Submission to the Senate Select Committee into Issues relating to Access and Affordability of General Practice under Medicare

RURAL DOCTORS ASSOCIATION OF AUSTRALIA

Caring for the Country

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Senate Select Committee into Issues relating to Access and Affordability of General Practice under Medicare

Recommendations

The Rural Doctors Association of Australia (RDAA) believes this Inquiry presents an important opportunity to address anomalies in Medicare in order to bring its operation at the beginning of the 21st century into line its stated principles and community expectations.

As set out in the attached submission, RDAA contends that this must be done through equitable adjustments to the patient rebate which is a fundamental mechanism of MBS.

RDAA therefore recommends that:

1. **The standard Medicare patient rebate be increased in order to cover the cost of the medical service provided.**

2. **A differential rebate, in the form of a rural consultation item number or a loading added to the standard rebate for services provided in communities of less than 25,000 people (RRMAs -4-7) be paid in order to cover the extra costs of medical care in rural and remote Australia and meet the higher healthcare needs of rural and remote communities.**

3. **Increased levels of bulk billing in rural and remote Australia be supported by maintaining and extending strategies to recruit and retain rural doctors, with an increasing emphasis on a continuum of support from medical school to rural general practice.**

4. **Access to direct electronic rebate claiming be made available to all rural GPs by February 2004.**

5. **The strategies in the Government's A Fairer Medicare package designed to increase the rural medical workforce be considered separately from the proposed incentives to increase bulk billing rates.**

RDAA believes that these strategies include a number of valuable proposals, for example the establishment of new medical school places, that are too important to be linked to other initiatives in a way which could preclude the rigorous examination they deserve.

SUBMISSION TO THE SENATE SELECT COMMITTEE ON MEDICARE

1. Rural Doctors Association of Australia

The Rural Doctors Association of Australia (RDAA) was formed in 1991 as an organization to give rural doctors a national voice.

The RDAA is a federal body with seven constituent members - the Rural Doctors Associations (RDAs) of all States and the Northern Territory. Each State has two delegates on the Board of Management of the RDAA, one of whom is president of the autonomous State/Territory association. The Board meets monthly through teleconferences which non-voting delegates with special expertise are often invited to attend. Each State/Territory association works and negotiates with relevant bodies in its own jurisdiction, while the RDAA Board of Management, supported by a small national secretariat in Canberra, has overall responsibility for negotiations with the Commonwealth and working with national bodies and decision makers.

In keeping with the overall demographic profile of the rural medical workforce, most of those in the Rural Doctors Associations across Australia are general practitioners and most are men.

The RDAA has a particular focus on industrial issues and seeks to promote the maintenance and expansion of a highly skilled and motivated medical workforce which is adequately remunerated and supported in order to provide quality medical care to the people of rural and remote Australia. Much of its work therefore concentrates on recruitment and retention issues and the viability of rural general practice. However, the RDAA is also an active participant in policy development on priority issues including Indigenous health, health financing and advanced nursing practice.

2. The health of Australians in rural and remote areas

Internationally, Australia ranks close to the top of those countries which enjoy good and improving health. However, the overall statistics mask persistent inequalities between parts of our population. Indigenous Australians, people of lower socio-economic status and those who live in rural and remote areas experience higher rates of morbidity and mortality than others. While the causes of this disparity are complex and diverse, less access to medical care because of the shortfall of doctors in rural and remote Australia is certainly a significant factor.

General practitioners (GPs) are "the hub in the wheel" of primary health care. Estimates of the general practice workforce vary widely, but recent research suggests that there is a shortfall of approximately 16% - 18% in rural and remote areas. Nearly half (44%) of the rural population lives in an area of severe shortfall.[1]

[1] Access Economics (2002). *An analysis of the widening gap between community need and the availability of GP services.* A report to the Australian Medical Association. Canberra, AMA

Therefore initiatives which aim to support and improve the health of those who live in the bush must include components which encourage the recruitment and retention of an adequate medical workforce.

They must also take into account the generally lower socio-economic status of people in most rural and remote areas. Twelve of the 20 least advantaged federal electoral divisions are classified as rural or remote. Thirty-six of the 40 poorest areas of Australia are rural or remote. Analysis using the Socio-Economic Indexes for Areas (SEIFA) shows that whether measured by indices of advantage and disadvantage, economic resources or education and occupation, people who live in the cities are generally better off than those who live elsewhere.

3. Medicare

The RDAA supports Medicare. It also acknowledges the need for change in a changing environment and has been advocating for adjustments to the system for some time. However, RDAA believes that all modifications must be grounded in the principles on which Medicare was based and must be targeted to promote universal and equitable access to general practitioners. They must depend on leverage through the rebate which is the fundamental mechanism of the system rather than initiatives which undermine the paradigms and practical effect of the system through piecemeal tinkering.

RDAA believes that reform is bound to fail unless it is based on a restructure of the rebate. This restructure must include an increase to bring the rebate into line with the current costs of medical service provision and a shift from the political and professional paradigm which regards an equal Medicare rebate for all as an immutable component of the health care system. The standard rebate has not kept pace with costs and an equal rebate no longer reflects the principle of equity or maintains the universality and access on which Medicare was based.

This enquiry represents a long awaited opportunity to take into account higher need and higher costs in rural and remote Australia and to make Medicare fair and meaningful for all Australians.

Medicare was designed to support the health of all Australians through a funding system based on five key principles: universality, access, equity, efficiency and simplicity. Its fundamental strategy is a standard rebate to consumers to ensure they can access primary medical care.

However, the standard Medicare rebate is based on urban cost structures and consultation content. It is insufficient to cover the higher costs of rural practice and thus acts as a disincentive to recruiting and retaining rural doctors. Rates of bulk billing have therefore fallen in country areas where patients whose health needs may be greater have to pay more for the services they need.

Universality within Medicare is often misunderstood to mean that all Australians have guaranteed access to bulk-billing. No such right is embodied in relevant legislation or

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[2] Elliot A (2003). Is Medicare universal? Research Note 37/2002/03. Canberra, Parliamentary Library

policy documents. Whatever the aspirations of those who designed Medicare and its predecessor Medibank, universal bulk-billing has never been guaranteed. Indeed, the "civil conscription" clause in the Constitution would probably prevent any government from enforcing bulk-billing. Medicare is a national insurance scheme, rather than a national healthcare system like the British National Health System. The pivotal component of the scheme, the rebate, is a payment to those who need to use Medicare, not to those who provide the service.

As the Commonwealth Parliamentary Library noted recently: *Despite the importance of bulk billing to Medicare, a decline in bulk billing does not necessarily challenge the universality of Medicare.*[2]

The universality of Medicare lies in free (at point of service delivery) and equal access to public hospital services and universal access to the insurance cover provided by the Medicare rebate. Community confusion and mis-informed or misleading public statements often present bulk billing as a right or socio-political marker rather than an indicator of market forces. While the level of bulk-billing is influenced by other factors – ideology, altruism and capacity to pay, for example - the critical factor is supply. The lower rates of bulk billing in rural areas reflect the higher costs of supplying medical services there, exacerbated by a shortfall in the supply of service providers. Thus halting and reversing the bulk billing decline in rural Australia can only be achieved through strategies which respond to the higher cost structures and workforce shortages there. Incentives to shift access to the rebate from a universal to a selective population would undermine the system while failing to address the underlying causes of the decline.

However, universality is challenged if, in practice, there is a mal-distribution of the benefits of Medicare. Though Medicare may theoretically be available to all, the 28% of the population which lives in rural Australia receives about 21% of the rebates for general practice services. On the basis of population and HIC figures for 1999-2000, it has been estimated that the average per capita Medicare benefit paid in metropolitan areas was $125.59, compared to $84.91 in other parts of Australia. This suggests that approximately $221,009,162 of the Medicare levy collected in non-urban areas flowed back to subsidize metropolitan services.[3]

Access to medical services in rural areas is the limiting factor. It is estimated that while there are approximately 306 medical practitioners per 100,000 patients in metropolitan areas, the ratio is 143 per 100,000 in other parts of the country.

> *The concentration of medical practitioners in metropolitan areas results in inequitable access to services elsewhere and as a consequence, the Medicare rebate which is repatriated to non-metropolitan areas is significantly less…In short, the Medicare levy which is collected from all Australians …regardless of where they live is not repatriated to all Australians equally.*[4]

[3] Wagga Wagga City Council (2003). Medical services in rural, regional and outer metropolitan areas in Australia. Unpublished

[4] *ibid.*

Thus reforms which assume that higher rates of bulk-billing will increase access to medical care overlook the fact that in rural and remote areas, access is limited not by [6]the cost to the consumer, but by the shortage of medical practitioners. The rural market for medical services is relatively inelastic in terms of both supply and demand. Therefore the most effective leverage will be achieved by enhancing the attraction and viability of rural general practice through a higher rebate in these areas.

RDAA has been advocating for a differential rebate for rural Australians for some years.[5] Gradually others have come to the view that equal rebates may not be equitable. Some now believe that those who experience greater socio-economic disadvantage should receive a higher rebate. RDAA agrees with this analysis, but believes a differential rebate on socio-economic grounds (as a proxy for lower health status) alone would be very difficult to apply nationally. However, as both the rate of socio-economic disadvantage and the cost of delivering medical services are generally higher in rural and remote Australia, the application of a rebate based on existing geographic classifications of rurality and remoteness would be manageable and help address the needs of 28% of the population whose lower health status is aggravated by lower access to medical services.

Equity relates to two aspects of Medicare. Its costs are covered from general revenue. Only a small component, approximately 23%, of these costs is raised by the Medicare levy which is paid as a percentage of taxable income. Equity is thus enshrined in proportional individual input. However, the widespread belief that this levy creates a quarantined pool of funding sufficient to pay for Medicare confuses informed public debate on the system.

As a Western Australian researcher wrote recently:
There are also different ways of conceiving of equity. For example, horizontal equity is about the equal treatment of equal, while vertical equity is about the unequal but equitable treatment of unequals. [6] Vertical equity is clearly the key to a fairer Medicare.

In terms of vertical equity, the outputs of the system must be distributed in such a way that those with higher healthcare needs receive rebates commensurate to these needs and appropriate to their environment. However, it is simplistic to assume that all those who have a higher need for care and a lower capacity to pay for it are covered by concessional health care cards. The current estimate of approximately 7 million cardholders – or about one-third of the total population – suggests the integrity of the healthcare card is open to doubt. Conversely, rural doctors who are part of the communities in which they practice know that there are many individuals and families who do not have health cards but whose income is insufficient to meet their medical service needs.

The National Centre for Social & Economic Modelling (NATSEM) at the University of Canberra has estimated that people in the lowest socio-economic quintile (Quintile 1) spend between 7.2% and 9% of their after- tax income on subsidized Pharmaceutical Benefits Scheme (PBS) drugs, as compared to approximately 2% spent by families which

[5] RDAA (1999). RDAA responses to Regional Australia Summit. Theme 3: Health. Canberra
RDAA (2001). Rural Consultation Item Numbers Information Pack 2001. Canberra
[6] Mooney G (2003). Inequity in Australian health care: how do we progress from here? *Australian & New Zealand Journal of Public Health* **27:**3

have concessional cards. Quintile 1 includes *the 'working poor', including the 40-64 year olds (35%) who may have worked in casual jobs, moved in and out of the workforce, and earned just above the cut-off levels for government benefits.*[7]

This already disadvantaged group, which is likely to suffer from the higher health care needs associated with lower socio-economic status, may be subject to double jeopardy under the present proposals. A scheme which subsidizes care for the neatly defined group of cardholders may, in the context of high practice costs, constrain the capacity of doctors to continue to bulk-bill many other needy patients who are not cardholders.

Targeting some of those with high health care needs in a way that makes others more vulnerable is unfair. It is also inconsistent with current research which identifies the gap between the rich and the poor in a society as a strong indicator of health status. In Australia, as elsewhere, this gap is widening.[8] Access to medical care is crucial to prevent a decline in the overall health of Australians and to support health status which facilitates participation in economic, social and educational activities which in turn contribute to good health.

Efficiency in the expenditure of Medicare funds suggest the benefits of allocating what is estimated to be an under-spend of between $220 million and $250 million in rural and remote areas to supporting the health and vitality of individuals and communities in these areas.[9]

The Commonwealth's Relative Value Study (1995 -2001) demonstrated that the Medicare rebate has long needed a very substantial increase to bring it into line with costs in the medical profession and parity with other professions. Without this adjustment, the future of the bulking billing component of Medicare and the viability of rural general practice must be in doubt.

Simplicity would be served by a differential rebate for medical services delivered within the boundaries defined by appropriate classifications already in place. It has been estimated that the cost of higher rebates payable to those in smaller rural centres, other rural areas and remote areas (RRMAs 4-7) would cost about $80 - $120 million annually – or less than the shortfall noted above.

4. The impact of the current rate of the Medicare Benefits and Practice Incentive Payments on practitioner incomes and the viability of bulk-billing practices

The Medical Benefits Schedule (MBS) rebate is not adequately indexed. Nor is any other system in place to ensure it keeps pace with current costs. High levels of bulkbilling are unlikely to generate sufficient income to maintain quality health care in a country practice. A heavy reliance on bulk billing would jeopardize the viability of many practices. Some

[7] Walker A (1999). *Distributional impact of higher patient contributions to Australia's Pharmaceutical Benefits Scheme*. NATSEM Discussion Paper 45. Canberra

[8] Spurrier NJ, Sawyer MG, Clark JJ & Baghurst P (2003). Socio-economic differentials in the health-related quality of life of Australian children: results of a national study. *Australian & New Zealand Journal of Public Health* **27**:1

[9] Stratigos S (2002) - *Equal is not equitable: Medicare in the bush*. Canberra, RDAA

rural practices have calculated they cannot sustain a level of bulk billing higher than 10%. Research soon to be released by the RDAA in association with Monash University indicates that the costs of rural general practice, and, in many cases, the level and complexity of services they provide, are significantly higher than in urban practice. General practice income is based on fee for service, and if this does not keep pace with expenditure and generate a sufficient surplus for those who provide the services, they will succumb to other negative factors and leave the bush.

The success of the RDANSW Rural Doctors Settlement Package in attracting and retaining doctors who work in rural hospitals indicates that agreed conditions and an indexed financial support scheme works well when it guarantees adequate remuneration and recognizes the value of the service provided. Since its inception in 1987, its scheduled fees have gradually risen from 85% to 130% of the MBS fee. The adoption of similar models in other states would help minimize workforce deficits.

The value of Practice Incentive Payments (PIP) is recognized and appreciated. They are a significant acknowledgement of the value of rural medicine as well as a practical and effective response to recruitment and retention difficulties. Unlike the Service Incentive Payments (SIP), RDA members generally find the system user friendly. *It's the SIP payments and the convolutions around qualifying and claiming that are very messy*.[10] However, incentive programs which are highly valued by rural practitioners can be subject to political change and pressures driven by urban perspectives.

The following response from a rural doctor in Victoria encapsulates the issues raised by many others.

> *In our practice we calculated two years ago that our underlying costs per consultation were $19. Bulk billing was thus not an option, as we were going broke! We subsequently completely abandoned reliance on rebates.*
>
> *Since abandoning bulk billing 2 years ago, we have been able to afford to purchase capital equipment including a new ECG ($3,000), a spirometer ($2,000), and a (second hand) combined automatic BP/ECG/O2 sat machine ($2,000), as well as upgrade our computer systems at a cost of approx $14,000 in equipment, and additional licence fees of approx $15,000. None of this would have been possible as a bulk billing practice.*
>
> *We are now more efficient in terms of access to up to date information and patient records and have a greater range of services for our patients. We have expanded the role of practice nursing, with three nurses employed to equivalent of 1 and a half FTE. This role is shortly to expand further when our planned clinic extension and extra consulting rooms are finished. Our clinic has employed a practice nurse for over 40 years, and we began to extend the role prior to the government's nursing initiative.*
>
> *We have attracted another partner to our practice in the last 6 months.*
>
> *We charge pensioners and health care card holders a discounted fee, and apply "compassionate discounting" ie the Medicare rebate, to those we deem in financial hardship, and also to DVA patients. Our clinic expects to compassionately discount approximately 10% of our services. We believe this is an achievable level financially. We will continue to provide*

[10] KM, rural GP, NSW, *pers com*. May 2003

compassionate discounting to those who cannot afford to pay. At 10% of our fee base, we can absorb these financially marginal consultations into our overall fee structure. In effect our fee paying patients are subsidising the medical care of these people.

Returning to bulk billing would seriously affect our ability to maintain this level of service. Ultimately the private fee would need to increase further, and we would have to reduce the nursing role and capital investment in our practice. This is what seems to happen in exclusively bulk billing practices.

As a rural practice, our costs are also considerably greater than in urban areas. All calls are STD, we have no ADSL internet, fuel is more costly and distances are greater. IT support visits demand travel time and overnight accommodation.

The idea of a universal rebate across Australia is simply not sustainable, and denies rural practices the capacity to bulk bill greater numbers of patients.

This is as much a factor in producing a lower bulk billing rate in rural Australia as our workforce limitations. As we get more remote, the costs of running a practice increase, the number of doctors decreases and the economies of scale in larger practices are lost, further exacerbating the cost of running a practice. It is really not surprising that rural bulk billing rates are low.[11]

5. The impact of general practitioner shortages on patients' ability to access appropriate care in a timely manner

The shortage of rural doctors and its impact on patient choice and waiting times is too widely recognized to need documentation here. As noted above, it is this shortfall in supply rather than access to bulk billing which restricts the access of rural patients to their fair share of Medicare payments.

The availability of a country doctor to see patients in the practice is also constrained by other professional commitments. Most rural doctors spend a proportion of their working time (ranging from 10% to 70%) providing acute care in the local hospital. This responsibility does not apply in urban areas where hospitals carry their own staff and other health care services are available to complement the range of care – acute, routine and preventive - which the country doctor has to provide without local backup.

A country GP wrote:

> *In our practice it is not unusual for patients to wait days to see their doctor of choice though we always have an on-call doctor on roster so emergency visits can be accommodated on the day.*
>
> *The single biggest factor in our ability to attract further doctors has been our abandonment of bulk billing. This has enabled us to expand our service to accommodate a further two doctors, and will allow us to build an extension of our practice building, which we own.*[12]

[11] GS, procedural GP, Victoria, *pers.com*. May 2003
[12] *ibid*

6. The likely impact on access, affordability and quality services for individuals, in the short- and longer-term, of incentives for free care from general practitioners limited to health care card holders or those beneath an income threshold

RDAA estimates that approximately 15% of members of the Rural Doctors Associations across Australia will take up the initiative. Their decision to do so will depend on analysis of potential monetary benefits in the context of specific financial pressures. Some will eschew the initiative on philosophical grounds, while others are likely to find the financial gains illusory. For example, doctors in areas of generally low socio-economic status may have such a significant proportion of cardholders on their books that the proposed CPI indexing will not be adequate to maintain the practice at an acceptable level. One doctor wrote to RDAA: *If I bulk bill all health card holders, that's probably 80% of my patients*.[13]

The importance of practice income on providing quality services has already been highlighted. Those who calculate that their capacity to provide quality care requires a higher level of payment than that proposed by government will not change at this point.

It is therefore problematic to assume that these proposals will achieve a positive outcome for rural patients. On the other hand, it is not difficult to predict that the proposed interventions will sap workforce morale, aggravate uncertainty and threaten financial viability and so diminish interest in investing in rural practice, and even in remaining in it.

Thus access will be decreased as the workforce shrinks and fewer doctors are able to maintain bulkbilling or low fees.

7. A change to bulk-billing arrangements to allow patient co-payment at point of services co-incidental with direct rebate reimbursement

This could certainly improve the situation for patients of practices which take up the initiative. However, feedback from all GP organizations suggests only a minority will find it helpful or acceptable, leaving other patients without this benefit. This will be particularly unfair if it affects people for whom the practice can no longer afford compassionate discounting. Medicare was not meant to operate through options which advantage some groups above others.

Those practices that can raise their levels of bulkbilling to include concessional card holders will benefit from improved cash flow and possibly lower administrative costs.

However, the amount so far proposed to assist with the costs of the necessary technology will not cover them in many rural areas. Some practices have found these to be as high as $30,000. As with others parts of the proposed package, this incentive links strategies which deserve separate consideration. In this case, the government asserts it has the capacity to have an electronic reimbursement system in any practice in Australia regardless of location. Rather than using this as a carrot to reward selective practices and their patients, government should use this capacity to ensure all rural practices have access to technology to support the provision of quality care and ease cash flow problems.

[13] SR, rural GP, *pers com*, June 2003

There has been considerable discussion of the impact of this strategy on practice charges. This is hard to gauge. There is talk of significant rises in gap payments. However, many rural communities cannot afford to pay more. The culture of rural general practice has generally supported a level of payment which is fair and feasible in its environment. RDAA believes that these two factors are likely to act as a self-regulating cap on gap payments.

8. A new safety net for concession cardholders only and its interaction with existing safety nets

As already indicated, a safety net or targeted subsidies for concession card holders is inequitable and unfair to others: "the battlers" and working poor who find it hard to meet healthcare costs yet are not eligible for healthcare cards. This group, which shares the lowest socio-economic quintile with most cardholders, includes young families, vulnerable individuals and the younger members of senior cohorts.

RDAA believes that if approximately one-third of the Australian population legitimately requires a health concession card, then our social, economic and health policies are in need of more fundamental overhaul than this flimsy safety net.

9. Private health insurance for out-of-hospital out-of-pocket medical expenses

Some have suggested that it would take a much higher than usual number of episodes of GP care to reach the point where the safety net comes into play and speculate that charges could rise in response to this. Others believe that fostering further dependence on the private health insurance system is inappropriate in relation to the provision of a public good.

Though the cost of this insurance is said to be low now, it is likely to rise if uptake rises and a high of those insured claim against it. This would be unfair to rural consumers whose use of services covered by insurance is much less because less of them are available in the country, a fact which now contributes to lower rates of private health insurance in country areas.

10. Alternatives in the Australian context that could improve the Medicare principles of access and affordability, within an economically sustainable system of primary care, in particular whether the extension of federal funding to allied and dental health services could provide a more cost-effective health care system

As it stands, Medicare apparently cannot afford to pay patients a rebate which covers the cost of their medical services. Extending it to other healthcare services would clearly reduce the amount available for GP services, unless significant extra funding were provided. This seems highly unlikely, so any extension would reduce the access to comprehensive GP care. If more funding is available, positive discrimination in favour of those in need of more medical care should be prioritized. As general practice is the gateway to all forms of healthcare for most Australians, it would then be feasible to extend

support for models of practice nursing and allied health services and GP led team-based advanced nursing practice.

RDAA supports the Federal Minister's strong emphasis on disease prevention. Rural doctors are increasingly expected to play a role in public health and population medicine, but as a leading researcher wrote recently:

> *Primary care physicians [are] naturally expected to play a major role in [these areas] but current remuneration packages make it very difficult for our general practitioners to give an appropriate amount of time to address lifestyle issues with those who most need that advice*.[14]

11. The implications of reallocating expenditure from changes to the private health insurance rebate

As already noted, lower access to relevant services means uptake of private health insurance is lower in rural than urban Australia. The needs of rural consumers would thus be better addressed by the diversion of this subsidy to prevention and curative health care services. Like the 79% of people whose opinion on tax cuts was sought recently, many rural Australians would rather see this money allocated to locally accessible healthcare.

12. Alternative remuneration models that would satisfy medical practitioners but would not compromise the principle of universality which underlies Medicare

The greater majority of GPs support Medicare in principle while acknowledging the need for reform. Most would prefer to work within an adjusted Medicare system to being subjected to a new system. RDAA sees three main areas where feasible modifications could make the system fairer and more efficient. These are:

- bringing the standard rebate into line with current costs;
- the establishment of a differential rebate for rural residents which would follow on from this; and
- changes to MBS Schedule to improve access to after hours care, preventive medicine, practice nurses and the Mental Health Initiative.

This paper is not the place to discuss these last matters in detail, though RDAA would be happy to do so should the Senate Committee find this useful.

The Relative Value Study (RVS) has already supported the case for increasing the rebate. This lengthy in depth review of the MBS was designed with a specific focus on equity and the stated intention to "remove perverse incentives" from its operation. All the bodies representing general practitioners have been advocating the implementation of the RSV since its completion. While some of its coverage of rural costs is problematic, the incremental implementation of the Study's recommendations would effectively raise bulk billing rates in a way which is consonant with the principles of Medicare and the needs of patients and doctors.

General medical practice varies according to its setting and population intake and country practice is different from urban practice in a number of ways:

[14] Dwyer J (2003). Opinion piece. *Australian Financial Review* June 12 2003.

> *Rural doctors carry a higher level of clinical responsibility and provide a wider range of services in relative isolation…Certainly rural doctors live and work in a different world from their urban counterparts. The psychology and sociology of rural communities are markedly different from the cities. Also the spectrum of illness and injuries with which rural doctors have to cope is specific to rural areas, and the structure and process of health services in the country are quite different.*[15]

In practical terms, these differences imply higher practice costs related to both the broader spectrum of clinical activities and operating a small business in rural and remote areas. For example, rural doctors are more likely to be in solo practice than their urban counterparts. Many small communities cannot sustain more than one doctor who therefore cannot benefit from economies of scale available in group practices. They are much more likely to be involved in procedural work - notably obstetrics, surgery anaesthetics and accident and emergency services. Without easy general access to specialists and other healthcare providers, rural doctors have to manage more, and more complex, matters than their urban counterparts. There is mounting pressure on rural practices to provide extended health services which emphasize prevention and community health, though these time consuming activities, that entail increased expenditure on staffing, infrastructure and facilities attract little or no remuneration.

Transport, communications and many consumer items generally cost more in the country. Locum relief, for example for professional development, may cost up to $5,000 a week. While the direct costs of renting or buying professional and domestic accommodation may be lower outside capital cities, property often represents a poor or negative return on the investment. The opportunity cost of losing the second income which is now the norm in Australian households often arises when a spouse cannot find suitable employment. Education costs are high if children have to be sent away to school or university.

It is difficult to quantify the cost differential between urban and rural practice, given the great diversity within each category. The economic environment in which rural practice operates can be extremely sensitive to external events like airline collapse or the withdrawal of other services and facilities. RDAA has estimated their members' practice costs to be double those of their urban counterparts. This calculation was based on figures including higher transport and communications costs, limited opportunities for economies of scale, higher costs of practice consumables, staff award rates for rural and remote areas and costs of both locums and travel for professional development. In some cases, the need to run branch practices or outreach clinics should be added to this list.

Economic uncertainty is one of the reasons many young doctors avoid rural practice. It is more profitable to work in the cities.

The cost and complexity of rural medical practice needs to be recognised and rewarded in the remuneration accessed by rural doctors through the MBS. This could be done through the establishment of a Rural Consultation Item Number (RCIN).

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[15] Strasser R (1995). Rural general practice: is it a distinct discipline? *Australian Family Physician* **24**:5

This strategy is advocated by RDAA based on current research and the practical experience of rural doctors across the country.[16] It would address both the complexity of rural medicine and the higher costs of service provision in rural and remote areas. It would also create a financial incentive which will assist in recruiting and retaining rural doctors and improving health outcomes in rural and remote areas. This is far more likely to be effective in the long run than a coercive bonding system.

At an estimated cost of $120 million, RCIN would be a manageable strategy to introduce the differential rebate which is now being thought of as a means to more equitable access to Medicare. It would also give people in rural and remote Australia a fair share of Medicare.

Another way to achieve this, at approximately the same estimated cost, would be to introduce a MBS loading for services supplied in certain rural areas. Under this option, Item Numbers would not change, but a loading would be added to the item where, for example, the service is generated in communities of less than 25,000 people (RRMAs 4-7).The loading should increase with remoteness and apply to both general practitioners and specialists. This option would be simple to initiate and administer and would minimize contention within general practice organizations.

RDAA contends that higher Medicare reimbursement for rural patients is the best way to address the declining rate of bulk billing in country areas and at the same time remove one of the barriers to viable rural medical practice.

> *At the end of the day we run a small business, we charge for our services and Medicare provides a method of reimbursing patients for those services. If the rebate was set at a level that allowed medical practices to be financially sustainable, then the bulk billing rate would increase. After all this is what happened when Medicare was introduced. It is only in the last few years as the Medicare rebate fell below any reasonable indexation and cost basis that GP's have had to raise their fees to remain viable.*[17]

[16] Mildenhall D, Mara P, Chater B, Rosenthal D, Maxfield N, Boots A, Humphreys J, Jones, J & Jones M (2003) – Sustaining healthy rural communities through viable rural medical practices. Paper presented at the 7th National Rural Health Conference, Hobart. [Copy attached]

[17] GS, procedural GP, Victoria. *per com* June 2003