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.

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.

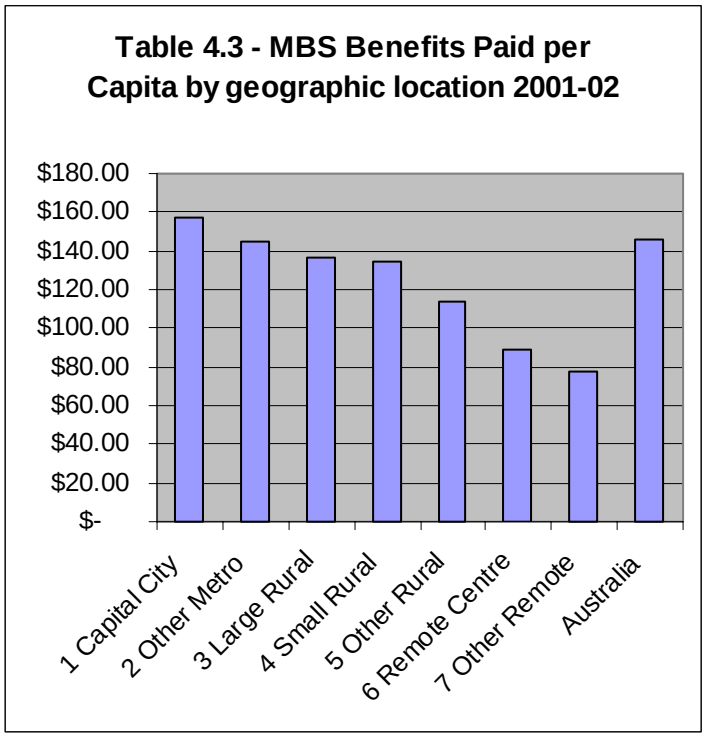
16 Report on Government Services 2003, Productivity Commission, February 2002, Table 10A.37, available at www.pc.gov.au/gsp/2003. Includes Other Medical Practitioners, such as non-VR GPs. Capital city = State and Territory capital city statistical divisions; other metropolitan centre = one or more statistical 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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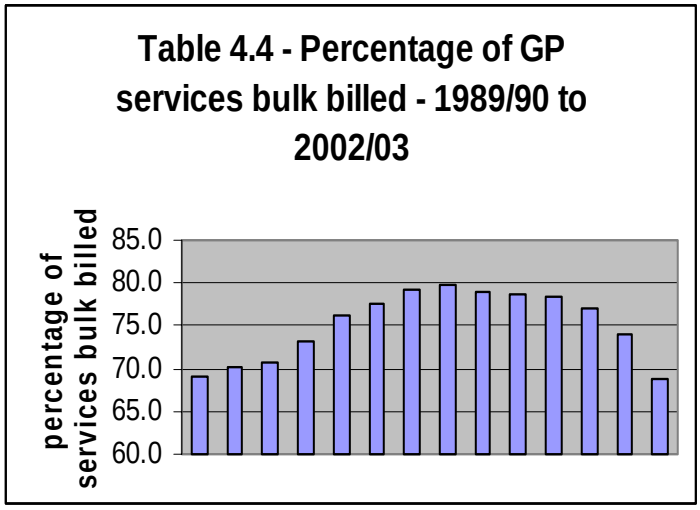
20 Australian Political Ministry Network (PolMin), Submission 35, p. 1

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

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:

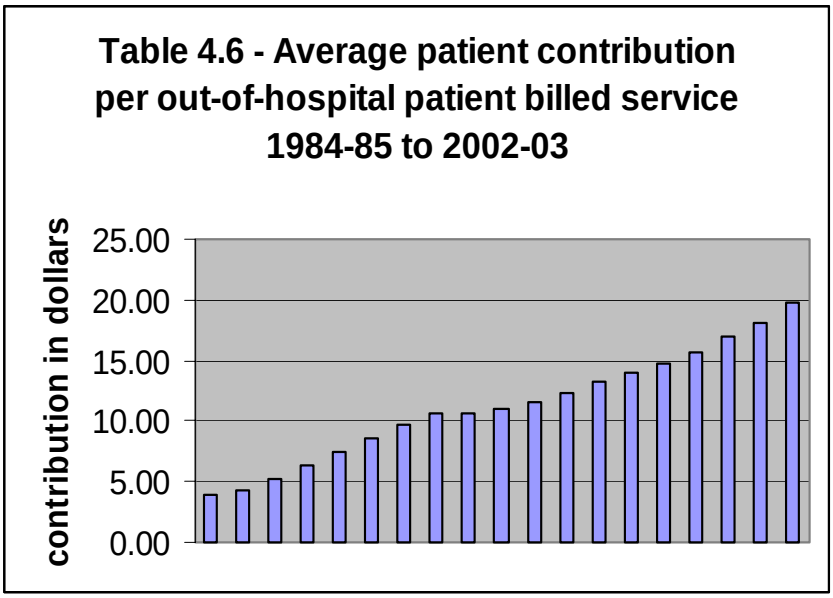
> Women and children who have been subjected to domestic violence and/or who have insufficient economic means to access private hospital treatment have to go to the Base hospital and wait their turn in Emergency…[m]any women leave without accessing the medical service they need or refuse to attend because 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]

Table 4.6 - Average patient contribution per out-of-hospital patient billed service 1984-85 to 2002-03



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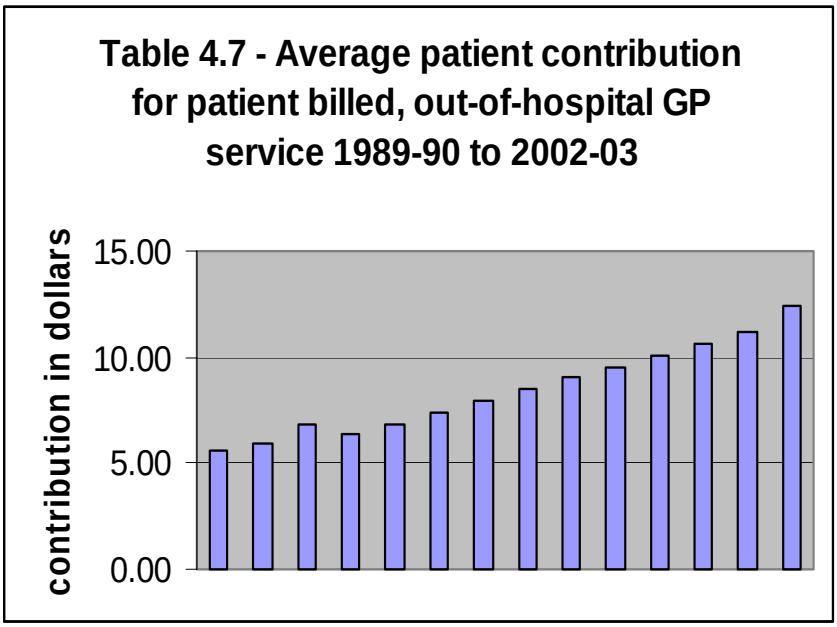
34 Mr Mehan, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 51

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,

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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

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

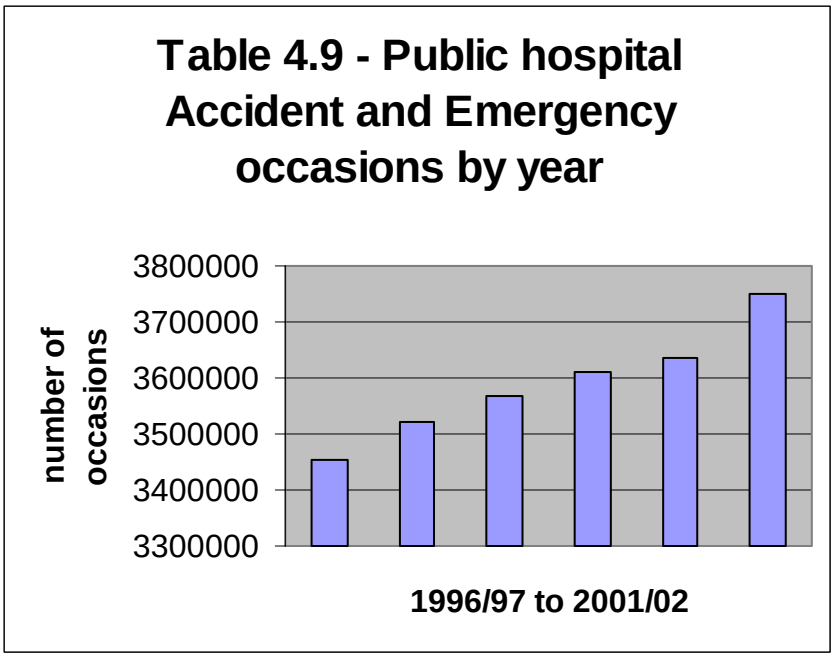
77 AMA, *An Analysis of the Widening Gap between Community Need and the Availability of GP Services*, Access Economics, February 2002, p. 5

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

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.

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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.