MONASH UNIVERSITY

Health Economics Unit
Faculty:
Business & Economics
Director:
Professor J Richardson

THE UNIVERSITY OF MELBOURNE

'rogram Evaluation Unit
)epartment of Public Health
)irector:
ıssociate Professor D Dunt

'he Health Economics Unit nd the Program Evaluation Jnit undertake collaborative esearch and teaching ctivities as the Centre for lealth Program Evaluation. :ach Unit also conducts an ndependent research rogram.

CENTRE FOR HEALTH PROGRAM EVALUATION

18 June 2003

Committee Secretary
Select Committee on Medicare
Parliament House
Canberra

Dear Sir/Madam,

Re: Select Committee on Medicare

I have attached to this letter a brief commentary which I wrote at the request of The Australian Financial Review. It was published 6 May 2003.

I apologise for my inability to expand upon this commentary. Unfortunately the timing of the enquiry coincides with the completion date of a major report for the Commonwealth Department of Health and Ageing and also the lead up to the International Conference of Health Economists where most senior Australian health economists will be presenting one or more papers (6 in my own case!). This is unfortunate as the enquiry deals with an area of our core interest and expertise.

Briefly let me parenthesise some of the comments in the AFR article.

The immediate effect of the proposed changes should be separated from their long term significance. In the short run very little will happen. General practitioners and doctors more generally alter the important elements of their practice relatively slowly after a change in policy parameters and the immediate change in incentives will be small. In the longer run, however, the effects may be profound but this will depend upon government policy. The changes permit, but do not make inevitable, very significant structural changes.

The two important changes are those referred to in Terms of Reference c(i) and c(iv). Separation of the rebate for health care card holders from the rebate for other patients permits a government, so inclined, to preserve the integrity of the insurance for card holders while forcing general practitioners to increasingly extra bill because of a failure by government to increase the general rebate. The rising level of co-payments would be unpopular. It is for this reason that the reintroduction of private health insurance for out of hospital medical expenses (Terms of Reference c(iv)) is of significance. The private sector will be able to provide the insurance cover for the growing out of pocket expenditures. The thousand dollar ceiling has little significance. It may be changed overnight.

In sum, these two changes will create a mechanism for the easy transfer of expenditures from the public to the private sector. The process is further facilitated by the measure alluded to in Terms of Reference c(ii), viz, permission for patient co-payment at point of service.

Postal Address: PO Box 477, West Heidelberg Vic 3081
Street Address: 2nd Floor, Boronia Centre, Austin & Repatriation Medical Centre, Banksia Street, West Heidelberg Vic 3081
Telephone: +61 3 9496 4433 **Facsimile**: +61 3 9496 4424 **E-mail**: CHPE@BusEco.monash.edu.au
Web Site: http://chpe.buseco.monash.edu.au/

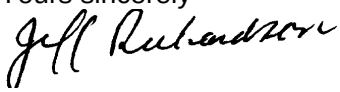
The prohibition of this at present discourages co-payments. Even a small co-payment results in administrative inconvenience for the patient who must seek reimbursement whether the co-payment is small or large. Removal of this impediment to co-payments will almost certainly encourage fees to rise.

There are a very large number of possible reforms which could usefully be considered. It is simply inefficient to use the general practitioner to carry out services in person which could be conducted by a nurse or by telephone. Present financial incentives ensure that these reforms will not spontaneously occur. With time there will be increasing pressure to limit co-payments to (non) core services. This suggests differential rebates depending upon the core or non core status of services which, in turn, may reflect both the cost effectiveness of services and their social importance. Present structures provide no incentive for best practice medicine. The GP is a highly efficient gatekeeper and this role could and should be extended and, in particular, to patients with chronic illnesses. Again, both organisational and financial incentives mitigate against this happening. A different structure of rebates could encourage family practice leading to the possibility of limited capitation payments for registered patients and reduced rebates for non-registered patients. These examples have in common a focus upon services and patients. In contrast the major restructuring of the fee schedules contemplated to date and reflected in the current enquiry focus upon fairness to GPs and the adequacy of their income.

With respect to the broader question of alternatives to the existing system of primary care (Terms of Reference (d)) there is a need for a thorough review of options in the context of a much enlarged enquiry. Present practise is not the outcome of rational planning or an on-going process of purposeful incremental reform. Rather it is shaped by an ongoing policy of appeasement of the medical profession and its determination to maintain financial, professional and organisational control of working conditions. This has resulted, *inter alia*, in the maximisation of professional and personal choice for medical practitioners and a glacial rate of change in the structure of incentives, geographic distribution and professional practice. As with most problem areas in the delivery of medical services there has been a woeful level of health service research reflecting the absence of any coherent plan for a research structure in the last 50 years, a situation which persists today. Rational national management of health services would ensure the collection and analysis of the data needed to identify problems and solutions on an ongoing basis. At present much information is collected but it is very largely ignored.

I trust these comments may be of interest.

Yours sincerely



Jeff Richardson
Professor and Director
Health Economics Unit
Centre for Health Program Evaluation

enc