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MINISTER FOR HEALTH

ATTORNEY GENERAL; ELECTORAL AFFAIRS

FOR WESTERN AUSTRALIA

Senator Jan McLucas
The Chair
Senate Select Committee on Medicare
Suite S1 30
Parliament House
CANBERRA ACT 2600

Dear Senator McLucas

Please find attached the Western Australian Government submission addressing the terms of reference for the Senate Select Committee on Medicare.

I look forward to the outcomes of this Committee, which I anticipate will improve the access and affordability to primary care for all Australians.

Yours sincerely

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MINISTER FOR HEALTH

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28 JUL 2003

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SENATE SELECT COMMITTEE ON MEDICARE
WESTERN AUSTRALIAN SUBMISSION

BACKGROUND

The Australian health care system continues to rank among the best in the world. The Medicare policy provides the framework for the system.

The principal of universality, which underpins Medicare, ensures that people are able to access the health services they need regardless of the ability to pay.

Under Medicare, through the Commonwealth's Medical and Pharmaceutical Benefits schemes, people can access services from private doctors and pharmaceuticals at subsidised rates or, in some cases, free of charge.

People requiring hospital care have the option to access free public hospital services if they choose to be treated as public patients. They can also elect to be treated as private patients in private or public hospitals, in which case they receive subsidised treatment.

There are few countries that maintain comparable standards of quality in training medical practitioners and other health professionals, or which have health infrastructure of a similar standard to Australia.

The principle of universality which underpins Medicare means that there is a single basis for the provision of care for all Australians. Government subsidies towards care mean that many people who would be unable to afford health care in other countries are able to access the highest quality care in Australia.

Despite the generous subsidies provided through Medicare, among nations Australia is not one of the highest spenders on health services. In 2000 Australia spent around 9.0% of our Gross Domestic Product on health, but this compares to countries such as the United States (13.0%), Germany (10.6%) and France (9.5%)[1].

PRESSURES ON THE HEALTH SYSTEM

While the Medicare policy has significant strengths, at the same time there are pressures on the health care system and it is increasingly showing increasing signs of stress.

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[1] Source: Australian Institute of Health and Welfare, "Health Expenditure Australia: 2000-01", 2002

People are on average seeing doctors more frequently and using more prescription pharmaceuticals[2]. In addition, new technologies are increasing costs, which is particularly evident in the area of pharmaceuticals. As a consequence, the cost of these programs has escalated rapidly.

While the Commonwealth has pursued a range of piece-meal measures to control expenditures, its main strategy has been to avoid increasing MBS schedule fees and rebates. As a consequence, the amount of MBS rebates has lagged behind growth in the cost borne by doctors in delivering medical services. That has in turn led to a reduction in the proportion of bulk-billed services, with the percentage of general practitioner attendances that are bulk billed nationally having decreased from 79.7% in 1996/97 to 74.1% in 2001/02 and 67.8% in the March quarter 2003[3].

In the area of pharmaceuticals, the Commonwealth has also pursued a number of piece-meal changes. In its 2002/03 Budget it sought to substantially increase patient co-payments under the PBS, but its proposed increases were rejected in the Senate.

Similarly, there have been large increases in the funding required to deliver public hospital services. Public hospitals are required to provide a full range of emergency and acute care services and ongoing care for people with chronic conditions. They are also expected to provide the latest available modes of service, provide training for medical practitioners and be leaders in research and development. Private hospitals do not provide an alternative to many of these public hospital roles.

Although Commonwealth expenditures on public hospitals increase automatically in response to growth in the number of MBS-subsidised services, the Commonwealth caps its financial contribution towards public hospital services, leaving States/Territories to bear the risk of growth in demand and costs. Unfortunately, States/Territories have limited financial capacity to respond to growing expenditure needs.

There is also recognition that the different parts of the health system often do not relate well to each other. In particular, there is lack of coordination across the primary, acute and continuing care sectors.

It is recognised that a factor hindering coordination is that the States manage public hospital service provision and a range of community care and continuing care programs, while services provided by general practitioners, pharmacists, private hospitals and medical specialists in private practice are usually Commonwealth-subsidised.

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[2] Source: Commonwealth Department of Health and Ageing, "Medicare Statistics", various editions.

[3] Source: Commonwealth Department of Health and Ageing, "Medicare Statistics, 1984/85 to March Quarter 2003", 2003

Some of the key problems that have arisen are:

- Confusion about the appropriate setting for care when patients are discharged from hospital - whether care should be provided through hospital outpatient departments or by the patient's general practitioner.

- Problems with the availability of general practitioners leading to people seeking treatment in public hospital emergency departments for problems that could be dealt with by a general practitioner.

- Shortages in the availability of residential aged care places resulting in persons requiring this accommodation being accommodated on a long term basis in public hospitals.

Another crucial problem is that the health system has not been effective in addressing the needs of some groups. Aboriginal people continue to have very poor health status compared to the population average. Mainstream modes of service delivery sometimes do not respond well to the health needs of Aboriginal people, which is evidenced by low levels of Aboriginal access to MBS-funded services.

An overlapping issue is the low availability of primary care services in rural and remote areas. In this regard, while in 2001/02 the Commonwealth spent on average $392 per person[4] on subsidising medical services through the MBS, in rural and remote areas the average per capital expenditure was often less than $100 per person[5] That is anomalous when the health status of people in rural and remote areas is comparatively poor, especially for Aboriginal people.

The low per capita MBS expenditure is principally explained by the shortage of doctors in rural and remote areas. This lack of access to private general practitioner services drives people in these areas to rely on public hospitals for all or almost all of the health services they require.

DEVELOPMENT OF A HEALTH REFORM AGENDA

Recognising the range of issues confronting the health system, State/Territory and Commonwealth Health Ministers agreed on the need to develop a reform agenda in early 2002.

Ministers established nine reference groups to consider and make recommendations on reform in key areas. The reference groups largely comprised independent experts.

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[4] Source: Commonwealth Department of Health and Ageing, "Medicare Statistics, 1984/85 to March Quarter 2003", 2003

[5] Source: derived from unpublished Health Insurance Commission statistics on MBS payments by postcode

The topics included:

(1) the continuum between preventative, primary, chronic and acute models of care;
(2) the interface between aged and acute care;
(3) collaboration on workforce, training and education;
(4) the interaction between hospital funding and private health insurance;
(5) improving indigenous health;
(6) improving mental health;
(7) improving rural health;
(8) quality and safety; and
(9) information technology, research and 'e-health'.

Using the reference group reports, Ministers identified a list of priority areas, which included:

- Hospital interface issues
- Strengthening the continuum of care
- Establishing a single, national system for pharmaceuticals.

Ministers also agreed the reform agenda would put a priority on population groups with the greatest need, and that particularly Aboriginal and Torres Strait Islander people would be a high priority.

A Health Deputy CEOs Group was convened to progress the Ministers' priorities and has now prepared a report with a proposed reform agenda.

However, the Commonwealth has placed a limit on a reform program, indicating that it will only be interested in reforms that can be pursued within existing resources.

State and Territory Health Ministers have expressed their strong concern over the Commonwealth limitation on the reform agenda. Their view is that improving health services for the community should be a priority of all governments, and that if a reform is of sufficient value then governments should be prepared to invest additional resources to allow that reform to proceed.

WESTERN AUSTRALIAN PERSPECTIVE

The Western Australian Government is anxious that Western Australians should receive the health services that will optimise their health outcomes. The State is concerned that services should be of consistently high quality and that the people should have equitable access to health services regardless of their income, geographic location and other circumstances.

The State is concerned by the range of problems confronting the health system described above, and strongly supports the reform process commenced by Health Ministers.

Western Australia also shares concerns by other States/Territories about issues including the need to better integrate health services, the decline in bulk-billing and the need for increased funding for public hospitals.

Four issues the State feels should be highlighted include:

- Because of the wide geographic spread of the State, many communities in rural and remote parts do not have access to primary health care services. The extremely low population base outside Perth makes it very difficult to provide primary medical services to these areas under the current Medicare arrangements.

- Access to primary health care services by indigenous communities in rural and remote areas is particularly poor because of a lack of general practitioner services.

- A significant part of the population outside of Perth does not have immediate access to private hospital services and therefore the lack of primary care has an even larger impact on the public hospitals.

RESPONSE TO INQUIRY TERMS OF REFERENCE

The access to and affordability of general practice under Medicare, with particular regard to:

(a) The impact of the current rate of the Medicare Benefits Schedule and Practice Incentive payments on practitioner incomes and the viability of bulk-billing practices;

As noted earlier, the Commonwealth has sought to achieve financial objectives by avoiding increases to MBS rebates, and a consequence has been that the rate of bulk-billing of general practitioner services has declined significantly since the mid - 1990s.

The medical profession has repeatedly raised concerns about the inadequacy of rebates.

In 1995 the Commonwealth Department of Health and Ageing and the Australian Medical Association commenced work on a *"Relative Value Study"*, intended to be a comprehensive review of the Medicare Benefits Schedule.

It is understood work on the Relative Value Study is still to be finalised. However, based on the work undertaken thus far, the AMA has

adopted the strong view that MBS schedule fees should be increased substantially. For example, the schedule fee for a Level B Consultation should be around $44, almost twice the present level.

Although the level of MBS rebates is an issue generally, the issue is greater in rural and remote areas. The Commonwealth provides MBS rebates at a nationally consistent rate. However, the cost of living is higher in rural and remote areas, and due to a range of lifestyle and other factors it is difficult to attract doctors to these areas.

Commonwealth data shows that in 2000/01 in capital cities 83.6% of general practitioner services were bulk-billed, but this declined to 58.5% of services in remote centres[6]. Knowledge that there are a comparatively high proportion of people on low incomes in remote areas makes this statistic more concerning.

The Commonwealth previously provided a loading for medical services delivered outside of normal working hours. However, this was discontinued, resulting in rebates being the same regardless of the time at which a service is delivered. This has resulted in it becoming difficult for patients to see doctors except during normal business hours. As a consequence, after hours a significant proportion of demand for general practitioner - type services has been shifted onto public hospital emergency departments.

The introduction of the Practice Incentives Program has provided some buffer to practitioner incomes although this has been very much at the margin. In any event, the scope for this to continue is becoming less. While this program has worked well in some instances such as immunisation, there are other areas including asthma and mental health where the program has not operated optimally. In fact many practitioners are of the view that the Practice Incentives Program is increasingly being hamstrung by red tape. In this regard there is a view that rather than focus on meeting agreed outcomes, practitioners spend much of their time dealing with cumbersome administrative arrangements.

In essence, practitioners gain little net benefit from the Program. Moreover, funding from this Program only represents a small proportion of the total operating revenue for most practices and therefore adds almost nothing in terms of maintaining a viable general practice.

[6] Source: Commonwealth Department of Health and Ageing, "Medicare Statistics", various editions.

The March 2003 Productivity Commission report "*General Practice Administrative and Compliance Costs*" found that in 2001/02 (using base case assumptions):

- the estimated administrative costs for general practitioners and general practice resulting from Commonwealth policies and programs was about $228 million, or 5% of the estimated total income of general practitioners; and

- nearly 39%, or $75 million of the $193 million outlay on the Practice Incentive Program (PIP) were accounted for by administration and compliance costs.

(b) The impact of general practitioner shortages on patients' ability to access appropriate care in a timely manner;

Many people in rural and regional Western Australia are not getting the primary health care that they need and which people in inner city suburbs take for granted.

There is no question that a patient's ability to access and receive timely and appropriate care is inextricably linked to the number of general practitioners providing primary health care services in their local area.

Western Australia has fewer medical practitioners per capita than other States/Territories. In this regard, the Australian Institute of Health and Welfare (AIHW) Medical Labour Force Survey determined there were:

- 224.6 clinicians per 100,000 population in Western Australia compared to the national average of 249.0 clinicians per 100,000 population;

- 81.6 specialists per 100,000 population in Western Australia compared to the national average of 89.7; and

- 99.7 primary care practitioners (i.e. general practitioners) per 100,000 population in Western Australia compared to the national average of 110.0.

Shortfalls in rural and remote areas are a primary contributor to the below average numbers in Western Australia.

The State's north west provides the most extreme example of the shortage of doctors. There are a total of 44 general practitioners in the Kimberley region and 47 in the Pilbara region[7]. Most of these doctors are either salaried or spend most of their time providing services as visiting medical practitioners (VMPs) on contract to public hospitals. The VMPs may offer private services in addition to their work at a public hospital. However, the total number of general practitioners providing exclusively private services is less than 10, while the region (the Kimberley and Pilbara combined) has a population in excess of 80,000.

The shortage of doctors leaves patients reliant on public hospital emergency departments to access primary care services. In the Kimberley region, for example, the demand from patients requiring general practitioner - type services has led most hospitals to establish an appointments system for people to book to attend their emergency departments.

Emergency departments are not an appropriate setting for the provision of primary care services. They are geared to respond to acute and urgent health care needs. Their infrastructure makes them an inefficient setting for the provision of primary care services. There is also the risk that the provision of primary care services in emergency departments may hinder their capacity to respond to genuine emergencies.

Addressing the issue of shortages of private medical practitioners will require substantial effort. It may be necessary to tailor solutions to the type of area or to specific areas.

In rural areas, some initiatives that could be considered are:

- Introduction of blended payment arrangements, so that doctors are not exclusively reliant on fee for service remuneration. This would be particularly attractive to general practitioners in localities where the population varies seasonally, as it would even out their income stream and allow the practice emphasis to shift to efforts (such as prevention and promotion) that are not currently rewarded under the MBS.

- Encouraging the formation of group practices across solo doctor towns to reduce overheads and provide support for individuals. This may include practice management and pharmacy services to be provided through Divisions of General Practice or through other organisations.

[7] Verbal advice from the WA Council for Rural and Remote Medicine

- Recognition of rural Shire financial contributions to attract rural general practitioners by supporting adjustments to Local Government Grants Commission formulae.

- Introduction of a rebate to rural shires in circumstances where they have underwritten the income of a general practitioner and the general practitioner is not vocationally registered.

For remote areas we need to accept that, regardless of incentives offered, it will not be possible to attain a sufficient medical workforce.

To meet needs in remote areas it is essential that we develop alternative service delivery models. In this regard, for example, the Commonwealth Primary Health Care Access Program (PHCAP) offers the potential to "cash out" funds that might be spent on delivering MBS-subsidised services and instead use the funds flexibly for meeting the primary health care needs of the local population. The PHCAP model has been applied extensively in the Northern Territory, but the Commonwealth has been reluctant to extend the program to other jurisdictions.

Another approach is to extend the role of nurses through a "nurse practitioner" model as has been legislated in Western Australia. Under this model, nurse practitioners can assess, diagnose, treat and discharge patients. Nurse practitioners are able to prescribe some medications, order of laboratory and radiological investigations and refer patients to specialists. The role could be enhanced if nurse practitioners were able to gain access to a Medicare provider number and/or be allowed to prescribe PBS pharmaceuticals.

(c) The likely impact on access, affordability and quality services for individuals, in the short and longer term, of the following Government-announced proposals:

(i) Incentives for free care from general practitioners limited to health care card holders or those beneath an income threshold,

Most general practitioners already provide bulk-billing for the majority of pensioners and cardholders. The new measures are unlikely to impact significantly to the way these groups pay for their services.

On the other hand, with no incentives offered to bulk-bill non-card holders, doctors may seek to extract greater payments from these patients, increasing the cost of services to these people. This is particularly concerning for families and people on low and moderate incomes, services for whom would not qualify for the Commonwealth subsidy.

(ii) ***A change to bulk-billing arrangements to allow patient co-payment at point of services co-incidental with direct rebate reimbursement,***

From a patient perspective, the patient paying only the difference between the rebate at the doctor's fee at the time of treatment could be more convenient. However, patients might gain a false impression that they are paying a lesser fee for the service they are paying than presently. The illusion of lower fees may allow doctors to more readily increase their fees.

Given the incentive to bulk-bill cardholders, fee increases associated with the co-payment at point of services would impact most on people on low and moderate incomes who do not qualify for health cards.

Assuming most cardholders will be bulk-billed, doctors are likely to charge all other patients a co-payment that, on average, could be $20 to $25. This is consistent with the drop-off in bulk billing generally seen over the last few years.

An implication may be that patients, instead of visiting their general practitioner, will ultimately attend the emergency department at the nearest public hospital. However, it is also likely they will present "sicker" having put off attending their general practitioner because of the cost.

(iii) ***A new safety net for concession cardholders only and its interaction with existing safety nets,***

The concept of a safety net is supported in principle as long as the system is administratively simple and automatic for all cardholders. It would be preferable that cardholders experience no out-of-pocket expenses for primary medical treatment, equivalent to public hospital services.

Under the existing arrangements the safety net is relatively simple covering all patients not just cardholders. The scheme provides for Medicare to pay the difference between the rebate and the scheduled fee once a patient has reached a threshold of $319.70 out of pocket expenses in any one calendar year.

As part of the new arrangements, the Commonwealth Government is now proposing a second scheme for cardholders only. Under this scheme, cardholders will have to reach a threshold of $500 per calendar year but thereafter, will be entitled to receive a benefit equivalent to 80 cents in every dollar for the difference between the Medicare rebate and the entire fee charged by the practitioner.

If nothing else, the additional safety net arrangements fail the test of administrative simplicity. Furthermore, the separate safety nets may lead to inequitable outcomes and a two tiered system. Depending on what level of fee a particular doctor charges, a cardholder may receive a benefit from one or other of the schemes. In the event the patient exceeds the current arrangements and reaches the criteria for the new safety net they will receive a different benefit from the existing scheme. Aside from being confusing and in all likelihood not well understood by the general public, a more equitable approach would be to have the one scheme for all patients.

(iv) Private health insurance for out-of-hospital out-of-pocket medical expenses; and

The proposal to allow private health funds to insure for out-of-hospital out-of-pocket expenses is unlikely to improve the access and affordability of primary health care.

It is understood the intent is that insurers would provide cover for costs totalling in excess of $1,000 per year. Insurance for out-of-hospital out-of-pocket medical expenses would be an optional add-on to health insurance policies, similar to insurance for ancillary services.

The restriction to costs in excess of $1,000 per year would make this type of insurance probably only relevant to people with chronic health conditions who are required to make frequent visits to medical practitioners.

People with chronic medical conditions are often on low or moderate incomes. However, people on these incomes are unlikely to be able to afford to purchase insurance or upgrade existing policies if they have them. Moreover, to the extent that the incentives for bulk-billing cardholders are successful, this form of insurance may not be relevant to people on low incomes.

People on higher incomes are the most likely to purchase insurance, but are generally able to afford out-of-pocket expenses for services delivered by medical practitioners.

A concern would be that the ability to insure for out-of-pocket expenses could remove existing constraints on doctors fees. Some doctors might feel an obligation to minimise fee increases, but with the knowledge that if they charge higher fees these will be covered by insurers, be prepared to increase their fees at a faster rate.

The Commonwealth might also regard the ability of people to insure for higher out-of-pocket expenses as diminishing its responsibility to adequately index MBS schedule fees.

Instead of the approach the Commonwealth is pursuing, it would seem more appropriate for them to pursue a more general safety net arrangement to protect against people paying an excessive proportion of their incomes on general practitioner services.

(d) Alternatives in the Australian context that could improve the Medicare principles of access and affordability, within an economically sustainable system of primary care, in particular:

(i) Whether the extension of federal funding to allied and dental health services could provide a more cost-effective health care system,

There are presently no MBS rebates for general dental and allied health services. Although it is possible to insure to obtain partial cover for these services.

The Commonwealth's 30% private health insurance rebate is, to an extent, subsidising allied and dental treatment by providing a subsidy for people to insure for ancillary services. This subsidy is benefiting people who can afford to purchase health insurance. It is ironic that the most financially disadvantaged people, who cannot afford insurance, are not able to access any Commonwealth subsidy towards these types of services.

Given the lack of MBS cover, people on low incomes are unable to afford adequate access to dental and allied health services. They tend to access dental services when emergencies arise, which is generally later than desirable to achieve the best patient outcome. They also avoid accessing services such as physiotherapy, except when this is provided free of charge through a public hospital.

There is wide recognition that dental health has strong links to an individual's general health.

In this regard, a report prepared for the Australian Health Ministers' Conference, titled "Oral Health of Australians: National Planning for Oral Health Improvement" (2001) highlighted the following connections between oral and general health:

- *"As a consequence of shared determinants, general disease and oral disease often occur together. Co-morbidity is most notable in older people."*

- *"An oral disease is occasionally the first clinical sign of a wider systemic disease. The oral cavity can act as a window to the body and has diagnostic advantages through direct observation of affected tissues."*

- *"Oral diseases and disorders are increasingly being conceptually and empirically associated with general diseases."*

The report concludes that oral diseases and disorders contribute substantially to the total burden of diseases and the cost of illness in Australia.

In a similar vein, allied health professionals can also play an important role in the determination of a persons general health. This is particularly the case with older more frail patients where they suffer from debilitating chronic illnesses. The provision of allied health services for people in the community not only has a direct impact on their immediate condition but also on their broader health and well being including their mental health.

Access to dental and allied health services in the community will clearly alleviate pressure on the public hospital system by, in some cases, avoiding the need for hospitalisation either through remedying the problem altogether or through better ongoing management of the condition. As a result of this strategy, many patients would be able to be treated in their preferred environment (in the community or their home) and it should also lead to cost savings to the health system.

Extending federal funding to allied health and dental health services could be achieved either through an extension of the MBS or through specific program funding.

For dental services, consideration could be given to the introduction of specific program funding similar to the former Commonwealth Dental Program which operated in the mid 1990s. Unfortunately, the CDHP was discontinued in December 1996 following the election of the current Commonwealth Government.

The cessation of the Commonwealth program left States and Territories under pressure to fill in the void left by the program. States/Territories have responded in different ways, and this has led to varied arrangements.

The existing State/Territory schemes continue to be under pressure with growing demand for subsidised services.

(ii) The implications of reallocating expenditure from changes to the private health insurance rebate, and

The Commonwealth is spending nearly $2.5 billion per year on the 30% private health insurance rebate.

A report by Professor John Deeble, *"The Private Health Insurance Rebate"* (January 2003), commissioned by State and Territory Health Ministers, argues that the rebate has failed on both economic and health service criteria. Deeble found that Lifetime Health Cover, the other major government reform, has had a far more dramatic affect on private health insurance membership.

Assessed against equity criteria, a high proportion of expenditure on the 30% rebate is contributing towards meeting the cost of insurance policies for people on middle and higher incomes. An analysis of the income status of people benefiting from the rebate should be possible using Commonwealth taxation data.

A particular issue is the relevance of the rebate and other incentives to purchase health insurance for people in rural and remote areas. People in these areas gain little from having health insurance because they do not have access to services for which insurance is relevant. For example, in Western Australia, there are only two private hospitals outside of the Perth metropolitan area.

Despite generally not having access to services for which insurance is relevant, under Commonwealth policies people on higher incomes in rural and remote areas are subject to a tax penalty if they do not have insurance. Under the Lifetime Health Cover they are also subject to having to pay increased premiums if they delay purchasing insurance, even if they decide not to purchase insurance for a period while living in a remote area.

Although the Commonwealth claims that the 30% rebate has shifted demand to private hospitals, and alleviated pressures on the public hospital system, it is not clear to what extent this has been the case.

There has been an acceleration in service provision in private hospitals, but instead of being wholly the result of a transfer from the public to private sector, this may be partly the result of factors such as a continuing trend for services previously provided by specialists in their rooms to instead be provided in private day surgery clinics. It is also the case in Western Australia that the State has increasingly contracted private providers to deliver public patient services. Service provision contracted to private providers is not reflected in national statistics counting public hospital services.

Furthermore, unlike public hospitals, private hospitals do not necessarily do work on the basis of clinical need. There is uncertainty about the extent to which increased health insurance membership is leading, via increased private hospital activity, to the nation better meeting the most urgent cases that should be dealt with by hospitals.

Given the differing views and the present lack of clarity about the implications of the health insurance rebate, a rigorous independent assessment should be undertaken. Such an assessment could investigate the impact of the rebate on health insurance membership, analyse the impact of any associated increase in insurance on the demand and mix of public and private hospital services and examine the rebate in relation to efficiency and equity principles. Consideration should also be given to whether and what extent the rebate is also contributing to areas such as the delivery of emergency services, clinical development and training and research, which are key functions of public hospitals, but not necessarily areas of significant interest for private hospitals.

If an assessment determines that the rebate is not an effective policy, there would be a number of options for use of the funds now devoted to the rebate.

Based on a 2000/01 AIHW estimate that the national average cost per casemix-adjusted separation was $2,834, the $2.5 billion per year now spent on the rebate could alternatively fund around 900,000 additional inpatient services in public hospitals.

There would also be the potential for some funds to be used to support the establishment of community health centres and multi purpose centres in rural and remote areas. The funds might also be used to increase Medicare rebates, particularly for services provided by general practitioners.

(iii) ***Alternative remuneration models that would satisfy medical practitioners but would not compromise the principle of universality which underlies Medicare.***

In designing remuneration arrangements for doctors, the primary objective should be to achieve the best delivery of care for patients in the most appropriate setting.

As noted earlier, Health Ministers have been developing a reform agenda which is considering issues such as how to improve the integration of services and achieve greater continuity of care.

Remuneration models for doctors would necessarily be considered as part of this work. For example, one outcome of work might be to introduce forms of blended payment systems, wherein doctors would receive remuneration for providing some services on a population basis in addition to the standard fee for service payments through MBS.

Another issue is the delivery of general practitioner - type services in public hospital emergency departments. Given that these services are equivalent to services provided outside-of-hospitals, it may be appropriate for these services to be funded through MBS.

Unfortunately, due to a Commonwealth limitation that reforms will only be considered if they are able to be pursued within existing resources, work on the reform agenda has largely stalled.

As noted earlier, Western Australia is particularly concerned about the shortage of doctors in rural and remote areas.

Remuneration arrangements to encourage more doctors to work in remote areas should be considered.

Telehealth services represent a mechanism through which some services might be extended to people in rural and remote areas. Unfortunately, the Commonwealth has indicated it is generally not prepared to fund medical services through MBS unless they are provided face-to-face. This is seen as a major impediment to the development of telehealth. One of the reasons is that, if private clinicians cannot gain access to MBS for providing telehealth services, then it restricts the development of telehealth to the public domain.