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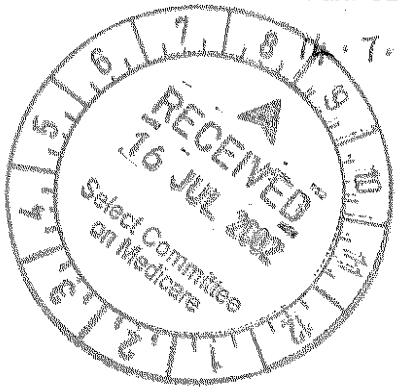

16.7.03

The Secretary,
The Senate Committee Inquiring into MEDICARE.
Parliament House,
Canberra. ACT.

Dear Secretary,

I crave your indulgence to receive these comments, and apologise that, as a busy country general practitioner I have neither time nor facilities to provide these comments in a typed form.

So you may be aware of the bases for these comments I advise that I graduated in Medicine 51 years ago, during which time I have been a country GP, a hospital administrator, Medical Director of the Health Insurance Commission and Chairman of the previous Capital Territory Health Commission. I have been responsible for development of alternative systems of health insurance and health delivery by HIC in 1975-80. As Chairman of CTHC 1980-85 I had responsibility, inter alia, for the provision of GP services to a large number of ACT population by salaried medical practitioners.

Since 1985 I have conducted a rural GP practice without hospital facilities. I am the local representative on the South East Division of General Practice.

I wish to put forward some views which may be seen as both radical and possibly retrogressive in the process of a review of the role, ambition and function generally related to Medicare, the funding arrangements for health care in the Australian community.

The present system is wholely a fee for service system outside the hospital environment. The system has been picked up by Corporate organisations with an eye to profit making.

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The fee for service system with approximately 75% of GP services historically since 1975 being "bulk billed" is failing to adequately support the traditional practitioner, outside Corporate practices, where "value adding" can be effectively managed, with corresponding increased Corporate profits.

The traditional GP, particularly in country, isolated and remote areas is finding the economics of practice becoming increasingly negative.

Changes to Medicare which only links with the level of rebate a "common fee" will not meet the needs of the Australian community as such changes will not support the "traditional" GP. Underline the fact for remote, isolated situations.

Some relief has been given by the Rural Retention Grants and some limited aspects of the Enhanced Primary Care items. Unfortunately in the busy GP practice little time is available to cope with the extension forms required for EPC. The other aspect of EPC is the feeling of many GP's that the items do not improve the level of client care as the requirements are only the matters normally conducted in practice, but the time required to document this fact is not available.

I must to make a few positive suggestions, some of these matters were investigated in 1975-80 but fell before the icon of "Community Rated Health Insurance."

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I would recommend that the Commonwealth, responsible for funding community services - to 55% or more of the common fee, should look at alternative methods other than "Fee For Service".

I recommend that investigation should evaluate a community salaried medical service, which could be generalised or localised to remote, isolated areas, to which doctors cannot be attracted.

Who could conduct a salaried medical service, designed to provide community health care without the motivation of profit making?

The Health Insurance Commission with Medibank wide cover could conduct services providing health care equally as well as they can conduct the current funding. This process would need a policy change to allow other Health Funds to equally provide health services to avoid monopoly and to meet requirements in relation to Competition.

Medibank Private has from its 1980 provided health insurance on an experience related basis. This enabled health insurance to cover members of associated organisations at half the cost of the then current Community rated insurance.

It was not a large step from experience rated insurance to provision of actual health care

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During my time with CTHC, the community medical practitioners provided full GP services including on call one night and weekend in four. They also provided health advice and lectures to schools, various supporting health organisations and local bodies. An example of this is the world wide use of bicycle helmets which can be traced to one Canberra salaried GP.

The CMP GP's in 1950's received salary of $60,000, free use of motor vehicle, INDEMNITY INSURANCE COVER, regular holidays and sabbatical leave. Offer this to GP's in equivalent terms and no shortage of applicants would ensue. For remote areas the fear of the solo doctor on call 24 hours, 7 day weekly and no holidays could be overcome by always providing the community with two doctors.

If tinkering is all that is acceptable, I would suggest the the Rural Retention Grant be significantly increase. That the current rebate should be increased for a standard item by at least 50 dollars immediately, other items pro rata. The EPC items should be deleted except in relation to diabetes, for which increased rebate is required. I would dispose of Healthcare plans, assessment which provide no client benefit.

It is a time for major changes. The health fund structure, have the ability to provide change of their policy chains are struck from their frames.

I am respectfully Ken Doust.