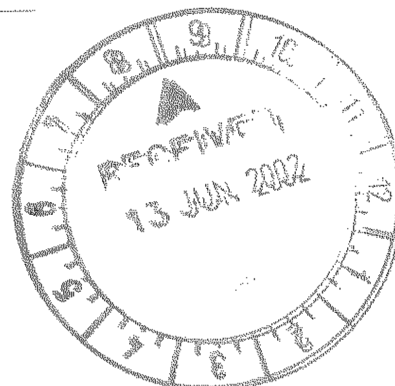
DIVISION
OF GENERAL
PRACTICE



The Secretary
Select Committee on Medicare
Suite S1 30.1
Parliament House
CANBERRA ACT 2600

Dear Sir/Madam

SELECT COMMITTEE ON MEDICARE–SUBMISSION

Thank you for the opportunity to put a submission to the select committee.

The Yorke Peninsula Division of General Practice Inc supports the general view of General Practitioners that the current Medicare rebate is insufficient to cover rising costs and needs to be increased. At the current level of rebate, financial viability for Medicare rebate only practices (bulk bill) is severely threatened. While "blended payments" have assisted in propping up any accredited practices who still bulk bill, the ability to attract doctors is curtailed dramatically. These payments go to the practice not direct to the doctors and because practice costs have increased without subsequent increases in the medicare rebates, they are not always shared, unless the employees have been able to successfully negotiate with their employers. Increased costs apply to GPs in all locations, and while we support any additional incentives to encourage doctors to come to the country, the proposed changes are certainly not equitable between Urban and Rural GPs.

The attached correspondence–the major reason for this submission- focuses on (d)(iii) of the terms of reference and we believe is a positive step toward increasing the efficiency of the medicare system.

The present system of sending a cheque, payable to a doctor, to the patient is costly and annoying to all concerned. The patient has to go to extra expense to get the cheque to the doctor, and if they lose or misplace the cheque, the doctor has to wait an unsatisfactory length of time (at present it can be in excess of 90 days) to receive payment for services provided. The HIC are also totally unhelpful to practices experiencing difficulty in collecting payment and appear to work against rather than with GP staff.

The correspondence attached identifies savings that will be achieved by changing from the costly method of sending out cheques, to a much more efficient direct credit system. The savings achieved could be put toward increasing the Medicare rebate.

Co-payment for services is the big issue and while there are some negatives that may arise, there are also positives. We are aware that a blanket approval to charge

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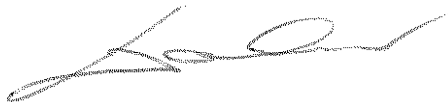
everyone a gap payment may prevent disadvantaged individuals and families from seeking timely health care. However we believe that our caring doctors would treat genuinely disadvantaged patients without additional costs. In fact the majority of our practices who have already abandoned bulk billing have put in place their own safety nets to prevent undue hardship. They also bulk bill only for discussion of test results and for multiple family consultations on the same day.

The present system encourages patients who may have a very minor ailment to seek medical attention, because (if they can find a GP who still bulk bills) there is no cost to them for doing so. Introduction of a small co-payment (with GPs discretion to waive this fee) would discourage this minority from using the visit to the doctor as a social outing. This would not only cut spending (allowing another source for an overall cost neutral medicare rebate increase) but could also reduce unnecessary congestion at doctors surgeries where getting an appointment is very difficult.

Should you require any additional information regarding this matter please feel free to contact me.

Yours sincerely



David Holman
Executive Officer

11/06/03

19/8/04

DIVISION
OF GENERAL
PRACTICE

Senator Alan Ferguson
100 King William St
ADELAIDE SA 5000

Dear Alan,

<u>Providing Medical Services to the Community</u>

On the 14th of August Neil Andrew, and his assistant David Little, attended the opening of a new service in Maitland, and I had the opportunity to speak to them.

It is apparent that our previous correspondence, regarding this issue, was somewhat unclear and I have attempted to clarify the situation. A copy of the letter that I have sent to Neil, is attached for your information.

The reduction in red tape, and simplification of the method of claiming, would be warmly welcomed by the doctors and patients alike, and the cost benefit to the government in the administration of the refund scheme would be enormous.

I urge you to consider the matter and to take the appropriate steps to amend the legislation that would allow a common sense solution to the problem. I do realise that this suggestion will not completely solve all of the problems in primary health care delivery, but it will certainly be a step in the right direction.

Yours sincerely

for
Dr Georgina Moore
Medical Director

06/06/03

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29/8/02 ✓

DIVISION OF GENERAL PRACTICE

The Hon Neil Andrew MP
Member for Wakefield
10 Adelaide Road
GAWLER 5118

Dear Neil

Thank you for the reply to our letter.

While we appreciate the responses you have made, there are, however, several points that we wish to reinforce.

The after hours trials that are taking place will be of interest to our members, but how many are taking place in areas such as ours. The difficulty in small communities is that the doctor needs to work all day and then provide cover for emergencies all night. We recognise that all doctors are not called out multiple times every night, but in a worst case scenario a tired doctor may make mistakes. We also recognise that the PIP provides incentives for doctors who provide 24 hour cover. This is not what we are trying to change though.

We are aware that co payment with bulk billing is illegal at present. This is what should be changed!

Patients are concerned about the increasing trend of doctors requesting full payment for services at the time of consultation, with the reasons for this the lengthy delays in obtaining payment for the service in many cases. Practices receive a substantial number of 90 day replacement cheques, indicating that patients do not bother to return them. A smaller proportion of amounts remain unpaid, even after the 90 days, and reference to HIC usually leads to fraudulent negotiation of the cheque or the comment "you will have to speak to the patient about that". This can be quite difficult if the patient has left the area.

The government is undertaking a review of red tape, and this is an area where they should start. Why should we need several different systems when one simple method of claiming could be introduced? A bulk bill with a co payment by the patient would simplify everything. The doctor would be assured of being paid, the patient would only need to find a smaller amount to pay the doctor and also not have to worry about returning cheques to the practice, and the government would save an absolute fortune by reduction in administration, postage and stationery.

The HIC is looking to impose direct claiming for patients at practices, which requires extra input from practice staff without financial support. Surely this common sense solution to this problem, bulk bill with gap payment, should prevail to the benefit of all.

Yours sincerely

TW

06/06/03

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2/9/02

DIVISION
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The Prime Minister
The Hon Mr John Howard
P O Box 59
SYDNEY NSW 2001

Dear Mr Howard

Legislative Change to Medicare rebates

We realise that it is a very difficult job to provide adequate and appropriate health cover to Australian citizens. Rather than complain we would like to make a simple suggestion that would not only make the administration of medicare refunds easier but also save the Commonwealth a substantial amount of money.

You will be able to see from the attached copies of correspondence that we are seeking to allow patients to pay a gap payment to the doctor and for the doctor to bulk bill the HIC for the declared patient rebate. As mentioned the savings to the Commonwealth would be enormous through the abolition of the need to post cheques – no cheque costs, no envelope costs and no postage costs.

The benefit for the patients is that they will not be expected to have to cover the full amount of the consultation at the time of consult (which is around $100 for an after hours consult), as many are now being asked to do, and they will not have the bother of returning a cheque to the doctor later.

The benefit to the doctors is also substantial. There will not be any doubt as to payment of accounts. There will be no need to scrutinise the date of medicare cheques returned to ensure that the bank will not charge $10.50 for any cheques that have had payment stopped after replacements have been issued. While we recognise that it is not reasonable for the HIC to pay for the same service twice, it is also unreasonable to expect doctors to forgo almost half of the medicare rebate should a cheque be dishonoured. Paying staff (and debt collectors) to chase outstanding debtors would become a thing of the past and the cost of provision of medical services would be reduced somewhat, by the reduction in administration.

Patients will only be prepared to pay the amount of the gap that they agree is value for money and the doctors would be prepared to waive or reduce this gap on a discretional or compassionate basis. The truly needy patients would receive sympathy, but doctors can hardly be expected to feel too much sympathy for patients crying poverty who are observed, drinking smoking and gambling.

Perhaps our suggestion is too radical to introduce on an Australia wide basis. We would be prepared to trial it in our area if desired. The opportunity also exists to introduce this co-payment system to areas where patients do not have access to "free" hospital care, and this may provide added incentive for more GPs to undertake medicine in rural and remote areas.

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In informal conversation, HIC staff have admitted the merit in this system but they are blocked by legislation. We believe that it would be a very positive move for the Australian Government to introduce a logical improvement to the medicare system.

The mooted on line claiming system will only be effective for people who are reasonably affluent or budget well and this is not the case for the majority of health care cardholders. There are already problems with the implementation of this system and a simple legislative change would enable a working system (bulk billing) to be enhanced to radically improve the administrative workings of the health system.

Yours sincerely

Dr Georgina Moore
Medical Director

06/06/03

10/10/02

DIVISION
OF GENERAL
PRACTICE

Senator

Dear Senator

Changes to Legislation – Medicare payments to doctors

Firstly allow me to apologise for not forwarding copies of the attached correspondence to you earlier, but we did not realise just how enormous a task we were taking on.

We naively believed that suggesting a common sense solution to a problem faced by patients, and doctors, in country areas would enable changes to be made which would have consequent benefits for everyone involved. We did not realise that it would be necessary to change legislation to enable common sense improvements to the medicare scheme to be made, but if that is what it takes then so be it.

You will read from the attachments that the problem which our doctors, and most other practices throughout Australia, face is one of obtaining payment for services performed. Patients face the possibility of having to meet an up front payment of $100 for out of hours treatment ($77.70 of which will be reimbursed by medicare) and in areas of low socio economic status this could mean the difference between life and death. Obviously in cases of real emergency the doctors will treat the patients, but often these after hours call outs are not life threatening.

In country areas there are no salaried doctors on call at hospitals and local GPs are called to attend patients who present in emergency departments after hours. In the cities this service is free, so there is an element of inequity of access, but when seeing doctors after hours our patients are usually attended to within a very short time frame.

Apart from the lower gap payment that the patient would need to pay on the spot, in allowing a co payment with a medicare claim, there seems to be large injustices in the way in which the present system works. Please allow me to explain. A patient attends the doctor, pays a gap and has his claim sent to medicare for a cheque (payable to the doctor) to be sent back – to the patient. The doctor has to then wait for payment until the patient sees fit to return the cheque to them. A recent change to the system of paying cheques still outstanding direct to the doctors account after 90 days has helped this system greatly. There is however another twist to this story. If a patient, either deliberately or inadvertently, negotiates the cheque (payable to the doctor), themselves, then a replacement cheque is not issued. Any attempts to find out from the HIC why a replacement has not been credited to the doctors account, usually meet the reply "you will have to speak to the patient about that." In many instances the patient is not contactable or refuses to cooperate. I might add that instances as described are not isolated.

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I am sure that if a politician's wages were handed to a third party to hand on to the politician, if they did not choose to spend the money themselves first – or hold onto it for 90 days, it would be an unacceptable arrangement. So I hope you can see the point that we are trying to raise.

The benefits of the changes that we are trying to have introduced are many, and everyone wins.

- The patient will win by only having to pay a gap to the GP and not have to worry about returning cheques. They will not have to come up with large amounts of cash to seek help after hours.
- The GP will win by being sure that their payment for services provided will be made within a reasonable time frame. They will not have to worry about bad debts (apart from any unpaid gaps) so this costly area of running a business can be eradicated and any savings attained will help to keep the gap payments down.
- The HIC will win in many ways. There will be huge savings on envelopes, postage and the cost of cheques, with all payments being made electronically direct to the doctors' bank account. There will be no need to monitor cheques to ensure they are not outstanding and arrange reissue after 90 days. The possibility of fraudulent negotiation of cheques will be eradicated. Queries to the HIC from practices will be greatly reduced. The savings in this area are absolutely enormous. The HIC are also trying to introduce online claiming for patients and there have been substantial difficulties with this. By adopting a co payment, there will be no need as everything would be bulk billed using the existing efficient system.

It has been said that the introduction of co-payment will spell the end of bulk-billing, but the media reports a rapid drop off in practices that still bulk bill in any case. The amount of the gap payment charged by doctors would be able to be contained if prompt guaranteed payments were made. Many doctors who have abandoned bulk billing already waive or reduce gap payments for disadvantaged patients and many cap the additional amount a patient has to pay for frequent visits. The public outcry would therefore be offset by the benefits to all outlined above.

I trust that you will see fit to support us in this effort to see common sense prevail. Please contact me if any clarification of the above is necessary.

Yours sincerely

Dr Georgina Moore
Medical Director

06/06/03

17/6/03.

DIVISION OF GENERAL PRACTICE

Mr Steven Smith
Shadow Minister for Health & Ageing
Parliament House
Canberra 2600

Dear Mr Smith

Medicare Co-Payment

Thank you, for your past endeavours on our behalf to attempt to address the issues faced by our doctors in regard to payment for their services to patients.

We are trying to overcome a problem of payment and also to prevent the need for all patients to pay in full for consultations on the spot.

We believe that our suggestions are valid but are thwarted by legislation that prevents any change, no matter how logical or cost effective that it may be.

To enable you to be completely informed and perhaps even allow you to advocate further on our behalf, I have enclosed a copy of the correspondence that we have received from the Minister's office and our subsequent reply.

We have offered to discuss this matter face to face to clarify all issues and would welcome your attendance should that eventuate.

Regards

Dr Georgina Moore
Medical Director

06/06/03

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The Hon Trish Worth MP
Parliamentary Secretary to the Minister for Health & Ageing
Member for Adelaide
Parliament House
CANBERRA ACT 2600

Dear Trish,

Thank you for your response to our communication regarding medicare refund cheques. We do not wish to be disrespectful but wish to clarify some of the issues that we raised. It is obvious from your letter that some of the points we are trying to address, remain unclear.

Medicare is an excellent scheme to keep health care affordable for the Australian people and to ensure that medical assistance can be obtained by everyone regardless of financial standing. We acknowledge that the purpose of medicare is to reimburse the patient for expenses incurred but unfortunately the goodwill of the doctors in waiting for the eventual payment of their accounts is being exploited. What other business of profession would put up with this situation?

We realise that the speed of payment for bulk billed transactions is an incentive for doctors to bulk bill patients but as has been well documented the medicare rebate is regarded as insufficient, having failed to keep pace with inflation. Perhaps if our scheme were adopted the bulk cheque could be issued after a 4 week waiting time, to retain some incentive to bulk bill. We also recognise that the Government has introduced a range of measures such as the PIP to offset the "low" medicare rebate, but these payments come with many strings and compliance costs are quite high to qualify for these payments.

Because of the inflexible stance taken by the HIC in this matter, many practices are resorting to charging the full fee up front and for many patients this is creating financial hardship. As stated by you the recompense of the patient expense is made to the patient, in the current scenario, how can the patient be reimbursed for something that they have not yet paid? ***In banking law, the rightful owner of the cheque is the payee, so why is the cheque not forwarded to the doctor?***

The 90 day cheque scheme is an excellent scheme and has cut the number of bad debts experienced by many doctors enormously and it has been a very positive step toward assisting doctors to provide a service to all, while also ensuring that doctors actually get paid for their service. Your comments, regarding this scheme, that have been passed on by the HIC are quite interesting. The doctors who we are writing about are all registered for the scheme, the patients are presented with an account and the practice actually send the accounts and claims to medicare themselves. The reason for this is to ensure the claims are processed as reliance on the patient to submit the claim could extend the time between treatment and payment even further. It is therefore interesting to note that outstanding provider accounts are due to non lodgement of claims.

Negotiation of cheques by the holder and not the payee is something that is now much easier to achieve as financial institutions reduce staff numbers and place greater pressure on those that are left to complete an increasing workload. Responsibilities such as ensuring cheques go to correct accounts are unfortunately one of the things that suffer, particularly if the cheques are presented by commercial customers, such as hotels, in large numbers. Enquiry with Financial Institution hierarchy would refute this claim, but front line staff would reluctantly confirm it. Any attempt to

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make the payee clearer would be welcome and removal of the patients' name from the face of the cheque would be a great place to start, although it would make identification of the patient's account to credit difficult if the cheque was detached and posted to the practice.

The numbers of occurrences of outstanding amounts that should have been repaid by the 90 day scheme, as previously advised, is a very real figure. Many of the original cheques may not have been issued because of a technicality such as a Medicare card being reissued and the patient presenting the old card. Others may have been issued but returned to the HIC because of an incorrect address. ***Why should the doctor have to bear the financial cost of this administrative problem?*** It appears ridiculous that the HIC will refuse to speak to practices about the reason why a replacement has not been issued. It seems decidedly unfair that after providing treatment to a visitor to the area that payment is refused by medicare without notification of why. If details provided to the practice are incorrect or the patient chooses to ignore contact, cost recovery is very difficult. Should practices insist on full payment of accounts, up front, for all visitors to their area, and also to local patients with a poor payment history, before medical services are provided?

We also applaud any initiatives to enable quicker claiming of refunds, but this does mean that the patient will have to pay the full amount at the time of the consult to take advantage of this system. Another difficulty with on line claiming is the extra expense, and time, that the practice has to go to in order to provide this service. Cost effective broadband internet access is needed for this to work efficiently and this is not available in most of our area. Increased staff time to process patients' claims is also required and the HIC does not recognise this additional input in any way, other than provision of PKI keys to authorise transmissions.

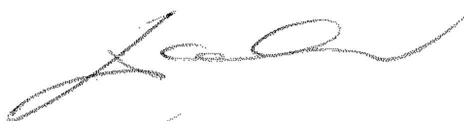
It is extremely difficult to pose all questions and difficulties by mail as any questions or uncertainties cannot be quickly answered or clarified. In an endeavour to resolve the issue, we would be pleased to meet with you, and/or the Health Minister along with HIC policy makers to discuss the issues.

We recognise that current legislation is in place to direct the way in which claims are dealt with, but surely if the legislation is fraught with problems, then it should be reviewed. We also understand that our suggestion is also creating further encouragement to abandon bulk billing which would be politically undesirable. The savings that could be obtained by our proposal could enable an increased rebate without additional cash input and this may be politically acceptable. An increase in the medicare rebate may also reduce pressure on doctors to abandon bulk billing and any gap payments could be kept to a minimum. In our area many of the GPs are putting financial safety nets in place, with a revision to bulk billing for patients who are forced to seek medical assistance over a certain number of occasions per year.

If all patients were required to make some form of payment for services it would significantly reduce the number of consultations for very minor ailments.

We trust that you can accept our criticism and suggestions as being constructive, conciliatory and positive and that we may be able to progress this matter to a satisfactory conclusion.

Yours sincerely



Dr Georgina Moore
Medical Director

06/06/03

5/3/03.

DIVISION
OF GENERAL
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Senator Kay Patterson
Suite MG 48
Parliament House
CANBERRA ACT 2600

Dear Senator Patterson

Thank you for your recent reply to our correspondence regarding co-payment of medicare items. We do understand that significant legislation would be necessary to effect any changes to the way that the Medicare system operates but we do believe that there could be significant benefits to the Government by making these changes.

We do not think that the cost savings that could be obtained by changes have been considered strongly enough and maybe deserve further consideration.

Unfortunately it is human nature to take advantage of anything that is free. Many individuals take every minor ailment to the doctor (if they are able to find one who still bulk bills) and this adds significantly to the MBS bill, unnecessarily in many cases. By introducing a small co-payment, the incentive to take every problem to the doctor is reduced and subsequently introducing a small co-payment also reduces the cost to the Government by a reduction in the numbers of claims.

The only practice on the Yorke Peninsula that bulk bills patients has closed its doors to new patients, and as such bulk billing has effectively ceased already.

While there has been some criticism from the community regarding having to pay to see their doctor, the majority have accepted the situation and in some cases commended the doctors for making the move, stating that they did not believe that access should be totally free. Doctors are still able to bulk bill any patients that they choose to, and most do not charge patients for reviewing test results and also provide discounts to families where more than one member is in need of treatment within short time frames. Doctors will always treat genuinely disadvantaged patients without insisting on full fees being paid up front.

In your response, you mentioned that the Government is taking steps toward reducing the paperwork burden for general practice, and this would be most welcome indeed. One of the greatest unnecessary contributors to practice workload is chasing up bad debts. The doctors of this Division, and I believe all others in Australia, are grateful to the Government for the introduction of the 90 day cheque scheme which has reduced the number of bad debts significantly, however it has not entirely solved the problem.

We recently surveyed our practices to determine numbers of 90 day cheques being received, and the results were quite disturbing. One practice reported receiving 216 90 day cheques over a 12 month period and another received 109 over a 4 month period. While their receipt has cut down the need to chase up bad debts significantly it does mean that the GPs are waiting for up to 120 days for payment – we are sure that you agree that this is not satisfactory. In addition to these figures it is more disturbing that the first practice, mentioned above, has 44 payments outstanding that should have been cleared by the 90 day scheme and the second practice has 130. While

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these figures are very insignificant on an Australia wide scale, when you consider that both towns have populations less than 6000 people, they are quite substantial.

The possible reasons that these items have not been covered by the scheme, would be that the cheque has been fraudulently negotiated or that the HIC have refused payment and not advised the practice or perhaps the HIC is unaware of the patients' current address. In any case requests from the practice to determine why payment has not been made is usually unsuccessful. This does create significant animosity, that doctors do not get paid for services that they have provided. It appears to be quite absurd that cheques payable to a doctor are actually sent to the patient, and while the reason for this system appears to be to ensure that the patient is aware of the amount of the billing, there must be a better way of confirming the transaction.

The vast majority of problem accounts for doctors are caused by visitors to the area, who really don't care whether the doctor gets paid or not, as the likelihood of having to return again to that doctor is extremely low.

We firmly believe that the time is right to make legislative change to allow co-payment. The significant benefits to Government would include:

- Removal of the mindset that currently exists, where some patients will visit the doctor because it is free, often treating the visit as a social outing. This would reduce the current expenditure on MBS and even allow for rebate increases without any overall increase in expenditure.
- A huge reduction in the cost of producing, distributing and reconciling/replacing cheques. A calculation of the number of cheques produced each day, multiplied by the cost to physically produce each cheque plus the cost of the envelope plus the cost of postage would give a picture of the enormity of the savings that could be made.
- Replacement cheques would not need to be produced resulting in reduced administrative time and costs in producing the replacements.

Should the government be reluctant to proceed upon this course, we do have an alternative proposal.

Rather than post out each cheque individually to the patients to take to the GP, we propose that weekly bulk mail outs be sent direct to the treating doctor. While cost savings would not be as significant, they would still be very substantial and pacify the doctors, who could then be assured of actually getting the payment that is due to them. Introduction of this system would enable doctors to relax their requirements of full payment up front because they would be assured of getting payment. In summary, Pay Doctor Cheques should actually be paid to the doctor – not the patient.

One of the Government aims of a reduction in the amount of paperwork could certainly be achieved by adopting either of these options.

We trust that you will see fit to recommend either of these proposals for implementation.

Yours sincerely

Dr Georgina Moore
Medical Director

06/06/03

3/3/03.

DIVISION
OF GENERAL
PRACTICE

Williams, Lea Stevens, Alan Ferguson
Kay Patterson, Neil Andrew, Steven Smith,
John Anderson, John Meier

Dr Steve Clark
CEO, Australian Divisions of General Practice
PO Box 1126
BELCONNEN ACT 2616

Dear Steve,

Providing Medical Services to the Community

There has been substantial criticism locally regarding the high cost of seeing a doctor after hours. We are sure that this criticism is not exclusive to the Yorke Peninsula and we wish to offer a solution that would be simple to implement and satisfactorily address the situation. Let me firstly outline the problems.

The fact that the medicare rebate has not kept up with inflation is widely known, and while we accept that an attempt to address the issue via blended payments has been made, this is not acceptable to most GPs because of the cost of compliance. Local GPs have expressed the view that they are moving away from PIP payments and the newly introduced EPC item numbers because of the difficulty in implementation and are relying on Fee For Service as the prime income source. Fees will inevitably need to increase. An article from the Medical Observer (26th July) is enclosed to support this viewpoint.

Difficulties in collection of accounts for after hours consults have led to some practices insisting on payment up front when called in to treat patients in hospital casualty areas. In the larger cities the patient attending casualty areas often does not have a financial outlay but may be kept many hours in the waiting area prior to being seen by a doctor. We realise that it is not possible to have permanent doctors on the staff in all small country hospitals because of the cost and there is no "free" service available. This means that the patient will often need to be able to have around $100 available in case they need to call a doctor after hours. A relevant article in the local paper is attached for information and strongly highlights this point.

There is no solution to rising costs, but there is a solution to enabling the patient to access after hours services (in emergency situations) without the huge financial cost which is current. This solution is quite simple and involves the introduction of a co payment for any service. This system is already in place at pharmacies, dentists, optometrists etc. Admittedly the co payment at dentists and optometrists is received via health benefit organisations but the system works.

There are benefits for everyone concerned by implementing this system. The patient would only have to outlay the amount of the gap payment, the doctor would benefit by a prompt payment of the fee and the HIC would benefit by being able to process all claims electronically thus cutting down the cost of issuing cheques and the follow up of lost misplaced cheques.

We urge you to address this issue as a matter of urgency.

Yours sincerely

Dr Tim Wood
Chairman Yorke Peninsula Division of General Practice Inc

06/06/03

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DIVISION
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Senator Neil Andrew
Federal Member for Wakefield
10 Adelaide Road
GAWLER SA 5118

Dear Neil

Providing Medical Services to the Community

I had the opportunity to speak to David Little on the 14th of August and it is obvious that there is some confusion regarding our recent letter.

The problem relates to the difficulty of some patients being able to cover the up front cost to see a doctor after hours.

The medicare rebate for an after hours call out is $77.70 and with the gap payment that is charged the total cost is around $100. The problem that rural doctors face is that many people in the country do not have amounts like that on hand and do not have ready access to after hours cash. A large proportion of patients in rural areas are also health care cardholders and a large unexpected payment such as $100 would severely affect their budget. ***Patients in urban areas are able to seek after hours treatment at public hospitals for little or no cost and as such the rural patients are severely disadvantaged.***

There are two ways to address this issue. The first is by way of co payment of the cost. This would allow the patient to pay a smaller amount with the remainder being bulk billed to medicare. Whilst the majority of patients return medicare cheques promptly to the doctor, there is a substantial percentage who do not. The 90 day cheque replacement scheme has gone a long way toward overcoming this issue, however some of the cheques are negotiated, fraudulently (either intentionally or accidentally) by the patient. Should this scheme be introduced extension to the whole rebate system would be very cost effective for everyone concerned. (Please refer to the attached sheet for examples)

The second method of addressing the issue of people being able to receive urgent medical attention after hours, is to introduce a scheme whereby the hospital pays the doctors for the treatments provided. This would certainly address the issue of equity of access for rural people. We are aware that this method is already in place in some areas. It would of course raise the issue that hospitals are already in difficulty with budgetary problems and unless funding was allocated to them to cover this it would create more problems than it would solve. One of the potential problems would be the possibility of more patients seeking "free care" after hours. To ensure equity Australia wide this would necessitate at least 3 doctors being added to the staff at every hospital in Australia with a Accident and Emergency clinic to provide 24 hour care.

I hope that this clarifies the matter.

Yours sincerely

Dr Georgina Moore
Medical Director

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Examples of payment of Doctors

The scenario for the majority of patients (and this applies whether it is an in hours consult or an after hours consult) is that they go to the doctor, pay the gap, eventually receive the cheque and forward it to the doctor.

The practice staff collate the claim forms and post them daily to the HIC. The cost of this action is borne by the practice and while the amount of postage equates to around $2 a day it also involves sending a staff member to the post office to post the mail.

In a best case scenario there is a 4 week turn around between the patient seeing a doctor and the cheque being returned. The norm would be around 6 weeks.

Should there be a problem with the address that the HIC has recorded for the patient, then the doctor has to wait for up to 120 days for the actual receipt of the payment, provided the cheque has not been fraudulently negotiated in the meantime. Should this be the case, a phone call to the HIC invokes the response – "you will need to speak to the patient about this". In the instance that the patient has been a visitor to the area, they are generally not contactable or ignore correspondence.

Do you think that it is reasonable to be dragged out of bed at 3am in the morning, following 3 or 4 other call outs that evening, only to find out some 4 months down the track that you are not going to be paid for your efforts? This is the case when a cheque has been fraudulently negotiated and the patient cannot be contacted to seek a "proof of presentation" to find out where the cheque has been banked. As the HIC staff will not discuss the matter with practice staff.

We realise that the medicare refund system is regarded as a sacred cow but this needs to be re thought, as the problems outweigh the benefits.

Why is it that the PBS can operate on a co payment system with the patient paying a large gap (unless they are a health care card holder) and the doctors cannot?

We also realise that the medicare rebate is a reimbursement to the patient "not a payment to the doctor", however this is really splitting hairs, and a common sense approach could save the government millions of dollars annually. Cost savings for doctors would also occur, which could reduce the amount of the gap charged to the patient because of a reduction in the need to chase bad debts.

The 90 day cheque scheme has gone some way to addressing the problem for doctors but because of the problems listed above, it has not solved them.

To allow doctors to bulk bill a patient and charge a gap, would have benefits, to the HIC, the doctors and the patients. Benefits are as follows.

HIC

No one will need to open thousands of envelopes every day and collate the claims for processing. Once checked, the claims would supposedly move to the area responsible for cheque issuance – this would not be required. There would also not be a need for the printing of millions of envelopes and the postage savings would also be significant. The extra benefit would be a cancellation of the need of staff to monitor when a cheque has not been negotiated after 90 days and arrange for a direct credit to the doctors nominated bank account and post an acknowledgement out. (More envelopes – more postage).

The simplified process would be a claim for bulk bill, checking of items, and a payment of the bulk bill to the doctors account with details sent electronically. The cost saving in this area would be enormous.

Doctor

The doctor will receive prompt payment for services provided. There is no need for staff time to collate the claims, take the envelopes to the post office and pay for the postage. The need to chase bad debts will be all but non-existent, with subsequent savings achieved. The problem of visitors ignoring requests for payment would also be substantially reduced. The resultant reduction in the amount of red tape would be something that would certainly be appreciated by the doctors.

06/06/03

Patient

The patient would benefit by only having to cover the amount of the gap payment, with the medicare rebate paid directly to the doctor. The patient would not have to wait for the cheque (electronic claiming facilities are far and few in the country) to pay the doctor and would not have the additional responsibility of either posting or returning the cheque to the practice. Many of the patients are still reluctant to have refunds paid to their bank accounts or do not have the funds available to cover the full amount of the consultation to enable this to happen.

Cost would not be a major consideration in the decision to seek urgent medical help and the possibility of a tragedy from this would be averted. (GP care would always be provided in genuine emergency cases and the issue of cost would be followed up at a later time).

On Line claiming of refunds by patients.

The HIC is in the midst of attempting to implement on line claiming for patients at practices across Australia. This will benefit all patients who have the financial standing to be able to pay the account in full at the time of the consult, as the money will be credited to their bank account within 48 hours. It will have no benefit at all for the patients who do not have sufficient funds available to pay the account to the doctor at the time of consult.

The situation that you do not have sufficient funds available to visit a doctor (either in or after hours) would seem unbelievable to many of us, but unfortunately it is true. Many of the socio-economically disadvantaged members of the community have more pressing priorities for their funds (alcohol, cigarettes and poker machines unfortunately) than providing for their health.

This new method of claiming will therefore have no benefit whatever for doctors, with unpaid accounts still requiring the issue of a cheque and the need for the patient to return that cheque to the doctor.

A simpler method of dealing with the issue (if co payment with bulk billing is not acceptable) would be to send the pay doctor cheques to the doctor. If this method is preferred savings could still be obtained, by the HIC, by including all cheques payable to one doctor in the same envelope. This would create problems however for automated mailing procedures.

If any of the additional information provided requires further clarification, please ring David Holman at the Division office.

Yorke Peninsula Division of General Practice Inc
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28th May 2003

Dear Senator

Government Medicare Package

Our Division has been advocating for some time to encourage the Federal Government to allow GPs to charge patients a gap payment for their services, and have the medicare rebate directly to the GP's account. The Federal Government has partially addressed this issue with its new Fairer Medicare Package, but the attached strings make acceptance of the package unpalatable to the majority of GPs.

One major sticking point is the use of terminology that insinuates that the medicare rebate is a doctor payment. This is not the case. The medicare rebate is a patient payment as the debt for service or treatment emanates from the patient doctor relationship. The patient is responsible for payment to the doctor for the service provided, irrespective of the amount charged, and the patient is then reimbursed by the HIC. Should the doctor choose to accept only the medicare rebate as payment for services (which is already less than the Government set scheduled fee) that patient reimbursement can be made directly to the doctors' bank account.

The directive from the Government that you need to opt in and bulk bill all health care cardholders, or be ineligible, is annoying. Why should GPs provide discounted medical care to patients whose clever accounting practices allow them HCC access? This medical treatment, is already subsidised by the GP as only 85% of the scheduled fee is paid by medicare. Some patients arrive in the latest 4WD, send their children to college, and go on frequent overseas holidays. These rorters of the system make it hard to see why a GP should not be given the opportunity to decide who pays a gap and who doesn't. The majority of our GPs that currently charge HCC patients a gap, already have a safety net in place and use compassion when faced with patients who truly cannot afford to pay for services. They also do not charge a gap for brief consultations, test result discussion or for multiple family visits on the same day (or same week in some practices).

Surely the decision of who is and who is not eligible for discounted fees should be made by the medical provider who is in a good position to identify who is truly disadvantaged and who is not. Doctors are, by nature of their profession, very caring people who have never denied access to care to anyone who was unable to pay a gap, but unless this situation is resolved by the government, the future is far from certain.

The medicare rebate needs to be set at a realistic level and should be the same to a GP regardless of whether the patient is public or private. The issue of gap payments should be left to the discretion of the GP and if the medicare rebate is insufficient to meet the cost of the service, then the patient will need to pay the difference. Provided that the rebate is set at a reasonable figure and keeps pace with inflation, then the gap payments will always be affordable to the majority.

The situation for a pharmacist is much clearer, where the pharmacist always gets paid the same amount regardless.

While the idea of allowing a gap payment for private patients as a co-payment does have some appeal, our members cannot see why the private patient needs to "subsidise" Health Care Cardholders. A fairer way of addressing this issue would be to increase the medicare rebate and allow doctors to charge co-

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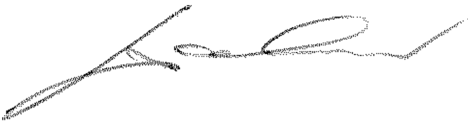
payments as determined by them. This co-payment could be capped for cardholders if thought to be necessary. Too high a co-payment would result in patients seeking care from other providers and a consequent drop in income for any GPs who sought to be too expensive. Market forces would govern maximum acceptable costs.

To continue the way we are going at present will rapidly see the majority of practices abandon bulk billing entirely and create further problems. Blended payments (PIP etc) are not the answer as many GPs are paid on a percentage of the income that they generate and the blended payments often are not passed on to the individual doctors by the practice owners. A main reason for this is that the payments are needed to support the viability of the practice.

I urge you to use you influence, and vote, to ensure that the better parts of the Medicare Package are adopted and that the inequities are addressed. Getting the package right is imperative and along with linked indexation of payments should go a long way toward solving these issues.

Yours sincerely



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06/06/03