DR SHAWN RUDD
18/36 BAROLIN ST
BUNDABERG.

New Sub
at Bundaberg
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Wide Bay Division of General Practice Assoc Inc

ABN 48 308 972 753

Supporting and enhancing general practice and its central role in an integrated approach to effective primary health care.

Senate Select Committee on Medicare

Access and Affordability of General Practice

(a) The impact of the current rate of the MBS and PIP on practitioner incomes and the viability of bulk-billing practices.

The current Medicare rebate is negatively impacting on the economic viability of both bulk billing and selective bulk billing practices. The slow decline in bulk billing rates mirrors the decline in real terms of the rebate's value. Bulk billing practices that were able to operate profitably in the 1990's are increasingly being squeezed and without improved remuneration are threatened to become unviable.

In 1995, the DHA/AMA Relative Value Study found that the fee for a standard consultation should be $44.00. Eight years later the standard consultation rate is $25.05 and for non-VR'ed overseas trained doctors in areas such as Bundaberg (RRAMA 3) only $17.85. The disparity is obvious and needs to be addressed.

The Division supports continuation of the blended payment system engendered in PIPs. The standards for accreditation are not onerous and are a realistic reflection of commitment to quality. The tying of PIPs to SWPEs (standardised whole patient equivalents) rewards practices that have high patient satisfaction (as demonstrated by patient returns). Continuity in patient care is then reflected in savings to the Commonwealth in reduced duplication of diagnostics and more cost-effective prescribing.

PIPs are a crucial part of practice income that can be used to maintain standards, improve facilities, upgrade technology and provide for staff continuing professional development. Without PIPs these costs would have to be met from fee-for-service income. The fear with that scenario is that greater emphasis may be placed on quantity at the expense of quality. There is greater potential for both professional and patient over-servicing.

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

There is no consensus on whether or not the Wide Bay area has a shortage of GPs. With the exception of several practices it is generally possible to obtain a GP appointment to receive treatment in a timely manner. However, the number of GP consultations per standardised whole patient equivalent (NRA_SWPE) are among the lowest in Queensland (5.55 cf with the Queensland average of 6.22) and the number of SWPE's per FWE GP is among the highest in Queensland (1030 cf with the Queensland average of 949).

These data may be an indication that the area is under-served for GPs or alternatively that the area's low bulk billing rate has prevented over-servicing.

Nearly 90% of the Wide Bay's population is SEIFA Category 2[1] and the 65+ population is over 17%. Both of these factors are associated with higher rates of chronic disease and generally poorer health outcomes. In addition, the population of the region is set to double in the next 20 years. There is clearly a need to start planning now to ensure that the region has a stable, affordable and effective primary care workforce to cater for these challenges. Issues that are likely to impact on workforce numbers over the next few years include:

- Low morale and high frustration amongst GPs with a significant number talking about the desire to leave general practice. From a Division's perspective we must increase the support we provide to GPs to help alleviate this frustration and attempt to address issues leading to morale problems.

- An ageing workforce with anticipated high rates of retirement over the next 5 - 10 years - coinciding with the rapid increase in population.

- General practices in Bundaberg have difficulty recruiting and retaining overseas trained doctors (OTDs) as the RRAMA rating for the area is Category 3 and hence any non-Vocationally Registered GP receives only $17.85 Medicare Benefit for a standard consultation. The area relies heavily on OTDs and there is a need to ensure that they are carefully selected and receive quality mentoring and support.

- In the past, there has been very low numbers of Registrar positions allocated to the region and hence limited opportunities for practices to demonstrate the positives of living and practicing general medicine in the area. This issue has been addressed and with greater numbers of Registrars assigned to the region it is anticipated that there will be a greater potential for Registrars to choose to remain in the region.

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

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

It would be remiss of us to not point out that GPs do not provide free care. Medicare (the health insurance system to which most Australian tax-payers contribute) reimburses GPs 85% of a scheduled amount for specific services.

In the Wide Bay area, it is believed that in the short-term the Fairer Medicare package is unlikely to have any positive impact on the number of patients able to access bulk billing.

Early indications are that only practices already exclusively bulk billing will take up the Fairer Medicare package and even this is contingent on addressing certain issues relating to after hours care. The incentives offered under the Fairer Medicare package are likely to keep bulk billing practices viable in the short although there is no guarantee that they will provide a long term solution.

Practices that do not opt into the Fairer Medicare package will be challenged to find ways to continue selective bulk billing of patients at the current rate of $25.05 or $17.85 for non-

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VR'ed GPs in Bundaberg. There is potential for these practices to actually reduce bulk billing.

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

It is believed that access to HIC on-line for practices that opt in to the Fairer Medicare package will have little impact on access and affordability of services across the board. In general it appears that only bulk billing practices will opt into Fairer Medicare and these practices already provide services for no out-of-pocket cost.

Real gains in access and affordability may however be achieved by making HIC on-line available to all practices – regardless of whether or not they opt into Fairer Medicare.

The low NRA_SWPE and SEIFA rates in the Wide Bay area indicate that affordability may be an issue for people. The majority of people pay some contribution towards GP services, however this contribution is lower than both the Queensland and National averages ($10.85 per standard consult cf with the National average of $12.00 and the Queensland average of $12.56). For people on low or even middle incomes, it is argued that it is more viable to find $10.85 to pay for a GP visit than it is to find $40+. GP services become more accessible simply because the patient only needs to find ¼ of the fee – not the whole fee.

The WBDGP would like to see the option of HIC on-line being taken out of the Fairer Medicare package and made available to all practices. The Division is well-placed to support practices in the take-up of this technology.

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

The introduction of a safety net for card holders is generally supported. However, whether or not this initiative will improve access and affordability will depend to a large extent on how the plan is operationalised. Card holders who need to find significant amounts of money 'up-front' will still have difficulty in affording and accessing services.

Administrative simplicity and consumer understanding will be a key to success of this initiative and this may be difficult to ensure given the existing safety net that has differing eligibility criteria and benefits.

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

Although this initiative relates to a safety net that will only take effect after $1,000 p.a. has been spent in out-of-pocket expenses, there is a fear that this may lead to a situation similar to that in the USA where the Insurer may have a greater say in treatment decisions than the GP.

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

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

With the burden of chronic disease and an ageing population, State and Federal Governments are continuing to place an emphasis on population health initiatives, early

intervention measures and better management of chronic disease in order to reduce more expensive secondary/tertiary health costs. These aspects of health are often ones that would benefit most from a multi-disciplinary approach that includes allied health services.

Any federal funding for allied health services should be aligned with the concept of a multi-disciplinary team approach with GPs playing a central role in referrals to ensure an holistic approach to health care.

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

It is believed that reallocation of the private health insurance rebate may have detrimental affects on both the private and public hospital systems.

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

The Commonwealth consistently advocates a primary health care model that has GPs playing a vitally important central role in the holistic and multi-disciplinary treatment of patients.

Any remuneration model should therefore reflect the importance of the GP role and the variety of skills that are required to play this role (e.g. comprehensive clinical knowledge, case management, leadership, preventative care expertise, knowledge of how to best apply early interventions). It is apparent that at present many GPs do not feel that their skills, experience and knowledge are appreciated or adequately remunerated. If this situation continues there is likely to be further erosion of the GP workforce with potentially greater increases in the far more costly Specialist and diagnostic workforces. This is contrary to the direction that the Commonwealth has identified in primary health care.

There are few other private professionals where there are such high expectations to provide a service for no out-of-pocket cost to the consumer. The decrease in bulk billing rates are clearly a result of market forces that in other circumstances the Government and public would simply accept. Medicare however has promised universal health care and the universality of the system is being increasingly compromised.

It appears that most GPs are supportive of the fee for service model of remuneration. Substantially increasing the rebate for services to a level that satisfies GPs may however prove to be unsustainable if complementary schemes that reduce the demand for GP services (without compromising holistic primary health care) are not implemented. Any alternative remuneration model therefore needs to include:

- Consideration and funding for the roles that a Practice Nurse may undertake in education, acute care, chronic disease management and population health through disease prevention.

- Greater encouragement of a multi-discipline approach to primary health care through the introduction of funding for GP referred allied health services, and

- Consumer incentives for qualitative vs quantitative use of GP services that include a price signal.