by many doctors for discretionary charging. However, concerns remain as to the validity of using anecdotal evidence as a basis for charging practices. Committee members raised concerns about the consistency (and hence the fairness) of such a discretionary form of discounting.[44]

The causes of reduced access

GP Morale, a falling participation rate and the ageing of GPs

4.45 The number of medical graduates choosing to enter general practice is trending downward, and it can be inferred that this is contributing to the overall shortage of GPs. From the evidence put before the Committee, the causes of this reduced popularity include a decrease in recruitment to general practice at one end, and a departure of established practitioners at the other.[45]

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40 Anglicare Tasmania, Submission 142, case study on page 8

41 Dr Gault, Submission 6, p. 2

42 See, for example, Professor Charlton, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 56

43 A large number of respondents submitted that the eligibility criteria for Health Care Cards is insufficiently rigorous, and that too many cards are currently in circulation. This is discussed in detail in Chapter 6.

44 Senator Knowles, *Proof Committee Hansard*, 30 July 2003, Adelaide p. 4

45 Primary Health Care for All Australians: An Analysis of the Widening Gap between Community Need and the Availability of GP Services, Access Economics (commissioned by the AMA), February 2002, p. 12

4.46 There are approximately 24,000 GPs in Australia, equating to around 16,700 full-time equivalent (FTE) practitioners. The number of FTE providers is falling[46] in line with the retirement of older male GPs who tend on average to work more hours than younger entrants to the profession, particularly women. It is in the context of the average GP working fewer hours that the workforce shortage is said to have arisen.[47]

4.47 It was reported that one in six GPs (about 16 percent) in Australia were actually employed in non-medical activities, exerting major downward pressure on the participation rate.[48] According to Dr Bain, the dominant reason expressed for choosing to abandon general practice is the falling real value of the rebate. However, Australian Institute of Health and Welfare data indicates that the participation rate is at a relatively high level, with about 92.5 percent of registered medical practitioners in Australia part of the medical labour force, and about 60 percent of the remainder being retired.[49]

4.48 The Committee heard evidence from a number of respondents suggesting that doctors entering general practice tend to want a better balance between their professional and personal responsibilities. Dovetailing with this is the growing proportion of women in the GP workforce, and the impact of that changing dynamic in the profile of the GP workforce and on the supply of GP services:[50]

> There is an expectation that the trend towards a higher number of female doctors will continue as a predominantly male cohort of older doctors is replaced by a cohort of younger doctors that is at least 50 percent female in any one year. A supply projection analysis of the GP workforce has assumed that there will be an increase in the proportion of female GPs from 35 percent to around 41 percent by 2010 and a decline in absolute numbers of the male workforce.[51]

4.49 There is also a disparity between male and female GPs in the profile and the number of patients typically treated:

> Most notably [men and women] have different levels and types of participation, with women working fewer hours over their working lives,

46 Report on Government Services 2003, Productivity Commission February 2003, p. 10.6

47 Dr Bain, *Proof Committee Hansard*, Monday 21 July 2003, p. 16.

48 Dr Bain, *Proof Committee Hansard*, Monday 21 July 2003, p. 16.

49 *The Australian Medical Workforce*, Occasional Papers: New Series number 12, Department of Health and Aged Care, August 2001, p 13. It should be noted that this statistic does not account for those with relevant medical training who are not registered to practice.

50 As a proportion of the GP population, women increased in proportion from 23% in 1985 to 34% in 2000. Mr Davies, *Proof Committee Hansard*, Monday 21 July 2003, p. 4. See also The Australian Medical Workforce, Occasional Papers: New Series number 12, Department of Health and Aged Care, August 2001

51 *The Australian Medical Workforce*, Occasional Papers: New Series number 12, Department of Health and Aged Care, August 2001, p. 16

> being less likely to work in rural and remote areas, and being more likely to choose primary care over another type of specialist practice[52]

4.50 This combination of factors inevitably results in the average doctor working fewer hours, and it was pointed out that, for every GP who drops their working hours by two hours per week, the equivalent of 1,000 FTE GPs is taken offline.[53]

4.51 The Committee wishes to put on the record its support for doctors creating a better balance between personal and professional lives. This can only bring about better outcomes for the patients and the practitioners themselves. While such changes in the profile of the medical workforce create challenges in delivering adequate supply, the efforts are nonetheless a worthwhile investment in a productive and sustainable practitioner population.

4.52 Pending an increased output from medical schools to bolster the participation rate, it has been submitted that more overseas-trained doctors need to be brought online.[54]

4.53 There were also reports of overseas-trained doctors residing in Australia who were yet to interact with the Australian medical sector. It was suggested that this may be the result of a system of assessing immigration visa applications which looks less favourably on those professing medical training.[55] The use of overseas-trained doctors is covered in more detail in chapter 12.

Declining out-of-hours, home and nursing home services

4.54 The causes of the decline in these services are difficult to isolate, but it can be inferred that the changing attitude of practitioners to working long hours would be a significant factor. Long hours (including time spent after hours) are frequently cited as a disincentive to undertake general practice, and the Department of Health and Ageing has recorded a decline in the average number of hours worked by doctors from 48.2 to 45.5 hours per week.[56] It is further argued, in the context of home and nursing home visits, that the rebate does not cover the costs of taking time away from normal practice, and that unless this is remedied, GPs will have increasing difficulty in

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52 *The Australian Medical Workforce*, Occasional Papers: New Series number 12, Department of Health and Aged Care, August 2001, p. 16

53 Dr Bain, *Proof Committee Hansard*, Monday 21 July 2003 2003, p. 16.

54 See, for example, South Kingsville Health Services Co-op Ltd, Submission 80, p. 4

55 Mr Gregory, *Proof Committee Hansard*, Monday 21 July 2003, p. 20

56 *Primary Health Care for All Australians: An Analysis of the Widening Gap between Community Need and the Availability of GP Services*, a report to the Australian Medical Association from Access Economics Pty Ltd, February 2002, p.12. See also Department of Health and Ageing, Submission 138, p. 10

providing out of hours bulk-billed services.[57] Home and after-hours visits also present security concerns.

The drop in bulk-billing

4.55 The overwhelming feeling among respondents, particularly those in medical practice, is that the level of rebate is the primary cause of the fall in bulk-billing, specifically because practitioners cannot afford to continue to bulk-bill at the current rate of rebate.[58]

4.56 However, it is also argued that bulk-billing rates are more affected by the supply of practitioners, and that current rates of bulk-billing are falling due to provider number restrictions introduced in 1996 and also the curtailing in the number of overseas-trained practitioners entering Australia:[59]

> On page 2 [of Dr Moxham's submission], the first graph shows the Australian population going up. The second graph shows the number of GPs, which goes up and then levels out in 1996. That is when the government introduced provider number restrictions, so that is no surprise. On page 3, there is a graph showing the number of GPs per 1,000 patients. If you plot the ratio, it goes up until 1996 and then it goes down again. The fourth graph shows the percentage of GP consultations that are bulk-billed. In 1984, 45 per cent of consultations were bulk-billed. This rose steadily until about 1998 and it has been falling since that time. If you look at those two graphs, they are very similar, so over on the next page we have plotted those two on the same axis, which shows that they do track each other. The doctor to patient ratio and bulk-billing percentage are very closely related, and that is not surprising, because it is simple economic supply and demand: if you increase the supply of doctors, the price goes down and bulk-billing increases.[60]

4.57 There is considerable data to support the contention that bulk-billing rates are driven by practitioner supply along with the MBS rebate.[61] Hand-in-hand with this argument is the contention that increasing rates of rebate and PIP simply have the effect of increasing practitioner incomes, and do little or nothing to assist in maintaining bulk-billing rates.

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57 Australian Divisions of General Practice, Submission 37, p. 2. Increased practice staff costs are noted as a particular burden.

58 South Kingsville Health Services, Submission 80, p. 1; Dr Keddie, Submission 89, p. 2; Womens Health Victoria, Submission 45, p. 1; Queensland Government, Submission 32, p. 2

59 Australian College of non-Vocationally Registered General Practitioners, Submission 48, p. 2

60 Dr Moxham, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 1

61 See, for example, *The Australian Medical Workforce*, Occasional Papers: New Series number 12, Department of Health and Aged Care, August 2001, p. 56

4.58 However, the extent of evidence naming the level of the rebate as a primary factor in the decision to stop bulk-billing is too compelling to ignore. The Committee sees the level of the rebate as playing a critical role in restoring bulk-billing, in tandem with that of ensuring adequate workforce supply and distribution.

The maldistribution of GPs

4.59 As demonstrated at Table 4.2, there is a significant variation in the number of practitioners between regions. The GP Workforce report of 2001 provides the following summary of issues affecting workforce supply in rural and remote areas:

- Work intensity. The survey revealed that GPs in rural and remote areas perceive huge disadvantages in country practice through long hours, being on-call, lack of holidays (due to a scarcity of locums), and after-hours work. They also report a higher level of diversity and skills challenge in these practices, as well as severely limited hospital, specialist, allied health, technological, professional and personal support.
- Family conflicts and costs. The difficulties in managing a partner's career, children's schooling, and a lack of family support all feature prominently. Separation from extended family and friends can be a particular problem for young or single practitioners.
- Business difficulties. The difficulty in securing business partners, running a small business, the cost of travelling for training, and higher practice costs in some cases, all auger poorly for retention of contented practitioners in rural areas.
- Lifestyle and other factors. Social isolation, a lack of diversity, and a lack of anonymity (particularly for minorities) are all perceived as part of rural practice for many of those surveyed. There are also widespread concerns around availability of childcare, higher community expectations, and the difficulty of working part-time.[62]

4.60 It should also be noted that this maldistribution has a particular effect on Indigenous Australians, who comprise 13 percent of the rural population, and 26 percent of the remote population, despite comprising only 2.1 percent of the overall population.[63]

4.61 An adequate response to the maldistribution involves more than simply moving doctors to areas of need. It is clear that any 'solution' must incorporate

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62 *Primary Health Care for All Australians: An Analysis of the Widening Gap between Community Need and the Availability of GP Services*, a report to the Australian Medical Association from Access Economics Pty Ltd, February 2002, p. 14

63 *Primary Health Care for All Australians: An Analysis of the Widening Gap between Community Need and the Availability of GP Services*, a report to the Australian Medical Association from Access Economics Pty Ltd, February 2002, p. 14

strategies for both short- and long-term sustainability of a suitably sized medical workforce. As Mr Gregory of the National Rural Health Alliance pointed out:

> We are now talking … not of rural and remote doctors but of doctors who will spend a part of their practice life in rural and remote areas. So we have gone away, hopefully, from the situation where we depend upon true heroes who spend 65 years, work until they drop, seven days a week, 24 hours a day – because that is not the way that we want them to have to work and not the way anybody wants to work.[64]

The increase in GP attendances

4.62 Despite the doctor shortage, there has been an ongoing increase in the number of GP consultations either partly or fully charged to Medicare over recent decades.

4.63 The number of GP attendances rose from 64.8 million in 1984/85 to 99.9 million in 2001/02. The growth in GP services slowed in recent years, and in 2002/03 fell to 96.9 million, in line with the increasing shortage of GPs and increase in out-of-pocket patient contributions.[65]

4.64 It should be noted that *total* services partly or fully charged to Medicare rose from 113 million to 221.4 million from 1984/85 to 2002/03,[66] indicating that while GP services account for the single largest block of MBS claims, there has been a steadier and more sustained increase in MBS claiming for the broad range of items contained within the Schedule. On a per capita basis, in 1984/85, an average of 7.2 Medicare services were dispensed, compared with 11.1 in 2002/03.

An increase in consumer expectations

4.65 Consumer expectation of health professionals is higher than ever before.[67] Previously, injuries or disease as a result of the ageing process were largely accepted and managed. The trend now is to seek treatments or procedures to heal ailments and illnesses that were previously not detectable or not treatable. This inevitably has an effect on utilisation of diagnostic services, as well as procedures and medications.

4.66 There are also changes in patients' expectations of ease and convenience in their access to medical service. Against a background of ease and speed in accessing services in other areas of their lives, patients expect that access to medical services and advice will be equally simple and convenient.

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64 Mr Gregory, *Proof Committee Hansard*, Monday 21 July 2003, p. 20

65 Department of Health and Ageing, Medicare Statistics 1984/85 to June Quarter 2003. p. 33 (www.health.gov.au/haf/medstats/)

66 Ibid p.33. Total services include GP and special attendances, obstetrics, anaesthetics, pathology, diagnostic imaging, operations, optometry, and other miscellaneous chargeable items.

67 Department of Health and Ageing, Submission 138, pp. 14-15

More chronic disease and a move into community-based care

4.67 With an ageing population, Australia now faces a recognisable increase in chronic disease prevalence. Since 1984, the number of people who are living to the age of 85 or older has more than doubled,[68] bringing with it a larger burden on health systems.[69] Much of this treatment happens outside the hospital setting, adding particular stress to the primary care sector.[70] This is illustrated in Table 4.8.

Table 4.8 - Most common health problems managed by GPs, 2001 -02[71]

Problem managed	*No of problems*	*% of total problems*	*Rate per 100 Encounters*	*95% LCL (a)*	*95% UCL (a)*
Hypertension (b)	8 735	6.3	9.0	8.6	9.5
Upper respiratory tract infection	6 035	4.3	6.2	5.8	6.6
Immunisation/vaccination-all (b)	4 516	3.3	4.7	4.2	5.1
Depression (b)	3 329	2.4	3.4	3.2	3.6
Diabetes (b)	2 993	2.2	3.1	2.9	3.3
Lipid disorder	2 841	2.0	2.9	2.7	3.1
Asthma	2 756	2.0	2.8	2.6	3.0
Acute bronchitis/bronchiolitis	2 644	1.9	2.7	2.5	3.0
Back complaint (b)	2 540	1.8	2.6	2.4	2.8
Osteoarthritis (b)	2 524	1.8	2.6	2.4	2.8
Subtotal	38 913	28.0	..	..	..
Total problems	**139 092**	**100.0**	**143.4**	**141.7**	**145.2**

(a) UCL = upper confidence limit; LCL = lower confidence limit.
(b) Multiple primary care classification codes.
.. Not applicable.

4.68 In addition to chronic-care management, other services provided outside the hospital setting have also increased in the last two decades, driven somewhat by technical innovation These services have been funded by a combination of patient and MBS contributions. They tend to be supplied by practitioners in private practice, who can set their own fees, and whose patients face an increased possibility of incurring gap charges. It should be noted that it is not simply GP services which are growing. Non-GP services are also contributing to out-of-pocket expenses.[72] These changes in

68 Mr Davies, *Proof Committee Hansard*, Canberra, Monday 21 July 2003, p. 5

69 In 2002/03, female patients aged over 55 used an average of around 22 Medicare services per capita, compared with an average of 13 for all age groups. Over the same period, older males consumed around 20 services on average, compared with a male population average of 9. Department of Health and Ageing, Medicare Statistics 1984/85 to June Quarter 2003. p. 185, 86 (www.health.gov.au/haf/medstats/)

70 Mr Davies, *Proof Committee Hansard*, Canberra, Monday 21 July 2003, p. 5

71 Britt H, Miller GC, Charles J, Valenti L, Henderson J et al. 2002, *General practice activity in Australia 2001-02*, AIHW, Cat. No. GEP 10. Canberra.

72 Mr Davies, *Proof Committee Hansard*, Canberra, Monday 21 July 2003, pp. 5-6.

how and where people tend to be treated are placing a growing burden on community GP capacity.

A move towards prevention

4.69 There has been increasing focus by government and health sectors on the importance of prevention as a long-term investment in good health care:[73]

> GPs are often the first port of call for people seeking information about their health and are ideally placed to offer advice and assist people to achieve a healthy balance in their lifestyles.[74]

4.70 This has resulted in an increased demand for GP services, on an absolute and *per capita* basis, over the longer term. Most recently, there has been a marked increase in the number of long (level C and D) consultations, co-incident with the small decline in level A and B services.[75] It is important to note that, while preventive health measures can initially be 'expensive' in terms of practitioner time, they prove an important and effective investment in the long term.

Over-servicing

4.71 While most respondents dismissed over-servicing as a minor and largely insignificant problem, demand-driven over-servicing is an issue for some GPs, and containing visits only to those medically necessary is an ongoing challenge. At least one submission referred to the need to re-educate the population on what constitutes 'medical need', as well as when it is appropriate to self-manage a condition.[76] Any move to reduce 'unnecessary' demand carried inherent problems:

> Demand may include 'inappropriate' under and over-utilisation. It is not a simple open and shut case to define 'inappropriate'. One approach is 'medical necessity'. Plenty of work has been done, for example, in seeking to establish the appropriate frequency of Pap smears for women of various ages. It is quite well documented that men tend to be poor custodians of their own health, under-utilising GP services and not always admitting to symptoms. Some patients may access GP services more often that might be predicted on the basis of physical indications, but may need to do so for mental health reasons.[77]

4.72 This issue needs to be explored as part of a more wide-ranging review, as discussed in the final chapter.

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73 Mr Davies, *Proof Committee Hansard*, Canberra, Monday 21 July 2003, p. 6

74 Department of Health and Ageing, Submission 138, p. 41

75 Department of Health and Ageing, Submission 138B, p. 2

76 Queensland Government, Submission 32, p. 4

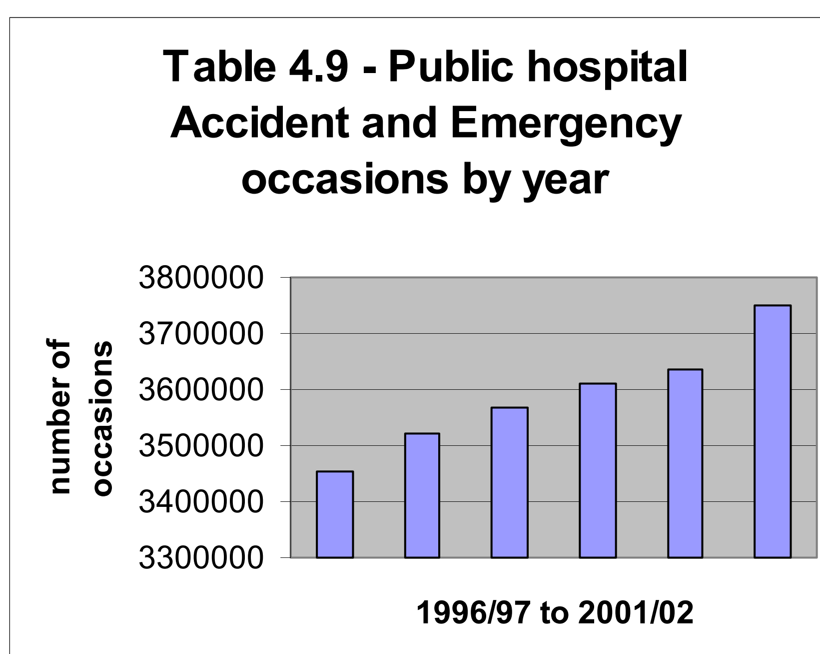
77 AMA, *An Analysis of the Widening Gap between Community Need and the Availability of GP Services*, Access Economics, February 2002, p. 5

Impact of the lack of access to GPs

Overflows from GPs to public hospitals

4.73 The Committee was given evidence of an increase in the throughput of Accident and Emergency departments (A&E) by state and territory governments, as well as by patient anecdote and health observers.[78] It was stated that over one million A&E occasions were treated in NSW in 2002.[79]

4.74 A clear and consistent increase in overall Accident and Emergency Occasions is discernible from 1995/96 to 2001/02.[80] Table 4.9 illustrates an increase in occasions of 1.6 percent per annum.[81]



4.75 It was broadly argued that the cause of this increase in utilisation was twofold:

- the shortage of GPs, resulting in the unavailability of GP services on a local level, and the need to solicit medical attention at an A&E department; and
- increases in the net out-of-pocket costs of consulting a GP, bringing about the same outcome. This is particularly apparent when respondents discuss the prospect of paying significant sums for out-of-hours consultations.[82]

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78 See, for example, NSW Department of Health, Submission 154, p.10, and Tasmanian Government, Submission 147, p. 4

79 Associate Professor Picone, *Proof Committee Hansard*, Sydney, 22 July 2003, p. 80

80 AIHW Australian Hospital Statistics, 2001/02 and previous issues.

81 AIHW Australian Hospital Statistics, 2001/02 and previous issues; data excludes NSW due to inconsistency in counting NSW services between years.

The necessity of attendance

4.76 While rates of presentation/separation at hospitals have risen, the question arises as to whether any of the new presentations are preventable. A patient registering in an A&E Department, has the complaint assessed for relative importance by a triage nurse, and is allocated a priority rating of between one and five, according to the National Triage Scale. States and Territories report significant increases in the number of patients presenting in categories four and five, the semi- and non-urgent categories, for which treatment by a GP would often, though not always, suffice.

4.77 The Committee heard that at Bundaberg Base Hospital, over 20,000 of the 29,000 Accident and Emergency presentations during 2002/03 were for Triage category four or five cases.[83]

4.78 In addition to evidence received from the state and territory jurisdictions, many individual examples were received. Typical of these were some case studies from the Victorian Medicare Action Group:

> A mother with three children in a large town in regional Victoria cannot afford to access a GP for herself and three children when they all have the flu. The total cost would be $160 plus pharmaceuticals. She simply doesn't attend. As the problem worsens she attends the emergency department of a hospital.
>
> A person attending a GP practice in a country town owes the GP money and is scared to re-attend the GP. A welfare agency intervenes to assist the person access a GP service. The nearest bulk-billing practice is over an hour away.[84]

4.79 Professor Picone, Deputy Director General NSW Health, argued strongly that many presentations to A&E were not necessary:

> Already one in five people who attend emergency departments are people who should be visiting GPs. I will give you some examples: 9,000 people went to emergency departments for the treatment of coughs, colds and sore throats; 2,800 for earaches and 900 for wax in the ears. In the old days, surely this was the domain of the general practitioner. Significant differences between regions in community access to Medicare is also evident. We undertook a survey last year to look at the variation, and we found that in towns where there was no bulk-billing, people accessed our

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82 See, for example, Queensland Government, Submission 32, p. 6, Victorian Council of Social Service, Submission 95, p. 4, NSW Dept of Health, Submission 154, p. 9, Ms Stephens-Green, Submission 167, p. 1

83 Ms Smyth, *Proof Committee Hansard*, Bundaberg, 25 August 2003, p. 42

84 Victorian Medicare Action Group, Submission 64, p. 2

> emergency departments 60 per cent more than in towns that had bulk-billing.[85]

Delays in consultation cause general deterioration of problems with greater long term costs and hospitalisation

4.80 General practitioners play an important 'gatekeeper' role, facilitating the effective and timely referral and/or treatment of cases as they become apparent to the patient. Delays in visiting a GP can lead to a delayed diagnosis which in the longer term can lead to greatly increased social and medical costs: eg. delayed diagnosis of an infectious disease such as Rotor virus could result in numerous other infections, or delays in having a mole checked, or a smear test, could lead to skin or cervical cancer:[86]

> [W]e have learned that patients can wait for weeks for a consultation, that some GPs have 'closed books' and a person has to wait until a patient of that practice dies or moves away or changes doctors. Again, it is the local hospital that then has to bear the brunt of such shortages, or the patient simply decides it is not worth the hassle, often with consequences for the community as well as for the patient and his/her family.[87]

4.81 Lack of access to a GP affects not only patients with acute conditions. A number of submissions pointed out the very real challenges continually faced by those with chronic conditions. In the rural context, the situation was described as follows:

> When we are dealing with major physical ailments or accidents, rural communities can access help generally through ambulance, flying doctor or a neighbour who will drive the patient to a hospital. But when we are dealing with ongoing and/or long term medical concerns, especially mental health problems, the need for a general practitioner as a first stopping place is often crucial and in many communities, non-existent.[88]

Reduced capacity to provide preventative health care

4.82 Despite the increased emphasis on preventative health care, and an awareness of its human and economic benefit, health care providers find it difficult to allocate sufficient time to its implementation:

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85 Associate Professor Picone, *Proof Committee Hansard*, Sydney, 22 July 2003, p. 82

86 See, for example, Health Consumers Council, Submission 62, p.1. See also Dr Robinson, Submission 4, pp. 1-2

87 Country Women's Association of NSW, Submission 68, p. 4

88 Country Women's Association of NSW, Submission 68, p. 3

> It takes longer to tell someone that they need to exercise more, eat less fatty food et cetera, than to write out a script for a pill for their cholesterol.[89]

4.83 Given the increased focus on the positive implications of investing in preventive health, the reduced capacity has potentially serious consequences for Australia's disease burden, and augurs badly for the successful increase in the role of preventative health as an investment in a healthy future. [90]

Conclusion

4.84 Access to effective, timely and affordable 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 patients' economic or geographic situation.

4.85 The Committee considers that the increasing shortage of access to GP services presents a considerable threat to both the short- and long-term health of Australians. Members recognise the need for readily accessible care in the treatment and prevention of both acute and chronic conditions, and the importance of the economic implications stemming from their neglect.

4.86 Analysis of access issues reveals the shortage of doctors to be significant. The falling rate of bulk-billing and the level of the MBS rebate pose real problems for those Australians who rely on MBS-funded services. To maintain the health of these individuals, as well as that of nation as a whole, bulk-billing availability must be restored to all Australians as a matter of urgency.

4.87 The Committee found a range of factors which together served to constrict access for patients. These included a consistent increase in GP attendances over time, which had not been matched by new entrants to the profession. A fair proportion of these 'new' attendances were the result of an increased focus on prevention, which the Committee applauds as a worthwhile investment in Australia's future good health. Other causes relate to structural changes in the way Australians seek and receive care, including a move away from hospital-based care, and the needs of an ageing population. From the perspective of demand, these were the main drivers.

4.88 On the supply front, it is clear that the Australian GP workforce is suffering from the restrictions and reductions placed on medical school places and provider numbers during the mid-1990s. It is also clear that the average age of GPs is increasing, and that many are on the doorstep of retirement. The Committee accepts that there is a perception that the MBS rebate is inadequate, and that this has served to discourage participation in general practice by both new graduates and existing practitioners. The Committee's views on the rebate are contained in Chapter 12.

89 Dr Moxham, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 11

90 See "A move towards prevention", above.

Finally it is apparent and pleasing that more practitioners are now structuring their working lives around external factors, such as family and lifestyle choices, but that they are tending to work slightly shorter hours as a result.

4.89 The implications of the shortage in relation to access do not only affect timeliness and quality of care, but also affordability through the reduced attractiveness of bulk-billing to GPs during times of under supply. The Committee concludes that the bulk-billing rates are predominantly a product of the level of the MBS rebate, as well as the relative supply of practitioners. Further, there is a view that some doctors are inherently opposed to bulk-billing. Along with this is the perception that current government policy implicitly supports private billing practice. Any successful strategy to restore bulk-billing rates to previous levels must address all of these variables.

CHAPTER 5

'A Fairer Medicare' Package

The government's A Fairer Medicare package aims to make out-of-hospital medical care more affordable, more accessible and more convenient for all Australians.[1]

Introduction

5.1 Paragraph (c) of the Terms of Reference calls for the examination of 'the likely impact on access, affordability and quality services for individuals, in the short- and longer-term, of the … Government-announced proposals'. This chapter gives an overview of these proposals and the provisions of the Health Legislation Amendment (Medicare and Private Health Insurance) Bill 2003 ('the HLA Bill') that would give effect to elements of the government proposal. A detailed examination of the package is contained in the following chapters.

The Government's proposed changes to Medicare

5.2 The government released 'A Fairer Medicare' package as part of the May 2003-04 Budget. The package is designed to be an integrated set of measures which builds on the Government's commitment to the universality of Medicare will make a range of medical services more affordable, particularly those delivered through general practice.[2]

5.3 The 'A Fairer Medicare' package has a budgeted cost of $916.7 million, and contains measures that aim to reduce the overall costs of accessing health care, particularly for concession card holders, and additional measures to improve access to health care, particularly in areas of medical workforce shortage in outer metropolitan and rural areas. The measures fall into three general categories:

- changes to the methods of payment and rebate;
- introduction of new safety nets; and
- workforce measures.

Changes to methods of payment and rebate

5.4 The package introduces the General Practice Access Scheme (GPAS). Under the scheme, practices that commit to bulk-billing all Commonwealth concession card holders will receive incentive payments of $1.00 per consultation in capital cities,

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1 Mr Davies, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 67

2 Senator the Hon Kay Patterson, *Medicare – for all Australians*, Budget Papers, May 2003

$2.95 in other metropolitan areas (such as Geelong or Newcastle), $5.30 in rural centres (such as Toowoomba, Cairns or Broken Hill) and $6.30 in other rural and remote areas (such as Coonabarabran, or Mt Isa).

5.5 Participating practices will be able to receive the rebate amount directly from HIC Online via electronic billing arrangements, with payment time reduced from eight to two days. Where there is a charge above the Medicare rebate fee, the patient will pay only the gap .

5.6 Participating practices will also receive a payment of $750 in metropolitan areas, and $1000 in rural and remote areas, to assist in the costs of setting up computer systems for using HIC online. It is also intended that practices in more remote areas will benefit from other, government wide, initiatives to develop broadband connectivity in rural and remote areas.[3]

5.7 These measures will cost $346.2m and $24.3m respectively, over four years.

5.8 The legislative changes necessary to give effect to the General Practice Access Scheme are contained in Schedule 3 of the HLA Bill 2003, and involve amendments to the *Health Insurance Act 1973*. A key change is the new subsection 20A(1A) in the *Health Insurance Act 1973* enabling a GP to receive an assignment of a Medicare benefit from a non-concessional patient, and if the general practitioner chooses to do so, charge that patient a copayment at the same time.

New safety nets

5.9 Under the proposed scheme, two new safety nets will be created. The first applies only to Commonwealth concession card holders, who will be reimbursed 80% of all out-of-pocket expenses once a threshold of $500 is reached. The program is budgeted at $67.1m over four years.

5.10 The legislative changes for the proposed safety net are contained in Schedule 2 of the HLA Bill 2003, and involve amendments to the *Health Insurance Act 1973*. In particular, the Bill inserts a definition of 'concessional person' in section 8 of the Act, and new sections 10ACA (to establish the new concessional safety net for families with a concessional member) and 10ADA (to establish the new concessional safety net for individuals).

5.11 For non-Commonwealth concession card holders, private health insurers will be able to offer a new product which extends insurance cover to include the out-of-pocket cost of Medicare funded out-of-hospital services, once a threshold of $1000 per family is reached in a year. This will cover the cumulative cost of the 'gap' between the Medicare rebate and the doctor's fee for out-of-hospital services. Access to this product will be supported by the 30% private health insurance rebate. The

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3 Mr Davies, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 52

government estimates that the insurance will cost around $1 per week for a family. The program is expected to cost $89.6m over four years.

5.12 The legislative changes for this second safety net are contained in Schedule 1 of the HLA Bill 2003, and involve amendments to the *Health Insurance Act 1973,* the *National Health Act 1953*, and the *Private Health Insurance Incentives Act 1998*.

Workforce measures

5.13 The package provides several measures aimed at increasing the supply of the medical workforce to outer metropolitan and rural areas of workforce shortage. The proposals include funding for 234 additional medical school places each year – amounting to a 16% increase in overall places – with students being required to work for a period of six years in areas of workforce shortage on completion of their training. In addition, 150 extra training places for GP Registrars will be provided each year – a 30% increase – targeted to areas of workforce shortage. These measures will cost $42.1m and $189.5m respectively, over four years.

5.14 The package also provides funding for up to 457 full time equivalent nurses to be employed in participating general practices. Practices may also elect to employ allied health professionals instead of nurses, where appropriate. This measure will cost $64.2m over four years.

Veterans and the Local Medical Officer scheme

5.15 The package changes current arrangements by enabling GPs registered with the Local Medical Officer (LMO) scheme to receive a veteran access fee of $3 for each consultation with an eligible veteran or war widow, in addition to the 100% of the MBS fee currently paid. This program will cost $61.7m over four years.

CHAPTER 6

Proposed billing arrangements

> *Any health system should be judged not on what level of care can be received by those with money and influence, but by the level of care offered to, and received by the vast majority of those who have the least amount of money and influence in society.*[1]

Introduction

6.1 A key aspect of the Government's 'A Fairer Medicare' package is the General Practice Access Scheme (GPAS). Under the scheme, practices that commit to bulk-billing all Commonwealth concession card holders will receive an incentive payment for each concessional patient bulk-billed. Payments vary according to location and are set at $1.00 per consultation in capital cities; $2.95 in other metropolitan areas (such as Geelong or Newcastle), $5.30 in rural centres (such as Toowoomba, Cairns or Broken Hill) and $6.30 in other rural and remote areas (such as Coonabarabran, or Mt Isa).

6.2 Participating practices will also be able to receive the rebate amount directly from HIC Online via electronic billing arrangements, with payment time reduced from eight to two days. Where there is a charge above the Medicare rebate fee, the patient will pay only the difference.

6.3 To assist in the costs of setting up computer systems that can connect with HIC online, participating practices will receive a payment of $750 in metropolitan areas, and $1000 in rural and remote areas. It is also intended that practices in more remote areas will benefit from other, government wide, initiatives to develop broadband connectivity in rural and remote areas.[2]

6.4 The General Practice Access Scheme is budgeted to cost $346.2 million over four years.

6.5 This chapter examines the GPAS in more detail and considers the likely outcomes when measured against the terms of reference – the viability of, and the access to, general practice.

The reaction of General Practice

6.6 The Government's 'A Fairer Medicare' proposal has not been well received by general practice, with the Committee receiving evidence from both individual

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1 Dr Carter, Submission 19, p. 1

2 Mr Davies, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 52

practitioners and all major GP professional groups that there are significant problems with the package. These criticisms are reflected in the evidence that nationally, less than 20% of GPs are likely sign up to the package.[3] Dr Walters of the Australian Divisions of General Practice told the Committee:

> ADGP did a national survey which generated 800 responses. This is an almost unheard of number for this sort of thing, in our experience. It came back pretty overwhelmingly that GPs did not support it.[4]

6.7 As a representative of the Ballarat Division of General Practice concluded:

> [T]he package just doesn't go far enough; it's skewed too far in terms of the political issues for us to take it on. A very small number of our GPs – two or three out of 90 – have responded by saying that they would be interested in looking at the package.[5]

6.8 From the perspective of GPs, the key problem with the package is that it does not make financial sense. This conflicts with the claims of the Minister and officers of the Department of Health and Ageing. Mr Davies, representing the Department, told the Committee:

> The financial incentive payments have been carefully designed to ensure that the vast majority of practices will be better off by joining the scheme.
>
> … This table shows the net gain in income for practices participating in the General Practice Access Scheme.[6] No two practices are the same, so we have had to make some assumptions. We have assumed a practice with about 10,000 annual concessional services, which is close to the national average, and we have assumed that those concession card holders are currently charged a gap of $10, which is actually a little above the average for concessional patients who do pay a gap. This table shows that the net additional income to practices can be quite substantial. I emphasise again that these are net gains after subtracting any forgone income from the practice ceasing to charge gaps that are currently levied on patients covered by a concession card.[7]

6.9 Mr Davies explained how the incentives were calculated:

> The process underlying that is, basically, careful examination of the current level of gap charges levied from concession card holders. Then we assumed that a practice that signed up would forgo that income from patients who

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3 Estimates from GP polling varies – see for example: Queensland Division of General Practice, Submission 146, p. 4

4 Dr Walters, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 58

5 Mr Howard, *Proof Committee Hansard*, Melbourne, 27 August 2003, p. 56

6 See DoHA, Submission 138, p. 37 – Table 7

7 Mr Davies, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 8

hold a concession card, and the job of the incentives is to replace the income that they lose.[8]

6.10 Overall, the government has geared these calculations with the intention of providing the majority – about 75% – of GPs with an incentive to sign on. It considered that efforts to provide inducements for the final group at the margin become too expensive:

> The higher that proportion is set, the more the government will be spending on increasingly fewer doctors who are increasingly harder to persuade because they are already charging significantly higher gaps. The level of deadweight loss goes up; the level of additional new doctors for each extra dollar goes down.[9]

6.11 However, most GPs do not agree. Dr Sprogis, in Newcastle, for example, explained why:

> It is really very straightforward. The current co-payment for patients now roughly ranges between $10 and $30, and for those who are in the cardholders category that the government is proposing that would be roughly $10, and I think the offer is $3. You do not have to be a rocket scientist to work out the difference.[10]

6.12 Similar comments were made by Professor Charlton on the Central Coast, who found in a member survey of their Division of General Practice that only 17 percent would opt in:[11]

> For the vast majority, 85 per cent of our consultations are what is called level B consultations and it is on those that we charge the gap ranging from $5 to $15. … if our practice took up the government's initiative it would be $30,000 per year out of pocket. Fifty per cent of our patients are health care card holders. Practices which have a higher proportion – 70 per cent – would be $60,000 to $80,000 out of pocket if they took on the government's initiative. You would have to be mad to go backwards by that amount.[12]

6.13 Dr Boffa, from the Aboriginal Medical Services Alliance of the Northern Territory (AMSANT), observed that some of Australia's richest GPs are rural GPs:

> [W]here there are so few doctors and there is so little competition, they can charge a lot, and they do. … When she went there, the minister was told by all the private practices that they will not take up her package. One GP said, 'Thank you very much. I charge concession card holders and pensioners $50

8 Mr Davies, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 70

9 Mr Stuart, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 71

10 Dr Sprogis, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 26

11 Professor Charlton, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 57

12 Professor Charlton, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 56

an hour. Why should I accept $33? It is an extra six dollars. I am not going to do it.'[13]

6.14 Dr Boffa summed up:

So the package, unfortunately, is not going to solve the problem because the GPs in areas of undersupply are already making such an amount of money that they are not going to accept reducing their income.[14]

6.15 Whether or not the package provides a real financial incentive for practices to sign on therefore depends principally on whose figures are to be believed. It is quite possible that the conflicting estimates of the effect of the package on GP incomes derives from inaccurate perceptions within the medical community in relation to what percentage of patients, and concessional patients, they currently bulk-bill.

6.16 Mr Stuart of the Department of Health and Aged Care, noted that about 10 per cent of doctors bulk-bill everybody, about 10 per cent bulk-bill nobody and about 80 per cent bulk-bill somewhere in between. Part of the problem is:

[I]f you listen to what GPs are saying, it is very difficult to understand how that number [the total bulk-billing rate] could be as high 68 per cent. After having had discussions with some GPs in different parts of the country, it is my belief that a part of the reason for that is that individual GPs are not always aware of the level of bulk-billing in their practices or of the proportion of concessional patients they are seeing in their practices. To an extent, some of those issues are dealt with by the front of house staff rather than by individual GPs, or GPs are making case-by-case decisions as patients come to see them but are not necessarily aware of how those numbers add up for their practice over time.[15]

6.17 Evidence from Dr Moxham, of the Australian College of Non-Vocationally Registered GPs, supported this view:

People say, 'I charge everybody,' but, when you actually go through who they do not charge, you find that they do not charge the clergy and they do not charge veterans and they do not charge health care card holders. Their average is less than what they actually say.[16]

Other issues

6.18 The Committee also notes several practical difficulties that may emerge with implementation. The first stems from the requirement that whole practices sign onto

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13 Dr Boffa, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 50

14 Dr Boffa, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 50

15 Mr Stuart, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 77

16 Dr Moxham, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 3

the package rather than individual doctors. Dr Bain of the AMA explained how this could cause difficulties:

> For practices that mix and match, with maybe a female GP coming in on Wednesdays to see female patients … every doctor who attends that practice will have to be prepared to sign-up. Getting a practice to sign-up to the package which might have seven or eight doctors rolling through it in the space of a week, and their locums and everybody else associated with it, will add a layer of extreme complexity to the whole exercise.[17]

6.19 Mr Grieves, from the Mackay Division of General Practice, commented on a problem that could arise during the roll-out of the package, where only a limited proportion of practices sign-on. He expressed concern at the effects on patient mix for the minority who do sign on:

> They are worried that if they take it up and the other practices around them do not, their practices will actually be altered in the terms of the patient mix and the number of patients within their practices who will be private billing in the future. The department has been asked about what will happen if a certain percentage of practices take it up within a region versus a very high proportion. They really have not done the modelling for that. The division is very worried that if there is only a small number of practices that take it up, those practices will be overwhelmed and patients will then be frustrated that the other practices have not taken it up.[18]

Conclusion

6.20 In spite of the department's modelling, it is clear that a large proportion of doctors in general practice do not consider the incentives in the government package to be sufficiently attractive to entice them to sign-on. The fact remains that irrespective of who is right, the package will not be workable if the majority of the medical profession do not sign-on.

Bulk-billing for Commonwealth Concession Card holders

6.21 As shown above, a key objective of GPAS is to ensure that holders of Commonwealth Concession Cards have access to bulk-billing. As Mr Davies told the Committee, this is an important focus of the government policy:

> This is, in fact, the first time since the launch of Medicare 20 years ago that those most in need have been offered a guarantee of bulk-billed services at specific practices. Secondly, A Fairer Medicare will reduce patients' out-of-

17 Dr Bain, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 33: see also Dr Gault, Submission 6, p. 2

18 Mr Grieves, *Proof Committee Hansard*, Bundaberg, 25 August 2003, p. 35

> pocket costs. Any patient who is charged a gap by their GP at a participating practice will leave the surgery with no more to do and no more to pay.[19]

6.22 However, numerous submissions have criticised the package for its focus on measures to guarantee bulk-billing rates for holders of Commonwealth Concession Cards. The objections focus on four key issues. Firstly – and critically – the policy steps away from the principle of universality of Medicare. Secondly, the proposal may be an attempt to solve a non-existent problem. Thirdly, a focus on concession card holders is not a useful or accurate measure of the need for medical services in the community. Finally, the proposed solution may itself act to create a differential lower level of health care for concession card holders.

A step away from universality?

6.23 A fundamental question is whether the government *should* create a policy that has the objective of achieving bulk-billing for concessional patients as distinct from the general population, and allocates higher rebates for concessional patients as the means to achieve this end.

6.24 Many critics of the policy described it as a move away from the fundamental principle of universality that underpins Medicare. As Mr Gregory of the National Rural Health Alliance asserted: 'As soon as you select any group you lose universality'.[20]

6.25 Whether or not the policy does run counter to the principle of universality depends on how 'universality' is understood. According to the government, universality is maintained, as Mr Davies explained:

> [U]nder 'A Fairer Medicare' that payment remains universal and it remains uniform. For all Australians who are entitled to the MBS, the level of rebate paid to the patient remains the same and it remains uniform.

6.26 He acknowledged the distinction, continuing:

> The incentive payments are paid to the practice. One might argue that that is a pretty fine distinction to be making, but it does remain the fact that the insurance coverage is universal and payments under that insurance coverage are uniform.[21]

6.27 In examining the concept of 'universality', it is useful to take into consideration the comments of Professor Richardson:

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19 Mr Davies, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 67

20 Mr Gregory, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 33

21 Mr Davies, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 35

> There are two quite distinct value systems which get confused in Australia so it makes it quite hard to separate them. One of them, which is associated with the left wing and the Labor Party traditionally, is what Europeans would call 'solidarity' – sometimes called 'communitarianism'. That is a social philosophy that says that certain commodities, certain activities, should not be part of the economic reward system – defence, law, public parks et cetera. The second value system is the liberal, libertarian value system which says that individuals should look after themselves as far as possible and the government will step in as a safety net. The implication of what has occurred is that we have set up a mechanism for transfer from the system of solidarity through time to a more liberal, libertarian social welfare system.[22]

6.28 Ms Flannery, from Queensland, described the package in similar terms:

> [T]hese changes signify a shift in the social philosophy and social principles undergirding our society. The Medicare scheme until now has been informed by an acceptance of community responsibility for the health care system, a commitment of Australians to Australians, …
>
> The proposed new system, on the other hand, takes the line that individuals can – and should – best look after themselves, and that the role of government is to provide a safety net for those exceptional people who can't.[23]

6.29 The Committee shares the view of most witnesses that the introduction of GPAS moves Medicare from being a universal health insurance scheme into a safety net system for concession card holders. Even if the establishment of such a change in philosophy were supported, evidence of low take-up and administrative difficulties suggests that it would be a largely ineffective one.

Is it a problem that needs to be solved?

6.30 Given the government's focus on providing bulk-billing for concessional patients, an important starting point in assessing the package is whether there is actually a need to design measures around this policy objective. According to the government, the current rate of bulk-billing disguises inequities in the system:

> [W]hether you will be bulk-billed depends, more than anything else, on where you live. Bulk-billing rates today are more a reflection of the number of GPs practising in a locality than the ability of patients in that locality to pay the GP's fees. We note in our submission that, as a general rule, people

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22 Professor Richardson, *Proof Committee Hansard*, Melbourne, 24 July 2003, p. 79

23 Ms Flannery, Submission 20, p. 1: see also Women's Health Victoria, Submission 45, p. 3; Missionary Sisters of Service, Submission 9, p. 1

> in cities are much more likely to be bulk-billed than those people outside cities.[24]

6.31 The government's argument therefore, is that some people who most need the bulk-billing are less likely to get it, while others who may not need it receive it, simply by accident of where they live.[25]

6.32 However, evidence given to the Committee makes it reasonably clear that the government is attempting to resolve a non-existent problem. Professor Richardson, in an article for the Australian Financial Review, argued that:

> The changes to Medicare have been introduced because, it is claimed, that they will 'improve the availability of bulk billing for concession card holders'. In December 2002, 81% of GP bills for people over 65 were bulk-bills. In rural areas the figure was between 65% and 75%. The average copayment for all persons above 65 was 94 cents. It is worrying that such a fundamental change has been introduced to solve a problem that does not seem to exist.[26]

6.33 The West Australian government made a similar observation:

> Most general practitioners already provide bulk-billing for the majority of pensioners and cardholders. The new measures are unlikely to impact significantly to the way these groups pay for their services.[27]

6.34 These views were borne out by figures produced in the report to the Committee by the Australian Institute for Primary Care. Table 6.1, reproduced from the report, shows that concessional patients, representing 34.8 per cent of the population, use 49.7 per cent of GP services overall. According to Professors Duckett and Swerissen, the figures indicate that in practice, most concession card holders are currently being bulk-billed, even in rural and remote Australia where the bulk-billing rates are much lower.[28]

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24 Mr Davies, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 68

25 for a detailed examination of bulk-billing rates, see chapter 4

26 Professor Richardson, Submission 52, Attachment: *The Amendments to Medicare of 28 April*, AFR, 6 May 2003.

27 WA Government, Submission 177, p. 9

28 Profs Swerissen and Duckett, *Proof Committee Hansard*, Canberra, 23 September 2003, p. 8

Table 6.1 Incidence of Concessional Health Card holders by geographic area[29]

	HC Card	Proportion of GP services used	Current bulk-billing rates
	%	%	%
Major Cities of Australia	31.7%	45.3%	72.3%
Inner Regional Australia	41.8%	59.8%	54.4%
Outer regional and remote Australia	40.1%	57.4%	54.7%
Total	**34.8%**	**49.7%**	**70.0%**

6.35 This conclusion was reinforced by anecdotal evidence from many doctors that even in private billing practices, a policy of discretionary billing is followed in which concessional patients are either bulk-billed or charged a lower rate.[30]

Concession Cards as a measure of need

6.36 Another underlying question is the extent to which concession cards provide an accurate basis on which to determine social need. This question concerned a great number of witnesses to the Inquiry, who raised three main issues: first, that those who hold concession cards are frequently not in any genuine need; second, that a system that focuses on concession cards will miss many other genuinely needy people; and third, that by allocating more financial support to those with concession cards, the government indirectly creates an incentive for people to remain in concessional categories.

6.37 There are three types of concession card relevant to the discussion: the Health Care Card; the Pensioner Concession Card; and the Commonwealth Seniors Health Card. There are in the order of seven million cardholders in Australia across the three categories.[31]

6.38 Various witnesses to this Inquiry expressed the opinion that the concession card is a poor measure of social and financial need. Dr Parker told the Committee:

> One of the problems I have with the health care card system is that it is based on your taxable income. Many people who have got good accountants can offset their tax to such a point that they are on a health care card, and yet

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29 AIPC Report to the Select Committee on Medicare, p. 22

30 See for example: Dr Del Fante, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 95; Prof Charlton, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 56; Dr Walters, *Proof Committee Hansard*, Hobart, 31 July 2003, p. 10

31 Deb Richards, *Card sharps*, Australian Doctor, 18 April 2003, p. 21

> they are employed in good jobs with good houses and good cars and they come in with a health care card.[32]

6.39 The Hon. Wendy Edmond, Queensland Minister for Health, expressed a similar view that:

> [S]ome people who hold concession cards – for instance, people on seniors benefits who may be self-funded retirees – may actually have a better ability to pay a gap than a person on a single income with three small children who all have asthma at the same time. [33]

6.40 The second issue addresses the opposite problem: not only may some concession cardholders not genuinely need them, but many who do face significant problems meeting the costs of accessing health care, are not entitled to any concession card. This problem arises from where boundaries are drawn, and affects any program that provides different entitlements for different categories of people. As Professor Duckett explained:

> A focus on pensioners and Health Care cardholders also will inevitably cause problems at the margin: working families not eligible for Health Care cards could find it difficult to access medical services without financial barriers. By definition, a targeted scheme creates a boundary line with people on one side of the boundary having access to the program, and people on the other not so entitled. A boundary line will always cause problems at the margin, where small increments in income could lead to large reductions in entitlements, creating a powerful disincentive to earn that marginal income increase. Boundary problems are particularly important in health care where there is an association between lower income and poorer health status. [34]

6.41 A differential program therefore creates winners and losers. Witnesses gave examples of the types of people who are likely to find themselves losers under the proposals. The Rural Doctors Association argued that:

> It is simplistic to assume that all those who have a higher need for care and a lower capacity to pay for it are covered by concessional health care cards.[35]

6.42 Dr Powell, the Principal of a General Practice in Bundaberg, related the experience of single income families:

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32 Dr Parker, *Proof Committee Hansard*, Bundaberg, 25 August 2003, p. 29

33 The Hon Ms Edmond, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 21

34 Professor Duckett, Submission 93, p. 3

35 RDAA, Submission 101, p. 5 see also: Australian Greens, Submission 100, p 8; SA Divisions of General Practice, Submission 33, p. 2; Women's Health Victoria, Submission 45, p. 6

> They may have three or four children, one or two of whom have a chronic illness. We find that they are a particularly financially distressed group who do not always fit the criteria for a health care card.[36]

6.43 These problems are particularly likely to affect those in industries in which there are high levels of underemployment and part time work. Ms Dorron, a nurse in Bundaberg, gave evidence of this problem in the field of aged care nursing:

> At my workplace 76 per cent of the nursing positions are part time. …the wages earned put these workers on the middle line whereby they earn too much to be eligible for Centrelink concessions such as the health card and the benefits of bulk-billing accorded to concession card holders. Consequently, they have to pay for visits to the GP – and in Bundaberg the average cost of a standard non-bulk-billing consultation ranges from $32 to $42, with the average consultation being $38.30. This significant shortfall means that people think twice before attending a doctor, when one also must take into account the cost of medication and other health services such as pathology or X-rays. For these families, health is becoming an either/or option. These are the people on the margins who will fall through the cracks with changes to the Medicare system.[37]

6.44 Sometimes, the rules can operate to the detriment of people in ways that are not immediately obvious. Professor Duckett gave one example of this:

> Typically, boundaries are set based on income limits but again for the poor, income can change rapidly as families drift in and out of employment. Poorer families are less well able to predict income variations, which can cause significant problems.[38]

6.45 Dr Boffa of the AMSANT gave another example from his practice area:

> The other point is that if you have one salary earner in a family and the family is large – Aboriginal families are still large extended families with large numbers of children – you might have someone earning $40,000 having to support 10 other people, and they will not get a health care card.[39]

6.46 The Consumers' Health Forum also warned that the creation of these boundary problems may run counter to the objectives of other Commonwealth health programs:

> Increases in out-of-pocket health care costs are a particular problem for people with high health care needs who are on low incomes or for families

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36 Dr Powell, *Proof Committee Hansard*, Bundaberg, 25 August 2003, p. 29: see for example Ms Hamill, Submission 41, p. 1

37 Ms Dorron, *Proof Committee Hansard*, Bundaberg, 25 August 2003, p. 40

38 Professor Duckett, Submission 93, p. 3

39 Dr Boffa, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 59

> with dependent children. Many of these individuals and families do not qualify for health care cards, for example, people who continue to try to work despite chronic or episodic health conditions. This large number of consumers would include most consumers targeted by the national health priority areas (asthma, cancer, cardiovascular health, diabetes, injury prevention, mental health, arthritis and musculoskeletal conditions).[40]

6.47 The third issue relates to the likelihood that a focus on providing benefits to concession cardholders provides a perverse incentive for those who are in a concessional category to avoid any changes that may result in the loss of that concessional status. According to the Tasmanian Organisation of Employment Seekers:

> One of the greatest mental barriers to overcome for many parents who are recipients of welfare payments, is a fear that if they were to obtain work and so no longer be eligible for a pension or a health care card, they would not be able to afford to obtain medical assistance for their children were they to become ill. … many people within this category would be happier to be in work, but feel that as things presently stand the responsibility they have to their families to ensure that they can access medical care, precludes them from entering the workforce.[41]

6.48 Finally, the Committee notes the concern raised by several doctors that there is considerable contractual uncertainty for any practice that signs onto GPAS. Participating practices are required to give an undertaking to bulk-bill all concession card holders but calculating the implications of this undertaking is difficult when the government is able at any time to vary the conditions of entitlement and thus, the number of beneficiaries under the system.[42]

Government view of concession cards

6.49 In defence of the concession card, Mr Davies, from the Department of Health and Ageing, responded that:

> The three concession cards that the GP access scheme component of 'A Fairer Medicare' works on are the same three concession cards that give entitlement to the lower rate of Pharmaceutical Benefits Scheme copayment, so ultimately there is an issue of consistency across the spectrum of Medicare.[43]

6.50 The obvious challenge, if some targeted measure is to be applied, is to find a better alternative. According to the Department, the criteria for any such alternative

40 Consumers' Health Forum, Submission 102, p 3

41 Tasmanian Organisation of Employment Seekers, Submission 139, p. 3: see also Council on the Ageing National Seniors Partnership, Submission 98, p. 7

42 ADGP, Submission 37, p. 2; Dr Alexander, Submission 11, p. 1; Dr Gault, Submission 6, p. 2

43 Mr Davies, *Proof Committee Hansard*, 28 August 2003, p. 82

are administrative simplicity, predictability and fairness. Mr Davies pointed out to the Committee the problems meeting these criteria. He explained that:

> [W]e looked at a variety of different ways of targeting. One that we had to consider was a new card, if you like – a new set of concession conditions. What became very obvious then was that, in operating a whole new set of income and asset testing, issuing new cards and maintaining those cards, keeping them up to date and linking the database to the HIC, we probably would have spent quite a considerable proportion of what we are now planning to spend on doctors and subsidies for patient care.[44]

6.51 The Department also considered using other measures, such as the Australian Bureau of Statistics SEIFA ratings (Socio-Economic Indices For Area, of which there are five), however the internal variation within postcodes of income, even in low SEIFA areas, was found to be much higher than that of income within these concession card groups.[45]

6.52 The Department concluded that, overall, it is very difficult to find a better predictor of low income status:

> These three cards, taken together, best pass that test. We know who the people are; they are readily identifiable. There is a direct relationship to other policy in the same area in relation to the PBS. They all have cards by which they can readily be identified at a GP surgery and so on. … The level of homogeneity within these three cards taken together is actually pretty good and you know quite a lot about their income status.[46]

6.53 The Committee acknowledges the wider issues of the appropriateness of selectively targeting concessional patients, but agrees with the Department's view of concession cards. While there are undoubtedly some problems with the allocation of cards, to develop an entirely new card for Medicare purposes would be costly in terms of administration. In general terms, concessional cards are also almost certainly a more accurate basis for determining need than *ad hoc* decisions by GPs made on the basis of impressions of wealth, which can be misleading and inaccurate.[47]

Restricted access for concession cardholders?

6.54 While concession cardholders are the intended principal beneficiaries of 'A Fairer Medicare', there are fears that the policy may in fact operate in ways that exclude concessional patients. This concern arises out of the potential for practices to

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44 Mr Davies, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 85

45 Mr Davies, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 82

46 Mr Davies, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 82. This view is shared by Dr Moxham, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 5

47 see for example Sen Knowles' comments, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 4

limit the percentage of concessional patients they accept, because they earn the practice less than full private patients.

6.55 This arises in part from the observation that the government scheme is likely to be more attractive to practices with a low percentage of cardholder patients. As the AMA's Dr Rivett told the Committee:

> It is a dream scheme if you have a small practice under the Centrepoint Tower in Sydney and you are dealing with business people who are all fit and healthy and coming in for check-ups, overseas travel and other things. It just hits the nail on the head for you. But, for the general practitioners out there servicing most of the population, it is not a way forward at all. In a few isolated cases, it will be very attractive to them.[48]

6.56 The point was extended by Dr Merigan in his submission:

> [P]ractices instead of seeing more card holders, would be economically influenced to not see new patients if they were card holders, and indeed, make it harder and harder for card holders to attend the practice. This would leave these patients with no where to go – other nearby bulk billing and obviously busy practices wouldn't want them, and they might not be able to afford to go to private billing clinics.[49]

6.57 In summary, practices with only a small percentage of concessional patients on their books could sign up, accept all the benefits of the package such as direct electronic payment of the rebates and practice nurses, and charge the majority of their patients a copayment, with only the requirement to bulk-bill their few concessional patients.[50] The AMA's concern with the government package was that:

> [I]t will provide a clear junction in health care, where we will see opt in practices providing for the less well-to-do and opt out practices providing for the others, and we will have two tiers of care in Australia. We will walk away from our universally funded health access.[51]

6.58 The Rural Doctors Association also saw the changes as encouraging a:

> [C]lear cut distinction between cardholders and other patients. Sadly, some doctors and/or their staff believe that patients who pay up front or contribute a copayment are more important than those who do not. … under the proposed changes the likelihood of cardholders receiving a second rate

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48 Dr Rivett, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 50

49 Dr Merigan, Submission 122, p. 1

50 see discussion Sen Lees, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 73

51 Dr Rivett, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 40: see also NSW Retired Teachers Association, Submission 23, p. 1

> 'safety net' standard of care, with reduced or delayed access to care, will be increased.[52]

Problems with access to After Hours services

6.59 The AMA's Dr Bain raised an additional problem:

> [D]octors who used to charge a co-payment on weekends or after hours, if they opt-in, will no longer be able to do that with concession cardholders. … So the incentive to be open at those times would be reduced and we expect that there would be a fall-off in the services that will be offered after hours by doctors who opt-in.[53]

6.60 As was discussed in Chapter 3, there are already significant problems in many parts of the country in accessing after-hours medical care from general practice, with supply of these services influenced by the long working hours and in some cases, safety concerns. These supply shortages are reflected in the often substantially higher than normal up front payments required to see a GP after hours. If, under the terms of their agreement with the government, GPs are prohibited from charging any gap payment to concessional patients (who, it will be remembered, account for around fifty percent of GP services) the effect is highly likely to be a dramatic further reduction in the availability of after hours services by GPs – as the AMA warned. This in turn, is likely to further drive up demand at public hospital accident and emergency departments.

6.61 The Department is aware of this problem and one suggested solution is the After Hours Primary Medical Care Program, which provides funding of $43m for a series of 85 trials, and of which the Hunter region service is an example.[54] Another solution is the splitting of practices, as Mr Davies explained:

> Some GPs may work in one practice during the day and in another one after hours … the daytime practice may register for the GP access scheme but the after-hours cooperative may choose not to do so. Basically, if anything, I think it adds a degree of flexibility to the way in which GPs organise their practices and their billing practices.[55]

6.62 However, for many GPs this would result in the need to maintain several sets of accounts, and the associated burden of complying with taxation, audit and other business administration. As suggested by the Department, some GPs may already be

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52 RDA, Submission 25, p. 2

53 Dr Bain, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 34: see also the comments of the Ballarat Division of General Practice – Mr Howard, *Proof Committee Hansard*, Melbourne, 27 August 2003, p. 56

54 Mr Davies, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 84. The Hunter Region services are discussed in greater detail in chapter 11.

55 Mr Davies, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 85

doing this, voluntarily, but the Committee does not support a policy that would institutionalise incentives to create more complex business structures.

Access to GPs for non-concession card holders

6.63 The proposed measures also have important implications for the access to general practice for those who do not have a Commonwealth Concession Card. According to evidence received by the Committee, two predictable results are: first, the package is likely to have an overall inflationary effect, driving up the cost of the gap payments for non-card holders. Second, the overall level of bulk-billing is likely to fall, greatly reducing the access of non-card holders to a bulk-billing GP.

Effects on gap payments

6.64 There is a widely held view that the package will exert pressure on doctors to increase gap payments to non-concessional patients in order to make up for the fees lost by bulk-billing card holders. Dr Moxham, an Adelaide GP, explained this view:

> The incentive is that you get paid a certain amount of money but you have to agree to bulk-bill all of your health care card holders. At the same time, if you agree to bulk-bill all your health care card holders, your income may well go down. You have to make up that income somehow, so you have to charge your non-health care card holders in order to obtain the same amount of income. No-one is going to sign onto this if they actually make less income. In order to have an equal amount of income, they are going to have to charge their non health care card holders more. It is going to create very much a divide between the health care card holders and the non-health care card holders.[56]

6.65 Dr Churcher, a GP from Ballarat, gave this example:

> If we were to change and go to that package, my income would drop by about $26,000 a year. With our small outpatient profile, we have a very high card-holding group; I would then have to try and recoup that $26,000 by charging an increasing gap payment to that group of people who do not have a card.[57]

6.66 These views were borne out in part by the modelling undertaken by the AIPC, who found that in order to meet income targets:

> [A]verage out-of-pocket costs per service would need to be set at $10.98 for metropolitan capital city practices, $11.40 for other metropolitan practices, $15.84 for rural practices, and $13.79 in outer rural and remote areas. This

56 Dr Moxham, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 3

57 Dr Churcher, *Proof Committee Hansard*, Melbourne, 27 August 2003, p. 55: see also Mr Mehan, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 53; Dr Woodruff, *Proof Committee Hansard*, Sydney, 22 July 2003, p. 61; Prof Deeble, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 46; Ms Thomas, Submission 21, p. 1

> would result in a reduction in the average out-of-pocket charge currently levied to non-bulk billed patients in metropolitan settings, but a probable increase in average out-of-pocket fees for rural and remote patients.[58]

6.67 Others rejected this view. Mr Davies from the Department of Health and Ageing told the Committee that:

> [T]he vast majority of practices who participate in this scheme will be financially better off without making any change to their current gap-charging policy. That provides no financial imperative or financial justification for them to introduce or increase their gap charges. They will make more money by virtue of participating in 'A Fairer Medicare'. …
>
> It is an axiomatic view that if this gives them more money then it does not give them any justification to introduce or increase gap charges.[59]

6.68 Mr Schneider of the Australian Health Insurance Association agreed, saying that the medical profession has always charged wealthier patients more than the poorer ones:

> That has occurred through bulk-billing or through any other system. I can see nothing in this package that would promote the idea that a doctor who is getting paid more for his concession card holders should not reverse the arrangement for a change and use that to cross-subsidise those people on slightly higher incomes which take them out of the concession area. Doctors could bulk-bill those people and continue the practice of charging the people they think can afford it whatever they think the market can bear.[60]

6.69 Dr Gault, a Port Fairy GP, also warned against placing too much faith on purely economic modelling:

> [G]eneral practice is not a business … that obeys quite the same rules of demand and supply that operate in other businesses. General practitioners, by their nature, are very closely connected with their patients and are concerned with issues of access. In our own case, as a solo practice in the town, we enjoy a monopoly in business terms. But, rather than exploit that monopoly, we have felt a duty to keep our fees on the low side, because we are concerned that people have nowhere else to go. There is also no Medicare office in town, so people cannot claim rebates easily.[61]

6.70 Dr Walters, of the Australian Divisions of General Practice, concluded that:

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58 AIPC Report to the Select Committee on Medicare, p. 28

59 Mr Davies, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 37. see also Mr Davies, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 69

60 Mr Schneider, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 38

61 Dr Gault, *Proof Committee Hansard*, Melbourne, 27 August 2003, p. 47

> This concept that general practitioners are, under changes in arrangements, suddenly going to jack their fees up and make radical changes to their billing is just fictitious. It is not going to happen. General practitioners do know their patients well. They make constant allowances.[62]

Effects on the overall rate of bulk-billing

6.71 A further effect of the package is that it would actually drive down the rate of bulk-billing for non card holders. The AMA's Dr Bain told the Committee that:

> Under 'A Fairer Medicare' package, the real value of the rebate will continue to sink and we expect that bulk-billing would continue to sink with it. As the participation rate falls, and there are fewer full-time equivalent doctors, that would also tend to reduce the rate of bulk-billing.[63]

6.72 Senator Forshaw also pointed out that doctors are likely to respond over time to the underlying policy settings of the government:

> If the message that is being sent is that bulk billing is … to be seen to be directed more at concessional patients, or health care card holders, then it follows as a matter of logic that while you can say, 'They can bulk-bill whoever they like,' that is not where the policy drive is anymore in this package for Medicare. It naturally follows that over time one would see a greater proportion of people who are not concession and health care cardholders not being bulk-billed in the future.[64]

6.73 Dr Moxham explained an additional aspect of this:

> [P]art of the package makes it easier to privately bill. One of the big barriers to private billing is that you have to chase the debts from the patients. If you make it easier to privately bill, the costs of chasing up debts, of writing letters to patients or of patients bringing cheques in disappear, so it actually becomes cheaper to privately bill under this new proposal than it would be if things were left as they are. Just the 45c for a postage stamp is an expense.[65]

6.74 There is also the possibility that the measures contained in the new package, working in connection with the forces discussed above, may trigger a sudden drop in bulk-billing rates. According to Dr Bain:

> [T]here was a very high expectation that there would be a quantum increase in the rebate, as a consequence of the relative value study. Now that the

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62 Dr Walters, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 61: see also Dr Haikerwal, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 38

63 Dr Bain, *Proof Committee Hansard*, Canberra, July 23 2003, p. 33: see also ACT Government, Submission 171, p. 6

64 Sen Forshaw, *Proof Committee Hansard*, Canberra, 28 August 2003, p.74

65 Dr Moxham, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 18

> government has sent the message that it is not going to implement the relative value study in any way, shape or form, the message we are getting back from the members is that they know they are on their own and that they will have to find ways of funding their own practices because it will not come via the rebate. The message from 'A Fairer Medicare' package is that, from the government's point of view, the RVS is dead. We believe the consequence of that will be that a lot of doctors will increase their charges … .[66]

6.75 Mr Goddard from the Australian Consumers Association agreed, suggesting that 'once things start to unravel in a fundamental sense, sometimes the rate can be fairly uncontrolled':

> It may be … that there is a cohort of practices out there that have been holding on to bulk-billing, or a high level of bulk-billing, and are starting to say: 'It is just not an option any longer. The things which are being proposed do not answer our objections.'[67]

6.76 The government response to this argument could be seen to condone this outcome. According to Mr Davies, there is not and never has been any implicit or explicit target level for bulk-billing, and a focus on the headline bulk-billing rate is not a useful indicator of access to health care:

> Whether the headline bulk-billing rate under this package went up or down, you would always want to supplement that information with information about the proportion of vulnerable Australians – card holders – who are being bulk-billed.[68]

6.77 Thus, for the government, the key outcome is whether there is an increase in the bulk-billing rate for those concession card holders.[69] As the AIPC modelling shows, this outcome is likely to be achieved, seeing a small rise in bulk-billing in rural and remote areas, but an overall reduction in bulk-billing rates to approximately fifty percent.

Direct rebate at point of service

6.78 As described above, medical practices that sign-on to the government package will be able to access the MBS rebate for each patient directly from the Health Insurance Commission for both bulk-billed and other patients. According to Mr Davies the current two-stage billing process is outdated:

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66 Dr Bain, *Proof Committee Hansard*, Canberra, July 23 2003, p. 47

67 Mr Goddard, *Proof Committee Hansard*, Canberra, July 23 2003, p. 34

68 Mr Davies, *Proof Committee Hansard*, Canberra, 28 August 2003, p.75

69 Mr Davies, *Proof Committee Hansard*, Canberra 21 July 2003, p. 39

> It has been described as patients actually acting as couriers carrying paper forms between the GP and the Medicare office. Once this was possibly the best available technology; it is certainly not the case any longer. In our daily lives, we have learnt to expect simple, quick and efficient one-stop service in other areas of our lives but many patients cannot get such service from Medicare. The current system imposes time costs on patients but also generates up-front costs that can be a barrier to access. More specifically for patients with very limited cash resources, having to pay for the government's rebate contribution on top of any gap charge and then claiming it back must sometimes be a barrier to accessing necessary care. Why should they have to be out of pocket by $25 or more even if only on a temporary basis?[70]

6.79 This change has significant cost savings implications for the government. Professor Marley told the Committee:

> [T]he more that it is electronic the lower the costs in the system to government as a whole. So, if you look at it purely as cost to government, the more the processing can be electronic the lower the cost will be to government.[71]

6.80 Savings have been estimated at around two dollars per transaction[72] and may in fact be greater – if the government package is widely taken up by general practice and direct rebates for all patients become the norm, at least parts of the national network of Medicare offices may become redundant.

6.81 The change also offers considerable benefits to patients who are not bulk-billed, who will no longer be required to act as go-between for the Health Insurance Commission and the doctor. As Mr Davies noted above, it also relieves the patient of meeting the initial up-front cost of the consultation prior to reimbursement. The Committee notes that these advantages are particularly beneficial in rural and remote areas where access to a Medicare office may be difficult. Dr Slaney of the Rural Doctors Association concluded that:

> [T]he ability for a patient to go in to pay the gap and have the amount rebated electronically to the doctor will, I believe, increase patients' access to medical care.[73]

Inflationary pressures

6.82 While the proposed arrangements for direct rebate at point of service will undoubtedly be more convenient for both doctors and non bulk-billed patients, it is

70 Mr Davies, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 4

71 Professor Marley, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 38

72 Dr Rivett, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 37

73 Dr Slaney, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 117

clear from the evidence that they also have a downside – the strong likelihood that by significantly changing price signals, out-of-pocket contributions are likely to increase in both size and frequency.

6.83 This comes as a result of the change from currently billing one entity – either by bulk-billing to Medicare or presenting an account to the patient – to a system in which a doctor can effectively bill two entities: the patient and Medicare.[74] This was described by the Australian Institute for Primary Care as the 'hard threshold':

> The incentive provided by the removal of the hard threshold will be to render highly marginal the demand response to actual increases in co-payments, as patients would be able to pay a much more modest up-front fee and avoid the transaction costs associated with claiming a rebate from Medicare. We are unable to cost these transaction costs within the constraints of this project, since they will vary significantly between individuals, with direct costs ranging from the price of a stamp and stationery to the costs associated with attending a Medicare office, and personal costs varying significantly between individuals depending upon their circumstances. However, the removal of the hard threshold is highly likely to induce an increased incidence of co-payments and a concomitant reduction in bulk-billing rates to the minimums required for access to the GP Access Scheme.[75]

6.84 Professor Swerissen elaborated:

> At the end of the day, it allows them to move from a situation where they are forced to issue a bill of, say, $40 on average to one where they can … issue a bill for $15 and then claim the rebate as the alternative. That is a very attractive proposition in terms of being able to adjust price signals for patients in a very sensitive way. At the moment they are forced into a very high threshold situation in order to achieve that, which is a very strong constraint on price because it is a non-marginal price signal. They would be able to move to marginal price signals, which, as I said in the presentation, have much less impact on utilisation.
>
> Going from, effectively, zero bulk-billing and a zero price signal to patients to a situation where you are no longer bulk-billing those patients and suddenly issuing $40 price signals is a very big jump.[76]

6.85 The overall result, according to the AIPC's modelling, is likely to be a:

- Reduction in average incidence of bulk-billing to the bulk-billing 'floor' of around 50% of services.

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74 Sen Forshaw, *Proof Committee Hansard*, Canberra, 28 August 2003, p.74

75 AIPC Report to the Select Committee on Medicare, p. 26

76 Professor Swerissen, *Proof Committee Hansard*, Canberra, 23 September 2003, p. 13

- Small increase in non-metropolitan bulk-billing rates of between three and six percentage points.
- Reduction in average co-payments for non-bulk-billed services in metropolitan areas, but increases in non-metropolitan areas.
- Increase in average co-payments (across all services) of around 56%.
- Improved convenience for those presently not bulk-billed, with possibility of lower actual out-of-pocket costs for this group.[77]

6.86 Many of these conclusions were supported by Professor Richardson, who argued in his submission that:

> Even a small co-payment results in administrative inconvenience for the patient who must seek reimbursement whether the co-payment is small or large. Removal of this impediment to co-payments will almost certainly encourage fees to rise.[78]

6.87 Professor Richardson also saw the hard threshold as one of three measures built into Medicare to limit inflationary pressures:

> First, bulk-billing was specifically designed so that a doctor who ceased bulk-billing inconvenienced their patients who must seek reimbursement of their expenses. Bulk-billing avoided this which increased the effects of price competition. Secondly, the elimination of copayments, by definition, minimises fees. Thirdly, patients presently see the total bill and will recognise (more or less) excessively high charges.[79]

6.88 Dr Woodruff of the Doctors Reform Society commented:

> [T]he idea of bulk-billing was that it was hassle free; it was hassle free for the doctor – no bad debts, no accounting system. It was also hassle free for the patient – just sign the form. To require a copayment was a hassle. The doctor had to have an accounting system – more complicated – and had to chase bad debts, and the patient had to go to get the Medicare cheque. … [T]he introduction of a system where we remove that hassle is simply going to make it easier for doctors to charge copayments.[80]

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77 AIPC Report to the Select Committee on Medicare, p. 5. See also p. 28

78 Professor Richardson, Submission 52, p. 2

79 Professor Richardson, Submission 52, Attachment, p. 1: see also Prof Marley, *Proof Committee Hansard*, Newcastle, 23 July 2003, pp. 31 & 36; Dr Ryan, Submission 14, p. 2

80 Dr Woodruff, *Proof Committee Hansard*, Sydney, 22 July 2003, p. 61

Conclusion: a three tier system?

6.89 This chapter has considered the key elements of the government's proposals relating to bulk-billing: 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.

6.90 Overall, the Committee is opposed to these measures, on both practical and philosophical grounds. As evidence to this Inquiry has argued, a policy that focuses on bulk-billing of concessional patients may not always provide access to the most needy group, since the majority of these people are in all likelihood already bulk-billed.[81] The AIPC research supports this, predicting a drop in bulk-billing rates to 50%. The Committee is inclined to agree the package essentially focuses on a solution to a problem that does not exist.

6.91 Far more serious are the practical ramifications of the proposals. The Committee accepts the view that, if put into effect, the General Practice Access Scheme will reduce levels of bulk-billing for those who are not concession cardholders. Many Australians in genuine need of bulk-billing, but who do not have concession cards, will have increasing difficulty in accessing it. As a consequence, they will have to cover both more gap payments, and overall, a rise in the cost of such payments.

6.92 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 up-front the whole consultation amount and subsequently gain reimbursement from a Medicare office. This is particularly the case in rural areas, where Medicare offices may be difficult (if not impossible) to access. However, as the evidence shows, this system plays an important part in maintaining price control over the system, and to separate the rebate and the out-of-pocket contribution would in all likelihood open the door to considerable price rises.

6.93 Further, allowing practitioners to charge Medicare and the patient concurrently at point-of-service will act as a disincentive on doctors to bulk-bill patients who are not concession card holders.

6.94 At a philosophical level, the Committee strongly considers that the government package amounts to a substantial 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

81 It is not possible with current statistical data to accurately determine the exact number and proportion of concessional patients who currently receive bulk-billing. The levels of bulk billing are therefore inferred from the analysis by the AIPC, and from anecdotal evidence of billing practices provided by GPs during the Inquiry.

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 for treating a concession card holding patient 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.

6.95 The Committee concludes that the underlying purpose of the General Practice Access Scheme is to move Medicare to the role of a safety net for concessional patients, instead of maintaining its intended role as a national, universal insurer.

6.96 The Committee notes the warnings about the implications for many in the community. 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.[82]

6.97 The Committee concludes that 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. Rather, the solution lies in a reorientation towards the role of Medicare as a universal insurer, granting equal benefits for everyone.

Recommendation 6.1

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

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

CHAPTER 7

Safety nets

> *[S]afety nets are desirable and necessary if you have copayments, but wouldn't it be nice if we did not need them?*[1]

Introduction

7.1 As outlined in chapter 5, 'A Fairer Medicare' package provides for two additional safety nets: a new safety net for Commonwealth Concession Card holders, and a private health insurance safety net available for everyone. These additional measures are designed to complement the three existing safety net systems under the Medicare system: the Medicare Safety Net; the Pharmaceutical Benefits Scheme (PBS) safety net (not discussed here), and a tax safety net.

7.2 The Medicare Safety Net enables individuals or families whose gap payments (the difference between the schedule fee and the rebate) exceed $319.70[2] in one calendar year, to receive increased benefits amounting to 100% of the schedule fee for any further out-of-hospital costs in that year. The scheme does not reimburse for any amounts charged in excess of the schedule fee, and gap amounts for in-hospital costs do not count toward the limit.[3]

7.3 The tax system also provides some relief in cases of high medical expenses. Once out-of-pocket medical expenses exceed $1500 annually, a person can claim a tax rebate of 20% on that additional expenditure.[4]

The need for additional safety nets

7.4 According to the Department of Health and Ageing, the two additional safety nets are designed to cover gaps in the existing nets. Mr Davies told the Committee that:

> [I]n 2002 there were a lot of individuals and households who faced considerable cumulative out-of-pocket costs despite the cover offered by Medicare. There are about 30,000 households who in that year paid more than $1,000 in out-of-pocket costs for out-of-hospital services. If we focus

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

2 This amount is adjusted annually for inflation, although what measure of inflation is used to calculate this is unclear.

3 Health Insurance Commission website, Medicare Safety Net, www.hic.gov.au, accessed 25 August 2003

4 Health Insurance Commission website, Financial tax statement, www.hic.gov.au, accessed 25 August 2003. Sen Forshaw, *Proof Committee Hansard*, Canberra 21 July 2003, p. 60

> on the most needy members of our society, we see that there are about 50,000 concession card holders who had costs totalling more than $500 in that year.[5]

7.5 At the same time, the decision to establish the boundary of the second government safety net at $1000 was largely arbitrary:

> It is one of those things where it could have been set at any figure. Obviously, the lower you set it, the higher the cost; the higher you set it, the lower the cost. Ultimately it is a trade-off between costs and benefits. Setting it at $1,000 means that about 30,000 people, we estimate, will stand to use that cover in any one year.[6]

7.6 Addressing the private health insurance safety net, Mr Davies explained:

> The current MBS safety net only recognises the gap between the rebate and the schedule fee, so it is only those payments, which are typically quite small, that count towards reaching the safety net threshold. Indeed, once the threshold is reached in a year, it is only those payments – the gap between the scheduled fee and the rebate – that are covered and are paid additionally under the safety net provisions. So any charges that a provider chooses to levy above the level of the scheduled fee are in effect invisible to the current MBS safety net.[7]

7.7 Mr Schneider from the Australian Health Insurance Association also supported the wider scope for private health insurance on the grounds of equity and practicality. In relation to equity he pointed out that:

> [T]hese charges are already being made. There are people who are very, very sick, who are having to incur quite considerable charges in a whole range of areas … these people are in a position where they have to meet that cost and I do not think it is equitable to deny them the capacity to be able to insure for it.[8]

7.8 Addressing practicality, Mr Schneider explained:

> [T]he way medicine is being delivered today is quite different from the way it was 20 or 30 years ago. It is quite illogical now to confine the operations of the health insurer to the boundaries of the hospital because there are many services which can be performed, probably more safely and better, outside hospital than inside hospital. But the way the system works at the moment is that we have a very perverse financial incentive which

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5 Mr Davies, *Proof Committee Hansard*, Canberra 21 July 2003, p. 4

6 Mr Davies, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 89

7 Mr Davies, *Proof Committee Hansard*, Canberra 21 July 2003, p. 8

8 Mr Schneider, *Proof Committee Hansard*, Canberra 21 July 2003, p. 59

> encourages both the patient and the doctor to admit the patient to a hospital facility … rather than to provide that treatment outside.[9]

7.9 As Mr Davies commented elsewhere, the existing prohibition on private health insurers offering coverage for out-of-hospital costs runs counter to the general trend towards out-of-hospital treatment, which is consequently exposing people to increased financial risk which they cannot insure against.[10]

Criticism of the proposals

7.10 Evidence to the Inquiry outlined four major criticisms of the proposed form of the safety nets. They:

- will cause an increase in complexity and administrative costs;
- will suffer from 'boundary problems';
- in respect to the private health insurance, represent a shifting of responsibility for health care from the public to the private sector; and
- involve inflationary pressures.

Increased complexity and administrative costs

7.11 Some witnesses suggested that adding two further safety net systems onto the existing systems is likely to be administratively complex and potentially confusing to members of the community. As Mr Goddard of the Australian Consumers Association explained:

> From the consumer's point of view, the other drawback of safety net schemes and entitlement schemes is that they tend to be complex. First of all, you have to know that you are entitled to these things. You have to organise your life in such a way that you are able to do the paperwork and make the claims. Some people do that but some don't. The people who do not are not necessarily the people – or their families – who do not need that claim.[11]

7.12 Mr Goddard's view received support from Professor Hall:

> There are always going to be people who do not understand, who do not know and who do not realise or just never get around to it. It may be the people who are least likely to understand the system who are in most need of the safety net provisions. If you could have something that was much

9 Mr Schneider, *Proof Committee Hansard*, Canberra 21 July 2003, p. 59

10 Mr Davies, *Proof Committee Hansard*, Canberra 21 July 2003, p. 89

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

> more automatic, you would have more confidence in the safety net covering all the people it was targeted at.[12]

7.13 On the basis of anecdotal evidence, this point may be borne out in the Department of Health's own experience. Health academic Ms Walker told the Committee that DoHA officials:

> … suspected that a number of people did not claim although they accumulated all the time. They did some inquiries and that seemed to have been due to the fact that a lot of people did not understand the system and they did not know that they could claim.[13]

7.14 In general terms, according to Mr Goddard, any new arrangements must pass the test of simplicity: 'simplicity for the consumer and simplicity for the doctor, the more safety nets you have, the more complex the system becomes …'.[14] Greater complexity means higher administrative costs, as Professor Hall stated:

> We know that if we have multiple payers in the system we are likely to have much more administrative overhead. It just costs more to have more payers. More systems have to be set up and more sorts of checking routines.[15]

7.15 The AMA concluded:

> The proposed dual safety net scheme is complex. The population will find it hard to negotiate. 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). This could well indicate a single safety net spanning both Medicare and the PBS. Access to the safety net should be at three levels: pensioner, health-care-card holder and non-concessional.[16]

7.16 The Western Australian government arrived at a similar view:

> [A]side from being confusing and in all likelihood not well understood by the general public, a more equitable approach would be to have the one scheme for all patients.[17]

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12 Professor Hall, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 57

13 Ms Walker, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 57

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

15 Professor Hall, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 44

16 AMA, Submission 83, p. 6; see also RACGP, Submission 86, p. 6

17 WA Government, Submission 177, p. 11

Boundary problems

7.17 A related problem is that a system of safety nets, focusing benefits on certain defined groups, tends to create winners and losers. This problem is most obvious at the boundaries of entitlement, especially for those who just fail to qualify. A key issue in this respect is the creation of the second safety net for concessional patients only, and the preceding chapter has already examined the problems inherent in using concessional status as a measure of need in the context of bulk-billing programs.

7.18 Mr Goddard gave evidence of research by the Consumers Health Forum on the safety net and its impact on out-of-pocket patient costs in the Pharmaceutical Benefits Scheme:

> It found that the people who just fell outside the concessional safety net scheme were substantially worse off, even though they had nominally higher incomes, than those who were covered by the concessional scheme. That is always one of the drawbacks with any scheme that falls short of universality. There are always going to be people just over the edge who fall outside and who tend not to be identified as needy, but who can quite often end up being far more needy than, for example, pensioners, the unemployed or the underemployed.[18]

7.19 The findings of this research seem to be borne out by evidence from Ms Walker of the National Centre for Social and Economic Modelling (NATSEM):

> We found that concessional patients on average pay less than two per cent of their after-tax take-home income. For general patients, the average goes up to about four or five per cent. But for the poorest of the general patients, when we divided the population by five, in 2000 it was about six per cent. … But then we did some projections to 2005 on the basis of the already announced increases in copayments, which were then CPI-related, and it was getting to about nine per cent. That is a huge amount for a relatively poor family.[19]

Transferring responsibility to the private sector

7.20 A further concern that relates specifically to the proposed private health insurance safety net is that it represents a general shift of responsibility for health away from government and to the private sector. This concern was expressed by the AMA:

> This proposal for private health insurance for out-of-hospital out-of-pocket medical expenses is a further implementation of the Government's implicit strategy of progressively shifting more of the burden of medical costs from Medicare to private health insurance.

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

19 Ms Walker, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 58

> The potential risks to the clinical independence of practitioners and their capacity to deliver clinically appropriate and high quality health care ensures that there is little support for this proposal. The AMA remains opposed to any measure that might encourage managed care to become a feature of the Australian health system. This proposal has that potential.[20]

7.21 The Hon. Wendy Edmond, Queensland Minister for Health shared this concern telling the Committee that: 'we are seeing an ideologically driven pressure to move more and more into the privatisation of health services and health service delivery.' [21]

7.22 According to Professor Deeble, the private health insurance safety net operates as a mechanism for transferring responsibility to the private sector by implicitly giving the government a way of avoiding responsibility for meeting rising health care costs. As costs rise, the government can leave rebate levels alone and allow the private health insurance to meet the rising gaps:

> There is a clear option here to say, 'We in the government and in the department know that there is a safety net which people pay for. So we can let the gaps grow a bit – we can freeze our rebate – and we know that it won't hurt anybody very much, and the rebate and the safety net exist for those people who are hurt.' And you do not pay the full amount of that; you pay only 30 per cent of it.[22]

7.23 Expanding the role for private health insurance in out-of-hospital expenses also introduces additional capacity for private health insurance companies to control treatment patterns by GPs, as alluded to by the AMA in the quotation above. This can amount to the introduction of powerful new policy players in the health care equation. For many Australian doctors, this raises the spectre of 'managed care' as practised in the USA. Dr McBryde related his experience in the United States:

> [I]n almost every practice that I went to I found that the general practice had to employ a full-time person just to deal with what can and cannot be done and to deal with questions with regard to what the claims are, how you claim it back and what will be paid. It is an absolute nightmare.[23]

7.24 Dr Kastrissios reported on his discussions with a practitioner from Florida in the United States, whose:

20 AMA, Submission 83, p. 7

21 The Hon Ms Edmond, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 20

22 Professor Deeble, *Proof Committee Hansard*, Canberra 21 July 2003, p. 63. See also WA Government, Submission 177, p. 12

23 Dr McBryde, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 99

> general practice routinely employed one coder and one staff member – two people – to handle the claims of the five or six HMOs, insurance companies, to which he was affiliated. He felt it was nightmarish.[24]

7.25 Dr Kastrissios also noted the problems that have already arisen in Australia, that would be likely to worsen:

> Our relationship as GPs with private health insurers is often problematic in that we are forced to be in a patient advocacy role defending the person's claim, and it becomes extremely difficult to manage that process. We are small business operators; they are big corporations with teams of lawyers. We have experiences with private health insurance companies that are not always positive.[25]

7.26 From the medical community, there is a strong view that the American experience of private insurer control over medical practice is one to be avoided in Australia.[26]

Inflationary pressures

7.27 The final issue relates to the concern that the availability of private health insurance to cover gaps will remove what has been a constraint on doctors' fees. Dr Boffa of the Aboriginal Medical Services Alliance of the Northern Territory (AMSANT) told the Committee that:

> Any move to gap insurance, any use of the private sector to fund health care and any system that says to GPs, 'You can charge what you like and health insurance companies will fund it,' will lead to them charging more.[27]

7.28 Similarly, Mr Goddard of the ACA commented:

> There is a substantial opening for moral hazard – for instance, for doctors, and specialists in particular, to structure their charges in such a way as to bring people up to the $1,000 threshold quite quickly so that they could then claim on the insurer. To the extent that that happened, it would put quite a lot of pressure on the insurer and quite a lot of upward pressure on premiums.[28]

7.29 Mrs Kendell of the Health Consumers Network expressed concern about the effect of inflationary pressures:

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24 Dr Kastrissios, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 99

25 Dr Kastrissios, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 99

26 See also, for example: Ms Dorron, *Proof Committee Hansard*, Bundaberg, 25 August 2003, p.40; Dr Churcher, *Proof Committee Hansard*, Melbourne, 27 August 2003, p. 60; Dr Gault, *Proof Committee Hansard*, Melbourne, 27 August 2003, p. 59

27 Dr Boffa, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 52

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

> Does the government not realise the proposed $1 extra a week to insure the gap for all medical out-of-pocket out-of-hospital expenses will very quickly soar when doctors start charging blue-sky fees, knowing their patients' private insurance will pay for them? While the government is suggesting that gap cover will add only $52 annually to the current costs for private insurance, an American family of four pays as much as $US13,000 annually for this sort of coverage.[29]

7.30 This argument was rejected by representatives of both the private health insurance industry and the government, on the simple grounds that a doctor does not necessarily know which patients are insured nor the level of reimbursement. Furthermore, as Mr Schneider explained:

> [I]f either the health insurance industry or the Health Insurance Commission discovered that the medical profession was exploiting any arrangement which was intended to cover catastrophic illness, I would be back in this room as quickly as I could possibly be, seeking some further refinement of the legislation to reduce the prospects of that continuing. … at this stage I think I am fairly confident that there are sufficient checks and balances in the system to preclude the sort of abuse that would concern all of us.[30]

7.31 In supporting this view, the Department of Health and Ageing noted that the HIC has the information that would enable them to detect cases where the same provider charged different prices for the same service before and after crossing the $1,000 threshold (although they do not currently do so).

7.32 Mr Davies, representing the Department, went on to argue:

> This product is 'catastrophic cover.' It is a premium which the insurance people call a high deductible premium: you have to have paid $1,000 out of your own pocket before you become eligible to claim under these policies. We estimate 30,000 people per annum will benefit from that and for those people it is a very valuable product, but actually I know that is substantially less than one per cent of the population. So the opportunity for doctors, particularly specialists, to increase their fees in response to the existence of this product seems to me extremely unlikely. They will not know who has already crossed the threshold, because they have no way of knowing that.[31]

7.33 Mr Davies also observed that the danger of inflationary effects of the safety nets is further ameliorated by the fact that the small number of patients who reach the safety nets are likely to have incurred expenses from a range of medical specialists

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29 Mrs Kendell, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 2; see also WA Government, Submission 177, p. 11

30 Mr Schneider, *Proof Committee Hansard*, Canberra 21 July 2003, p. 68

31 Mr Davies, *Proof Committee Hansard*, Canberra 21 July 2003, p. 68

and not just from a single doctor. As such, doctors will generally be unaware that patients have reached the safety net.[32]

7.34 Finally, the Department is able to draw on its experience with the operation of the existing safety net arrangements:

> … if doctors were in the habit of finding patients who had crossed the safety net and increasing their fees to capitalise on the lower price sensitivity of such patients, then we might expect to see, in current data, prices for equivalent services going up for patients who have crossed the safety net. Some very recent analysis that we have carried out suggests that that is not happening. That is as close as we can get to concrete evidence that the medical profession is not in the habit of pumping up its prices once people have crossed the safety net.[33]

7.35 Accurately judging the extent of any inflationary effects is complex, and this was one of the issues on which the Committee commissioned research from the Australian Institute for Primary Care. In their findings, the AIPC authors found that:

> It is extremely difficult to assess the actual inflationary impact of such a measure, since the actual cost to individuals will be dependent on the costs of the insurance product, which will also depend on the characteristics of those taking up the insurance product.
>
> Similarly, the provision of a publicly funded 'safety net' set at $500 per annum (indexed) for out-of-pocket costs to concession cardholders may induce some inflationary effects, but it is extremely difficult to assess these. It is unlikely that inflationary effects (if any) arising from these initiatives will impact at the level of GP fees. It is possible that some specialist medical practitioners providing frequent services to regular patients may identify an opportunity to increase fees.[34]

Conclusion

7.36 Arriving at a final view on the proposed new safety nets is not an easy exercise. 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, it also considers the establishment of two additional layers of safety net to be inefficient, likely to increase the overall administrative costs and to cause further confusion to the intended beneficiaries of the scheme, particularly in the wider context of safety net arrangements under the Pharmaceutical Benefits Scheme. On this point the Committee is also concerned that the very people who most need the safety nets may also be those whose access is compromised by bureaucratic complexities.

32 Mr Davies, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 70

33 Mr Davies, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 91

34 AIPC Report to the Senate Select Committee on Medicare, September 2003, p. 35

7.37 The chapter considered the danger of 'boundary problems' – of people 'falling through the cracks' of the system. These problems are inherent in any differentiated system that steps away from the principles of universality and, in this respect, revisits many of the arguments made in relation to bulk-billing made in the preceding chapter. The Committee notes here the comments of Mr Goddard:

> 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 there is going to be a significant level of copayment or out-of-pocket expenses.[35]

7.38 There is the danger a system focusing on safety nets implicitly serves to separate the wealthier part of society from the benefits of a system they continue to pay for. This was expressed by the Hon. Wendy Edmond:

> We all pay taxes, and then people start objecting to paying for a safety net system at the same time as they are paying large amounts for private health insurance and, on top of that, copayments. So cuts happen in those areas that general taxes go towards. That is what happens in the United States. People object to increasing public health care and improving the quality of it for those who are left behind.[36]

7.39 On the evidence presented, the Committee does not consider inflationary pressures to be a significant concern arising out of the proposed safety nets. However the Committee does share the concerns of the many doctors who fear the potential for increased control over primary care by private health insurers. As Dr Gault, a GP in Port Fairy put it: 'It would be much worse than the HIC would ever be.'[37]

7.40 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 feel the greatest financial impact.

7.41 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. However, to the extent that there is a need for safety nets, the Committee considers that any reform should focus on creating a single, simple, and automatic payment system. This would parallel the arrangement for safety nets under the Pharmaceutical Benefits Scheme,

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

36 The Hon Ms Edmond, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 20

37 Dr Gault, *Proof Committee Hansard*, Melbourne, 27 August 2003, p. 59

minimise the wastage of administrative costs, and ensure that those who need the assistance actually receive it.

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.

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

CHAPTER 8

Workforce and business measures

Introduction

8.1 As discussed in detail in chapter 4, Australia faces considerable medical workforce shortages, both overall and particularly in certain outer-metropolitan, rural and remote areas. Current supply problems are substantially due to earlier government policies partly designed to limit GP numbers which, as noted, included: measures to reduce the number of university and training places; restrictions on the entry of overseas trained doctors; and the introduction of restrictive provider number legislation in the 1996.[1]

8.2 As explained in chapter 5, the government package provides several measures aimed at increasing the supply of the medical workforce to outer metropolitan and rural areas of workforce shortage. This includes funding for 234 additional medical school places each year – amounting to a 16% increase in overall places – with students being required to work for a period of six years in areas of workforce shortage on completion of their training. In addition, 150 extra training places for GP Registrars will be provided each year – a 30% increase – targeted to areas of workforce shortage. These measures will cost $42.1 million and $189.5 million respectively, over four years.

8.3 The package also provides funding for up to 457 full time equivalent nurses to be employed in participating general practices. Practices may also elect to employ allied health professionals instead of nurses, where appropriate. This measure will cost $64.2 million over four years.

8.4 These workforce measures have two rationales. The first is to address the outright, and in some areas critical, shortages of medical services in outer metropolitan, rural and remote areas, as were detailed in preceding chapters. The second issue is to increase the number of general practitioners as a means of leveraging market forces of supply and demand and thereby contain costs. As Mr Davies of the Department of Health and Ageing (DoHA) told the Committee:

> [I]ndirectly, more doctors will mean more competition, which should help restrain fees and out-of-pocket costs to patients.[2]

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1 AMA, Submission 38A, p. 2: see also DOHA, Submission 138, p. 10. See paragraph 4.44 for further detail.

2 Mr Davies, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 7

8.5 The current initiatives follow the *More Doctors, Better Services – Rural Health Strategy* announced as part of the 2000-2001 Budget, which included funding for nine new clinical schools in regional areas and three new University Departments of Rural Health, and an additional 100 bonded rural scholarships. Other existing programs include:[3]

- financial incentives for rural general practitioners;
- support for specialists providing rural outreach;
- the Rural Australian Medical Undergraduate Scholarship Scheme (RAMUS);
- the John Flynn Scholarship scheme;
- General Practice Registrars Rural Incentive Payments Scheme (RRIPS); and
- the HECS reimbursement scheme.

8.6 The Medical Rural Bonded (MRB) scholarships attaches to the 100 new medical school places and pays students $20,950 (indexed annually) per year. Students agree to practice in rural areas of Australia for six years upon completion of basic medical and postgraduate training.

8.7 Under the RAMUS program, up to 400 medical students with a rural background[4] receive $10,000 annually, and although not bonded, are required to participate in a rural doctor mentor scheme and undertake rural training activities.[5]

8.8 Under the John Flynn scholarships, medical students commit to a two week placement in the same rural or remote community each year, over four consecutive years of their medical courses. The program has up to 150 new places each year, and covers travel and accommodation with an additional $1000 paid to cover other expenses.[6]

8.9 The Registrars Rural Incentive Payment Scheme (RRIPS) was introduced in the 2000-2001 Budget as part of the Rural Training Pathway, and provides 200 training places for registrars, who receive an incentive payment for every year of their training spent in RRMA[7] 4-7 locations, up to a maximum of $60,000 (on a sliding

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3 DoHA, Submission 138, p 39

4 Which in this case should be distinguished from areas of workforce shortage, which can include metropolitan areas as well.

5 RAMUS information sheet, DoHA website: www.health.gov.au, accessed 23 June 03

6 John Flynn Scholarships information sheet, DoHA website: www.health.gov.au, accessed 23 June 03

7 RRMA stands for Rural, Remote and Metropolitan Area categories. Seven categories are included in this classification – 2 metropolitan, 3 rural and 2 remote zones. The classification is based on Statistical Local Areas (SLA) and allocates each SLA in Australia to a category based primarily on population numbers and an index of remoteness. See http://www.ruraldoc.com.au/

scale according to the percentage of their training time is spent in the designated areas).

8.10 The HECS reimbursement scheme applies to medical graduates and enables participants who undertake training or provide medical services in designated rural and remote areas of Australia to have one-fifth of their HECS fees reimbursed for each year of service.[8] As at September 2003, 80 graduates had applied to the scheme and 63 had received payments.[9]

8.11 These programs appear to have had some success in addressing workforce shortages, although for some of the programs the period of operation is too short to make an informed judgement. According to government figures, the labour supply of GPs in rural areas has increased by 11.4 percent over the last five years, and by 4.7 percent in the past year.[10] While these figures have been questioned,[11] the analysis in chapter 3 certainly supports some degree of improvement, although it may be too early to judge the success of the individual workforce programs discussed above.

Bonded medical places

8.12 The provision for additional medical school places is generally welcomed, although there is the obvious, but inevitable, limitation that it will take ten years before the new university places translate into fully qualified doctors on the ground. However, as Mr Davies noted in relation to GP trainees:

> The fact that they will be working as they train means they will provide an immediate increase in our medical resources in those currently undersupplied areas.[12]

8.13 From the outset it also needs to be recognised that it is unlikely that the additional numbers of doctors created by these measures will fully meet existing needs. As Dr Sprogis observed, no-one has ever successfully achieved a rural and regional work force that is similar to a work force based in a capital city.[13]

8.14 The University of Sydney also noted that these workforce measures fall short of meeting rural needs, even though they complement existing compensatory arrangements:

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8 HECS Reimbursement information sheet, DoHA website: www.health.gov.au, accessed 23 June 03

9 Department of Health and Ageing, Submission 138B, Question 13

10 Department of Health and Ageing, Budget Papers 2003-2004: Continued support for rural and remote doctors.

11 See evidence from the Rural Doctors Association: *Proof Committee Hansard*, Canberra, 28 August 2003, pp. 107 and 109

12 Mr Davies, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 7

13 Dr Sprogis, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 12

> … such as the admirable Royal Flying Doctor Service, Aboriginal Medical Services, regional trauma centres, regional obstetric centres and the scaling up of primary care services offered by nurse practitioners do overcome some of these difficulties. However, the disparities in terms of access, quality and timeliness of care remain.[14]

8.15 Nevertheless, it is imperative that steps are taken to equalise numbers to greatest extent possible.

8.16 However, while the additional medical school places received wide support, the tying of these places to bonding provisions has been received far more critically. Critics of the bonded places raised three principle objections relating to:

- equity issues;
- the workability of bonding; and
- the fear that it will create two tiers of medical practitioner.

Equity issues

8.17 Medical students associations around the country expressed strong opposition to the entire concept of bonded places in universities. As well as articulating certain practical concerns, which are dealt with separately below, medical students argued that the bonding system is fundamentally inequitable. According to the Australian Medical Students Association (AMSA):

> Asking students to enter into such strict contracts before they have even begun their studies, and before they have gained some insight into their chosen career is detestable and completely irresponsible. Forcing students to make major judgements about their future in an unknown career is unfair. No student has a complete understanding of what a career in medicine entails before they begin their training. Many of the students who will be tempted into this arrangement could be as young as 17 years old and may not fully comprehend the ramifications of signing the contract. Their situations and plans will change dramatically as they progress through their life and their studies.[15]

8.18 Mr Brown, the National President of AMSA, stressed that the bond is not served until a doctor is fully qualified, which for most doctors takes 10 or 12 years including the time taken to complete undergraduate studies, clinical years as interns, and postgraduate training as registrars. This means that:

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14 Faculty of Medicine University of Sydney, Submission 148, p. 2

15 AMSA, Submission 15, p. 7. The arguments of AMSA are mirrored in the submissions from the state bodies of AMSA: NSW, Submission 160; SA, Submission 207; and WA, Submission 211

> [Y]ou are asking 16- and 17-year-old students to sign a contract which will not affect them for well over a decade, and we think that aspect of the scheme is particularly unfair.[16]

8.19 Professor Marley of the University of Newcastle expressed a similar view:

> The evidence really is that bonding has never been a particularly successful thing anyway, whenever it has been tried. … People do not realise what they are getting themselves into.[17]

8.20 Expressing views supported by the AMA,[18] Mr Brown also pointed to the results of an AMSA survey of 1,000 medical students which found that 98.7 per cent of respondents considered it unfair of the government to require such a decision of medical students, and 96.6 per cent thought that medical students would not have sufficient insight into their career paths to make this decision at such an early stage.[19]

8.21 However, a number of other individuals and organisations indicated support for the general principle of bonding as a solution to the overriding need to resolve the doctor shortages. Dr Moxham told the Committee that:

> People have tried all sorts of ways to get doctors out into small country towns. They have tried giving doctors money. At the end of the day, you have to get people out there. … It is a free choice. These are intelligent people. It is not like they are being forced to do something. They can choose to take the scholarship up, and then they know what the deal is; they know they have to go out to the bush. I think it has some merit. Of all the schemes that have been tried, you have to give this one a shot.[20]

8.22 Ms Anderson told the Committee that the Aboriginal Medical Services Alliance of the Northern Territory (AMSANT) also supports bonded scholarships:

> I think it is an indication of our desperation that we will try anything to get doctors out there – and we do not apologise for that.[21]

8.23 In AMSANT's view, increasing the number of medical places, while important, is not of itself enough to rectify current supply and demand problems:

> If these new doctors all end up working where there is an undersupply of GPs then of course it is going to have an impact. But they are all likely to go

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16 Mr Brown, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 71

17 Professor Marley, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 46: a view also supported by representatives of the AMA, Submission 83, p. 4

18 Dr Glasson, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 42

19 Mr Brown, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 73

20 Dr Moxham, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 18

21 Ms Anderson, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 41

> where everyone else goes, which is the north shore of Sydney and the eastern suburbs of Melbourne. Unfortunately, without the second tier – better ways of regulating where doctors set up shop – it will not necessarily have an impact.[22]

8.24 Dr McKenna, from the School of Medicine at the University of Notre Dame, also suggested that bonding is a reflection of an appropriate social obligation owed by those who receive an expensive education:

> I come from a generation where my wife was a bonded school teacher. Life was not easy for a few years but we were in the first generation that got a free tertiary education and there was a social debt that went with that. Perhaps there has been a loss of understanding that there is a responsibility to the providers of this type of expensive education and perhaps attitudes are changing about where people practise and what they do.[23]

8.25 His colleague Professor Carmichael agreed:

> As you have indicated, the medical student societies generally believe that is an unfair approach, but I think that has to be weighed against the requirement to actually ensure that we do have people move to areas of the work force. … I think this is one way of trying to balance up the difficult issue of needing more places – which I think are imperative – and ensuring that at least some of those places will actually end up in the areas of greatest need.[24]

8.26 In supporting the issue of bonded places, Dr Moxham also drew the parallel with scholarships offered by the Australian Defence Force for students to go through medical and dental school under a similar scheme:

> You sign up and you get some advantages, but you know that you have to pay it back at some stage in the future. Those people went into that with their eyes open; they knew exactly what they were doing.[25]

The workability of bonding

8.27 Critics of the bonding arrangements also suggested that it will be ineffective, with many students so desperate to get into university to become a doctor, they will accept a bonded scholarship, but will do so with an attitude of resentment and avoidance. The wider consequence is that it strengthens the perception that working in areas of need, in many cases rural, is an unattractive and onerous obligation to be avoided wherever possible. Dr Mackey suggested that:

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22 Dr Boffa, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 57

23 Dr McKenna, *Proof Committee Hansard*, Perth, 29 July 2003, p. 22

24 Professor Carmichael, *Proof Committee Hansard*, Hobart, 31 July 2003, p. 62

25 Dr Moxham, *Proof Committee Hansard*, Adelaide, 30 July 2003, pp. 18-19

> [T]he scheme appears to reinforce the image of rural general practice as a sentence rather than an exciting challenge. The package could thus undermine some of the work force initiatives that are out there that the Commonwealth has already started.[26]

8.28 A negative attitude among those fulfilling bonding obligations also has implications for those required to train them. Dr Powell commented on her experience in rural Queensland training doctors under these circumstances:

> I know how difficult it is to have somebody in the area when they do not want to be here. It is very hard work. As soon as they get an opportunity, they go. So you put in a lot of hard work and you know that it is not going to contribute to the long-term solutions for the area or the practitioners who are here.[27]

8.29 Not surprisingly, the doctors who wanted to be there learned a lot while those who resented being there contributed little and were not viewed as 'a good group of doctors to have.'[28] Consequently, the unhappy doctors were unlikely to remain in the area after the period of their bond requirement, while still having absorbed scarce training resources.

8.30 It also evident that the effectiveness of the scheme may be undermined by participants simply avoiding their obligations. This may occur in two ways.

8.31 For some, the bonded places simply offer a path into medical school, after which they have the incentive to pursue qualifications in higher paying specialisations, other than general practice, and buy out of their bonding obligations. On the estimates of the Department, this would amount to a cost of $15,000 per year for each year of default on their bond.[29] This concern was evident in the comments of Dr Mackey of the Rural Doctors' Association, who although not against bonding:

> … feels that, in the way it is set up, there are no incentives to it at all, apart from the incentive of being a medical undergraduate. … The way it is set up, we can easily believe that a large number, if not the majority, will simply pay out their bond. We see it as simply being a fee-paying student, and not much more than that.[30]

8.32 Secondly, bonded doctors may be tempted to take their qualifications overseas. Doctors in North Queensland point out that there is ongoing demand for

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26 Dr Mackey, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 107

27 Dr Powell, *Proof Committee Hansard*, Bundaberg, 25 August 2003, p. 35

28 Dr Powell, *Proof Committee Hansard*, Bundaberg, 25 August 2003, p. 36

29 Mr Wells, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 101

30 Dr Mackey, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 111; see also the AMA's Dr Glasson, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 42; Dr McKenna, *Proof Committee Hansard*, Perth, 29 July 2003, p. 32

doctors in Britain, and Europe generally, where they can work under contract with incentive payments and thereby avoid both their bonding and HECS obligations.[31] Mr Grieves, the CEO of Mackay Division of General Practice commented that there is little understanding that doctors are in an international marketplace:

> If you bond the students then all you are doing is encouraging them to go overseas when they finish their training. That is all that is going to happen. … They are not silly people. All they will do is go overseas.[32]

8.33 Newly graduated doctors who go overseas have the opportunity to earn significant amounts free of HECS repayments, making it commensurately easier to buy out their bonding requirements.

8.34 In answering these criticisms, the Department argued that the obligations are not as extreme as many are suggesting. In particular, the bonding applies to 'areas of workforce shortage' which are just as likely to be outer suburban as remote and rural. Furthermore, the scheme will have some degree of flexibility in that graduates will be able to nominate their preferences for particular places and it is not necessary to spend the entire six years in the one place.[33] Professor Carmichael commented that in Tasmania:

> [T]he requirement there is to practise in an area of need – and that could well be in a centre like Launceston which did not happen to have a radiologist or something of that sort – where there is a real requirement in the work force.[34]

8.35 In the view of Dr Tannock and Dr McKenna from Notre Dame University, there is also the increasing likelihood in Western Australia that by the time the new bonded students are being placed in areas of shortage, these areas are most likely to be outer metropolitan areas.[35]

Two tiers of graduates?

8.36 The third major criticism of the scheme is that it will result in lower quality intakes of medical students, creating not only a sub-class of students, but also a sub-class of graduates and the emergence of a two-tiered medical system. It is feared that this lower quality group will then be sent to the areas of workforce shortage. AMSA argued that:

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31 Dr Parker, *Proof Committee Hansard*, Bundaberg, 25 August 2003, p. 23

32 Mr Grieves, *Proof Committee Hansard*, Bundaberg, 25 August 2003, p. 36

33 Mr Wells, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 100

34 Professor Carmichael, *Proof Committee Hansard*, Hobart, 31 July 2003, p. 60

35 Dr McKenna & Dr Tannock, *Proof Committee Hansard*, Perth, 29 July 2003, p. 23

> Because the scheme is one that lacks incentive and appeal, the Government will be forced to draw its participants from those who have failed to secure a non-bonded position in Medical School. … By targeting vulnerable students who have failed to meet the entrance requirements of a 'normal' position, the Government is shifting the criteria for becoming a doctor away from merit and towards one's level of desperation. This will not result in the best doctors being attracted into this scheme.[36]

8.37 Mr Brown added that the scheme itself contributes to a growing number of reasons why studying medicine is becoming less desirable:

> [F]rom a medical student's point of view, there are more disincentives to studying medicine today than there ever have been. We have an indemnity crisis, we have red tape, we have spiralling HECS costs, we have an increase in postgraduate education costs, we have a restriction on provider numbers and a restriction on college training places, we have increased workloads because of doctor shortages, we have increased demands for family life and a greater lifestyle, we have declining bulk-billing rates, we have decreased public expenditure on medicine and now we are seeing an excessive and, we feel, unnecessary control on medical student places and on students trying to get into medicine.[37]

8.38 However, in the context of the current huge unmet demand for places in medical schools, it is unlikely that the scheme would effectively lower standards. According to Professor Carmichael:

> I think the concern about these students being of lesser merit is a very marginal one when you look at the very large number of capable students we get who just cannot get into the system in any circumstances at the moment.[38]

8.39 This concern should also be considered in the context of a general move away from pure academic standards for selection to medical schools, in order to attract a broader range of people and a more diverse skill set to the medical profession.[39]

Alternatives

8.40 Evidence to the Inquiry canvassed alternatives to the bonded medical school places, which include:

- enhancing and expanding existing workforce measures;

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36 AMSA, Submission 15, p. 8

37 Mr Brown, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 72

38 Professor Carmichael, *Proof Committee Hansard*, Hobart, 31 July 2003, p. 62; see also Mr Wells, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 100

39 Professor Carmichael, *Proof Committee Hansard*, Hobart, 31 July 2003, p. 60; see also Dr McKenna, *Proof Committee Hansard*, Perth, 29 July 2003, p. 24

- commencing the service of the bond period at an earlier stage;
- shortening the bond period; and
- designating the additional medical school places as HECS-free.

8.41 In considering these alternatives, evidence to the Committee supported several underlying propositions. First, measures to address the workforce shortage should provide incentives to participate, and as such, should be voluntary. According to Mr Brown from AMSA:

> The scheme itself paints rural practice in a negative light. By simply having to employ a big stick to enforce this, and to solve the problems, suggests that there is something wrong with rural areas and working in rural areas, and that is obviously not the case – I would like to make that very clear. Rural service does provide many great opportunities for students and doctors but having to enforce such an onerous contract with a big stick and without any incentive paints a really negative picture of that setting.[40]

8.42 Second, past experience has shown that the doctors most likely to remain in rural areas are those that either come from those areas or are trained there. Professor Marley, of the University of Newcastle told the Committee:

> It is very clear that if you have come from a rural background you are much more likely to go back and work there. If you have trained in a rural background, whether you come from metropolitan or rural, you are more likely to stay. If you have got both of those things in place, then you are highly likely to stay.[41]

8.43 Professor Marley's statements are borne out by the findings of a recent AMWAC report, *Career decision making by doctors in vocational training*.[42] Training in rural and secondary hospitals offers additional advantages in medical education, as Dr McKenna explained. Rural hospital experience counteracts the emphasis of tertiary training hospitals on high-technology and high-intervention medicine, which can give medical students a distorted view of what the practice of medicine is actually like:

> That produces two problems: firstly it makes them comfortable only with high-tech interventions and approaches and secondly, it makes them think they are the areas most valued by the community and by other doctors. They do not tend to look outside those areas for their careers very easily. [43]

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40 Mr Brown, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 72

41 Professor Marley, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 41; see also AMSA, Submission 15, p. 7

42 Australian Medical Workforce Advisory Committee Report, *Career decision making by doctors in vocational training*, May 2002, p. 20

43 Dr McKenna, *Proof Committee Hansard*, Perth, 29 July 2003, p. 29

8.44 The Committee heard anecdotal evidence of opportunities to improve the bonded placements scheme. For example, the University of Queensland receives funding for students to spend their third year at the rural clinical school. This limited opportunity needs to be extended, however:

> If they want to stay for their fourth year – which is optimal because then they will do their first year of internship in a regional hospital, which makes them far more likely to be prepared to consider more rural locations – unfortunately, the funding does not apply to that fourth year. They can be funded for only one year, and at this stage that funding has been determined for the third year. If they stay for the fourth year, our training campus has to bear the cost of that.[44]

8.45 A useful modification of the government proposal could be to enable the bonding period to commence while a doctor is still undergoing postgraduate vocational training, rather than wait until full qualification.[45] This would allow for a less onerous bond obligation but, more importantly, would enhance existing initiatives by creating incentives for students to do part of their training in areas of need – especially in rural areas – thereby increasing the likelihood that they will remain there after qualification. Dr Boffa of AMSANT, explained that working-off the bond period during the vocational training/registrar stage also provides substantial workforce benefits:

> It is difficult enough to get the rural stream filled, so if those bonded scholars choose to go into the rural stream then that should count straightaway because they are a major part of our work force. These registrars do seven clinical sessions a week; they are reasonably competent when they start.[46]

8.46 The Committee notes the concerns of both the Department and the Rural Doctors Association in relation to bonding during training:

> If we were to allow all the bonding to be completed during the training period, those communities would effectively be put into the situation where most of the doctors they would get would be trainee doctors and the mix of qualified and trainee doctors that most other communities expect would not be available to them. It would skew the doctor supply in those areas in that there would be a greater number of trainees.[47]

8.47 The main point of differentiation is the stage of training a doctor has reached. Interns are not yet qualified doctors. As trainees, they require constant supervision,

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44 Dr Powell, *Proof Committee Hansard*, Bundaberg, 25 August 2003, p. 24

45 See for example: Dr Slaney, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 112

46 Dr Boffa, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 60. This idea was supported by Prof Del Mar, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 77

47 Mr Wells, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 101

and therefore, do not increase the productivity of a practice. Registrars, although not yet through their postgraduate training, are qualified to see patients independently and require only limited training and supervision, thereby constituting a productive element of the practice workforce.[48] For this reason, it would be viable for bond obligations to be paid off during this later post-graduate registrar period.

8.48 Within the framework of bonded medical school places, another option is to provide some incentive for accepting the bonded places by making them HECS exempt. Mr Brown of AMSA estimated this would amount to around $1.8m in foregone revenue, which is a relatively insignificant amount in the context of overall health spending.[49]

Conclusion

8.49 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 earlier discussions showing that the doctor shortage in Australia reflects in part a maldistribution rather than an outright lack of doctors, it is reasonable to place some bonding requirements on these places. On the evidence presented to the Committee, there also seems little doubt that the additional bonded places will be filled. Mr Wells of the Department of Health and Ageing told the Committee:

> Certainly on the advice we are getting from the medical deans, there should be no trouble filling the places. We have had no advice from the deans other than that they expect to fill all those places and to be able to continue to fill them into the future.[50]

8.50 These views were borne out by academics from the Universities of Notre Dame and Tasmania.[51]

8.51 At the same time, the Committee does see significant practical and equity problems in imposing such significant career choices on students very early in their career. Combined with the absence of any real incentives to join the scheme, the Committee agrees with evidence that suggested that the program's objectives will be highly likely to be undermined by attitudes of resentment and avoidance, reflected in moves overseas, buying out of bonds, or simply poor attitude.

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48 Dr Slaney, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 112

49 Mr Brown, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 80; this idea received support from various commentators. See for example: Dr McKenna, *Proof Committee Hansard*, Perth, 29 July 2003, p. 32; and Dr Glasson, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 42

50 Mr Wells, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 100. Prof Carmichael of the University of Tasmania agreed: *Proof Committee Hansard*, Hobart, 31 July 2003, p. 62

51 Dr McKenna, *Proof Committee Hansard*, Perth, 29 July 2003, p. 26; Professor Carmichael, *Proof Committee Hansard*, Hobart, 31 July 2003, p. 59

8.52 The Committee is also cautious about accepting comparisons with the military bonded scholarships and expecting any sense of social obligation among graduates. In the case of the former, the military pay not only all HECS fees but also a salary, whilst the resulting Return of Service Obligation is calculated as one year in return for each year of training, plus one. In the latter case, a sense of social obligation is less likely in an era of high student contributions.

8.53 It must also be noted that on early indications, the system by which the government will distribute bonded places to various universities appears to be inequitable, 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.[52]

8.54 Overall, in the interests of simplicity and common sense it would seem logical to expand existing measures in preference to commencing an entirely new program. As outlined at the beginning of the chapter, there are a number of programs in place to enhance the medical workforce in areas of shortage. Given the real problems associated with the bonded places, it is surprising that the government now seeks to implement a new and somewhat punitive placements scheme in preference to assessing and, if necessary, refining existing programs.

8.55 For all these reasons, the Committee considers while some degree of bonding is acceptable for public policy reasons, the proposals should be amended to include a greater level of incentives. As AMSA stated:[53]

> I think that with a few subtle changes and a few concessions we will be able to achieve something whereby students will actually want to enter into this scheme, as opposed to it being something which they settle for.[54]

8.56 The Committee is also of the view that the government has still not done enough to recruit students from rural and regional areas. It has been clearly demonstrated that it is students from rural and regional areas that are most likely to return to the bush after they are qualified.

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.

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52 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

53 AMSA, Submission 15, pp. 10-11

54 Mr Brown, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 79

Additional practice nurses

8.57 The proposal to include funding for additional practice nurses, detailed at the beginning of the chapter, received wide support during the Committee's Inquiry. As with other workforce measures, the current proposals need to be considered in the context of an existing program that aims to address the shortage of nurses in general practice.[55]

8.58 This program, announced in the 2001-2002 budget, has three elements. The first provides $86.6 million over four years to general practices to employ more practice nurses. This involves an incentive payment in the order of $8,000 per GP and is available to practices in rural and other areas of workforce pressure. The incentive is paid quarterly in line with the current PIP payment process, with a rural loading applicable to practices in regions categorised under the Rural, Remote and Metropolitan Areas (RRMAs) index, levels 3-7.

8.59 The second allocates $12.5 million over four years to provide training and support to nurses working in general practice, with the immediate priority of enhancing support infrastructure for nurses in general practice, through: developing information resources on nursing in general practice; identification of the training and education needs of nurses; and working with the Divisions of General Practice to increase their capacity to support practice nursing through sharing the knowledge and infrastructure between Divisions.

8.60 The third provides $5.2 million for 400 nursing scholarships per annum, aimed at removing some of the barriers for former nurses living in rural areas to re-entering the workforce. The scholarships provide recipients with financial assistance of up to $3000 and target former nurses in rural and remote areas who wish to return to work in the non-acute health sector.[56]

The role of practice nurses

8.61 It is clear from the evidence received during the Inquiry that practice nurses are both a valued and often underutilised resource for general practice. The Office of Rural Health listed of the roles for practice nurses as including:[57]

- clinical nursing services;
- coordination of patient services;
- management of the clinical environment by assisting the practice to meet relevant standards and legislative requirements;

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55 Practice Nurses – Extending Primary Health Care, Rural Health Website, www.ruralhealth.gov.au/workers/practicenurses.htm

56 The Australian Remote and Rural Scholarship Program

57 Office of Rural Health, website: www.ruralhealth.gov.au accessed 12 September 03

- health promotion and education activities;
- management of human and material resources; and
- management of health through immunisation, recall systems and acute and chronic disease management.

8.62 A practice nurse is thus able to perform a wide range of administrative and clinical tasks that enables the doctor to focus attention on a smaller number of more difficult issues, representing a more efficient allocation of resources. As Ms Mohle, from the Public Hospitals, Health and Medicare Alliance of Queensland told the Committee:

> There is basically very little case management and case coordination that goes on. The practice nurse positions that have been put in place in a number of general practices are beginning to do that. That is an essential issue that needs to be addressed. There needs to be a coordination of care across practice settings and a focus on primary health care rather than on curing people once they get into the acute care system.[58]

8.63 Dr Ruscoe, in putting forward a model for Integrated Primary Care, argued that proper levels of support from practice nurses and nurses with specialist qualifications (such as in population health nurses or educators) is critical to the ability of GPs to provide proper care and to implement chronic care initiatives such as the EPC program.[59]

8.64 Nurses offer other advantages as well, as Professor Wilson explained:

> [F]rom a consumer perspective, particularly in rural areas, where the work force is predominantly male, nurses can offer a balance, particularly for women, who may want to have some sorts of service provided to them by another woman, and nursing is still largely female dominated in that regard.[60]

8.65 While the value of nurses in general practice is not doubted, the Committee received mixed evidence in relation to the numbers needed. Hunter Health in Newcastle told the Committee that in their experience, a ratio of between 1 – 1.3 practice nurses per GP is ideal.[61] Similarly, Mr Walters representing the ADGP explained that:

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58 Ms Mohle, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 13

59 Dr Ruscoe, Submission 153, pp. 10-11. this list could be widened to include specialist nurses such as midwives and theatre nurses: Ms Stratigos, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 25

60 Professor Wilson, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 23

61 Professor McGrath, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 13

> The ratio would depend to a certain extent on the style of practice and on its location. However, utilised correctly, a ratio of one practice nurse to every two or three doctors would seem to be about right.[62]

8.66 In contrast, Dr Moxham, President of the Non-Vocationally Registered GPs, suggested that while nurses are very useful and the rural practices use nurses a lot more than the city areas, he did not think 'the average, middle-of-the-city GP necessarily needs a nurse'.[63]

Scope of the program

8.67 While there is virtually universal support for the proposal to provide additional practice nurses, the view expressed by many witnesses to the Committee was that the government's program does not go far enough. The AMA, among others, would like to see the additional nurses available to all practices, rather than just those participating in GPAS:

> The practice nurses are seen as a great boon. All doctors that have practice nurses believe that it makes them more efficient, they give better service et cetera. Whether it will actually encourage bulk-billing I am not sure, but one way of extending the medical workforce is to assist with practice nurses. We would like to see the government, in the 'A Fairer Medicare' package, incorporate practice nurses right across the board.[64]

8.68 The benefits of practice nurses being more widely available received support from Dr Walters of the ADGP:

> [T]he practice nurse initiative has been very successful. In this time of gross general practitioner shortages, we believe that an extension of that right across the system could help alleviate some of the problems by taking the pressure off general practitioners in the short term whilst measures are taken to increase the number of general practitioners in the community.[65]

8.69 The cost of widening the program in this way is surprisingly modest. According to Mr Davies of the Department of Health, the total gross cost (including existing programs) of providing one practice nurse for every two GPs would be around $320m per year.[66]

8.70 Perhaps the wider problem is the capacity to find additional nurses in the context of an existing national shortage,[67] while ensuring that nurses attracted into

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62 Dr Walters, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 64

63 Dr Moxham, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 7

64 Dr Bain, *Proof Committee Hansard*, Canberra 21 July 2003, p. 21

65 Dr Walters, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 64

66 Mr Davies, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 97

67 Professor Hall, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 23

general practice by these policies are not drawn out of the hospital or aged care systems which can ill-afford to lose them. However, according to the evidence of both the Department and Dr Sprogis of the Hunter Division of General Practice, this is not generally a problem, with most nurses being drawn from the pool of those who have left nursing for reasons of family and other pressures. This group finds that general practice offers a very flexible work environment:

> It is not critical to have a nurse on board all the time. If they have to knock off to pick up their kids from school, for example, they knock off at three o'clock and off they go, having done six hours work rather than the full seven or eight – and no nights of course. We have had a bit of a look at the nurses that we have recruited and it appears that we are not pulling them out of the public hospital system; we are pulling them from this other pool – that is, the thousands who are out there that have knocked off nursing.[68]

Conclusion

8.71 In line with most evidence to the Inquiry, 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.

8.72 The Committee appreciates the government's desire to attach as many inducements as possible to the package to encourage the participation rate. However, the importance of practice nurses to relieving the current workforce shortage, and their key role in achieving the transition of the general practice to a more integrated primary care focus, combine to create a powerful argument to support a more universal scheme, especially in light of the modest cost. It should also be recognised that, on all present indications, very few practices around Australia will actually sign up to the government package, which makes the likely effects of the additional nurses part of the package negligible.

8.73 The Committee also notes the concern of Ms Mohle, of the Queensland Nurses Union. She says that if the federal government does not provide the leadership in recruitment and retention of nurses, the likelihood is that various state government programs will be at cross purposes. Ms Mohle said:

> [T]he state governments in various forms … have all had their own recruitment retention task force or their equivalent processes … There have been some improvements in Queensland because of our local recruitment

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68 Dr Sprogis, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 14. See also Mr Davies, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 24

> retention task force, but it is a national problem and, by solving problems in one state, you create problems in another area.[69]

8.74 Accordingly, there is a need for the Commonwealth government to create national policies.

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.

Assistance with IT infrastructure

8.75 The government package includes measures to support general practice to adopt electronic connectivity with the Health Insurance Commission, via HIC Online. Measures include reducing the direct billing payment lag from the HIC to general practices from eight to two days; incentives to providers of GP software to incorporate HIC online links in their software; and, for each practice that opts into the government package, a payment of $750 in metropolitan areas and $1000 in rural and remote areas to assist with equipment and set up costs. These measures are costed at $24.3 million over four years (depending on take up rates).[70]

8.76 Mr Davies from the Department of Health and Ageing also noted that this specific assistance to support the cost of introducing broadband technology in rural regions is intended to work in conjunction with wider government measures to roll out broadband access into remote areas. Mr Davies pointed out that:

> [W]e are not here talking about setting up broadband for health and then going and setting up broadband again for some other government initiative. This is an issue where there is potential for synergy across government initiatives. As I mentioned, we are working with other government departments and government bodies to have an integrated approach to this broad-banding issue.[71]

8.77 Reactions to these proposals were similar to the reactions to proposals for additional practice nurses. Most commentators considered the proposals to be a positive development, but queried whether the proposed level of assistance is adequate relative to the costs involved in getting practices online. Secondly, there was criticism of the limitation of key parts of the proposal to 'participating practices'.

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69 Ms Mohle, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 11

70 Department of Health and Ageing, Fact Sheet 8: Business benefits for general practice

71 Mr Davies, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 53

8.78 Evidence by doctors suggested that getting practices properly equipped and operating the HIC online services carries an average cost of $30 000, but can go as high as $70 000.[72] Rural practices face much higher set up costs for IT infrastructure, as Ms Stratigos of Rural Doctors Association explained:

> [W]e are told by rural doctors that they just laugh at $1,000. In fact, we recently saw a quotation for $30,000 for a practice to upgrade itself to broadband. As you are aware, you are not just paying for the technology; you have to pay for the travel and accommodation of the people who are going to do it, and so on. So is there provision for the actual cost of providing broadband and the related technology? If there were not, clearly doctors in rural and remote Australia would be puzzled by the advantage of this offer.[73]

8.79 Dr Kastrissios, a Queensland doctor, told the Committee:

> It is going to be quite interesting to see what happens in the next three years. I can guarantee you that the degree of technical expertise that you have to buy in to maintain a viable, secure private network in your practice has been underestimated by most general practitioners.[74]

Conclusion

8.80 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 an important stepping stone to the adoption of higher technology practices, information sharing, electronic patient records and online education.

8.81 For these reasons, the Committee does not agree with the government policy to limit these assistance measures to 'participating practices' – for the same reasons it objects to this policy in relation to the provision of practice nurses, discussed above. The Committee acknowledges Mr Davies' point that 'this is all part of an incentive package to get practices to behave in a particular manner, therefore there is a logic to making it available to those practices who come to the party, as it were.'[75] However, wide-scale national adoption of best practice information technology is in the national interest and should be encouraged for all practices.

8.82 The Committee has not received sufficient detailed evidence to make a final determination of what the appropriate dollar figures for the assistance should be. In general terms, the Committee accepts that the costs associated with getting online are likely to be quite high, but at the same time, the incentives are not designed to meet

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72 Ms Nesbitt, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 43

73 Ms Stratigos, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 52

74 Dr Kastrissios, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 101

75 Mr Davies, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 53

the whole of the cost, but rather to make a contribution. This is appropriate given that, notwithstanding its wider significance to best practice health care, information technology is a business cost that must be met by all businesses and one that offers a general practice significant financial dividends through increased efficiencies.[76] As such, there should not be an expectation that the government shoulder the majority of the cost.

8.83 The Committee also agrees with the view put by the ADGP that facilitating access in each area is an ideal role for the Divisions, and recommends that this option be given further consideration and support.[77]

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.

76 see for example the comments of Dr Moxham, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 17

77 Dr Walters, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 66

CHAPTER 9

The ALP Policy

Introduction

9.1 The Australian Labor Party's response to the government's 'A Fairer Medicare' package was announced by the Leader of the Opposition, the Hon. Simon Crean MP, as an element of the Budget reply speech of 15 May 2003. The policy highlights the fundamental premise, that 'A civilised society demands health care based on medical need.' As such:

> [E]very Australian must have the right to access a doctor who bulk-bills, and they must have the right to attend a well-funded public hospital without charge.[1]

9.2 The ALP policy proposes to immediately lift patient rebates to 95% of the scheduled fee, with a subsequent increase to 100% for every bulk-billed GP service. As well, GPs who meet bulk-billing targets will receive additional incentive payments as follows:

- Doctors in metropolitan areas[2] who bulk-bill 80% of services will receive an additional $7,500 per year.
- Doctors in outer-metropolitan areas[3] who bulk-bill 75% of services will receive an additional $15,000 per year.
- Doctors in rural and regional areas[4] who bulk-bill 70% of services will receive an additional $22,500 per year.

9.3 According to Mr Crean:

> This is the equivalent of increasing your patient rebate by as much as $6.30 for a doctor in a metropolitan area, $7.80 in an outer metropolitan area and $9.60 for a doctor in a rural area.[5]

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1 The Hon Simon Crean, House of Representatives Hansard, 15 May 2003, p. 14759

2 Determination of areas is based on the Remote, Rural and Metropolitan Area (RRMA) Index. Mapping of all RRMA areas is available at www.health.gov.au/workforce/new/more.htm: RRMA 1: metropolitan, excludes outer metropolitan areas as designated by the Department of Health and Ageing.

3 RRMA 2: Outer metropolitan areas.

4 RRMA 3 – 7: All other areas.

5 The Hon Simon Crean, House of Representatives Hansard, 15 May 2003, p. 14759

9.4 Labor's policy also allows for 'areas of need' to be identified, where bulk-billing rates are so low, or the decline so great, that the relevant incentive is not regarded as sufficient. In such cases, the Minister can increase the incentive payment to that of an adjoining area, in order to increase the attractiveness to continue, resume, or commence bulk-billing.[6]

9.5 The ALP policy differs from the government policy in the important respect that it is not necessary for a practice to 'sign on' in order to receive the benefits of the ALP package: the incentive payments are made to individual GPs who reach the relevant bulk-billing threshold.

9.6 These moves are designed to reach a national target level of bulk-billing of 80%. Overall, the ALP policy represents a rejection of all elements of the 'A Fairer Medicare' package *except* for the workforce initiatives aimed at alleviating doctor shortages, and measures to increase the GP rebate for veterans and war widows.[7]

9.7 Mr Crean has proposed the ALP policy as the first of a number of steps which aim to restore bulk-billing to previous levels of around 80%.[8]

Reactions to the ALP plan

9.8 Commentary on the ALP plan in written submissions was limited, and the majority of feedback was received through witnesses at public hearings.

9.9 Most respondents were more optimistic about the Labor proposal than that of the Government. Dr Woodruff of the Doctors' Reform Society told the Committee that:

> The reform proposal from the Labor Party goes a little way towards addressing the monumental problems that doctors like us face when we are confronted by patients who are struggling to afford their medical bill. It does not go all the way; it is not a total solution. But one thing it does, in complete contrast to the government's proposal, is support the principle of Medicare, in that it encourages bulk-billing no matter who the person is and no matter where the person lives. In contrast, the coalition's package encourages bulk-billing of health care card holders only.[9]

9.10 A similar comment was made by Dr Rivett of the AMA:

> I was at a large GP forum in Sydney a couple of months ago, and we asked for hands up for the Government package, and there was an absence of

6 ALP Medicare Fact Sheet no. 2

7 'Labor intends to spend $1.9 bn to revive bulk-billing', AAP 15 May 03

8 Mr Crean, Labor's New Deal to Save Medicare, Media Release, 19 May 2003

9 Dr Woodruff, *Proof Committee Hansard*, Sydney, 22 July 2003, p. 53

> hands; hands up for the Labor Party package, and there were about six; and hands up for neither package, and I think there were about 250.[10]

9.11 Dr Rivett went on to say:

> The whole system needs redrafting and shoring up with proper indexation and recognition of what a GP consultation costs and is worth to the community.[11]

9.12 Dr Alexander wrote that:

> Both packages offered by Liberal and Labour [sic] are appalling. They will do nothing to stop the slide in bulk-billing rates. They will do nothing to stop the falling morale and numbers of GPs.[12]

9.13 The ALP plan focuses on increasing the rate of bulk-billing as a measure of access to health care and the effectiveness of Medicare. Professor John Deeble commented favourably on the likelihood of the proposal's success in this regard, saying that Labor's aim of 80% bulk-billing under the policy was conservative:

> They are in a position to expect 100% [bulk-billing]. That does not mean they will get it, but they are in a position to expect it.[13]

9.14 Some evidence to the Inquiry has argued that bulk-billing is not the real issue, and that, of itself, is not an accurate measure of health outcomes. Dr Kastrissios was a case in point:

> The only concern I have with your proposal … is that, if you set targets that look at bulk-billing as an outcome, you will achieve those targets, and I am not confident that what we want in the community is more bulk-billing as an outcome. What we want is better health outcomes … .[14]

9.15 A number of respondents were loathe to either endorse or reject the Labor proposal, most often citing the variable outcomes it could have on different practices. Dr Rivett of the AMA warned that:

> It is an additional gross amount, presuming the doctor drops all gaps and does not factor in the gaps that he was charging previously. If he was charging gaps previously it may be a net loss. So the $22,000 is a gross figure and the outcome depends entirely on the bottom line and what gaps his population base is used to paying in the past as to whether he will be

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10 Dr Rivett, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 54

11 Dr Rivett, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 54

12 Dr Alexander, Submission 11, p. 2

13 Quoted in David Wroe, *Labor's Medicare Praised*, The Age, 17 May 2003, p. 9

14 Dr Kastrissios, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 104

> ahead or behind. It does not just equate to a better bottom line without factoring in all those drivers.[15]

9.16 In the context of an across-the-board increase in rebate, Dr Png echoed those sentiments:

> The problem is that individual practices have different circumstances; basically, what might suit one practice might not suit any other practice. So when you put a blanket rule out there it is going to disadvantage some practices.[16]

9.17 There was also an element of dissatisfaction with the perceived lack of innovation evident in the proposal. There was a strong feeling that complex problems at hand required new and innovative responses. Mr Howard of the Ballarat Division of General Practice told the Committee:

> [M]ore than one of our members said it is 100 per cent of not enough.[17]

> I think the response there was similar [to the government package], in that it was a variation of the theme. It did not attend to some of the core issues that have been tabled today, and therefore it was not particularly any more attractive than the current offer on the table from the government.[18]

9.18 Dr Png felt similarly:

> [J]ust topping up the current system is not going to do that [increase bulk-billing], because in five years time, when we have not had any rebate increases, we will be back with the same argument again.[19]

9.19 However, Mr Skidmore of the Combined Pensioners and Superannuants Association of NSW felt that: ‘the Federal Opposition’s pledge to … lift the rebate … to 100% of the schedule fee has merit.’[20]

9.20 Mr Skidmore went on to support the provision of lump sum payment to doctors who bulk-bill a set proportion of patients:

> CPSA would regard this scheme [bonuses to bulk-bill] as worthy of consideration. Because of the extra problems the decline in bulk-billing is

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15 Dr Rivett, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 54

16 Dr Png, *Proof Committee Hansard*, Perth, 29 July 2003, p. 44

17 Mr Howard, *Proof Committee Hansard*, Melbourne, 27 August 2003, p. 62

18 Mr Howard, *Proof Committee Hansard*, Melbourne, 27 August 2003, p. 56

19 Dr Png, *Proof Committee Hansard*, Perth, 29 July 2003, p. 44

20 Mr Skidmore, Submission 50, p. 5

> causing people in relatively isolated areas, there is a strong argument for greater financial incentives going to rural medical practitioners.[21]

9.21 There was relatively strong support from some quarters for a health system which was funded primarily through the tax system. When asked for his views on the respective proposals, Mr Wilson, Convenor of the Victorian Medicare Action Group, replied in part:

> What we are saying in our submission is that by and large the feedback we get is that people want a taxpayer funded health care service that meets their basic requirements. To the degree that the Labor Party's policy is about support of public health services, we applaud it. And, to the degree that the coalition's policy is about user pays, we have concerns about it.[22]

9.22 Labor's proposal was seen by some respondents as better reflecting the universality of Medicare, particularly with regard to expansion of bulk-billing. The Victorian Health Minister, the Hon. Bronwyn Pike, said:

> My understanding of what is being proposed by federal Labor is that it is an underpinning of the universal character of Medicare by a greater level of reimbursement to doctors and by incentives for people to treat more and more bulk-billing patients in those areas.[23]

Key findings from the AIPC Report

9.23 The research commissioned by the Committee from the Australian Institute for Primary Care provides an important source of analysis of the ALP policy. As noted previously, the possible inflationary effects of the ALP policy were examined alongside that of the Government by the Institute.[24]

9.24 In summary, the AIPC Report concluded that based on specified assumptions, the Opposition package would meet its bulk-billing targets and achieve an overall increase in bulk-billing incidence to about 77%. The package would also see out-of-pocket contributions remaining steady for non-bulk-billed services, with an overall 25% reduction in such contributions across all services. Professor Duckett noted:

> The difference between the two packages is that, by and large [under the Government's proposal], to restore their income doctors have to go with the out of pockets, whereas, under the Labor package, to restore their income it comes through the rebate.[25]

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21 Mr Skidmore, Submission 50, p. 7

22 Mr Wilson, *Proof Committee Hansard*, Melbourne, 24 July 2003, p. 60

23 The Hon Ms Pike, *Proof Committee Hansard*, Melbourne, 24 July 2003, p. 68

24 Australian Institute for Primary Care, Report to the Select Committee on Medicare.

25 Professor Duckett, *Proof Committee Hansard*, Canberra, 23 September 2003, p. 31

9.25 Importantly, the maintenance of the existing prohibition of payment of the rebate to the doctor at point of transaction arrangements – what the report labels a ‘hard threshold’ – means that price signals to patients would remain very prominent, thereby maintaining continued downward control over out-of-pocket costs for patients.[26]

9.26 Modelling was carried out on various scenarios, and concluded that the most likely of these to eventuate under the Opposition proposal was, in turn:

> … likely to have the effect of decreasing the costs to individuals of accessing GP services at the same time as it increases GP incomes.[27]

Conclusion

9.27 The Committee took insufficient evidence on the ALP policy’s reception to provide a definitive response. Frequently, witnesses had not considered the alternative policy; had done so fleetingly; or were reluctant to make detailed comparisons with the government’s proposal. This included a general lack of recognition that the ALP policy is ‘automatic’, and does not require the practitioner to ‘opt in’.

9.28 It is clear, however, that where opinions or comparisons were offered, Labor’s proposal was, with rare exception, preferred over that of the government. 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 most, while others saw it as a short-term fix to a complex and long-term problem. Workforce measures, which the Labor and government packages share, enjoyed some support, although they were criticised as being ‘too little, too late’.

9.29 From the AIPC Report, it is also apparent that the Labor proposal has less potential for adverse inflationary outcomes than that of the Government, and it is probable that bulk-billing rates would climb under the ALP package, auguring well for the ongoing universality of Medicare.

26 Australian Institute for Primary Care, Report to the Select Committee on Medicare, p. 31

27 Australian Institute for Primary Care, Report to the Select Committee on Medicare, p. 32

CHAPTER 10

Allied and Dental Health Care

> *[Health care] is not done just by these people called doctors. ... we have to broaden our view of what we want a health service to do in a country where the government has a legitimate role of custodianship.*[1]

Introduction

10.1 Term of Reference (d)(i) directs the Committee to consider:

> whether the extension of federal funding to allied and dental health services could provide a more cost-effective health care system.

10.2 This chapter therefore examines the role that allied and dental services play in the overall health care system; the adequacy of current arrangements in providing appropriate levels of care in these services, and the extent to which the Commonwealth's policy could be improved.

Dental Heath Care

10.3 This section discusses the importance of dental care, details current arrangements for the provision of public dental services and their adequacy, and considers several proposals for improving access to services.

10.4 Under current arrangements, dental health care in Australia is largely performed by privately billing dentists,[2] with relatively small public dental programs provided by the state and territory governments. These programs are targeted at school children and the less well off. The Commonwealth government is indirectly involved in dental funding via the Private Health Insurance rebate and through the VA, which is discussed in greater detail below. According to Dr Madden from the Australian Institute of Health and Welfare, the total national spending on dental services is estimated at about $3 billion, of which a little over $600 million, or 20%, derives from government (including the PHI rebate).[3] Analysis provided by the Australian Dental Association suggests that, reduced to a per capita figure, this amounts to an allocation of public funds equivalent to $57.50 per eligible person (i.e. concession card holders), or $14.31 per capita across the whole Australian population.[4]

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1 Professor Sainsbury, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 69

2 Department of Health and Ageing, Submission 138, p. 41

3 Dr Madden, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 75

4 Australian Dental Association, Submission 184, p. 3. The ADA's calculations are based on total public expenditure figure of $270m, excluding the impact of the Private Health Insurance Rebate.

10.5 In practice this means, as Dr Madden observes, that about two-thirds of expenditure on dental services in Australia is directly from patients' pockets. This fact must be considered in the context of steeply rising costs, outstripping inflation, of dentistry in Australia.[5]

The importance of dental health

10.6 Evidence to the Inquiry has stressed the importance of dental health, and its relationship to a person's general health. A report prepared for the Australian Health Ministers' Conference, *Oral Health of Australians: National Planning for Oral Health Improvement* (2001), stated that:

> As a consequence of shared determinants, general disease and oral disease often occur together. Co-morbidity is most notable in older people.
>
> An oral disease is occasionally the first clinical sign of a wider systemic disease. The oral cavity can act as a window to the body and has diagnostic advantages through direct observation of affected tissues.
>
> Oral diseases and disorders are increasingly being conceptually and empirically associated with general diseases.[6]

10.7 The Queensland Government quoted from a recent paper prepared by Professor John Spencer for the Australian Health Policy Institute:

> Medically necessary dental care has been suggested to be integral to comprehensive treatment to ensure optimum health outcomes for patients undergoing chemotherapy; having heart valve and other heart surgery; transplantation; suffering from diabetes; hepatitis C and HIV infection; and living with long term renal dialysis and haemophilia.'[7]

10.8 Professor Spencer concluded that 'oral health should be seen as an integral aspect of general health and dental care as a component of health care'.[8]

10.9 It is evident that access to dental care is particularly important to certain groups with higher health care needs who often having high levels of chronic illness. These groups include Aboriginal and Torres Strait Islander peoples, recent arrivals (particularly refugees), low income earners, dependent elderly and people in rural and remote areas.[9] The Northern Territory government noted that:

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5 Dr Madden, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 76

6 Quoted in WA Government, Submission 177, p. 13

7 Queensland Government, Submission 32, p. 9, quoting Spencer, J., *What options for organising, providing, and funding better public dental care?*, Australian Health Policy Institute.

8 Queensland Government, Submission 32, p. 9

9 Public Health Association of Australia, Submission 213, p. 1

> Oral health is particularly important in Aboriginal health because of the extremely high prevalence of chronic disease. In their strategic framework, the National Aboriginal and Torres Strait Islander Health Council has identified oral health as one of the top 10 priority areas requiring urgent government attention.[10]

10.10 Professor Wilson also described the link between economic status and oral health:

> This is a condition which is probably, of all the conditions in Australia, the most strongly socio-economically related. The people who have the worst oral health are the most disadvantaged in the community. … there is a large amount of dental disease in the community, and we need a strategy to deal with it.[11]

Access to dental services in Australia

10.11 Given the importance of oral health, the Committee is concerned at the evidence of major deficiencies in access to dental care for many communities and, in particular, certain disadvantaged groups. It is also disappointing to see that little has changed in the five years since the Senate Community Affairs References Committee examined the issue of public dental health.[12] According to the National Dental Health Alliance:

> Recent research show there are 500,000 adult Australians on low incomes who are now waiting for access to the very limited dental care services currently provided by state and territory health services.
>
> The waiting lists for these limited public dental services are so long that some people are waiting up to four years before they receive treatment.[13]

10.12 In their submission, the Combined Pensioners and Superannuants Association explained that:

> Because of the expense of even basic dental procedures such as root canal therapy and fillings, people on pensions are not encouraged to visit dentists regularly. This means they must put up with considerable pain and distress for long periods before they are attended to by a NSW public dental service provider. By then, a simple procedure invariably has turned out to be a more complicated procedure with more difficult treatment.[14]

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10 NT Government, Submission 82, p. 5

11 Professor Wilson, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 73

12 Senate Community Affairs References Committee, *Report on public dental services*, May 1998, Parliamentary Paper No.88 of 1998.

13 The National Dental Health Alliance, Media Release, 17 September 2001

14 Combined Pensioners and Superannuants, Submission 50, p. 7; see also NCOSS, Submission 84, p. 5

10.13 A similar situation exists in Tasmania, where:

> [A] state funded dental service – Oral Health Services, Tasmania – will provide care for school children and welfare recipients, but the demand upon this service effectively means that only emergency treatment is available. Waiting lists for anything other than an emergency are so long that some people report having waited for many years without being called in for treatment. …
>
> The present waiting list with Oral Health Services Tasmania for the fitting of a full set of dentures is three years – with a consultation for partial dentures requiring a wait of between five and six years.[15]

10.14 In the city of Darebin:

> [T]he publicly funded dental services are in crisis. With the closure of the federally funded national dental health program, state funded local Community Health Services are faced with extremely long waiting lists. People in Darebin, for example, must wait for approximately two years to see a dentist unless they have an acute dental issue.[16]

10.15 It is frustrating to note that while Australian children have excellent levels of oral health, in part due to extensive school programs, these gains are lost later in life.[17] Australia now has comparatively higher levels of dental problems among those in the 35-44 year age group, while Australians 65 years old and over have the fourth highest rate of total loss of teeth among OECD countries.[18] Professor Spencer also reported that Commonwealth concession card holders are nearly 20 per cent less likely than non-cardholders to visit for a check up and 2.2 times more likely to have a tooth extracted.[19]

10.16 Even those with private health insurance face significant out-of-pocket costs of almost fifty percent of the total fee.[20]

Options for a wider Commonwealth role in dental services

10.17 The Committee acknowledges the importance of dental care, the relationship between socio-economic status and dental health, and the extent of current problems in accessing dental services. It therefore sees a strong need to introduce measures to improve Australians' access to dental care. The best way to meet this need can be

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15 TOES, Submission 139, p. 9; see also Tasmanian Government., Submission 148, p. 5

16 City of Darebin, Submission 39, p. 3

17 The National Dental Health Alliance, Media Release, 17 September 2001; see also Australian Research Centre for Population Oral Health, Submission 212, p. 1

18 Public Health Association of Australia, Submission 213, p. 1

19 Australian Research Centre for Population Oral Health, Submission 212, p. 1

20 Australian Research Centre for Population Oral Health, Submission 212, pp. 1-2

determined by studying the answers to two questions. First, what is the appropriate role for the Commonwealth in dental care? Second, (as required by the term of reference) would increased Commonwealth funding for dental care provide a more cost effective health care system?

The role of the Commonwealth

10.18 There is ongoing debate over the appropriate role of the Commonwealth in dental care. While it is clear that the Commonwealth has Constitutional power to become involved in dental care,[21] it is the view of the Government that dental care is, and has always been, the responsibility of the state governments.[22] As the Department of Health and Ageing submission to the Inquiry stated:

> The Commonwealth and the States play different roles in supporting Australia's mixed system of public and private dental and allied health care.
>
> The Commonwealth government has no direct role in the provision of public dental and allied health services. …
>
> The States are best placed to identify and resolve structural, management or financial problems affecting the quality and accessibility of public health care. If more funding is needed for the public dental and allied health network, States can choose whether to use their own revenue sources or commit some of the additional $10,000 million offered in the next round of the Australian Health Care Agreements.[23]

10.19 This view reflects the sentiments of the Government's response to the 1998 Senate Community Affairs References Committee Report on Public Dental Services:

> Notwithstanding the Committee's finding that some low income earners currently have difficulty accessing public dental services, the Government's position continues to be that the provision of public dental services is a State responsibility and that the States must resolve the structural, management and financial problems in their dental services. …
>
> With the introduction of the GST, States will be better off than they would be under existing Commonwealth/State financial arrangements. The additional revenue that will accrue to the States through the GST will be at the disposal of the States to augment the range of health services available to the public, including public dental services.[24]

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21 See chapter 2. See also: Senate Community Affairs References Committee, *Report on public dental services*, May 1998, chapter 4.

22 See for example, Senator Knowles, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 70

23 Department of Health and Ageing, Submission 138, p. 41

24 Government response to the Senate Community Affairs References Committee Report on Public Dental Services, February 1999, p. 1

10.20 Critics of this view argue that (in addition to the private health insurance rebate, discussed below) the Commonwealth already has an ongoing role in providing dental health for veterans and their dependents, members of the Australian Defence Force, and refugees.[25] According to the Australian Consumers Association:

> The 1946 constitutional amendment specifically enabled the Commonwealth to pay benefits for dental as well as medical services and, incidentally, said nothing about the civil conscription of dentists. The only cogent reason that Medibank and Medicare did not cover dental services was that governments believed the bottom-line cost for their own budgets would be too great.[26]

10.21 The Victorian Minister for Health, the Hon Bronwyn Pike, argued that dental care is a shared responsibility:

> The state of course recognises that we are not wanting to shift the cost to the Commonwealth at all. We understand that we have an obligation in the provision of all sorts of health care …. So we are really asking the Commonwealth to be part of the dental health system as it was in the past so that the state does not have the full burden of that responsibility, because we recognise that dental health is as much a part of people's health as mental health and health within the hospital system.[27]

10.22 Mr Gregory of the National Rural Health Alliance concluded:

> [I]t is far too serious an issue not to have the Commonwealth exercise leadership. Whether or not that leadership comes down to spending money is a later question.[28]

Dental care and private health insurance

10.23 Many view the government's disavowal of responsibility for dental care as being irreconcilable with the operation of the private health insurance rebate. Dental care accounts for 48% of ancillary benefits paid out under private health insurance, amounting to an indirect subsidy in the order of $325 million.[29] As the WA Government stated in its submission:

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25 Australian Research Centre for Population Oral Health, Submission 212, p. 1

26 Australian Consumers Association, Submission 72, p. 11

27 The Hon Ms Pike, *Proof Committee Hansard*, Melbourne, 24 July 2003, p. 75

28 Mr Gregory, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 72. see also; Uniting Care, Submission 70, p. 6

29 The exact figure is difficult to calculate. The submission from the Department of Health and Ageing states that total ancillary benefits amount to $1500 million, of which 48% is dental. Thirty percent of that figure is $216m. (DoHA, Submission 138, p. 41). In contrast, an Australian Health Policy Institute paper estimates the figure to be in the range of $316-$345m. Prof J. Spencer, *What options do we have for organising, providing and funding better public*

> It is ironic that the most financially disadvantaged people who cannot afford insurance, are not able to access any Commonwealth subsidy towards these types of services.[30]

10.24 Professor Sainsbury told the Committee:

> To me, it was ludicrous when the Commonwealth dental health program, which was costing I think $100 million a year, was abolished – a program that did provide some form of dental care for poor, disadvantaged people who often had bad oral health. What we have now with the rebate is the government spending $300 million to $350 million a year subsidising dental care for people who have health insurance.[31]

10.25 This view was shared by Professor Spencer:

> The combined effect of the cessation of the Commonwealth Dental Health Program and the introduction of the 30% rebate on private dental insurance has been to shift public funding from those with the poorest oral health, where significant gains in health status can be made, to those with the best oral health, where the gains are likely to be small.[32]

10.26 The net result is that higher income adults using private dental insurance and dental care receive nearly five times the subsidy received by aged pensioners seeking public dental care.[33] Critics point to the opportunity cost of the funds used for the private health insurance rebate, and suggest a range of public dental health programs that could be funded by reallocating some or all or the rebate.[34]

10.27 The Australian Dental Association, however, supported the use of the rebate, arguing that it helps fund members to access 20 million dental services a year worth $1 billion:

> If these benefits are removed, then many of the families who could no longer afford private insurance would, if eligible, be forced to seek their dental treatment in the public arena… .[35]

A cost effective Commonwealth role

10.28 Controversy surrounds the question of whether Commonwealth intervention in dental care would help in the provision of a cost effective health care system.

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dental care?, APHI, Commissioned Paper Series 2001/2002, p. 39. See also Prof Deeble, Submission 85, p. 8

30 WA Government, Submission 177, p. 12

31 Professor Sainsbury, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 69

32 Australian Research Centre for Population Oral Health, Submission 212, p. 1

33 Mr Webber, Submission 3, p. 7; see also NSW Government, Submission 154, p. 21

34 Australian Research Centre for Population Oral Health, Submission 212, p. 2

35 Australian Dental Association, Submission 184, p. 6

Supporters argue that a relatively small scale but well-targeted Commonwealth dental program could produce significant gains in other aspects of the health care system, through prevention of more serious general illnesses. Professor Richardson concludes that selected services would be highly cost effective.[36] Similarly, the NSW Retired Teachers Association suggested that:

> Under present arrangements many people go without dental care and suffer ill health. There is evidence that bad teeth cause long term health problems. The inclusion of dental care in Medicare would increase the over-all cost of the health care system. The benefits would be less call on the services of hospitals and doctors, less worktime lost and a happier healthier population.[37]

Extending Medicare to cover dental services

10.29 Given the apparent incongruity of treating oral and general health under separate systems, one method for integrating Commonwealth involvement is the extension of the existing Medicare Benefits Schedule to cover dental services: the so-called 'Denticare' option. As the Doctors Reform Society stated:

> Medicare is a very cost effective way of providing hospital services, drugs, and medical primary care. Extension to dental and other health care would provide an opportunity to greatly improve access to such care for those who are currently denied it because of costs. It would also help to control the escalating costs of these services.[38]

10.30 Estimates of the cost of such a program vary. The ACA suggest that extending public dental cover to 100% of the population could cost about $2.5 billion (assuming the continuance of the 45% gap) or $4.5 billion (assuming no gap and not including any of the likely cost efficiencies associated with such a scheme). However, these figures would be affected by the scope of cover and the agreements that it could negotiate with service providers.[39] In this respect, the ACA notes these cost estimates might in practice be reduced:

> [T]he massive buying power of a single public authority could produce substantially improved price discipline and far better cost-effectiveness than the nation enjoys at the moment.[40]

10.31 However, as the Queensland government comments, any proposal to include dental cover in Medicare 'would, in all likelihood, be resisted by the Commonwealth

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36 Professor Richardson, *Proof Committee Hansard*, Melbourne, 24 July 2003, p. 80

37 NSW Retired Teachers Association, Submission 23, p. 2

38 DRS, Submission 25, p. 6

39 ACA, Submission 72, p. 11. This estimate accords with that of Dr Madden, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 75

40 ACA, Submission 72, p. 11

government as it would involve extending an already uncapped program.'[41] This concern was also put by the Australian Dental Association:

> Medicare is already under severe financial strain and the addition of a comprehensive universal dental scheme would simply lead to total collapse… .[42]

10.32 Costs aside, Professor Deeble also questioned the suitability of applying a universal insurance scheme such as Medicare, to dental care:

> The main problem with Medicare covering the [dental] industry is its basic uninsurability.
>
> … insurance works for best for things that are episodic and unpredictable. Dental illness is slow: it is not episodic and it is not unpredictable, because you know you have it for quite a long time. You do not suddenly discover that you have a dental problem. It should be treated, but it should not be treated within an insurance approach.[43]

A new Commonwealth dental health program

10.33 A second option, which received wider support, is the reintroduction of a Commonwealth dental health program along similar lines to the program that operated between 1994 and 1996.

10.34 The Commonwealth dental health program aimed to improve the dental health of financially disadvantaged people in Australia, and to direct the dental care received by adult Health Card holders from emergency to general dental care; from extraction to restoration; and from treatment to prevention.[44] The program had funding of $245 million over four years, and operated via agreements with the states and territories.

10.35 Holders of Commonwealth Health Cards were eligible for basic dental care under the program, although certain procedures, such as dentures and some specialist services, were excluded.

10.36 It is estimated that 1.5 million services were provided under the scheme, which is generally assessed as being successful in increasing access to, and quality of, dental care among disadvantaged groups, and reducing waiting times in public dental programs. In particular, a review found that an additional 200,000 concession-card holding patients per year received treatment under the program, while the proportion of card holders waiting less than a month for a check up increased from 47.5 percent

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41 Queensland Government, Submission 32, p. 9

42 ADA, Submission 184, p. 6

43 Professor Deeble, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 71

44 Senate Community Affairs References Committee, *Report on public dental services*, May 1998, p. 27

to 61.5 percent. It was also found that the proportion of card holders who had visited a dentist in the preceding twelve months increased from 58.6 to 67.4 percent.[45]

10.37 A number of submissions supported the reintroduction of a Commonwealth dental scheme,[46] even if the reintroduced scheme were to be only of limited duration, and intended as a 'catch-up' program, to enable the overloaded public dental programs around the country to reduce the current backlog:

> I believe that even if there were a short-term five-year program, you could make the public dental program work much better in Australia if we had some catch-up phase to do that work.[47]

10.38 Alternatives for a Commonwealth scheme include a targeted oral health program for indigenous people and older adults in residential care, both groups for whom there are direct Commonwealth responsibilities,[48] or an extended school dental service for children up to about 18 years of age. This would be a preventive service covering the period of puberty and adolescence where most dental conditions are likely to emerge:

> The problem is that dental disease gets established in childhood and never gets remediated properly. … So the problems are established and, once they reach adulthood, you have to do something about it early.[49]

10.39 Others have also suggested that the Commonwealth needs to take a leadership role in addressing a national shortage of dentists, noting a requirement for an additional 120 dentists per year.[50]

10.40 The Committee sees a need for a more collaborative relationship between Commonwealth and state governments on the issue of dental health. As Professor Spencer commented: 'a constructive dialogue between the Commonwealth and State or Territory governments needs to begin'. This dialogue would detail an agreement on

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45 Senate Community Affairs References Committee, *Report on public dental services*, May 1998, pages 30-31. For a detailed description and assessment of the CDHP, see generally chapter 3.

46 For example: Darebin Community Health, Submission 40, p. 2; Queensland Government, Submission 32, p. 9; and Australian Dental Association, Submission 184, p. 7

47 Professor Wilson, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 73

48 Public Health Association of Australia, Submission 213, p. 2

49 See the discussion of Professors Wilson and Deeble, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 74

50 Dr Madden, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 76; ADA, Submission 184, p. 4. Note also references to the shortage of dentists in South Australia (South Australian Dental Service, Submission to the Generational Health Review, p. 11), NSW ('Fears shortage to put bite on dental service', ABC News, 11 August 03), and the Northern Territory (Jane Aagaard, NT Minister for Health and community Services, 'Aagaard calls for action on national dentist shortages', Media Release, 28 July 2003). For a general review of dental numbers, see Australian Institute of Health and Welfare, *Dental labour force, Australia 2000*, University of Adelaide.

the objectives for public dental care, the allocation of roles, and the associated financial arrangements.[51] While state and territory cooperation is essential to achieving these objectives, it requires leadership by the Commonwealth to initiate and carry through such an agreement.

Conclusion

10.41 The Committee agrees that dental health plays a crucial role in overall health, and is concerned at the evidence which demonstrates that many Australians experience significant problems in accessing timely and effective dental care. This has both unfortunate consequences for the individuals concerned, and implications for society as a whole, as it triggers declining population health, increases pressure on public hospitals and potentially counteracts the success of other Commonwealth programs aimed at preventive care.

10.42 For these reasons, the Committee does not accept the simple assertion that dental care is a matter of state and territory responsibility. Adequate access to dental care is too interrelated with other aspects of Commonwealth health care responsibility for any neat jurisdictional lines to be drawn. Furthermore, the social justice implications of the current problems are too great for the Commonwealth to ignore.

10.43 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.

10.44 Currently, the principle form of Commonwealth involvement in dental care is via the private health insurance rebate. The issue of this rebate and whether the funds could be more effectively allocated to other public purposes is discussed in a later chapter. However, the Committee is concerned that in practice, current Commonwealth involvement is generally limited to the more affluent of Australian society, while providing no targeted assistance to those most in need. In the Committee's view, if the Commonwealth's involvement is to be limited, it should encompass measures that target those groups that have the greatest need.

10.45 However, the Committee considers that for Commonwealth intervention to take the form of incorporating dental care into Medicare is undesirable, both by reason of the enormous budget implications of such a move, and because it would represent a virtual Commonwealth takeover of dentistry that does not fit easily with the shared responsibility with the states.

10.46 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

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51 Professor Spencer, *What options do we have for organising, providing and funding better public dental care?*, AHPI, 2000, p. 50

significant increases in access to dental care among those most in need. As with the original scheme, such a program needs to be developed in close consultation with the state and territory governments to ensure that it does not simply substitute for current dental funds.

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.

Allied Health Services

10.47 Allied health services cover a wide range of disciplines including, but not limited to, physiotherapy, occupational therapy, psychiatry, social work, speech therapy, pathology, midwifery, dietetics and nutrition, optometry and podiatry. It should be noted that practice nurses are not considered to fall within the definition of allied health professionals, and are considered in chapter 8.[52]

10.48 Allied health services play an important role in overall health care, a role that can be overlooked in a system which tends to focus on doctors. Allied health professionals can provide both primary care services and a wide range of specialist diagnostic and treatment services for both referred and unreferred patients. These services are employed in a widespread effort to create a more integrated and prevention-focused health care system.

10.49 This section examines current arrangements for the use of allied health services, problems with access under these arrangements, and some of the suggested methods to enhance the effectiveness of allied health services in overall health care.

Allied Health Spending

10.50 The exact levels of total allied health spending in Australia are unclear due to an absence of data.[53] However, the Australian Health Insurance Association's CEO Mr Russell Schneider estimated total national expenditure on allied health at between $5 billion and $7 billion (including dentistry, estimated at $3 billion).[54]

10.51 The Department of Health and Ageing's Submission to the Inquiry stated that the distribution of funds to allied health services is a responsibility of the states through the state-federal Australian Health Care Agreements (AHCA), with states funding and administering free but limited access to allied health professionals through the public hospital system and Community Health Centres. However, the Department also submitted that core allied health services are Commonwealth-funded to the extent of $1.5bn (including dentistry) through the PHI rebate for private health ancillary cover.[55]

10.52 The remaining expenditure on allied health services in Australia is incurred through out-of-pocket costs to patients and state and territory programs including workers' compensation schemes.

10.53 As discussed above in relation to dentistry, there are concerns that the focus of Commonwealth involvement in allied health is via subsidies to private health

52 This distinction was pointed out by Mr Gregory, *Proof Committee Hansard*, Canberra, 21 July 2003, pp. 76-77 and Ms Mickel, *Proof Committee Hansard*, Melbourne, 24 July, p. 6

53 Dr Madden, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 75

54 Mr Schneider, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 75

55 Department of Health and Ageing, Submission 138, p. 41

insurance. The University of Sydney Faculty of Medicine submission referred to this arrangement as an 'inside out safety net: the rich are reimbursed with public money while the poor miss out'.[56]

Current Provision for Allied Health under Medicare

10.54 Allied health services presently included on the MBS are limited to prescribed psychiatry and optometry services. No other allied health services are funded under Medicare. This section also considers pathology services, although it is recognised that they are not traditionally categorised as an 'allied health service'.

10.55 Pathology represents a substantial cost to Medicare despite funding being capped by the Commonwealth through agreements with the two peak pathology bodies.[57] The number of pathology services provided in 2002-03 was 70,482,000, at a cost to the Commonwealth in excess of $1.3 billion. Of these, 84% were bulk-billed. Pathology services have been growing at a considerable rate over the past decade; per capita the number provided for 2002-03 was 3.5, up from 2.2 a decade ago.[58]

10.56 Despite the relatively high rate of bulk-billing, the pathology industry argues that it faces increasing difficulty in continuing to provide equitable access to pathology services in the context of expanding demand pressures and capped Medicare funding. According to the Australian Association of Pathology Practices, costs in the industry over the life of the existing agreement have risen 14% against a notional cost escalation of less than 6% allowed for in the agreement. The Association submitted that cost increases associated with providing pathology services have been hitherto absorbed by the industry through efficiency gains, but that the situation is no longer sustainable and that bulk-billing rates are likely to fall.[59]

10.57 Given the importance of diagnostic services, any significant fall in bulk-billing by pathologists has significant implications for both gap payments and the overall costs of accessing health care. However, the Committee is also mindful of the view that mergers and consolidation in the sector has resulted in major economies of scale and reduced overheads.[60]

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56 University of Sydney Faculty of Medicine, Submission 148, p. 6; see also WA Government, Submission 177, p. 12

57 Australian Association of Pathology Practices, Submission 108, p. 1

58 Department of Health and Ageing, *Medicare Statistics 1984/85 to June Quarter 2003*, pp. 33-39

59 Australian Association of Pathology Practices, Submission 108, p. 1 – Attachment: David Kindon, *Pathology feels the pinch*, Australian Doctor 30 May 2003, p. 28. See also Morgan Melish, *Bulk-billed pathology at risk*, Australian Financial Review, 25 August 2003, p. 4; and Mark Metherell, *Pathologists face loss of bulk-billing*, Sydney Morning Herald, 25 August 2003, p. 7

60 *Keep a lid on pathology fees*, Sydney Morning Herald, 26 August 2003, p. 12

10.58 Optometry services in 2002-03 numbered 4,573,000 at a total cost to Medicare of $182 million. Services were bulk-billed at a high rate, 96.5 per cent of the time.[61] This can be explained by the dual role of medical practitioner and retailer, which has historically enabled optometrists to subsidise the former activity with the latter.[62]

10.59 Optometrists are also reporting increasing difficulties with continued high rates of bulk-billing. In arguments closely reminiscent of those of general practitioners, optometrists claim that cross subsidisation of consultations by sales of spectacles reflects the declining real value of the Medicare rebate for consultations. They contend that the value of the rebate has not kept up with a significantly more complex and expensive diagnostic environment, including imaging equipment, direct opthalmoscopy, slit lamp biomicroscopes, and tonometers for the detection of glaucoma.[63] Over time, they argued, cross subsidies cannot be sustained:

> Consumers will tend to go to optometrists for a good quality professional service (which they are getting cheaper than is optimal, due to caps on optometrists fees) and then take their prescriptions to optical dispensing companies (which do not have to increase its prices to make up for lost income elsewhere). High quality providers cannot survive in this climate.[64]

Difficulties providing Allied Health Services under Medicare

10.60 A number of issues arise from the exclusion of all the other categories of allied health care from the Medicare schedule.

10.61 First, although in many cases an allied health professional rather than a doctor may be the most appropriate provider of treatment, only the service provided by the doctor is supported by Medicare. This means that many (poorer people and/or those not having Private Health Insurance Ancillary cover) who cannot afford the costs of allied health services simply go to the doctor instead. As the Health Consumers' Forum argued, cost represents the main deterrent to patients' accessing appropriate allied health care services:

> Despite improving public awareness of illness prevention and health promotion there are few options for consumers to use General Practitioners more appropriately as part of the health care team. Consumers who might benefit from using allied health services such as counsellors, dieticians or complementary health care providers may currently choose to visit a General Practitioner because it is the least expensive option.

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61 Department of Health and Ageing, *Medicare Statistics 1984/85 to June Quarter 2003*, pp. 33-39

62 Optometrists Association of Australia, Submission 136, p. 3

63 Optometrists Association of Australia, Submission 136, pp. 4 & 6

64 Optometrists Association of Australia, Submission 136, p. 4

> Providing consumers with more affordable and timely access to allied health services may in turn decrease the demand on General Practitioner's services, leading to more appropriate use of other members of the health care team.[65]

10.62 Secondly, different revenue sources for General Practice rebates and most allied health services, creates an inherent difficulty in integrating the two, posing a problem for government programs which seek a multi-disciplinary approach, such as the Enhanced Primary Care (EPC) items (described in chapter 3). Both the AMA[66] and the ADGP noted the disincentive to utilise allied health workers for GPs attempting to operate a financially viable practice.

> Even the most conservative of general practitioners have come to the realisation that good primary health care is about a team approach. It is not only practice nurses but a number of other allied health workers that can assist in providing this to the community. At the moment the pressure on the general practitioners, where remuneration can only be obtained if the practitioner touches or is face to face with the patient, puts a bit of a skew on it and sometimes creates farcical situations.[67]

10.63 The EPC extends the scope of the MBS, to provide an incentive for GPs to incorporate a range of allied health professionals into the realm of GP primary care. The scheme offers additional GP rebates for multidisciplinary care planning and case conferencing.[68] However, while GPs are provided incentives under the EPC program to incorporate allied health professionals as part of a multidisciplinary approach, only the GP is paid for their involvement. Other team members receive no recompense for their time.[69]

10.64 The North West Tasmanian Division of General Practice praised the intention of EPC, but noted its inappropriateness for busy GPs in poorly serviced areas:

> Not only is the average GP very busy but, even if they did want to take up that incentive and even if they had the time in their day to do so, there is very little opportunity to link in an easy way with the allied health workers. They are just not there or, if they are there, they are often not willing to participate … It was a great idea, but it did not take into account the reality of how rural GPs work on the ground and the availability of other services to contribute.[70]

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65 Health Consumers' Forum, Submission 102, p 3

66 Dr Rivett, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 48

67 Dr Walters, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 64

68 www.health.gov.au/epc/index.htm, accessed 9 September 2003

69 Australian Physiotherapy Association, Submission 94, p. 13

70 North-west Tasmanian Division of General Practice, *Proof Committee Hansard*, Hobart, 31 July 2003, p. 79

10.65 There is evidence that measures such as the EPC case conferencing are largely underutilised. According to the Productivity Commission's report into *General Practice Administrative and Compliance Costs* case conferences were used by 3,121 participating GPs, who claimed for just 10,727 services in the year 2001-02,[71] and a recent Department of Health and Ageing report into EPC reflects many of the problems discussed above.[72]

Other Commonwealth Funded Allied Health Programs

10.66 Two other Commonwealth programs are relevant to the enhanced provision of allied health services; MAHS and AAHSIMH.

More Allied Health Services Program (MAHS)

10.67 MAHS began in 2000-01 as part of the Commonwealth's *Regional Health Strategy: More Doctors, Better Services* initiative. The program has facilitated links between rural GPs and allied health professionals by allocating targeted funding to employ additional allied health professionals in rural areas. MAHS is a $49.5 million program administered over four years by eligible rural Divisions of General Practice.[73]

10.68 Mental Health Council CEO, Dr Grace Groom, referred positively to MAHS in evidence to this Inquiry, but called for it to be more broadly implemented:

> An interesting phenomenon occurred through the More Allied Health Service Program … What we saw there was a real trend for those rural divisions to use their allied health money primarily for mental health care – there was a much higher percentage – but we were very clear when we were negotiating the better outcomes initiative that the allied health pilot should be both metropolitan and rural. One of the great areas of need in mental health is actually those outer urban areas – and even some of the inner urban areas – where we are seeing a decline in bulk-billing and people not being able to get access to care.[74]

10.69 The Australian Physiotherapy Association criticised the program, however, for inappropriately distributing funds to subsidise practice nurses:

> The MAHS program was very specifically for more allied health services. In our opinion nursing is not allied health, yet in the last year, 30 per cent of the funding in the MAHS program for more allied health services has gone to putting practice nurses into general practices … Only five per cent of that

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71 Productivity Commission, *General Practice Administrative and Compliance Costs*, 31 March 2003, pp. 24 & 60

72 Department of Health and Ageing, *Evaluation of the Enhanced Primary Care Medicare Benefits Schedule Items, Final Report*, July 2003, p. 5

73 www.ruralhealth.gov.au/services/mahs.htm, 9 September 2003

74 Dr Groom, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 37

> MAHS funding has gone to providing physiotherapy services, yet we are one of the biggest allied health professions in this country.[75]

Access to Allied Health Services in Mental Health

10.70 This program is a component of the Commonwealth's *Better Outcomes in Mental Health Care* initiative. It aims to improve the community's access to primary mental health services by providing GPs with better education and training and more support from allied health professionals via sixteen pilot sites across Australia.[76]

10.71 The South Australian Division of General Practice offered praise for the program but lamented the limited impact it could have due to insufficient funding:

> That is a very good initiative, but it is only half the size of what it needs to be. Even large divisions of general practice would only be able to employ one or two full-time, or perhaps a few more part-time, mental health workers or psychologists under that initiative … It is really not big enough to provide responsive, collaborative mental health workers who will work in conjunction with general practice.[77]

Allied Health under 'A Fairer Medicare'

10.72 As discussed above, the Government's 'A Fairer Medicare' package would enable participating practices in urban areas of workforce shortage to utilise the services of any salaried allied health professional in preference to a practice nurse. The package has earmarked 457 new places for this scheme, an indeterminable proportion of which would be filled by allied health professionals.

Alternatives for enhancing the role of Allied Health

10.73 Evidence to the Inquiry suggests there are significant potential benefits to be gained by enhancing the role of allied health professionals in the health care system. These include economic benefits accruing from a reduced burden on overworked GPs, and improveed health outcomes derived from greater access to allied health professionals. These will become critical with the increasing rate of chronic illnesses such as diabetes and mental illness. At the Committee's roundtable discussion, Professor Wilson questioned the existing primary health funding paradigm:

> We have to get around some of the historical issues around public funding flowing only through the doctor. We have to think more creatively about how we fund these services so that people can have access to [allied health] care.[78]

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75 Ms Mickel, *Proof Committee Hansard*, Melbourne, 24 July 2003, p. 6

76 www.gpcare.org/phc/overview.htm, 10 September 2003

77 Dr Wade, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 91

78 Professor Wilson, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 74

10.74 Professor Sainsbury emphasised the need for a flexible strategy in treating increasing rates of chronic illness:

> The burden on health services is now not so much from acute illnesses – particularly, infectious diseases – but more from chronic illnesses and complex illnesses. And the population have come to expect a broader range of therapies … So it is appropriate that we think not just about whether we can afford to pay anyone other than doctors and whether they will all just rip us off, but rather about what is the function of a health service in society.[79]

10.75 The ADGP also recommended that allied health services provided in the GP setting fall within the ambit of Medicare funding:

> The problem we have at the moment is that using allied health professionals within practices is an expensive business unless you are in one of the areas where it is subsidised. We think that there should be some consideration of being able to obtain remuneration for services performed by allied health professionals under the direction of the general practitioner – possibly even through the MBS … There is the capability to do that.[80]

10.76 Articulating a different perspective, President of the Australian College of Non-Vocationally Registered GPs Dr James Moxham suggested that a lack of GP knowledge about allied health services was as significant as the availability and access to those services:

> There are private people and there are also dieticians, physios and all of those allied health people associated with public hospitals to whom it is not that difficult to refer people. Sure there are waiting lists, but people can still get in to see a dietician or a physiotherapist in a public hospital. In fact, many doctors do not realise that you can actually refer to those people … I think those resources are available if people choose to take them.[81]

10.77 Four specific areas of allied health were identified as priorities for an expanded role: physiotherapy, dietetics and nutrition, mental health, and midwifery.

Physiotherapy

10.78 There are presently no Medicare rebates available for physiotherapy services. These services are covered by private health ancillary cover or incur out-of-pocket expenses for patients.

10.79 The Australian Physiotherapy Association (APA) submission argued that physiotherapy management of incontinence and knee joint osteoarthritis is the most cost effective treatment for these conditions. They called for the creation of two new

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79 Professor Sainsbury, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 74

80 Dr Walters, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 64

81 Dr Moxham, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 11

MBS item numbers and the extension of the EPC to allow broader access to these services:

> In both cases diagnosis is discrete and relatively simple, economies will be gained by applying physiotherapy interventions rather than pharmaceutical or invasive interventions, the physiotherapy interventions required could easily be defined into MBS discrete item numbers, health consumers will be afforded greater choice and pressure will be taken off overworked GP's allowing them to apply skills appropriate to other areas of practice.[82]

10.80 Mr Peterson, a Bundaberg physiotherapist, indicated to the Committee that access to allied health services affected the delivery of optimal treatment methods and ultimately health outcomes:

> We see patients who have been medicated to the point where, had they perhaps received some sort of musculoskeletal intervention previously, they might have had a better outcome.[83]

Dietetics and Nutrition

10.81 The Committee also heard about the potential role of allied health professionals to more effectively manage the community's increasing rates of diabetes. Professor Wilson told the Committee that:

> In Australia somewhere between one in 10 and one in 20 Australians within five to 10 years will be suffering from diabetes. If we are going to provide proper care for them, we need to think about how they can get appropriate access to things like nutritionists, podiatry services and the other services, which we know are essential to providing good care for people with chronic illness.[84]

10.82 Professor Marley also urged strongly for improved access to dieticians for diabetes sufferers:

> The extension to allied health is essential. The biggest prospective study of diabetes, which was conducted in the UK, showed that the thing that made the most difference was access to a dietician. It was not access to hospital clinics or doctors or medication, it was access to a dietician. Given the prediction that within 10 years 50 per cent of the population aged over 50 will have diabetes, then addressing this is essential. I think that the only sustainable model of care is to reduce the dependency on doctors through care delivered by those most appropriate to the role.[85]

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82 Australian Physiotherapy Association, Submission 94, p. 17

83 Mr Peterson, *Proof Committee Hansard*, Bundaberg, 25 August 2003, p. 63

84 Professor Wilson, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 74

85 Professor Marley, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 31

Mental Health Treatment

10.83 Mental illness encompasses a range of psychiatric disorders including unipolar depression, alcohol abuse, bipolar affective depression (manic depression), schizophrenia and obsessive compulsive disorder.[86]

10.84 According to the ABS' *National Survey of Health and Wellbeing* almost one in five adult Australians had suffered from mental illness twelve months prior to the survey and of these only 38% had accessed health services.[87] The Mental Health Council of Australia (MHCA) estimates that over one million Australians suffer from mental illness.[88] This highlights the importance of GPs as the first line of diagnosis and treatment of mental health problems.

10.85 Furthermore, mental health is likely to become an increasingly significant health issue in the coming decades. According to global figures, in 1990, five of the ten leading causes of disability were psychiatric conditions, and projections show that psychiatric and neurological conditions could increase their share of the total global burden by almost half by 2020.[89]

10.86 MHCA called for a reorientation of Medicare towards early intervention in mental illnesses:

> Investment of early intervention and increasing access options to effective treatments is urgently required. The absence of such access will ultimately result in greater costs at both a Commonwealth and State/Territory level becoming evident in other areas of service systems.[90]
>
> The Australian Psychological Society's (APS) submission highlighted current anomalies between the provision of Medicare rebates for patients for psychiatric services, which receive $141.90 per session for up to 50 sessions, with psychological services, which attract no Medicare rebate.[91]

10.87 They also expressed concerns that inadequate access to evidence-based intervention would worsen under the proposed 'A Fairer Medicare' package:

> What concerns the Australian Psychological Society about the current proposed reforms is that they further increase the problems of access for many sufferers of health disorders by exacerbating the gap between services that are currently supported and those that are not. The dilemma is intensified by the fact that there is now substantial scientific evidence that

86 Mental Health Council of Australia, Submission 113, p. 3

87 Quoted in Mental Health Council of Australia, Submission 113, p. 5

88 Mental Health Council of Australia, Submission 113, p. 5

89 Mental Health Council of Australia, Submission 113, p. 5

90 Mental Health Council of Australia, Submission 113, p. 11

91 Australian Psychological Society, Submission 49, p. 8

> some of the services currently unsupported by Medicare are in fact the ones as effective, if not more so, in treating these health disorders.[92]

10.88 They added that proposed safety provision for out-of-hospital expenses would further exacerbate this inequity of access to alternate treatments by generating increased demand for psychiatric services.[93]

10.89 The Health Consumers' Council of West Australia also supported improved patient access to psychologists as an alternative to pharmaceutical treatment:

> I would say that in the area of mental health, psychologists providing people with the capacity for talking therapy would be very useful because people see that pharmacology has taken over in psychiatry from engaging with people as human beings. Psychologists are seen as the vanguard in allied health for providing people with that kind of attention.[94]

10.90 APS asserted that 12 to 15 sessions with a clinical psychologist can achieve significant change amongst patients with anxiety and/or depression and further claimed that if supported by Medicare registered psychologists could provide a cost-effective resource to supplement a poorly distributed psychiatric workforce.[95] Views differ on the optimal number of allowable treatments. Professor Martin indicated to the Committee that:

> I do not know of any treatment given by a psychologist or psychiatrist of more than 20 sessions where someone has been able to demonstrate that is the treatment of choice. I have no evidence of that at all. I do not know how anyone can justify funding beyond 20 sessions.[96]

Midwifery

10.91 The Maternity Coalition Inc (MCI) and the Australian Midwives Act Lobby Group (AMALG) stated in their submissions that primary care throughout pregnancy and birth is recognised internationally as best practice. They claim that current Medicare arrangements create a monopoly of prenatal services for GPs, restricting the ability of pregnant women to choose their preferred method of care[97] It should, however, be noted that midwifery services may be insured under private health ancillary cover.[98]

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92 Australian Psychological Society, Submission 49, p. 3

93 Mr Stokes, *Proof Committee Hansard*, Melbourne, 24 July 2003, p. 16

94 Ms Drake, *Proof Committee Hansard*, Perth, 29 July 2003, pp. 71-72

95 Australian Psychological Society, Submission 49, pp. 7-8

96 Professor Martin, *Proof Committee Hansard*, Melbourne, 24 July 2003, p. 16

97 Maternity Coalition Inc, Submission 169 and Australian Midwives Act Lobby Group, Submission 200

98 National Medicare Alliance Fact Sheet 2, www.nma.org.au/fact_sheet02.html, 8 September 2003

10.92 Both MCI and AMALG propose the establishment of a funding arrangement operating independently of Medicare to offer rebates for using midwifery services. They reason that funding implications would be minimal as midwives are less expensive and pregnancy terms, unlike chronic illness, are limited.[99]

Conclusion

10.93 As noted above, the Committee 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.

10.94 While the Committee agrees with this evidence, it recognises that any extension of the MBS to cover allied health services has considerable and complex economic and financial consequences.

10.95 The cost implications are very large, requiring an increase of Commonwealth funding of potentially $3-4 billion, depending on the scope of the additional services covered (although this does not take account of any savings resulting from any reallocation of subsidies to private health insurance ancillary benefits).

10.96 While such measures could in all likelihood result in overall savings from reduced demand for GP and public hospital services, these savings would be difficult to quantify. However, the inclusion of allied health services would be justified where targeted preventative health measures provided by allied health professionals could be shown to generate cost-effective health outcomes.

10.97 A further complication is that savings generated via improved access to primary care and allied health professions, funded by the Commonwealth would potentially emerge in areas of health care currently funded by the states and territories, which might necessitate further renegotiation of the relative responsibilities for health services provision.

10.98 Secondly, the broader cost effects of wide scale additions to the MBS are also difficult to predict. An extensive range of allied health services included on the MBS could trigger an explosion of supply-induced demand for allied health services, with attendant stress on Medicare funding. Conversely, Medicare could impose pricing discipline on the allied health professions, thereby reducing overall costs.

10.99 Thirdly, extending the MBS to cover allied health also raises the important issue of which services would receive priority for Medicare funding and which would not qualify. The decision about which allied health services to include on the MBS is difficult because of, among other things, the varying allied health needs of different

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99 Maternity Coalition Inc, Submission 169 and Australian Midwives Act Lobby Group, Submission 200. The Committee notes existing funding arrangements under the Alternative Birthing Services Program administered through Commonwealth/State Public Health Outcome Funding Agreements. See Senate Community Affairs Committee Report into Childbirth Procedures, December 1999 and Government Response to Report, August 2000.

regions in the Australia, the choice of allied health services to include on the MBS is difficult. Few areas have identical requirements or priorities and moreover, such a decision could arbitrarily create a financial windfall for certain professions while excluding others.

10.100 Finally, given the problems inherent in the fee-for-service model of payment used by Medicare (and discussed in greater detail in chapter 12), it is not desirable to exacerbate the issue by enlarging the number of MBS rebateable items.

10.101 For these reasons, the Committee does not advocate any broadening of the scope of services covered by the MBS. While recognising that there is a legitimate need to enhance accessibility of allied health professionals, 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, and providing funding for shared access to resources via groups such as the Divisions of General Practice.

10.102 These options are explored in greater detail in the final chapter that examines options for enhancing integrated primary care models.

CHAPTER 11

Private health insurance rebate

Introduction

11.1 Term of Reference (d)(ii) requires the Committee to examine:

> The implications of reallocating expenditure from changes to the private health insurance rebate.

11.2 The Commonwealth government's 30 per cent rebate on private health insurance (PHI) came into effect on 1 January 1999,[1] and aimed to:

> … restore the balance in our health care system. A balanced system will ease the burden on Medicare and the public health system and give more Australians greater choice and access to private hospitals. The Commonwealth 30% Rebate makes private heath insurance more affordable. This will help encourage more Australians to take up private health insurance, which will ensure Australia's unique mix of public and private health care continues to be viable.[2]

11.3 The rebate means that, for every dollar spent on a private health insurance premium, the Federal Government reimburses thirty cents. The rebate is available to all Australians who are eligible for Medicare, and who are either members of a registered health fund, or are paying the premium for another person. The rebate is available irrespective of family type or income, and is available on hospital cover, ancillary cover or combined cover.

11.4 The rebate can be claimed via reduced premiums, direct payment from Medicare offices, or a tax rebate in the annual tax return.

11.5 Under the Lifetime Health Cover policy, health funds are able to charge different premiums based on the age at which each member first takes out hospital cover with a registered health fund.

11.6 People who delay taking out hospital cover pay a two per cent loading on their premium for every year they are aged over 30 when they first take out hospital cover. The maximum loading a person can be required to pay is 70 per cent, payable by people who first take out hospital cover at age 65 or older.

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1 Department of Health and Ageing website, http://www.health.gov.au/privatehealth/rebatefaq/whenavail.htm

2 Department of Health and Ageing website, http://www.health.gov.au/privatehealth/rebate/consumers/rebate.htm

11.7 The Commonwealth has estimated it will spend $2.26 billion on the PHI rebate for the year 2003-04.[3] However, the Committee notes that some commentators have estimated the real costs to be higher. Dr Costa from the Doctors Reform Society claimed:

> Leonie Segal from Monash University did a study on this $2.5 billion rebate and it is actually $3.7 billion when you take away the Medicare levy foregone and the added cost.[4]

11.8 This chapter examines some perceived problems with the rebate, including concerns relating to social equity, access to private services in rural areas, and the efficiency and effectiveness of the rebate in achieving objectives. The possibility of reallocating the funds to alternate public health measures is canvassed, followed by an analysis of the effect of such a change on both the private health insurance industry and the wider health system.

Criticisms of the PHI rebate

11.9 Critics of the PHI rebate dispute the use of public funds to subsidise private health insurance, arguing that it is inequitable, inefficient and ineffective. More specifically, they consider that it is neither the best nor fairest way to achieve public policy objectives, and has not in fact achieved these objectives.

Social equity

11.10 A common view of the current rebate arrangements is that it directs a large amount of public money to wealthier parts of society which can already afford private health insurance. Professor Sainsbury commented that the individual's right to choose should not be subsidised by others:

> People should be allowed to choose private health care if they so wish. But, again, the question becomes: if you want to choose private health care, why should the rest of society subsidise your choice to have it? By all means have the choice but do not subsidise it.[5]

11.11 The Western Australian Government levelled a similar criticism at the policy:

> Assessed against equity criteria, a high proportion of expenditure … is contributing toward meeting the cost of insurance policies for people on middle and higher incomes.[6]

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3 Department of Health and Ageing, Portfolio Budget Statements 2003-2004, p. 217

4 Dr Costa, *Proof Committee Hansard*, Sydney, 22 July 2003, p. 56

5 Professor Sainsbury, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 85

6 WA Government, Submission 177, p. 14

11.12 While supporters of the PHI rebate argue that over one million Australians earning less than $20,000 per year benefit from the rebate,[7] Dr Woodruff suggested that this figure may be somewhat misleading:

> If we were to analyse that group of one million, I am quite sure we would find – and you probably have the figures, even – that almost every one of them owns their own home and does not have to pay a significant proportion of their weekly income in rent, which really takes away a huge group of those people.[8]

11.13 The WA Government also questioned the validity of that claim:

> Many of the people on low incomes who access private health insurance do so at the very basic hospital rate to meet the lifetime guarantee and those sorts of things that encourage people to take out private health insurance… The issue of who has private health insurance cover needs to be considered in the context of who has what private health insurance, what that covers, [and] whether there are large gaps … .[9]

11.14 The alternative perspective was put by the Australian Private Hospitals Association (APHA), who reiterate the importance of choice, which they argue means access to affordable private health insurance in Australia's mixed private and public system:[10]

> The public system must prioritise and ration … and as society's resources are not infinite, ultimately someone must be denied access or made to wait for services which in the view of the health professional's assessment of resources and priorities, are of lower priority than others.
>
> But individuals may, and often do, have differing priorities, especially when their own health or that of their family is concerned, and what may seem to be a reasonable prioritisation for one health professional (though not necessarily for another) may not be reasonable for the individual. So private systems allow choices.[11]

11.15 This view concludes that the rebate achieves social equity by reducing the cost of exercising choice by 30 per cent.

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7 AHIA, Submission 105, p. 9. See also the discussion by Senator Knowles, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 83

8 Dr Woodruff, *Proof Committee Hansard*, Sydney, 22 July 2003, p. 53

9 Ms Prudence Ford, *Proof Committee Hansard*, Perth, 29 July 2003, p. 17

10 APHA, Submission 99, p. 2

11 AHIA, Submission 99, p. 2

Access to private health insurance benefits in rural areas

11.16 A related issue is the widely varying degree of access to private health insurance infrastructure between the metropolitan and rural insured. All tax paying Australians are both subject to the tax penalty and Lifetime Health Cover provisions, and beneficiaries of the rebate. However, this equal treatment does not take into account the discrepancies in the availability of private health infrastructure in rural and remote communities.

11.17 The National Rural Health Alliance argued that 'the Commonwealth should recognise that its private health insurance rebate is of little value to rural and remote areas residents',[12] with Mr Gregory suggesting that on average seven percent fewer people take out PHI in rural areas than in cities:

> Again, this is another one of those deficit arguments about how rural areas are missing out on the rebate, compared with the situation that would apply if it were distributed on a per head basis.[13]

11.18 The Australian Health Insurance Association (AHIA) partly acknowledged the discrepancy:

> [P]rivate health insurance numbers in rural areas are lower if there is no private facility. In those areas where there is a private hospital or a private facility of some sort, participation rates are actually quite high.[14]

11.19 Such remarks highlight one aspect of the inequity: that people who live in rural areas where private facilities are unavailable have less choice about the type of care they access.

11.20 Moreover, people living in areas where there are no private facilities can find themselves obliged (through the tax system) to obtain PHI, even though they have no opportunity to utilise it. This contrasts with the situation of those in metropolitan areas, and represents a demonstrable structural inequity.

11.21 Patients with PHI who have no access to private medical facilities still require care, and evidence presented to the Committee suggested that some patients in rural areas are opting to take out private cover to avoid penalties while continuing to use the public health facilities they can access. Patients in this situation effectively subsidise the PHI industry at the expense of their local public health services and of other taxpayers.

11.22 The West Australian Government provided a useful example. Outside of the Perth metropolitan area, there are only two private hospitals, therefore:

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12 NRHA, Submission 87, Position paper, p. 15

13 Mr Gregory, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 83

14 Mr Schneider, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 83

> People in these areas gain little from having health insurance because they do not have access to services for which insurance is relevant. People on higher incomes in rural and remote areas are subject to a tax penalty if they do not have insurance. Under the Lifetime Health Cover they are also subject to having to pay increased premiums if they delay purchasing insurance … .[15]

11.23 The Queensland Minister for Health told the Committee the potential for utilising private cover was minimal in many areas of Queensland:

> Perhaps the most anger I have received about private health insurance has been from rural areas where there is no access to private health facilities. The only access to health facilities is in the public sector, with our rural hospitals or GPs, so they are being forced in many instances – or they believe they are being forced – into taking out private health cover or paying higher tax penalties et cetera when they do not really have any option of using private health cover.[16]

11.24 Similar issues emerged from the Northern Territory:

> Figures for the NT population indicate that the number of people with health insurance is around 8 to 10 per cent below the national average. There is only one private hospital in the NT so options for utilisation of private hospital insurance are limited.[17]

An inefficient path to public health objectives?

11.25 There are conflicting views on the efficiency of the PHI rebate as a mechanism to achieve the purposes outlined above.[18]

11.26 Supporters of the rebate assert that the rebate is a sound investment on the basis that the 30 per cent contributed by the government leverages more than double that amount from the private health insurance holder. The argument follows that the subsidy operates to swell the overall health funds pool by encouraging people to contribute to their own health care costs. The AHIA highlighted the benefits of relatively young and healthy people bolstering the total insurance pool:

> [O]ne of the things that tends to be overlooked in discussion of the private health insurance rebate is the very significant effect of community rating in the Australian health care system ... Community rating means that everyone, regardless of their means, age, sex or state of health, is entitled to the same benefit at the same price. What it does, in effect, is bring in a large pool of people who are healthy, whose contributions to the pool subsidise those of

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15 WA Government, Submission 177, p. 14

16 The Hon Ms Edmond, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 18

17 NT Government, Submission 82, p. 6

18 see paragraph 11.2

> the sick. That instantly leverages a lot of money from people who would otherwise spend it on other things, I suppose, and certainly would not spend it on their own health care because, by definition, they do not need very much. ...
>
> We tend to overlook that when we talk about the rebate, because what the rebate actually does is produce even more leverage for the financial impact of community rating. Every 30c that the government puts into the private health insurance system via the rebate turns into a dollar to be spent on the health care system. You cannot get that sort of leverage from taxation … .[19]

11.27 The AMA also emphasised the impact of government funds in leveraging private sector funds:

> If you distributed that $32.5 billion to the public hospital system it would probably not allow that many services to take place. It is great value for money for the government because, although the 30 per cent is paid by the taxpayer, 70 per cent is paid out of post-tax dollars for everybody else. That represents pretty good value for money for the government and for the people of Australia.[20]

11.28 In his analysis, Professor Harper from the Melbourne Business School, regarded this as a de facto subsidy by those who are privately insured, who in effect pay twice for health care:

> They contribute through income and other taxes to the cost of the public health system as well as paying for the right to access private health care.
>
> In effect, they pay for the option of using either the public or the private system whenever they need (or elect to have) hospital treatment. These additional resources help to keep the average cost of health care down in both the public and the private systems.[21]

11.29 Thus, 'as people abandon private health insurance, the cost of providing public health care and the cost of PHI both rise, reflecting the loss of the implicit subsidy paid by those who take out PHI in addition to paying taxes to fund public health treatment.' Professor Harper concluded that, although expensive in public revenue terms:

> [S]o long as the cost incurred is outweighed by the value of the implicit subsidy, the net impact is positive.[22]

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19 Mr Schneider, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 80

20 Dr Haikerwal, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 40

21 Prof Harper, Submission 127, pp. 4-5

22 Prof Harper, Submission 127, pp. 4-5

11.30 In dollar figures he calculated it would be cost effective for the government to pay up to $4.3 billion per annum into the private health system to keep it going.[23]

11.31 However, the Committee also heard considerable evidence that diverting public funding through the private health system represented an inefficient means of achieving public policy objectives. As a percentage of GDP, the contribution of the private health funds to overall health expenditure has remained largely constant over the period 1984-85 to 2000-01, and this fact casts doubt on the leverage argument.[24] The point was taken up by Professor Sainsbury:

> The private health insurance rebate did not increase the dollars that the public directly invested in private health insurance. This can be quite easily demonstrated arithmetically. If we say that the uptake rate was 30 per cent before the rebate and that it was 45 per cent after the rebate was introduced, and if premiums stayed the same, that was a 50 per cent increase in the amount of money that went into the funds. … But 30 per cent of the total amount is now provided by the government, which is just about the same amount as the extra money invested by the public directly.[25]

11.32 The Committee also notes that Professor Deeble, in his report to the state and territory health ministers on the operation of the PHI rebate, argued that:

> If more hospitalisation was the main objective – and given Australia's very high hospitalisation rate, that is not self evidently necessary – the rebate has clearly been the most inefficient way of funding it. About 12% of it has been absorbed in administrative costs and of the remainder only 40% has gone to supporting hospital and medical services per se. Over two thirds of that may have been associated with existing patients shifting from public to insured patient status, leaving only a small real increase.[26]

11.33 In more general terms, Professor Jeff Richardson described the Australian PHI policy arrangements as 'strange but true', explaining that:

> Because of the levy that we put on the wealthy, for a family with an income of over $100,000 – or rather less than that – the price that a family pays for its private health insurance is negative. At the end of the year you have more money in your pocket if you buy private insurance than if you do not buy the insurance. I know of no other product in the world that has a negative price. But there is a degree of equity, because if you use your private health insurance then you will be out of pocket financially in a way that you will

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23 Prof Harper, Submission 127, p. 20

24 DHA, Submission 138, p. 11; see also discussion at *Proof Committee Hansard*, Canberra, 28 August 2003, p. 88

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

26 Prof Deeble, *The Private Health Insurance Rebate*, Report to the state and territory health ministers, p. 11

> not be if you do not have insurance. So you are paid to have insurance but you are penalised if you use it.[27]

11.34 The Committee was told that the private system delivers less public health per dollar than the public system. Dr Woodruff from the Doctors' Reform Society noted administrative inefficiency and the profit motive inherent in the private health system:

> Why go over to a private system where 15 per cent is spent on administration and 25 per cent on profits for shareholders, leaving 60 per cent of the health dollar for health, when Medicare administration costs are only three per cent?[28]

11.35 Many respondents urged that the most efficient way to reduce the pressure on public hospitals is through direct funding. The National Rural Health Alliance considered that:

> If one wants to do something for the public hospital system – if that is what it is about – then it would be much more effective, all things being equal, to divert the money directly to public hospitals.[29]

11.36 Professor Duckett argued in his submission:

> The Health Minister has recently cited a 245,000 increase in separations from private hospitals in 2000/01 and a 5,000 reduction in separations from public hospitals as evidence of the success of the policy. Although later figures don't bear out the magnitude of the shift, even these figures call into question the efficacy of the rebate.
>
> Given the rebate costs around $2.5 billion per annum, the government is paying over $10,000 per additional patient treated through private hospitals. This is over three times the average cost per patient treated in a public hospital. Eighty per cent of the private hospital increase is in same day admissions.
>
> Direct support for public hospitals is clearly a more efficient way of assisting public hospitals than an indirect policy such as the rebate.[30]

11.37 A further concern raised with the Committee is that the policy ties the Commonwealth into uncapped expenditure of a private health system that is becoming

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27 Professor Richardson, *Proof Committee Hansard*, Melbourne, 24 July 2003, p. 90

28 Dr Woodruff, *Proof Committee Hansard*, Sydney, 22 July 2003, p. 50; a view shared by National Medicare Alliance, Fact Sheet 4: Equity, Efficiency and health care, www.nma.org.au accessed 10 June 03

29 Mr Gregory, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 83

30 Prof Duckett, Submission 93, p. 4; see also Mr Goddard, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 66; and Prof Deeble, *The Private Health Insurance Rebate*, Report to the state and territory health ministers, p. 11

steadily more expensive. The higher premiums rise, the greater the amount of money the government needs to return to policy holders. Articulating this concern, Sharryn Jackson MP stated that:

> I worry for the future about this 30 per cent of an unknown figure, which the government has to commit each year.[31]

11.38 As table 11.1 illustrates, PHI premiums have demonstrated significant growth rates, and since 1996-97, have averaged a rise of 10.6% each year in real terms.

Table 11.1 Contributions income by Registered Health Benefits Funds, Australia, constant prices 1984-85 to 2000-01 ($ million)

Year	Contributions income	Annual growth Rate (%)
1984-85	2,494	..
1985-86	2,701	8.3
1986-87	3,094	14.5
1987-88	3,379	9.2
1988-89	3,396	0.5
1989-90	3,502	3.1
1990-91	3,833	9.5
1991-92	4,308	12.4
1992-93	4,496	4.4
1993-94	4,535	0.9
1994-95	4,458	-1.7
1995-96	4,449	-0.2
1996-97	4,559	2.5
1997-98	4,814	5.6
1998-99	5,027	4.4
1999-00	5,462	8.7
2000-01	6,825	24.9
Average annual growth rates		
1984-85 to 2000-01		6.5
1984-85 to 1988-89		8.0
1989-90 to 2000-01		6.3
1996-97 to 2000-01		10.6

11.39 In 2003 alone, the top five private health insurance funds, controlling over 70 per cent of the market, all had premium increases well above the CPI benchmark,

31 Ms Jackson, *Proof Committee Hansard*, Perth, 29 July 2003, p. 61. These concerns are also reflected in Catholic Health Australia, Submission 96A, p. 3

with the weighted average increase of 7.4 per cent as against a 3.2 per cent CPI benchmark.[32]

Ineffective at meeting its objectives

11.40 As outlined at the beginning of this chapter, the objectives of the PHI Rebate were to increase membership of private health funds; reduce the load on public hospitals; and make the choice of private health insurance more affordable to all in the community.

11.41 Critics suggest that despite the significant costs involved, the policy has not succeeded in meeting these objectives.

Raising numbers in the insurance pool

11.42 In outright terms, it is evident that the objective of increasing private health insurance membership has been met. Since the rebate's introduction in 1999, the proportion of the Australian population covered by PHI has increased from 30% to around 45%.[33]

11.43 However, the PHI Rebate was introduced about 18 months prior to the Lifetime Health Cover initiative, encouraging younger people to take out private cover by providing disincentives to doing so later in life, and introducing a 1% surcharge in the Medicare levy for high-income earners not covered by private health insurance.[34] The impact of these disincentives must be measured in any valid assessment of the effectiveness of the rebate in increasing membership of private health funds.

11.44 The Australian Institute of Health and Welfare, among others, argued that it is the effect of these latter two initiatives, and not the PHI rebate, that has been the primary cause of the membership increase:

> The greatest immediate influence on the level of coverage was the lifetime health cover provision. Coverage increased from 32.3% [of the population] at the end of March 2000, to 45.8% at 30 September 2000, reflecting the full implementation of the Commonwealth Government's lifetime health cover arrangements during the September quarter.[35]

11.45 The effect of the Lifetime Health Cover was heightened by the 'run for cover' media campaign. Mr Greg Ford commented:

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32 Amanda Elliott, *Regulation of private health insurance premiums*, Research Note, Department of the Parliamentary Library, June 2003, p. 2

33 Professor Harper, Submission 127, p. 12

34 Department of Health and Ageing, Submission 138, p. 6

35 Australian Institute of Health and Welfare, *Australia's Health 2002*, Canberra, p. 266

> People might remember the ads at the time, with the umbrellas – the 'run for cover' ads. Such was the rush for people to join private health insurance companies that the deadline was extended from the end of June until mid-July because insurers were overwhelmed by numbers joining. The argument is that it was lifetime health cover at no cost, which got people into private health insurance, not the 30 per cent rebate.[36]

11.46 As Professor Deeble argued in his report to state and territory health ministers:

> Its basic message was that the government could not provide universal access to an adequate standard of hospital care through Medicare and the only way to ensure personal coverage was to take private insurance now.[37]

11.47 The Department of Health and Ageing insisted that it is impossible to establish a causal link between increased membership of private funds, Lifetime Health Cover, and the rebate:

> [T]his is, essentially, an evidence-free zone. We cannot separate the two. We introduced lifetime health cover in a world where there was a 30 per cent rebate. We have not conducted a controlled trial, so it is impossible to say what the impact of lifetime health cover would have been had there not been a 30 per cent rebate in place. I would suggest that that is ultimately an arid topic for debate. The reality is that we went into the sequence of rebate and lifetime health cover, and it is methodologically impossible to untangle the impact of the two.[38]

11.48 Mr Schneider of the AHIA adopted a more optimistic approach to the impact of the rebate:

> I do not believe … that it would have been possible to have got that sort of participation rate at the prices that would have prevailed at that time without the rebate. Around 1997 or 1998 an organisation called TQA Research … determined that the attrition that was taking place would require a minimum 30 per cent reduction in the price of health insurance to be stopped or turned around.
>
> The moment the 30 per cent rebate was introduced, the erosion stopped and turned around. I would draw your attention to the fact that, several quarters before the 30 per cent rebate was introduced, the government did experiment with a means tested rebate, but it failed – it increased participation rates for one quarter only. After that, the trend resumed its downward path. The rebate instantly turned things around. … Indeed, one wonders whether any government would have been willing to introduce

36 Mr Ford, *Proof Committee Hansard*, Canberra, 21 July 2003, pp. 78-79

37 Professor Deeble, Submission 85, p. 5

38 Mr Davies, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 84

> lifetime health cover without the attraction of the 30 per cent reduction in the price achieved by the rebate.[39]

11.49 As Mr Schneider and others have noted, community rating (ie the take up of insurance products across all demographics) is important to the sustainability of the sector. If these trends were to continue the long term sustainability of the industry could be in question.

11.50 In considering the rising membership base of the private health insurers, it is necessary to look deeper into the age profiles of members. In research prepared for the Australian Consumers' Association, Martyn Goddard and Ian McAuley point out that between September 2000 (the first quarter after Lifetime Health Cover was introduced) and June 2003, 384,000 fund members aged below 55 gave up their private health cover, replaced by 234,000 people aged 55 or more. Although the net decrease of 150,000 seems insignificant in a total membership of 8.5 million, they note that in the June 2003 quarter alone 67,894 people aged 0-54 dropped out, while 9356 aged 55 and over joined.[40]

11.51 These figures have significant financial implications for the health funds:

> Someone under 55 brings an average of about $570 a year in gross profits to the funds (they claim $570 a year less than they pay) and someone of 55 or over costs the funds about $500). On the basis of those figures, the younger people dropping out over the most recent quarter will cost the industry $38.7 million a year and the older people joining will cost $4.7 million. In all, the industry will be about 43.4 million every year worse off as a result of the demographic shift in just that three months.[41]

Easing the burden on public hospitals

11.52 The rebate has also been criticised on the basis that it has failed to meet its original aim to reduce the burden on the public hospital system.

11.53 Supporters of the rebate, in particular AHIA and APHA, produced evidence to demonstrate the increasing role that private hospitals, funded by private health insurers, are playing in Australia's overall health system. According to the AHIA, once the rebate was introduced private hospital episodes increased and are still increasing from a low of 1.5 million to an expected 2.2 million this year. These episodes are likely to include:

- 168,000 orthopaedic operations, including hip replacements, knee reconstructions, etc.;

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39 Mr Schneider, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 81. See also Prof Harper, Submission 127, p. 12

40 Martyn Goddard and Ian McAuley, *Beyond the private health rebate*, ACA, 2003, p. 6

41 Martyn Goddard and Ian McAuley, *Beyond the private health rebate*, ACA, 2003, p. 6

- more than 60,000 cataract operations or other eye disease treatments;
- 130,000 cancer treatments;
- 135,000 patients receiving cardiac treatment or heart surgery; and
- 43,000 patients receiving plastic and reconstructive surgery (not including cosmetic surgery).[42]

11.54 The AHIA submission also pointed out that private hospitals provide fifty per cent or more of overall treatments in a number of significant categories, including:

- Chemotherapy 50%
- Cardiac valve procedures 56%
- Mental health treatment (sameday) 65%
- Knee procedures 75%[43]

11.55 Overall, the average increase in hospital separations from 1997-98 to 2001-02 has been 3.5% per annum, with public hospitals handling a 1.3% rise per annum. Private free-standing day hospital facilities saw an increase of 11.0% per annum since 1997-98, while private hospitals overall increased by 7.9% over the same period.[44] APHA state:

> In 1998-99, the private hospitals sector provided 28.3 per cent of total overnight separations and 37.4 per cent of same day separations. In 2001-02, the private hospitals sector provided 32 per cent of total overnight separations and 43.5 per cent of same day separations. That is, the proportion of both overnight and same day separations has increased in the private hospitals sector since 1998-99 … .[45]

11.56 AHIA also pointed to the increasing numbers of people over 65 benefitting from PHI:

> In March 2003 health funds paid more than $2 billion in hospital benefits to people aged more than 65 [which is] almost equivalent to the total cost of the 30 percent rebate. Insured patients aged more than 65 occupied almost 3 million bed days.[46]

11.57 Critics suggested that these positive statistics mask a more complex reality, and have not translated into any real reductions in public hospital workloads.

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42 AHIA, Submission 105, p. 7

43 AHIA, Submission 105, p. 8

44 Australian Institute of Health and Welfare, *Australian Hospital Statistics 2001-02*, p. 16

45 APHA, Submission 99A, p. 1

46 AHIA, Submission 105, p. 9

Professor John Deeble submitted that the rebate has not flowed through to the hospital system in the way it was intended:

> Only about half of the rebate's cost went to additional hospital treatment. The remainder went to more ancillary services (mainly dentistry); to more and higher gap insurance for in-hospital medical fees; to higher levels of insurance cover, higher administrative cost and to reducing the premiums of people who were already insured. It had increased admissions to private hospitals considerably, but the overall cost per additional admission was over twice the public hospital average and the effect on public hospitals had been small.[47]

11.58 Others commented that the rebate has merely generated extra demand for private hospital services without effectively reducing demand for the public system. The Tasmanian government for example had seen:

> … no significant reductions in waiting lists for elective surgery and the pressure on public hospitals continues to grow. While demand has increased in the private sector, there has been no reduction in demand on the public sector. The effect of the increased uptake in private health insurance has therefore been to stimulate additional demand for private hospital services.[48]

11.59 In contrast, the AHIA dismissed the suggestion that people would seek medical treatment for reasons other than need:

> Unless people are being admitted by doctors to hospitals when they do not need to go and are going into hospitals voluntarily to be put under anaesthetic and be cut open for the fun of it, by definition we almost certainly have to believe that they would otherwise be going into public hospitals or be on public hospital waiting lists.[49]

11.60 Nonetheless, most evidence presented to the Committee indicated little impact had been made on public hospital demand. The Queensland Government stated that the rebate had been ineffectual:

> [T]he activity in Queensland public hospital emergency departments has grown from 674,000 to 747,000 patients over a couple of years. That is 10.94 per cent growth. That is way ahead of any population growth and is totally unsustainable. … We keep hearing how the private health system with the private health insurance subsidy has taken pressure off the public hospital system. We simply cannot find that in any of our data. We have

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47 Professor Deeble, Submission 85, p. 10

48 Tasmanian Government, Submission 147, p. 6; a similar view was put by the NT Government, Submission 82, p. 6

49 Mr Russell Schneider, *Proof Committee Hansard*, Canberra, 28 August 2003, p 45

> seen that, yes, it plateaued for a small period and now it is going up again ahead of population growth.[50]

11.61 The NSW Government aired a similar criticism:

> We do hear from time to time that in fact the public hospital system is not as busy as it used to be because of the reforms in the private health care arrangements and the private sector. This claim is simply not correct. A recent analysis by NSW Health of our activity and also of private hospital activity has shown that we have had a two per cent increase in activity overall. We provided 22.6 million services to inpatients and the data put together suggests a preliminary increase of 5.8 per cent in activity in New South Wales alone.[51]

11.62 ACT Minister for Health, Mr Simon Corbell noted that:

> We are seeing an increasing pressure on our public hospital system even though we have one of the highest level of take-up of private health insurance in the country. Our private hospitals are simply not delivering the complexity of services that people are expecting, and the burden is still falling very heavily on our public system.[52]

11.63 The imperatives of the private system also came under scrutiny in the context of working towards achieving the best outcomes for the neediest patients. It was alleged that private hospitals are inclined to choose patients and procedures selectively on the basis of profitability rather than clinical need.

11.64 The WA Government questioned whether increased admissions levels actually represent addressing urgent health care priorities:

> [U]nlike public hospitals, private hospitals do not necessarily work on the basis of clinical need. There is uncertainty about the extent to which increased health insurance membership is leading, via increased private hospital activity, to the nation better meeting the most urgent cases that should be dealt with by hospitals.[53]

11.65 One effect of the Lifetime Health Cover policy has been to drive many people into getting the minimum possible private cover, in order to avoid the penalty provisions. In this context, Queensland Minister for Health, the Hon Wendy Edmond, highlighted the issue of ‘front end deductibles’. Queensland currently has 62.4 per cent of front-end deductibles compared to an average of 59.2 per cent across Australia:

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50 The Hon Ms Edmond, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 34

51 Associate Professor Picone, *Proof Committee Hansard*, Sydney, 22 July 2003, p. 80

52 Mr Simon Corbell, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 16

53 WA Government, Submission 177, p. 14

> [W]e have the highest rate of front-end deductibles, which means that most people go in to get the cheapest private health insurance they can, with the intention that they will never use it. In fact, we have shown statistically that people joined private health insurance not because of the rebate in the system but because of the penalties involved with higher taxation levels et cetera and the lifetime cover. As a result many of them took front-end deductibles and still use our public health system totally; they do not use their private health cover.[54]

Increased affordability

11.66 The final consideration is whether the PHI Rebate has made private health insurance more affordable for people across all socio-economic levels.

11.67 As noted previously, supporters of the rebate pointed to the outright increase in numbers of people with private health insurance, and in particular to the fact that these numbers include over one million Australians with annual incomes of less than $35,000, and over 600,000 in the $35,000 - $50,000 income bracket.[55] Similarly, in an Access Economics analysis commissioned by the Australian Private Hospitals Association, it is concluded that the rebate has restored PHI affordability to a level equivalent to the late 1980's.[56]

11.68 However, Professor Deeble criticised the methodology of the Access Economics Report, arguing:

> At the technical level, the paper claims a highly significant statistical relationship between affordability and coverage but even a simple inspection of the data shows otherwise. Apart from the coverage data being wrong, there was an 18% reduction in the 'affordability index; between 1984-85 and 1988-99, but no change in the proportion of the population privately insured. Conversely, there was almost no change in the index between 1992-93 and 1998-99 but a 25% reduction in the proportion of the population covered. That leaves only 5 years in which some association might be found and there the results were random.[57]

11.69 The Committee also notes that the rapid and sustained rises in the PHI premiums over the past four years (see table 11.1 above), have occurred regardless of both the rebate and the increased numbers in private health insurance schemes.

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54 The Hon Ms Edmond, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 18

55 AHIA, Submission 105, p. 9

56 Access Economics, *Striking A Balance*, p. 9, attachment to APHA, Submission 99

57 Professor Deeble, Submission 85, Attachment: The private health insurance rebate, p. 7

Reallocation of rebate to public health

11.70 A significant number of submissions and witnesses to the Inquiry continued to oppose the PHI rebate and advocate its abolition with reallocation of the funds to other public health priorities.[58]

11.71 This suggestion raised two questions:

- What would be the likely effects of removing the rebate?; and
- What are the alternative uses of the funds?

Effects of removing the rebate

11.72 The Committee considered the effect the removal of the rebate would have on the viability of the PHI industry; the numbers of people who would retain private health insurance; the cost of premiums, and the wider implications for the overall balance of the health system.

11.73 The immediate effects of abolishing the subsidy for private health insurance are difficult to predict. Mr Schneider of AHIA indicated that without the subsidy premiums would rise considerably:

> I think it goes without saying that it would instantly increase the price of health insurance, and not by 30 per cent. If you do the maths, it would actually be in excess of 42 per cent, simply because of the oddity of mathematics. It would be a very savage percentage increase.[59]

11.74 This would mean additional costs of $230 on average for family cover and up to $400 a year for others.[60] The inevitable outcome of rising premiums would be an attrition in membership, as Mr Greg Ford commented:

> [T]here are a number of young, healthy people who have the cheapest private health policy because that costs less than the penalties through lifetime health cover. So I would imagine that people would drop out if we got rid of lifetime health cover as well.[61]

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58 see for example: Council of Social Service of NSW, Submission 84, p. 5; Australian Greens, Submission 100, p. 8; Mr Nilsson, Submission 119, p. 2; Australian Nursing Federation, Submission 159, p. 6; Public Interest Advocacy Centre, Submission 170, p. 2; Women's Action Alliance, Submission 183, p. 4; Mr Goddard (Australian Consumers Association), *Proof Committee Hansard*, Canberra, 21 July 2003, p. 66

59 Mr Schneider, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 81

60 AHIA, Submission 105, p. 16

61 Mr Ford, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 82

11.75 The decrease in numbers of people in lower risk categories with private health insurance drives what is described as an 'adverse selection spiral',[62] as Mr Schneider explained:

> The inevitable assumption must be that the first to go would be the best risks. They would make the logical decision that, given that they are healthy, they do not need to be paying for it, and they would carry their own risk. Therefore, the actual impact on price is more likely to be something like 50 per cent. The inevitable impact of that, of course, would be that those on the lowest incomes would be the least able to maintain their insurance. Almost by definition, those people are retired. Most of them are over 65 and many are over 70.[63]

11.76 AHIA concluded this would transfer between 313,000 – 417,000 episodes from the private to the public sector, which would cost between $704 - $939 million, or waiting lists would increase by 400,000 people.[64]

11.77 The AHIA also tabled a document containing the statements of several hundred people, outlining the importance of the PHI rebate to them, and the implications of its removal. The following comments provide an example typical of these sentiments:

> If the rebate is taken away I will no longer be able to afford private health fund [membership] and will pull out. I am a pensioner and $139 a month is a big cost each month to me out of my pension. If the 30% rebate is taken away I will drop out of the private health fund and let the government look after me.[65]

11.78 The Association of Independent Retirees made their views similarly clear:

> AIR strongly supports the 30% rebate for private health insurance, carried by over half its members, and will oppose any attempt by any party to remove or reduce this subsidy.[66]

11.79 Removal of the rebate could also be expected to have a significant impact on allied health professionals, many of whom opposed abolition of the rebate unless the funds were reallocated to their services. For example, the Australian Physiotherapy Association told the Committee:

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62 Professor Harper, Submission 127, p. 6

63 Mr Russell Schneider, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 81

64 AHIA, Submission 105, p. 18

65 Mr Richard Thorne, NSW, extracted from *Health fund contributors and their 30% rebate*, AHIA, tabled document, Canberra, 28 August 2003

66 AIR, Submission 97, p. 10

> We have certainly aired concerns that, if the 30 per cent private health insurance component that covers physiotherapy services is touched in any way, it must be put somewhere else into the system. Therefore we are totally opposed to those submissions and proposals from groups that suggest it be put into GP services and nursing services.[67]

11.80 According to the AHIA, the removal of the rebate on ancillary cover alone would cause around 46% of the 8.2 million people who currently have ancillary insurance to opt out.[68]

Alternative uses for the funds

11.81 If the 30 per cent PHI Rebate were to be abolished and the funds reallocated, a second question is how to redistribute the funds most efficiently and equitably. Several commentators consider that putting the money directly into the public hospital system would be more cost effective than indirect support via the rebate. Similarly, the Western Australian government stated that:

> Based on a 2000/01 AIHW estimate that the national average cost per casemix-adjusted separation was $2,834, the $2.5 billion per year now spent on the rebate could alternatively fund around 900,000 additional in-patient services in public hospitals.[69]

11.82 An alternative suggestion, that the funds in part be used to support bulk-billing by increased MBS rebate levels and other community health initiatives, was made in several submissions. The SA Divisions of General Practice observed that:

> The Divisions network has achieved substantial success in delivering integrated patient care though a number of initiatives including the More Allied Health Services Program. Funding from the private health insurance rebate could be redirected to expand this program so that patients in both rural and urban areas have better access to coordinated general practice and allied health services.[70]

11.83 The Doctors' Reform Society offered the Committee the most detailed alternative, targeting a variety of health sectors:

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67 Ms Katie Mickel, *Proof Committee Hansard*, Melbourne, 24 July 2003, pp. 5-6

68 AHIA, Submission 105, p. 16

69 WA Government, Submission 177, p. 15

70 SA Divisions of General Practice, Submission 33, p. 4; see also ADGP, Submission 37, p. 7; Australian Greens, Submission 100, p. 13

Table 11.2 Alternative allocation of Private Health Insurance Rebate funds[71]

Item	Amount
Supporting General Practice through a $5 increase per GP consultation, made up by addition of $140 m from current Gov proposals)	$280m
Package for GPs who bulk-bill everyone (yearly bonus, practice nurse, support for capital infrastructure, medical indemnity)	$80
Additional funding to community based primary care, aged care, mental health and hospitals.	$860
Dental Health Scheme	$800
Saving the PBS: Education Program for Doctors Prescribing Drugs (to reduce pressure on PBS from pharmaceutical industry)	$160
Aboriginal Health (increase by 10%)	$120
TOTAL	**$2,300**

Alternatives to abolishing the rebate

11.84 Abolition of the private health insurance rebate is not, however, the only alternative: there are a range of other options by which the rebate could be retained but its application refined to ensure the optimum public policy results. As Professor Deeble commented, the current rebate arrangements are 'unconditional, undirected and uncapped.'[72] There are four principal options.

11.85 Firstly, expenditure on the rebate could be capped. As discussed above, there are already concerns that the Commonwealth has committed itself to funding rebates amounting to thirty percent of an amount that continues to grow rapidly, with no sign of slowing. It may, therefore, be necessary to limit the extent of the public commitment to the scheme by imposing a maximum level of subsidy, which would provide budgetary certainty and allow additional funding to be allocated to other public health priorities.

11.86 A second option is to remove the rebate for private health insurance ancillary cover. As Professor Deeble pointed out:

> Nearly $500 million is involved. Apart from dentistry, the services it covers are poor candidates for subsidy and there are no clear offsets on the public side. In dentistry, the offset was effectively taken by the cancellation of the Commonwealth dental program in 1996, but an undirected subsidy of even

71 Doctors Reform Society, Submission 25, p. 5

72 Professor Deeble, Submission 85, Attachment 1, p. 12

> cosmetic dentistry at over twice the cost in rebate is demonstrably less effective and less equitable than the specific program for the aged and disadvantaged people which it replaced.[73]

11.87 It is acknowledged that removal of ancillary cover would be likely to have some impact on access to the services of allied professionals such as psychologists, physiotherapists, chiropractors, and nutritionists. There is evidence showing that expenditure on allied professionals does result in improved health outcomes, but more definitive work needs to be done.

11.88 Thirdly, it has been argued that a more efficient way to use private hospitals, and thereby reduce the pressure on the public hospital system, is by means of direct funding. This would effectively involve by-passing the private health insurers. Mr Goddard of the Australian Consumers Association argued:

> A more appropriate scheme would involve fee-for-service payment in accord with AR-DRGs,[74] augmented with block funding to recognise the total cost of running a hospital, including infrastructure and return on investment. … As with Medicare, a schedule fee would be set for each item, with the benefit being paid to the patient with the capacity to assign that benefit to the provider if the provider elects to bulk-bill.[75]

11.89 He noted that a cheaper and more cost effective version could be created by funding only those services which public hospitals could not adequately deliver.

11.90 This method retains the advantages of private hospitals, while utilising the economies of scale, efficiency and public control of Medicare as the universal health funding agency.

11.91 A final option is to change the arrangements for providing funding to increase the transparency of the use of public funds and the public health policy outcomes from those funds. This would involve the imposition of a greater range of conditions on private health insurers and private hospitals to ensure that funds are spent on public health priorities and also that public funds are not used in the private system to duplicate or undermine the public system. According to Professor Deeble:

> $2.1 billion is a large enough sum to force some integration and it should be used as such. Despite the rebates' deficiencies there is a case for certain private sector subsidies but the community is entitled to see that they are used efficiently, costs are controlled and that the most effective services are provided.[76]

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73 Professor Deeble, Submission 85, Attachment 1, p. 13

74 'Australian Defined Diagnosis Related Groups' – referring to patient case-mix management techniques.

75 Martyn Goddard, *Beyond the private health rebate*, ACA, 2003, p. 9

76 Professor Deeble, Submission 85, Attachment 1, p. 14

11.92 The Commonwealth would have every right to:

> … require transparent and independent utilisation review processes. That would be not more than the public hospitals are now forced to do.[77]

11.93 The Committee was made aware of the need to refine the relationship between public and private hospitals so that they are working as a single, complementary system, rather than as competitors. In this context, the Committee notes the comments of Mr Goddard of the ACA who stressed the necessity to:

> … create complementarity between the public and private hospital systems, rather than continuing today's wasteful duplication. … the nation cannot afford two competing hospital systems, we need one system, adequately and fairly funded, of which private hospitals are an integrated part.[78]

11.94 As Professor Deeble advocated, one means of achieving this complementarity is to link the receipt of public insurance subsidies to participation in joint public-private sector planning.[79]

11.95 The relationship between the public and private insurance systems and the private and public hospital systems is complex and interrelated, and changes to any part of the system must be carefully considered for its wider effects. Nevertheless, the amounts of public funds currently invested through the private health insurance rebate are enormous, and the public have every right to expect that these funds are spent in a transparent way, with a clearly defined and measurable outcome.

11.96 The Committee is not convinced that this is currently the case, and concludes that the options discussed above deserve detailed consideration.

Conclusion

11.97 To determine definitively whether the expenditure on the rebate is equitable and has met its objectives is a complex task. The Committee is concerned that the argument has been diverted into a debate about the relative effectiveness of the public and private sectors rather than the broader question of resources. In the interests of best use of funds, and with an understanding of the historical context of our hospital system, more attention should be applied to seeking collaboration between the two sectors. The Committee also considers it a priority that confidence in the public health system must be restored. To this end, the Committee recommends that further inquiry into the effectiveness of the rebate is required.

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77 Professor Deeble, Submission 85, Attachment 1, p. 14

78 Martyn Goddard, *Beyond the private health rebate*, ACA, 2003, p. 9

79 Professor Deeble, Submission 85, Attachment 1, p. 14

11.98 Such a view was expressed by the West Australian government:

> Given the differing views and the present lack of clarity about the implications for the health insurance rebate, a rigorous independent assessment should be undertaken.[80]

11.99 Since 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.

11.100 Nevertheless, the Committee considers that sufficient evidence has already been presented to cast doubt on the overall effectiveness of the PHI rebate in contributing to the improvement of Australia's health system. In the light of the large amount of money involved in the subsidy, and the alternate uses to which it could be put, these criticisms must be taken seriously.

11.101 The Committee considers it premature to form any conclusions on alternative allocation of the resources, but the options outlined in this report will remain as future assessments of the PHI rebate policy are made. Professor Sainsbury framed the question of the allocation of the rebate in this way:

> 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?[81]

11.102 Total removal of the rebate would probably have immediate and adverse implications for the take-up of private health insurance. 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.

11.103 The advice of the ACA is this respect is sound: 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, particularly of publicly purchased hospital services, must be restored.[82]

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80 WA Government, Submission 177, p. 15

81 Professor Sainsbury, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 85

82 ACA, Submission 72, p. 12

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.

Chapter 12

Other reform options

Introduction

12.1 The report has so far considered problems in the access to and affordability of general practice for consumers; the viability of general practice for doctors; and has examined both the government and opposition proposals to reform Medicare.

12.2 This chapter concludes the report by looking at other proposals put to the Committee during the course of the Inquiry.

12.3 These include raising the level of the MBS rebate for consultations; other more general reforms to general practice payments; moving to a greater focus on health care teams; and reforming overall funding arrangements. Finally, the chapter considers the priority areas for greater research, and issues relating to Australia's reliance on overseas trained doctors.

Raising the Medicare Schedule Fee and Rebate

12.4 Many groups have argued that the simplest solution to the current declining rates of bulk-billing and other problems related to access is to raise the MBS Schedule fee above its current level of $29.45 (with a payable rebate of $25.05).

12.5 The Australian Medical Association, other medical groups and many individual doctors attribute the falling rates of bulk-billing to the fact that rebates have not kept up with the cost of running a medical practice. A representative comment came from doctors in Mackay:

> The Government Schedule fee rebate has not kept pace with inflation and the gap between the AMA schedule and the Government schedule has widened … this has led to an increased cost to the patient to see a non-bulk-billing doctor.[1]

12.6 Dr Brook, Executive Director of Rural and Regional Health and Aged Care with the Victorian Depart of Human Services, claimed that medical practice costs:

> … move significantly higher than the CPI in all aspects, including salaries and wages for health workers who are not medical practitioners working in general practices elsewhere, and in terms of consumables, equipment and

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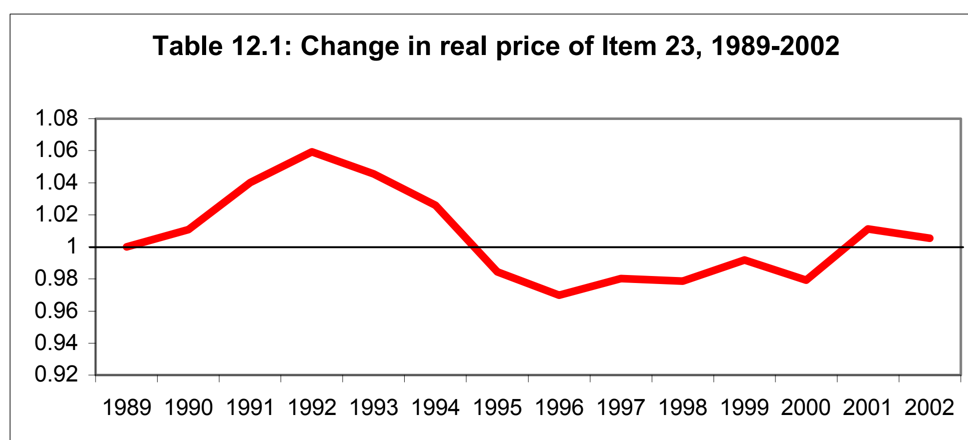
1 Family Medicine Mackay, Submission 218, p. 2

the like. In the last 10 years, for all but two years, the rebate level has been below the CPI.[2]

12.7 Tracking the real value of the rebate over time is not straightforward. When measured against the consumer price index, it is apparent that regular rises in rebate levels have generally matched and at times exceeded CPI.[3] Professor Duckett made this comment on the relative level of the rebate over time:

> In the five years or so before the election of the Liberal government, in all but one year the GP rebate item was indexed at least in line with the Consumer Price Index (CPI). In the years since the election of the Liberal government, the increase in the rebate was less than CPI in all but two years … .[4]

12.8 Table 12.1,[5] illustrates the trend of the rebate against CPI.[6] However, in the view of many doctors, these rises disguise the fact that the real costs of running a general practice have risen ahead of CPI, with the rebate no longer reflecting these costs. The issue of practice costs is discussed in detail in chapter 3.



What is the role of the rebate?

12.9 An important starting point for examining claims for increasing the level of the MBS fee and/or the rebate, is a clear focus on what the rebate is intended to represent.

12.10 It has been argued that the role of the MBS rebate is to reimburse patients for 85% of the real cost of attending a GP. The level of 85% was established recognising the administrative costs of billing a patient. This contention is based on the situation at

2 Dr Brook, *Proof Committee* Hansard, Melbourne, 24 July 2003, p. 69

3 See Chapter 3, Practice Costs.

4 Prof Duckett, Submission 93, p 1

5 Note that Item 23 on the Medicare Benefit Schedule is a standard GP consultation.

6 Professor Duckett, Submission 93, p. 1

the instigation of Medicare in 1983, when the Schedule Fee at the time represented a realistic, even generous, consultation fee amount. This was designed to elevate the level of control government had over cost increases, as Professor Deeble explained:

> The higher the level of bulk-billing, the higher the level of adherence to the fee, the more control, in effect, the government had over the rate of increase in those fees.[7]

12.11 From the perspective of those promoting an increase bulk-billing rates, it is strongly argued that the rebate should reflect market rates for general practice, as a logical and fundamental precursor to bringing about a perception in the medical fraternity that bulk-billing is viable.

12.12 Others contend that the rebate can only represent a contribution to the cost of health care, in an era when governments find it prohibitive to fund comprehensively and in which doctors remain free to set their own prices. According to the AMA analysis:

> It is clearly up to the government to decide what that rebate level should be – what they can afford to pay – and it is up to the doctor to decide what he or she needs to charge to provide that service. The smaller the gap between what the doctor needs to charge to provide the appropriate service and what the government insurance arm or Medicare pays as a rebate, the more likely it is that the patient not going to be out of pocket … .[8]

12.13 There is certainly no clear public consensus on this issue, either from the government or doctors' groups. However, the purpose of the rebate is a question at the core of Medicare's future, and some consensus is needed if wider issues relating to Medicare are to be resolved.

What should the rebate be now?

12.14 Notwithstanding the above discussion, the Committee did attempt to elicit from doctors their estimation of what would constitute a fair level for the rebate. Many were reluctant to nominate a particular figure, but several options for calculating the rebate were frequently mentioned.

12.15 The first of these was the Relative Value Study (RVS), which, as discussed in chapter 3, was conducted by the Government and the medical community to determine the value of a GP consultation.[9] Many individual doctors and medical groups such as the AMA argue that on the basis of the RVS, the schedule fee should be set at around $50. Dr Bain of the AMA told the Committee:

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7 Professor Deeble, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 13

8 Dr Glasson, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 46

9 for further detail on the RVS, see Department of Health and Ageing, Submission 138, p. 22

> We spent seven years working with the government on the relative value study and that came up with the figure of about $50. That is where the schedule fee should be. Whether the government can pay 80 per cent, 50 per cent or 10 per cent of the schedule fee is another issue but we are saying that the schedule fee should be where the RVS says.[10]

12.16 The Department of Health and Ageing has taken issue with some of the interpretations of the RVS made by the AMA and others, and has claimed that:

> [T]he RVS showed that, if anything, there was some slight under funding of GP services and some slight overfunding of other non-GP specialist services.[11]

12.17 The overseeing committee of the Medical Services Review Board could not reach agreement on a range of issues important to the modeling of payments, and as a result, there was no agreed methodology for modeling and no agreed RVS outcome.[12]

12.18 In subsequent modeling, the Department changed four key assumptions, relating to:

- GP Workload (expressed as the number of services performed by GPs annually);
- practice costs;[13]
- target income for GPs; and
- the work value of a standard consultation.[14]

12.19 The resulting models indicated a slight underfunding of GP attendances.[15] However, the Department argues that other, non-rebate payments 'more than offset' this underfunding. Specifically, the Department points to $750 million over four years in additional funding to general practice which was announced in the 2001-02 Budget, as well as the remuneration available through various blended payments.[16]

12.20 Critically, the RVS does not explicitly recommend a dollar figure of any amount. The AMA interpreted the findings of the Study, modelled them, and arrived at a conclusion that a GP consultation was worth approximately $50.[17] The

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10 Dr Bain, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 47

11 Mr Davies, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 50

12 Department of Health and Ageing, Submission 138B, Question 10

13 See also Chapter 3 for further details on Practice costs.

14 Department of Health and Ageing, Submission 138B, Question 10

15 Department of Health and Ageing, Submission 138B, Question 10

16 Department of Health and Ageing, Submission 138B, Question 10

17 Amanda Elliot, *What is the Relative Value Study?*, Parliamentary Library Client Memorandum, August 2003.

Department argues that inaccurate assumptions were used in the AMA modelling, and that:

> The RVS study did not produce a dollar figure. The AMA have subsequently chosen to interpret it in dollar terms; the department has never done that.[18]

12.21 Professor Swerissen agrees, and suggests that the real value of a GP consultation would be less than $50:

> We agree with the government's submission that that is probably a somewhat optimistic view of what would be required. I would say that it would be at the high end of the aspirations.[19]

12.22 However, the AMA refutes the Department's view of the RVS, and defends the accuracy of their claim:

> The costs were not referenced against specialists; they were referenced against overseas doctors and also against like professional groups in the community. Five of those were chosen for direct comparisons, including, I think, chemical engineers, geologists, accountants and solicitors.[20]

12.23 The AMA's view is echoed by doctors themselves. The rebate, they say, is completely insufficient to sustain a practice and until it increases substantially, bulk-billing rates will not improve. For example, Dr Matthews from Queensland stated that: 'it reached the point where we had to either start charging patients or close down',[21] while Dr Winterton, a West Australian GP, said:

> The current rebate is no longer a viable fee after one takes into account that 4% of every rebate fee is for medical indemnity insurance costs, 20% of every fee is for staff costs, 10% of every fee is for rent, and another 13% of the rebate is for other practice expenses.[22]

12.24 And Dr Alexander, in Tasmania:

> Discussions about rebates should never involve the CPI. The CPI bears no relation to the rising costs of general practice … [the funding of which] … must be increased significantly and urgently.[23]

12.25 Mr Davies argued it is impossible to determine an accurate standard fee:

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18 Mr Davies, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 98

19 Professor Swerissen, *Proof Committee Hansard*, Canberra, 23 September 2003, p. 9

20 Dr Rivett, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 41

21 Dr Matthews, Submission 110, p. 3

22 Dr Winterton, Submission 115, p. 1

23 Dr Alexander, Submission 11, p. 2

> The fee a doctor charges can and does vary widely and it relates to a number of factors, including the input costs of the practice; the efficiency of the business operations … the level of demand and supply within the local marketplace, as evidenced by the close relationship between bulk-billing and the supply of doctors; the style of practice; and, indeed, the personal views of the doctors on what is an acceptable fee for patients and what is an acceptable income for themselves and their partners in the practice. [24]

The relationship between bulk-billing rates, doctor shortage and the MBS rebate level

12.26 While doctors argue for a rebate increase to support an increase in bulk-billing rates, there has been considerable disagreement over whether this is the optimal way to achieve the outcome. An alternate view is that the supply of bulk-billing services is determined more by the numbers of practitioners available.[25]

12.27 Some evidence suggested that falling bulk-billing rates are a reflection of the shortage in the supply of GPs, which in turn stemms at least in part from a range of measures introduced in 1996 designed to limit supply.[26] According to this view, the easiest way to raise the rates of bulk-billing is to increase supply via extra training places. [27]

12.28 The submission from the College of Non-Vocationally Registered GPs stated:

> In 1984 the ratio was 1.08 doctors per 1000 patients. Bulk billing was 45%. The ratio peaked in 1996 at 1.35/1000. Bulk billing peaked a year later. The ratio is currently 1.24/1000 and bulk billing is falling at about 2-3% per annum.[28]

12.29 The College lists the following arguments:

- Bulk-billing rates rose during the 1980's and most of the 1990's despite GP rebates falling in real terms through most of this time.
- Virtually all specialists have substantially higher rebates than GP's and much lower bulk billing rates.
- Bulk billing rates vary widely geographically despite rebates being the same Australia wide.

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24 Mr Davies, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 90

25 See chapter 3

26 These measures to restrict supply are discussed in chapter 4, and include restricted provider numbers, and a reduced number of medical school places.

27 Dr Moxham, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 1

28 College of Non-VR GPs, Submission 48, p. 2

- Non VR and VR GP's bulk bill about the same, despite the considerable rebate differential.[29]

12.30 In support of this last point, Dr Moxham notes that the VR rebate for a standard consultation is $25.05, compared to $17.85 for the same consultation from a non-VR doctor. The bulk-billing rates in 2001-02 were 74.1 per cent for VR doctors with their higher rebate, and 83.1 per cent for non VR doctors.[30]

12.31 Accordingly, Dr Moxham suggests that the rebate levels could actually be reduced to the levels of non-VR GPs in order to pay for additional training places in medical schools.[31]

12.32 Dr Ruscoe, a NSW GP, pointed to the changes in the GP environment since the inception of Medicare, from an oversupply of GPs to the current undersupply: 'This has resulted in GPs in areas of GP undersupply controlling their workload by the use of patient copayments to discourage trivial attendances.' He added:

> To seek to increase bulk-billing through untargeted increases in GP attendance benefits is likely to be counterproductive to social goals for two reasons:
>
> - GP using co-payments to control their workload are likely to add their co-payment on top of the new benefits.
> - High attendance benefits are likely to exacerbate the present bias in favour of acute care as against chronic care and thus further increase hospital chronic care loads.[32]

12.33 The government has consistently argued through the Inquiry that simply increasing the rebate level will not necessarily increase bulk-billing rates. Using three graphs,[33] Mr Davies made the following points, which are worth quoting at length:

> The first [graph] is a simple comparison of the GP bulk-billing rate against the standard rebate for item 23, expressed in nominal terms [Table 12.2]. It shows that the last three or four years, which has been the period when the rebate has been rising at the fastest rate since the establishment of Medicare, has been the period when the bulk-billing rate has been dropping at the fastest rate. That tends to give the lie to the argument that if we were to increase the rebate then bulk-billing rates would go up.

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29 College of Non-VR GPs, Submission 48, p. 7

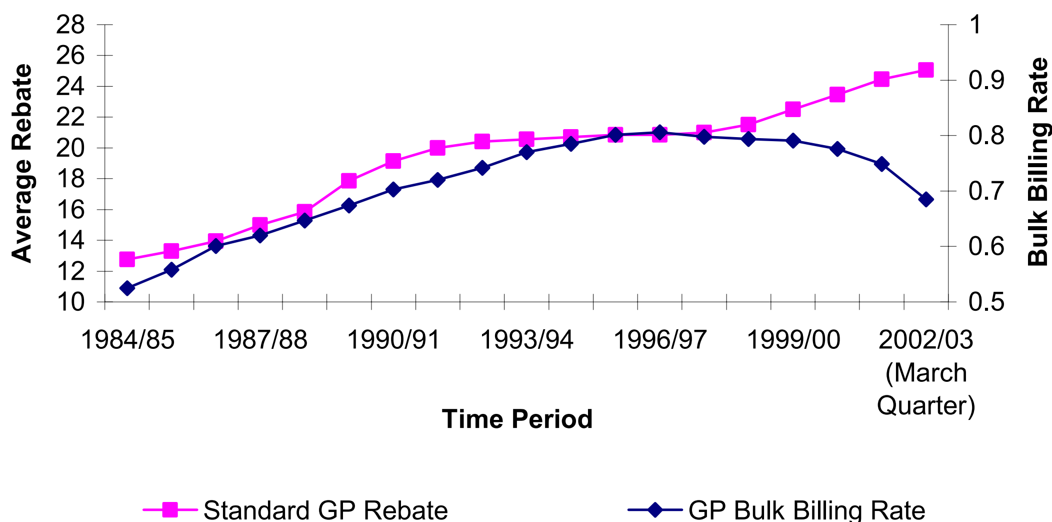
30 Dr Moxham, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 2

31 College of Non-VR GPs, Submission 48, pp. 8-9

32 Dr Ruscoe, Submission 153, p. 7

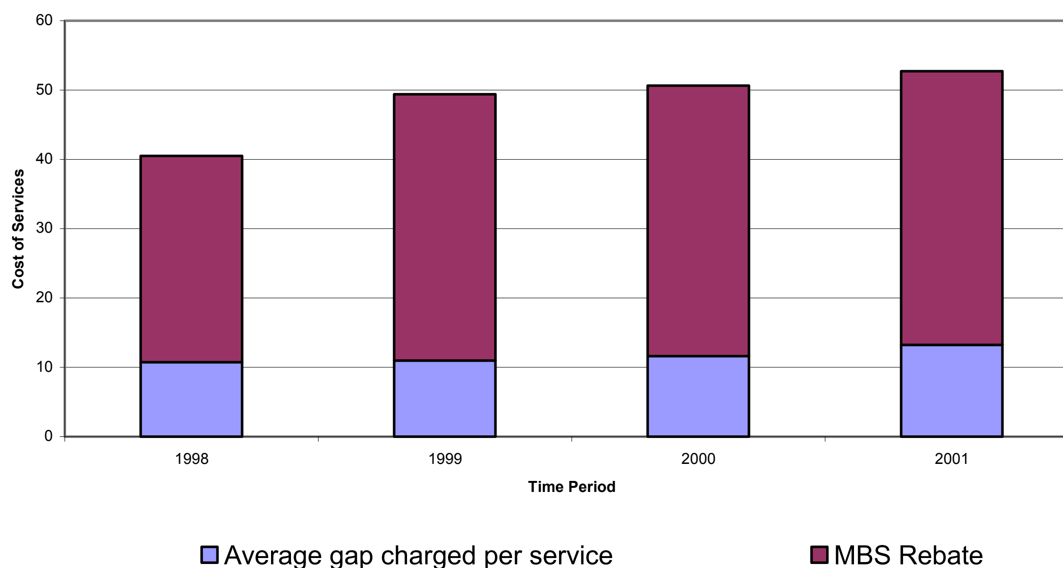
33 Department of Health and Ageing, Tabled documents, Canberra, 21 July 2003

Table 12.2 - Comparison of Standard GP Rebate (Item 23) with GP Bulk Billing Rates



More tellingly, I have a couple of other graphs to table which look at the impact of a couple of other changes where rebates have been increased significantly. The first looks at radiation oncology [Table 12.3]. Between 1998 and 1999 there was an increase, by eye, of about $8 in the rebate for a couple of radiation oncology items. The logic that underlies the case that if we increase the rebate, gaps will go down or bulk-billing will go up does not seem to hold up in this case at least, because despite an $8 increase in the rebate the average gap per service appears to have remained totally unchanged. The increase in the rebate has all been absorbed in the form of additional income to radiation oncology service providers.

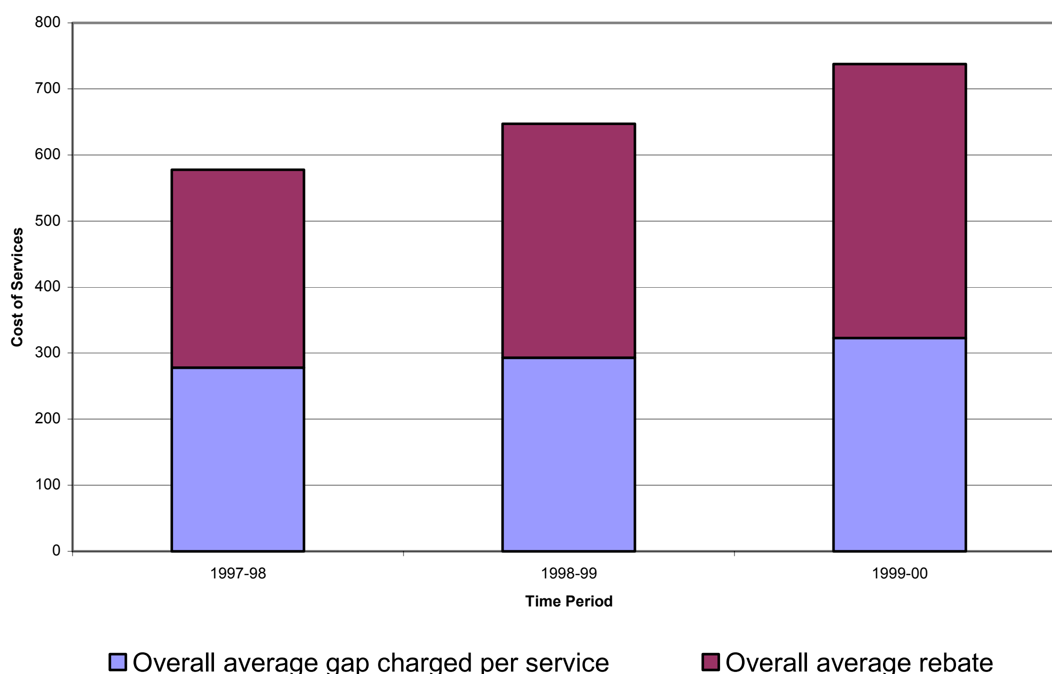
Table 12.3 - Radiation Oncology (MBS Items 15203, 15207): MBS Rebate and average gap charged



We see a very similar thing in the case of obstetrics [Table 12.4]. In fact, this case is even more telling. The average rebate has, again, in two consecutive years increased significantly but, lo and behold, the average gap charged has also risen across those two two-year periods. I venture to suggest that taking those three graphs together – and this may sound counterintuitive – raises the question of whether an increase in the rebate is actually going to flow through to a reduction in gap charges or an increase in the bulk-billing rate.[34]

34 Mr Davies, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 50

Table 12.4 - Obstetrics (MBS Items 16519, 16520, 16522): MBS Rebate and average gap charged



12.34 Mr Davies concluded that there is no compelling reason to believe that increasing the rebate, of itself, would produce the outcomes required:

> If we took all of the $917 million budgeted for A Fairer Medicare, including the work force measures and the safety nets, and spent it entirely on an increase to the rebate, it would yield an increase of about $2.30 per visit. In return there would be no guarantee of improved access to GPs, no guarantee of improved affordability for patients and, indeed, no guarantee of improved equity.[35]

12.35 Professor Deeble also had an interesting contribution on this point:

> If you really wanted to encourage bulk-billing of the disadvantaged, I would pay doctors more than they would get from charging patients. But under the proposals, and this is true of all the proposals, they will still get less – that is, a doctor will get more money from treating a non-concessional patient than from treating a concessional patient. If you really want them to treat the concessional patient, you pay them more, not less.[36]

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35 Mr Davies, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 69

36 Professor Deeble, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 35

Setting the MBS rebate level in the future

12.36 The other question that arises in this context is what mechanism should be used in the future to determine the MBS level. The current system for setting the MBS rebate is based on the use of one of the standard government indices, in this case, one known as the WCI5, which is a hybrid index of wages and costs.[37]

12.37 The Department of Finance has developed a series of wage cost indices to measure specific purpose payments, Commonwealth own purpose payments and running costs. The WCIs are based on the Safety Net Adjustment (SNA) handed down by the Australian Industrial Relations Commission and underlying inflation. The SNA covers wage components while underlying inflation covers the non-wage component of labour costs. There are a range of indexes to choose from depending on the weighting of the wage and non-wage costs of the program to index.[38]

12.38 The Committee heard evidence that the rebate should be based on a more accurate index, specifically tied to costs of medical practice.[39] The AMA argued for indexation that takes account of the growing costs of health care, including the ageing of the population, the wider range of available treatments, and expanded consumer expectations:[40]

> Three large factors drive costs in general practice: we have an ageing population which takes considerably longer to service and which has many more needs, the number of therapies available to that population has exploded, and people's awareness of those therapies has also exploded. So we have a much better informed consumer population, many more treatment modalities which GPs need to be abreast of and a much bigger ageing population which is going to continue to grow in Australia. There is no easy way out of it without spending substantially more dollars to get a quality system in place.[41]

12.39 The AMA also noted the failure of the RVS to address the issue of indexing.[42] Dr Rivett expanded on this in Brisbane:

> Indexation was not looked at, which has been the bugbear of the whole system. Without proper indexation there cannot be a sustainable solution into the future. You have to have indexation that matches rising practice

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37 Mr Davies, *Proof Committee Hansard*, Canberra, 21 July 2003, pp. 63-64

38 taken from the Department of Finance website: www.finance.gov.au

39 See, for example, Dr Alexander, *Proof Committee Hansard*, Hobart, 31 July 2003, p. 42, Dr Djakic, *Proof Committee Hansard*, Hobart, 31 July 2003, p. 69, Professor Kidd, *Proof Committee Hansard*, Melbourne, 24 July 2003, p. 23, Ms Pike, *Proof Committee Hansard*, Melbourne, 24 July 2003, p. 68

40 Dr Rivett, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 40

41 Dr Rivett, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 40

42 Dr Rivett, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 52

> costs and average weekly earnings jointly; otherwise, we are just wasting out time putting in any solutions because they will be like bandaids on a dike – things will get worse. So indexation has to be countenanced, and it is not in either of these packages, which is a huge disappointment.[43]

12.40 By way of alternative example, the RDA noted the Rural Doctors Settlement Package, used to remunerate doctors for work in NSW state public hospitals:

> In 1987, after a dispute, rural doctors accepted 85 per cent of the Medicare schedule fee at that time as full payment for services. Additional in that system of payment was a formula for indexation which included the costs of practice – medical indemnity insurance, running a car, employing staff and providing for their superannuation. It took into account a whole range of factors. So, over time, the only difference between the MBS fee and the rural doctors settlement package in New South Wales is the formula for indexation. As a consequence of that formula, the payment, which in 1987 was 15 per cent below the MBS fee, is now 30 per cent greater than the MBS fee.[44]

12.41 However, this issue should also be considered in the context of earlier processes for setting the rebate level. As Professor Deeble points out in his submission, 'until the mid-1980's, the recommendations of the Medical Fees Tribunal were public, but the AMA subsequently withdrew from the process in the (mistaken) belief that it could do better by direct action.' This change left the Medicare system with no documented defence of its benefits.[45]

Conclusion

12.42 The central question for this section is whether the MBS fee should be raised, and if so, to what level. As concluded in Chapter 3, the Committee acknowledges the probability that practice costs have increased in excess of CPI, but heard no compelling evidence that this is the case for either metropolitan or rural GPs.

12.43 The Committee is mindful of the limitations inherent in the fee for service model, which are discussed later in this chapter, and of the strong and compelling arguments that an increased rebate does not automatically equate to more bulk-billing and better health outcomes.

12.44 The Committee is not convinced that substantially increasing the MBS rebate would, of itself, improve levels of bulk-billing. It is clear that other incentives are also required. In an era of increased emphasis on the delivery of quality, integrated health care, the Committee recommends containing increases in the rebate to moderate levels, pending the outcome of the a comprehensive analysis of the advantages of

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43 Dr Rivett, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 52

44 Dr Mackey, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 118

45 Prof Deeble, Submission 85, p. 10

implementing other methods of payment for GPs. These are discussed in more detail later in this chapter.

Addressing perverse incentives: refining payments to General Practice

12.45 As described in Chapter 3, there are three basic models of payment to medical practitioners, based on salaried remuneration, capitation or fee-for-service.

12.46 While still employing a model based on fee-for-service, Australia has moved in recent years towards a system which incorporates blended payments, whereby in addition to fee for service payments based largely on patient throughput, practitioners are able to access extra payments when government-prescribed objectives are met. In addition, capitation-based payments are used, in conjunction with mixed mode funding, in some Aboriginal services.[46]

12.47 This section examines some of the calls to explore other funding options for GPs, and some reasons why the fee-for-service model is said to encourage perverse incentives for both GP and patient, resulting in sub-optimal health outcomes. As well as encouraging shorter consultations, the model is also argued to drive a higher levels of referrals and prescriptions, instead of more time consuming activities such as counselling on lifestyle issues, diet, weight loss, exercise etc.[47]

12.48 There was strong support from the medical profession and others for the current fee-for-service based system.[48] However, the Committee heard evidence supporting a fresh look at funding models, and a thorough examination of the relative advantages and disadvantages of each. Time constraints preclude a comprehensive examination by the Committee, but some discussion is possible.

12.49 Dr Kerridge, a Newcastle-based specialist, supported an open minded approach to funding systems:

> Obviously some overseas experience – with the HMOs in the US, and with the NHS in the UK – has shown that for some things, such as immunisations, pap smears and so on, it is worthwhile having a fee-for-service element. And there are some components of the health care system, such as teaching, research or administration that are better paid by a salary component system.[49]

12.50 Dr Kerridge saw the issue in terms of quality of care:

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46 Dr Boffa, *Proof Committee Hansard*, Adelaide, 30 July 2003, pp. 43-44

47 Dr Walters, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 59

48 See, for example, RACGP, Submission 86, p. 6; AMA, Submission 83, p. 1

49 Dr Kerridge, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 54

> The bulk-billing system that we have now does not encourage [ongoing and coordinated care]. In fact, if anything, it commodifies health care. It enables them to see each service as a discrete episode; to think that they can just go in and give that service.[50]

12.51 Dr Moxham, of the College of non-VR GPs observed that a privately billing practice sees four patients an hour, compared to six or seven at a bulk-billing practice. This disadvantage of the fee-for-service model became a recurrent theme when discussing bulk-billing in the current context. According to Dr Moxham:

> When patients are being churned through, I do not think they get as much care; they are limited in the number of issues they are allowed to bring up. If they come in for a script, probably all they will get is a script. If, at the end of the consultation, they bring up, 'Actually, I've got major marriage problems,' that probably would not get discussed; whereas, in a private consultation, it probably would be discussed. I think bulk-billing clinics, in that situation, would tend to say, 'Come back tomorrow and we'll book a separate appointment.' In actual fact that turns into two consultations, and of course it costs the taxpayer twice as much. The incentive is there to move people through very quickly. Certainly the way the rebate is set up – between six and 20 minutes – the incentive is to spend six minutes with everybody.[51]

12.52 Dr Powell, a GP from Bundaberg, elaborated on the different lengths of time spent on a 'standard' consultation:

> [S]ix minutes of the general practitioner's time is of equal value to 19 minutes of the general practitioner's time. … You could spend three times as long with a patient for the same Medicare rebate.[52]

12.53 She also pointed out how these time differences can disadvantage practices that do not bulk-bill:

> [E]ven a 10-minute differential still gets to be a significant amount of time that impacts on your costs and service delivery. … Our current experience is that those patients when they need that type of [short] consultation will go to a bulk-billing clinic and when they need more complex care they will come to us, particularly if they need something like palliative care. There are two ways of looking at it: firstly, we are not able to offer them the full range of our services and, secondly, we are missing out on the easy stuff.[53]

12.54 The advantages associated with hourly payment to doctors, as opposed to fee-for-service, were illustrated by Dr Sprogis:

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50 Dr Kerridge, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 53

51 Dr Moxham, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 10

52 Dr Powell, *Proof Committee Hansard*, Bundaberg, 25 August 2003, p. 28

53 Dr Powell, *Proof Committee Hansard*, Bundaberg, 25 August 2003, p. 30

> Bulk-billing is absolutely driven by needing to see people to make an income. In our case, we do not need to see people to make an income; that is the difference. So the demand management is quite different. I would argue that nobody, in that quality care system, can sustain after-hours care by bulk-billing under the current funding formula. After-hours care in general should not be a place where you have incentives that drive people to be seen; what you should be driving is optimal care, which means that they may not be seen.[54]

12.55 Although not proposing a departure from fee-for-service, the Australasian Integrative Medicine Association emphasised the value of longer consultations in the delivery of high quality clinical care.[55] The Association cited evidence to support longer consultations for patients who are chronically ill or need complex care. The Association called for better incentives for longer consultations, so that practitioners could undertake longer consultations without being financially disadvantaged for doing so. This would involve a substantial recalibration of the current Schedule, which delivers diminishing returns as consultation time lengthens.[56]

Blended payment

12.56 As noted in Chapter 3, there was wide agreement that blended payment systems enhance quality of care, but they do present challenges in attaining administrative efficiency:

> [T]he three programs aimed at encouraging high quality care (Practice Incentives program, vocational registration and Enhanced Primary Care) account for over three quarters of GP's measurable administrative and compliance costs.[57]

12.57 The move to a blended payment system comes partly from a recognition of the weaknesses inherent in a pure fee-for-service model. This was elaborated on by Professor Marley:

> I think fee for service is a fatally flawed method of delivering health care because there is the opportunity to generate unnecessary services in a market where the consumer is not usually that well informed. … Probably the ideal model — and having said that, there is no ideal model, but the best compromise is some kind of blended payment model where there is some element of fee for service but you do get block funding for achieving targets such as immunisation and so on.[58]

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54 Dr Sprogis, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 9

55 Australasian Integrative Medicine Association, Submission 197, p. 1

56 Australasian Integrative Medicine Association, Submission 197, p. 1. See also Dr Bott, *Proof Committee Hansard*, Perth, 29 July 2003, p. 49

57 ACT Government, Submission 171, p 9

58 Prof Marley, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 34

12.58 The Western Australian Government proposed the extension of the Primary Health Care Access Program (PHCAP) currently used in the Northern Territory. This model offers the potential to 'cash out' Medicare funds and convert the money to block funding on a per capita basis, instead of fee for service MBS and PBS subsidised services.[59] Such a scheme also allows more flexible remuneration of doctors in areas with transient or seasonal populations, and offers the opportunity to engage in health promotion and disease prevention activities not currently funded under the MBS.[60]

12.59 While expressing strong support for the retention of the fee-for-service model, the RACGP countenanced the possibility of alternate models:

> The RACGP concedes that there may be particular circumstances where the quality of general practice care would be supported by non-volume payments … retention payments are made to some rural locations on a non-volume basis at a low administrative cost to General Practitioners and government. This model could be extended to other areas of workforce need… .[61]

Capitation

12.60 Dr Kerridge, who has considerable experience in innovative health service delivery, elaborated on his support for a capitation-based model:

> To my mind, there is a fundamentally better system: what are traditionally called capitation payments. When a patient registers with a GP, the GP gets paid for having that patient on their books. It would generally not be an individual GP but would be, say, a group practice. If I, as a reasonably healthy 47-year-old with so-and-so risk factors, register with a practice then they get paid for providing my standard-level health care.
>
> If I need immunisations I go along and they are provided by the practice nurse and there is no question of my having to see the doctor and wait around. All those other services can be provided by the practice appropriately. It is in the practice's interest to keep me happy with the standard of care I am getting. Otherwise I will go and register with another practice. They are getting paid for keeping me happy as a patient over the long term, rather than providing bits and pieces of payments.[62]

12.61 Mr Schneider, from the Australian Health Insurance Association, gave evidence along similar lines:

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59 WA Government, Submission 177, p. 9

60 WA Government, Submission 177, p. 9. See also AMSANT, Submission 157 and 157a attachments.

61 RACGP, Submission 86, p. 7

62 Dr Kerridge, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 54

> [W]e seem to have accepted fee for service as being an inevitable part of the system. I wonder whether it would not be worth exploring some form of capitation, perhaps, as an option for those doctors who wish to provide cost-free services to their members without going through a fee-for-service system.[63]

Differential Rebate

12.62 The Committee considered the question of whether the rebate should be increased for all claimants. The concept of a 'differential rebate' is a potential way to encourage bulk-billing and to extend it to a broader category than just health care card holders. Under this model a higher rebate applies if a patient is bulk-billed and a lower one applies if the patient is charged a gap. Alternatively, practitioners may receive a higher rebate in areas of bulk-billing shortage. A differential rebate could thus encourage bulk-billing while simultaneously containing the cost of an increase in the rebate.

12.63 Citing inequitable access to affordable primary health care for those living in rural areas, the Rural Doctors' Association proposed the introduction of a differential rebate for regions with RRMA 4-7 classification.[64]

Geographically based item numbers

12.64 The Rural Doctors Association proposed the implementation of Rural Item Numbers, which would deliver a higher rebate per patient service. In calling for geographically based rebates, the Association pointed to the higher skill levels of rural GPs, higher practise costs (including equipment), higher workloads and lack of support afforded to rural GPs. Many of these claims in relation to practice costs have been examined in detail in chapter 3.

12.65 The Aboriginal Medical Service Alliance of the Northern Territory (AMSANT) disagree that geographically differentiated rebates promote equity:

> [T]he Rural Doctors Association love differential rebates, because they will get more money out of it. … In Central Australia I know there are doctors earning more than one-quarter of a million dollars a year. With differential rebates, they will earn $300,000 a year. So you need to look at how you are going to do it in a way that does not put more money into the pockets of doctors who are already making that sort of money. So differential rebates, across the board, will reward the GPs in rural areas who are already making a lot of money and this will not necessarily mean that they will start bulk-billing. It is just not targeted well enough. We prefer grants.[65]

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63 Mr Schneider, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 91

64 RDA, Submission 101, pp. 5-6

65 Dr Boffa, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 57

12.66 Geographically based rebates did not elicit support from the AMA, either:

> [T]he AMA does not support geographical rebates. If the government wants to move down a path of supporting differential rebates on economic grounds or whatever, that is their business. But at the end of the day our principle is that there is universal access to this system and it worries me that, once you start breaking it down into little groups, there will be a whole group of patients out there that not picked up by cards – these are the young families with two or three kids who are paying off a mortgage.[66]

Improving after hours access

12.67 The Department of Health and Ageing provided a summary of the after-hours models currently being funded. It was reported that 85 projects had been funded nationally through the After Hours Primary Medical Care (AHPMC) Development Grants Program, including 54 seeding grants,[67] ten information management/information technology grants, two infrastructure grants,[68] and 19 service development grants.[69] According to the Department, the majority of trials have recently commenced, and will be followed by an evaluation process.[70]

12.68 The WA Government also raised the possibility of an after-hours loading, and attributed the difficulty in access to after-hours care to the discontinuance of a previous loading program:

> The Commonwealth previously provided a loading for medical services delivered outside of normal working hours. However, this was discontinued, resulting in rebates being the same regardless of the time at which a service is delivered. This has resulted in it becoming difficult for patients to see doctors except during normal business hours. As a consequence, after hour a significant proportion of demand for general practitioner-type services has been shifted onto public hospital emergency departments.[71]

12.69 Professor McGrath described a system of after-hours care in the Hunter region, whereby doctors are paid based on a salaried system.[72] This system meant that doctors knew when they would be required to work after hours, because they worked on a roster:

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66 Dr Glasson, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 46

67 Seeding Grants provide funding for the performance of needs analysis and/or business plan development.

68 Information technology/infrastructure Grants provide funding for limited infrastructure and IT projects where this would lead to the improvement or implementation of the AHPMC services.

69 Service development Grants provide funding for after hours service implementation.

70 Department of Health and Ageing, Submission 138B, 16

71 WA Government, Submission 177, p. 6

72 For further discussion on the Hunter region initiatives, refer to 12.109, below.

> The GPs are paid an hourly rate; it is in the GPs' interests to see fewer patients because they are paid an hourly rate [whereas] If you have a bulk-billing user pays system, you do not turn anyone away because you need to see the patients to get the money. The incentive is there for the GPs to sit there and spend the hour doing nothing and still get paid $140 an hour. So you only see the patients you really need to see because you are doing it at the end of a busy day … Their incentive is to manage demand so it is only the genuine patients, who need something that night, who they see.[73]

12.70 The RACGP reported remuneration through the MBS for care rendered after-hours was the subject of an Attendance Item Restructure Group,[74] a working party of the medical profession, including the ADGP, the AMA, the RACGP and the RDAA, and the government. The Group was formed in February 2002, to determine the preferable structure for general practice attendance items, and to improve incentives for the provision of quality care. At the time of writing, their Report has not been released by the Department.

12.71 The importance of minimising structural disincentives to after-hours care was highlighted by Dr Davis, a non-VR doctor who pointed out that, even in accredited Medical Deputising Services (MDS), non-VR doctors do not have access to Schedule A1 rebates available to VR doctors in outer metropolitan and rural areas:[75]

> It has now become a paradox that doctors working in outer metropolitan areas by day have access to superior remuneration than when attending the more demanding problems seen during the after hours period.[76]

Conclusion

12.72 The Committee noted a definite interest among some respondents in comprehensively re-examining the way Australia's method of remunerating doctors. This interest is fuelled by an awareness of the weaknesses in the fee-for-service model, which still dominates this country's approach to funding. It is possible that the Attendance Item Restructure Group has investigated many of these issues, and it is important that the findings of the group be made public as soon as possible in order for discussion to move ahead. In the context of this report, the Committee encourages further investigation of the options, particularly those relating to enhancement and extension of the current blended payment arrangements.

Building primary health care teams

12.73 This chapter has suggested a number of ways to improve delivery of general practice services by means of altered payment arrangements. These suggestions are all

73 Prof McGrath, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 20

74 RACGP, Submission 86, p. 1

75 Dr Davis, Submission 196, p. 1

76 Dr Davis, Submission 196, p. 1

in the basic framework of fee-for-service private general practice. However, there are reasons why it is sometimes necessary to look for solutions beyond the conventional model of general practice.

12.74 Firstly, the combination of low GP numbers and high demand in some areas creates an unsustainably high workload for doctors who find they cannot recruit additional practice doctors to help or replace them and cannot employ locum doctors to provide relief. This problem is complicated by the fact that some remote communities do not have the population to support a viable general practice operation.

12.75 Secondly, the complexity of modern medical practice and diagnostic capacities supports an argument for significantly enhancing access to a wide range of allied health professionals (as discussed in chapter 9). This has the added and important advantage of reducing the load on GPs and making more efficient use of their particular expertise.

12.76 Thirdly, as shown in chapter 3, the aspirations of a new generation of general practitioners are different from many of their predecessors. Professor Marley told the Committee in Newcastle that:

> The young graduate is much more interested in lifestyle than income. They are not interested in owning practices and buildings. They want to walk into a well-managed environment, do the job and go home. They would work in a salaried environment; many of them choose to do just that – work on salaries in general practices and so on. So the nature and shape of the work force is really changing quite dramatically.[77]

12.77 Finally, existing Medicare funding arrangements, which are predominantly fee-for-service, have delivered inequitable outcomes in some parts of Australia. As Chapter 4 showed, the levels of bulk-billing and Medicare benefits paid per capita vary markedly across regions, with people in inner metropolitan areas often receiving up to twice the benefits of those in regional and rural areas.

12.78 An example of such inequity was provided by the Hunter Urban Division of General Practice. According to their own calculations, since the inception of Medibank/Medicare, HUDFP has received $1 billion less in government funding than comparable populations in capital cities have received.[78]

12.79 One way to address these issues is to move towards a different model for providing general practice medical services, in what can generically be referred to as an Integrated Primary Care model or IPC. The focus here is on total preventive care, rather than reactive, acute care. Effectively this involves regular check-ups, proactive

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77 Prof Marley, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 30: see also Prof Wilson, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 19

78 HUDGP, Submission 162, p. 2

recall of patients, lifestyle education, immunisations and extensive use of a range of practice nurses and allied professions.[79]

12.80 The Committee supports the comments of Dr Walters from the Australian Divisions of General Practice about the need to move to improve primary care practice:

> We have to get more bang for our health dollar, which will be achieved through a greater focus on primary care, on the preventive, comprehensive whole patient care that can be delivered through general practice. Part of the problem is that primary care is not as dramatic a headline as MRIs or lung or heart transplants, but it is where the greatest difference to health status can be made. It is where huge financial savings can also be made. Good general practice saves dollars. We think that investment by governments, both Commonwealth and state, needs to be rebalanced to reflect that.[80]

12.81 The Hon. Ms Edmond, Queensland Minister for Health, gave an example of the success of this type of program:

> We have reduced admissions of patients with diabetes in the Torres Strait by 40 per cent and reduced the number of amputations by 40 per cent by being what I call 'aggressively' active in the primary health area. … when I say aggressive health care I mean that when they are passing people who know them in the health care business those people will say, 'It's time for you to have your check. We need to check that you are not getting into strife, that your blood sugar is fine and all the rest of it.'[81]

12.82 It should be noted that the need for a change in Australia's provision of primary care is well recognised, and already a focus of various government programs. Examples include the Practice Incentive Payments program, and the Enhanced Primary Care policy with its associated Medicare item numbers for coordinated care plans, case conferences and health checks.[82]

Perverse incentives

12.83 The current fee-for-service basis of Medicare militates against achieving the IPC model, principally because a practice can charge an activity to Medicare only if it is performed by the doctor, since only the doctor has a Medicare provider number. As witnesses commented, there are two problems with this: it ignores the fact that the doctor's time can often be used more efficiently, and it does not adequately recognise the skills of other professionals. Professor Marley in Newcastle commented that:

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79 See also Dr Ruscoe, Submission 153, pp. 8 - 10

80 Dr Walters, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 57

81 The Hon Ms Edmond, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 31

82 see chapter 2 for a general description of these programs.

> There are a lot of incentives in the Medicare scheme to prevent people working as part of teams, using these other practitioners in that kind of way.[83]

12.84 Prof Marley gave this illustration:

> [S]omebody comes in with a laceration, which needs suturing. Now, unless you do it, there is no income. If your nurse sutures the laceration, which she is perfectly capable of doing, then you do not have anything to pay for the nurse's time in doing that.[84]

12.85 The Hon. Ms Edmond added the following:

> GPs say to me that they cannot use a nurse practitioner to really take any of the load off them. They can use them for support, but there is no provider number through which they can get recompense for a nurse practitioner seeing people and providing what could be quite extensive primary health care and prevention care. There are elements built in there, but they probably do not go far enough. If GPs could be fund holders for a range of services, such as physiotherapy or podiatry for diabetics, and provide that access, that, I believe, could be a very good preventive measure.[85]

12.86 According to Dr McBryde, President of the Brisbane North Division of General Practice:

> [O]ne of the problems at the moment is that practice follows the funding instead of the funding following the way we should practise. Currently it is face-to-face fee for service in the main, and that can be very difficult. In some practices there are GPs who do every single thing, and a lot of that is nursing duties. If we could free up some of those duties and give them to an appropriate person within the general practice team, our work force shortage would start to be alleviated.[86]

12.87 This view was summed up by Mr Stafford of Morningside in Queensland:

> MBS benefits are not payable to health professionals other than medical practitioners. This means that in practice GPs cannot delegate counselling to psychologists, nutritional advice to dieticians etc. this means that general practitioners have to do work that others are better trained for and at greater

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83 Prof Marley, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 32

84 Prof Marley, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 42

85 The Hon Ms Edmond, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 30

86 Dr McBryde, *Proof Committee Hansard*, Brisbane, 26 August, 2003, p. 98: note also the comment of the ADGP – Dr Walters, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 64; and Mr Mehan, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 52

> expense. Probably most critically, it takes up time that could be utilised for diagnosing, prescribing and the other skills that GPs are trained for … .[87]

12.88 Mr Stafford concludes that the current Medicare benefits relate to a previous era: 'The current health issues require a different approach to meet the principal health issues relating to lifestyle issues, most notably obesity, poor nutrition, a lack of physical exercise, and stress.'[88]

12.89 A second issue is that, in both metropolitan and rural areas (although often for different reasons) it is sometimes useful to have GP services delivered using hospital facilities – buildings, consultation rooms, etc – and diagnostic back-up resources – such as x-ray and pathology services. However, current Medicare arrangements do not allow bulk-billing for any on-hospital treatment. The reason for this ruling is that public hospitals are a state responsibility, and Commonwealth funding is already provided by means of the Australian Health Care Agreements. Thus, the current arrangements sometimes prevent the most efficient delivery of medical care, and this anomaly needs to be clarified and resolved.

A new model for Community Primary Health Care

12.90 Another model that could be useful is the joint funding of community-run not-for-profit health centres using a mix of salaried GP's, allied health professionals, and practice nurses. For example:

> [P]rimary health care centres employ salaried doctors and allied health workers as one of the strategies – it is not the only strategy – to provide accessible and affordable health care. It is a relatively unexplored area. It obviously would require cooperative federal arrangements.[89]

12.91 Dr Boffa of AMSANT told the Committee that:

> [A] multidisciplinary primary health care service with salaried GPs is a better and more attractive working environment than the private practice model, at least in disadvantaged areas.[90]

12.92 The Hunter Area Health Service has an innovative approach to local health care provision, enabling patients to access a variety of health professionals in one location. Professor McGrath outlined to the Committee the benefits of utilising GP's more effectively as part of a multi-disciplinary team:

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87 Mr Stafford, Submission 22, p. 2. It should be noted that the government has moved to address these factors through the EPC program, and subsidisation of practice nurse salaries. See Mr Stuart, *Proof Committee Hansard*, Canberra, 38 August 2003, p. 96 and chapter 9.

88 Mr Stafford, Submission 22, p. 2

89 Mr Wishart, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 26

90 Dr Boffa, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 43

> The pressure on doctors is coming from the elderly – that is, the elderly with chronic disease, the elderly with loneliness and the elderly for whom you can pre-empt a lot of the problems and avoid their need to go to the GP. We in the area health service recently combined our community health and aged care community services into one service which has all of those professionals. It has nurses, physiotherapists, rehabilitation services, geriatricians, podiatrists, speech pathologists, occupational therapists, home physios, dieticians; it has all the multidisciplinary team. With the community health information system we now have we are developing a common assessment tool. Patients will be able to ring one number and be triaged, if you like, according to their needs.[91]

12.93 A related example was offered by the South Kingsville Health Cooperative in the western suburbs of Melbourne, which provided evidence to the Committee on the benefits of the co-location of GPs and allied health professionals providing acupuncture, massage and speech therapy.[92] The organisation receives no direct government support, but is funded by fees from its members, bulk-billing rebates and some fee-for-service activities.[93] There is also the potential to expand the use of hospital-based GP clinics (although noting the problem with current Medicare charging discussed above).[94]

Salaried doctors

12.94 A sometimes controversial element to these types of operation is the employment of salaried doctors. In the past, the policy of salaried doctors at community medical centres was:

> … totally opposed by the AMA, which opposed the salary medicine concept and opposed the concept of doctors working for another employer – and they still oppose that, by and large, except in Aboriginal health, where they are happy to support community controlled health care. It got opposed by the states, which disliked the idea that the Commonwealth was directly funding health services in their jurisdictions because they have constitutional responsibility for health. They saw this as an unwanted intrusion into their turf by the Commonwealth.[95]

12.95 However, this situation may have changed, driven by the different attitudes of many younger doctors. The changing expectations and priorities of the general practice profession are discussed in earlier chapters: in this context it is worth adding that the evidence suggests doctors are finding salaried positions increasingly attractive. It is important though to note, however, that there is a greater preference

91 Professor McGrath, *Proof Committee Hansard*, Newcastle, 23 July 2003, pp. 21-22.

92 Dr Chris Watts, *Proof Committee Hansard*, Melbourne, 27 August 2003, p. 70.

93 Submission 80, p. 12.

94 WA Government, Submission 177, p 10; Dr Ruscoe, Submission 153, p. 10

95 Dr Boffa, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 44

salaried general practice in public service or community clinics than corporate medical positions.[96]

Conclusion

12.96 There is evidence of an accepted need to change the focus of medical practice towards more integrated primary care. And it is clear that in some respects the current fee-for-service model is acting as a roadblock to progress.

12.97 As various successful trial programs have demonstrated, practical and successful alternatives do exist and the Committee was particularly impressed with the initiatives in the Hunter Region in this respect. The Committee notes the view advanced by Professor Marley that further progress would be assisted by a mechanism to grant exemptions from the normal rules of Medicare, to enable additional trials to take place.[97]

12.98 While generally agreeing with this idea and acknowledging the success of these trials, the Committee considers that there is sufficient evidence in place to move beyond further trials. The emphasis must now be on moving to implement a more flexible system that enables other methods of primary care to operate in a diversity of circumstances.

12.99 In advancing the case for a greater use of salaried doctors and community health care centres, three things should be stressed.

12.100 First, this model has been used in the past,[98] and remains a feature of remote area practice in areas such as the Northern Territory, where a significant proportion of their medical workforce are District Medical Officers.[99]

12.101 Second, this model is not proposed as a replacement for private practices around the country. Rather, experience has shown that it can be a useful and effective model for establishing a comprehensive medical service in areas where private practices may not be viable due to a small and/or poor patient base,[100] or where there are no other support services available. This model also needs to be considered in the context of changing business patterns small one- and two-doctor practices becoming increasingly less workable.[101]

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96 See Mr Wishart, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 26; Dr McBryde, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 90-91; Australian Greens, Submission 100, p. 11.

97 Prof Marley, *Proof Committee Hansard*, Newcastle, 23 July 2003, pp. 34-35

98 See for example: Dr Walker, Submission 44, p. 2

99 Mr Dawson, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 65

100 Dr Mackey and Dr Jacobs, *Proof Committee Hansard*, Canberra 28 August 2003, pp. 109-110

101 Dr Chew, *Proof Committee Hansard*, Canberra 28 August 2003, p. 110

12.102 Third, no single model is likely to meet the needs of all areas, so any adoption of this approach must embed sufficient flexibility to adapt the model to particular needs.

12.103 Therefore, while supporting the concept of this model, the Committee recognises two important questions that 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 should be the employer.

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.

Funding mechanisms

12.104 The preceding discussion focused on the means of allocating funds to individual medical practitioners. However, a continuing problem in managing health care in Australia is the shared responsibility for health between state and Commonwealth governments and the process by which funds are allocated by and between them.

12.105 A proper examination of the issues in health funding is a major task in itself, and is not a focus of this Committee's terms of reference.[102] Nevertheless, it seems reasonable to comment that the system is frequently characterised by mutual suspicion, cost-shifting, and turf protection between jurisdictions. The outcome is that the innovation and flexibility necessary to find solutions to the health care needs of particular regions is often absent. As Dr Chris Brook, of the Victorian Department of Human Services, told the Committee:

> The relationships we tend to find ourselves in with the Commonwealth are what may be called boundary protection, more than anything else. I am sure the Commonwealth would say the same thing about its relationship with the

102 for a general discussion of many of these issues, see Senate Community Affairs References Committee, *Report of the inquiry into public hospital funding*, December 2000.

> states … . It does mean, however, that it is incredibly difficult to engage in innovation, except in small pilot arrangements. Like other states, we have a number of small pilot arrangements … but is only ever going to be a pilot because there is no enthusiasm for providing that kind of extremely valuable service to the whole community.[103]

12.106 This situation was recognised by the recent Australian Health Care summit. In the resulting communiqué, it was noted:

> Jurisdictional inefficiencies associated with Federal and State Governments having different responsibilities are the major barriers to quality and cost effectiveness in our health system; [and]
>
> Structural inefficiencies inhibit the development of integration across the continuum of health care services.[104]

12.107 Dr Sprogis, from the Hunter Urban Division of General Practice told the Committee:

> To support innovative models we need preparedness to co-operate and look at new models across the interface between Commonwealth and state, and new funding models to support innovative models that share the burden with GPs and with multidisciplinary staff – practice nurses, community health nurses, allied health staff et cetera.[105]

12.108 Professor McGrath, Head of Hunter Health stressed the importance of this flexibility to tailor funding to local needs:

> I think it is about communities tackling community problems and producing solutions. I do not think you can have a one-size-fits-all solution. That is why I think we should be looking at innovative models. We need a much greater preparedness by the funding agencies centrally to look at different funding models in addition to what we have now – we need more diversity of funding models…[106]

12.109 The Victorian Medicare Action Group pressed the Committee to consider a shift in focus from fee-for-service health care to funds pooling arrangements:

> There is not a Commonwealth set of services that sit over here, a state set of services that sit over there, and the local government sitting somewhere else. The reality is that a lot of these things come together on the ground. We need to institutionalise that. We need to require them to come together and not just let them come together on an ad hoc basis. If we required state-

103 Dr Brook, *Proof Committee Hansard*, Melbourne, 24 July 2003, p. 72

104 Australian Health Care summit, Communique, p. 1

105 Dr Sprogis, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 4

106 Prof McGrath, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 24

> funded and Commonwealth-funded services to work together on the ground, we could do a lot better than we are currently doing. That is why we say that a national primary health care policy is one of the things that is desperately required.[107]

12.110 The Committee noted that there are cases where this has successfully occurred, and which demonstrate the types of solutions that must become more widespread.

Hunter Region initiatives

12.111 A good example is the GP Access After Hours (GPAAH) service, developed as a cooperative scheme in the Hunter Urban Region. This system is based on a pooled funding model using contributions from: Medicare; Hunter Area Health Service; the Department of Health and Ageing; and the Hunter Urban Division of General Practice.[108]

12.112 The scheme serves a population of 450,000, using five GP clinics situated adjacent to emergency departments or in community health facilities, and sees 60,000 patients per year after hours. The system includes a telephone advice line, staffed by nurses using decision support software, which: arranges either appointments in the clinics, or home visits; organises funded taxi transport; or provides advice that allows patients to stay at home.[109]

Primary Health Care Access Program

12.113 Another example of pooled funding is the Primary Health Care Access Program (PHCAP) operating in the Northern Territory. Evidence of this program was given to the Committee by representatives of the Aboriginal Medical Services Alliance of the NT (AMSANT).

12.114 PHCAP arose out of the recognition that per capita spending under Medicare in remote areas falls far short of national averages, particularly when measured against the higher primary health care needs of remote Aboriginal communities.[110] The PHCAP program is a cooperative program involving the Commonwealth, and state and territory governments, the community controlled health sector and ATSIC.[111] The agreements deliver a balanced mix of primary clinical care; population health and

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107 Mr Walker, *Proof Committee Hansard*, Melbourne, 24 July 2003, p. 59: see also Mr Wishart, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 26

108 Hunter Urban Division of General Practice, Submission 162, Attachment 1

109 Hunter Urban Division of General Practice, Submission 162, Attachment 1

110 AMSANT, Submission 157A, p. 3: see also Mr Houston, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 62

111 AMSANT, Submission 157A, Attachment 4, p. 3

preventative care; and clinical support programs including pharmaceutical supplies and health information.[112]

12.115 A feature of the NT program is the agreement with the Commonwealth government that the Medicare earnings of the salaried doctors go back into the health service.[113]

Additional funding

12.116 Notwithstanding the range of possible funding models, the bottom line may be that funding in some areas needs to be increased. If more money is needed to deliver better health outcomes, there are three principle potential sources of funds: reprioritisation of current spending programs, increasing the Medicare levy, and/or reallocating funds from the 30% Private Health Insurance rebate. The latter option is discussed in detail in the preceding chapter and will not be re-examined here.

12.117 Increasing revenue from either the Medicare levy or reprioritising general taxation is fundamentally a political decision informed by the values of society generally, and what people are prepared to pay for. In this context, the Committee notes a number of submissions that accepted the principle of raising the Medicare levy if necessary.

12.118 Mrs Kendell of the Health Consumers Network, for example, drew to the Committee's attention:

> A news poll of 700 people commissioned by the ACTU and released in the last week highlighted that 71 per cent of the people polled would support an increase in the Medicare levy if this would ensure the continuation of bulk-billing. Another survey of 1,000 voters nationally found that 75 per cent of voters, including 69 per cent of coalition supporters, would prefer the government to spend money on services like hospitals and schools instead of tax cuts.[114]

12.119 The AMA suggested a shift in priorities:

> Last year saw a budget surplus of $4.2 billion, of which $2 billion was returned to taxpayers in small tax cuts. Major polls conducted by both the major media chains in Australia show that more than 70 per cent of Australians would have preferred that $2 billion to go to health and education.[115]

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112 AMSANT, Submission 157A, Attachment 3

113 Dr Boffa, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 44

114 Mrs Kendell, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 4

115 Dr Rivett, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 51

12.120 This comment is timely in so far as, at the time of writing, the government has announced an expected budget surplus of $7.5 billion dollars for the 2002-03 financial year.[116]

Conclusion

12.121 In the light of the current large budget surplus, the Committee does not consider raising additional revenue to be appropriate at this time. The importance of the polling outlined above is in its demonstration of the level of community commitment to Medicare, and if necessary, a preparedness to pay more to support it.

12.122 However, as shown above, there is considerable scope to improve current funding arrangements. The Australian Health Care Summit called for the development of:

> … an intergovernmental instrument for reform in partnership with consumers, clinicians and other health professionals to review current jurisdictional inefficiencies.[117]

12.123 The Summit also recommended the creation of a National Health Reform Council, in part to address these issues.

12.124 On the basis of the evidence presented on this issue, the Committee concludes that workable solutions are already available for many of the problems outlined here – as shown by the success of the programs discussed above. The key ingredients for seeing these successes expanded into normal practice 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. For further discussion about community participation, see paragraph 12.148.

Need for research and analysis

12.125 It is essential to have accurate and wide ranging statistical information, backed up by research and analysis for several reasons: to make sense of what is happening in health care in Australia; to make accurate predictions on future conditions; and to develop future policy. While a considerable amount of such information is currently available, there remain consistent grey areas – as several witnesses pointed out. Professor Wilson, Deputy Director of the University of Queensland Centre for General Practice, noted that:

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116 The Age, 1 October 2003, p. 1

117 Australian Health Care Summit, communiqué, p. 1

> [I]n Australia we do not … have very good data at the moment that relates individual outcomes to the systems of care that they are being managed under. It is possible to do it; other places have done it. [118]

12.126 Professor Hall, from the University of Sydney, also gave evidence that:

> [O]ne of the problems we have every time we have a debate about the Australian health care system is the lack of evidence. Some of it is lack of data, but a lot of it is lack of use of the data that are available and lack of independent analyses. … This country lags behind the rest of the world in its investment in health services research, and it hampers our ability to deal with these really important policy issues.[119]

12.127 Ms Walker from NATSEM[120] agreed:

> [T]here is now a lot more data around than there was earlier and we have not really mined it properly. So I would like to see the possibilities of getting the data and linking it so that we can see how sectors impact on people, and not just separations and things like that.[121]

12.128 Professor Richardson also commented on the limited use that is made of existing data:

> In Australia we spend remarkably little on using this data. It is collected and, to a large extent, ignored. … In contrast to that, the largest funding body in the United States, the National Institutes of Health – and it is only one of several large funding organisations – spends, in Australian dollars, between $2.5 and $3 billion every year on these issues. If you adjust for their GDP in America, that would translate in Australia to about $120 million. If that sounds a lot, it is about 0.2 of one per cent of the health bill.
>
> At the moment we would be spending significantly less than 0.1 of one per cent of the health bill. You would be hard-pressed to find any other industry in Australia or elsewhere that spends such a remarkably small amount on finding out what it is doing and the consequences of its own actions in the marketplace.[122]

12.129 A number of witnesses gave examples of particular areas of deficiency:

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118 Prof Wilson, *Proof Committee Hansard*, Canberra 21 July 2003, p. 30: see also p. 29

119 Prof Hall, *Proof Committee Hansard*, Canberra 21 July 2003, p. 43

120 National Centre for Social and Economic Modelling, University of Canberra.

121 Ms Walker, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 89

122 Prof Richardson, *Proof Committee Hansard*, Melbourne, 24 July 2003, p. 83

- Dr Bain of the AMA raised the issue of holes in the HIC data on GP fees, which does not account for doctors who charge booking fees, or discounts on early payment.[123]
- Mr Schneider of the Australian Health Insurance Association discussed delays of twelve to eighteen months in the availability of categories of public hospital data.[124] Mr Schneider also identified the usefulness of the ABS data collection of PHI takeup.
- Dr Walters of the Australian Divisions of General Practice supported more research into primary care.[125]
- Dr Adkins of Bayside Division of General Practice saw the need for further research into ways to assist the general practice profession to measure quality outcomes.[126]
- Finally, Mr Gregory from National Rural Health Alliance:

> [We] would love to know the distribution of total health costs by region and socioeconomic status. We would like to know more about what health services people in remote areas actually get and by what means they do so because, in the data sense, remote areas are doubly difficult because of small numbers [127]

12.130 These comments reflect the Committee's direct experience of the limits of information and analysis that are 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.

12.131 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 closer analysis and research, which would ultimately assist in a more informed and 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.

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123 Dr Bain, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 62

124 Mr Schneider, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 91

125 Dr Walters, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 65

126 Dr Adkins, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 100

127 Mr Gregory, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 93

Improving Australia's use of Overseas Trained Doctors

12.132 The final issue to be considered is whether the shortage of doctors, particularly in rural and remote areas, could be relieved in the short term by a greater use of overseas trained doctors (OTDs).

12.133 The Committee notes the extent of Australia's existing reliance on this category of medical practitioners. As Professor Hawthorn from the University of Melbourne stated:

> Australia's work force is now extraordinarily reliant on people who are overseas born. By 1991, 40 per cent of doctors, up to 48 per cent of engineers, 43 per cent of IT professionals et cetera were overseas born. In terms of medicine this trend is dynamic. By 1996, 44 per cent of the medical work force was overseas born and, by the 2001 census, the figure was at 47 per cent.[128]

12.134 This was supported by the comments of Dr McKenna in Perth:

> OTDs are saving our bacon at the moment; they are filling a very large gap, and many of them are doing it very well.[129]

12.135 And by Dr Bain of the AMA:

> The only thing that has kept the work force going, really, is overseas trained doctors, who have filled the gap in the last few years.[130]

12.136 It is also noteworthy that all of Bundaberg's bulk-billing doctors are OTDs.[131]

12.137 In considering the role of OTDs, three issues emerged:

- the problems that OTDs have in accessing work in Australia;
- problems with the qualifications and supervision of OTDs; and
- the extent to which Australia should rely on OTDs as a solution to current medical workforce shortage.

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128 Prof Hawthorn, *Proof Committee Hansard*, Melbourne, 27 August 2003, p. 1; See also Submission 208, with three attached papers.

129 Dr McKenna, *Proof Committee Hansard*, Perth, 29 July 2003, p. 33

130 Dr Bain, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 17: see also in Tasmania – Prof Carmichael, *Proof Committee Hansard*, Hobart, 31 July 2003, p. 61; and Alice Springs – AMSANT, Submission 157A, p. 6

131 Mrs Plant, *Proof Committee Hansard*, Bundaberg, 25 August 2003, p. 65

Problems in accessing work

12.138 Firstly, many overseas trained doctors experience considerable difficulties in accessing medical practice in Australia. Mr Gregory of the National Rural Health Alliance estimated that there are currently up to two thousand OTDs in Australia who are not working.[132] Of the possible explanations for this statistic, one of these may be that the criteria used by the Department of Immigration to select migrants operates at cross-purposes to other government policies:

> I have heard case studies where a couple enters on the formula that the department of immigration specifies, where the breadwinner is in one of the categories that we have in demand and therefore scores highly. But I am told that because in fact there is a penalty of 10 points for medical practitioners entering the country so declared, some of these people have come in as partners and have not declared their medical training and skills.[133]

12.139 A further issue is the complexity of the rules relating to gaining recognition. Professor McGrath, Chief Executive Officer of the Hunter Areas Health Service, told the Committee that as an employer of OTDs:

> [We] still find the rules totally confusing. There are so many models about overseas doctors. … I do not believe there is one person in the state or in the Commonwealth of this nation who understands the morass of rules about overseas doctors.[134]

12.140 Professor Wilson explained another structural element:

> For example, Australian resident overseas trained doctors who complete the first part of the AMC examination have a very high success rate of getting through to the second part of the AMC examination, but the difficulty is finding enough training places each year, enough examination places in that second part, for them to get through. … There appeared to be some issues, which there have now been major attempts to try and address, around the processes that the professional colleges had for accreditation, particularly of specialists, in that regard.[135]

12.141 Professor Wilson also pointed out that up to a third of these doctors will also have considerable difficulties in meeting Australian standards 'by even the most generous allowance':

> They had major problems because of language and the types of training systems that they had come through and … the period of time in which they

132 Prof Wilson doubts this figure, and considers the actual numbers unclear: *Proof Committee Hansard*, Canberra, 21 July 2003, p. 25

133 Mr Gregory, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 20

134 Prof McGrath, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 12

135 Prof Wilson, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 26

> had been out of practice, which impacted very much on their currency and their likelihood of ever being able to get back into the work force.[136]

Problems with qualifications and supervision

12.142 In the light of the preceding discussion concerning the difficulty in gaining Australian accreditation, the Committee received evidence of gaps in the accreditation system. Professor Hawthorn told the Committee:

> If you do not come in through skilled migration, you are not compelled to have your qualifications assessed in a way that assesses your eligibility for registration. … If you come on a temporary basis, we have the anomaly that you do not have to be accredited, nor do you have to sit for pre-accreditation exams in order to practise.[137]

12.143 This is based on the fact that, while all medical practitioners need to be registered in each State or Territory in which they practice, an overseas trained doctor who is either a temporary or permanent resident may obtain conditional registration without passing the Australian Medical Council examinations. These conditional registrations are usually granted for areas of workforce shortage as determined by the States and Territories.[138] As a result:

> We are now in a period where, for demand driven processes integrally linked with the issue of medical maldistribution across Australia, we have an unprecedented reliance on overseas trained doctors, who have not yet achieved full Australian medical accreditation to work, in three contexts. The first is as junior doctors in the public hospital system; the second is as general practitioners, particularly in areas of need across rural and regional Australia; and the third is as conditionally registered specialists in fields such as psychiatry, surgery and emergency medicine … .[139]

12.144 Professor Hawthorn gave several examples of the outcomes of these deficiencies, including medical practitioners newly arrived from other countries practising without complete registration and without any detailed knowledge of the Australian medical and legal frameworks. They are also often expected to commence practice without the benefit of bridging training in cultural issues, such as indigenous health, or in areas such as obstetrics, gynaecology and routine general practice procedures.[140]

12.145 The Committee is aware that the criticism it heard was not directed at the skills, enthusiasm or commitment of the doctors concerned, but at the systemic failure

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136 Prof Wilson, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 26

137 Prof Hawthorn, *Proof Committee Hansard*, Melbourne, 27 August 2003, p. 9

138 DoHA, Submission 138b, answer to Question on Notice No. 15

139 Prof Hawthorn, *Proof Committee Hansard*, Melbourne, 27 August 2003, p. 1

140 Prof Hawthorn, *Proof Committee Hansard*, Melbourne, 27 August 2003, p. 7

to check qualifications before the doctors start work and the absence of the necessary bridging training and support services.

The extent to which Australia should rely on OTDs

12.146 The third issue is the extent to which Australia should attempt to make-up its medical workforce shortfall by using overseas trained doctors. As Dr Sprogis in Newcastle explained, widespread use of OTDs should be construed as a major policy failure:

> There will be about 1,000 Australian young people who will apply for 60 places in our medical school shortly. … If we are going to solve our work force problem with the use of OTDs while we have got a queue of young people applying for medical schools then people should hang their heads in shame.[141]

12.147 An added problem is that recruiting doctors from overseas represents a drain of expertise from other, often developing, countries, that may ill afford the loss of scarce doctors. This point was made by the Royal Australian College of General Practitioners:

> Australia cannot rely heavily on overseas doctors, whether or not they train in Australia. Australia has an ethical obligation to contribute to the overall supply of doctors, proportionate to its demand for doctors. Policies that would create strong incentives for GPs in poorly serviced countries to migrate to Australia are not acceptable.[142]

Conclusion

12.148 In several respects, 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 imported medical professionals, particularly when there are so many Australians wanting to enter medical courses. As a matter or 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.

12.149 The Committee is concerned over the apparent lack of supervision over, 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 easier means by which they can enter and practice in areas of medical workforce shortage.

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141 Dr Sprogis, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 28

142 RACGP, Submission 86, p. 4

12.150 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. These measures 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 employment of overseas trained doctors in Australia and consider ways to address the current difficulties of training and support.

A national consensus?

12.151 As a final issue, the Committee notes the suggestion in a number of submissions that Australia urgently needs a broad-based debate on the nature of our society's health care needs; our priorities; the cost of solutions; and how health care should be paid for. Dr Adkins argued that:

> Health resources are a finite quantity, and the general public have higher and higher expectations of them. They expect that anything can be achieved, but in reality there are only a limited number of resources to go around. The community need to be better educated in the fact that these are limited resources and to be part of a debate on what things are funded. I think the community expect that everything should be funded, and that is just not possible. That debate needs to be had, and it has not been had to date.[143]

12.152 One model drawn to the Committee's attention is the 'Commission on the Future of Health Care in Canada' led by Mr Roy Romanow QC.[144] That Inquiry staged a comprehensive public debate into the future of health care, and used a variety of often innovative means to achieve this. These included commissioning a range of research papers; holding discussion forums; hosting nationally televised policy forums; organising public meetings, expert workshops, and partnered dialogue

143 Dr Adkins, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 96: see also Mr Webber, Submission 3, p. 8; Australian Pensioners' and Superannuants' League Qld, Submission 5, p. 1; Ms Flannery, Submission 20, p. 1

144 Details of the Commission can be found at their website: http://www.healthcarecommission.ca

sessions; and commissioning surveys.[145] The Committee supports the institution of such a process to promote informed community dialogue.

12.153 The purpose of such a public discussion is not simply to enable politicians to ascertain the views of constituents. Rather, it is to host an informed national debate to enable all members of society to form their views and (ideally) reach some consensus on health issues. In this respect, it differs from the role of this Committee, whose inquiry process has been necessarily constrained in its range of consultative processes by the timeframe and terms of reference established by the Senate.

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.

Senator Jan McLucas

Chair

145 These are described in detail in Romanow, *Building on Values – the future of health care in Canada*, November 2002, Appendices.

GOVERNMENT SENATORS MINORITY REPORT

Introduction

The Government Senators believe that public consultation regarding the sustainability of Australia's health system is a useful and productive exercise. Access to and affordability of general practice services under Medicare are issues that concern all Australians. Unfortunately, the opposition parties have skewed the inquiry, resulting in a narrow ideological debate about the concept of universal health care and the ensuing belief that bulk billing is its embodiment.

The Terms of Reference also perpetuate the misconception that the Howard Government is attempting to undermine the universality of Medicare. *A Fairer Medicare* is an integrated set of measures that builds on the Government's commitment to Australia's universal health system. All Australians will continue to be eligible for the Medicare rebate. Further, doctors will remain in control of their billing practices and can choose to provide care at no cost to the patient, regardless of whether or not they hold a Commonwealth concession card.

Medicare is an Australian Government funded health insurance scheme designed to increase equity and access to medical services within the confines of private enterprise. As former Labor Health Minister Dr Neal Blewett stated in 1983,

> Medicare will restore the right of access to health care. It is the comprehensive, universal, equitable, scheme that we see as essential to guarantee access within the limits of a fee-for-service system.

A Fairer Medicare maintains these universal principles of Medicare. However, it also brings new and very significant financial protection to those with the greatest health and financial needs. Moreover, the package strives to address some of the inequities in Australia's health care system such as timely access to medical services, which is currently largely determined by geographical location.

The focus of the Government package is achieving equitable access to GP and other health services. No political party, including the government, proposes to dismantle Medicare. This proposition is arrant nonsense and reflects the criticism – bordering on hysteria – that some in the community reacted with, and evident in the views expressed by Dr Costa of the Doctors Reform Society, who told the Committee:

> It is turnstile medicine. It is not good enough. This is not Africa; this is Australia, and yet we are being treated like sub-Saharan Africa when it comes to health care.[1]

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1 Dr Costa, *Proof Committee Hansard*, Sydney, 22 July 2003, p. 52

Australia's health in context

Throughout this inquiry, opposition Senators have painted a bleak picture of health care in Australia. But Australia's health system is not in crisis – claims of a crisis are an overreaction. Medicare can certainly be improved, and the Government's *A Fairer Medicare* package has been created to do this, but it is important to keep in mind that Australia's health care system is either the best or among the best in the world.

Health outcomes in Australia compare favourably with other OECD countries, demonstrating the high quality of the Australian system. For example, Australian males are expected to live 76.6 years, the fifth highest of all developed countries, while females in Australia have a life expectancy of 82.1, the sixth highest.[2] Another useful indicator of Australia's good health is our low rate of infant mortality, with only one percent of Australian infants dying within one year of being born.[3]

The high standard of Australia's health care means that Australians are less likely to die from infectious disease and are living longer than ever before. Consequently, our ageing population is increasingly prone to chronic illnesses such as diabetes, heart disease, stroke and dementia, placing increased pressure on Australia's health care costs now and into the future as many Australians move into later life. Already, chronic diseases are responsible for up to 80% of the total burden of disease.[4]

Again though, it is important to note the significant progress already made in preventive health care: Australia's smoking rates are among the lowest in the western world, and recently, the National Obesity Taskforce was established to look at factors contributing to ill-health among both adults and children. Added to this, is the recently released National Health and Medical Research Council (NHMRC) Nutritional Guidelines, while Government Senators and Members of Parliament have also taken the initiative by hosting healthy lifestyle forums to combat childhood obesity.

Seven years ago, immunisation rates among children in Australia ran at 53%, while today they stand at over 90%,[5] while rates of vaccine-preventable childhood diseases are at a record low.

The 2003-04 Budget builds on this record by providing $4.3 million over three years to promote the prevention role of general practice to both GPs and to the community. Specific elements of the initiative include a national approach to lifestyle prescriptions, encouraging for example, physical activity, moderate drinking, and healthy eating.

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2 Australian Institute of Health and Welfare, *Australia's Health 2002*, p. 12

3 Australian Institute of Health and Welfare, *Australia's Health 2002*, p. 37

4 Senator the Hon. Kay Patterson, Media Release, *Budget Delivers Prevention, Safety and Quality for a Healthier Australia*, 13 May 2003

5 Senator the Hon. Kay Patterson, *Medicare – for all Australians*, May 2003, p.3

The recently negotiated Australian Health Care Agreements (AHCA) reflect the Government's commitment to meeting Australia's burgeoning health care needs. Despite the erroneous claims of the State Premiers, the new AHCA increased health funding to the States by seventeen percent in real terms, meaning an increase of $10 billion to a total of $42 billion over the next five years. This represents the largest increase in Australian Government health funding in history. The growing commitment is also evident in the fact that over the past decade, the Australian Government's share of overall health expenditure has grown from 3.3 as a per cent of GDP in 1990-91, to 4.3 per cent in 2000-01, while state and local government contributions have remained static at 2 per cent.[6] Similarly, Australian Government share of public hospital funding has increased from 44.6% in 1992-93 to 47.9% in 2001-2, while over the same period, state and territory government funding has declined slightly from 46.3% to 46.2%.[7]

However, the increasing costs associated with an ageing population must be addressed as a matter of urgency as Australia's demographic shift continues. For example, the cost to the Australian taxpayer of the PBS has escalated dramatically over the last ten years, from $1 billion in 1990-91, and is expected to reach almost $6 billion in this financial year.[8] This is estimated to rise even further, to $7 billion in two years. The Government has recently introduced a system of full disclosure for the PBS, whereby prescribed medicines covered under the PBS are subject to package labelling outlining the actual cost of providing the medicine, which can sometimes run into thousands of dollars. This measure is intended to lessen waste of prescribed medicines by raising patient awareness of the cost of the PBS, thus saving public funds.

Government Senators believe the principle of full disclosure should also be extended to include patients' attendance at their GP. As with prescription medicine, patients utilising GP services should do so with a full understanding that a major (or total) proportion of the cost is borne by the taxpayer. This measure would help prevent misuse of GP services and relieve pressure on Medicare and overworked GPs.

Recommendation

Government Senators recommend that requirements be introduced to ensure that the real costs of a GP attendance and the extent of the government rebate payment are clearly displayed to patients.

Viable General Practice in Australia

Term of Reference (a) directly implies that the current levels of the MBS schedule are resulting in general practice becoming financially non-viable in Australia.

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6 Department of Health and Ageing, Submission 138, Answer to Question on Notice No. 6

7 AIHW, *Health expenditure Australia 2001-02*, Health and welfare expenditure series No. 17, September 2003

8 Department of Health and Ageing, Submission 138, p. 5

Government Senators do not believe this is the case. As figures from the Department of Health and Aged Care demonstrate, GPs around the country still receive significant incomes – with, for example, those in outer metropolitan centres averaging $236,328, which rises to $239,960 for those in large rural centres.[9] Allowing for practice costs of around 50%, this still allows for take-home pay for most GPs that easily exceeds $100,000, which is equivalent to 4.7 times the level of Average Weekly Ordinary Time Earnings (AWOTE).[10]

However, it is also evident that in many cases, especially for some country GPs, real incomes have declined.[11] Overall, GPs' income expectations, which are based on their perceptions of other specialists' and professionals' incomes, is one of the key factors driving the need for an increase in the rebate.

It is important that General Practice is an attractive career option both to current and prospective practitioners, and a central plank of achieving this is to ensure that General Practice is financially viable and can deliver reasonable incomes for doctors.

A number of actions have been taken by the Government to address these income issues. Importantly, there has been an increase in Australian Government payments for general practice services of around 30% from 1996-97 to 2002-03, rising from $2,400 million to an estimated $3,130 million. The six years since 1996 have also seen the Medicare rebate for a standard GP consultation increase by 20%, and for longer consultations by 26%.[12] This compares to increases of 9% for a standard consultation and 5% for a long consultation that occurred during the preceding six years of the Labor Government.[13]

The government has also made important contributions to GP incomes via the Practice Incentive Program (PIP) (described in paragraphs 3.44 – 3.51 of the Majority Report). PIP complements fee-for-service payments and recognises the importance of a broader practice-based approach to the delivery of health care. It aims to compensate for the some of the limitations of fee-for-service such as the perverse incentive for faster throughput of patients.

The PIP provides direct financial support to regional and rural practices, and encourages practices to operate in more efficient ways by supporting practice infrastructure such as information technology and practice nurses.

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9 Department of Health and Ageing, Submission 138a, Attachment A: referring to RRMAs 2 & 3.

10 This has declined from 5.2 times AWOTE ten years ago. AIPC Report to Select Committee on Medicare, p. 11

11 Department of Health and Ageing, Submission 138a

12 Department of Health and Ageing, Submission 138, pp 18 and 19.

13 Sen Knowles, *Proof Committee Hansard*, Melbourne, 24 July 2003, p. 22

In 2002-03, around $284 million will be paid to general practices through the PIP, with $21 million of this allocated to the management of specific conditions such as asthma, diabetes and mental health. PIP comprises around 10% of Australian Government remuneration to GPs.[14]

Ultimately, GPs are responsible for running their own businesses and setting their own fees in order to meet their income expectations, within the limits of what the market will pay. It is not the responsibility of the government to make general practice viable. However, existing government programs make a significant contribution to overall practice incomes, and have benefited from substantial increases over time.

Improved viability under A Fairer Medicare

A Fairer Medicare contains a number of initiatives that will benefit General Practice. Mr Davies of the Department of Health and Ageing made clear during the public hearings that the package has been carefully designed to ensure that GPs will be better off by signing on, and that the incentive to bulk bill will be highest in those areas currently witnessing low levels of bulk-billing availability. These same areas are also marked by relative declines in GP income compared to their city colleagues.[15] In addition, participating practices will receive a financial contribution toward the cost of accessing HIC Online, and in the case of practices in areas of workforce shortage, toward hiring practice nurses.

Government Senators are also mindful that the viability of general practice is as much a function of practice costs as it is of gross earnings and although the MBS rebate has increased in-line with the Consumer Price Index (CPI), many GPs reported an extraordinary increase in practice costs over recent years. Key contributors to these rising costs are medical indemnity insurance and administrative costs.

The Howard government has taken measures to address both issues.

The financial collapse of the Medical Defence Organisation UMP triggered a crisis in Australian medical indemnity arrangements. Although this crisis fundamentally represents a problem arising from the failure of a commercial entity, in the course of normal business operations, the Australian Government has stepped in to assist and has taken a number of important actions to ensure the continued protection of medical practitioners from insurance risk. These actions include a rescue package under which the Government has assumed responsibility for $460 million worth of UMP's unfunded liabilities plus $353 million of subsidies and exemptions for doctors.[16] The Government has also announced an extension of the high cost claims scheme to cover fifty percent of claims between $500,000 and $20 million, and exempted those doctors

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14 Department of Health and Ageing, Submission 138, pp 18 and 19

15 Department of Health and Ageing, Submission 138a, Attachment A. ie RRMAs 4-6.

16 Senator The Hon. Helen Coonan, Minister for Revenue, Media Release, *Paying for doctors' past mistakes?*, 1 October 2003.

in public employment or aged over 65 from the IBNR (Incurred But Not Reported) levy.[17]

In addition, the Minister for Health The Hon. Tony Abbot MP, announced the formation of a new Medical Indemnity Policy Review Panel which will make recommendations to ensure a fair, affordable and sustainable medical indemnity insurance system. This panel is to report in December.[18]

These actions represent a strong commitment by the Government to assist the medical profession. As the former Minister for Health, Senator Kay Patterson, stated:

> By any measure, the Australian Government has implemented far-reaching reforms and has given very generous taxpayer-funded assistance to doctors. No profession has ever received this much assistance for insurance costs from any government.[19]

This Government support for the viability of general practice must also be taken into account when considering the wider issues of GP remuneration and rebates, discussed below. It should also be noted though, that part of the reason for the failure of UMP and the current medical indemnity problems is the lack of tort law reform by state and territory governments.

The Government has also recognised the important issue of practice costs, especially in relation to the blended payments schemes, and this has already seen the creation by the Minister for Health and Ageing of a Red Tape taskforce. While recognising the importance of the fee-for-service model, Government Senators are mindful of the benefits and underlying worth of blended payments such as the Practice Incentive Program (PIP) and are committed to its retention. However, a large number of respondents expressed frustration at the administrative requirements of the system as it currently operates, including the disproportionately large amounts of time required by the claims process. Government Senators reiterate the importance of the Minister's Red Tape Taskforce in addressing these concerns and returning the financial as well as clinical benefits to the blended payment system.

For these reasons, Government Senators endorse the conclusions of the Majority Report in relation to importance of the Red Tape Taskforce, and support Recommendation 3.1 that the Australian Government undertake a similar review of the Practice Incentive Program (PIP).

Addressing the problem

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17 The Hon. Tony Abbot MP, Minister for Health and Ageing, Media Release, *New Medical Indemnity Arrangements*, 10 October 2003. Note that the rescue package also contains a range of other measures not detailed here.

18 The Hon Tony Abbot MP, Media Release, *The New Medical Indemnity Policy Review Panel*, 16 October 2003.

19 Senator The Hon. Kay Patterson, Media Release, *Australian Government committed to fair and manageable scheme to assist doctors to meet their liabilities*, 28 September 2003.

However, Government Senators recognise that the Medicare rebate constitutes a central element of GP remuneration and this method of remuneration enjoys support from the majority of general practitioners. At the same time, it is clear that an increase to the rebate does not guarantee an increase in the bulk-billing rates. When every $1 increase in the rebate costs the Australian taxpayer $100 million, increases must be carefully assessed.

Government Senators believe that the process of setting the rebate, and rises in it, would benefit from greater transparency. This would have the effect of demonstrating to practitioners the process through which the rebate is determined and while many may still consider the level at a given time is insufficient, might reduce the sense that levels are set arbitrarily, and with little reference to realistic need.

A useful example of this process is the current Review of Pricing Arrangements in Residential Aged Care, in which economist Professor Warren Hogan has been asked to provide information on the financial situation in the aged care sector and recommend new pricing mechanisms to underpin planning for residential aged care. The report is expected to be completed in December.[20]

Recommendation

Government Senators recommend reforms to the method of determining the level of the rebate, to increase the transparency and accountability of the process and to reflect more accurately the cost of running a general practice.

Government Senators also call for the finalisation of the Relative Value Study (RVS), in order to inform the determination of the rebate. The RVS failed to emerge with any clear outcome, due to lack of agreement by the overseeing committee on assumptions relating to GP workload, practice costs, target income, and the work value of a standard consultation.[21] Unfortunately, the overall outcome of the process has been the widespread, but incorrect, view within the medical profession that the RVS estimated the value of a GP consultation to be in the order of $50, but that its findings have been ignored by the Government.

Recommendation

Government Senators recommend that further work needs to be undertaken to either finalise the outcomes of the Relative Value Study (RVS) or utilise other relevant means to assess the costs of running a general practice.

20 The Hon. Kevin Andrews MP, ‘A National Vision for Community Care: An Australian Government Perspective’, 28 March 2003

21 DOHA, Submission 138b, Answer to Question on Notice No. 10

Access to General Practice

By focussing the discourse on the notion that the proposed changes to Medicare will result in a 'two-tiered American-style' health system, the opposition parties have limited what could have been a highly informative and comprehensive inquiry. The emphasis of the Terms of Reference on the bulk billing practices of general practitioners and the subsequent focus on declining bulk billing rates at the public hearings have similarly narrowed and politicised the debate. The Government considers that it is the shortage of services (of whatever billed nature) which is of most concern, and has acted to address workforce supply and retention issues as a priority. As Dr Robert Bain of the AMA stated:

> Access is much more important. We hardly ever get a complaint about a GPs charge.[22]

The key issue here is partly an outright shortage of GPs but, more particularly, the mal-distribution of the existing medical workforce. Further, declining morale and a shift in the make-up of the GP workforce could see a further worsening of the workforce shortage over the next 10- to 15 years. Therefore, while the decline in bulk billing is of concern to the Government Senators, of greater concern is equitable access to GP and other health services across Australia. An example of this problem was given by Dr Sprogis of the Hunter Urban Division of General Practice:

> I will go to work this afternoon in a socio-economically deprived area and the copayments range between $10 and $30 on top of Medicare fees, and our books are closed in this practice I am in. The problem in our region is not the availability of bulk billing; that is a non-issue in this town. It is whether you can get in to see a doctor at all … [i]n fact, new people coming to this region could expect to ring six to ten surgeries before they were accepted as a new patient …[23]

A Fairer Medicare maintains the universal principles of Medicare. However, it also brings new and very significant financial protection to those with the greatest health and financial needs. Further, the package strives to address some of the inequities in Australia's health care system such as timely access to medical services, being largely determined by geographic location.

The relationship between bulk billing and access

The Government Senators are concerned about the declining rate of bulk billing. However, they also recognise that bulk billing figures can be misleading because they hide inequalities within the system. Bulk-billing rates vary widely between regions, with rural and outer-metropolitan areas recording some of the lowest levels. Mr Davies from the Department of Health and Ageing analysed the situation this way:

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22 Dr Bain, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 90

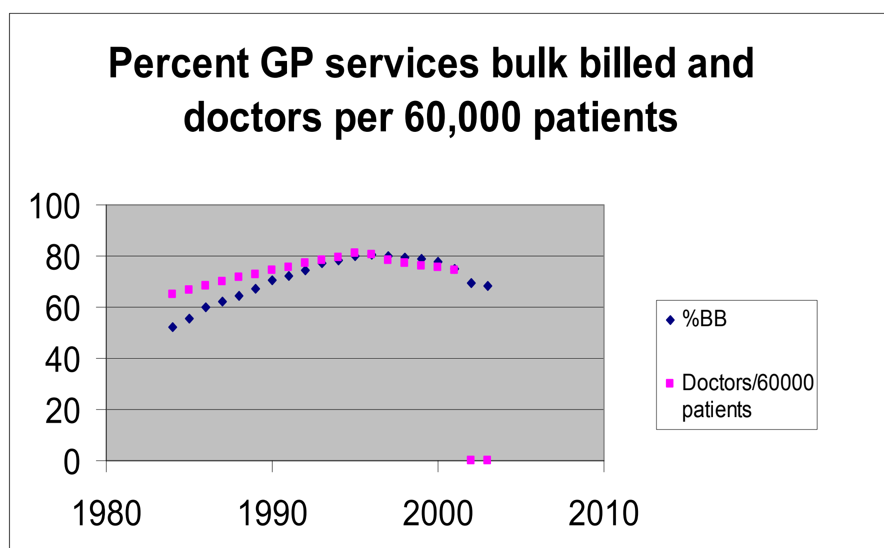
23 Dr Sprogis, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 2.

> [bulk billing rates] are unrelated to people's means. Much of the debate in recent months around reform to the health system has focused on the one-dimensional measure of the headline bulk-billing rate. But the headline bulk-billing rate is simply a gross measure of how many items of service are bulkbilled. The headline bulk-billing rate tells us nothing about how many individuals or households benefit from bulk-billing. It tells us nothing about the characteristics of the people who are bulkbilled, where they live or, for example, what their health status might be. So the headline bulk-billing rate, which we do tend to focus on, is at best a very crude indicator of the well-being of Medicare and general practice. For example, this next slide shows you that bulk-billing rates are much higher in capital cities than in rural and remote areas of our country. In fact, that difference is almost 30 percentage points between your likelihood of being bulk-billed in a capital city and your likelihood of being bulk-billed in rural and more remote areas.[24]

Dr James Moxham, President of the Australian College of Non Vocationally Registered General Practitioners, explained the cause of the disparity at the Adelaide hearing:

> The doctor to patient ratio and bulk billing percentages are very closely related, and that is not surprising, because it is simple economic supply and demand: If you increase the supply of doctors, the price goes down and bulk billing increases.[25]

This relationship is also evident in the following graph:[26]



The Government believes this uneven distribution of both doctors and benefits under Medicare is unfair and has structured the *A Fairer Medicare* package to focus on rectifying these problems of access in those areas of highest need.

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24 Mr Davies, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 3

25 Dr Moxham, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 1

26 Dr Moxham, tabled documents, Adelaide, 30 July 2003.

Improving access in Rural and Remote Regions

Government Senators point to the comprehensive range of measures put in place by the Government, prior to the *A Fairer Medicare* package, to address medical workforce shortages both in GPs and nurses.

In the short term, the Australian Government has been able to direct overseas-trained doctors to provide medical care to rural and regional communities by granting conditional Medicare provider numbers, requiring them to work in districts experiencing workforce shortage. This meant that in 2001-02, an estimated 4,910 exemptions were granted to 1,279 overseas-trained doctors to work in areas of workforce shortage, mostly in rural and remote areas.[27]

Other medium- to long-term strategies to redistribute the medical workforce have also been introduced, many as part of the *More Doctors, Better Services – Rural Health Strategy* released with the 2001-02 Budget. These programs are detailed in paragraphs 8.1-8.11 (in relation to GPs) and 8.56-8.59 (in relation to nurses) of the Majority Report.

Since 1996, the Australian Government has spent more than $2 billion on rural health initiatives including more than $500 million through *More Doctors, Better Services*, to get more doctors and health workers out to areas of need and keep them there.

The evidence shows that these policies are working. The number of full-time equivalent general practitioners in rural Australia has increased by 11.4% over the past five years, including a 4.7% rise in the most recent year. In addition, as at the end of June 2003, some 58 general practitioners are receiving assistance to relocate to outer metropolitan areas under the *More Doctors for Outer Metropolitan Areas* program, with a further 22 general practice registrars undertaking 6 month placements in these areas. [28]

The Government committee members also recognise that Aboriginal health continues to be an enormous challenge for all levels of government across Australia. In response to this challenge, the Government has committed $264 million per annum to Indigenous specific health services by 2004-05, which amounts to a doubling of funding since 1996.[29]

A major component of this spending commitment is the Primary Health Care Access Program, commenced in 1999. This innovative scheme uses a funding formula and funds pooling arrangements with State and Territory Governments to address the current inequitable access to health care services for Indigenous Australians. The

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27 Department of Health and Ageing, Submission 138, p. 39

28 Department of Health and Ageing, Submission 138, p. 39

29 Senator the Hon Kay Patterson, Media Release, *Major funding announced for new and improved indigenous health facilities*, 27 March 2003

arrangement locks in funding commitments, and helps to ensure greater resources and access to health care for aboriginal people living in remote areas of Australia.[30]

What else is being done?

A Fairer Medicare makes a significant long-term investment of around $300 million to ensure the medical workforce is of a sufficient size and availability to meet the projected future needs of the Australian population.

Government Senators reiterate that the package provides an additional 234 medical school places every year commencing in 2004. These places are bonded to areas of workforce shortage for six years. This represents an increase of 16% in medical school intake on current levels and ensures that around 20% of the future medical workforce are contracted to work in areas of workforce shortage for a period of their career. The quantum of the increase is in line with recommendations from the Australian Medical Workforce Advisory Committee.[31]

In addition, the package provides an additional 150 training places each year for GP registrars. These registrars will work primarily in areas of workforce shortage while they are training, providing an immediate increase in the number of practitioners working in those areas. Government Senators believe it is worth considering increasing the numbers of registrar training places even further.

Recommendation

Government Senators recommend that consideration be given to increasing the number of additional registrar training places beyond the additional 150 places provided for in *A Fairer Medicare* package.

Funding for 457 nurses to be employed in general practices that are part of the General Practice Access Scheme is also provided, and it is anticipated that around 800 practices will be assisted to employ nurses through this initiative. This measure was met with universal approval by both individual doctors and doctors' groups throughout the inquiry.

Practice nurses provide a valuable tool in providing GPs with clinical support and assisting with the management of chronic conditions such as diabetes. This leaves the doctors free to concentrate on the 'high-end' tasks of diagnosis and illness management, and makes the most effective use of Australia's limited number of GPs. As Dr Sprogis, Chief Executive of the Hunter Urban Division of General Practice advised:

> I think the answers are really simple and really straightforward. You make up for doctor undersupply by other workforce … [The region has seen an

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30 AMSANT, Submission 157a, Attachment 1, p. 3

31 Department of Health and Ageing, Submission 138, p. 31

> increase] in the last two years from 40 nurses in general practices to nearly 170, and the numbers are still growing. It has been a great advantage to us.[32]

Professor Marley made a similar observation:

> [Nurses are] liberating doctors to do the things they are really trained for, and which you need all of that training to be able to do, and making it more appropriate for other professionals to deliver the care that doctors do not need essentially to do.[33]

Importantly, the scheme provides the flexibility to employ allied health professionals such as physiotherapists, podiatrists and Aboriginal health workers.

Given this important role, the Government Senators support the recommendation in the Majority Report to expand the number of practice nurses proposed in *A Fairer Medicare*. However, Government Senators do not agree with the recommendation to uncouple provision of the additional practice nurses to practices signing on to the General Practice Access Scheme. It is entirely legitimate for the Government to link the two measures, as part of developing an attractive package for GPs.

Government Senators also note that, as with GPs, there is likely to be a considerable number of qualified nurses in Australia who are not currently working. These are likely to be either Australian trained nurses who have left the hospital nursing system, or overseas trained nurses who for various reasons may not be working. Many of these nurses are likely to find the flexibility of work hours in general practice very attractive.

This group constitute an important resource, and every effort must be made to bring the skills and experience of this group back into the medical workforce. The Government's *Rural Health Strategy* has already initiated important workforce programs to achieve this, although it is too soon to assess the success of this program. However, Government Senators see merit in an early review of these programs, with a view to directing additional resources to those measures that are having the greatest success.

As identified in the Majority report (paragraphs 12.80 onwards), a major disincentive to many practices making the greatest use of their practice nurses is the fact that under present Medicare arrangements, GPs are the only member of the medical team that have provider numbers and can charge a service against a MBS item number. This is a serious impediment to giving full scope to the additional practice nurses that will be provided under the Government's *A Fairer Medicare* package, but one that is relatively easily rectified.

Government Senators note that a number of initiatives that form part of the Enhanced Primary Care package go some way to introducing these measures. EPC health

32 Dr Sprogis, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 2

33 Professor Marley, *Proof Committee Hansard,* Newcastle, 23 July 2003, p. 32

assessments include provision for nurses to work under the supervision of the GP in collecting information about the patient for the health assessment. There is also scope under the Medicare Benefits Schedule for nurses and other health professionals to assist in care deliver whilst acting under the supervision of a GP.[34]

Government Senators applaud these developments but consider there is scope to go further.

Recommendation

Government Senators recommend the Government consider the creation of a number of new Medicare item numbers that would enable practice nurses to charge under the Medicare system for a range of routine medical procedures such as wounds treatment and immunisations.

Government Senators also note the important role of the Australian Government in funding a range of models for after hours access to general practice.[35] One example of the operation of this program is *GP Assist*, which has emerged out of a successful Australian Government funded trial program, with a full program now due to commence operation in Tasmania on 1 November this year. Australian Government funding of $6.5 million has enabled the development of a state-wide call centre using a telephone triage service. The service is staffed by experienced Nurse Practitioners, who are supported by computerised decision making software, and who will either provide advice, call an ambulance or arrange a home visit by a GP, according to the circumstances. The trial program met with a high degree of patient satisfaction, and during the trial period, up to 70% of calls resulted in patients' medical needs being met in the comfort of their own home.[36]

Government Senators commend the success of this and similar trials, which provide a model for improving better after-hours GP services around Australia, with the associated reduction in the work pressures on GPs to provide these services themselves.

Recommendation

Government Senators recommend additional funding be given to the After Hours Primary Care Development Grants Program to enable the extension of the program to other areas of need.

Two final areas of special need must be considered. Firstly, Government Senators acknowledge that many Accident and Emergency Departments in hospitals around the country are struggling to cope with the numbers of patients seeking attention. To some

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34 Department of Health and Ageing, Submission 138b, Answer to Question of Notice, no. 9

35 See DoHA, Submission 138b, Answer to Question on Notice No. 16

36 Senator the Hon Kay Patterson, Media Release, *$6.5 million for 24 hour medical care across Tasmania*, 13 July 2003.

extent, this is driven by difficulties in accessing GPs (especially after hours). Accordingly, Government Senators consider there is a need for the Government to develop a program of special incentives for GPs to practice in or around Public Hospital Accident and Emergency Department areas.

This could be done by means of salaried GPs, or preferably, by funding enabling hospitals to tender for GP services.

Secondly, Government Senators saw evidence during the inquiry of considerable difficulties experienced by people in aged care facilities in gaining access to GPs. This problem has particularly severe implications for aged care residents given their inability – in many cases – to travel to see doctors in other locations.

Government Senators consider that this problem needs to be addressed, possibly through a program of special targeted measures.

Enhanced use of Overseas Trained Doctors

Another key to resolving the current shortage of GPs is to make better use of Overseas Trained Doctors (OTDs). Although agreeing with much of the discussion on OTDs in the majority report, Government Senators wish to stress several additional points.

First, there is evidence to suggest that there may be as many as two thousand OTDs in Australia who are not currently working,[37] which seems to be caused in part by disincentives to enter Australia as a doctor (as discussed at paragraphs 12.39 onwards). This represents a major un-utilised resource that, by itself, could do much to meet the unmet need for GPs. The challenge for Government is therefore to focus on removing any obstacles that currently prevent these doctors from working, and develop a package of incentives that will bring this group back into the workforce, and working in areas of need.

The Government Senators agree in general with recommendations of the Majority Report, but consider that more needs to be done.

As a first step, immediate steps should be taken to clarify the current situation. For a number of reasons, it is impossible to ascertain the exact number of OTDs currently in Australia and how many of them are working. A starting point for any program to better utilise OTDs must be to rectify this program, coordinating information from sources such as the Royal Australian College of General Practice, the Australian Government Departments of Health and Immigration,[38] and Medical Registration Boards.

Secondly, as part of a number of workforce measures introduced during the late 1990's, changes were made to the system of Medicare provider numbers, limiting

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37 Dr Bain, Canberra, 21 July, p. 17

38 DoHA and DIMIA.

their availability for OTDs. Some of these measures may still perform a useful role, such as those requiring a Temporary Resident Doctor to work in districts of workforce shortage, however, a review of the operation of these measures would be timely to ensure that they are still delivering outcomes in accord with public policy. This review should be coordinated between the health and immigration portfolios. The review should also include the extent of the current scope for mutual recognition of overseas medical and specialist qualifications such as with New Zealand, and whether these may be extended to additional countries to provide greater ease of access to practice in Australia.

Thirdly, Government Senators believe additional measures are needed to encourage more OTDs to come to Australia to work, both on a temporary and permanent basis.

It is noteworthy that the National Health Service (NHS) in the UK has embarked on a dedicated program to recruit OTDs from selected countries. Measures include a website to provide a central point of information, as well as the creation of two schemes aimed at medical practitioners:

- a managed placement scheme, offering the opportunity to work as an NHS consultant on a temporary basis; and
- NHS International Fellowships, running for a two year period.

Government Senators consider there is merit in developing a similar program in Australia.

However, for both OTDs coming to Australia and those already here, a concerted effort must be made to ensure that they receive the necessary support and training. This should include bridging training programs addressing the specialist needs for general practice requirements in Australia as well as training to enable OTDs to meet Australian GP accreditation standards. Importantly, the Government should also consider providing financial assistant to these doctors to enable them to undertake this training.

Government Senators also note the model of a joint venture between the Outer Metropolitan Workforce Planning Group, the Australian Medical Association Western Australia, and the Royal Australian College of General Practitioners Western Australia, titled *GP Workforce Solutions*. This plan brings together a number of measures to better utilise the skills of permanent resident OTDs who are not working. Government Senators commend the plan to the Government.

Recommendation

Government Senators recommend:

- **a program to ascertain the exact numbers and skills of OTDs currently in Australia;**

- **a review of the operation of the current immigration laws with respect to OTDs entering or working in Australia as medical practitioners, with a view to removing any unnecessary obstacles. This review should include an assessment of the scope and extent of recognition of foreign qualifications.**

- **the development of a program of targeted measures to encourage and assist OTDs to come to Australia to work;**

- **the development of an integrated series of support measures to ensure that both OTDs in Australia and those coming here to work are given coordinated training, support and mentoring in a timely manner to assist them to gain Australian medical qualifications and to practice effectively in Australia.**

Finally, Government Senators stress that the use of OTDs is a temporary solution that would complement existing measures to relieve pressure on areas of workforce shortage, until the effects of the wider workforce measures come into effect.

A Fairer Medicare Package

Government Senators wish to state their disagreement with the criticisms and findings of the Majority Report in relation to specific aspects of the *A Fairer Medicare* package.

Bulk billing for Concessional Patients

A Fairer Medicare will not disadvantage the ‘working poor’ for the simple reason that the package takes nothing away from the current system – it simply adds key measures that will act to address the current gaps. It is these gaps that are unfair, and that are causing hardship, as explained in detail by Mr Davies, Deputy Secretary in the Department of Health and Ageing during the Canberra hearings.

Under *A Fairer Medicare* package, all Australians will continue to be eligible to receive Medicare rebates and will remain eligible to be bulk billed. They will continue to benefit from free care in public hospitals and subsidised medicines through the pharmaceutical benefits scheme. These universal elements of Medicare will not change.

The Majority Report criticised the focus on concession cards, and their usefulness as a measure of need, pointing to those who will not be covered. Three points must be made in response to this criticism.

First, the three Commonwealth concession cards, which are used as the basis of a number of entitlements including the PBS, provides a fair, constantly updated and government-wide system for identifying need. As with any system, it is possible to find examples where the system does not work perfectly. However, it remains the best and simplest way of targeting need. It is certainly less arbitrary than relying on individual doctors’ decisions to discount patients they perceive as being in financial need. It is also more accurate than any of the other generalised indices of

disadvantage, as demonstrated in the majority report. As the majority report also correctly identified, it would be too expensive and administratively unwieldy to attempt to construct a separate, additional, concessional system exclusively for Medicare.

Second, those who do not fall within one of the concession card categories still have the protection offered by one, or possibly both, of the two added safety nets that will provide protection from out-of-pocket expenses for Medicare services provided outside hospitals. These are discussed in more detail below.

Third, there is nothing in *A Fairer Medicare* package that will cause doctors to increase their fees. Since doctors have always been free to set their own fees, it is a question of incentives, and as Mr Davies told the Committee, the government modelling was premised upon practices that sign onto the General Practice Access Scheme being financially better off through the incentive payments. Participating GPs will enjoy higher incomes with no need to raise their fees.

The Government Senators also note that the calculations made by many doctors about the lost revenue arising from bulk billing all concession card holding patients appear to be based on the assumption that they currently charge all these patients full private billing rates. However, both the statistics and the anecdotal evidence of doctors themselves indicate that many practices already bulk-bill some or all of their concessional patients, and discount their fees for those who are privately billed. This suggests that many GPs have over-calculated the effects of moving to full bulk-billing of these patients, particularly after including the additional revenue from the government incentive payments.

Direct rebate at point of service

Under A Fairer Medicare, participating practices will be able to receive their Medicare rebate directly at the point of service, via HIC Online. HIC Online is an internet-based electronic lodgement, claiming and payments facility.

This change offers major improvements for patients, doctors and the system as a whole.

For patients, it means that when they visit a doctor at a participating practice, they can assign their Medicare rebate to the doctor and pay only the gap rather than the full up-front fee. They can leave the surgery with no more to do and no more to pay. A lower upfront fee, where a doctor chooses not to bulk-bill, will make visiting a GP more affordable, and will make a big difference for many poorer families for whom trying to find the $30-odd dollars up-front for a consultation is a significant obstacle to seeing a GP. It will also make it more difficult for doctors to increase their fees without patients noticing the increase. It will be very clear, arguably for the first time, how much they are out of pocket.

For doctors, HIC Online provides substantial benefits, including improved cash flow resulting from improved edit checking which will substantially reduce the number of

claims that are rejected and have to be re-submitted. This means faster payments, and greatly reduced administrative costs from billing and debt collection.

Doctors still have the choice of whether to direct bill in relation to a service or charge the patient. The decision to direct bill a patient service is one for the doctor to determine taking into account the patient's circumstances and their ability to pay for the service. HIC Online will have no bearing on this decision.

Feedback from doctors indicates that they recognise the benefits of lodging direct bill claims using HIC Online.

For the Medicare system, the widened use of HIC Online will increase transparency and convenience, and greatly save on the current administrative costs involved in the cumbersome procedure of mailing cheques to individuals.

Safety nets

A Fairer Medicare is designed to benefit all Australians, and despite claims made by the opposition parties, the Howard Government is committed to protecting those in greatest need. One of a number of initiatives encompassed in the *A Fairer Medicare* package is the introduction a new safety net for Commonwealth concession card-holders whose illness, frailty or level of need exposes them to high medical costs.

The existing safety net only calculates the gap between the rebate fee and the scheduled fee, but does not include the actual out-of-pocket costs incurred. With these average gap payments increasing over time, this can add up to a significant amount, particularly for individuals and families who require multiple visits to GPs, need to make frequent use of specialist services, and/or are high users of diagnostic and treatment services.

The new MBS safety net will pay 80% of all out-of-pocket costs once a $500 threshold is reached. The threshold amount of $500 was calculated using data produced from Medicare statistics identifying concessional families that would receive the most benefit. This means the proposed safety net will provide a major benefit for around 50,000 of the poorest and sickest in our society.

At the same time, the new safety net will not involve any new administrative work for GPs or patients. Once patients register with the HIC, the safety net will be calculated and paid automatically.

The second proposed private health insurance safety net also rectifies a long-standing hole in the health insurance arrangements. In an era where best practice medical care is increasingly being provided on an out-of-hospital basis, it is an anomaly that patients are only able to have insurance protection for hospital treatments. The current arrangements are therefore both unfair to individuals and present a disincentive for medical service providers to minimise hospital treatments. This is likely to result in higher costs for the hospital system at a time when they are already under considerable pressure from high patient numbers.

This additional protection offered by the proposed private health insurance safety net is likely to cost as little as $50 per year for a family, making it easily affordable for many who are currently forced to 'self-insure' for these risks.

Departmental estimates put the number of potential beneficiaries of these reforms at 50,000 in the case of the safety net for concession card holders[39] and 30,000 for the opening up of the opportunity for gap insurance for out-of-hospital out-of-pocket expenses.[40] Government senators believe that it would be irresponsible to deny these Australians access to relief from these increasing expenses.

With respect to the issue of gap insurance, Australians are able to insure commercially against a large range of risks. It is illogical to single out health for a special prohibition on the offering of a product to a willing market. We note that the Association of Independent Retirees called for:

> ... consumer freedom of choice to insure against such out of pocket expenses.[41]

The Private Health Insurance Rebate

The 30 per cent private health insurance (PHI) rebate is vital to maintaining Australia's balance between public and private sector provision of health services. This mix of public and private funding maximises the capacity of the dollars available to meet Australia's health needs. As intended, the PHI rebate has allowed millions of Australians to benefit from the health care choices associated with PHI and has reduced pressure on an overburdened public hospital system, while its removal would have serious detrimental consequences for Australia's mixed health system.

The success of the PHI Rebate

Since the introduction of the PHI Rebate and Lifetime Health Cover, the uptake of private health insurance hospital cover has increased from 32 per cent of the population in June 2000 to 43.8 per cent in March 2003.[42] Notably, the rebate has also assisted over one million Australians earning less than $20,000 per year to take out PHI cover,[43] and will see Australians receive private health insurance benefits worth an estimated $7 billion in 2003-04.[44] Currently, a total of 9.9 million Australians – or nearly 50% – have some form of private health insurance cover.[45]

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39 Mr Davies, *Proof Committee Hansard,* Canberra 21 July 2003, p.4

40 Mr Davies, *Proof Committee Hansard,* Canberra, 28 August 2003, p. 89.

41 Association of Independent Retirees, Submission 97, p.8.

42 Department of Health and Ageing, Submission 138, p. 6

43 Department of Health and Ageing, Submission 138, p. 6

44 Australian Health Insurance Association, Submission 105, p. 1.

45 Australian Health Insurance Association, Submission 105a, p. 14.

This increasing membership means that more Australians have the opportunity to benefit from a substantially improved range of choices when planning for their future health care needs. Private health cover allows patients to decide who they are treated by; where they are treated; and, perhaps most importantly, when they are treated. For Australians with PHI, knowing that they will avoid lengthy waiting times if and when they require treatment provides valuable peace of mind.

Increased numbers of people with private cover also enhances the timely access to care of those reliant on the public hospital system. By encouraging more people to move into the private hospital system, the PHI rebate has significantly reduced pressure on public hospitals. Despite claims to the contrary, there is a plethora of evidence to support this position. As Dr Glasson, President of the AMA, said:

> The only reason the public hospitals are surviving to any extent that they are at the moment is because of the 30 per cent private health insurance rebate.[46]

In 2000-01, total public hospital admissions fell by 4,591 while private hospital admissions rose by 245,129,[47] and in 2001-02 private hospitals accounted for 76 per cent of new hospital separations.[48] With the number of total separations in Australian hospitals increasing by 4.4 per cent per annum over the past seven years, these figures demonstrate that the private hospital system is carrying the majority of the increasing burden on Australian hospitals.[49] While the argument is made that public hospital admissions are still increasing, the fact remains that they are not increasing at a rate nearly as high as if the rebate were not in place.

Data from the Australian Institute of Health and Welfare further demonstrates the effect of the rebate in easing pressure on the public system. Figure 1 demonstrates that private hospital sector growth has outstripped public sector growth every year since 1997-98.[50]

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46 Dr Glasson, *Doctor's waiting room the great divide*, Courier-Mail newspaper, Thursday 31 July 2003, p. 1

47 Australian Health Insurance Association, Submission 105, Executive Summary, paragraph iii

48 Australian Health Insurance Association, Supplementary Submission 105a, p. 2

49 Australian Health Insurance Association, Supplementary Submission 105a, p. 2

50 Australian Health Insurance Association, Supplementary Submission 105a, p. 4

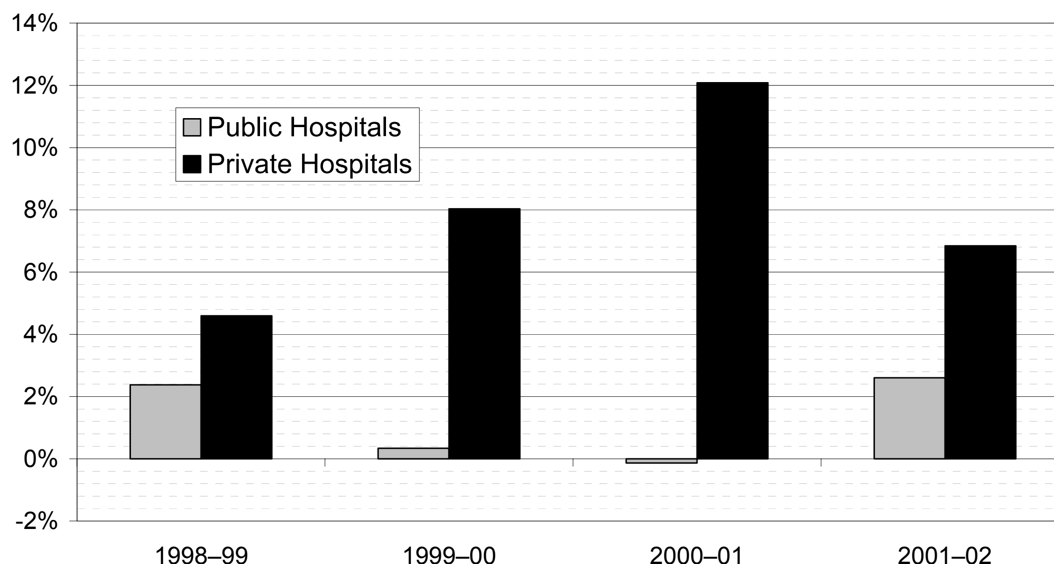
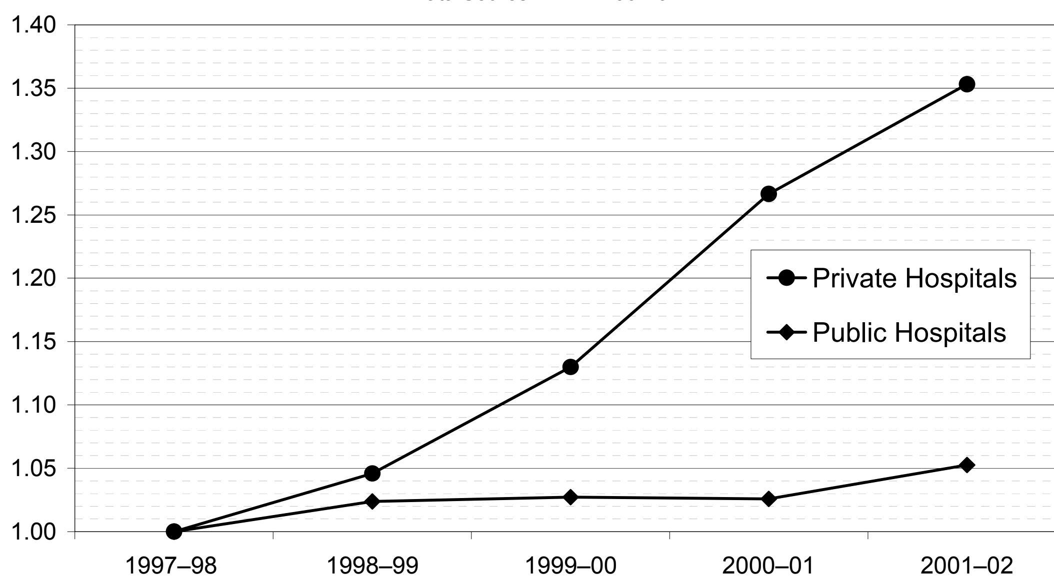


Figure 2 shows that over the same period the private sector workload has increased 35 percent, compared to a much lower five per cent increase for the public sector.[51]



It is also important to note the nature of the work carried out in private hospitals, which is clearly contrary to some claims that private hospitals 'cherry pick' only the most profitable procedures.[52] Private hospitals, for example, currently perform more

51 Australian Health Insurance Association, Supplementary Submission 105a, p. 4

52 For example see WA Government, Submission 177, p. 15

than half of all malignant breast conditions, chemotherapy, cardiac valve and hip replacement procedures.[53]

The rebate is also critically important to providing access for many Australians to a range of other health services, through support to those opting to take out ancillary cover, which includes services such as dentistry, physiotherapy and optometry. As the Department of Health and Ageing stated in its submission:

> Most dental and allied health services are provided in private practice. For many Australians, especially families, the key to accessing affordable services has been through private health insurance ancillary cover. Eighty percent of ancillary benefits paid to members were for core health services of dental (48%), optical (17%), chiropractic (7%) and physiotherapy (7%).[54]

Australian Government support for these services adds up to over $1,500 million a year, paid via the private health insurance rebate.

Removal of the rebate on ancillary benefits would be likely to triggering a sharp reduction in the numbers of people electing to retain ancillary cover, with an estimated 3.8 million Australians no longer be to affordable the extra cover.[55] Again, the impact on the public system would be considerable. For example, the already overburdened state-run public dental programs would face significantly higher demand if Australian Government funds directed to dental services through the PHI rebate were to disappear.

Similarly, a number of respondents called for the scrapping of the PHI rebate in its entirety. However, the consequences of dismantling the rebate would be disastrous for Australia's entire health system.

Should the rebate be fully removed, privately insured Australians would face a 43 percent increase in their premiums.[56] For the private health funds attempting to maintain relatively low premiums, the effects would be immediate, as the first to leave PHI would be the young and healthy, who provide the best risk to the health funds and effectively subsidise the cover of older insurees. Premiums would then spiral upwards, forcing a vicious cycle of declining membership, leading to a smaller pool of higher risk people, leading in turn to higher premiums. This would replicate the situation prior to the Government's reforms. The effect would be an increasingly unviable private health industry, and reduced availability of private health insurance for many low income Australians, a large proportion of whom are aged over 65 and most in need of cover. This would inevitably exacerbate existing pressures on the already overburdened public health system.

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53 Australian Health Insurance Association, Submission 105, p. 8 and Australian Health Insurance Association, Supplementary Submission 105a, p. 11

54 Department of Health and Ageing, Submission 138, p. 41

55 Australian Health Insurance Association, Submission 105, p. 17

56 Australian Health Insurance Association, Submission 105, p. 17

The effects would also be seen in other aspects of the health system. Even taking into account the 30 per cent rebate, Australians with private health insurance voluntarily contribute $5.1 billion to the total health pool in addition to their taxes and Medicare levies.[57] The pre-rebate trend suggests that, without the rebate, only 3.5 million people would today be insured – 5.1 million less than with the rebate.[58] If this money were removed from the private system, the overall health system would be required to recoup this lost funding through tax increases.

Overall, it is clear that the PHI rebate generates significant leverage for health funding and saves the Australian Government billions of dollars annually by encouraging ordinary Australians to contribute to the cost of their own health care.

Labor policy on the PHI Rebate

Although the Federal Labor Party has yet to clarify its position on the PHI rebate, the positions taken by their state counterparts provides a likely indication of their views. Of the eight Labor state and territory governments, five told the Committee they did not support the rebate. These were the governments of Queensland, South Australia, Tasmania, the Northern Territory and the ACT.[59] For example, the ACT Minister for Health, The Hon Simon Corbell MLA, stated in evidence that:

> Given the level and pressure for services in the public health system, the ACT government's view is that that $2 billion to $3 billion could be better spent and that you would get better outcomes – certainly more significant than just a shift of 200,000 people across the country – by putting it into public health systems. So we are quite unashamed about saying that the private health insurance rebate could be better spent in the public health system.[60]

The New South Wales and West Australian state governments also expressed concerns over the policy, noting the potential benefits of redirecting the funds to other areas of the health system, and calling for an independent assessment into the rebate's effectiveness.[61] This view is mirrored in both the discussion and recommendation of the Majority Report and, in light of the views of the state and territory governments, is clearly code for the eventual abolition of the rebate by any Federal Labor government.

57 Australian Health Insurance Association, Submission 105, p. 18

58 Australian Health Insurance Association, Supplementary Submission 105a, p. 23

59 See Queensland Government, Submission 32, p. 9, South Australian Government, Submission 161, p. 4, Tasmanian Government, Submission 147, p. 6, Northern Territory Government, Submission 82, p. 7 and Simon Corbell MLA, *Proof Committee Hansard*, Canberra, August 28 2003, p.28 respectively

60 Simon Corbell MLA, *Proof Committee Hansard*, Canberra, August 28 2003, p.28

61 See Professor Picone, *Proof Committee Hansard*, Sydney, 22 July 2003, p. 85 and West Australian Government, Submission 177, pp. 14-15

The NSW government support for an increase in the Medicare levy should also be noted.[62]

Conclusion – strengthening the PHI rebate

Government Senators fully endorse this successful government initiative and based on its success, further recommend increasing the PHI rebate to 35 per cent and 40 per cent, or higher, over time. This measure would allow even more low income Australians to access PHI and the benefits of choice it provides, while continuing to ease pressure on the public system. As rising levels of private health insurance continue to reduce the workload of public hospitals, there is likely to be a commensurate reduction in the need for public spending on public hospitals. These savings could potentially be redirected into raising the level of the rebate even further.

Australia's health system requires an appropriate mixture of public and private sector involvement to maximise the capacity of Australians to fund high quality health services. The PHI rebate is a crucial policy in achieving the right balance.

Recommendation

Government Senators recommend consideration be given to increasing the level of the PHI Rebate from 30% to 35%, with a subsequent increase to 40% or higher over time, subject to the results of careful monitoring and analysis of its effect, including the outcome on public hospital workloads.

Government Senators further recommend consideration of a special rebate increase for people aged 65 years of age and over.

The ALP Medicare policy

Relatively little attention to the ALP policy was given by many individuals and groups during the inquiry, and it is perhaps unfortunate that it has not been subject to a proper degree of public scrutiny.

Government Senators make three comments in relation to the ALP policy.

First, and as discussed in greater detail above, bulk billing is not and should not become, the definitive reference point for the success of the Australian health system. Access and affordability are, and it is these elements that the Government package addresses.

The ALP package, by its over-emphasis on the issue of bulk-billing misses the point.

Secondly, by setting of lower target levels of bulk-billing in regional and country areas, the ALP package sets up a two-tier system, which treats rural and regional Australians as second class citizens.

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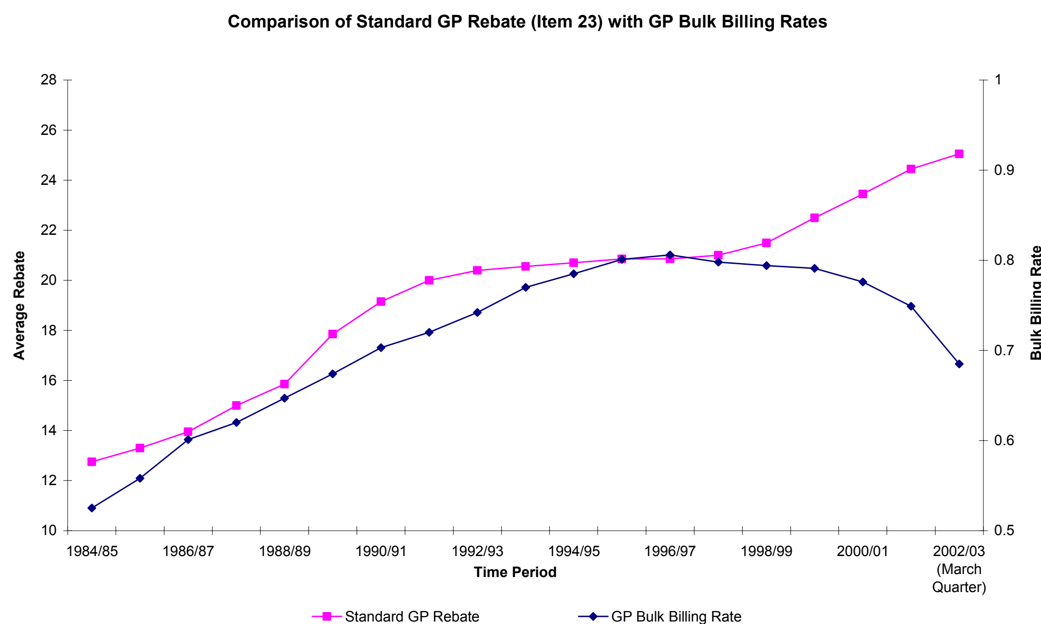
62 NSW Department of Health, Submission 154, p. 24

Thirdly, Government Senators consider that the emphasis in the ALP package on raising the level of the rebate as a means to achieve higher bulk-billing rates is misguided. What is evident from both the evidence provided by the Department and in the following graph,[63] is that there is no guarantee that raising the rebate will increase bulk-billing. Despite blanket increases in the rebate from 1996-97 to the present, the bulk-billing rate continued to fall.



The AIPC Report

Finally, Government Senators wish to reiterate their views of the research commissioned by the Committee from academics at the Australian Institute of Primary Care. The key to any proper academic research, particularly when it is paid for by public funds, is the independence of the researchers. From the beginning, Government Senators were opposed to the selection of the research team – comprising Associate Professor Hal Swerissen, Professor Stephen Duckett and Mr Charles Livingstone – on the grounds of clear bias.

In particular, Professor Swerissen is a former staff member for Labor Member of Parliament Ms Carmen Lawrence, Professor Duckett, at the time the research was commissioned, had already put on the public record his critical views of the Government's *A Fairer Medicare* package in a submission to the Committee.[64] Similarly, Mr Livingston published an article highly critical of the government in the magazine *Dissent*.[65]

63 Department of Health and Aged Care, tabled documents, Canberra, 21 July 2003

64 Prof Duckett, Submission 93

65 Livingstone, C., & Ford, G., 'Paying for Medicare', *Dissent*, No 11, Autumn/Winter 2003

It remains the view of Government Senators that it is inappropriate for the Committee to commission work from academics with a known and public bias in relation to the work they are being asked to undertake. This bias casts into serious doubt the findings of the AIPC Report.

Dental services

Government Senators also wish to record their disagreement to Recommendation 10.1 of the Majority Report for the reintroduction of a Commonwealth dental health program.

Government Senators concur with the long held view of the Howard Government that the provision of public dental services have long been and remain the responsibility of the State and Territory governments. This view is set out in paragraphs 10.18 & 10.19 of the Majority Report.

As described elsewhere in this report, States and Territories will enjoy an increased level of funding under the new Australian Health Care Agreements that will increase the overall resources they have to address public dental health issues. This comes on top of the additional funds already delivered to the States and Territories via the dedicated stream of GST funds.

Conclusion

The proposed reforms enveloped in the Australian Government's *A Fairer Medicare* package are long term, economically responsible measures aimed at strengthening Australia's universal health system. It strives to enlarge Australia's medical workforce, ensure more equitable access to medical services across Australia and provides significant protection to those with the greatest health and financial needs.

Recommendation

Government Senators recommend the adoption of the Government's *A Fairer Medicare* package.

Senator Guy Barnett (Deputy Chair)

Senator Gary Humphries

Senator Sue Knowles

DEMOCRATS ADDITIONAL COMMENTS

The Democrats support the Chair's Report, with one minor exception.

Recommendation 8.1 of the Report 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 Democrats do not accept that the current bonding proposal has merit, for two reasons. The first is that the evidence presented to the Committee suggests that rural experience should be marketed as an opportunity and an integral part of medical training. Rural training provides medical students with greater skills in a non-interventionist non high-technology tertiary hospital environment. This should be valued as an important part of primary health care.

Secondly, it is not clear that rural communities will welcome being treated by reluctant freshly-trained doctors. Flexibility is important, to allow medical students the capacity to leave a town should they not be sufficiently interested in living in that community, for the sake of patients in that community.

The Democrats consider therefore that the recently implemented HECS reimbursement scheme, which enables participants who undertake training or provide medical services in rural areas to have one fifth of their HECS to be reimbursed for each year of service, should be continued and expanded.

Senator Lyn Allison
27 October 2003

APPENDIX 1

LIST OF PUBLIC SUBMISSIONS, TABLED DOCUMENTS, SUPPLEMENTARY INFORMATION AND OTHER WRITTEN MATERIAL AUTHORISED FOR PUBLICATION BY THE COMMITTEE

1 Mr Michael F Waterhouse, PhD (QLD)
2 Ms Loris Erik Kent Hemlof, (SA)
3 Mr E D Webber, (NSW)
4 Dr Dorothy L Robinson, (NSW)
5 Australian Pensioners' and Superannuants' League Qld Inc. (QLD)
6 Dr Andrew Gault, (VIC)
6a Dr Andrew Gault, (VIC)
7 Dr Ian Cormack, QLD)
8 Ms Jean Hayes, (TAS)
9 Missionary Sisters of Service (QLD)
10 Dr Ruth Stewart, (VIC)
11 Dr Graeme Alexander, (TAS)
11a Dr Graeme Alexander, (TAS)
12 Alliance of New South Wales Divisions of General Practice (NSW)
13 Dr Chris Boyle, (NSW)
14 Dr Rowena Ryan, (VIC)
17 Ms Jane Smith, (TAS)
18 Ms Michelle Kaden, (TAS)
19 Dr Warwick Carter, (QLD)
20 Ms Wendy Flannery, (QLD)
21 Ms Kate Thomas, (NSW)
22 Mr John Stafford, (QLD)
23 NSW Retired Teachers Association (NSW)
24 Yorke Peninsula Division of General Practice Inc (SA)

Tabled at Adelaide Public Hearing 30.7.03

- Opening statement
- Health Services Map, related press clipping

25 Doctors Reform Society (NSW)
26 Ms Catriona Caw, (NSW)
27 Ms Prudence Watson, (NSW)
28 Mr Edward Boyapati, (VIC)
29 Dr Nirmala Valleru, (VIC)
30 Dr Ian Readett, (TAS)

31 Mr J D Potts, (VIC)
32 Queensland Government (QLD)

Tabled at Brisbane Public Hearing 26.8.03

- Opening remarks and overheads and graphs on Queensland public hospital expenditure

33 SA Divisions of General Practice Inc (SA)
33a SA Divisions of General Practice Inc (SA)
34 Eurobodalla Greens (NSW)
35 Australian Political Ministry Network Ltd (PolMin) (NSW)
36 Eastern Riverina Greens (NSW)
37 Australian Divisions of General Practice Ltd (ACT)
37a Australian Division of General Practice Ltd (ACT)
38 Geelong West Branch of the ALP (VIC)
39 Darebin City Council (VIC)
40 Darebin Community Health Service Inc (VIC)
41 Ms Sonia Hamill, (VIC)
42 Ms Genevieve Caffery, (QLD)
43 Ms Judy Thallur, (SA)
44 Dr Robert Walker, (TAS)
Tabled at Hobart Public Hearing 31.7.03

- Opening statement

45 Women's Health Victoria (VIC)
46 Mr Ange Kenor, (VIC)
47 Public Hospitals, Health & Medicare Alliance of Queensland (QLD)

Tabled at Brisbane Public Hearing 26.8.03

- Copy of article 'Down the Gurgler?', Tracy Schrader, New Doctor 79, Winter 2003

48 The Australian College of Non Vocationally Registered General Practitioners Inc (SA)

Tabled at Adelaide Public Hearing 30.7.03

- Opening presentation by Dr Moxham
- Various graphs

Supplementary information

- Department of Health and Aged Care Occasional Paper New Series No 12 August 2001 – containing statistical information

48a The Australian College of Non Vocationally Registered General Practitioners Inc (SA)

49 Australian Psychological Society (VIC)

Tabled at Melbourne Public Hearing 24.7.03

- Printout of presentation slides containing a statement ‘Cost-effective Treatments in Heart Disease and other Physical Disorders’

50 Combined Pensioners & Superannuants Association of NSW Inc (NSW)
51 Dr Jeannette Johanson, (VIC)
52 Professor Jeff Richardson, (VIC)

Tabled at Melbourne Public Hearing 24.7.03

- Graphs: Fee Income to Average Weekly Earnings 1984/85

  Fee Income, Full Time GP’s and Specialists 1984 - 2002

52a Professor Jeff Richardson (VIC)
53 North West Tasmanian Division of General Practice Ltd (TAS)
54 Mr Gene Adam, (WA)
55 Ms Mary Tinney, (QLD)
56 General Practice Education and Training (ACT)
56a General Practice Education and Training (ACT)
57 Geelong and Region Trades and Labour Council (VIC)
58 Queensland Nurses’ Union (QLD)

Tabled at Brisbane Public Hearing 26.8.03

2 articles

- ‘Taxes and Social Spending: The shifting demands of the Australian public’, Shaun Wilson and Trevor Breusch; and
- ‘The emerging roles of the practice nurse’, Sueanne Robertson

59 Allergy, Sensitivity & Environmental Health Association Qld Inc (QLD)
60 Blue Mountains Division of General Practice Inc (NSW)
61 Bayside GP Division (QLD)
62 Health Consumers’ Council (WA)

Tabled at Perth Public Hearing 29.7.03

- ‘Additional material’

63 Health Issues Centre (VIC)
64 Victorian Medicare Action Group (VIC)

Tabled at Melbourne Public Hearing 24.7.03

- ‘Improving the lives of people with chronic illness’ findings, No3 April 2001.

65 Mrs Deborah Scholem, (NSW)
66 Wagga Wagga City Council (NSW)
67 Central Coast Trades & Labour Council (NSW)
68 Country Women’s Association of NSW (NSW)
69 Health Services Union of Australia (VIC)

70 UnitingCare NSW.ACT (NSW)
71 Carers Australia (ACT)
72 Australian Consumers' Association (NSW)
73 City of Whittlesea (VIC)

Tabled at Melbourne Public Hearing 27.8.03

- 'Human Service Gaps at the Interface between urban and rural', RMIT Centre for Applied Social Research, March 2003

74 Loddon Mallee Women's Health (VIC)
75 Ms Sharon Valles, (QLD)
76 Dr S Messina, (WA)
77 Social Action Office (QLD)
78 Moreland Council (VIC)
79 Professor Doris Young, (VIC)

Tabled at Melbourne Public Hearing 27.8.03

- Paper 'PIP General Practitioner teaching payment: Is it time for a change?

80 South Kingsville Health Services Co-op Ltd (VIC)
81 Professor Wilson, Professor Del Mar & Dr Watt (QLD)
82 Northern Territory Government (NT)
83 Australian Medical Association (ACT)
83a Australian Medical Association (ACT)
84 Council of Social Service of NSW (NSW)
85 Professor J S Deeble, (ACT)
86 The Royal Australian College Of General Practitioners (VIC)
86a The Royal Australian College Of General Practitioners (VIC)
87 National Rural Health Alliance Inc (ACT)
88 Dr Trish Baker, (QLD)
89 Dr Peter Keddie, (VIC)
90 Mrs Nancy Valbo, (VIC)
91 Mr Henryk Michal Kowalik, (WA)
92 Catholic Welfare Australia (ACT)
93 Professor Stephen Duckett, (VIC)
94 Australian Physiotherapy Association (VIC)
95 Victorian Council of Social Service (VIC)
96 Catholic Health Australia (ACT)
96a Catholic Health Australia (ACT)
97 Association of Independent Retirees (AIR) Ltd (VIC)
Tabled at Melbourne Public Hearing 27.8.03

- Health Insurance Survey by St Luke's Health, September 2002 and other information

98 Council on the Ageing National Seniors Partnership (VIC)
99 Australian Private Hospitals Association (ACT)

Tabled at Canberra Public Hearing 28.8.03

- Opening statement containing figures

100 Australian Greens (ACT)
101 Rural Doctors Association of Australia (ACT)

Tabled at Canberra Public Hearing 28.8.03

- Medical labour force 2000 (AIHW Bulletin – Issue 5 June 2003)

102 Consumers' Health Forum of Australia Inc (ACT)
103 Australian Diagnostic Imaging Association (ACT)
104 Dr Bertram Vanrenen, (VIC)
105 Australian Health Insurance Association Ltd (ACT)

Tabled at Canberra Public Hearing 28.8.03

- Health fund contributors and their 30 percent rebate,
- graph 'Number of individuals benefiting from the current MBS Safety Net and total benefits paid.'

105a Australian Health Insurance Association Ltd (ACT)
106 Australian Council of Social Service (NSW)
107 Cairns Division of General Practice Ltd (QLD)
108 Australian Association of Pathology Practices Inc (ACT
108a Australian Association of Pathology Practices Inc (ACT
109 Geelong Ethnic Communities Council (VIC)
110 Dr Ian Matthews, (QLD)
111 Mr Stan Mead, (TAS)
112 General Practice Computing Group (ACT)
113 Mental Health Council of Australia (ACT)
114 Dr Thomas Lyons, (QLD)
115 Dr Peter Winterton, (WA)
116 Dr Joe Cordaro, (NSW)
117 The Victorian Government (VIC)

Tabled at Melbourne Public Hearing 24.7.03

- Opening presentation by the Hon Bronwyn Pike, Minister for Health

117a The Victorian Government (VIC)
117b The Victorian Government (VIC)
118 The National Association of Maritime Union of Australia Veterans (NSW)
119 Mr Tomas Nilsson, (TAS)
120 Dr Katriona Herborn, (NSW)
121 Dr Peter Tait, (NT)
122 Dr Dick Merigan, (VIC)
123 Dr Elizabeth Dodd, (NSW)
124 Hobart Women's Health Centre (TAS)

Tabled at Hobart Public Hearing 31.7.03

- Opening statement

125 Ms Denise Goodfellow, (Lawungkurr Maralngurra) (NT)
126 Australasian Faculty of Musculoskeletal Medicine (VIC)
127 Professor Ian Harper, (VIC)
128 The Christian Fellowship known as Brethren (NSW)
129 Mr G Goutzimanis, (VIC)
130 North West Melbourne Division of General Practice (VIC)
131 Northern Territory Council of Social Service (NT)
132 Australian Council of Trade Unions (VIC)
133 National Association of People Living with HIV/AIDS (NSW)

Tabled at Melbourne Public Hearing 27.8.03

- Preamble to submission

133a National Association of people living with HIV/AIDS (NSW)
134 Australian Federation of AIDS Organisations Inc (NSW)
135 ASU Victorian Authorities & Services Branch (VIC)
136 Optometrists Association Australia (VIC)
137 Rockingham Kwinana Division of General Practice (WA)
138 Department of Health and Ageing (ACT)

Tabled at Canberra RoundTable Briefing 21.7.03

- The Relative Value Study: Stage 3 Modelling - A Technical Report May 2001 - by Health and Aged Care
- Printout of presentation slides
- Tables: Obstetrics MBS Rebate and average gap charged; Costs of General Practice; Contribution to total increase in private hospital separations by Major Diagnostic Category, Australia, 1997 – 98 to 2000-01.
- Graphs: GP Income – Australian Government and patients
- Comparison of Standard GP Rebate (Item 23) with GP bulk billing rates; Share of public hospital emergency department services by triage category
- AMWAC Report 2000.2 (August 2000) The General Practice Workforce in Australia – Supply and Requirements 1999 – 2010
- AIHW – Australian Hospital Statistics 2001-02 and previous issues: Public Hospital Accident and Emergency Occasions of Service by State and Year.

138a Department of Health and Ageing (ACT)
138b Department of Health and Ageing (ACT)
139 Tasmanian Organisation of Employment Seekers (TAS)
140 New South Wales Nurses' Association (NSW)
141 Unions ACT (ACT)
142 Anglicare Tasmania (TAS)
143 Australian Medical Association Queensland (QLD)

144 Australian Women's Health Network (VIC)
145 Bundaberg & District Women's Domestic Violence Service Inc (QLD)
146 Queensland Divisions of General Practice (QLD)
147 Tasmanian Government (TAS)
148 Faculty of Medicine – University of Sydney (NSW)
149 Mr Paul Bobb, (ACT)
150 Ms Mary Burchell, (ACT)
151 Mr Joe Pasqualina, (VIC)
152 Union of Australian Women – Newcastle Branch (NSW)
153 Dr Warwick Ruscoe, (NSW)
154 NSW Government (NSW)
155 Mr John Bartlett, (MP) (NSW)
156 The Poverty Coalition – Tas (TAS)
157 Aboriginal Medical Services Alliance NT (NT)
157a Aboriginal Medical Services Alliance NT (AMSANT)(NT)
158 Health Consumer's Network (QLD)

Tabled at Brisbane Briefing 26.8.03

- Communique and open letter from Australian Health Care Summit, dated 22 August 2003

159 Australian Nursing Federation (ACT)
160 Australian Medical Students' Association (AMSA) (NSW)
161 South Australian Government (SA)
162 Hunter Urban Division of General Practice (NSW)
163 Dr Ross Kerridge, (NSW)
163a Dr Ross Kerridge, (NSW)
164 St Vincent de Paul Society National Council (NSW)
165 Dr John Flynn, (QLD)
166 Mr Mark Lipscombe, (VIC)
167 Ms Sherri Stephens-Green, (NSW)
168 Miss Andrea McRae, (NSW)
169 Maternity Coalition Inc (VIC)

Tabled at Melbourne Briefing 27.8.03

- Medicare savings from maternity services reform

170 Public Interest Advocacy Centre (NSW)
171 ACT Government (ACT)
172 Dr Ken Doust, (NSW)
173 Dr Graham Mayze, (NSW)
174 Mr Claude Phillips, (NSW)
175 National Centre for Social and Economic Modelling (ACT)
176 The Bessie Smyth Foundation (NSW)
177 Western Australian Government (WA)
177a Western Australian Government (WA)
178 Western Sydney Division of General Practice (NSW)
179 Carrington Residents Action Group (NSW)

180 Dr Michael Pietryk, (VIC)
180a Dr Michael Pietryk, (VIC)
180b Dr Michael Pietryk, (VIC)
180c Dr Michael Pietryk, (VIC)
180d Dr Michael Pietryk, (VIC)
181 Ms Alison Reid, (NSW)
182 Women's Action Alliance (Aust) Inc (SA)
183 Preston-Reservoir Progress Association (VIC)
184 Australian Dental Association (NSW)
185 Mr John Randles, (WA)
186 Mr Eric Manning, (NSW)
187 Mr Michael Halley, (VIC)
187a Mr Michael Halley, (VIC)
188 Union of Australian Women (South Australian Branch) (SA)
189 Australian College of Midwives Incorporated (ACT)
190 Dr Pat Cranley, (WA)
191 Ms Karen Struthers, MP (QLD)
192 Mackay Division of General Practice Ltd (QLD)
193 Ms Samantha Bobb, (ACT)
194 Mr Samuel Bobbin, (VIC)
195 Dr J H Grey, (VIC)
196 Dr John Davis, (TAS)
197 Australasian Integrative Medicine Association (VIC)
198 Mr Norm Nanos, (VIC)
199 Ararat Medical Centre Pty Ltd (VIC)
200 Australian Midwives Act Lobby Group (SA)
201 Ms Sharryn Jackson, MP (WA)
202 Mr Desmond Hughes, (NSW)
203 Hunter Area Health Service (NSW)
203a Hunter Area Health Service (NSW)
204 Dr Catherine Regan, (NSW)
205 University of Notre-Dame – School of Medicine (WA)
206 Humanist Society of Victoria Inc. (VIC)
207 Australian Medical Students' Association (AMSA) (SA)
208 Associate Professor Lesleyanne Hawthorne, (VIC)
209 Dr Gawie Roux, (QLD)
210 Mr John Sadnis, (SA)
211 Western Australian Medical Students' Society (WAMSS) (WA)
212 The Australian Research Centre for Population Oral Health (SA)
213 Oral Health Special Interest Group (SA)
214 Nowra/Bomaderry Branch, ALP (NSW)
215 Dr Umberto Boffa, (VIC)
216 Australian Liquor, Hospitality And Miscellaneous Workers' Union (WA)
217 Wide Bay Division of General Practice Assoc Inc. (QLD)
218 Dr D M Parker, (QLD)
219 Mr Ross Temple, (NSW)

220 Jon and Gillian Kaub, (WA)
221 Nimbin Needs Doctors Rural Action Group (NSW)
222 Albion, Ned (VIC)
223 The National Advisory Committee on Oral Health (SA)
224 Hornsby Ku-ring-gai Ryde Division of General Practice Ltd (NSW)
225 Bothal, Ms Judy (VIC)

Additional information

Provided by Australian Consumers' Association (Sub 72) on 15 September, 2003

- The Australian Consumers' Association is an independent advocacy and information organisation. It promotes consumer rights through its publications, including Choice magazine, and through policy advocacy. Specialist policy officers are employed in the areas of health, financial services, communications and IT, and food. The ACA is not funded by industry or government, and is a not-for-profit company limited by guarantee.

Provided by Mrs Barbara Plant a representative of the Wide Bay Division of General Practice, after the public hearing in Bundaberg, Monday 25 August, 2003, referring the Hansard transcript of the Bundaberg Medicare hearing.

- 'There was one question that you asked on page 66 regarding the charge for After Hours consultations. I responded to Dr Rudd with "The rebate is $20 or $22" and I was actually referring to the "out of pocket" expense that generally exists for After Hours Consultations.
- Senator Knowles clarified this a little further on, but I am concerned that my statement does not provide accurate information.
- Also, on page 67, Senator Stephens asked about the situation with domestic violence patients having access to a GP after hours. In my reply, I stated that I believed it would be appropriate for this responsibility be taken on by the hospital. It is not clear that I am only referring to after hour's incidents. During the day we have a system at the surgery for handling these patients so that they are managed discretely and can be seen by a bulk billing GP as an urgent appointment.
- When I was referring to the need for the Base (Public) Hospital to take responsibility for victims of domestic violence, it was in the after hours situation when it is not suitable or safe for a GP to attend at patient. It concerned me that my reply could be interpreted as all hours.'

Commissioned Report

As noted in Chapter 1, the Committee commissioned the Australian Institute for Primary Care (AIPC) at LaTrobe University, headed by Professor Hal Swerissen, to conduct research into what, if any, inflationary effects on health care costs for consumers are likely to emerge from the Government's 'A Fairer Medicare' package as well as the Opposition proposal. The AIPC report is included as Attachment 1.

Campaign Mail and Petitions

Petitions

In the course of the inquiry, several petitions relating to Medicare were tabled in Parliament, and which were drawn to the attention of Committee Senators. The text of these is reproduced below.

The first, addressed to the Prime Minister, The Hon. John Howard MP, states:

> To the Honourable Speaker and Members of the House of Representatives assembled in Parliament. The petition of certain citizens of Australia draws to the attention of the House: We the undersigned object to the Federal Government's proposed changes to Medicare that will:
>
> - Deny bulk-billing for around 4.3 million people in NSW;
> - Increase the cost of basic health care for middle Australia;
> - Place further pressure on our public hospital system;
>
> Medical treatment and the safeguarding of our children's health should be a right not an expense.
>
> We therefore pray that the House reverses their decision and considers the Carr Government plan to save bulk-billing and protect Medicare.

The second states:

> To the Australian Senate:
>
> We the undersigned call upon the Senate to oppose the Government's Medicare package because it is likely to reduce access to bulk billed services and increase out-of-pocket expenses for many people.
>
> We further call on the Senate to take steps to abolish the Private Health Insurance Rebate and direct the savings to public health services, including Medicare, as advocated by the Australian Greens.
>
> All Australians should be guaranteed timely access to quality public healthcare on the basis of need and not ability to pay. This objective is best achieved through strengthening and extending Medicare, including covering more dental and mental health services.

APPENDIX 2

WITNESSES WHO APPEARED BEFORE THE COMMITTEE AT PUBLIC HEARINGS AND ROUNDTABLE DISCUSSIONS

Monday, 21 July, Expert Roundtable Discussion, Parliament House, Canberra

Dr Robert Bain, Secretary General, Australian Medical Association
Mr Philip Davies, Deputy Secretary, Department of Health and Ageing
Professor John Deeble, Australian National University
Mr Greg Ford, Project Coordinator, Health Issues Centre, La Trobe University
Mr Martyn Goddard, Senior Policy Officer (Health), Australian Consumers Association
Mr Gordon Gregory, Executive Director, National Rural Health Alliance
Professor Jane Hall, Centre for Health Economics Research and Evaluation, University of Technology Sydney
Dr Richard Madden, Director, Australian Institute of Health and Welfare
Mr Charles Maskell-Knight, Acting First Assistant Secretary, Acute Care Division, Department of Health and Ageing
Associate Professor Peter Sainsbury, National President, Public Health Association of Australia Inc
Mr Russell Schneider, Chief Executive Officer, Australian Health Insurance Association
Ms Susan Stratigos, Policy Advisor, Rural Doctors Association of Australia
Ms Agnes Walker, Principal Research Fellow, National Centre for Social and Economic Modelling, University of Canberra
Professor Andrew Wilson, Deputy Director, Centre for General Practice, School of Population Health, University of Queensland

Tuesday, 22 July 2003, NSW Parliament House, Sydney

Western Sydney Division of General Practitioners

Dr Peter Clyne, Chief Executive Officer

Alliance of NSW Divisions of General Practice

Dr Ian Ardaire, Chief Executive Officer

NSW Council of Social Service

Mr Gary Moore, Director
Ms Samantha Edmunds, Senior Policy Officer

Uniting Care NSW/ACT

Reverend Dr Ann Wansbrough, Principal Policy Analyst and Theologian

NSW Nurses' Association

Mr Brett Holmes, General Secretary
Ms Angela Garvey, Professional Officer

Doctors' Reform Society

Dr Timothy Woodruff, President
Dr Con Costa, Vice President

Combined Pensioners and Superannuants Association of NSW

Mr David Skidmore, Policy and Information Officer
Mr Mario Mifsud, State President

NSW Department of Health

Associate Professor Debora Picone, Deputy Director General
Ms Catherine Katz, Director, Government Relations
Mr Stephen Cameron, Senior Policy Analyst

Wednesday, 23 July 2003, Newcastle Town Hall, Newcastle

Hunter Area Health Service Health (Hunter Health)

Professor Katherine McGrath, Chief Executive Officer
Ms Megan Cahill, Senior Health Services Planner

Hunter Urban Division of General Practice

Dr Arne Sprogis, Chief Executive Officer

Faculty of Health, University of Newcastle

Professor John Marley, Pro Vice-Chancellor Health

Central Coast Trades and Labour Council

Mr David Mehan, Secretary

Central Coast Division of General Practitioners

Dr Ian Charlton, Chairman

Union of Australian Women, Newcastle Branch

Mrs Iris Andrews, President
Mrs Betty Mawdsley, Secretary

Mr John Bartlett MP, State Member for Port Stephens

Mr Bryce Gaudry MP, State Member for Newcastle

Dr Ross Kerridge

Carrington Residents Action Group

Mr Robert Pittman, President

Thursday, 24 July 2003, Melbourne Town Hall, Melbourne

Australian Psychological Society

Professor Paul Martin, President
Ms Amanda Gordon, Vice President
Dr Lyndel Littlefield, Executive Director
Mr David Stokes, Manager of Professional Issues

Australian Physiotherapy Association

Ms Katie Mickel, President
Mr David Malone, Chief Executive Officer
Ms Kerren Clark, National Public Policy Officer

Royal Australian College of General Practitioners

Professor Michael Kidd, President
Mr David Wright, Chief Executive Officer
Mr Ian Watts, National Manager, GP Advocacy & Support

Darebin City Council Darebin & Community Health Service

Mr Bruce Hurley, Chief Executive Officer, Darebin Community Health Centre
Mr Dean Griggs, Municipal Public Health Planner

Victorian Medicare Action Group

Mr Rod Wilson, Convenor
Ms Marilyn Beaumont, Women's Health Victoria
Dr Christine Walker, member of Chronic Illness Alliance Inc

Victorian Government

The Hon Bronwyn Pike MP, Minister for Health
Dr Christopher Brook, Executive Director, Rural and Regional Health and Aged Care Services

Monash University Health Economics Unit

Professor Jeffrey Richardson, Director

Council on the Ageing National Seniors Partnership

Mr David Deans, Joint Chief Executive
Ms Patricia Reeve, Director, National Policy Secretariat

Tuesday, 29 July 2003, Exchange Plaza Building, Perth

Western Australian Government, Department of Health

Mr Andrew Chuk, Deputy Director-General, Corporate and Finance
Mr Mark Miller, Manager, State/Commonwealth Relations
Ms Amelia Linnert, Senior Policy Officer, State/Commonwealth Relations
Ms Prudence Ford, Group Director, Planning and Workforce

University of Notre Dame

Dr Peter Tannock, Vice Chancellor
Dr Mark McKenna, Planning Head of School of Medicine

Rockingham Division of General Practitioners Ltd

Dr Andrew Png, Director
Mr Andrew McGaw, Chief Executive Officer

Canning Division of General Practitioners

Dr Donald Bott, Chairman

Ms Sharryn Jackson MP, Federal Member for Hasluck

Health Consumers' Council (WA)

Ms Michelle Kosky, Executive Director
Ms Maxine Drake, Deputy Director

Hospitality, Liquor and Miscellaneous Workers Union

Ms Helen Creed, National President
Ms Laura Murray, Member
Mr Mark Hayward, Member
Mr Gavin O'Dea, Member

Fremantle Women's Health Centre Inc

Dr Marie Byfield, Medical Practitioner
Dr Apollonia Lobo-Braganza, GP/Gynaecologist
Dr Danica Bredemeyer, Medical Practitioner
Ms Diane Moore, Administrator

Wednesday, 30 July 2003, Adelaide Town Hall

Australian College of Non-Vocationally Registered GP's Inc

Dr James Moxham, President

South Australian Alliance of Health Consumers

Mr John Wishart, Chief Executive Officer

Aboriginal Medical Service Alliance Northern Territory

Ms Patricia Anderson, Chief Executive Officer
Dr John Boffa, Public Health Medical Office

Northern Territory Government, Teleconference

Mr Shane Houston, Acting Assistant Secretary, NT Department of Health & Community Services
Ms Maxine Clark, Medicare Project Coordinator, NT Department of Health & Community Services
Mr Shane Dawson, Chief Executive Officer, Top End Division of General Practitioners

Yorke Peninsula Division of General Practice

Dr Georgina Moore, Medical Director
Mr David Holman, Chief Executive Officer

South Australian Divisions of General Practice Inc

Dr Bruce Alcorn, Chair
Dr Victoria Wade, Medical Director
Dr Peter Del Fante, Board Member

Thursday, 31 July 2003, Hobart Town Hall, Hobart

Dr Robert Walker

Hobart Women's Health Centre

Ms Joan Barry, Coordinator
Ms Julianne Campbell, Health Worker

Claremont Village Medical Centre

Dr Graeme Alexander, Principal Practice Doctor
Mrs Michelle Kaden, Practice Manager

University of Tasmania, School of Medicine

Professor Allan Carmichael, Dean and Head of School

Tasmanian Organisation of Employment Seekers

Mr Richard Lang, Chairman
Ms Kaye Saunders, Secretary

North West Tasmania Division of General Practice Inc

Dr Emil Djakic, Chairman
Dr Patrick O'Sullivan, Deputy Chairman
Ms Elvie Hales, Executive Officer

Monday, 25 August 2003, Burnett Riverside Motel, Bundaberg,

Bundaberg and District Women's Domestic Violence Service Inc

Ms Verelle Cox, Service Director

Bundaberg Autism Spectrum Disorder Support Group

Mr Lionel Evans, Committee Member

Millbank Medical Practice

Dr Denise Powell, Practice Principal
Ms Valerie Hosking, Practice Manager

Mackay Division of General Practice

Dr David Parker, Medical Director
Mr Christian Grieves, Chief Executive Officer

School of Nursing and Health Services, Central Qld University

Mrs Sonja Cleary, Lecturer, Nursing and Health Studies

Ms Cheryl Dorron, Aged care nurse

Ms Vicki Smyth, Accident and Emergency nurse

Wide Bay Division of General Practice

Dr Shaun Rudd, Chairman
Mrs Barbara Plant, Practice Manager

Mr Neil Peterson, Physiotherapist
Ms Rona Thomas, Executive Officer

Tuesday, 26 August 2003, Brisbane City Hall, Brisbane

Public Hospitals and Medicare Alliance of Queensland

Dr Tracey Schrader, Member
Mr Brian Frost, Pensioner Group Representative

Health Consumers' Network

Mrs Kathryn Kendell, Coordinator

Queensland Nurses' Union

Ms Beth Mohle, Project Officer
Ms Gay Hawksworth, Secretary

Queensland Government

The Hon Wendy Edmond MP, Minister for Health
Ms Norelle Deeth, Deputy Director General Policy and Outcomes
Associate Professor Michael Cleary, Medical Superintendent, Prince Charles Hospital
Associate Professor Richard Olley, District Manager, Royal Brisbane & Women's Hospital

Australian Medical Association

Dr William Glasson, President
Dr Mukesh Haikerwal, Vice President
Dr Robert Bain, Secretary-General
Ms Julia Nesbitt, Acting-Director of General Practitioners
Dr David Rivett, Chair, AMA Council of General Practice

Australian Divisions of General Practice

Dr Stephen Clark, Chief Executive Officer
Dr Robert Walters, Chairman

Australian Medical Students' Association

Mr Nicholas Brown, President

University of Queensland Centre for General Practice School of Population Health

Professor Christopher Del Mar, Professor of General Practice
Dr Marli Watt

Queensland Divisions of General Practice

Dr John Kastrissios, Vice President

Bayside Division of General Practice

Dr Peter Adkins, President

Brisbane North Division of General Practice

Dr Ann McBryde, President

Wednesday, 27 August 2003, Stamford Plaza Hotel, Melbourne

Faculty of Medicine, Dentistry and Health Services, University of Melbourne

Associate Professor Lesleyanne Hawthorne, Director, Faculty International Unit

Department of General Practice, University of Melbourne

Professor Doris Young, Head of Department

Australian Greens

Ms Valerie Kay, National Health Policy Coordinator
Dr Richard Di Natale, Health Spokesperson

Association of Independent Retirees Ltd

Mrs Joan Heard, President
Dr Clyde Scaife, Health Committee Chair

National Association of People Living with HIV/AIDS

Mr David Menadue, President

Dr Andrew Gault

Ballarat Division of General Practice

Dr Mark Churcher, Committee Chair
Mr Andrew Howard, Chief Executive Officer

City of Whittlesea

Mr Stephen Woodland, Manager of Family Services

Moreland Council

Councillor Mark Higginbotham, Portfolio Councillor for Social Development

South Kingsville Health Services Co-operative

Dr Christopher Watts, Medical Director

Maternity Coalition Inc

Ms Joyce Johnston, Secretary
Ms Leslie Arnott, Victoria Branch President

Australian Women's Health Network

Dr Helen Keleher, National Convenor

Thursday, 28 August 2003, Parliament House, Canberra

General Practice Education and Training

Ms Kate Carnell, Chair
Dr Bill Coote, Chief Executive Officer

ACT Government, ACT Health

Mr Simon Corbell MLA, Minister for Health
Dr Anthony Sherbon, Chief Executive Officer
Mr Ian Thompson, Director Health, Policy and Reform
Mr Rhys Ollerenshaw, Manager Health Policy and Primary Care

Consumers' Health Forum of Australia Inc

Ms Helen Hopkins, Executive Director

The Mental Health Council of Australia

Dr Grace Groom, Chief Executive Officer

Australian Health Insurance Association Ltd

Mr Russell Schneider, Chief Executive Officer

Australian Private Hospitals Association

Mr Michael Roff, Executive Director
Mr Paul Mackey, Director Policy and Research

Commonwealth Department of Health and Ageing

Mr Philip Davies, Deputy Secretary
Mr Andrew Stuart, First Assistant Secretary, Primary Care Division
Ms Judy Blazow, First Assistant Secretary, Medical and Pharmaceutical Services Division

Mr Charles Maskell-Knight, Advisor, Acute Care Division
Mr Robert Wells, First Assistant Secretary Health Services Improvement Division

Rural Doctors Association of Australia Ltd, Teleconference

Dr Ken Mackey, National President
Ms Susan Stratigos, Policy Advisor
Dr Graham Slaney, Vice President, Industrial
Mr Brian Curren, Executive Officer
Dr Denis Chew, President Northern Territory
Dr Nevin Damien, President, Queensland
Dr Graham Jacobs, President, Western Australia
Dr Ross Maxwell, Treasurer, Queensland

Tuesday, 23 September 2003, Parliament House, Canberra

Australian Institute For Primary Care

Associate Professor Hal Swerissen, Director
Professor Stephen Duckett

Hospitals visited by the Committee during the inquiry:

Bundaberg District Base Hospital, Bundaberg

APPENDIX 3

BIBLIOGRAPHY

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Wooldridge, The Hon. M., and Anderson, The Hon. J., *More Doctors, Better Services: Regional Health Strategy*, Federal Budget Health Measures 2000-2001

MEDICARE – WEB RESOURCES

Australian College of Remote and Rural Medicine

http://www.acrrm.org.au

Australian Divisions of General Practice (ADGP)

http://www.adgp.com.au

Australian Health Policy Institute (University of Sydney)

http://www.usyd.edu.au/chs/ahpi/index.html

Australian Institute of Health and Welfare

http://www.aihw.gov.au

Australian Institute of Primary Care (AIPC)

http://www.latrobe.edu.au/aipc

Australian Medical Association (AMA)

http://www.ama.com.au/

Australian Primary Health Care Research Institute (ANU)

http://www.anu.edu.au/aphcri

Australian Private Hospitals Association (APHA)

http://www.apha.org.au

Commission on the Future of Health Care in Canada (the Romanow Commission)

http://www.healthcarecommission.ca

Consumers' Health Forum

http://www.chf.org.au/

Department of Health & Ageing, Medicare site

http://www.health.gov.au/fairermedicare

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http://www.ruralhealth.gov.au

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www.drs.org.au

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http://www.aph.gov.au/library/intguide/sp/sphealth.htm

General Practice Statistics and Classification Unit, University of Melbourne

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Health Insurance Commission (HIC)

http://www.hic.gov.au

Health Issues Centre

http://home.vicnet.net.au/~hissues/

Health Online

http://www.health.gov.au/healthonline/about/sumt2003.html

Health Services Union

www.hsua.asn.au

Australian Health Care Summit 2003

www.healthsummit.org.au

Office of Aboriginal and Torres Strait Islander Health (OATSIH)

http://www.health.gov.au/oatsih/index.htm

National Aboriginal Community Controlled Health Organisation (NACCHO)

http://www.naccho.org.au

National Centre for Social & Economic Modelling

http://www.natsem.canberra.edu.au

National Medicare Alliance

http://www.nma.org.au

National Rural Health Alliance

http://www.ruralhealth.org.au

Primary Health Care Research and Information Service

http://www.phcris.org/

Private Health Insurance Administration Council

http://www.phiac.gov.au

Public Health Association of Australia

http://www.pha.org.au

Royal Australian College of Physicians

http://www.racp.edu.au

Royal Australia College of General Practitioners

http://www.racgp.org.au

Rural Doctors Association of Australia

http://www.rdaa.com.au

ATTACHMENT 1

AUSTRALIAN INSTITUTE FOR PRIMARY CARE

REPORT

‘An analysis of potential inflationary effects on health care costs for consumers associated with the Government’s “A Fairer Medicare”, and the Opposition proposal’

An analysis of potential Inflationary effects on health care costs for consumers associated with the Government's 'A Fairer Medicare', and the Opposition proposal

September 2003

PREFACE

This report was commissioned by the Department of the Senate from the Australian Institute for Primary Care, La Trobe University. The Australian Institute for Primary Care (AIPC) promotes quality improvement and best practice in all areas of primary health care. It supports the integration of theory and practice in primary health care and promotes the standing and visibility of primary health care and community health services. The report was prepared by Associate Professor Hal Swerissen, Director of the AIPC, Professor Stephen Duckett, Professor of Health Policy, La Trobe University, and Mr Charles Livingstone, Senior Research Fellow, AIPC.

EXECUTIVE SUMMARY

Key features of proposals

The Government proposes to introduce a “Fairer Medicare” package. The package introduces a participating practice scheme. GP practices that agree to charge a no gap fee to concessional patients will be eligible for increased Medicare rebates for these patients. The level of the proposed increase for the rebate is $1 in metropolitan city practices, $2.95 in non-metropolitan city practices, $5.30 in rural centre practices, and $6.30 in outer rural and remote areas. The cost of this measure is estimated at $346 million over four years.

Other measures to implement safety net, insurance, and gap billing procedures are also proposed. The total cost of these measures over four years is $537 million.

The Opposition proposes to immediately lift the rebate to 95% of the scheduled fee for all bulk billed patients. This is an average increase of $3.35 per consultation. The Opposition proposes to increase the rebate to 100% of the scheduled fee by the 2006/07 financial year. This would raise the average rebate for a consultation by $5. The estimated cost of this proposal is $1.115 billion over four years.

The Opposition further proposes to introduce incentive payments for GPs who meet specified bulk billing targets. A payment of $7,500 is proposed for GPs in metropolitan areas who bulk bill 80% of their patients. A payment of $15,000 is proposed for GPs in outer metropolitan and major regional centres who bulk bill at least 75% of their patients. Under the Opposition package all other GPs are eligible for an incentive payment of $22,500 if they bulk bill at least 70% of their patients. The estimated cost of this measure is $391 million over four years.

Our analytic model

Our framework proposes that out-of-pocket costs are heavily influenced by GP income aspirations. In turn, the extent to which GPs are able to reach their target incomes are a function of Commonwealth Medicare rebates for GPs, system administrative and regulatory constraints to restrain GP fees, the supply of GPs, and practice costs. Out-of-pocket costs to consumers are also influenced by the impact they have on consumer utilisation of services.

We have canvassed a number of relevant issues and made a number of assumptions in the development of this model, and these are summarised in this section.

In this report, we have utilised the relationship between average weekly ordinary time earnings (AWOTE) and payments by the Commonwealth to GPs to assess the extent to which GPs may perceive that their base incomes have fallen in comparison to those of the more general community. This is a critical assumption in our model. We believe it to be

conservative; that is, alternative assumptions would be that GP income relativity expectations may be related to groups whose income has increased faster than AWOTE. It is likely that GPs will attempt to offset the impact of he comparative decline in payments by the Commonwealth by charging additional amounts to their patients where this is possible. These payments are known as out-of-pocket expenses or co-payments.

Trend data indicate that overall bulk billing increased steadily from the introduction of Medicare in 1984/85 to approximately 70% in the mid-1990s. Bulk-billing rates for GP services have generally been about 10% higher than the overall bulk-billing rates over the last decade, reaching a plateau of about 80% in the mid-1990s. Bulk-billing rates have declined significantly since 2000. Average GP bulk billing fell to 68% by March 2003.

There are significant variations in GP bulk-billing rates across geographic settings, ranging from more than 75% in capital cities to less than 55% in rural and remote areas.

Out-of-pocket payments for GP patients increased overall between 1984–1985 and 2002–2-03. In the case of patient billed services only, average patient contributions have risen from $6.90 to $12.91, an increase in real terms of about 44.7%. In the case of all services (i.e., patient and bulk-billed services), average patient contributions have risen from $1.74 to $3.90, an increase in real terms of about 73.3%.

The supply of GPs per capita generally increased from the inception of Medicare to about 1996. There has been a commensurate increase in the number of Medicare services per capita over the same period.

Since 1996 there are indications that the availability of GP services per capita has declined.

Increased out-of-pocket costs may reduce utilisation of GP services and thereby constrain prices. However, the available literature on the impact of prices on demand for GP services (price elasticity) suggests that the effect of price on demand for services will be marginal when potential GP responses are taken into account.

It would be anticipated that GPs will seek to maintain or, if possible, restore their perceived relative income position by increasing the proportion of their earnings derived from out-of-pocket charges made to patients, and any incentive payments associated with billing practices. The comparative decline in bulk-billing rates in the past three years suggests that this strategy is becoming more widespread across GP practices.

The current Medicare administrative provisions set a significant pricing threshold which makes the application of out-of-pocket charges more difficult in circumstances where patients have relatively good choice of GP, as occurs in relatively well supplied metropolitan city areas. However,

reductions in GP availability suggests that GPs are now in a stronger position to reduce bulk-billing levels and introduce out-of-pocket charges to patients in metropolitan areas, as the availability of GP services per capita has begun to reduce, while demand for services has increased or remained stable.

There is no definitive method for predicting the target income that GPs will seek to achieve. The actions they take are likely to be a function of the options available to them. However, the trend data indicate that bulk-billing rates were relatively stable when Commonwealth expenditure per FTE GP was around 5.2 times average weekly earnings. Over time, as the value of FTE GP Commonwealth expenditure has declined as a proportion of AWOTE, bulk-billing rates have declined and out-of-pocket costs have increased. Current GP behaviour could be interpreted as attempting to restore past relativities.

Maintaining relativity with AWOTE is probably a conservative approach to estimating GP target incomes. It is important to note that estimation of target incomes is likely to be based largely on the perceptions by GPs of movements in relativities, rather than particular calculations. Further, it is very likely that GPs will be more influenced by perceived movements in relativities with specialist medical practitioner incomes. However, trend data on specialist incomes were not available within the constraints of this analysis.

Estimated current net FTE GP incomes from rebates and out-of-pocket charges ranged from $91,000 in metropolitan city areas to $110,249 in remote rural settings. Differences across geographic settings are attributable to variations in bulk-billing rates.

We have taken the view that GPs are likely to seek to increase that part of their income over which they exercise most control (i.e., via adjustment of fees charged and/or volume of services provided). We have assumed that CDHA estimates of average GP volume (i.e., 7,000 services per FTE GP per annum) will not change. We have thus assumed that GPs will seek to optimise income via adjustment of fees charged and the incidence of bulk billing in order to increase current income levels by about 10.6%, being the increase required to achieve a target of perceived restored relativity with AWOTE.

Modelling the packages

Our modelling assumes that GPs will seek to increase their incomes to the level that would apply if Commonwealth expenditure on FTE GP incomes were 520% of AWOTE. A uniform increase of 10.6% is applied to current estimated FTE GP incomes to model this effect.

Three scenarios are modelled:

- bulk-billing rates and out-of-pocket charges are assumed to remain at their current levels;
- bulk-billing rates are assumed to fall so that only concessional patients are bulk billed and out-of-pocket charges remain at their current level;
- bulk-billing rates are assumed to fall so that only concessional patients are bulk billed and out-of-pocket charges are altered to ensure that the GP income target is met.

Outcomes of modelling

In summary, based on our modelling and relying on the assumptions we have set out in this report, the likely effects of the packages on consumers would be as set out below.

Government package:

- Reduction in average incidence of bulk billing to the bulk-billing 'floor' of around 50% of services.
- Small increase in non-metropolitan bulk-billing rates of between three and six percentage points.
- Reduction in average co-payments for non-bulk-billed services in metropolitan areas, but increases in non-metropolitan areas.
- Increase in average co-payments (across all services) of around 56%.
- Improved convenience for those presently not bulk-billed, with possibility of lower actual out-of-pocket costs for this group.

The 'target setting' scenario for the Government package would deliver 100% of targets but would also have the effect, facilitated by the removal of the 'hard threshold', of increasing the incidence of co-payments, even though average co-payments for those who are not bulk billed would be likely to decline in metropolitan settings. The increased incidence of such payments, however, would mean that average co-payments across all patients would increase by more than 55%, from around \$3.90 to around \$6.15 on average. However, it is also possible that some GPs will further increase co-payments in order to maximise income, assisted by the removal of the hard threshold, which at present provides a substantial barrier to the implementation of co-payments. As we have already noted, the removal of this hard threshold is likely to substantially modify the patient's perceptions of actual costs incurred and will also reduce transaction costs by an unquantifiable amount. It will also enable a sensitive capacity for price discrimination between patients attending GPs, whether on a geographic or personal basis, and may lead to substantially variable out-of-pocket costs for those paying them between regions or localities.

Opposition package:

- Some increase in the incidence of bulk billing to around 77% of services.
- No change to average co-payments for non bulk-billed services.
- Reduction in average co-payments (across all services) of around 25% .

In our opinion the most likely scenario arising from the Opposition package would be for GPs to meet the bulk-billing targets and thus maximise the rebate and incentive payment income offered under the Opposition package. This is because doing so allows GPs in all geographic areas to achieve income targets (as with the scenario described above for the Government package). The achievement of bulk-billing targets would increase the overall bulk-billing rate to around 77%, ensuring that the vast majority of concession cardholders would be bulk billed.

Assuming the income targets we have set, if GPs adopted the Opposition package average, out-of-pocket costs to patients would reduce by about 25%, from an average at present of around $3.90 to an average of about $2.95. This would derive from a reduction in the incidence of co-payments because of the increased rate of bulk billing. It is possible that patients paying out-of-pocket costs could pay higher costs than at present, but the maintenance of the hard threshold means that price signals to patients would be very prominent.

Our analysis of both proposals is predicated on the notion that GPs will seek to increase their incomes. The Government's proposal provides additional government expenditure for this purpose and protects concessional patients, but it also makes it easier for GPs to raise their incomes through increased patient contributions. The Opposition package relies on increased public sector expenditure to meet the same goal, while maintaining current administrative constraints on gap fees. The relatively higher level of government expenditure outlined in the Opposition proposals reflect this difference.

Table 1 summarises the impact on FTE GP gross fee based incomes (including incentive payments) of each scenario modelled.

Table 1

Scenario 1				Opp'n package	
Region	Total fees income current	Total target fees income	Govt package Total fees income	Total income @ 95%	Total income @ 100%
Metro CC	221,676	245,174	224,849	239,558	248,498
Metro other	228,725	252,970	238,086	244,771	252,794
Rural	241,196	266,763	258,516	253,995	260,395
Rural/remote	240,925	266,463	263,825	253,795	260,230
Scenario 2				**Opp'n package**	
Region	**Total fees income current**	**Total target fees income**	**Govt package Total fees income**	**Total fees income @ 95%**	**Total fees income @ 100%**
Metro CC	221,676	245,174	252,565	260,057	265,390
Metro other	228,725	252,970	258,753	260,057	265,390
Rural	241,196	266,763	258,516	250,403	257,435
Rural/remote	240,925	266,463	263,825	252,028	258,774
Most likely scenario				**Opp'n package**	
Region	**Total fees income current**	**Total target fees income**	**Govt package Total fees income**	**Total fees income @ 95%**	**Total fees income @ 100%**
Metro CC	221,676	245,174	245,174	244,384	253,795
Metro other	228,725	252,970	252,970	255,226	264,049
Rural	241,196	266,763	266,763	266,068	274,303
Rural/remote	240,925	266,463	266,463	266,068	274,303

Introduction

This report presents an analysis of what, if any, inflationary effects on health care costs for consumers are likely to emerge from the:

Government's 'A Fairer Medicare' package, including incentives to practices that agree to bulk bill all concession card- holders, the capacity for non-concessional patients to pay only the gap at the point of service, the introduction of a new $500 safety net for concession cardholders, and the creation of a category of private health insurance for out-of-hospital costs where they exceed $1000; and

- **Opposition proposal**, including measures to increase the patient rebate to 95% of the scheduled fee for bulk-billed services, and the introduction of incentive payments to encourage bulk-billing target rates in metropolitan, outer-metropolitan and rural and regional areas.

The following sections describe the Government and Opposition proposals in detail. An analytic framework to address the extent to which inflationary effects on health care costs for consumers is then developed and applied to examine the two sets of proposals. Various scenarios are developed and discussed and then the proposals are compared and conclusions about likely inflationary impacts are drawn.

SUMMARY OF PROPOSALS

This section summarises the key features of the Government and Opposition proposals included in the analysis.

Key features of the Government's proposal

The Government proposes to introduce a "Fairer Medicare" package. The package introduces a participating practice scheme. GP practices that agree to charge a no gap fee to concessional patients will be eligible for increased Medicare rebates for these patients. The level of the proposed increase for the rebate is $1 in metropolitan city practices, $2.95 in non-metropolitan city practices, $5.30 in rural centre practices, and $6.30 in outer rural and remote areas. The cost of this measure is estimated at $346 million over four years.

Participating practices will continue to have the capacity to determine fees for non-concession cardholders, including the option of bulk billing. However, if they choose not to bulk bill these patients, they will no longer have to charge them the scheduled fee plus the co-payment. Instead they will be able to charge the patient the co-payment and claim the Medicare rebate direct from the Health Insurance Commission through HIC online billing facilities. Non-concession cardholders charged a gap payment by a participating practice will no longer be required to claim the Medicare rebate themselves. The estimated cost of this measure plus support and promotion for online billing is estimated at $35 million.

A new MBS safety net will be available for those covered by concession cards with out-of-pocket costs greater than $500 in a calendar year. Charges in excess of the scheduled fee will be included, as will the costs of specialist and diagnostic services. Eighty per cent of out-of-pocket costs above the $500 threshold will be met through this safety net. The cost of this measure is estimated at $67 million over four years.

Private health insurers will be able to offer insurance coverage for the cumulative cost of out-of-hospital medical services over $1,000 for a family in a calendar year. This includes costs above the scheduled fee across a range of out-of-hospital services, including GP and specialist consultations and diagnostic tests. The cost of this measure is estimated at $89 million over four years. The Government estimates that insurance products for this coverage are likely to cost around $50 per year for families, and the 30% private health insurance rebate will apply to these products.

The total cost of these measures over four years is $537 million.

The Government's package also includes proposals to introduce additional medical school places, additional GP training places, additional nurses and allied health professionals in general practice, and measures for veterans. The impact of these measures on potential inflationary effects on patients, if any, were not considered in this analysis.

Key features of the Opposition proposal

The Opposition proposes to immediately lift the rebate to 95% of the scheduled fee for all bulk-billed patients. This is an average increase of $3.35 per consultation. The Opposition proposes to increase the rebate to 100% of the scheduled fee by the 2006/07 financial year. This would raise the average rebate for a consultation by $5. The estimated cost of this proposal is $1.115 billion over four years.

The Opposition further proposes to introduce incentive payments for GPs who meet specified bulk-billing targets. A payment of $7,500 is proposed for GPs in metropolitan areas who bulk bill 80% of their patients. A payment of $15,000 is proposed for GPs in outer metropolitan and major regional centres who bulk bill at least 75% of their patients. Under the Opposition package all other GPs are eligible for an incentive payment of $22,500 if they bulk bill at least 70% of their patients. The estimated cost of this measure is $391 million over four years.

The total estimated cost of the Oppositions proposals over four years is $1.505 billion.

ANALTYTIC MODEL

In accordance with the brief provided by the Department of the Senate, the analysis of the Government and Opposition proposals described in this report focused on the impact of the two proposals on direct health care costs to consumers.

In both the Government and Opposition proposals, any inflationary effects on health care costs for consumers will be a function of two factors: the proportion of services which are subject to a co-payment (i.e., not bulk billed) and the level of co-payment (i.e., 'out-of-pocket' costs to consumers) required for these services. This paper reports on likely impact of the Government and Opposition proposals on bulk-billing rates and out-of -pocket costs for those who are not bulk billed.

A conceptual framework to guide the modelling of the impact of the Government and Opposition proposals was developed. The framework draws on the published literature on utilisation and fee setting in fee-for-service systems for GPs and an examination of the current Medicare system.

The framework proposes that out-of-pocket costs are heavily influenced by GP income aspirations. In turn, the extent to which GPs are able to reach their target incomes are a function of Commonwealth Medicare rebates for GPs, system administrative and regulatory constraints to restrain GP fees, the supply of GPs, and practice costs. Out-of-pocket costs to consumers are also influenced by the impact they have on consumer utilisation of services.

The following sections examine each of these parameters of the framework in turn.

Commonwealth expenditure on GPs

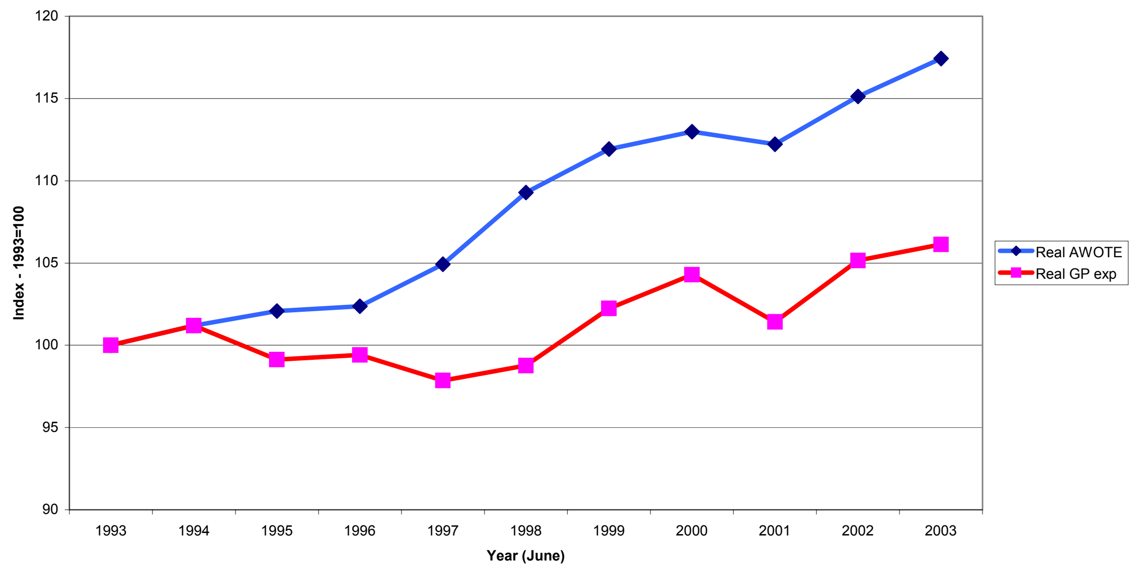
Commonwealth expenditure on Full Time Equivalent (FTE) GPs as a percentage of annual Average Weekly Ordinary Time Earnings (AWOTE)[1] increased from the inception of Medicare in 1984/85 until 1992 and then progressively declined until 1997/98. In 1992/93 Commonwealth expenditure on GPs was about 5.2 times AWOTE or about $160,000 p.a. in nominal dollars. Subsequently, this ratio fell to 4.7 times AWOTE in 2002/03[2]. On this basis in our estimation, Commonwealth expenditure on GPs in 2002–2003 was about $219,400 p.a., which is consistent with Commonwealth estimates of about $220,000 expenditure per annum per FTE GP in 2002.[3]

[1] Australian Bureau of Statistics (ABS), Catalogue No 6302.0, May 2003 (released 14/8/03)

[2] Submission of the Commonwealth Dept of Health and Ageing (CDHA) to Select Committee on Medicare, 2003, p.20

[3] Submission of CDHA, 2003, p.19

Chart 1 compares indices of real (i.e., adjusted for inflation via the Consumer Price Index[4]) Commonwealth expenditure on GPs with real changes in AWOTE. From 1993 to 2003 AWOTE had increased by 10.6% more than Commonwealth expenditure on GPs. Thus, although real expenditure on GPs by the Commonwealth increased over this period, real AWOTE increased by a somewhat greater amount.



We note that GPs are able to charge patients amounts in excess of the rebate income provided under Medicare, and income derived from these payments is not incorporated in Chart 1. We also note that GPs receive non-fee payments from the Commonwealth, which in 2002 amounted about to an additional 10% approximately of rebate income, or about 9% of total payments by the Commonwealth to GPs.
In this report, we have utilised the relationship between AWOTE and payments by the Commonwealth to GPs to assess the extent to which GPs may perceive that their base incomes have fallen in comparison to those of the more general community. This is a critical assumption in our model. We believe it to be conservative; that is, alternative assumptions would be that GP income relativity expectations may be related to groups whose income has increased faster than AWOTE. The comparative decline in payments by the Commonwealth has some relationship to the extent to which GPs may attempt to recover perceived relative income decline by charging additional amounts to their patients where this is possible. These payments are known as out-of-pocket expenses or co-payments.

Practice costs

Trend data on practice costs for GPs could not be identified. Information on GP practice costs for 1999 are available from the Practice Cost Study conducted by Pricewaterhouse Coopers (2000) for the Medicare Schedule

[4] ABS, Catalogue No 6401.0, June 2003, Table 1a – weighted average 8 capital cities (released 23/7/03)

Review Board as part of the Relative Value Study. This study found that practice costs for a three-doctor GP practice were $113,526 in 1999[5].

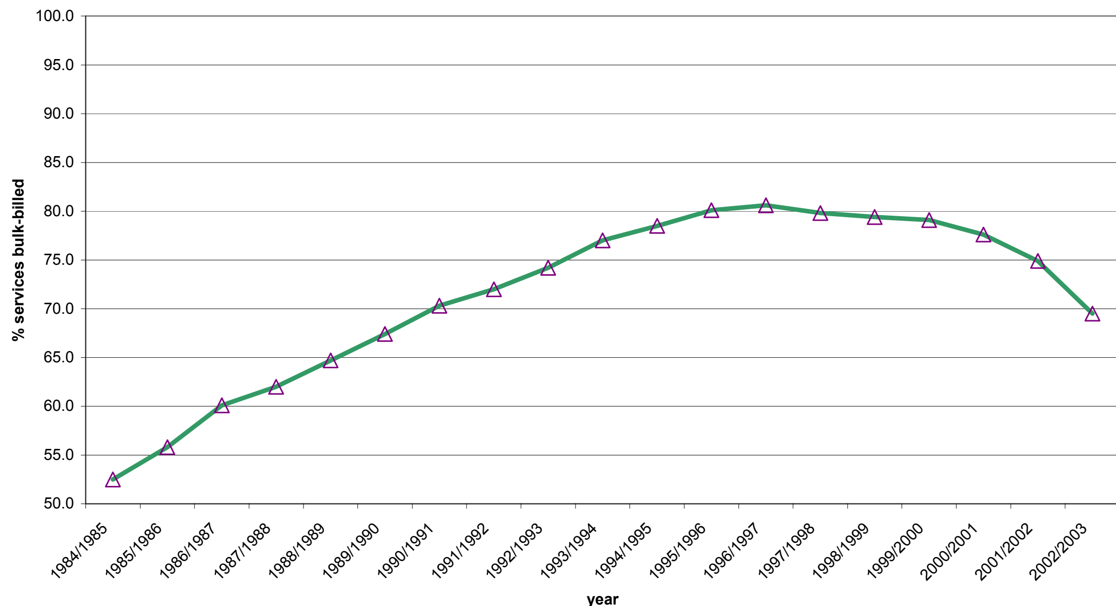
The major categories that influence GP practice costs are salaries and wages of administrative and support staff, occupancy costs, office expenses, and motor vehicle expenses. These costs are likely to move broadly in line with the Consumer Price Index (CPI).

Bulk-billing trends

Trend data indicate that overall bulk billing increased steadily from the introduction of Medicare in 1984/85 to approximately 70% in the mid-1990s. Bulk-billing rates for GP services have generally been about 10% higher than the overall bulk-billing rates over the last decade, reaching a plateau of about 80% in the mid-1990s. Bulk-billing rates have declined significantly since 2000. Average GP bulk billing fell to 68% by March 2003.

Chart 2 describes the trend in overall bulk-billing rates from 1984/85 to 2002/03.[6]

Chart 2: Proportion of GP services bulk-billed - 1984-5 to 2002-3



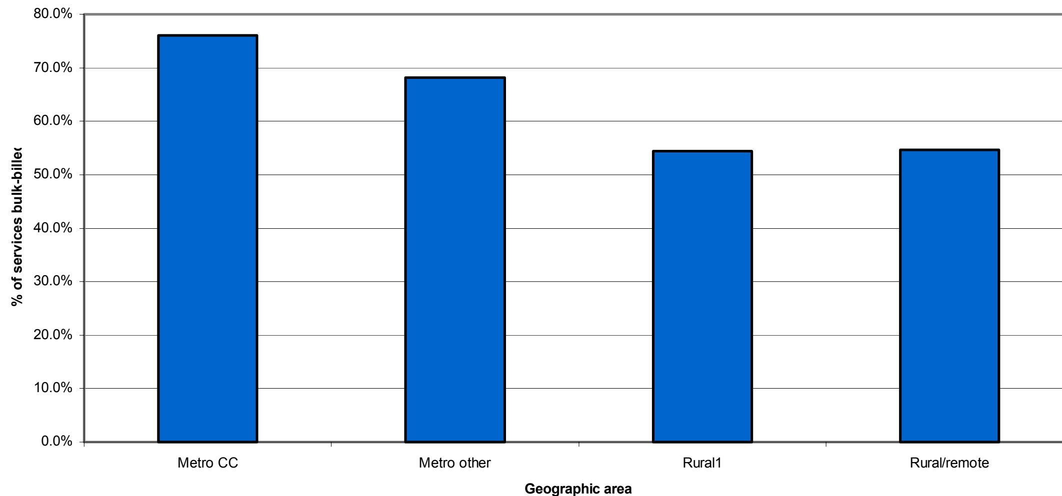
There are significant variations in GP bulk-billing rates across geographic settings.

In 2002/03 (to the December quarter) we calculate that in metropolitan city settings (RRMA 1) 76% of GP services were bulk billed. In other metropolitan settings (RRMA 2) the bulk-billing rate was 68.2%. In rural

[5] Pricewaterhouse Coopers, Medicare Schedule review Board, "A resource-based model of private medical practice in Australia – final report: Volume 1" (2000), p20
[6] Source: MEDICARE STATISTICS http://www.health.gov.au/haf/medstats/index.htm

(RRMA 3 & 4) and remote rural settings (RRMA 5 to 7) bulk-billing rates were 54% and 55% respectively.[7] We also note that the DHA submission to the Senate Select Committee on Medicare advised that bulk-billing rates for the above categories were (for the 2002 year) 77.9%, 69.8%, 56.6% and 56.4% respectively.[8] The Opposition package incorporates estimates that bulk-billing rates were 75%, 65-75%, 60-70% and 55% respectively.[9]

Chart 3: Current bulk-billing rates - geographic areas
Source: Answer to q. E03-189

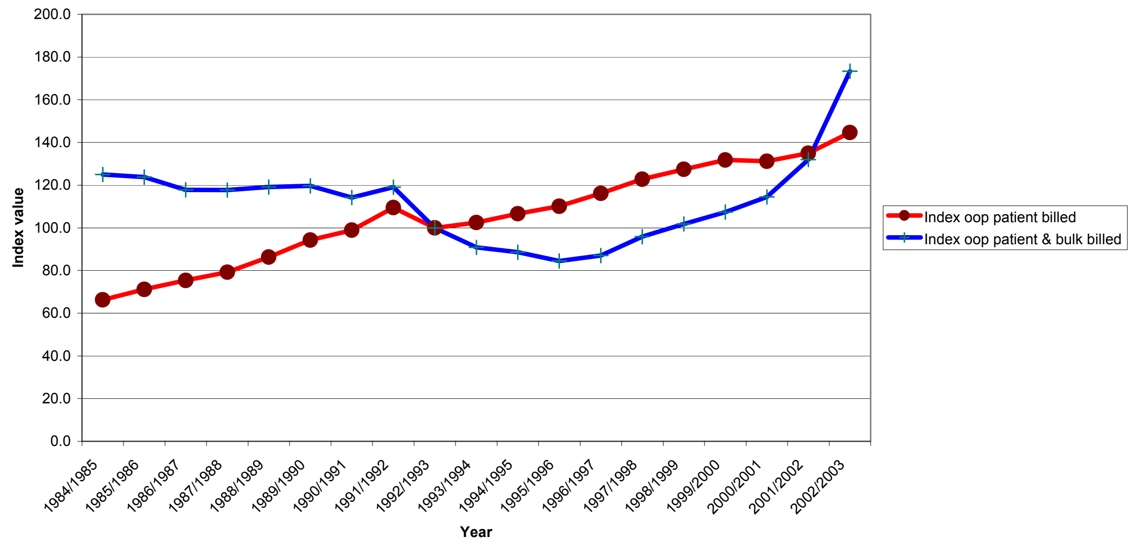


Out-of-pocket costs

Out-of-pocket payments for GP patients increased overall between 1984–1985 and 2002–2003. In the case of patient-billed services only, average patient contributions have risen from $6.90 to $12.91, an increase in real terms of about 44.7%. In the case of all services, (i.e., patient and bulk-billed services) average patient contributions have risen from $1.74 to $3.90, an increase in real terms of about 73.3%.

Chart 4 sets out indices of average out-of-pocket costs for patient-billed services only and patient- and bulk-billed services. It will, however, be noted that average out-of-pocket costs for patient-billed services only have increased generally in real terms over the period 1984–1985 to 2002–2003,

[7] Sources: Senate Community Affairs legislation Committee - Answers to Estimates Questions on Notice - Health & Ageing Portfolio, Question E03-189 - Senator McLucas - part (a) 'Bulk-billing rates for unreferred services by RRMA
E. Savage & G. Jones, "An analysis of the proposed General Practice Access Scheme on GP salaries, bulk billing and consumer co-payments." CHERE, UTS, 2003, Table 2. We have calculated weighted mean values for bulk-billing rates for RRMA 3 & 4 and RRMA 5,6 & 7, based on the incidence of services provided within those discrete areas.
[8] Submission of CDHA, 2003, p.26
[9] Opposition Medicare package, Fact Sheet2, www.alp.org.au, accessed 13/8/03



whereas average out-of-pocket costs for patient- and bulk-billed services generally declined over the period 1984–1985 to 1996–1997 but then increased markedly over the period 1996–1997 to 2002–2003.

GP supply

The supply of GPs per capita generally increased from the inception of Medicare to about 1996. There has been a commensurate increase in the number of Medicare services per capita over the same period.

Since 1996 there are indications that the availability of GP services per capita has declined.

This trend is partially explained by the ageing of the GP workforce and an increasing proportion of female GPs, which has resulted in fewer hours being provided per GP.

Policy initiatives have also decreased the availability of GPs. These included capping the number of medical school places, reductions in access for overseas trained GPs, and the requirement that GPs undertake training to become vocationally registered for GP Medicare rebates. This latter requirement appears to be of considerable significance, given that since the high point of total GP services per annum (1996–1997) total GP services have declined by an amount almost entirely accounted for by the reduction in ‘other’ attendances.[10]

There is considerable variation in the supply of GPs across geographic settings. Overall there were about 85 Full-time Workload Equivalent GPs per 100,000 population in 2001/02. However, there were generally fewer than 80 GPs per 100,000 in rural settings and in remote settings this were

[10] Source: MEDICARE STATISTICS http://www.health.gov.au/haf/medstats/index.htm

fewer than 60 GPs per 100,000. On the other hand in capital city areas there were over 90 GPs per 100,000 people.[11]

Price elasticity and out-of-pocket charges

Increased out-of-pocket costs may reduce utilisation of GP services and thereby constrain prices. However, the available literature on the impact of prices on demand for GP services (price elasticity) suggests that the effect of price on demand for services will be marginal when potential GP responses are taken into account.

In a comprehensive review of the effect of consumer co-payments on medical care Richardson suggested that a 30% to 50% increase in the proportion of the total medical fee paid by Australian Medicare patients would probably reduce service use by 5% to 10%. Similarly, Van Vliet calculated a co-payment elasticity of -0.085 for general practitioner visits in the Netherlands. Thus, as Savage notes, the fall in demand resulting from increased co-payments is likely "to be relatively small".[12]

Richardson also notes that out-of-pocket charges to patients have differential effects depending on patient incomes. People on lower incomes (and possibly those who have the greatest health needs) are more likely to reduce their use of GPs for both necessary and unnecessary services.[13]

Impact on GP incomes

This section discusses how the factors that have been reviewed above together are likely to influence the target incomes GPs set for themselves. GP incomes from patient services are a function of Commonwealth rebates plus non-fee based payments derived form the Commonwealth (including the Practice Improvement Program and others), plus patient out-of-pocket payments, less practice costs. Currently the Commonwealth has significant control over GP incomes through its capacity to set the CMBS fees, the rebate levels and the administrative rules that apply to payments. However, GPs and other medical practitioners are able to exert control over incomes by increasing either the fees they charge patients or by increasing the volume of services provided or both.

GP patients can claim 85% of the Commonwealth Medicare Benefits Schedule (CMBS) for services they receive. Currently the CMBS fee for a standard GP consultation is $29.45 with a rebate of $25.05. When bulk billed the patient assigns the $25.05 rebate to the GP and the Commonwealth makes direct payment of this amount to the GP. The patient is not issued a bill, does not make an out-of-pocket payment and therefore does not claim a rebate.

[11] Submission of CDHA, 2003, p.17
[12] J. Richardson, *The effects of Consumer Co-payments in Medical Care*, 1991, Background Paper No 5, National Health Strategy; R. Van Vliet, 'Effects of price and deductibles on medical care demand estimated from survey data', 2001, in Applied Economics 33, cited in Savage & Jones, 2003; Savage & Jones, 2003, p.12
[13] Richardson, 1991

On the other hand, if the GP charges any out-of-pocket costs to the patient a bill for at least $29.45 plus the out-of-pocket charge must be issued. The patient then generally pays the GP the full amount of the bill and claims the $25.05 rebate from Medicare. There is therefore a significant threshold effect in the price difference between the free bulk-billing service and any service which attracts out-of-pocket charges, even when the actual out-of-pocket charge may be small. In circumstances where there is a relative oversupply of GPs and patients have real choice of practitioner the current Medicare administrative arrangements provide a considerable incentive for GPs to bulk bill patients. It is important to note that there a threshold effect operates for GPs administratively in choosing not to bulk bill patients, as well as for patients who must meet transaction costs associated with paying a bill and reclaiming a rebate.

The current geographic variation in bulk-billing rates appears to reflect variations in the supply of general practitioners. As noted above, where there is a relatively high availability of GP services per capita in metropolitan capital city areas, the best available estimate of current bulk-billing rates is approximately 76%. Where there is a relatively more limited availability in rural and remote areas (RRMA 3 to 7), bulk-billing rates are around 55%.

From the inception of Medicare in 1984/85 until 1992/93 there was an overall increase in Commonwealth expenditure on GPs relative to average weekly earnings. Over the same period there was also an overall increase in the supply of GP services and an increase in per capita utilisation of GP services. Subsequently, Commonwealth expenditure per FTE GP has fallen relative to increases in average weekly earnings. This fall has been most pronounced from 1996/97 to 1998/99. Assuming that costs have continued to increase at CPI then it is likely that GPs have experienced a net income loss relative to movements in average weekly earnings as defined by AWOTE over this period.

It would be anticipated that GPs will seek to maintain or if possible restore their perceived relative income position by increasing the proportion of their earnings derived from out-of-pocket charges made to patients, and any incentive payments associated with billing practices. The comparative decline in bulk-billing rates in the past three years suggests that this strategy is becoming more widespread across GP practices.

The current Medicare administrative provisions set a significant pricing threshold which makes the application of out-of-pocket charges more difficult in circumstances where patients have relatively good choice of GP, as occurs in relatively well supplied metropolitan city areas. However, reductions in GP availability suggests that GPs are now in a stronger position to reduce bulk-billing levels and introduce out-of-pocket charges to patients in metropolitan areas, as the availability of GP services per capita has begun to reduce, while demand for services has increased or remained stable.

Estimating GP target income

We note that there are essentially two approaches to estimating the level at which GPs (or others) will seek to set incomes. The first is income maximisation. The second is income target setting. McGuire and Pauly (1991) "show that target income behaviour and profit (or income) maximisation lie at opposite ends of a spectrum of income effects".[14] Target setting is essentially a conservative option for modelling, and we have chosen this option for this reason.

There is no definitive method for predicting the target income that GPs will seek to achieve. The actions they take are likely to be a function of the options available to them. However, the trend data indicate that bulk-billing rates were relatively stable when Commonwealth expenditure per FTE GP was around 5.2 times average weekly earnings. Over time, as the value of FTE GP Commonwealth expenditure has declined as a proportion of AWOTE, bulk-billing rates have declined and out-of-pocket costs have increased. Current GP behaviour could be interpreted as attempting to restore past relativities.

Maintaining relativity with AWOTE is also a conservative approach to estimating GP target incomes. It is important to note that estimation of target incomes is likely to be based largely on the perceptions by GPs of movements in relativities, rather than particular calculations. Further, it is, very likely that GPs will be more influenced by perceived movements in relativities with specialist medical practitioner incomes. However, trend data on specialist incomes were not available within the constraints of this analysis.

In this section, current GP incomes are estimated and compared with those that would be required to restore these incomes from the current level of 470% of AWOTE to the level of 520%, which applied in 1992/93. Arguably, all other things being equal, if this relativity were restored, pressure to reduce bulk-billing rates and to increase out-of-pocket charges would be relaxed.

The following parameters were combined in Table 2 to provide estimated average incomes for FTE GPs across four geographic settings:

- The average rebate for all GP Medicare services in 2002/03 of $28.57.
- The average out-of-pocket payment for non-bulk-billed GP services for 2002/03 of $12.91.
- Practice costs for a three-doctor GP practice, inflated by CPI to produce an estimated practice cost of $130,676 for 2002/03.

[14] McGuire, T. "Physician Agency" (2000) in A. Culyer & J Newhouse (eds) *Handbook of Health Economics Vol 1*.

- Variations in bulk-billing rates across metropolitan city, outer metropolitan, rural and remote rural settings were included.

- Commonwealth estimates that the average FTE GP performs 7,000 services per year.[15]

Table 2: Estimates of average baseline GP income

Region	% bulk billed	bulk billed services N	non-bulk billed services N	Est non bulk billed income	Est bulk billed income	Est total fee income	Est net income
Metro CC	76.0%	5,320	1,680	69,686	151,991	221,676	91,000
Metro other	68.2%	4,774	2,226	92,334	136,391	228,725	98,049
Rural	54.4%	3,808	3,192	132,403	108,793	241,196	110,520
Rural/remote	54.7%	3,829	3,171	131,532	109,393	240,925	110,249

Estimated net FTE GP incomes from rebates and out-of-pocket charges ranged from $91,000 in metropolitan city areas to $110,249 in remote rural settings. Differences across geographic settings are attributable to variations in bulk-billing rates.

We note that non-volume related payments by the Commonwealth are additional to the income estimates set out in Table 1. However, as have already noted, CDHA estimates that Commonwealth payments to GPs were approximately $220,000 per GP per annum in 2002,[16] including non-volume related payments, a total amount closely approximated by our calculations based on relativities with AWOTE (see above).

We have taken the view that GPs are likely to seek to increase that part of their income over which they exercise most control (i.e., via adjustment of fees charged and/or volume of services provided). We have assumed that CDHA estimates of average GP volume (i.e., 7,000 services per FTE GP per annum) will not change. We have thus assumed that GPs will seek to optimise income via adjustment of fees charged and the incidence of bulk billing in order to increase current income levels by about 10.6%, being the increase required to achieve a target of perceived restored relativity with AWOTE.

We also note that changes to policy settings provide incentives to GPs to modify their billing and other practice behaviour, and we expect that most if not all GPs will respond to these changes. Estimates of current FTE GP incomes and target incomes are presented in Table 3.

Table 3: Estimates of current FTE GP incomes and FTE GP target incomes

[15] Submission of CDHA, 2003, p.19
[16] Submission of CDHA, 2003, p.19

Region	Est gross fee income	Est net fee income	Est gross target income	Est net target income
Metro CC	221,676	91,000	245,174	114,498
Metro other	228,725	98,049	252,970	122,294
Rural	241,196	110,520	266,763	136,087
Rural/remote	240,925	110,249	266,463	135,787

Estimating health card service utilisation

The Government's proposals limit increased CMBS rebates for bulk billing to patients who hold a Pensioner Concession Card, a Health Care Card or a Commonwealth Seniors Card. It is therefore necessary to estimate the proportion of services these concessional patients will use.

Data from the ABS National Health Survey were used for this purpose. While concessional patients are about 35% of the population they utilise GP services at about 1.43 times average service use, equivalent to about 50% of all GP services.[17] We have further confirmed these estimates by comparison with estimates by the Commonwealth in the "A Fairer Medicare" package of the implied average incidence of service usage by HC holders[18] and by comparison with similar estimates set out in the CDHA submission.[19]

The proportion of concessional patients also varies geographically. Table 4 presents the incidence of concessional patients for metropolitan city, regional, and outer regional and remote settings. We note that the geographic categories utilised for reporting data from the Australian Health Survey are distinct from those utilised by other data sources we have drawn upon for this report. We have resolved this by utilising the incidence of HC holders for major cities of Australia (31.7%) in modelling GP incomes for both the 'Metro Capital City' and 'Metro other' categories. Similarly, we have utilised the incidence reported for Inner Regional Australia (41.8%) in the category of 'Rural' and the incidence reported for Outer regional and remote Australia (34.8%) in the category of 'Remote'.

[17] ABS, National Health Survey Catalogue No 4364.1, 2001, Table 26; we were also able to access NHS data on CD-ROM provided by ABS and this analysis confirmed the incidence ratio for HC holders of ~1.43 times the average service incidence
[18] *A Fairer Medicare Questions & Answers* – www.health.gov.au/fairermedicare accessed 23/7/03, p.5
[19] Submission of CDHA, 2003, p.36

Table 4: Incidence of Concessional Health Card holders by geographic area

	HC Card	Proportion of GP services used	Current bulk-billing rates
	%	%	%
Major Cities of Australia	31.7%	45.3%	72.3%
Inner Regional Australia	41.8%	59.8%	54.4%
Outer regional and remote Australia	40.1%	57.4%	54.7%
Total	**34.8%**	**49.7%**	**70.0%**

It is worth noting that the current levels of bulk billing which are included in the final column of Table 3 above are close to the estimated levels of service use by concessional patients in rural and remote rural areas, where GPs are in comparative under supply and have considerable scope to levy out-of-pocket charges on their patients.

In areas where there is comparatively greater supply of GP services, bulk-billing rates rise because patients are likely to choose GPs who bulk bill and GPs need to compete for patients in order to maintain their incomes. Again the threshold effect associated with the administrative requirements for charging out-of-pocket costs are also likely to provide an incentive for bulk billing.

MODELLING THE GOVERNMENT'S PROPOSALS

This section presents an analysis of the potential inflationary impact, if any, on health care costs for consumers of the Government's 'A Fairer Medicare' proposals. Medicare data for 2002/03 were used for the analysis. Both the Government's estimated average concessional patient rate of 50% and the regional estimates for concessional patients derived from our analysis of the National Health Survey were used in the analysis. The parameters of the Government's proposals described earlier in this report were applied.

The modelling assumes that GPs will seek to increase their incomes to the level that would apply if Commonwealth expenditure on FTE GP incomes were 520% of AWOTE. A uniform increase of 10.6% is applied to current estimated FTE GP incomes to model this effect.

Three scenarios are modelled:

- bulk-billing rates and out-of-pocket charges are assumed to remain at their current levels;
- bulk-billing rates are assumed to fall so that only concessional patients are bulk billed and out-of-pocket charges remain at their current level;
- bulk-billing rates are assumed to fall so that only concessional patients are bulk billed and out-of-pocket charges are altered to ensure that the GP income target is met.

In each of the scenarios, additional rebate income for bulk billing concessional patients of $1 for metropolitan city practices, $2.95 for non-metropolitan city practices, $5.30 in rural centre practices and $6.30 for remote rural practices were applied. If is further assumed that each FTE GP performs 7,000 services per annum.

Scenario 1: Current bulk-billing levels

In scenario 1, the current bulk-billing rates and out-of-pocket charges have been modelled using the Government's proposals to examine their likely impact on FTE GP incomes. We believe that this scenario is most likely to be representative of the initial period following the introduction of the Government's package, noting that GPs are likely to introduce any changes cautiously, particularly in regions of comparatively high GP supply.

It is of course quite possible that GPs who agree to participate in the GP Access Scheme will implement significant changes to their billing practices immediately after they commence their participation in the scheme. However, it is also likely that a number of GPs will retain current practice until they are able to ascertain the impact that the reforms will have on their practice and income patterns. Thus, this scenario provides insight into the impacts on GP FTE fee income of participating in the package.

It is also important to note that the Government's costings include the assumption that an average of approximately 3,500 HC services per annum will be provided by an FTE GP. However, we note that GPs wishing to access the Government's incentive payments will be required to bulk bill all HC holders and in rural and rural/remote areas, this is likely to require a slight increase in bulk-billing rates (requiring an average increase in the number of bulk-billed patients of between three and six percentage points), which we have incorporated into our estimation on the assumption that GPs will seek to marginally adjust their current billing practice to obtain access to incentive payments. Thus, in our estimation, GPs in these geographic areas would receive no bulk-billing income from non-concessionary patients, but would be able to access the 'soft threshold' of direct billing and charging a co-payment to non-concessional patients.

Table 5 presents the estimated income levels for FTE GPs in each of the four geographic settings included in the analysis. The first column presents GP incomes derived using the government's overall estimate that 50% of services will be incurred by concessional patients. The second column presents GP incomes estimated using the regional variations in concessional patients derived from the National Health Survey. The third column presents gross GP target incomes used for the analysis. The fourth column presents current estimated practice costs. The fifth and sixth column set out the net estimated FTE GP incomes based on average HC usage and regional variations in concessional patients, respectively. The final column presents assumed net GP target incomes..

Table 5: Model of Scenario 1 for Government package

Region	EFT GP gross fee income - Govt estimate	EFT GP gross fee income - LTU estimate	EFT GP estim'd gross fee income target	Practice costs	EFT GP net fee income - Govt estimate	EFT GP net fee income - LTU estimate	EFT GP estim'd net fee income target
Metro CC	225,176	224,849	245,174	130,676	94,500	94,173	114,498
Metro other	238,975	238,086	252,970	130,676	108,299	107,410	122,294
Rural1	259,696	258,516	266,763	130,676	129,020	127,840	136,087
Rural/remote	262,975	263,825	266,463	130,676	132,299	133,149	135,787

Table 5 indicates that there is only slight difference in the use of the Government's estimate and the regional variations in concessional patients.

For this scenario, FTE GP incomes for rural/remote settings come close to reaching the target income as a result of the higher rebate levels for concessional patients. However, target income levels for FTE GPs practicing in metropolitan city, other metropolitan, and rural settings are not achieved. This suggests that additional revenue to meet income targets would have to be derived from patient out-of-pocket charges in these areas if the assumed income targets were to be met. This would require individual out-of-pocket rates to increase and/or bulk-billing rates to decline.

Scenario 2: bulk billing concessional patients only

In scenario 2, it is assumed that only concessional patients are bulk billed. Out-of-pocket charges remain at current levels. The Government's proposed payments for concessional patients have been modelled with these parameters to examine the likely impact on FTE GP incomes. We note that this scenario represents a possible response to the requirement of the Government package that all concessional patients be bulk-billed in order for GPs to access increased rebates and the soft threshold of direct billing and charging co-payments to non-concessional patients. This scenario is one adjustment that is available to GPs wishing to assess the impact of the new system on service and income profile, and is modelled in order to assess the impact that partial change of this nature would have on income. It should be noted that the elasticity effect of introducing co-

payments will in our view be minor as the soft threshold introduced via the Government's package substantially reduces the 'up-front' cost to patients, and thus minimises the price effect as compared to the hard threshold currently operating. As in scenario 1, above, we estimate that this scenario will require increases on average of the number of patients bulk billed in rural and rural/remote areas of between three and six percentage points, whereas Government estimates are that concessional patients account for around half total services.

Table 6 presents the estimated income levels for FTE GPs in each of the four geographic settings included in the analysis. The columns in Table 6 provide information as set out in Tables 4 and 5.

In this scenario, FTE GP income levels are exceeded for metropolitan areas, and in the Government's estimate for rural/remote. The additional income derived from reducing bulk billing to concessional cardholders only is sufficient to meet income targets.

Table 6: Model of Scenario 2 for Government package

Region	EFT GP gross fee income - Govt estimate	EFT GP gross fee income - LTU estimate	EFT GP estim'd gross fee income target	Practice costs	EFT GP net fee income - Govt estimate	EFT GP net fee income - LTU estimate	EFT GP estim'd net fee income target
Metro CC	248,673	252,565	245,174	130,676	117,997	121,889	114,498
Metro other	255,751	258,753	252,970	130,676	125,075	128,077	122,294
Rural1	263,794	258,516	266,763	130,676	133,118	127,840	136,087
Rural/remote	267,223	263,825	266,463	130,676	136,547	133,149	135,787

Scenario 3: Potential inflationary impact

This scenario models what we believe would be the most likely outcome for the government's proposals if income targets are to be met. In this scenario, concessional patients are bulk billed (necessitating, as above, a modest increase in bulk-billing rates in non-metropolitan areas, but a likely substantial fall in metropolitan areas), and non-concessional patients charged a co-payment. However, the co-payment is adjusted to achieve the income targets we have estimated for FTE GPs in each region. In metropolitan areas, the incidence of the co-payment would rise although the average co-payment for individuals would decline.

As previously noted, the Government's package requires that all concessional patients are bulk billed for GPs to be eligible for enhanced concessional rebate levels. When practices agree to participate in the new arrangements they will also be to charge out-of-pocket payments direct to non-concessional patients, and claim the rebate electronically from the Health Insurance Commission. This removes the hard threshold effect for charging out-of-pocket costs under the current Medicare rules and would, for example, reduce the current perceived average fee when out-of-pocket costs are incurred from $41.48 to $12.91.

The incentive provided by the removal of the hard threshold will be to render highly marginal the demand response to actual increases in co-payments, as patients would be able to pay a much more modest up-front fee and avoid the transaction costs associated with claiming a rebate from Medicare. We are unable to cost these transaction costs within the constraints of this project, since they will vary significantly between individuals, with direct costs ranging from the price of a stamp and stationery to the costs associated with attending a Medicare office, and personal costs varying significantly between individuals depending upon their circumstances. However, the removal of the hard threshold is highly likely to induce an increased incidence of co-payments and a concomitant reduction in bulk-billing rates to the minimums required for access to the GP Access Scheme.

Of course, we also believe that some practices will continue to charge co-payments to all patients, or to bulk bill only some classes of HC holder, such as pensioners and veterans. Some practices may also bulk bill all patients. Nevertheless, the scenario presented here is a rational response to the incentives provided by the Government package, assuming a target income hypothesis, and provides GPs with an opportunity to achieve income targets with minor or no impact on service demand, particularly in rural and rural/remote areas where GP supply issues impact on service demand.

Under the proposed arrangements it is likely that most concessional patients will be bulk billed. At present, data provided by CDHA indicate that about a third of services provided to HC holders in non-metropolitan areas are not bulk billed, whereas between 13–22% of services provided to HC holders in metropolitan areas fall into this category.[20] However, the new rebate levels that apply for bulk billing concessional patients under the governments proposals will not provide sufficient revenue to reach the FTE GP income targets assumed for the modelling conducted in this analysis. Instead, additional aggregate out-of-pocket charges would be required to meet income targets.

In principle, a range of distributions for out-of-pocket costs is possible. However, for administrative convenience it is likely that GP practices would determine the concessional status of the their patients and levy a standard out-of-pocket charge to all non-concessional patients in order to achieve their income target. Other arrangements, such as levying differential charges on the basis of non-concessional patient income, would introduce additional transaction costs which GPs are likely to avoid. Table 7 presents the results of this modelling.

[20] Submission of CDHA, 2003, p.26

Table 7: Most likely scenario – Government package

Region	EFT GP gross fee income - BB HC only	% BB	EFT GP gross fee income - non BB income	Total income (=target income)	Average OOP fee req'd to meet target
Metro CC	93,830	45.3%	151,344	245,174	10.98
Metro other	100,017	45.3%	152,953	252,970	11.40
Rural1	141,717	59.8%	125,046	266,763	15.84
Rural/remote	139,967	57.3%	126,496	266,463	13.79
Weighted mean	105,260	48.6%	145,872	251,132	11.99

Bulk-billing levels would, in this scenario, settle at the level of concessional patients. This would require modest average increases in bulk billing for rural and rural/remote areas, but significant reductions in metropolitan settings.

To meet income targets across settings, average out-of-pocket costs per service would need to be set at $10.98 for metropolitan capital city practices, $11.40 for other metropolitan practices, $15.84 for rural practices, and $13.79 in outer rural and remote areas. This would result in a reduction in the average out-of-pocket charge currently levied to non-bulk billed patients in metropolitan settings, but a probable increase in average out-of-pocket fees for rural and remote patients.

However, there would be a substantially increased incidence of out-of-pocket costs in metropolitan settings, leading to an overall increase in average out-of pocket costs. Average out-of-pocket costs would increase by around 56% from $3.94 to $6.16. Under this scenario, average bulk-billing levels would fall to about 50%, from their current levels of around 70%. We note however that the incidence of bulk billing for concessionary patients in non-metropolitan areas is likely to rise by between three and six percentage points, depending on locality.

MODELLING THE OPPOSITION'S PROPOSALS

This section presents an analysis of the potential inflationary impact, if any, on health care costs for consumers of the Opposition's proposals to reform Medicare. Medicare data for 2002/03 were used for the analysis. The parameters of the Oppositions proposals for increasing the rebate for bulk-billed patients and providing incentive payments to GPs who meet specified bulk-billing targets described earlier in this report were applied in scenarios modelled in this section. Both the transitional (95%) and final (100%) scheduled fee rebate levels specified in the Opposition's proposals are included in the analysis. The modelling incorporated regional variations in the level of concessional patients.

Scenario 1: Current bulk-billing rates and out-of-pocket charges

In the first scenario applied to the Opposition's proposals, bulk-billing rates and out-of-pocket costs were set at their current levels and the impact of the increased rebate levels (95% and 100% of the scheduled fee) on GP incomes in metropolitan city, non-metropolitan city, rural and outer rural and remote areas were modelled. As with the modelling of the Government's package, this scenario is utilised to provide a 'starting point' for the assessment of the impact of the package on GP fee incomes.

It is possible that GPs may simply maintain their existing service and fee profiles for some time until they have been able to assess the impact of the system, and this scenario is intended to model that situation. The results of our analysis are presented in table 8. We note that the opposition package also contains a series of incentive payments for achieving bulk-billing targets set at variable regionally determined levels. We recognize that in reality variations across practices would ensure that a proportion of practices would reach the proposed bulk-billing targets even when they are not reached on average. However, we did not obtain information on variations in bulk-billing levels across practices. In this scenario, therefore, these payments would not be paid because the targets would not be met. In effect, the scenario reflects only the impact of the Opposition's proposed rebate increases for bulk billing on GP incomes and therefore under estimates the overall effect on incomes.

Table 8: Model of scenario 1, Opposition package **Region**	**% BB**	**EFT GP gross fee income - 95% rebate***	**EFT GP gross fee income - 100% rebate***	**EFT GP estim'd gross fee income target**	**Practice costs**	**EFT GP net fee income - 95% rebate**	**EFT GP net fee income - 100% rebate**	**EFT GP estim'd net fee income target**
Metro CC	76.0%	239,558	248,498	245,174	130,676	108,882	117,822	114,498
Metro other	68.2%	244,771	252,794	252,970	130,676	114,095	122,118	122,294
Rural1	54.4%	253,995	260,395	266,763	130,676	123,319	129,719	136,087
Rural/remote	54.7%	253,795	260,230	266,463	130,676	123,119	129,554	135,787

Note: * includes incentive payments (if applic)

This scenario indicates that the Opposition's proposed increased rebates for bulk-billed patients approximately meets or exceeds FTE GP income targets for metropolitan practices, but not remote or rural practices at 100% of the scheduled fee. Income targets are not met at 95% of the scheduled fee.

Scenario 2: Bulk bill concessional patients only

In this scenario, bulk-billing rates are assumed to fall to the level of concessional patients only. Out-of-pocket charges are set at their current average level and the impact on GP incomes for metropolitan city, non-metropolitan city, rural and outer rural and remote areas were modelled for the proposed increased rebate levels for bulk-billed patients (95% and 100% of the scheduled fee). This scenario is included in order to assess the

impact of a radical alteration of service and fee profiles on GP incomes, and in order to provide a comparison with the equivalent scenario modelled for the Government package. The results of our analysis are presented in table 9.

Table 9: Model of scenario 2, Opposition package **Region**	**% BB**	**EFT GP gross fee income - 95% rebate***	**EFT GP gross fee income - 100% rebate***	**EFT GP estim'd gross fee income target**	**Practice costs**	**EFT GP net fee income - 95% rebate**	**EFT GP net fee income - 100% rebate**	**EFT GP estim'd net fee income target**
Metro CC	31.7%	260,057	265,390	245,174	130,676	129,381	134,714	114,498
Metro other	31.7%	260,057	265,390	252,970	130,676	129,381	134,714	122,294
Rural1	41.8%	250,403	257,435	266,763	130,676	119,727	126,759	136,087
Rural/remote	40.1%	252,028	258,774	266,463	130,676	121,352	128,098	135,787

Note: * includes incentive payments (if applic)

In this scenario, FTE GP income targets are exceeded for metropolitan city, non-metropolitan city and rural areas for both the 95% and the 100% rebate levels. However, income targets are not reached for rural and rural/remote areas.

Comparison of scenario 1 and 2 indicates that in the absence of incentive payments, increased rebates for bulk billing are insufficient in non-metropolitan areas to offset the potential income gain from reductions in bulk billing at current levels of out-of-pocket charges. However, the Opposition proposal does not relax the administrative threshold to out-of-pocket charges that currently applies. Consequently, it is unlikely that bulk-billing rates in metropolitan areas would in fact fall to concessional patient levels only.

Scenario 3: Incentive targets achieved

In this scenario the combined impact of the Opposition's proposed rebate increases and incentive payments for achieving bulk-billing targets on FTE GP incomes is modelled. The scenario assumes that all bulk-billing targets proposed by the Opposition are met. Rebate effects for both the 95% and 100% CMBS rebate levels are modelled. Out-of-pocket charges are set at current levels, but because bulk-billing targets would be met under this scenario, achieving an overall bulk-billing rate of about 77%, the incidence of these is reduced, and thus average co-payments decline from about $3.95 to about $2.95. Under this scenario, it appears almost certain that the majority of concessional patients would be bulk billed. The results of our analysis are modelled for metropolitan city, non-metropolitan city, rural and remote rural area. Table 10 presents the outcomes for this scenario.

Table 10: Most likely scenario, Opposition package

Region	% BB	EFT GP gross fee income - 95% rebate*	EFT GP gross fee income - 100% rebate*	EFT GP estim'd gross fee income target	Practice costs	EFT GP net fee income - 95% rebate	EFT GP net fee income - 100% rebate	EFT GP estim'd net fee income target
Metro CC	80.0%	244,384	253,795	245,174	130,676	113,708	123,119	114,498
Metro other	75.0%	255,226	264,049	252,970	130,676	124,550	133,373	122,294
Rural1	70.0%	266,068	274,303	266,763	130,676	135,392	143,627	136,087
Rural/remote	70.0%	266,068	274,303	266,463	130,676	135,392	143,627	135,787

Note: * includes incentive payments (if applic)

FTE GP income targets are met (to within $1000) or exceeded across all geographic settings. However, when compared to scenario 2, the combined impact of incentives and rebates on FTE GP metro incomes is less than would be achieved if GPs reduced their bulk billing to concessional patients.

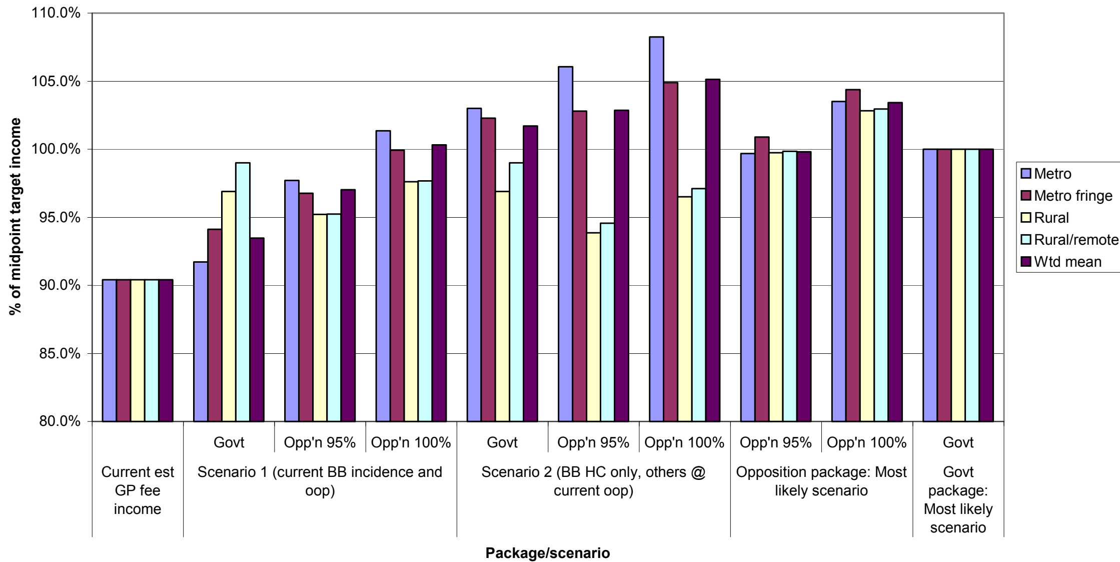
However, the effects of GP supply issues in metropolitan areas, combined with the maintenance of the hard threshold are likely to mitigate against either increases in out-of-pocket fees or reduced rates of bulk billing.

We also note that the staged introduction of increased rebates for bulk-billed patients (the 100% rebate level commences in 2006–2007) provides an offset to increased practice costs over the period of the package's implementation, offering GPs the prospect of increases in the range of $10,000 within a three-year period.

We believe that the approach set out in this scenario represents a rational response to the Opposition package and is likely to have the effect of decreasing the costs to individuals of accessing GP services at the same time as it increases GP incomes.

COMPARISON AND CONCLUSIONS

Chart 5 sets out a comparison of the relationship between GP target incomes and the packages modelled in the above section.



As noted above we are of the view that the most likely scenarios in response to the Government and Opposition packages are those that allow GPs to optimise their incomes to perceived target levels.

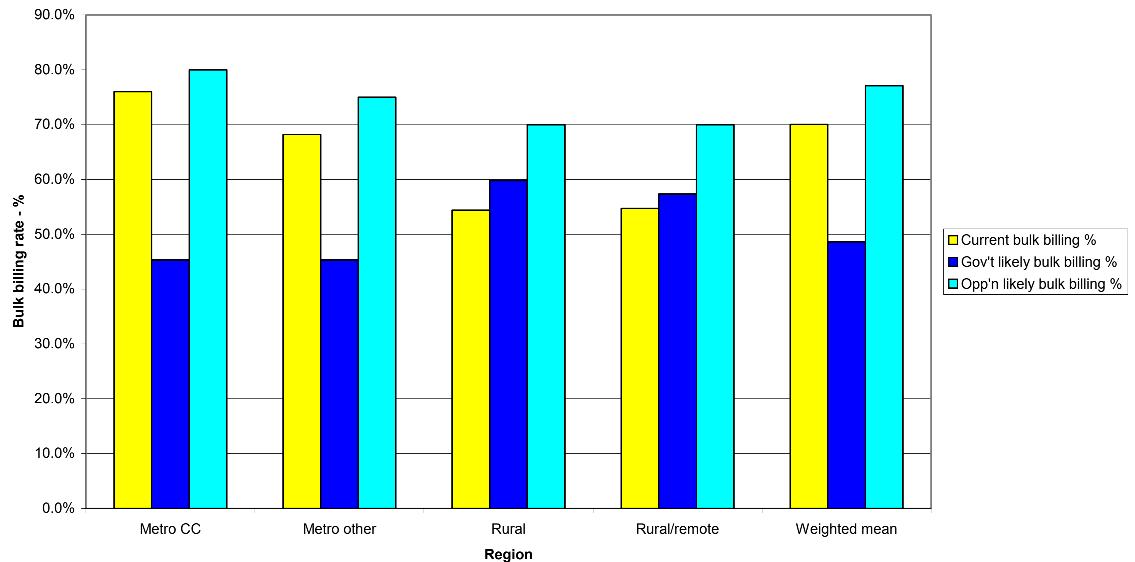
In summary, based on our modelling and relying on the assumptions we have set out in this report, the likely effects of the packages on consumers would be as set out below.

Government package:

- Reduction in average incidence of bulk-billing to the bulk-billing 'floor' of around 50% of services.
- Small increase in non-metropolitan bulk-billing rates of between three and six percentage points.
- Reduction in average co-payments for non bulk-billed services in metropolitan areas, but increases in non-metropolitan areas.
- Increase in average co-payments (across all services) of around 56%.
- Improved convenience for those presently not bulk billed, with possibility of lower actual out-of-pocket costs for this group.

Opposition package

- Some increase in the incidence of bulk billing to around 77% of services.
- No change to average co-payments for non bulk-billed services.
- Reduction in average co-payments (across all services) of around .25%.

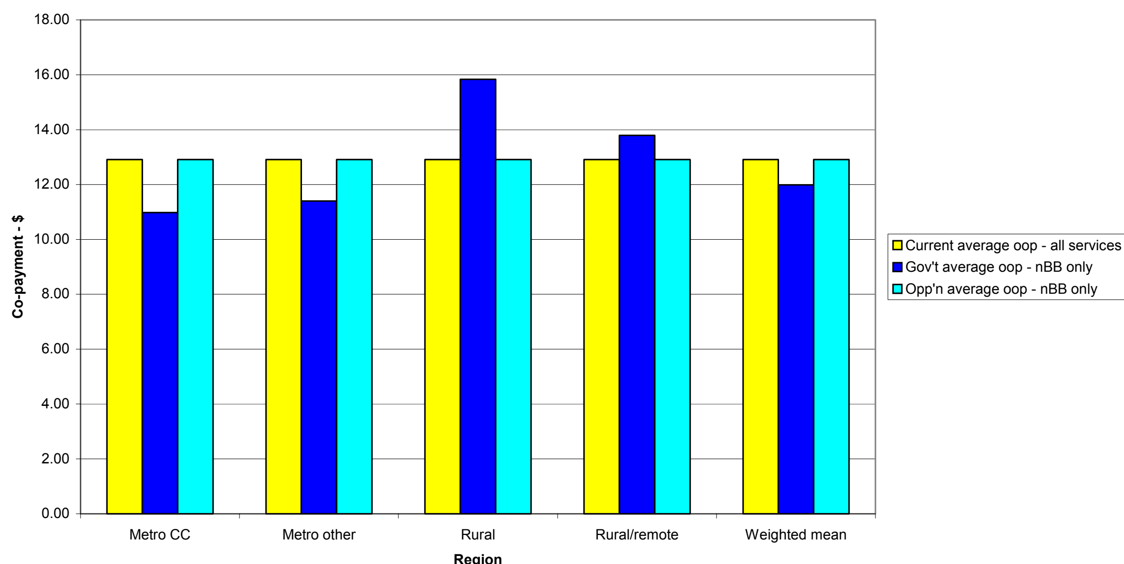


These points are also summarised in Charts 6, 7 and 8.

The 'target setting' scenario for the Government package would deliver 100% of targets but would also have the effect, facilitated by the removal of the hard threshold, of increasing the incidence of co-payments, even though average co-payments for those who are not bulk billed would be likely to decline in metropolitan settings. The increased incidence of such payments, however, would mean that average co-payments across all patients would increase by more than 55%, from around $3.90 to around $6.15 on average. However, it is also possible that some GPs will increase co-payments in order to maximise income, assisted by the removal of the hard threshold, which at present provides a substantial barrier to the implementation of co-payments. As we have already noted, the removal of this hard threshold is likely to substantially modify the patient's perceptions of actual costs incurred and will also reduce transaction costs by an unquantifiable amount. It will also enable a sensitive capacity for price discrimination between patients attending GPs, whether on a geographic or personal basis, and may lead to substantially variable out-of-pocket costs for those paying them between regions or localities.

We are of the view that overall bulk-billing rates are likely to decline to around 50% of services provided, even though it is likely that bulk-billing rates in non-metropolitan areas will rise modestly (by between three and six percentage points). Under the Government's package, it is likely that the majority of concession cardholders would be bulk billed.

Chart 7: Comparison of likely average co-payments (non bulk-billed services only) by region

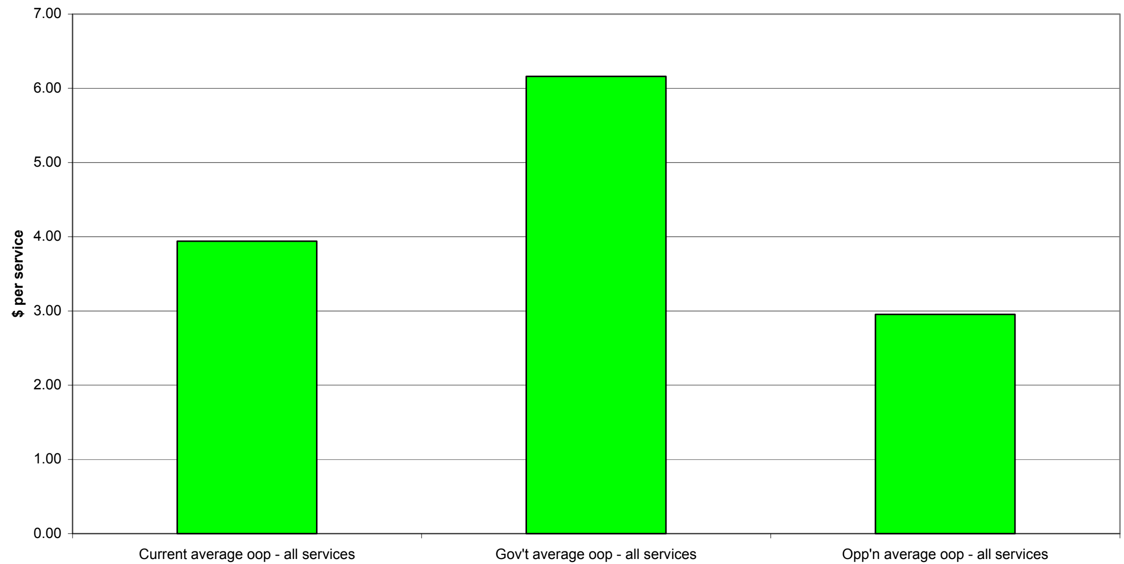


We note that the widespread adoption by GPs of the GP Access Scheme, and the associated availability of direct billing for non-bulk-billed patients, would also permit substantial savings to be made in administrative costs for Medicare, as Richardson has noted in another context[21]. It would theoretically be possible to substantially reduce the number of retail outlets currently required to provide patients with rebate payments, etc.

An additional aspect of the government package is the availability of 'gap' insurance to meet out-of-pocket costs in excess of $1,000 per annum (not indexed). CDHA estimates that about 30,000 individuals or families would exceed this amount of out-of-pocket expenses per annum. It is extremely difficult to assess the actual inflationary impact of such a measure, since the actual cost to individuals will be dependent on the costs of the insurance product, which will also depend on the characteristics of those taking up the insurance product.

Similarly, the provision of a publicly funded 'safety net' set at $500 per annum (indexed) for out-of-pocket costs to concession cardholders may induce some inflationary effects, but it is extremely difficult to assess these. It is unlikely that inflationary effects (if any) arising from these initiatives will impact at the level of GP fees. It is possible that some specialist medical practitioners providing frequent services to regular patients may identify an opportunity to increase fees.

[21] Richardson, 1991, p.55



In our opinion the most likely scenario arising from the Opposition package would be for GPs to meet the bulk-billing targets and thus maximise the rebate and incentive payment income offered under the Opposition package. This is because doing so allows GPs in all geographic areas to achieve income targets (as with the scenario described above for the Government package). The achievement of bulk-billing targets would increase the overall bulk-billing rate to around 77%, ensuring that the vast majority of concession cardholders would be bulk billed.

Assuming the income targets we have set, if GPs adopted the Opposition package, average out-of-pocket costs to patients would reduce by about 25%, from an average at present of around $3.90 to an average of about $2.95. This would derive from a reduction in the incidence of co-payments because of the increased rate of bulk billing. It is possible that patients paying out-of-pocket costs could pay higher costs than at present, but the maintenance of the hard threshold means that price signals to patients would be very prominent.

Our analysis of both proposals is predicated on the notion that GPs will seek to increase their incomes. The Government's proposal provides additional government expenditure for this purpose and protects concessional patients, but it also makes it easier for GPs to raise their incomes through increased patient contributions. The Opposition package relies on increased public sector expenditure to meet the same goal, while maintaining current administrative constraints on gap fees. The relatively higher level of government expenditure outlined in the Opposition proposals reflect this difference.

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ATTACHMENT 2

AUSTRALIAN INSTITUTE FOR PRIMARY CARE

APPENDIX A

Appendix A

Model - GP services

Medicare Data Source: MEDICARE STATISTICS http://www.health.gov.au/haf/medstats/index.htm

Current situation - 2002/3

N services total	N bulk-billed	N service not bulk-billed	Avg Patient contrib - non BB only - $	Total billings	Avg Billing	Total patient contrib	Total cost to Medicare	Avg cost to medicare	Avg OOP cost
96,919,000	67,338,000	29,581,000	12.91	3,150,832,000	32.51	381,890,710	2,768,941,290	28.57	3.94

Note: BB = Bulk billed; nBB = not Bulk billed; Avg Pat = Average Patient contribution for nBB only;
Govt est. = C'wealth estimates of impact/cost;
HC = Health Care card holders or billings, etc; service use factor = extra use factor for HC holders; N = number
nHC = non HC holders; service incidence = usage of services

BB & HC data

Region	Current BB %	Current HC %	Current HC service incidence %	Current HC incidence N	Current implied Incidence BB nHC N	Implied incidence nBB N*	Avg billing - nBB	HC service use factor	FTE GP services pa
Metro CC	76.0%	31.7%	45.3%	3173	2,147	1680	41.48	1.43	7,000
Metro other	68.2%	31.7%	45.3%	3173	1,601	2226			
Rural	54.4%	41.8%	59.8%	4184	0	2816			
Rural/remote	54.7%	40.1%	57.3%	4014	0	2986			
Weighted mean	70.0%	34.0%	48.6%	3404					

Note: * Assumes all HC holders bulk-billed

Government package

Region	Additional Rebate	New rebate	Govt est. - additional income per FTE GP - $pa	Implied BB HC N	Implied BB nHC N	Implied nBB N
Metro CC	1.00	29.57	3,500	3,500	1,820	1,680
Metro other	2.95	31.52	10,250	3,475	1,299	2,226
Rural	5.30	33.87	18,500	3,491	317	3,192
Rural/remote	6.30	34.87	22,050	3,500	329	3,171
Weighted mean	2.36	30.93				

Opposition package

Region	New rebate - BB @ 95%	New rebate - BB @ 100%	Incentive payment	Incentive targets - BB rates
Metro CC	31.93	33.61	7,500	80%
Metro other	31.93	33.61	15,000	75%
Rural	31.93	33.61	22,500	70%
Rural/remote	31.93	33.61	22,500	70%
Weighted mean				77.1%

Baseline model - current estimated fee income & income targets

Region	Estimated income - BB	Estimated income - nBB	Total fees income	Total target fees income
Metro CC	151,991	69,686	221,676	245,174
Metro other	136,391	92,334	228,725	252,970
Rural	108,793	132,403	241,196	266,763
Rural/remote	109,393	131,532	240,925	266,463

Scenario 1 - current BB rates maintained, current average oop maintained

Government Package (assumes BB rate @ not less than HC service incidence)

Region	Govt estimate - income from BB HC	LTU estimate - income from BB HC	Govt estimate - income from BB nHC	LTU estimate - income from BB nHC	Govt estimate - income from nBB	LTU estimate - income from nBB	Govt estimate Total fees income	LTU estimate Total fees income	Practice costs	LTU-PC
Metro CC	103,494	93,830	51,997	61,334	69,686	69,686	225,176	224,849	130,676	94,173
Metro other	109,517	100,017	37,124	45,735	92,334	92,334	238,975	238,086	130,676	107,410
Rural	118,224	141,717	9,069	0	132,403	116,799	259,696	258,516	130,676	127,840
Rural/remote	122,044	139,967	9,399	0	131,532	123,858	262,975	263,825	130,676	133,149

Opposition package (assumes current BB rates)

Region	Estimate income from BB @ 95%	Estimate income from BB @ 100%	Estimate income from nBB	Incentive payment	Total income @ 95%	Total income @ 100%	Practice costs	LTU-PC 95%	LTU-PC 100%
Metro CC	169,872	178,812	69,686	0	239,558	248,498	130,676	108,882	117,822
Metro other	152,438	160,461	92,334	0	244,771	252,794	130,676	114,095	122,118
Rural	121,592	127,992	132,403	0	253,995	260,395	130,676	123,319	129,719
Rural/remote	122,263	128,698	131,532	0	253,795	260,230	130,676	123,119	129,554

Scenario 2 - BB HC only, current average oop maintained

Government package

Region	Govt estimate - income from BB HC	LTU estimate - income from BB HC	Govt estimate - income from nBB	LTU estimate - income from nBB	Govt estimate Total fees income	LTU estimate Total fees income	Practice costs	LTU-PC
Metro CC	103,494	93,830	145,179	158,736	248,673	252,565	130,676	121,889
Metro other	109,517	100,017	146,233	158,736	255,751	258,753	130,676	128,077
Rural	118,224	141,717	145,570	116,799	263,794	258,516	130,676	127,840
Rural/remote	122,044	139,967	145,179	123,858	267,223	263,825	130,676	133,149

Opposition package

Region	Estimate income from BB @ 95%	Estimate income from BB @ 100%	Estimate income from nBB	Incentive payment	Total income @ 95%	Total income @ 100%	Practice costs	LTU-PC 95%	LTU-PC 100%
Metro CC	101,322	106,655	158,736	0	260,057	265,390	130,676	129,381	134,714
Metro other	101,322	106,655	158,736	0	260,057	265,390	130,676	129,381	134,714
Rural	133,604	140,636	116,799	0	250,403	257,435	130,676	119,727	126,759
Rural/remote	128,170	134,916	123,858	0	252,028	258,774	130,676	121,352	128,098

Most likely scenarios

Government package - GPs set fees to achieve target, BB HC only

Region	Target income = Total income	Estimate income from BB HC	Estimate income from nHC	Average nBB fee	New average oop - nBB only
Metro CC	245,174	93,830	151,344	39.55	10.98
Metro other	252,970	100,017	152,953	39.97	11.40
Rural	266,763	141,717	125,046	44.41	15.84
Rural/remote	266,463	139,967	126,496	42.36	13.79
Weighted mean	251,132	105,260	145,872	40.56	11.99

Opposition package - GPs BB to regional targets, maintain current average OOP

Region	Estimate income from BB @ 95%	Estimate income from BB @ 100%	Estimate income from nBB	Incentive payment	Total income @ 95%	Total income @ 100%	Practice costs	LTU-PC 95%	LTU-PC 100%
Metro CC	178,812	188,224	58,072	7500	244,384	253,795	130,676	113,708	123,119
Metro other	167,637	176,460	72,589	15000	255,226	264,049	130,676	124,550	133,373
Rural	156,461	164,696	87,107	22500	266,068	274,303	130,676	135,392	143,627
Rural/remote	156,461	164,696	87,107	22500	266,068	274,303	130,676	135,392	143,627

Overall impacts - 2002-3 data, utilising most likely scenarios

Government package

N services total	N bulk-billed	N service not bulk-billed	Avg Patient contrib - non BB only - $	Total billings	Avg Billing	Total patient contrib	Total cost to Medicare	Avg cost to medicare	Avg OOP cost	Avg billing - nBB
96,919,000	47,125,205	49,793,795	11.99	3,477,069,735	35.88	597,094,392	2,879,975,343	29.72	6.16	40.56

Opposition package @ 95%

N services total	N bulk-billed	N service not bulk-billed	Avg Patient contrib - non BB only - $	Total billings	Avg Billing	Total patient contrib	Total cost to Medicare	Avg cost to medicare	Avg OOP cost	Avg billing - nBB
96,919,000	74,739,087	22,179,913	12.91	3,306,492,095	34.12	286,342,679	3,020,149,417	31.16	2.95	44.07

Opposition package @ 100%

N services total	N bulk-billed	N service not bulk-billed	Avg Patient contrib - non BB only - $	Total billings	Avg Billing	Total patient contrib	Total cost to Medicare	Avg cost to medicare	Avg OOP cost	Avg billing - nBB
96,919,000	74,739,087	22,179,913	12.91	3,432,096,159	35.41	286,342,679	3,145,753,480	32.46	2.95	45.37