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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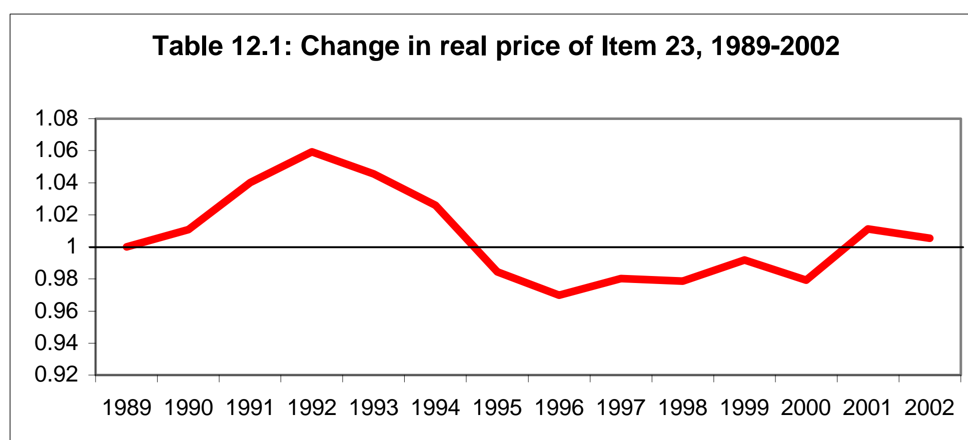
1 Family Medicine Mackay, Submission 218, p. 2

> 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

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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

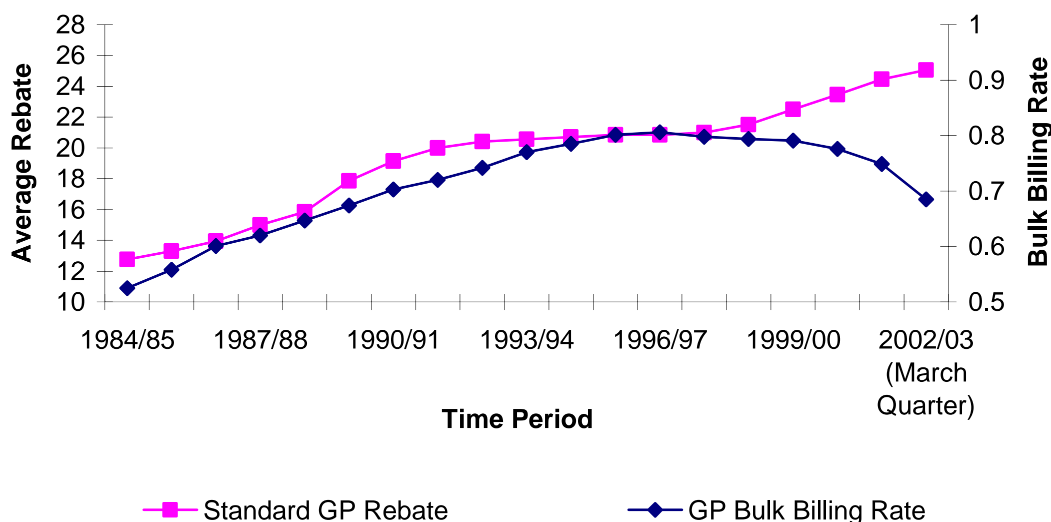
30 Dr Moxham, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 2

31 College of Non-VR GPs, Submission 48, pp. 8-9

32 Dr Ruscoe, Submission 153, p. 7

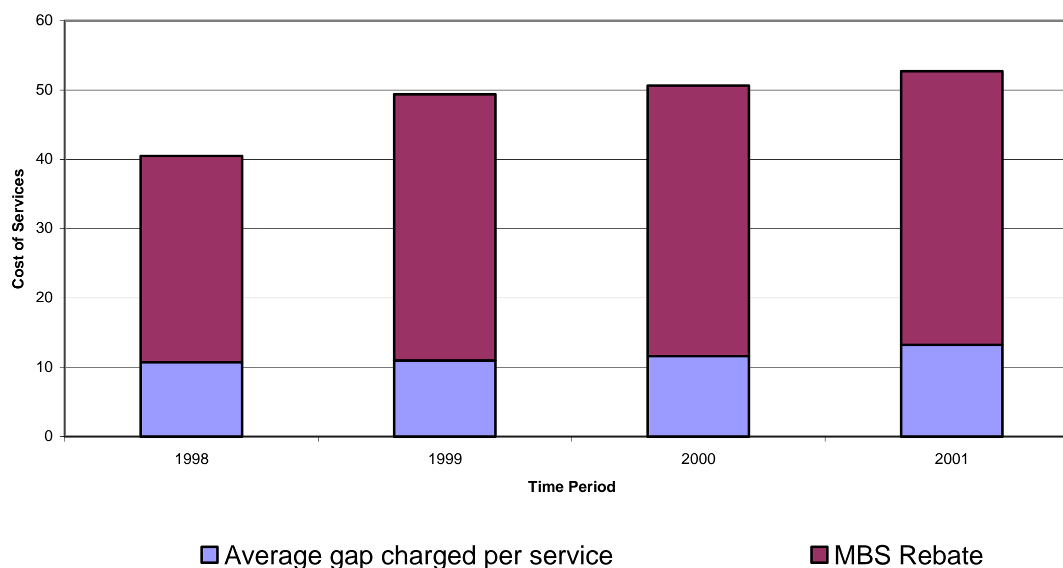
33 Department of Health and Ageing, Tabled documents, Canberra, 21 July 2003

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.

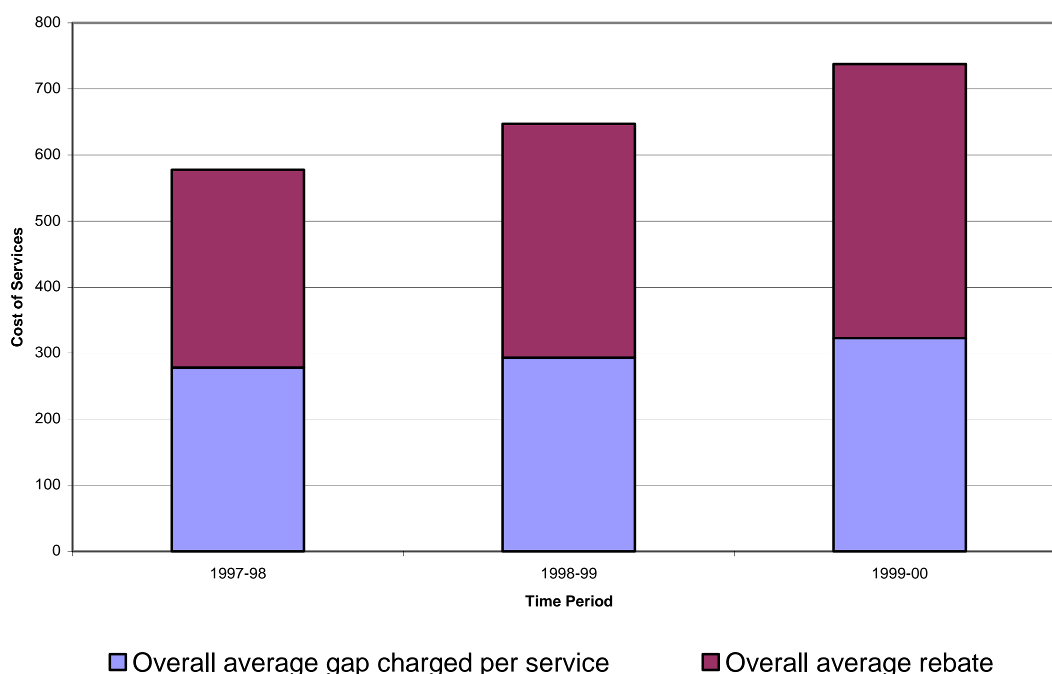
Table 12.3 - Radiation Oncology (MBS Items 15203, 15207): MBS Rebate and average gap charged



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]

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

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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

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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-

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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:

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.