AUSTRALIAN SENATE

Select Committee on Medicare

Inquiry into

The access to and affordability of general practice under Medicare

Submission of the

Commonwealth Department of Health and Ageing

Commonwealth Department of
Health and
Ageing

TABLE OF CONTENTS

FIGURES & TABLES

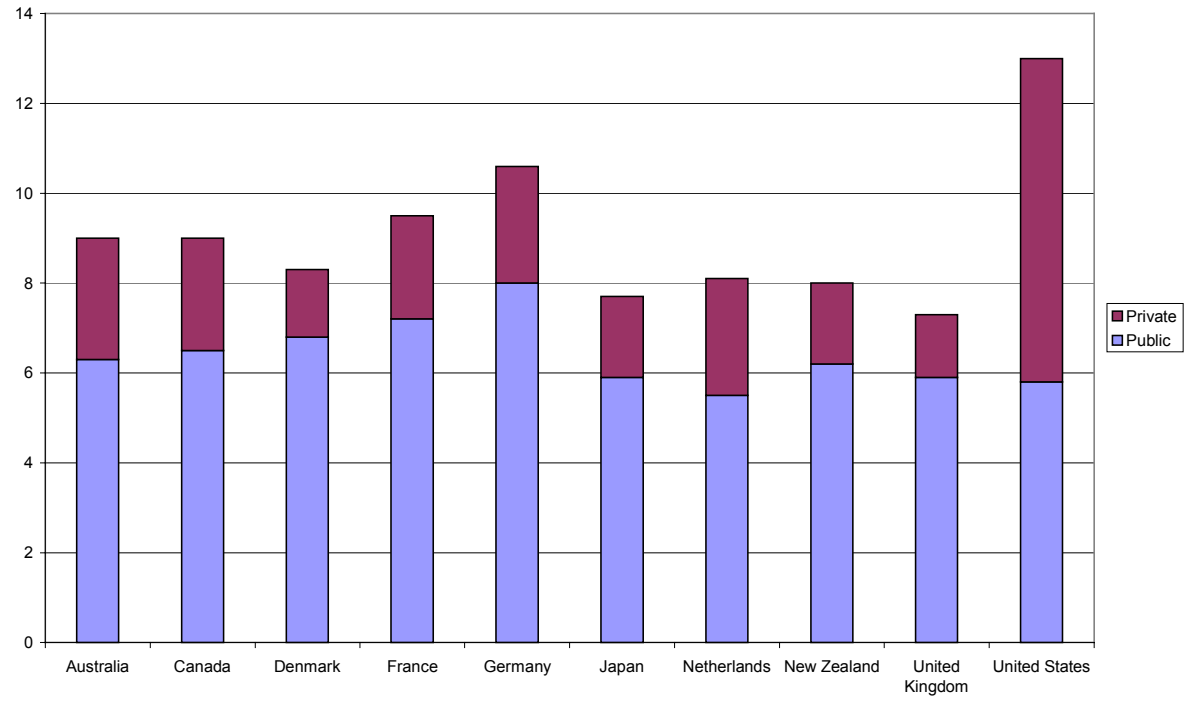
1. THE AUSTRALIAN HEALTH SYSTEM

Australia's health system is world class, supporting universal access to medical, pharmaceutical and hospital services that are high quality and affordable, while helping people to stay healthy through health promotion and disease prevention activities.

In 2000/01, total health expenditure in Australia was more than $60,800 million, equivalent to 9 percent of Gross Domestic Product (GDP) - sixth overall when compared to other OECD countries.

Figure 1 shows health expenditure, both public and private, as a proportion of GDP, in Australia and nine OECD countries. In general, these countries spend a similar proportion of GDP on health and have similar ratios of public to private sector spending. The exception is the United States, where health spending comprises around 13 percent of GDP, distributed more or less evenly between the public and private sectors.

Figure 1 - Health Expenditure from Public and Private sectors, as a Percentage of Gross Domestic Product, Australia and selected OECD countries, 2000/01



Australia's health care system has been built on a foundation of mixed public and private sector financing and provision.

1.1. Commonwealth Government

The public or government sector assists individuals with their health care costs, and directly funds health services. Medicare is the major way that this occurs. Medicare has three pillars: the Medicare Benefits Schedule, the Pharmaceutical Benefits Scheme and the Australian Health Care Agreements[1].

Medicare is financed largely from general taxation revenue, supplemented by a Medicare levy of 1.5 percent of a person's taxable income. $4,605 million was collected from this levy in 2000/01, equivalent to around 16 per cent of the Commonwealth government's expenditure that year on health.

The Commonwealth and State/Territory governments have different roles in the Australian health system. The private sector also has an important role.

The Commonwealth government directly supports patient access to affordable health care, through the Medicare Benefits Schedule and Pharmaceutical Benefits Scheme. These elements of Medicare subsidise patients for the costs of services and therapies delivered predominantly by private practitioners and suppliers. In 2000/01, the Commonwealth provided just over $12,000 million to subsidise access by individual Australians to medical and pharmaceutical services.

In addition, the Commonwealth provides funding to State governments to ensure access to free public hospital services. From 1998-2003, some $31,800 million was provided to the States through the Australian Health Care Agreements. Over the coming five years, $42,000 million has been offered, an increase of 17 per cent in real terms.

The Commonwealth takes a leadership role in areas of national policy significance including protecting the overall health and safety of the population, improving access to health services by the Aboriginal and Torres Strait Islander population, guiding national research and evaluation, trialing innovative service delivery approaches and coordinating information management.

As well, the Commonwealth aims to ensure there are enough doctors and other health professionals to meet community needs, and that they are located where most needed.

1.2. State/Territory and Local Governments

The State and Territory governments provide public hospital infrastructure and services, including in emergency department and outpatient settings, and are the major providers of community based health programs. Public dental services and allied health services have traditionally been a State government responsibility and continue to be so, either through the public hospital system, or through State funded community health services.

There are many examples in the health sector of the Commonwealth and State/Territory governments cooperating effectively in areas of shared interest. A range of jointly funded and administered programs operate including in such areas as Home and Community Care, population screening and the supply of blood and blood products.

[1] Further description of these three elements of Medicare is at Section 1.4 below.

Other areas of shared activity are underpinned by jointly agreed approaches such as the national tobacco campaign, and the national mental health strategy. There is also shared participation in time-limited trials that aim to effect some longer term system change such as GP/Hospital Integration Demonstration Programs, models of After Hours Primary Medical Care and Coordinated Care Trials.

The local government sector also delivers health programs, often contributing a portion of funds through cash or 'in-kind' contributions.

1.3. Private Sector

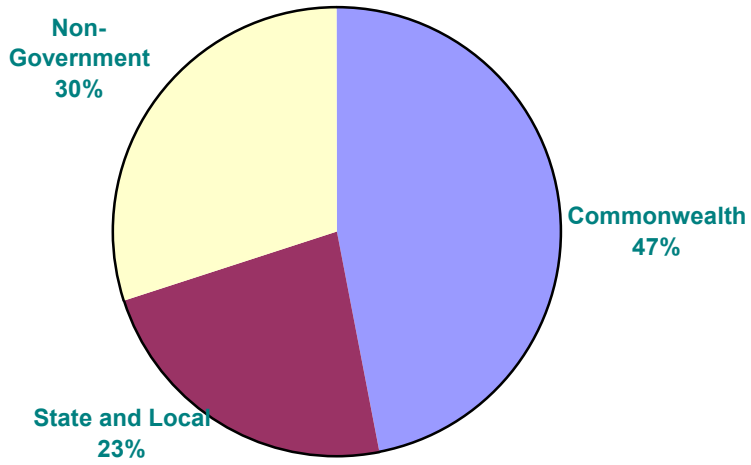
Within the Australian health system, the private sector delivers a significant proportion of primary, specialist and allied health care through a medical workforce that includes general practitioners (GPs), specialists, pharmacists, physiotherapists, dentists and the like.

In Australia, the Commonwealth's contribution to health funding provides universal access to affordable, quality services under Medicare, while allowing choice for individuals through a substantial private sector engagement in the delivery and financing of health services. The private sector operates private hospitals and, through health funds, offers private health insurance.

People have a choice whether to attend private or public hospitals. From 1999/2000 to 2001/02, there has been an increase of 16 per cent – or an extra 400,000 patients – using private hospitals.

Access by individuals to private providers – whether medical practitioners, diagnostic services or private hospitals - is often heavily subsidised through Medicare and private health insurance. Figure 2 illustrates the contributions of the government (Commonwealth, State/Territory and Local) and non-government sectors to total health spending in 2000/01.

Figure 2 - Health Expenditure by Sector



Source: Health Expenditure Australia 2000-01, AIHW, p18.

1.4. Three Elements of Medicare

Through Medicare, Australians access universal health care.

Medicare Benefits Schedule

The Medicare Benefits Schedule (MBS) offers patients subsidies for the costs of privately provided medical services. It provides direct financial assistance to patients, through access to rebates, to assist in covering the cost of medical services, including visits to general practitioners. In some instances, the patient assigns their Medicare rebate to the practitioner. The Medicare rebate is, however, fundamentally a payment to the patient not the doctor, and is in effect a public insurance benefit.

In 2001/02, total spending through the Medicare Benefits Schedule was $7,830 million, of which $2,742 million (or around 35 percent) was for "un-referred services[2]", generally accepted as a measure of GP attendances. This equates to almost 100 million services, or around 45 percent of the 220.7 million total Medicare services claimed in the period.

Table 1 shows services provided and benefits paid through the MBS in 2001/02.

Table 1 - MBS benefits and services by broad type of service, 2001/02

	Benefits	Services	Services per capita
	$m	' 000	
GP attendances	2,742.2	99,921	5.1
Specialist attendances	1,038.4	19,761	1.0
Obstetric services	70.5	1,479	0.1
Anaesthesia	187.2	2,025	0.1
Pathology	1,254.1	68,022	3.5
Diagnostic Imaging	1,216.9	12,753	0.7
Operations	746.6	6,132	0.3
Optometry	171.9	4,409	0.2
Other	401.8	6,202	0.3
Total MBS	7,829.6	220,704	11.2

Source: Medicare Statistics

Pharmaceutical Benefits Scheme

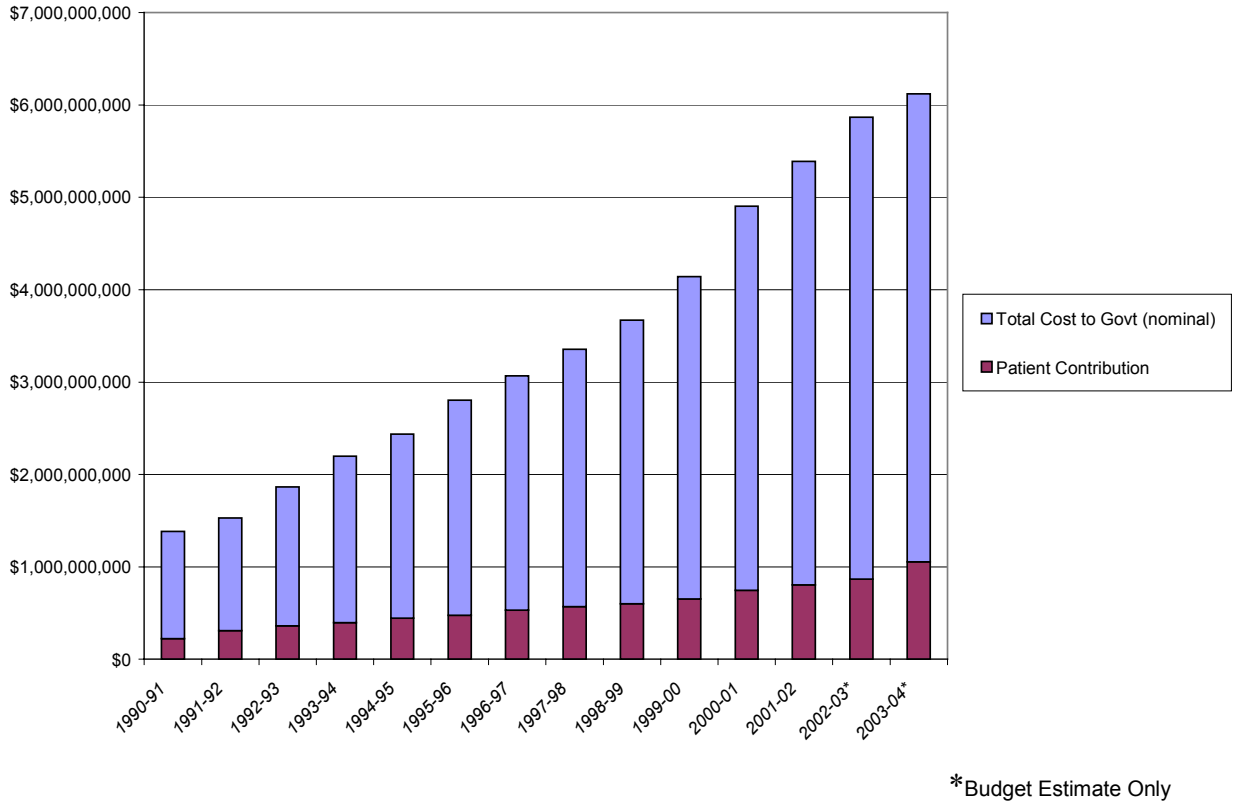
In many cases, access to medicine is central to achieving optimal health outcomes. The Pharmaceutical Benefits Scheme (PBS) provides Australians with affordable, reliable and timely access to necessary and cost-effective medicines. The PBS is a world class scheme based on rigorous analysis of the benefits and efficacy of individual medicines. The PBS subsidises the cost of pharmaceuticals by providing all Medicare-eligible people with access to effective and necessary prescription medication at a reasonable cost to them and the nation. Special safeguards are in place for individuals covered by Commonwealth concession cards.

[2] While there are a small number of un-referred attendances claimed by non-GPs, and similar numbers of GPs claiming small numbers of procedural items, it is generally accepted that the patterns for un-referred attendances can be used to represent GP services.

There are now over 1,400 products listed on the PBS as 2,500 different branded items. In 2001/02, around 155 million prescriptions were subsidised through the PBS at a cost to Government of $4,300 million. It is estimated that three-quarters of all prescriptions dispensed in Australia are subsidised.

The PBS is the fastest growing component of the Commonwealth's health budget. Over the decade 1990/91 to 2000/01, PBS expenditure grew by an average 13.6 percent per annum, compared with average growth in GDP of 3.3 percent. Government and patient expenditure on items provided under the PBS is expected to exceed $6,000 million in 2003/04. Since 1990, the cost to government of the PBS has risen from $1,000 million to an estimated $5,000 million in 2003/04.

Figure 3 - Growth in PBS Expenditure 1990/91 to 2001/02



*Budget Estimate Only

Australian Health Care Agreements

The Australian Health Care Agreements (AHCAs) provide universal access to free public hospital care, delivered through the State/Territory government sector. The AHCAs are five-year bilateral agreements between the Commonwealth and each State and Territory.

Through these Agreements, the Commonwealth provides financial assistance to the States to meet the cost of providing public hospital services in accordance with specified principles. These principles include that public hospital services must be provided free of charge to public patients on the basis of clinical need and within a clinically appropriate period, regardless of geographic location.

In 2000/01, the latest year for which data is available, total recurrent funding of public (non-psychiatric) hospitals was $15,545 million of which approximately 48 percent was contributed by the Commonwealth government, 43 percent by the States and Territories and 9 percent by the private sector.

This funding supports around 750 public hospitals and 52,600 public hospital beds across Australia. In 2000/01, the public hospital sector accounted for 3,849,000 patient separations and around 40 million occasions of non-admitted patient services.

1.5. Private Health Insurance

In addition to expenditure and services delivered through the three elements of Medicare described above, private health insurance also plays an important role in Australia's health system. It contributes around 11 percent of total national health care spending.

The Commonwealth government encourages the take-up of private health insurance through:

- a 30 percent rebate on private health insurance premiums (PHI Rebate);
- an additional 1 percent tax surcharge for high-income individuals who do not have private health insurance;
- Lifetime Health Cover, which places a surcharge on premiums for people who wait to take out private health insurance until they are older (over 30 years of age).

The uptake of private health insurance hospital cover following the introduction of the PHI Rebate and other initiatives increased from 32 percent of the population in June 2000 to 43.8 percent in March 2003. In addition, many people choose to take out ancillary cover. In March 2003, dental, optical, chiropractic, and physiotherapy services accounted for around 80 percent of all benefits paid under ancillary cover.

Under current legislation, private health insurance cannot provide cover for out-of-hospital MBS services. Any service delivered by a medical practitioner outside a hospital setting and for which an MBS subsidy is paid cannot be covered by private health insurance. Consequently people cannot insure against the out-of-pocket costs they incur as a result of using routine GP services, or more costly specialist services such as out-of-hospital radiation oncology.

The 30 percent PHI Rebate makes private health insurance more affordable for Australian families and is universal by intention. It contributes an average of some $750 every year to the health care costs of millions of Australian families.

Importantly, the PHI Rebate is helping families on low incomes. Over 1 million Australians on incomes of less than $20,000 per year now have private health insurance cover. If the PHI Rebate were abolished Australian families, including many less well-off families, would face an immediate 43 percent increase in premiums.

2. CURRENT CONTEXT

In the almost two decades since the introduction of Medicare the health system in Australia has altered dramatically in response to changes in demography, the medical workforce, technology, and consumer expectations. These changes are impacting, and will continue to impact, on the operation and sustainability of financing systems and structures (like Medicare) that were introduced twenty years ago.

2.1. Demographic Change

While the population increased by around 30 percent in the period from 1981 to 2001, the proportion of the population aged over 65 increased disproportionately, from less than 10 percent to over 12 percent of the total.

Figure 4 maps the age distribution of Australia's population in 1981 and in 2001, clearly showing the increased numbers of adults in the population and the strong growth associated with the baby-boomer generation.

Figure 4 - Population ageing trends 1981 to 2001

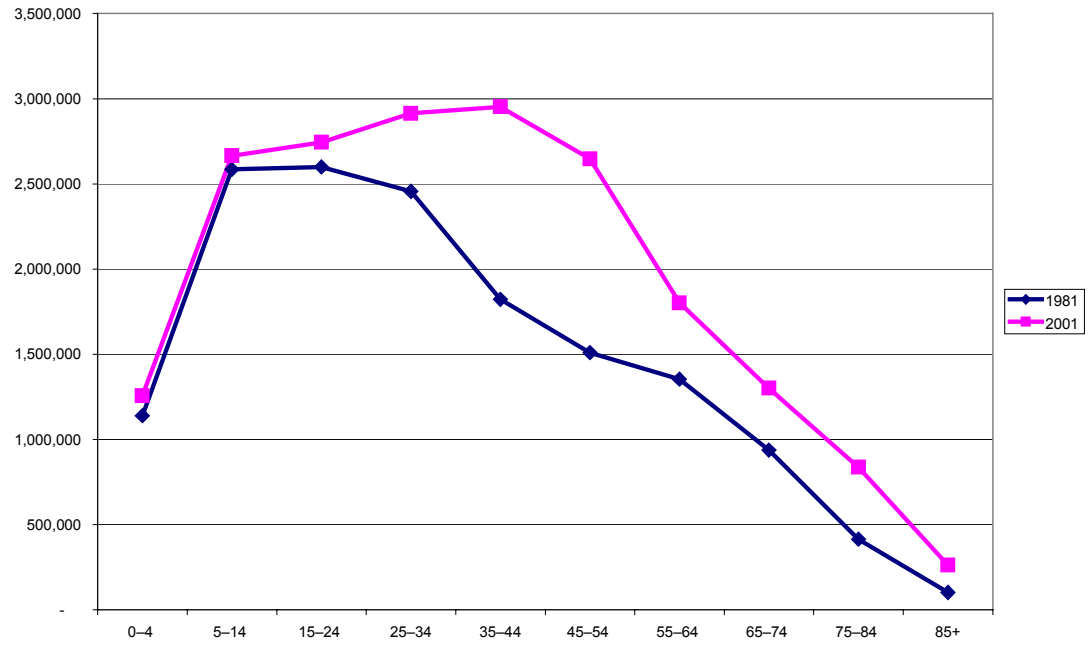
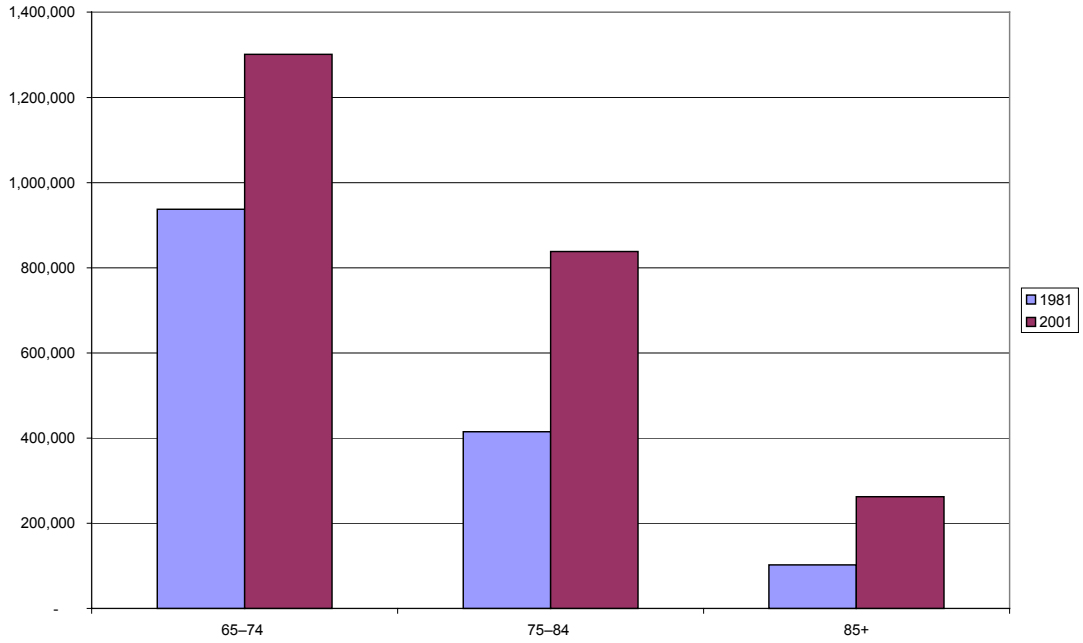


Figure 5 compares the age composition of Australia's 65 and over population in 1981 with that in 2001. The number of persons in this older age group increased from 1.5 million persons to 2.4 million. This has significant implications for health spending, as the over 65 population have a considerably higher need for health services than the younger population.

Figure 5 - Growth in Australian population aged 65 years or older, 1981 to 2001



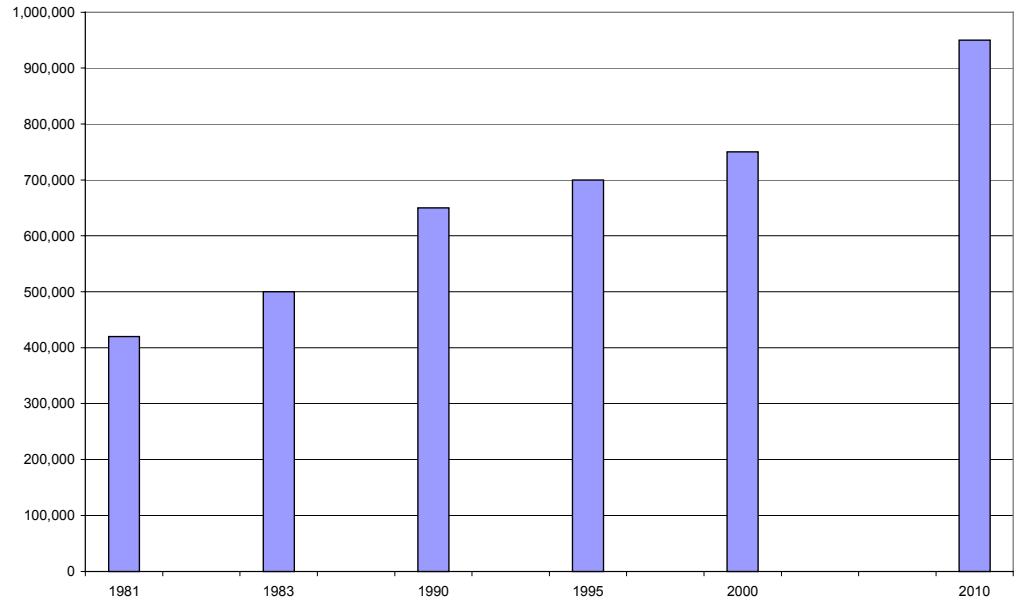
2.2. Population Health

As is the case for many more developed countries, life expectancy in Australia continues to rise. In the past 40 years, life expectancies have increased by more than 8.3 years for men and 7.6 years for women.

With population change comes changes in the health profile of the population. The Australian Institute of Health and Welfare (AIHW) estimates that chronic disease affects some 10 percent of the population but accounts for around 80 percent of the total burden of disease.

There is now much less ill health related to infectious disease than there has been in the past and a much greater prevalence of chronic conditions such as asthma, diabetes, high blood pressure and heart disease. For example, from the period 1981 to 2010, the number of persons with diabetes is expected to more than double, from around 400,000 in 1981 to an expected 950,000 in 2010.

Figure 6: Estimates and projections of diabetes prevalence in Australia, 1981-2010[3]



Many chronic conditions have behavioural determinants and are therefore substantially preventable. Risk factors that have been identified include smoking, physical inactivity, poor diet and obesity, and harmful alcohol consumption. The incidence of chronic disease can be expected to decline when behavioural risk factors are effectively managed.

Changing health status brings challenges for health services. General practitioners in particular will play an increasing role in the management of chronic disease, through diagnosis, care planning, treatment and monitoring of health conditions and patient outcomes. Effective management of chronic conditions will contribute to prevention of disease and illness by reducing the likelihood of complications or other associated with chronic conditions.

2.3. Medical Workforce

There have also been significant shifts in the medical workforce, particularly during the last decade. In the mid-1990's there appeared to be a large oversupply in the medical workforce, coupled with a significant maldistribution between rural and urban areas. This oversupply resulted in significant growth in Medicare outlays which outstripped population growth in many areas. At the same time, some rural areas suffered chronic shortages in medical practitioners. Two major policy prescriptions were developed in response.

Firstly, in 1996 the Commonwealth moved to control medical workforce supply by capping the number of medical school places. This restricted national medical school intakes to around 1,250 per year, a figure which remained relatively stable until quite recently. In 2003, intakes are expected to be around 1,470 places.

3 Estimates and projections include both diagnosed and undiagnosed diabetes
Sources: Based on data from Amos et al (1997); McCarthy et al (1996).

Secondly, in 1995/96, Medicare provider number legislation was introduced. This aimed to ensure that all doctors working in general practice were suitably trained to provide quality care, and to address the maldistribution of the general practice workforce. It achieved this by requiring that Australian medical graduates could only gain an unrestricted Medicare provider number to deliver MBS-subsidised services once they had achieved formal post-graduate qualifications. It also placed restrictions on overseas-trained doctors, targeting those doctors to districts of workforce shortage.

These measures have had the effect of channelling medical practitioners into specialist training programs (including general practice) or to work in areas of workforce shortage. Improvements in the quality of GP services have been encouraged, and there is greater capacity to adjust supply between different specialities to meet changes in demand.

Since the measures were introduced, the number of doctors practising in rural areas has increased by 11 percent and the number of doctors entering specialist or GP training has increased by 2 percent. This is helping to close the gap in the relative supply of doctors between metropolitan and non-metropolitan areas.

More importantly the overall medical workforce supply situation has now moved into shortage, particularly apparent in outer metropolitan areas. This overall shortage is mainly due to significant changes in the supply characteristics of the medical workforce. For example, new doctors of both genders are seeking to work shorter hours than they have in the past.

The AIHW, in its recent report on the medical labour force (2000), found that the overall numbers of practitioners had risen by 8 percent. However, this was offset by a decline in the average hours worked per week by practitioners from 48.2 to 45.5 hours resulting in a decline in the national Full Time Equivalent (FTE)[4] measure of medical workforce from 279 per 100,000 population in 1995 to 270 per 100,000 population in 2000. Although there are now more doctors relative to the population, they are typically working shorter hours with a resulting slight fall in their overall availability.

The Commonwealth government has responded in a timely and effective way to workforce challenges. For example, some State and Territory Health Departments had indicated that they were having problems with filling all available intern positions in their public hospitals. In response, the Minister for Health and Ageing and the Minister for Immigration and Multicultural and Indigenous Affairs jointly agreed to allow international students studying in Australian medical schools to stay on in Australia temporarily after they graduate and work in public hospitals on a temporary visa. That decision meant that an additional 107 graduates were able to take up internships in public hospitals in 2003.

In light of these changes to overall medical workforce supply the Commonwealth government has moved in the 2003/04 Budget to increase the number of undergraduate medical school places by 234 per annum, in line with recommendations from the Australian

[4] The measure of full time equivalence used by the AIHW is developed from the National Medical Labour Force Survey which surveys all doctors at the time of their renewal of registration with State and Territory Medical Registration Boards. AIHW FTE is calculated by (1) multiplying the number of practitioners by the average hours worked then (2) dividing by the number of hours in a standard working week (currently 45 hours for medical profession).

Medical Workforce Advisory Committee (AMWAC). However, to ensure that the increase in practitioners translates into increases in supply in areas of workforce shortage, the places have a bonding obligation requiring graduates to work in areas of workforce shortage for six years after becoming a fully qualified practitioner. These changes are described further at Section 6.1

2.4. Trends in health expenditure

Since the introduction of Medicare, health expenditure has increased from 7.4 percent of GDP in 1984/85 to 9 percent of GDP in 2001/02. Expressed as a proportion of GDP, the government (or public) share has increased by 1 percentage point and the non-government (or private) share by 0.6 percentage points.

At the same time, the share of total expenditure contributed by government has declined slightly from 71.6 percent to 70 percent. These changes are shown in Table 2. They reflect a shift in the balance of spending from institutional health services (which are 80 percent government funded) to services provided in the community (which have lower proportions of government funding). From 1984/85 to 2000/01, total spending on institutional health services decreased from 51.1 percent of total health spending to 43.1 percent. A substantial component of the increase in government spending on services in the community is attributable to growth in pharmaceutical services' subsidies through the Pharmaceutical Benefits Scheme.

Table 2 – Health expenditure by source, as per cent of GDP

	Public				Private				
	C'W	**State/ Local**	**Total**	**% of total spend**	**Health Funds**	**Individual**	**Other**	**Total**	**% of total spend**
1984/85	3.4	1.9	5.3	71.6	0.6	1.0	0.4	2.1	28.4
2000/01	4.3	2.0	6.3	70.0	0.6	1.6	0.5	2.7	30.0

2.5. Hospital Services

Between 1985/86 and 2000/01, acute hospital separations per capita increased by 45 percent. Over the same period, as shown in Table 3, there were significant declines in:

- the number of patient days per capita – declined by 20 percent;
- the average length of stay - declined by 42 percent;
- the number of available hospital beds per capita - declined by 22 percent.

Overall, there has been a significant increase in the population's use of hospital services. However, as people generally now spend much less time in hospital during each stay these additional services are provided using fewer beds.

Table 3 - Hospital trends – Summary of separation, patient day and average length of stay statistics, Australia, 1985/86 to 2000/01

	1985/86	2000/01
Separations per 1,000 population	209	304
Patient days per 1,000 population	1,346	1,076
Average length of stay (days)	6.4	3.7
Beds per 1000 population	5.3	4.1*

* Latest available data is 1999/00.

While the increase in separations in part reflects the ageing population, it also reflects two consequences of technological change:

- An increase in technologically advanced hospital procedures to address previously untreatable conditions;
- An increase in same day admissions for many procedures which previously required an overnight stay. Data for the period 1991/92 to 2000/01 shows an average 10 percent per year increase in day only admissions, to the point that more than half of hospital admissions are now same day.

The technological changes, which have affected the pattern of services, include the introduction of scoping procedures (gastroscopy, colonoscopy, hysteroscopy, arthroscopy) and laparoscopic surgery. These support earlier diagnosis and treatment, allowing patients to leave hospital earlier. Another change has been the improvement in anaesthetic techniques and post-operative care, which has also enabled earlier discharge as well as making many surgical procedures available to older and frailer patients.

The Commonwealth government is responding to these changes through the "Pathways Home" package, announced in the 2003/2004 Budget. Through "Pathways Home", $253 million over five years is being provided to State and Territory governments to increase efforts in the provision of step-down and rehabilitative care services for older Australians leaving hospital to return home in a timely and appropriate manner.

2.6. Medical Services

In 2000/01, almost 84 per cent of Australians accessed one or more medical services subsidised by the MBS.

Table 4 distributes the population who accessed MBS services in 2000/01 across the number and types of services used. Significantly, more than 21 percent of Australians accessed 15 or more MBS services in that year.

Table 4 - MBS services per year by proportion of Australian population

Number of MBS services in 2000/01	0	1 to 5	6 to 10	11 to 15	15 to 20	20+
Proportion of Australian population	16.3%	33.2%	18.5%	10.9%	6.8%	14.3%
Proportion of Australian population (cumulative)	16.3%	49.6%	68.0%	79.0%	85.7%	100.0%

Source: Health Insurance Commission Annual Report 2001/02

Between 1984/85 and 2001/02, the total number of medical services funded under Medicare grew in per capita terms by 55 percent from 7.2 to 11.2 services per person per year:

- a third of this increase was due to increased GP consultations - up almost 25 percent from 4.1 to 5.1 per year;
- a further third was an increase in pathology items from 1.4 to 3.5 per capita;
- other areas to experience strong growth include diagnostic imaging – up from 0.3 to 0.7, and 'Other Services', such as radiation oncology - from 0.2 to 0.3 per capita.

While the increase in GP services is largely attributable to an increased general practice workforce and to increased demand with the ageing of the population, the other increases have been strongly influenced by technological change.

In pathology services, the development of new tests and automation of basic tests has resulted in significant growth. Advances in diagnostic imaging, including the introduction of Magnetic Resonance Imaging (MRI) and Positron Emission Topography (PET) testing and the growth of Ultrasound and Computerised Tomography (CT) scanning, together with developments in nuclear medicine have led to increased service volumes. For 'other services', Radiation Oncology has become a major modality for treating cancer outside the hospital setting.

This changing pattern of service provision and technology is reflected in spending patterns under the Medicare Benefits Schedule, which has grown by 64 percent in real terms. Growth rates for MBS expenditure in the areas of Ultrasound (318 percent), Computerised Tomography (246 percent), Nuclear Medicine Imaging (643 percent) and Radiation Oncology (305 percent) have been significantly greater than the average.

Patient contributions for out of hospital services increased in real terms by almost 96 percent between 1984/85 and 2001/02. Consistent with trends in MBS spending, the most significant increases in patient contributions have been in the areas of Ultrasound (845 percent), Computerised Tomography (939 percent), Nuclear Medicine (700 percent) and Radiation Oncology (349 percent).

Table 5 shows the percentage growth in Commonwealth and patient contributions for selected Medicare services from 1984/85 to 2001/02.

Table 5 - Percentage Growth in Contributions to Non-Hospital MBS services (in real terms[5]), 1984/85 and 2001/02

	C'Wealth	Patient	Total
Unreferred Attendances	66%	65%	66%
Specialist Attendances	26%	158%	42%
Pathology	64%	-33%	57%
Ultrasound	318%	845%	363%
CT	246%	939%	270%
Radiology (X-Rays)	-6%	31%	-3%
Nuclear Med Imaging	643%	700%	646%
Radiation Oncology	305%	349%	310%
Total	64%	96%	67%

The increase in patient contributions for these service types can be attributed to the shift from public institutional services to private non-hospital services, technological advances and changing consumer expectations. Within this changing landscape, there is an increasing need to safeguard patients from accumulating out-of-pocket costs, especially those individuals or families that have chronic conditions or multiple health problems requiring a combination of treatments. Increasingly these services are provided outside a hospital setting and without the financial protections available through public hospitals and private health insurance.

2.7. Consumer Expectations

With technological advances, increased public health measures, higher levels of consumer awareness and increases in the level of consumer wealth over time, there is a greater level of consumer expectation regarding health care than ever before. International evidence suggests that, for every percentage point increase in their GDP, countries increase health expenditure by 1.2 percent.

Previously, injuries or disease that were a result of the ageing process were largely accepted and managed. The trend now is to seek treatments or procedures to heal ailments and illnesses that were previously not detectable or not treatable.

Australians demand access to more expensive diagnostic services and procedures and medications, which in turn drives up health expenditure. The *Intergenerational Report 2002-03*, released as part of the 2002/03 Budget, identified this non-demographic factor as a major driver of health care costs when compared to population ageing and growth.

Patient expectations are also changing in respect of how easy and convenient it should be for them to access medical service. In today's world, everyone can access a wide range of health related information from the Internet and other electronic media; ATMs, Internet banking and telephone help-lines are increasingly commonplace. Customer service is a key source of competitive advantage. Against that background, patients expect that access to medical services and advice will be equally simple and convenient.

With these trends come challenges for government. There is the need to respond and support the population's access to health care that is of the highest quality and efficacy in addressing

[5] Calculated using the June quarter Weighted Average of 8 Capital Cities.

health need. This is achieved through supporting access to the latest technology and ensuring the medical workforce is equipped with the knowledge and skills to deliver new procedures and treatment protocols.

At the same time, governments must maintain the affordability of health care both for individuals and the community, needing to strike a balance between consumer and taxpayer expectations.

There are emerging challenges to ensure that the way in which health care is financed and subsidies are provided can strike this balance effectively. One way in which this is addressed in the 2003/2004 Budget is through financial safeguards to protect individuals and families from high cumulative out-of-pocket costs related to the increased proportion of services, once delivered in hospitals, that are now accessed in community settings. These safeguards are further described in Section 6.2, 'Safeguarding from Cumulative Costs'.

3. GENERAL PRACTICE IN AUSTRALIA

General practice has a central role in the health care of Australians.

GPs are at the front line of the delivery of primary health care. They diagnose and treat chronic and acute illness, deliver preventive through to palliative care, and act as key referral and coordination points, directing and managing patients through the health sector.

General practice is strongly utilised. Each year it is expected that around 85 percent of the population will visit a GP, around 100 million GP services will be provided or an average of 5.1 services per head of population.

As the environment changes, so too does the role that general practice is required to play. With the increasing prevalence of chronic disease associated in part with the ageing of the population, GPs spend less time responding to acute presentations, more time supporting patients to improve their health and managing chronic conditions.

3.1. The GP Workforce

In Australia, general practice is delivered predominantly by medical practitioners in privately established businesses, undertaking individual doctor-patient consultations.

At the end of 2001/02, there were 24,307 non-specialist medical practitioners who claimed MBS benefits. The Department of Health and Ageing uses a standardised measure to estimate the workforce supply of GPs. This measure, the Full-time Workload Equivalent (FWE)[6] adjusts for the partial contribution of casual and part-time doctors and the contribution of GPs who work more than the average full-time doctor. At the end of 2001/02, there were 16,736 FWE GPs in Australia.

The GP workforce has changed in important ways since the introduction of Medicare in 1984:

- The proportion of female GPs has steadily increased from 23 percent of the GP population in 1985 to 34 percent in 2000. The pattern of medical school enrolments in the past twenty years suggests that this trend will continue. Currently, sixty percent of new GP Registrars are women;
- In the year 2000, female GPs under the age of 45 represented 45 percent of GPs but they delivered 32 percent of GP workload. This reflects the high rate of part-time and casual workforce participation of female doctors;
- The GP workforce has aged, from an average of 41 years in 1985 to 46 years in 2000. This rise in average age links to the ageing of the population, and the continued activity

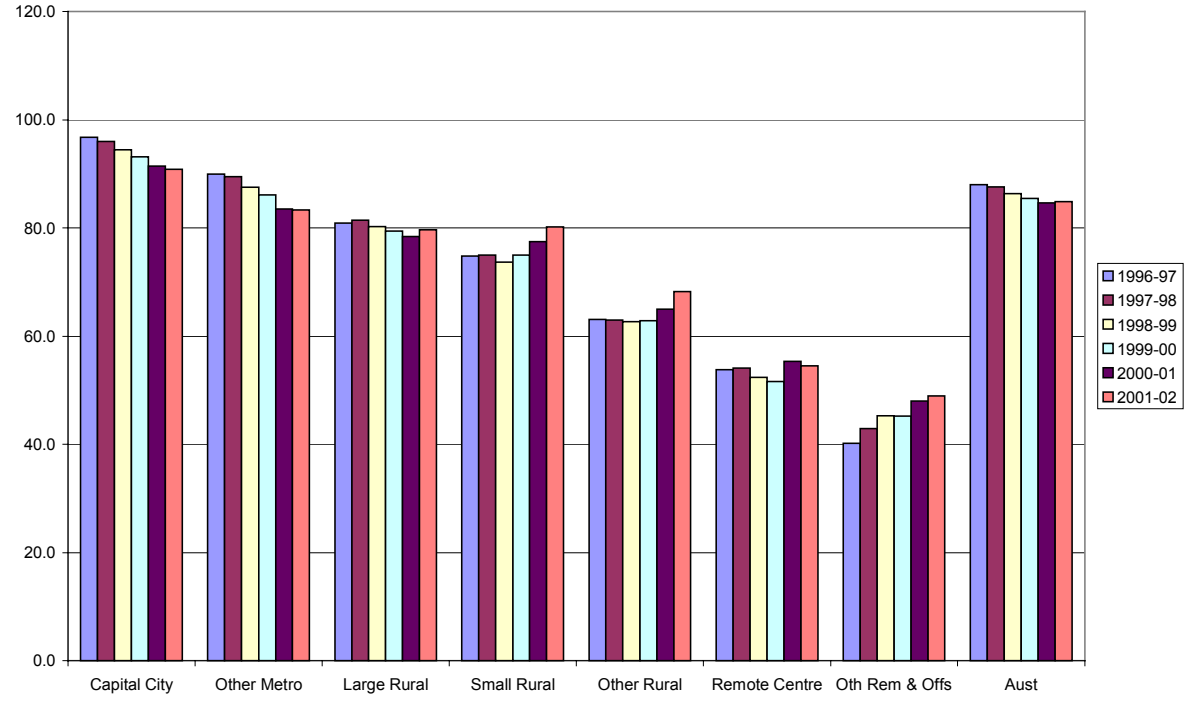
[6] The methodology for calculating FWE value of each practitioner begins by obtaining the average earnings of all practitioners whose income is greater than a preliminary threshold. This preliminary threshold is indexed annually in accordance with CPI figures published by the Australian Bureau of Statistics. The threshold for the 2001/02 financial year was $82,415. FWE is calculated for each doctor by dividing the GPs Medicare billing by the mean billing of full-time GPs (that is, GPs who billed more than the threshold). For example, a FWE value of 2 indicates that the GPs total billing is twice that of the mean billing of a full-time GP. FWE is a measure of service provision.

of GPs past normal retirement age. Interestingly, the average female GP is 6 to 7 years younger than her male counterpart.

The geographic distribution of GPs is also uneven. Measured as the number of full time GPs per 100,000 persons, there are many more GPs in metropolitan areas than there are in non-metropolitan areas - the more remote an area, the lower the number of GPs per head of population.

Figure 7 compares the number of FWE GPs per 100,000 population for different geographic areas in recent years. There is a marked and consistent variation across geographic areas, although the last six years has seen a gradual upward shift in the numbers of GPs practising in non-metropolitan areas and a corresponding fall in GP per population ratios in some historically better serviced areas of the country. There has been steady progress towards greater equity in the geographical distribution of GPs.

Figure 7 : Full time workload equivalent GPs per 100,000 people by region, 1996/97 to 2001/02



This can be attributed to the impact of government incentives on the recruitment and retention of GPs in rural and remote areas. In the past five years, the supply of FWE GPs in rural Australia has increased by 11.4 percent, compared to an increase of 0.1 percent in GPs in metropolitan areas.

3.2. Fee Setting in General Practice

The MBS operates as an insurance arrangement for patients in private markets where doctors set their own charges. It is based on providing a universal subsidy through the Medicare rebate for privately provided services.

The Commonwealth government sets a schedule fee for specific items of consultation through the Medicare Benefits Schedule. For a standard consultation, the schedule fee is currently $29.45. A rebate – set at 85 percent of the schedule fee – is paid to patients to support their access to medical services. For a standard consultation, the Medicare rebate is currently $25.05.

While the Commonwealth government is responsible for setting the schedule fee for Medicare benefits purposes, and for paying those benefits, the actual fee charged is a matter between the doctor and the patient. Many doctors charge an additional amount above the schedule fee, others charge a level between the rebate and the schedule fee. Doctors may also vary their fees to reflect what they consider to be fair or affordable given their knowledge of a patient's circumstances.

Where a doctor charges a fee that exceeds the rebate, the patient must generally pay the full doctor's fee (including the Medicare rebate) up front, and seek reimbursement of the rebate from a Medicare office. In 2001/02 the total patient contributions made in Australia for General Practice services were $295 million, accounting for around 9 percent of GP fee-for-service income.

Bulk-billing is the practice by which a doctor charges a patient only the amount of the Medicare rebate. In these circumstances, the patient assigns the Medicare rebate direct to the doctor. The patient therefore incurs no out-of-pocket cost. The 'bulk-billing' rate is a measure of the total number of services delivered at no cost to the patient.

It is important to note in the context of fee setting, that the Commonwealth has no direct power or authority under the Constitution to determine the fees charged by doctors or their billing practices, nor can it compel them to observe the schedule fee for any particular service. Doctors are free to place their own values on their services. In this sense, it is doctors, not the Government, that determine the rate of 'bulk-billing'.

3.3. Payments for General Practice

Over the past six years, Commonwealth payments in respect of general practice have increased by around 30 percent from $2,400 million in 1996/97 to an estimated $3,130 million in 2002/03.

Blended Payments for General Practice

Payments for general practice services are delivered through a 'blended' payment system, comprising rebates to patients in respect of individual GP consultations, and payments to practices for specified activities.

Fee-for service payments (through the MBS) for GP services increased from $2,340 million in 1996/97 to $2,845 million in 2002/2003, accounting for around 90 percent of the total Commonwealth payment for GP services.

The growth in MBS payments reflects several factors including:

- increased MBS rebates:
  - since 1996, the MBS rebate for a standard GP consultation (Item 23) has increased by over 20 percent, from $20.85 to $25.05;
  - rebates for longer GP consultations (Items 36 and 44) have increased by an average of more than 26 percent from $37.65 and $55.45 to $47.60 and $70.05 respectively.

- the addition of new items to the MBS for Enhanced Primary Care (EPC):
  - these new items support and enhance primary care, particularly for older Australians and those with chronic and complex conditions;
  - in 2002/03, some $68.6 million is expected to be paid through the MBS for EPC items in respect of annual health assessments, care planning and case conferencing.

Since February 1995, the Commonwealth government has offered supplements to fee-for-service through payments to general practices that promote the delivery of quality general practice, with a particular focus on prevention strategies and chronic disease management[7]. These payments currently provide around 10 percent of the Commonwealth government contribution to participating general practitioners.

In 2002/03, total expenditure on these practice based programs will be around $284 million of which $21 million is for specific chronic disease initiatives for managing asthma, diabetes and mental health conditions and a screening program for cervical cancer.

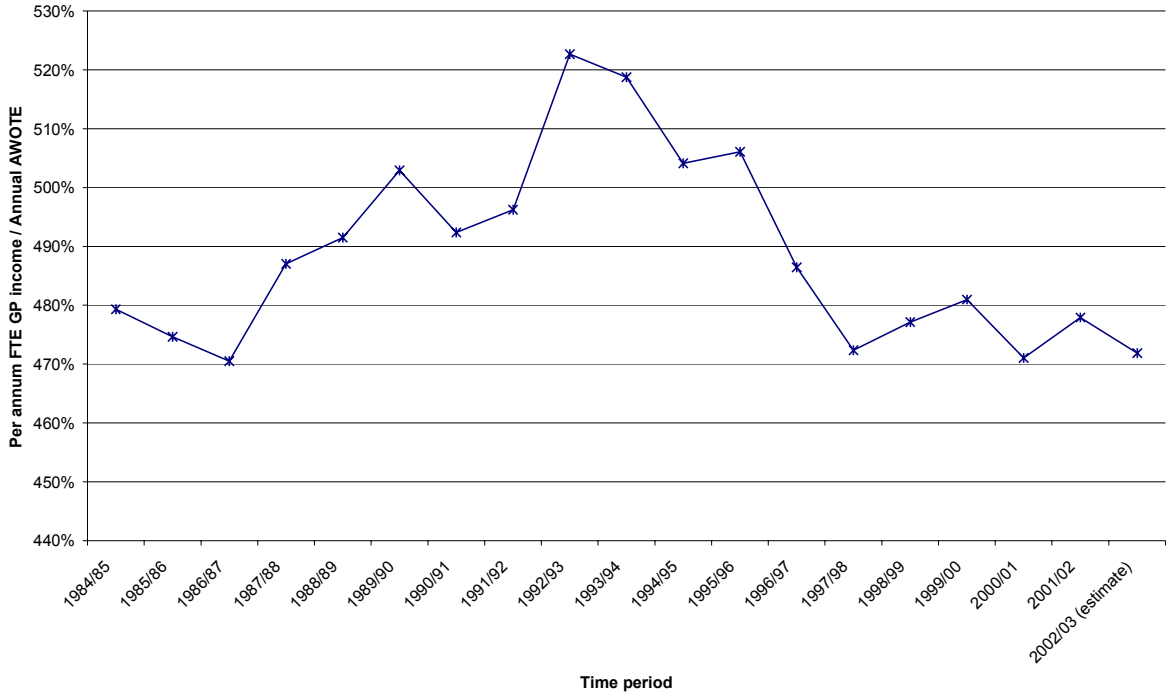
In 2002, the average Full Time Equivalent [8] (FTE) GP performed some 7,000 services. The Government, on average, would support such a level of service with MBS rebate payments of around $200,000 in that year, assuming an average mix of services, and non fee-for-service payments of around $20,000 a year, bringing the total payment to $220,000.

Practice payments have been an important supplement to the income of general practice. Figure 8 shows the annual Commonwealth expenditure per FTE GP including Practice Incentive Program and GP Immunisation Incentive Program payments, as a percentage of Average Weekly Ordinary Time Earnings (AWOTE) since the introduction of Medicare in 1984. As demonstrated by this graph, average annual funding from the Commonwealth to support general practice services have not fallen below 4.7 times AWOTE since the introduction of Medicare. The graph also shows how the decline during the early 1990's in GP's gross income from Commonwealth-funded sources has been arrested and reversed since 1997/98 when the non fee-for-service components are taken into account. This graph does not include income that GPs receive from patient contributions.

[7] Current non fee-for-service payments, the Practice Incentives Program (PIP). Within this program there are specific outcome payments, sign on payments and service incentive payments. The PIP was designed in close consultation with the medical profession.

[8] The methodology for calculating the FTE value of each practitioner involves obtaining average earnings of all GPs whose income is greater than an accepted preliminary threshold. This preliminary threshold is indexed annually in accordance with CPI figures published by the Australian Bureau of Statistics. The preliminary threshold for the 2001/02 financial year was $82,415. The average MBS income is then calculated for a "full time" provider (ie those providers with an MBS income above this preliminary threshold). This average is used to determine if a provider is an FTE or not. All doctors earning above this average value are counted as 1 FTE GP – under this weighting system it is not possible to be valued greater than 1 FTE - while doctors earning below this average are counted as the fraction their earnings constitute of the average.

Figure 8: Average Annual Commonwealth expenditure per FTE GP (inc PIP & GPII funding) as % of Annual Average Weekly Ordinary Time Earnings (AWOTE)[9]



Complementary Nature of GP Payments

Blended payments work in a complementary way. The fee-for-service approach supports the patient's right to choose their doctor, encourages GPs to make their services accessible, and rewards the efficient delivery of services.

Non fee-for-service payments encourage active management of chronic conditions including longer consultations and patient recall systems, allow system inequities to be addressed, for example, by providing special support to rural and regional practices, and encourage practices to be of high quality with the infrastructure to optimise patient outcomes through, for example, patient information systems and practice nurses.

In the context of the ageing of the population and the increased prevalence of chronic disease, a blended payments approach supports general practice to respond not only to acute presentations, but also to the increasing need of the population for health information, prevention advice and ongoing chronic disease management with patients.

The blended payment system is mutually reinforcing. Neither component would work well in isolation. Where a fee applies to each individual service, as is the case in fee-for-service, the more services that are delivered, the greater the income generated. This encourages faster throughput and shorter consultations and of itself does not encourage long term management

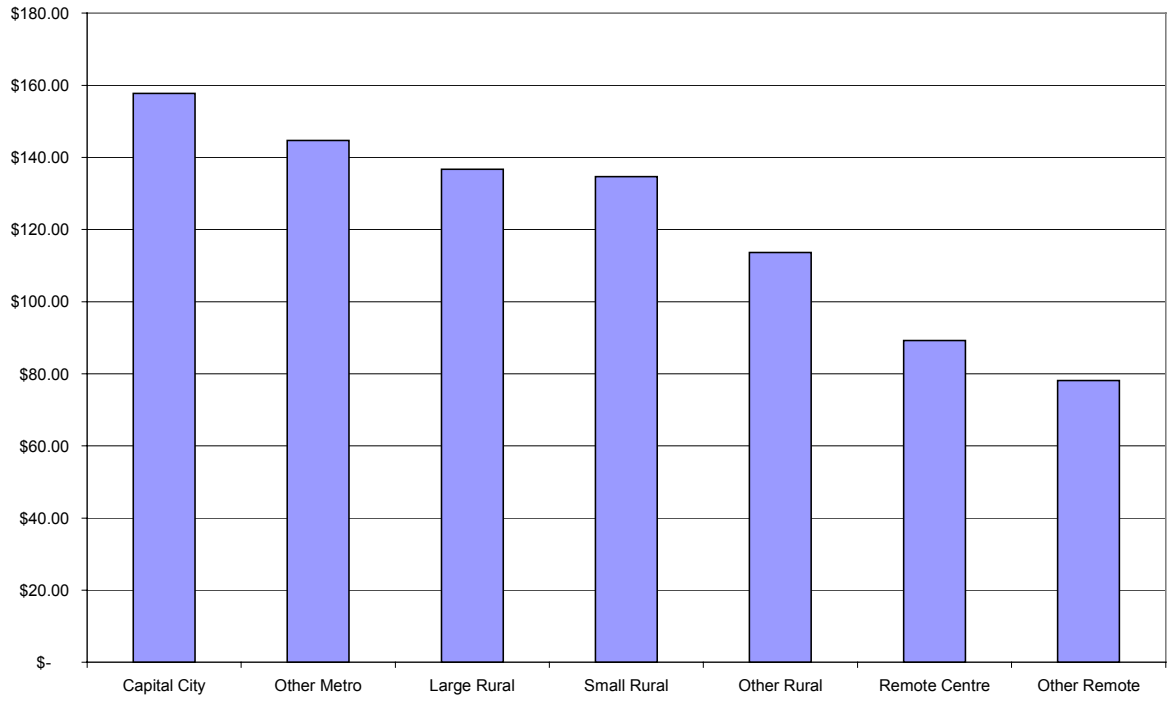
[9]. Figure 8 includes non fee-for-service payments and all items paid for 'un-referred' attendances, on average per FTE general practitioner, as a proportion of average weekly ordinary time earnings, per annum.

of patients with specific care needs. It can also make it difficult to plan the distribution of GP services and thus to ensure equity of access across the population.

Figure 9 illustrates this point. It shows the MBS benefits paid to GPs per head of population in 2001/02 differentiated by geographic location, revealing significant disparities in how fee-for-service funding provides benefits across geographic populations.

Fee-for-service payments can expose both Government and patients to a situation where an increase in the number and availability of GPs results in a disproportionate growth in service utilisation. This contributes to an inequitable distribution of services and subsidies on a geographic basis.

Figure 9: MBS Benefits Paid per Capita by Geographic Location for services provided by GPs, 2001/02



Practice based payments also have limitations when considered in isolation. By linking payments to specific activities, there is a drive for accountability and with that government 'red tape'. Doctors perceive a need to jump through 'hoops' to qualify for practice payments, reducing the time they are able to spend with patients. Work is currently underway through the Red Tape Taskforce[10] to review programs and policies that have a compliance implication for general practice.

The current blended payment system balances the important need to financially support patient access to individual doctor consultations with the need to encourage the delivery of quality health care and support rural practices. Blended payments are able to accommodate

[10] The Red Tape Taskforce is a Commonwealth cross-portfolio group that has been formed to take a whole of government approach to reducing GP administrative and compliance costs. The Taskforce has been established in response to the Productivity Commission Research Report on General Practice Administrative and Compliance Costs (March 2003).

the different pressures in the system around access, geographic equity, and optimal patient management while at the same time allowing general practice to be responsive to changing patient needs and expectations.

Australia has the potential to secure the 'best of both worlds' through its system of blended payments.

3.4. Recent Financing Developments

In the mid to late 1990s, there were two important developments that have informed the directions of general practice financing decisions – the Relative Value Study and the General Practice Memorandum of Understanding. It is important to note these two developments when considering general practice in 2003.

Relative Value Study

The value of rebates delivered through the Medicare Benefits Schedule has been the subject of considerable debate in recent years. Some of this debate has gone to the findings of the Relative Value Study (RVS).

This Study commenced in 1995 under the direction of the Medicare Schedule Review Board (MSRB) which comprised representatives from the Department and the Australian Medical Association (AMA). It was a comprehensive cross-professional review of the relative value of each item of service in the General Medical Services Table of the MBS. It sought to compare the typical resource inputs (including doctors' time) required to deliver the various services that are subsidised by the MBS and to ensure that the relativity between items in the schedule provided a fair and accurate reflection of variations in resource requirements.

In December 2000, three technical reports were forwarded by the MSRB to the then Minister for Health, and to the President of the AMA. These reports did not provide a definitive RVS outcome but a source of information to inform future policy discussions.

The AMA has expressed a view that the standard consultation fee emerging from the RVS should be set at about $50. This interpretation is based on the AMA's own modelling of the data contained in the RVS reports, using its own assumptions. The Department of Health and Ageing considers that the conclusion that the AMA has drawn in this regard is incorrect.

By comparison, modelling by the Department of Health and Ageing, based on the same technical reports but using different assumptions, showed that while general practitioner attendances were under-funded to a small degree, Government budget decisions since the RVS was undertaken has more than offset this under-funding.

In fact, the issue of whether there is any such thing as a 'correct fee' is arguable. The fee a doctor or practice charges will and does vary widely. This relates to a number of factors, including the particular input costs of a practice, the efficiency of business operations, the level of demand and supply within the local marketplace, the style of practice and personal views on what is an acceptable fee for patients and what is an acceptable practice income.

The General Practice Memorandum of Understanding

In the late 1990s, a General Practice Memorandum of Understanding (the GP MoU) was developed over 12 months of discussion and negotiation between the Department of Health and Ageing and the four major General Practice organisations - the AMA, the Royal Australian College of General Practitioners, the Rural Doctors Association of Australia and the Australian Divisions of General Practice.

In 1999, the GP MoU was signed by the Commonwealth and three of these four groups (the AMA opted not to sign the agreement). The MoU covered a three year period.

The three main commitments of the MoU were:

- guaranteed MBS outlays for 'un-referred attendances', with the provision that this funding would be increased if new policy decisions made by the Commonwealth affected spending in this area;
- provision of a guaranteed minimum alternative funding for General Practice Services Programs (including the PIP and GP Links programs);
- minimum guaranteed funding for General Practice Infrastructure Training and Support Program.

The GP MoU concluded in June 2002. The Commonwealth offered the signatories to the MoU an extension to the agreement. This offer was rejected.

4. THE NEED FOR CHANGE

Discussion around the performance of Medicare is often focussed on the one-dimensional issue of bulk-billing rates. This is unfortunate. As shown in Sections 2 and 3 above, the challenges faced by the current system are far more complex.

The Commonwealth government has clearly stated its strong commitment to sustaining Medicare as the means of providing universal health care for Australians.

As described earlier in this paper, however, there are important differences between the society in which Medicare was introduced in 1984 and our 2003 society:

- the population has aged, putting greater demand on services;
- services have grown in variety and cost and are increasingly being delivered outside a hospital setting;
- both government and patient contributions to services have increased;
- high cumulative costs and patient convenience are significant issues facing patients;
- there have been very significant advances in technology, and in consumer expectations about what to expect from medical services.

These complex and interrelated factors are crucial elements of the current landscape, and yet they are rarely mentioned in public debate about the effectiveness of Medicare. They are, however, challenges that require a response which is multi-faceted, integrated and broad in scope.

In particular, the Commonwealth has identified three ways that the affordability of out-of-hospital health care services are becoming a barrier to access:

- the out-of-pocket expenses ('gap' fees) faced by patients who visit a doctor who charges above the MBS rebate. These out-of-pocket expenses are of particular concern where the patient or their family has a low income;
- the up-front costs and inconvenience faced by patients who visit any doctor who does not bulk-bill. These patients must pay the full doctor's fee up front, and later claim the rebate amount back from the Medicare office;
- the high cumulative out-of-pocket costs faced by families and individuals who find they need to use multiple services during the course of a year, possibly including specialist consultations, treatments and tests.

The Commonwealth government has identified the need for a comprehensive policy response that addresses barriers to affordable access.

4.1. Bulk-billing rates

The headline bulk-billing rate has been the focus of recent attention. This single parameter simply indicates what proportion of **services** are delivered at no out-of-pocket cost to the patient. It reveals nothing about:

- the number of **individuals or families** who receive all or some services at no cost (ie, **population coverage** of bulk-billing);

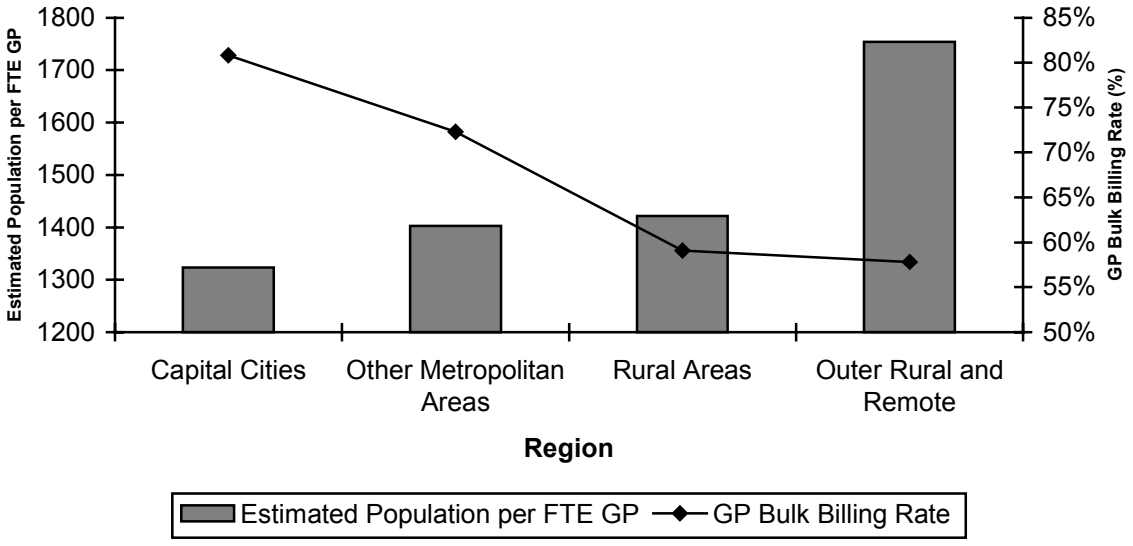
- which population groups have access to bulk-billed services (ie, **equity** of bulk-billing);
- the types of services that are, or are not, bulk-billed (ie, **effectiveness** of bulk-billing).

Bulk-billing rates for general practice vary widely between regions. As a general rule, people in cities are much more likely to be bulk-billed than those outside cities.

In 2002 some 77.9 percent of GP services delivered in Capital Cities were bulk-billed, compared to 56.4 percent of visits in Other Rural and Remote areas. This reflects the strong link between the supply of general practitioners and the availability of bulk-billing services.

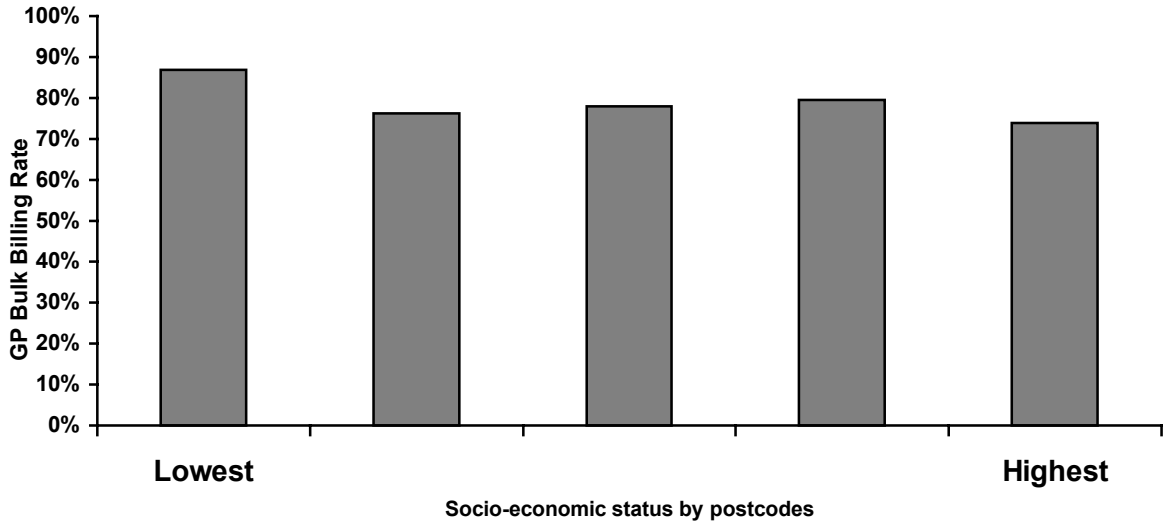
As shown in Figure 7 (Section 3.1), the rate of population per general practitioner varies on a regional basis. In the city, where the number of people per GP is low, the bulk-billing rate is high. In rural and remote areas, where the number of people per GP is high, the bulk-billing rate is low. Figure 10 clearly shows the link between geographic location and service cost. The headline bulk-billing rate conceals this important relationship.

Figure 10 - Estimated Population per Full Time Equivalent GP and Bulk-Billing Rate by Region, 2001/02



While the bulk-billing rate varies significantly by region, it is fairly unresponsive to patient income. Figure 11 shows that, in 2001/02, the bulk-billing rate for services delivered to people on high incomes was almost as great as the rate for services delivered to people on low incomes. The headline bulk-billing rate also conceals this fact.

Figure 11 - GP Bulk-Billing Rate by Income Quintile, 2001/02



When patients covered by Commonwealth concession cards[11] are considered, the same phenomenon is apparent.

Table 6 shows that the bulk-billing rate for services delivered to patients with concession cards is considerably lower in rural areas than it is in metropolitan areas. In fact, services delivered to these patients in the more remote country areas are around 10 percentage points less likely to be bulk-billed than **any** service delivered to a resident of a capital city (regardless of income).

Table 6 - Bulk-Billing Rates by Region, Services to all Patients, Services to Patients with a Commonwealth Concession Card, 2002

Bulk Billing Rates	Capital cities	Other Metropolitan Areas	Rural areas	Other rural and remote
Services to all Patients	77.9%	69.8%	56.6%	56.4%
Services to patients with a concession card	86.9%	78.1%	65.8%	67.5%

There is a clear equity problem in the current arrangements when the cost of visiting a GP depends more on where a person lives than on their ability to pay.

[11] Commonwealth concession cards include Pensioner Concession Card, Health Care Card and Commonwealth Seniors Card.

4.2. Cumulative Gap charges

Public hospital care is provided at no cost to the patient. The PBS limits patient contributions to fixed co-payments with a safety net. In the case of medical services funded under the MBS, however, there are only limited protections against high out-of-pocket costs.

This relates not only to the cost of GP services, but also to the cost of a wide range of other services covered by the MBS such as specialists, imaging, and pathology. Section 2.4 describes the rapid growth since the introduction of Medicare in the availability and use of these services – particularly outside hospital - as well as the increase in cost, both for the Government and for patients.

Under current MBS arrangements, there is a safety net which covers the difference between the Medicare rebate and the schedule fee for out-of-hospital MBS services. Once a family or individual's spending on fees **up to the level of the schedule fee** reaches the safety net threshold in a calendar year ($319.70 for 2003), the rebated amount for further services provided in that year effectively increases to 100 per cent of the schedule fee. In 2001, an estimated 37,000 families and individuals benefited from the current MBS safety net.

There are two significant gaps in the current MBS safety net arrangements:

- any out-of-pocket costs paid in excess of the schedule fee are excluded from the assessment of progress towards the safety net threshold. When doctors levy fees that are above the schedule fee (which they are free to do), a family or individual may be obliged to pay out much more than the threshold level (currently $319.70) before the safety-net applies;
- once the safety net threshold is reached, families and individuals still receive no protection against costs above the schedule fee. Patients who see a doctor who charges more than the schedule fee may continue to face significant out-of-pocket costs even after they are covered by the safety net.

In short, the current MBS safety net might be considered to offer only limited protection against cumulative out-of-pocket medical costs.

In 2002 it is estimated that:

- 50,000 families and individuals covered by Commonwealth concession cards paid out-of-pocket costs for out-of-hospital MBS funded services of more than $500 in the year;
- another 30,000 families and individuals not covered by concession cards paid more than $1,000 in out of pocket costs for these services in the year.

In both cases, these would be families and individuals with high health care needs. Again, the headline bulk-billing rate reveals nothing about this issue.

The Commonwealth government is concerned at the impact of these cumulative costs on people's capacity to access services when they are needed. This problem is of particular concern as the number, complexity and likely cost of out-of-hospital services increases (described at Section 2.4), as the population becomes more likely to experience chronic and complex conditions associated with ageing, and as consumer expectations about the

availability and breadth of service continue to grow. In this context, addressing cumulative out-of-pocket costs of out-of-hospital services becomes a necessity.

4.3. Patient Convenience

There are aspects of the current Medicare system that are inconvenient for patients.

Under current arrangements, where a doctor chooses not to bulk-bill a patient, the patient generally meets the full cost of that service up front, and claims the rebate component back from Medicare. To receive the rebate quickly, as many need to for financial reasons, the family must attend the Medicare office.

This 'two-stage' process of first visiting a GP and then attending a Medicare office to claim a rebate can be a source of considerable frustration and inconvenience, especially for older people, people with mobility problems, families with small children and workers who face extended absences from their workplace. In economic terms, the system imposes significant additional time (i.e. non-cash) costs on patients. It is inconsistent with consumer expectations of a world increasingly dominated by the convenience of on-line solutions and information systems.

4.4. Findings

The Commonwealth government considers that these key features of the current system are unfair:

- the association between where you live, rather than what you earn, and the level of out-of-pocket costs for medical services;
- the lack of adequate protection for patients with high out-of-pocket costs; and
- the inconvenience and cost to patients of the current two-stage process of paying and claiming back the Medicare rebate.

The 2003/04 Budget responds to these challenges with an integrated package of measures, which address both the accessibility and affordability of general practice and the cumulative costs of out-of-hospital services.

5. GUIDING PRINCIPLES

In developing a response to the challenges for Medicare in the year 2003, the Commonwealth government has established several policy principles that need to guide solutions.

5.1. A Universal Medicare

Medicare was founded on the principle of universality – that all Australians have access to affordable health care, no matter where they live or how much they earn. Under the principle of universal access:

- all Australians receive the same MBS rebate and are eligible to be bulk-billed;
- all Australians are able to benefit from free care in public hospitals;
- all Australians are able to receive subsidised medicines through the Pharmaceutical Benefits Scheme.

5.2. Equitable Access to Doctors

An adequate supply of doctors is crucial if high quality, accessible and affordable services are to be available for all.

It is clear that measures to improve the affordability of GP services will only be effective if they are coupled with increases in the medical workforce, targeted to areas of greatest need. This recognises the strong link between the rate of population per general practitioner and the rate of bulk-billing. The evidence suggests that increased supply of doctors and the effect this has on competition for clients is effective in putting downward pressure on fees.

5.3. Fairness

Patients living in non-metropolitan settings currently face significant disadvantage in accessing affordable health care services. In structuring incentives to improve the affordability of services, it is important that people in similar financial circumstances are treated equitably regardless of where they live.

5.4. Sustainability

Any change to health care funding in Australia needs to recognise the significant budgetary implications that may be involved. Decisions need to be assessed carefully both in terms of the impact on the budget bottom line, and the capacity of a new approach to realise its intended outcomes.

As an example, every $1 increase in the MBS rebate for GP services will cost tax-payers around $100 million per year. However, there is no guarantee that simply increasing the MBS rebate will improve access to GPs, will improve the affordability of services for patients, will improve health outcomes, or will address regional inequities for patients.

In the past 6 years, total funding for general practice has increased by around 30 percent. This has not stopped the decline in the rate of bulk-billing. Increases in rebates do not require

doctors to reduce the levels of co-payments they charge. As such increasing rebates alone is an inefficient and ineffective means of addressing the affordability of medical services.

5.5. Simplicity

For patients and doctors, it is important that the health care system is as simple and transparent as possible.

The recent *Report of the Productivity Commission on Administrative and Compliance Costs in General Practice (2003)*, found that the cumulative impact of Commonwealth and other government programs causes confusion and adds to the administrative costs of general practice. The Productivity Commission recommended that better coordination between agencies and assessment of impacts on GPs during program development would help to address this.

There is an expectation among doctors, and a commitment by the Commonwealth government, that the amount of red tape in general practice in particular needs to be reduced and that such a reduction needs to be sustained in the long term. A 'Red Tape Taskforce' has been established that is taking a whole of government approach to reducing GP administrative and compliance costs.

From the patient's point of view, the requirement to go from the GP's surgery to the Medicare office to obtain reimbursement under the MBS is burdensome, frustrating and increasingly anachronistic in the modern environment.

5.6. Adherence to current fee setting parameters

In the context of the Australian health system, GPs set their own fees. The Commonwealth government cannot require a doctor to set a certain fee or to bulk-bill all or a certain percentage of their patients. While all Australians are currently eligible to be bulk-billed for services provided under Medicare, doctors can bulk-bill (or not bulk-bill) anyone that they choose.

Proposals that would establish certain fee levels within general practice – including the requirement to bulk-bill all patients or a sub-set of patients - need to be able to attract the voluntary participation of doctors.

6. A FAIRER MEDICARE

In the 2003/04 Budget, the Commonwealth government has moved to respond to the current challenges of the health care system, particularly as these relate to general practice and the medical workforce.

The guiding principles of a universal Medicare, equitable access to medical services, workforce supply, fairness, sustainability and simplicity, outlined in Section 5, have contributed to the design of a package of measures to strengthen the capacity of Medicare to deliver accessible health services now and in the future.

A Fairer Medicare contributes an additional investment of $917 million over four years. It identifies and assists those members of the community who have the greatest need for support – people on low incomes, those who are unable to access affordable medical care because they live in rural or remote areas, and those facing high out of pocket medical expenses.

It achieves this through a combination of short, medium and long-term measures, some of which focus on an immediate improvement in affordability, others of which address the long-term availability of an appropriate medical workforce.

6.1. Addressing Supply

Through A Fairer Medicare, a significant long-term investment of around $300 million over four years is ensuring that the medical workforce is of a sufficient size and availability to meet the projected future needs of the Australian population.

A Fairer Medicare provides:

- An additional 234 medical school places every year commencing in 2004. These new places are bonded to areas of workforce shortage for six years:
  - this number of places are in line with the recommendations of the Australian Medical Workforce Advisory Committee;
  - this will increase medical school intakes by 16 percent on current levels and ensures that around 20 percent of the future medical workforce are contracted to work in areas of workforce shortage for a period of their career;
  - if these additional places were not bonded to areas of workforce shortage, current inequities in distribution of the GP workforce would simply be exacerbated.

- An additional 150 training places each year for GP Registrars, also commencing in 2004:
  - these GP Registrars will work primarily in general practices in areas of workforce shortage while they are training, and will provide a range of medical services (under supervision) to patients;
  - this provides an immediate increase in the number of practitioners working in areas of workforce shortage.

- Funding for the equivalent of 457 full time nurses to be employed in general practices that participate in the General Practice Access Scheme (described in Section 6.2) and that are located in urban areas of workforce shortage:

- practice nurses allow GPs to focus on diagnosis and clinical care, effectively increasing the time available to patients and the accessibility of general practice;
- around 800 practices are expected to be assisted to employ nurses who will assist with practice activities such as the management of chronic diseases like diabetes and asthma, undertaking health assessments and providing clinical support;
- allied health professionals such as physiotherapists, podiatrists, and aboriginal health workers may also be employed under this initiative.

These supply measures are both medium and long-term responses to a key determining factors in the affordability of general practice services – the availability of a GP.

6.2. Removing Barriers to Access

A Fairer Medicare addresses the three barriers to accessing affordable services delivered through the MBS. It will make general practice more affordable, more accessible and more convenient.

A key feature of A Fairer Medicare is the introduction of a new General Practice Access Scheme. The Scheme will improve access to bulk-billed General Practice services for those seven million Australians who are covered by a Commonwealth concession card[12]. The General Practice Access Scheme does not require that doctors charge above the Medicare rebate for any patient. All Australians will continue to be eligible for bulk-billing.

Practices that take up the General Practice Access Scheme will offer their patients three important benefits:

- A guarantee of medical care at no cost for patients covered by Commonwealth concession cards;
- Reduced up-front costs for all patients;
- Being able to leave the surgery with no more to do and no more to pay.

In addition, A Fairer Medicare introduces two safety nets for patients who have high medical costs that build up over the course of a year.

These initiatives are described in more detail below.

Reducing Costs for Concessional Families and Individuals

The General Practice Access Scheme protects those Australians who are most financially vulnerable. It does so in a simple way, by linking a guarantee of bulk-billing at participating practices to eligibility for a Commonwealth concession card. This eligibility criterion mirrors that applied in the case of access to concessional subsidies for pharmaceuticals through the PBS – a Scheme which is widely accepted by the community at large.

The General Practice Access Scheme is not a move by the Government to make bulk-billing available only to patients covered by concession cards. As has been the case since the inception of Medicare, GPs will remain free to set their fees, and to choose whether or not to

[12] As at March 2003, there were 7, 217,218 card-holders and dependents, consisting of: Pensioner Concession Cards - 4,181,543; Health Care Cards – 2,754,486; and Commonwealth Seniors Health Cards – 281,189.

bulk-bill their patients. By choosing to participate in the General Practice Access Scheme, a practice will guarantee to bulk-bill all patients covered by a Commonwealth concession card, not to restrict their bulk-billing to those patients.

There is nothing in the Scheme that provides reason or justification for GPs to raise their fees to non-concession card holders. The monthly incentive payments being provided to participating GPs have been carefully designed to ensure that the vast majority of GPs will be financially better off. The additional income received by a practice choosing to participate in the General Practice Access Scheme compensates for any income forgone by bulk-billing more of their concessional patients.

From the point of view of a concession card holder, the Scheme means that if they attend a participating practice, they can have confidence that all services will be bulk-billed. This is the first time since the launch of Medicare that any Government has offered a group of citizens a guarantee of bulk-billed services.

Reducing Up Front Costs

The General Practice Access Scheme does not require or justify the introduction of, or increase to, charges above the MBS subsidy level for any patient. A general practice that has joined the General Practice Access Scheme will retain the right to charge fees above this subsidy level for services delivered to patients not covered by a concession card. For those patients who use a participating practice and are not bulk-billed, the Scheme will offer the convenience of new electronic billing arrangements.

Where there is a charge above the Medicare rebate, only that amount (the gap between the Medicare rebate and the doctor's fee) will be paid by the patient at the surgery. There will be no need to pay the entire fee up front, and later claim the rebate back from the Medicare Office.

This removes an impediment to access for those patients who find it difficult to pay the entire fee up-front, as well as improving convenience for patients.

This feature is available only to those practices that participate in the GP Access Scheme and which therefore are bulk-billing (at a minimum) their concessional patients.

As noted earlier, the monthly incentive payments being provided to participating general practices have been carefully designed to ensure that the vast majority of such practices will be financially better off. There will be no need for participating GPs to introduce or increase charges for non-concessional patients. As is the case now, all doctors will retain their right to provide care at no cost to the patient regardless of whether or not that patient is covered by a Commonwealth concession card.

Safeguarding from Cumulative Costs

A Fairer Medicare introduces protections for all patients and families whose out-of-pocket expenses accumulate in the course of a year due to their individual circumstances. It will protect those individuals and families who require multiple visits to GPs, need to make frequent use of specialist services, and/or are high users of diagnostic and treatment services.

Where these patients are covered by a Commonwealth concession card, they will be eligible for a new MBS safety net which will pay 80 percent of the out-of-pocket cost in excess of an annual threshold of $500 per individual or family. The cost of all out-of-pocket expenses for out-of-hospital MBS services will contribute to the annual threshold, including expenses above the schedule fee. It is estimated that around 50,000 families and individuals a year will benefit.

Some commentators have expressed concerns that the new MBS safety net may put upward pressure on doctors' fees. This is not so. The number of patients who reach the new MBS safety net will be a small proportion of the total patient population. Those patients who do reach the new MBS safety net are likely to have incurred expenses from a range of medical specialists, not just a single doctor. In most cases doctors will not even be aware that patients have reached the safety net. As a result there will be little opportunity for doctors to manipulate the system or incentives for them to change their charging. Such behaviour would also run counter to the ethical standards of the medical profession. In addition, it should be noted that patients will continue to pay 20 percent of out of pocket costs. This will act as a constraint on price and will encourage patients to seek out lower cost providers.

Those who are not covered by a concession card will also be able to protect themselves against high out-of-pocket costs. From 1 January 2004, private health insurance funds will be able to offer a new product to cover 100 percent of the out-of-pocket costs for out-of-hospital MBS funded services once an annual threshold of $1,000 per individual or family is reached. Some 30,000 families or individuals are expected to reach the $1,000 threshold in a year.

This new product will cover all out-of-hospital services that attract MBS rebates, such as radiology, pathology, other specialists and general practice. Preliminary indications are that the cost of this new product will be less than $1 per week for families. The new product will be made available independently of other private health insurance products.

Community rating will apply to 'out-of-hospital insurance plans', so that all Australians will pay the same premium regardless of health status. Further, they will pay the same premiums regardless of age or health status. These premiums will be offset by the operation of the 30 percent private health insurance rebate.

As with the MBS safety net, some people have expressed concerns that the new private health insurance product may cause an increase in doctor's fees. Again this is highly unlikely as doctors are unlikely to know when families and individuals have reached the threshold. Similarly, suggestions that they might behave in such a manner indicate a lack of trust in doctors' professional behaviour.

The Health Insurance Commission (HIC) will monitor costs for patients who reach both the MBS and private health insurance safety net thresholds, to determine if there are significant changes in charging patterns.

Addressing the needs of the Aboriginal and Torres Strait Islander Population

The measures contained in A Fairer Medicare will assist in overcoming some of the barriers experienced by Indigenous people when accessing medical services, particularly that of cost. A guarantee of bulk-billing for concession card holders at participating practices will benefit

the 75 percent of our Aboriginal and Torres Strait Islander population estimated to be eligible for these cards.

As well, the Government is continuing to implement other measures targeted specifically towards improving access for Indigenous Australians, including improving rates of Medicare enrolment, introducing a new Medicare item for an Indigenous adult health check, and the provision of Indigenous specific services to complement the availability of primary health care services.

6.3. Providing an Effective Incentive to GPs

The General Practice Access Scheme is a purely voluntary scheme, reflecting the principle that doctors retain the right to set their own fees. To be effective, incentives offered to practices need to:

- be sufficiently attractive to make it beneficial for practices to join;
- be fair for practices in different locations; and
- ensure that there is no need for practices to increase charges to non-concessional patients.

This is achieved in several ways. Firstly, incentives have been carefully designed to ensure that the vast majority of practices are better off by joining the Scheme.

Secondly, the level of incentive varies depending on practice location. This reflects the differential bulk-billing rate for services delivered to concessional patients in different locations and therefore the need for practices in some areas to have a greater incentive to bulk-bill a higher proportion of their services. The incentives offered under this Scheme are based on a payment per concessional service. The total amount of incentives per participating practice is wholly dependent on the number of bulk-billed services that such a practice provides to concessional patients.

Thirdly, the level of incentives will be indexed to the consumer price index to ensure that they keep up with the inflation rate.

Finally, practices participating in the Scheme will receive a number of additional benefits, including:

- assistance with the cost of connecting to HIC Online[13];
  - a payment of $750 for metropolitan practices and $1,000 for non-metropolitan practices will be made. For the vast majority of practices that are already computerised this will be a significant contribution to any additional information technology costs;
  - for practices in rural and remote areas that do not have access to broadband technology, there will be additional assistance with a broadband connection;
- access to support for employing a practice nurse, for those practices in urban areas of workforce shortage;

[13] HIC Online is an electronic means of allowing direct bill and patient claims to be lodged from medical practices via the Internet to HIC. It will be the mechanism by which practices participating in the General Practice Access Scheme can reduce up-front costs for any patients who are charged a gap fee.

- assistance to improve scheduling and management of their waiting lists. Funds will be made available for 'collaboratives' of participating practices to examine service demand patterns and develop more efficient appointment systems.

For a 3-doctor practice that joins the General Practice Access Scheme and currently provides 10,000 services to concessional patients per year, the annual additional funding would be between $10,000 and $63,000 depending on the location of the practice.

Table 7 provides summary information on the annual increase in income that practices with different billing practices and concessional workloads can expect to receive through the General Practice Access Scheme. The "Net Gain" for a practice is the amount received from payments under the GP Access Scheme minus the total current amount of money gained from gaps charged to patients covered by concession cards.

The scenarios are based on a practice preforming 10,000 concessional services per annum. This is close to the national average and corresponds to the level that might be found in a practice with three full-time GPs.

Table 7 models the effect of different concessional bulk-billing rates and different average concessional patient charges. The Net Gains are further split into four categories (based on Rural Remote and Metropolitan Area classifications or RRMA[14]) to reflect the differing payments per concessional service dependent on the locality of the practice. Under each category, the shaded cells indicate the current estimated average level of bulk-billing for services delivered to patients covered by concession cards.

Table 7 shows for example that practices with a close to average bulk-billing rate and currently charging a $5 gap for concessional patients who are not bulk-billed, will be better off by $5,000, $19,500, $38,000 and $45,500 respectively for RRMAs 1, 2, 3-4, and 5-7 upon opting in to the GP Access Scheme.

[14] The Rural, Remote and Metropolitan Areas (RRMA) Classification is a seven-scale classification, with two metropolitan classes, three rural and two remote classes. The foundation unit of RRMA is the Statistical Local Area (SLA). RRMA has an 'index of remoteness measure' that mixes distance and population factors. Developed in 1994 by the (then) Department of Human Services and Health in collaboration with Primary Industries and Energy, the classification uses 1991 SLA boundaries and 1991 Census population data.

Table 7 - Net Gain Scenarios based on a practice with 10,000 concessional services

Practice Concessional Bulk billing rate	Practice Average concessional patient charge	Capital Cities (RRMA 1) **Net Gain**	Other Metropolitan (RRMA 2) **Net Gain**	Rural (RRMAs 3+4) **Net Gain**	Other Rural (RRMAs 5-7) **Net Gain**
100%	N/A	**$10,000**	**$29,500**	**$53,000**	**$63,000**
95%	$2	**$9,000**	**$28,500**	**$52,000**	**$62,000**
	$5	**$7,500**	**$27,000**	**$50,500**	**$60,500**
	$10	**$5,000**	**$24,500**	**$48,000**	**$58,000**
90%	$2	**$8,000**	**$27,500**	**$51,000**	**$61,000**
	$5	**$5,000**	**$24,500**	**$48,000**	**$58,000**
	$10	**$0**	**$19,500**	**$43,000**	**$53,000**
85%	$2	**$7,000**	**$26,500**	**$50,000**	**$60,000**
	$5	**$2,500**	**$22,000**	**$45,500**	**$55,500**
	$10		**$14,500**	**$38,000**	**$48,000**
80%	$2	**$6,000**	**$25,500**	**$49,000**	**$59,000**
	$5	**$0**	**$19,500**	**$43,000**	**$53,000**
	$10		**$9,500**	**$33,000**	**$43,000**
75%	$2	**$5,000**	**$24,500**	**$48,000**	**$58,000**
	$5		**$17,000**	**$40,500**	**$50,500**
	$10		**$4,500**	**$28,000**	**$38,000**
70%	$2	**$4,000**	**$23,500**	**$47,000**	**$57,000**
	$5		**$14,500**	**$38,000**	**$48,000**
	$10			**$23,000**	**$33,000**
65%	$2	**$3,000**	**$22,500**	**$46,000**	**$56,000**
	$5		**$12,000**	**$35,500**	**$45,500**
	$10			**$18,000**	**$28,000**
60%	$2	**$2,000**	**$21,500**	**$45,000**	**$55,000**
	$5		**$9,500**	**$33,000**	**$43,000**
	$10			**$13,000**	**$23,000**
50%	$2	**$0**	**$19,500**	**$43,000**	**$53,000**
	$5		**$4,500**	**$28,000**	**$38,000**
	$10			**$3,000**	**$13,000**
40%	$2		**$17,500**	**$41,000**	**$51,000**
	$5			**$23,000**	**$33,000**
	$10				**$3,000**
30%	$2		**$15,500**	**$39,000**	**$49,000**
	$5			**$18,000**	**$28,000**
	$10				
20%	$2		**$13,500**	**$37,000**	**$47,000**
	$5			**$13,000**	**$23,000**
	$10				
10%	$2		**$11,500**	**$35,000**	**$45,000**
	$5			**$8,000**	**$18,000**
	$10				
0%	$2		**$9,500**	**$33,000**	**$43,000**
	$5			**$3,000**	**$13,000**
	$10				

*The shaded boxes indicate the approximate average bulk-billing rate (used as a proxy for Commonwealth concession card holders) for patients aged 65 or older in each RRMA category.

6.4. Simplicity

A Fairer Medicare is simple and convenient for patients. Patients will have the information to make informed choices about the practice they attend.

Practices participating in the General Practice Access Scheme will be easy for patients to identify. There will be signs in practices declaring their participation in the Scheme and both a 1800 telephone number and a web site will enable patients to identify their nearest participating practice. Patients eligible for a Commonwealth concession card will be able to easily identify bulk-billing practices and to be confident that they will be guaranteed no out-of-pocket costs when they utilise such practices.

Similarly, patients who are subject to the bulk-billing guarantee will be easy for practices to identify – on the basis of whether they are covered by a Commonwealth concession card.

For doctors, there will be no unnecessary red tape. The use of HIC Online will allow practices to lodge claims directly with the HIC. HIC Online uses information already stored electronically by a practice, eliminating the need to re-enter information or keep duplicate records.

As doctors take up the new technology of HIC Online there will be less processing of face to face transactions in Medicare Offices. The HIC is committed to keeping the Medicare Office network open and viable.

6.5. Value for Money

A Fairer Medicare produces value for money outcomes for the community. It targets a significant $917 million investment over four years to those elements of the health care system that will most effectively address the accessibility of services – the supply of doctors, the affordability of general practice, and high cumulative costs.

It will make it more affordable to visit a GP, by reducing the up-front costs of a visit where the doctor chooses not to bulk-bill and encouraging doctors to treat Commonwealth concession card holders at no cost to the patient. It will increase the numbers of doctors, nurses and other health professionals.

A Fairer Medicare is an integrated set of measures precisely because it is dealing with some complex challenges for which there are not simple, one-dimensional solutions.

7. RELATED GOVERNMENT INITIATIVES

A Fairer Medicare is the most recent response by the Government to some long-term challenges for the Australian health system. It is important to consider this broader context and to note the considerable success that many existing programs are having in addressing some of the key issues facing Australia's health care system. At the same time, it is important to be clear about the roles and responsibilities of various players at the Commonwealth, State and non-government levels.

7.1. Workforce Programs and Effectiveness

Measures have been successfully implemented to more closely align the distribution of the medical workforce to population needs and improve access to GP services. These measures have been designed to have an impact over the short, medium and long term.

In the short term, the Commonwealth has been able to direct overseas-trained doctors to provide medical care to rural and regional communities by making their access to Medicare provider numbers dependent on them working in districts which are experiencing workforce shortages.

In 2001/02, an estimated 4,910 exemptions were granted to around 1,379 overseas trained doctors to work in locations where there was a shortage of doctors. The majority of these locations are in rural and remote areas.

Several medium to longer-term strategies to redistribute the medical workforce have been introduced. These include:

- support for primary care in regional areas;
- financial incentives for rural general practitioners;
- support for specialists providing rural outreach;
- establishing a network of Rural Clinical Schools and University Departments of Rural Health;
- scholarships for rural students in medical and health courses.

Since 1996, the Commonwealth government has spent more than $2,000 million on rural health initiatives including more than $560 million, through 'More Doctors, Better Services', to get more doctors and health workers out to areas of need and keep them there.

The evidence to date suggests that these policies are working well. The number of FWE general practitioners in rural Australia has increased by 11.4 percent over the past five years, including a 4.7 percent rise in the most recent year. As at the end of June 2003, some 58 general practitioners had been approved to relocate to outer metropolitan areas under the More Doctors for Outer Metropolitan Areas program and a further 22 general practice registrars were undertaking 6-month placements in these areas.

However, further improvements are needed and the workforce supply initiatives in A Fairer Medicare address these needs. As noted, these include short and long term measures through new medical school and general practice training places and additional nurses and allied health professionals in general practice.

The new initiatives are focussed on areas of workforce shortage in rural, remote, and outer urban communities and will complement current rural and remote programs in reducing workforce imbalances.

7.2. Managing Chronic Disease

In Australia, chronic diseases that are mostly preventable are estimated to be responsible for 80 percent of the total disease burden.

The Commonwealth government is addressing chronic disease prevention and treatment across a wide range of activities, including through:

- Enhanced Primary Care items for health assessments, multidisciplinary care planning and case conferencing;
- introducing a new Medicare item (in 2001) to support GP involvement in collaborative medication management reviews with pharmacists;
- supporting Coordinated Care Trials that are identifying better ways of managing care for those with chronic and complex conditions.

The Commonwealth government introduced general practice incentives in the 2001 Budget to improve the management of asthma, diabetes and mental health.

Through the Sharing Health Care Initiative, $14.4 million has been provided over four years to assist people over 50 to understand their illnesses and identify better ways to manage their conditions. Sharing Health Care aims to improve quality of life and to contribute to a strong evidence base on self-management models and methods for the Australian health care system. Funding for this initiative has been continued in the 2003 Budget with a further $21.8 million becoming available over the next four years.

The Commonwealth government has for several years identified national health priority areas, many of which have been areas of chronic disease. The programs listed above link closely with these priority areas, which also have their own funding for a range of targeted activities. They are also closely aligned with the research undertaken by the National Health and Medical Research Council through its Systems of Care for Chronic Disease Research Program. Projects funded by the Council include the management of diabetes care in Indigenous communities, multidisciplinary collaborative care for vascular disease, chronic disease self-management, and telephone support from chronic heart failure patients.

7.3. Focus on Prevention

It is the intention of the government to make prevention a fundamental ‘fourth pillar’ of Medicare. To prepare for meeting the needs of an ageing population, it is essential that the health system becomes focussed on health rather than illness.

As part of the 2003/04 Budget, some important steps are being taken. The *Focus on Prevention – Community Awareness and Infrastructure* initiative provides $4.3 million over three years to promote the prevention role of general practice to both GPs and the community.

GPs are often the first port of call for people seeking information about their health and are ideally placed to offer advice and assist people to achieve a healthy balance in their lifestyles. This initiative will include the development of a national approach to lifestyle prescriptions, which GPs can use to encourage healthy lifestyles such as not smoking, drinking in moderation, eating healthily and being physically active.

Up to $20.4 million over four years is being provided to a new initiative to promote a quality improvement culture in general practice and primary health care. The Primary Care Providers Working Together Initiative is part the prevention focus, aimed at improving prevention, health promotion and chronic disease management across the primary health care system.

The Initiative will bring together small groups of GPs, other health professionals and consumers in their own communities to work on improving a particular issue, following a method of continuous quality improvement based on a methodology successfully undertaken in the primary care environment in the UK, USA and Europe.

7.4. Dental and Allied Health

The Commonwealth and the States play different roles in supporting Australia's mixed system of public and private dental and allied health care.

The Commonwealth has undertaken some specific initiatives of relevance to the provision of allied health services. These have focussed on capacity building and information analysis and the provision of Medicare funding for a limited range of services of surgical and diagnostic nature that are delivered by allied health professionals.

The Commonwealth government has no direct role in the provision of public dental and allied health services. Where these services are provided as public hospital services, funding is provided to the States through the Australian Health Care Agreements. This funding is not separately identified for the provision of particular types of public hospital services, such as dental or allied health services. However, where particular types of services were provided free of charge as public hospital services on 1 July 1998, under the AHCAs, States are responsible for ensuring that those services continue to be so provided

The States are best placed to identify and resolve structural, management or financial problems affecting the quality and accessibility of public health care. If more funding is needed for the public dental and allied health network, States can choose whether to use their own revenue sources or commit some of the additional $10,000 million offered in the next round of the Australian Health Care Agreements.

Most dental and allied health services are provided in private practice. For many Australians, especially families, the key to accessing affordable services has been through private health insurance ancillary cover. Eighty percent of ancillary benefits paid to members were for core health services of dental (48 percent), optical (17 percent), chiropractic (7 percent) and physiotherapy (7 percent). The Commonwealth government funding for these services is provided indirectly through the 30 percent PHI Rebate. That is over $1,500 million a year for these four services.

8. CONCLUSION

Australian's health care system is widely regarded as world class, both from an efficiency and effectiveness perspective. The Australian people are among the healthiest in the world, with among the highest life expectancy and 'healthy' life expectancy in the world.

Medicare has underpinned the Australian health care system for almost twenty years. In that time, it has served the health care needs of Australians well, ensuring universal and affordable access to necessary services and treatments, whether provided within a hospital or community setting.

In those twenty years, there have been some important changes to the environment in which Medicare operates.

The population is ageing, increasing the expected utilisation of health services and the incidence of chronic disease. Technological advances are increasing the capacity of our health system to respond to disease, but also adding very significant cost pressures to the system. The nature of service delivery is changing. Many procedures and treatments that were once only available in hospitals are now provided safely in the community. Consumers expect more from the health system. Conditions that were tolerated in the past are now widely accepted to be treated.

The demands on the system over the past twenty years are becoming manifest in:

- pressure on primary care services to prevent and manage chronic conditions;
- reduced access to affordable services, particularly outside the capital cities;
- increased cost (for government and patients) of medical services, particularly where technology has enabled these services to move from hospital to community settings.

The Commonwealth government has developed A Fairer Medicare as a considered and balanced response to the challenges that have emerged over the last twenty years. It has been developed in a way which reflects the guiding principles – the universality of Medicare; equitable access to doctors; fairness; sustainability; simplicity; and adherence to current fee setting parameters.

Some essential features of A Fairer Medicare are:

- a sustained investment in the medical workforce, targeted to areas of greatest need where insufficient doctor numbers are impacting on patient access and cost;
- targeted incentives for general practice that address barriers to affordable patient access, both in regard to the cost of services for those on low incomes, and the up-front cost;
- safeguards to protect those members of the population who need multiple services in a year from significant accumulating costs.

Through A Fairer Medicare, the commitment to maintaining and strengthening the fundamentals of the Medicare system remain, ensuring – in a changing environment - that all Australians are able to access appropriate, affordable medical services when needed.