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SENATE

SELECT COMMITTEE ON MEDICARE

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SENATE

SELECT COMMITTEE ON MEDICARE

Monday, 21 July 2003

Members: Senator McLucas *(Chair)*, Senator Knowles *(Deputy Chair)*, Senators Allison, Barnett, Forshaw, Humphries, Less and Stephens

Senators in attendance: (Senators Allison, Barnett, Forshaw, Humphries, Knowles, Lees, McLucas and Stephens

Terms of reference for the inquiry:

To inquire into and report on:

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;

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

(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;

  (ii) a change to bulk-billing arrangements to allow patient co-payment at point of services co-incidental with direct rebate imbursement;

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

(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;

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

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

WITNESSES

Committee met at 9.09 a.m.

Participants

BAIN, Dr Robert, Secretary General, Australian Medical Association

DAVIES, Mr Philip, Deputy Secretary, Department of Health and Ageing

DEEBLE, Prof. John Stewart (Private capacity)

FORD, Mr Greg, Project Coordinator, Health Issues Centre, La Trobe University

GODDARD, Mr Martyn Stewart, Senior Policy Officer (Health), Australian Consumers Association

GREGORY, Mr Gordon, Executive Director, National Rural Health Alliance

HALL, Prof. Jane, Centre for Health Economics Research and Evaluation, University of Technology Sydney

MADDEN, Dr Richard Cawley, Director, Australian Institute of Health and Welfare

MASKELL-KNIGHT, Mr Charles Andrew, Acting First Assistant Secretary, Acute Care Division, Department of Health and Ageing

SAINSBURY, Associate Prof. Peter Geoffrey, National President, Public Health Association of Australia Inc.

SCHNEIDER, Mr Russell John, Chief Executive Officer, Australian Health Insurance Association Ltd

STRATIGOS, Ms Susan, Policy Advisor, Rural Doctors Association of Australia

WALKER, Ms Agnes, Principal Research Fellow, National Centre for Social and Economic Modelling, University of Canberra

WILSON, Prof. Andrew, Deputy Director, Centre for General Practice, School of Population Health, University of Queensland

CHAIR—Ladies and gentlemen, thank you for coming to this first meeting of the Senate Select Committee on Medicare. I formally declare open the first meeting of the inquiry and welcome you to this roundtable. Subsequent to today we will be spending some 10 days taking evidence in a range of places around Australia. Those hearings will be of a more traditional Senate inquiry style, but today's roundtable is intended to set the scene for the inquiry, which is why you have been invited. Each of you has a long and distinguished background in various aspects of the health sector. It is the committee's intention in convening this roundtable to draw out this expertise to assist with our deliberations and to help the Australian community make sense of the complex area of health.

In today's proceedings, I am hoping that we can have an orderly but free-flowing discussion. I do not want to put a stopwatch on speakers but I ask that you be aware that there are many participants here, all wanting to contribute, so shorter rather than longer contributions would be appreciated. These proceedings also differ from the usual format of Senate hearings, where we senators usually formally question witnesses. Today we are here as the Senate committee to both participate in and listen to the discussions that will flow. Nevertheless, I remind everybody that, as formal committee activities, these proceedings are covered by parliamentary privilege.

The major objective of the roundtable is to tease out the concepts and assumptions that underpin the Medicare debate in Australia and to understand the complex interactions between the community, GPs and other parts of the health system. I think this is essential to understanding both the current problems with Medicare and the most effective ways to improve it. For each of the sessions today, one of you in the group has agreed to offer some introductory comments. In view of the limited time available, I would ask that we keep the length of these comments to no more than three to five minutes, and after that I will open the floor to discussion. I—and, I am sure, all my colleagues—look forward to hearing your comments and your discussions today.

To start off, I welcome officers of the Department of Health and Ageing. Given that we have started a little late, which is not a good sign, I invite you to make a presentation about the government's A Fairer Medicare policy and the associated Health Legislation Amendment (Medicare and Private Health Insurance) Bill 2003. At the close of your comments there may be an opportunity for us to clarify some of the points that have been made, but I would like us to try to keep to the schedule as much as we can. Welcome, Mr Davies.

Mr Davies—Thank you very much. I would like to begin by thanking the committee for giving the department the opportunity to present information on the government's A Fairer Medicare package and to participate in the subsequent roundtable discussion. I hope this presentation will help to inform and focus today's deliberations and assist the committee in its work in the later stages of the inquiry. Before we start, Madam Chair, I have copies of the presentation if people would like those—maybe for taking notes. Would you be happy to distribute those?

CHAIR—That would be useful, Mr Davies. You can pass those up.

Mr Davies—Since it has been almost three months since the announcement of the government's package, I assume that its main features are reasonably well known and familiar to those of us here today. So, rather than simply describing those features yet again, I thought I would look behind the policy and explain its rationale in the context of a changing health system. What I would like to do today is to take you quickly through five areas. Firstly, I will give a brief overview of the current Medicare and general practice system. Secondly, I will look at some of the problems that now confront Medicare as a result of the changes in health and society during the 20 years since Medicare was established. Thirdly, we will look briefly at some of the possible causes of those problems. Fourthly, we will run over the guiding principles that the government applied in shaping its policy solutions to the problems facing Medicare. And, finally, I will outline the approach that the government has adopted to address the problems.

We will start by looking at Medicare and general practice. As we all know, the government's primary investment in health care in Australia is through Medicare and under Medicare every Australian has access to the same MBS rebate and an entitlement to be bulk-billed. Every Australian has access to subsidised essential medicines through the PBS and every Australian has the same entitlement to free public hospital care. The Medicare Benefits Schedule, or MBS, offers patients subsidies for the cost of privately provided medical services. These include a wide variety of diagnostic and specialist services provided out of hospital, as well as the familiar general practice. The Medicare rebate for these services is fundamentally a payment to the patient, not to the doctor or the service provider. It is in effect a public insurance benefit.

Slides were then shown—

Mr Davies—This slide aims to demonstrate that general practice is big, diverse and affects us all. Therefore, policies in this area need to be very carefully thought through. They need to take account of the central part that general practice plays in our health system as well as reflecting its inherent complexity. Superficially appealing quick fixes may not be the answer in this arena.

Now I would like to turn to some of the problems that are facing our current system. Three main problems have emerged. Firstly, there are large variations in bulk-billing rates around the country that are not linked to patients' capacity to pay. Secondly, costs can add up. The cumulative costs can add up over a period of time for individuals or households, particularly those with high health needs. Thirdly, an outdated Medicare claiming process imposes unnecessary costs and inconvenience on patients.

I would like to expand on each of these points. If we start with the variations in bulk-billing, these are unrelated to people's means. Much of the debate in recent months around reform to the health system has focused on the one-dimensional measure of the headline bulk-billing rate. But the headline bulk-billing rate is simply a gross measure of how many items of service are bulk-billed. The headline bulk-billing rate tells us nothing about how many individuals or households benefit from bulk-billing. It tells us nothing about the characteristics of the people who are bulk-billed, where they live or, for example, what their health status might be.

So the headline bulk-billing rate, which we do tend to focus on, is at best a very crude indicator of the well-being of Medicare and general practice. For example, this next slide shows you that bulk-billing rates are much higher in capital cities than in rural and remote areas of our country. In fact, that difference is almost 30 percentage points between your likelihood of being bulk-billed in a capital city and your likelihood of being bulk-billed in rural and more remote areas.

However, the next slide shows that bulk-billing rates are more or less uniform across different socioeconomic localities. Access to bulk-billing is not particularly progressive. Now that position may or may not accord with an individual's view of fairness, but certainly if we take the World Health Organisation's definition of what constitutes a fairly financed health system, that has an underlying notion of each household contributing to health costs through tax or out-of-pocket payments according to its capacity to pay. That is a progressive notion which this slide shows that our current bulk-billing arrangements do not offer.

Turning to the issue of the cumulative costs, in 2002 there were a lot of individuals and households who faced considerable cumulative out-of-pocket costs despite the cover offered by Medicare. There are about 30,000 households who in that year paid more than $1,000 in out-of-pocket costs for out-of-hospital services. If we focus on the most needy members of our society, we see that there are about 50,000 concession card holders who had costs totalling more than $500 in that year. This is all in spite of the existence of an MBS safety net, and these are people about whom the headline bulk-billing rate tells us nothing of their predicament.

Moving on to the issue of inconvenience, the current two-stage billing process is outdated. It has been described as patients actually acting as couriers carrying paper forms between the GP and the Medicare office. Once this was possibly the best available technology; it is certainly not the case any longer. In our daily lives, we have learnt to expect simple, quick and efficient one-stop service in other areas of our lives but many patients cannot get such service from Medicare. The current system imposes time costs on patients but also generates up-front costs that can be a barrier to access. More specifically for patients with very limited cash resources, having to pay for the government's rebate contribution on top of any gap charge and then claiming it back must sometimes be a barrier to accessing necessary care. Why should they have to be out of pocket by $25 or more even if only on a temporary basis? That two-stage system is certainly no longer technologically necessary.

I have outlined the problems of fairness, the problems of cumulative costs adding up over time and the issue of inconvenience. What I would like to do now is move on to describe some of the pressures that have emerged or grown in scale over the last two decades since Medicare was first introduced. These are the pressures that have given rise to those problems that I just outlined. We all know that Medicare was established 20 years ago, but we also know that the health landscape has undoubtedly changed dramatically since 1983. Medicare, however, has remained fundamentally unchanged.

Some factors in that changing landscape include changes in the medical work force and unevenness in the supply of general practitioners. For one example of the scale of change in this regard, we can look at the feminisation of the GP work force. It is undeniably good news that the proportion of female GPs has steadily increased from 23 per cent of the GP population in 1985 to 34 per cent in the year 2000. Females now form the majority of our young people who are entering medical school and who are training to be GPs, but there is clear evidence that, on average, female GPs tend to work shorter hours and take time out for child rearing. This is shown by the fact that in the year 2000 female GPs under the age of 45 accounted for 45 per cent of GPs but delivered a disproportionately low percentage of the GP workload—only 32 per cent. That is one example of how the work force is changing, and the work force supply is uneven, as I will demonstrate in just a moment.

Secondly, we have an ageing population with a corresponding increase in chronic disease, and we have services that are growing in variety and cost and are increasingly being provided outside the hospital setting. Perhaps the most striking example of change in that area has been the growth in radiation oncology. There have also been significant changes and increases in consumer expectations over the 20 years since Medicare was established.

Coming back to the issue of unevenly distributed work force, access to GPs is clearly higher in our capital cities and it is lower the more remote the area you look at. In capital cities like

Sydney and Melbourne, there are nearly 90 GPs for every 100,000 people. In larger rural towns, like Geelong or Toowoomba, and smaller rural towns, like Broken Hill and Casino, the ratio falls to fewer than 80 GPs per 100,000. In remote places, like Mount Isa, Emerald or Halls Creek, we average around 50 GPs per 100,000 people—just over half the ratio we see in our capital cities. This disparity has recently reduced somewhat as a result of the government's policies and programs, and the last five years have actually seen the full-time workload equivalent GPs in metropolitan areas remain more or less stable, but in rural and remote areas it has increased by just over 11 per cent.

But these differences do undoubtedly remain and they are undoubtedly significant. If we were to plot an equivalent graph detailing how much is spent per capita by Medicare in these same different locations we would see a very similar pattern with Medicare providing a great deal more resources to people living in the capital cities than in the rural and remote parts of the country.

But this is about more than just whether you can find a GP when you need to because, as this slide shows, there is clearly an inverse relationship between the level of bulk-billing in a region and the supply of GPs in that region. In the cities, shown on the left, where the number of people per GP is low—in other words, we have a lot of GPs—the bulk-billing rate is very high. In rural and remote areas, we see the converse: the number of people per GP is high and the bulk-billing rate is low. Once again, this is a relationship where the headline bulk-billing rate—that single percentage—tells us nothing.

Moving on to other changes, the population is ageing. The older that people are, the more health care they consume, and it is the oldest age group—those 85-plus—that is increasing the fastest. Since 1984, the number of people who are living to the age of 85 or older has more than doubled in size, and these people place greater demands on our health system. Partly as a result of that ageing, the prevalence of chronic disease is also rising. For example, diabetes has increased significantly since 1981, and this is projected to continue. Other chronic diseases on the increase include, for example, asthma, depression and arthritis. These chronic diseases require careful and ongoing management by health professionals and currently account for about 80 per cent of Australia's burden of disease.

I have talked about the work force, I have talked about ageing and I have talked about the growth in chronic disease. Now I would like to turn briefly to the growth in out-of-hospital services. One of the most significant trends of the last two decades has been the movement of services from hospital settings into the community, often driven by technological innovations. This chart shows that GPs account for less than half of total out-of-hospital health system costs and that other out-of-hospital service costs, such as specialist and diagnostic services, have grown significantly faster than GPs' costs since 1984-85. So we are able to do much more now outside the public hospital setting than we were able to at the time that Medicare was first established.

These out-of-hospital services are overwhelmingly supplied by providers in private practice, who are able to set their own charges. The Commonwealth government continues to pay Medicare benefits for these out-of-hospital services, but the patients who use them face an increased possibility of gap charges. That is a reality driven by technological change. That growth in out-of-hospital charges to patients has been a long-term trend since the establishment

of Medicare. It is also a trend that looks set to continue and it thus presents a challenge to established views on how Medicare should operate.

Much of the recent debate has been about general practice bulk-billing, but this chart suggests that, as a result of that movement to out-of-hospital services, much of that debate is focused in the wrong place. Out-of-hospital costs have grown faster and larger for non-GP services, and it is actually the non-GP services, rather than GP costs, that are contributing to those numbers of households I outlined earlier which are paying above $500 or in some cases even $1,000 a year for their out-of-hospital services. This is not just about GPs, and A Fairer Medicare is not just about GPs. The government has observed this trend and is responding. I will come back to that later.

The final area of change I wanted to highlight was the change in consumer expectations. Over the last 20 years consumer expectations of health care have undoubtedly changed, as have other aspects of our daily lives. We do now have access to these new treatment technologies that mean problems that used to require hospital admission can now be treated without the need to stay in hospital. Within the medical and wider community there is a growing focus on prevention. We also know that health is what the economists call a superior good, which means that growth in health spending can be expected to outstrip growth in a country's GDP. If we look internationally, we see that richer countries tend to spend a larger share of their national resources on health services. Finally, as I have already mentioned, consumers have grown accustomed to user-friendly service industries, so they ask, 'Why can't health be just as user friendly?'

In developing its response to the challenges for Medicare in the year 2003, the Commonwealth government has taken account of several policy principles that need to guide solutions. We are working here within a constrained environment. These are the principles that the government has worked within. I will just talk briefly about each of these. Firstly, there is universality. Any solution to the problems facing Medicare needs to ensure that the fundamental principle of universality is maintained. In Australia, all citizens are entitled to the same MBS rebate and are entitled to be bulk-billed—and that is not going to change. All Australians have an entitlement to free care in a public hospital, to which the Commonwealth government makes a significant contribution. All Australians have an entitlement to subsidised access to essential medicines through the Pharmaceutical Benefits Scheme. That will not change either.

Another fundamental principle is access. All Australians should have access to essential care, regardless of where they live. As we have seen, there is a close relationship between access to and affordability of GP services. Fairness is another guiding principle. As we have seen, there is evidence that patients in non-metropolitan settings currently face significant disadvantage in accessing affordable health care services. People surely should be treated equitably, regardless of whether they live in the city or the country and regardless of their financial circumstances. A further principle is sustainability, which is about whether we can afford what we would like to do. For example, evidence suggests that increasing the MBS rebate by $1 across the board would cost us about $100 million a year in total, and we would still have no guarantee that those who most needed to be bulk-billed would be bulk-billed.

Simplicity is the next guiding principle. Medicare must be simple and it must be transparent for both patients and doctors—certainly our somewhat baroque claiming procedures at the

moment can hardly be described as simplicity. Finally, there is private practice. As private practitioners, GPs do set their own fees. This has been a feature of Medicare from the beginning. The Australian government cannot require a doctor to set a certain fee or to bulk-bill a certain percentage of the population. As a result of this, no government can commit to achieve a target rate for bulk-billing across the population as whole.

I have outlined the problems and their causes. What are the solutions? The A Fairer Medicare package is designed as an integrated package to ensure that the fundamental problems facing Medicare that I have discussed earlier are addressed. Solutions under A Fairer Medicare are both direct and indirect, as this diagram attempts to show. For example, the GP Access Scheme, shown in the centre of the table, offers higher incentives in rural and remote areas to compensate for lower bulk-billing rates in these areas. Indirectly, however, the increase in the rate of bulk-billing for concessional patients will mean a reduction in out-of-pocket costs and, hence, cumulative costs across the course of a year. Similarly, the work force measures will increase access to doctors in rural and remote areas, thereby improving access and improving fairness for people who live in those areas. But, indirectly, more doctors will mean more competition, which should help restrain fees and out-of-pocket costs to patients. We can see from this matrix the integrated nature of the solution offered by A Fairer Medicare.

I will go through some of those measures individually. A Fairer Medicare has two sets of measures that are designed to address the problems of regional inequity in bulk-billing, which we have demonstrated so graphically. These include work force measures targeted particularly to areas of undersupply and the General Practice Access Scheme. The work force measures are represented by an investment of $300 million to ensure that the medical work force is of a sufficient size and availability to meet the future needs of the Australian population. There will be an additional 234 medical school places each year, starting next year, 2004. That figure of 234 is in line with recommendations from the independent Australian Medical Workforce Advisory Committee. They are bonded to areas of work force shortage for six years after completion of training to ensure that we get the additional work force where we most need it. Also under the work force measures, there will be an additional 150 GP trainees, again starting from next year. They will work primarily in outer metropolitan and rural areas. The fact that they will be working as they train means they will provide an immediate increase in our medical resources in those currently undersupplied areas.

Finally, funding is available to GPs located in urban areas of work force shortage who participate in the General Practice Access Scheme to employ up to 457 full-time equivalent nurses to work in their general practices. As an alternative, they can use those resources to employ allied health professionals, such as physios, podiatrists and Aboriginal health workers. I want to emphasise that the work force measures are all targeted to areas of work force undersupply, which, as we have seen, will have a direct impact on access and thus an indirect impact on affordability.

I would now like to dwell for a few moments on the GP Access Scheme, which is really at the centre of the A Fairer Medicare package. The measure offers three important things to patients who attend a practice that has elected to join the scheme. Firstly, it will offer a guarantee of bulk-billing to concession card holders at participating practices. This is in fact the first time that any Australian government has been able to give any group of patients such a guarantee. Secondly, it will reduce upfront costs for all patients who use a participating practice. Those patients who are

charged a gap will only pay that gap and they will not be out of pocket for the value of the government's rebate. Thirdly, it removes the two-stage payment process. Patients will no longer need to attend the Medicare office to claim back the rebate from the GP services, which really does improve the convenience of the whole system for both the patient and the doctor.

The A Fairer Medicare package is aimed primarily at helping patients, but there are of course benefits for practices and practitioners that choose to participate in the scheme as well. These include financial incentives, which I will describe shortly; funding to support the employment of practice nurses, which I have already alluded to; a contribution to their IT and telecommunications infrastructure, including the cost of implementing HIC online claiming; and assistance with accessing broadband technology for remote areas. In addition, those participating practices will get the rebate paid directly to the doctor in less time than under the current system. The turnaround time from the HIC will be only two days.

The financial incentive payments have been carefully designed to ensure that the vast majority of practices will be better off by joining the scheme. In this scheme there is nothing that means that practices will need to increase their charges to any group of patients. If you look at some of the numbers in that table, I think you will have to agree. The level of incentive paid varies, depending on the practice location, from just $1 in the capital cities to $6.30 in the rural and remote areas. I will speak more about that in a moment, but it actually reflects the differential bulk-billing rates for services delivered to concessional patients in those different locations. Basically, it reflects the fact that we need to invest more to lift bulk-billing rates for concession card holders in rural and remote areas, whereas in the cities the scale of the problem and therefore the level of investment needed is much less.

This table shows the net gain in income for practices participating in the General Practice Access Scheme. No two practices are the same, so we have had to make some assumptions. We have assumed a practice with about 10,000 annual concessional services, which is close to the national average, and we have assumed that those concession card holders are currently charged a gap of $10, which is actually a little above the average for concessional patients who do pay a gap. This table shows that the net additional income to practices can be quite substantial. I emphasise again that these are net gains after subtracting any forgone income from the practice ceasing to charge gaps that are currently levied on patients covered by a concession card. These figures obviously also exclude any non-cash benefits, such as access to a practice nurse.

The government's key response to rising out-of-hospital costs, which we saw earlier and which really are inevitable, is the introduction of two new safety nets to cover all MBS out-of-hospital costs. The current MBS safety net only recognises the gap between the rebate and the schedule fee, so it is only those payments, which are typically quite small, that count towards reaching the safety net threshold. Indeed, once the threshold is reached in a year, it is only those payments—the gap between the scheduled fee and the rebate—that are covered and are paid additionally under the safety net provisions. So any charges that a provider chooses to levy above the level of the scheduled fee are in effect invisible to the current MBS safety net. For the first time under A Fair Medicare, safety nets will be available to cover the entire gap from the rebate paid by the government to the actual fee that the patient is required to pay. The new safety nets will not just apply to the gap between the rebate and the scheduled fee. These new safety nets will give real peace of mind to households that their MBS out-of-pocket costs can be limited to no more than $1,000 in any calendar year no matter what illness or accident might strike.

That brings us to the end of the presentation. To recap, I have talked about the significant influences and changes that have affected Medicare over the last 20 years since it was established. These are undoubtedly changes and influences that we cannot ignore and there are changes that have led to a need for Medicare to evolve. I have discussed the problems that Medicare now faces and I have outlined the causes of these problems. I have also outlined the policy principles that should govern any solution to the challenges that are posed to Medicare by those 20 years of change. Finally, I hope I have identified how A Fairer Medicare can provide solutions to those problems, subject obviously to the passage of the enabling legislation through parliament. Thank you very much.

CHAIR—Thank you, Mr Davies. Given the time, I think we might continue with the program rather than go to questions. A lot of the issues you have raised will reappear during the sessions that are planned for the rest of the day. I understand you are going to stay with us, so we can direct our comments or questions to you. We now move to session 2, which is intended to go through the background and policy objectives of Medicare. I have asked Professor Deeble to give us an introduction to this session. Thank you very much, Professor Deeble.

Prof. Deeble—How long do you want this to be?

CHAIR—We did schedule half an hour for this session. If we can keep it to 25 minutes and try to catch up, that would be lovely.

Prof. Deeble—Thank you. The history of Medicare goes back to the history of Medibank, and the history of Medibank goes back to the 1960s. It was really conceived from a lot of things, but locally it was conceived from the position that the previous subsidised private health insurance had reached by the late 1960s. I am not going to talk about the hospital side; I will talk only about the medical insurance side. The principal problem in that scheme was that in the absence of any schedule of fees and any real adherence to fees the medical insurance side of the voluntary system was very poor on the specialist end.

It was not so bad for the GPs. GPs had a set of fees which were not binding at all but they were local organisations. Local medical organisations set up their own little cartels to recommend fees to their colleagues and by and large those fees were known, but fees were not known in the case of the specialists. As those people had been around all that time—and Russell will remember—there were strenuous efforts to get a fee schedule, known as the common fee, in the early 1970s to try to get better coverage of the specialist side, which was genuinely quite poor. It was generally about 50 per cent of fee coverage from the most expensive specialties.

At the same time, though, it was obvious, even in the 1960s—and this was a much greater requirement—that medicine was becoming much more expensive. I started my life in a very high-technology hospital and I could see in the sixties that that cost explosion was going to put the level of premiums that people would have to pay to cover this high-technology medicine well beyond the capacity of the average person. That meant more government subsidy. No voluntary insurance scheme ever operated without substantial government subsidy and no voluntary insurance scheme ever covered or ever could cover the last 20 per cent of the population—the lowest income group in the population.

If it were true that governments had to subsidise private insurance substantially then there was a question about whether it was the most efficient way to do that. If the government were going to have to subsidise, why did it detach itself from the operation of the health insurance system? There was also evidence from overseas and particularly evidence from our sister country, Canada, that it was possible to run a universal insurance scheme economically. It was possible to do that without a blow-out in costs. It was possible to do it while offering full coverage.

So the origins of Medibank and Medicare—and they are basically the same, but with some procedural improvements in the second round which were not possible, for political reasons, in the first round—are that they came into existence partly to meet the immediate problems of the schemes which they replaced and partly to meet the long-term problem of rapidly increasing technology. By the way—and this remark is not to do with history—do you know that, since Medicare began, for every visit to the doctor there is now a 50 per cent higher chance of having a hospital admission and a 50 per cent higher chance of having a diagnostic test or a procedure? That is for every visit to the GP or specialist. That is what technology has been doing.

Universal insurance, if it is to be universal insurance—and that was what was being offered—must have certain principles. First of all, most Australians see insurance as covering costs; they do not see it as a government handout. It is not discretionary. You do not buy an insurance policy to have the insurer decide how much you will get. You buy an insurance policy—and that is what Medicare was supposed to be—to give you a predictable and guaranteed level of coverage. For that to be the case, there would have to be adherence to a set of fees. It is impossible to provide insurance against something which is unknown—you can provide assistance against that, but you cannot provide insurance. As we all know, there is a general belief and acceptance that the government cannot set doctors fees or, in effect, do anything which impinges on the practice of medicine. I do not believe that that is entirely true but I do believe that all of the parties think it is best to accept that, so nobody has really tested the possibility of fee regulation.

On the specialist side, the competition within Medicare was and has been between the public hospital system offering free care and, effectively, full insurance for specialist services within the public sector. It is a contract with the states to do it. There is some competition, though not as much, I think, as originally was believed, between the outpatient specialist services, non-hospital care, and out-of-hospital private specialist services. It is not as great as was considered or, in fact, intended, because the budgetary position of the hospitals has not really allowed them to do that. Anyway, one of the favoured sources of cost shifting was to reduce the outpatient component of the state public hospitals' work.

On the GP side, the only process which would give full insurance coverage was bulk-billing. It was there to provide good insurance; it was not necessarily there to provide free care as such. To most Australians, good insurance means no out-of-pocket costs. Bulk-billing provides that. It is the only device that has. How much was expected or wanted? One of the great advantages of a universal system, if it is truly universal, is that you do not have do worry that the people within it are being treated fairly. You do not have to make special provision for the underprivileged, low-income people or the medically indigent, as they used to be called—that is, people who are not indigent in any absolute sense but have high health-care needs. You do not have to worry about them, because if there are no financial obstacles within the system you can ignore that and look at the overall provision.

It was never specified anywhere what the level of bulk-billing should be—as high as possible was the hope and expectation. It was generally believed—and this is a personal opinion but, from being around this for 40 years, I think I know—that the 80 per cent that it reached at the maximum was satisfactory. It was certainly going to cover all of those patients who were in need, as might be defined by some income or other test, and it would extend to other people as well. That meant some people would not get quite as good insurance as others—that is, most people would get 100 per cent coverage; some people would get less than 100 per cent coverage, but those people would be a minority and, it was believed, there would be a chance for them to avoid that situation. In country areas that certainly was not always the case and was sometimes not the case at all. But I know of no evidence, until very recently—and I mean within the last year—of any substantial charging of concessional patients as a routine. That is what the principles were.

Medicare was always conceived of as an insurance system. It was a system which gave universal access to services and funded that access in an equitable way. I have to reply to one thing that Philip pointed out: if you have unequal contributions on the contributions side then the logical thing is not to have unequal access on the use side. It is perfectly right and consistent to have higher contributions from high-income people but you should not also load those high-income people with higher charges. That is just doubling up. If you think that higher income people should pay more, they should pay through their contributions, not through their charges. That is part of the confusion that is fairly widespread. Universal access to bulk-billing is quite consistent and quite equitable across areas or across income groups if the contribution rate through tax varies; it is not unfair. Probably, in terms of what it was supposed to do, and apart altogether from opinions, I think that is probably as much as I can say.

I think it is a key element in insurance. Medicare is not a delivery system. There is a popular view that Medicare is the whole of the Australian health care system, that every problem in the health care system is Medicare. That is not strictly correct. I know that it has happened, and to some degree it was inevitable that that would happen, but Medicare does not deliver the medical services to this country; the medical profession does. It does not run the public hospitals; the states do. It does not determine the distribution of doctors because it is doctors' choice, and that distribution is not only geographic but also amongst the specialties. Medicare can influence those things but a financing system cannot do them. It can encourage desirable things but it cannot produce those desirable things. Better quality care and a better distribution has to come from within the health care delivery system. It is not a role that Medicare can well play.

I think you can see from some of the efforts of people who have looked at improving practice through incentive programs that, in the minds of the general practitioners, they are disconnected. The fee and the system which provides them with a daily living is one thing and the incentives to do better are another, and in the minds of most general practitioners, the two are not related at all. I do not think Medicare can be used to improve medical practice when those practice improvements have to come from within the profession. They can be encouraged but they cannot be produced.

CHAIR—I would now like to open up this discussion about the background and policy objectives of Medicare. Do we have any other contributions either from my colleagues or from the panel?

Mr Gregory—I understand what John says when he stresses that Medicare is not a delivery system, but it cannot be denied that the shape of Medicare determines the shape of the delivery—that is, while ever Medicare does not include the work of podiatrists with diabetics, it significantly determines what the delivery of a primary health care system looks like and therefore outcomes and lots of other things. I think the distinction you are making therefore is a semantic one rather than a practical one related to health outcomes.

Prof. Deeble—There is certainly a bias by effectively limiting Medicare to services by or on behalf of a doctor. There are services that could be provided within the practice if the doctor employs a professional that could be funded by Medicare, but they are funded by the doctor payment. There is no prohibition on any doctor, including ancillary services within his practice, and Medicare will pay an amount of money to that doctor. But of course it has to be profitable to him before it makes good economic sense. It could quite easily be included and there is no reason why it cannot be, it is just that that is not the way they operate.

Mr Schneider—One other thing I recall that was said of the concept of bulk-billing at the time, though not said very loudly or very publicly, was that it would also contribute by competition to suppressing the rate of growth of medical bills and that if you had enough doctors who were bulk-billing and enough patients demanding access to bulk-billing doctors, other doctors would feel constrained about the charges that they themselves rendered, so that you would actually achieve a depressive effect on medical charges and incomes across the board. In those days one of the very real problems was increasing charges that were being made by the profession. I do not make a particular point at the moment other than to say we should not forget the fact that there was an intention to trade that sort of competitive stimulus within the profession which over the years has not really achieved its objective.

Prof. Hall—I think what we have seen with the bulk-billing rate and the changes in the bulk-billing rate to my mind is very much price competition in the face of increased numbers. Bulk-billing has not facilitated that price competition; if anything it has reduced the effect of it by providing a floor price under which doctors' charges will not go because there is a guaranteed minimum that the Commonwealth will pay. So I think the two issues are being conflated in a way that is inappropriate. What we have seen is price competition where there are a lot of doctors. We have seen the Commonwealth Department of Health and Ageing make moves to reduce the number of doctors, particularly in general practice, and we have seen the bulk-billing rate change. It is just a response to numbers and competition. By depressing the price of general practitioners, we have seen total expenditure go up so that, although the prices are lower, the utilisation has been much higher and total expenditure has been much higher than if prices had been maintained higher with utilisation at the same levels.

Senator KNOWLES—Professor Deeble, I would like to ask you a couple of questions of clarification, given your long association with Medicare. I cite a couple of quotations, the first from Neal Blewett in questions without notice on 13 September 1983:

> This Government would prefer doctors to direct bill or bulk bill, but it has not the power to compel them to do so and nor does it desire to compel them to do so.

Furthermore, from Labor's new health plan in 1983:

It is expected that doctors will use this bulk billing procedure for pensioners, low income patients, the chronically ill and those in need.

A most eminent person made this quote:

Direct billing is not intended only to minimise administrative costs or secure adherence to schedule fees, although it does both of these. It also allows doctors to selectively provide care without charge to the chronically ill and low income people, without substantial loss to them.

That is from your good self of course, Professor Deeble, in 1991. With those three quotes—and we are talking about the history of Medicare—I ask you, Professor Deeble, whether that is not still an accurate reflection of your recollection of the whole intent of Medicare at that time?

Prof. Deeble—No.

Senator KNOWLES—It is not?

Prof. Deeble—No.

Senator KNOWLES—That is interesting.

Prof. Deeble—People do not always say all they mean. It was an intention that it be substantially higher than the demonstrably disadvantaged, and that was to do what Russell was talking about. It was also a cost control. The higher the level of bulk-billing, the higher the level of adherence to the fee, the more control, in effect, the government had over the rate of increase in those fees.

Senator KNOWLES—No, but that is not my question.

Prof. Deeble—No, but I am just saying to you that it was also intended to be more than the statements there. It was certainly true that Dr Blewett's statement—about the government not intending to—was technically correct. It was not intending to direct any doctors or require any levels of bulk-billing. It was hoping for a higher level, though.

Senator KNOWLES—That might be so, but the quote to which I refer and about which I ask for your clarification is:

This Government would prefer doctors to direct bill or bulk bill, but it has not the power to compel them to do so and nor does it desire to compel them to do so.

Prof. Deeble—I think that both of those things were true.

Senator KNOWLES—And they are true today, because there is not the power to compel—

Prof. Deeble—I do not wish to discuss whether they might have the power or not. At the moment there is no legislation that gives them the power. So the government cannot direct doctors on fees—that is true.

Senator FORSHAW—They do not have the power to force people to take out private health insurance either, but they can certainly try and encourage it or even penalise people for not doing it.

Prof. Deeble—Yes.

Senator KNOWLES—That is true, but I think that is the whole point. That is the whole point of the issue of the A Fairer Medicare package: trying to create incentives for people to bulk-bill, as opposed to compelling them to bulk-bill, which has now become part of the argument and the debate that is raging at the moment—that there is some way in which doctors can be compelled to bulk-bill.

Prof. Deeble—No, they can be persuaded to bulk-bill, and that depends on what you offer them.

CHAIR—Dr Bain, you wanted to make a comment?

Dr Bain—Professor Deeble, in recent times there has been a trend for the government, rather than increasing rebates to make payments for asthma, pap smears or whatever, to go in for what they call quality incentives. Do you want to comment on how that might impact on doctors' incentives and the way in which the Medicare package operates if we increasingly let the real value of rebates decline and fill some of that gap with individual quality incentives of one sort or another?

Prof. Deeble—To some extent that parallels some UK practices where there is a capitation rate, but supplemented by a number of fee-for-service type payments—but that has changed with different fund holding practices too. I have no problem with separating out some items of general practice for an encouragement payment. My concern is that I do not think that the doctors necessarily see it that way. If you listen to the debates, they will all be about the level B consultation. Those incentive payments could be quite high, but because they are not evenly distributed amongst doctors—some doctors take them up more than others, some doctors have practices where there are a greater number of people who might fit into those categories for which there are incentive payments—that is in a sense dismissed. I am not sure that it helps very much in this debate; in fact, I think the government pays about $140 million in those better practice payments, which does not even enter into the calculations for most cases. So in that sense they are a distinct and separate item which most doctors do not see as part of practice at all.

CHAIR—Senator Allison, I call you, then we will move on to the question of the viability of general practice.

Senator ALLISON—Professor Deeble, I know that Medicare does not cover a lot of allied health areas—it does cover optometry and psychiatry—but can you look back in history and tell us whether you think there have been major changes in the need to access some of those services and perhaps the way in which some are now being seen as primary health care agents. Has an argument been developed over the last 20 years for Medicare to do more than cover optometry, GP and psychiatry?

Prof. Deeble—In a strange way it also covers a lot of scientists too through pathology. It covers those organisations which traditionally work with the medical profession—that is, the scientists who work in laboratories are paid via the doctor. I have to say it is a strange way to pay them. It goes through the doctor as if the doctor were providing that service, when in fact it is a large laboratory that is doing it. My impression is that in the past—and I could be corrected by people with more direct experience—most of the referrals for items like physiotherapy basically came from the specialists in the area and the hospital system. They did not come from the general practitioner as much. The reasoning then was that if that was the case and the public hospital system was a major source of that kind of referral, then it should go through the state provision. But if it is true now that there is a larger number of referrals by the general practitioner to alternative services as distinct from referrals to, say, orthopaedic surgeons, for example, then Medicare could certainly add that coverage.

The medico-political problem has always been the medical profession's insistence that they work under medical direction. I was on a committee in 1985-86, the Layton committee, which looked at extension to a whole range of ancillary services in which self-governance—which means having standards of utilisation, appropriate use and so on—educational standards and cost control were criteria for adding those services to Medicare, and very few of them actually qualified. They either did not have universally recognised educational standards—though they are better now than they were 15 years ago—or they had no professional control over people who might abuse the system and so on. They could be added, but there are two obstacles—the ability to control the activities and otherwise it has to be under medical referral. It is the fact that most of those ancillary groups in private practice do not want to work under medical control that keeps them out.

CHAIR—It is a challenge.

Mr Davies—Correct me if I am wrong Professor Deeble, I think you quoted a figure of $140 million for practice incentive payments?

Prof. Deeble—Yes, something like that.

Mr Davies—In the 2002-03 year it was actually $250 million. It is about nine per cent of practice income.

Prof. Deeble—I am a year out.

Mr Davies—Arguably it is quite a significant slice of income.

Prof. Deeble—Yes, it is a fair slice of income, which is not generally referred to much in the debate on how doctors are paid. If that became larger, what would you then be talking about? If that became larger, then you would be talking about doctors' incomes and not about doctors' fees.

Dr Madden—I want to make comment as a former bureaucrat in the New South Wales Health Commission and Health Department. In his statement, Professor Deeble made a comment about outpatient services and attributed the lack of domination of those services to cost shifting by the states. At least in New South Wales in the period I was associated with it, that was not the reason

for the lack of domination of outpatient services; it was that the medical practitioners who provided them withdrew their services and went private after the introduction of Medibank. If Professor Deeble attributes things to cost shifting, I think we need to be very careful because that can get a life of its own. I do not think the facts actually support that.

CHAIR—I now to move to the next session on our agenda and invite Dr Robert Bain to start off our discussion on the viability of general practice.

Dr Bain—Having only just got back from leave this morning and picking up these papers, I do not have a very prepared set of comments, but even when you go on leave you cannot entirely escape this issue. The headline on the local paper that I picked up was 'Health services face "disaster": GP'. You seem to get that in almost any country newspaper you collect because country towns are very much in competition for the availability of medical services.

The issue I want to talk briefly about this morning is the participation rate. The most relevant figure that I felt was put up by Philip Davies was that, while there are 24,000 GPs in Australia, in full-time equivalent terms there are 16,700 but that figure is dropping quite quickly so that, although by OECD standards we have quite a good number of medical graduates per capita of population, we have a plummeting participation rate, which is what is producing the medical shortage. If the average GP who is currently working 40-odd hours a week drops their participation by two hours, we lose 1,000 full-time equivalent GPs, which is more than twice the number we train every year. What we are seeing is that our older male members, who tend to be in their 50s and work 50 to 60 hours a week, are retiring now at a rate of knots and the younger GPs coming in tend to be female and to work around 35 hours a week. As that moves through the workforce, it is going to cause that full-time equivalent number to drop even more.

As Philip said, the youngest 45 per cent of the GPs provide 30 per cent of the services and, while he said that the females are taking a bit of time looking after family and rearing children, a heck of a lot of them are doing non-general practice work—either non-medical work or non-general practice work. In other words, they are doing some anaesthetics, they are assisting with operations, they are spending a day a week at the divisions. They are looking to do anything they can to earn more money by doing other things. So, while some of them are rearing children, a heck of a lot of them are doing other medical or non-medical work—or they have dropped out of medicine entirely. According to the last census, one in six Australian doctors is not practising medicine at all—that is, the under-65-year-olds. We are not talking about retirees.

The first reason that they always give us when we do surveys and ask them about their declining participation is the declining real value of the rebate. That is seen as the major factor in the decline in participation. The second is a mix of bureaucratic interference and red tape. The government has a task force now looking at red tape. Our members, as John Deeble said, do not see these schemes for PIP payments and EPC payments and so forth as incentives. Frequently they—as my GP does—find them insulting. She says, 'I was trained to look after people with asthma; I don't need to fill in more forms and try and generate more revenue out of that.' They are very much resented by our members—78 per cent of them said in a recent survey that they do not like these schemes. As John also pointed out, it varies very greatly as to which practices take them up. But generally the practices in a higher income areas that have a well-paid practice manager who is able to keep track of all of the forms and so forth are much more likely to take

these schemes up than people in the outer metro or urban areas are. So we think they are probably regressive in terms of their income effect.

Somehow or other, we have to find a way of increasing the participation rate of the doctors that we have. We can bolster the work force. The only thing that has kept the work force going, really, is overseas trained doctors, who have filled the gap in the last few years. We can top that up by using practice nurses and other alternatives to support doctors, but at the end of the day we have to keep that participation rate up. Our surveys suggest that if the rebate were higher a percentage of doctors would spend more time in clinical general practice than they do on running restaurants or whatever else they are doing to get an alternative form of income.

Ms Stratigos—I would like to complement some of the things that Bob has said about this. First of all we have, very rightly, been reminded about the impact of feminisation. I think we use that term a little loosely. I would like to point out that this change does not only refer to differing approaches to participation rates amongst women doctors; it actually is reflected in the incoming generation of doctors—male and female. If we continue just to look at it as one part—for example, as the women—we might think, 'Okay, when their kids are older, or something, this will even out,' but there is in fact quite a lot of evidence that young men also want a different balance of professional and personal responsibilities. There has been some work done by the Australian College of Rural and Remote Medicine which suggests that of the registrars and interns—doctors in training—that they are working with 60 per cent of the females said that they wanted to work part-time at some stage in their career or to take time out but so did 30 per cent of the men. I think when we are looking at the future work force we have to look at this and other issues relating to retention of the medical work force.

Now I speak about the rural and remote medical work force. From our feedback, this is perhaps not just related to the rebate but related to indemnity issues, after hours issues and lifestyle issues. There is no doubt that remuneration will have some effect upon this—higher remuneration for after hours services would certainly make a difference. We believe that it would. When we are looking at bulk-billing and retention, which are certainly related areas, we have to consider those other three issues as well.

Senator ALLISON—In this discussion about viability we tend to skirt around the question of incomes for doctors. Can I pose some questions? Professor Deeble offered some suggestions as to average revenues for doctors. He said that on average they were $204,300 plus services for vets plus $10,000 in other payments and that we have assumed in the past that expenses were running at somewhere between 50 and 55 per cent of that total revenue. Is it possible for the AMA or anyone else to tell the committee whether 50 to 55 per cent is accurate? Is that what costs are running at, or is it higher than that? Has there been any modelling done by the department? Are there any figures that might be helpful to the committee in understanding whether we are talking about a seriously unviable business? Or is it so variable across the board that this is not a useful question to ask?

Dr Bain—It is extremely variable across the board. When we did a survey of GPs we found a range of net hourly incomes between $30 and $60. That would encompass most GPs—there would be some above that and a few below it. There were a lot earning around $30 net an hour. One of the real problems for them is that there are very big economies of scale in general practice. As you go up from one to about five doctors, your average costs come down very

sharply. A doctor in a small town which can only support one or two doctors is at a very strong cost disadvantage. A practice with up to six or seven doctors gets very good economies of scale and gets the average costs down very sharply. After that it does not make a lot of difference. So doctors stuck in a really small practice are at a real cost disadvantage.

Senator ALLISON—So can you answer that question? Can we look at 50 per cent of revenue being expenses, or is it higher than that?

Dr Bain—It would be of that order. It is, as I say, very variable, partly because of this economies of scale effect. It would be less for large practices and more for small practices.

Senator ALLISON—So the income of GPs might be around $130,000 a year.

Dr Bain—It would probably be in the range of $80,000 to $200,000. That would encompass most of them. There would be a few on less than $80,000.

Dr Madden—The Bureau of Statistics does a survey of medical practices about every five years which must be one of the least analysed surveys done—at high cost—in Australia. There is very detailed information available which really is little put in the public domain. I do not have any particular answers for you, but there is a substantial objective data source.

Senator KNOWLES—Are you talking about the RVS, the relative values study?

Dr Madden—No, I am talking about the survey the ABS does of medical practices as part of its service industry survey program.

Prof. Deeble—The figures in that submission of mine are not too far away from those that were in the relative values study, so I am told.

Prof. Wilson—In interpreting that comment, one of the things which has not been highlighted so far is the variety and heterogeneity there is in general practice. We are not talking about one type of practice. General practice has vastly changed over the past 20 years. When you look at these average incomes, you are talking about averages which go across set-ups which literally can consist of a shopfront with a doctor, a receptionist—who may well be his spouse—and very few other facilities. In some of the facilities that I had reason to inspect in New South Wales in my previous life, one sink was literally the only equipment in the shop. Set-ups range through to the larger sorts of practices that Dr Bain was referring to, which have very sophisticated management systems in place and a very high level of technology available on site and where a large proportion of all care or referrals is provided within that same institution. I think it is important to think about that when we talk about any sort of average cost and what people are earning as so-called average income.

I will make a couple of other comments about sustainability. I was going to make these comments later, but it is probably worth while making them at this point. One of the features of general practice at the moment—it has been touched on but not highlighted—is the extraordinarily high levels of dissatisfaction. As Dr Bain highlighted, a major source of this dissatisfaction is the belief among general practitioners that they are undervalued. Whether they are or not, that is a very widespread belief among general practitioners, and at least part of that is

a belief that they are under-remunerated. If you want it at an anecdotal level, I do not think that I have ever spoken to a general practitioner who has not tried to equate how much they earn to that of a tradesperson and done so in an adverse way. I know for a fact that is not always the case, but let me just say that is a widespread belief.

The other factor that I think is quite evident is that, for those reasons and a number of other reasons, it would appear that general practice looks vocationally unattractive for doctors at the moment. Putting on my academic hat, I think that universities have not stopped graduating doctors over the last five years. In fact, the number of doctors who have been graduating has been progressively increasing. But it would appear that the attraction for people to go into general practice has substantially fallen over that time. I think there is a real question—which Richard might be able to address, as he sits on AMWAC—of where those doctors, junior doctors in particular, are going at the moment.

The last comment I would make in this regard is that, when we talk particularly about the interest in part-time work in general practice and younger people coming into general practice, we should not assume that they have the same views of fee for service as do those people who have been in the practice for longer. Younger people, because of the flexibility that can come, find non-fee-for-service approaches to funding more attractive. They are also more used to that sort of approach than are some of the longer established members of the general practice community.

Senator FORSHAW—Can I ask you to follow up that in terms of specialists and their attitude? I am assuming that they are not as disillusioned as GPs. It is an area that we do not often really talk about too much in terms of this whole debate.

Prof. Wilson—I might flick that one to the AMA to comment on. I do not have any information that I can give you. As for the information that I am providing on the other, I know that there is evidence that backs it up. I know that there is some evidence which shows that there are significant levels of dissatisfaction among some hospital based specialists. I do not have information to comment on people in the private sector.

Senator FORSHAW—I am assuming it is not, because bulk-billing is not as big an issue. Secondly, one assumes that the levels are higher. Maybe Dr Bain wants to comment.

Dr Bain—The specialists who are not terribly happy are the ones who largely treat older people—geriatric, rehabilitation and nephrology—where they mostly have elderly patients and they are mostly bulk-billing. They are in a very similar situation to the GPs. Putting my AMWAC hat on, in a lot of those specialties the training places are just not being filled. On the procedural side it is a different story.

CHAIR—Mr Davies, do you want to make some comments on this issue of specialists?

Mr Davies—They would actually be on the more general issue. They would be responding to Senator Allison's request for data, so I will come back to that later if you would prefer.

CHAIR—I will go to Mr Gregory and then to you.

Mr Gregory—As an advocate for rural health and rural health consumers, it would be most irresponsible of me if I were to suggest that it was easy to fix our health work force problem—because we all know it is not. But I think there are a couple of good news items that I want to add into this fairly depressing conversation.

The first is that the statistic that two hours a week extra converts to 1,000 FTE—which frankly I find surprising but I believe it, and I did read it in your submission—should surely be seen as an opportunity as well as a threat, because if we get things right, if we get the context right, then two hours a week extra is not a lot. So I would have thought it means that we have to hasten with all of the contextual policy matters which will make it right, so that we do get a greater number of people delivering two hours extra a week.

The second point is—and I am conscious of the fact that I am surrounded by people who know the numbers much better than I do, but I will have a stab anyway—that I am informed that there are about 2,000 overseas trained doctors in Australia who have not yet even begun the process of interacting with the system. I am told that many of these people, curiously enough, are still hiding their light under a bushel, because they may have entered the country not declaring that they did in fact have medical training, because of the way the immigration visas work. I have heard case studies where a couple enters on the formula that the department of immigration specifies, where the breadwinner is in one of the categories that we have in demand and therefore scores highly. But I am told that because in fact there is a penalty of 10 points for medical practitioners entering the country so declared, some of these people have come in as partners and have not declared their medical training and skills—and my information is that there are around 2,000. So this is 2,000 people who have not yet begun to interact with the AMC or any other part of the medical sector.

The third and last point I want to make is on the sustainability question. Clearly we are all now wise enough to be talking not just about the micro or the individual questions—that is, what do you do in a particular practice for it to be sustainable? We are talking now, in the case of the organisation that I work for, not of rural and remote doctors but of doctors who will spend a part of their practice life in rural and remote areas. So we have gone away, hopefully, from the situation where we depend upon true heroes who spend 65 years, work until they drop, seven days a week, 24 hours a day—because this is not the way that we want them to have to work and not the way that anybody wants to work. We have changed our thinking, hopefully, so that all doctors, whether they come from city or country, can be enticed to spend maybe four to six years of their practice life in country areas. That will help a great deal.

Mr Davies—I do have a couple of sheets with data on costs and incomes for average GP practices. If it would be helpful we could table those—

CHAIR—That would be very useful.

Mr Davies—noting very strongly Professor Wilson's comment that averages can conceal a great deal. It is very close, actually, to what Senator Ellison suggested. The average income for a practice participating in the PIP is around $242,000. As regards the costs for a one-doctor practice, I understand the AMA's estimate was about $115,000. The relative value study came up with about $127,000. If you get into larger practices they do indeed reduce on a per doctor basis

because the overheads are shared, but it is very close to that 50 to 55 per cent that you mentioned. I will table those papers if you would like me to.

CHAIR—Thank you, Mr Davies. Senator Lees.

Senator LEES—Dr Bain, you said that 78 per cent of doctors that you surveyed are not terribly impressed with the various other ways of earning an income. Have you surveyed the doctors and looked at the provision of nurses, and is that an incentive to increase bulk-billing rates?

Dr Bain—The practice nurses are seen as a great boon. All doctors that have practice nurses believe that it makes them more efficient, they give better service et cetera. Whether it will actually encourage bulk-billing I am not sure, but one way of extending the medical workforce is to assist with practice nurses. We would like to see the government, in the A Fairer Medicare package, incorporate practice nurses right across the board.

Senator LEES—I was just coming to that. I was wondering particularly about some of those practices, within the cities, that are in quite economically depressed areas—whether there is a mechanism we can look at for helping GPs in those areas to also access practice nurses. Is there a formula; is there something that you could recommend?

Dr Bain—At the moment, for the outer metro areas, it is based on an area of need. Then there is a funding cap. Once you hit the funding cap, they cannot allocate any more nurse time. We think that a bigger investment in practice nurses in those outer metro areas would certainly pay off. The analysis that the department uses to show that the level of bulk-billing is roughly the same across every SEIFA category is actually misleading in a sense because it confuses supply and demand issues. In the higher SEIFA areas there tend to be more doctors, there is more competition among doctors and there is more bulk-billing. In the outer metro areas and lower socioeconomic areas there is a real shortage of doctors, but there is more bulk-billing because the doctors there are dealing with low-income people. They have started bulk-billing and, by and large, they will not stop bulk-billing that community. A lot of them will pack up and move to a higher socioeconomic area rather than start charging their low-income patient base. They would much rather move to a higher income area where people are used to paying. So saying that bulk-billing is the same across all the SEIFAs actually confuses the issue. Those low-income SEIFAs—even though bulk-billing is quite high there—are very short of doctors.

Senator LEES—Looking overseas we see some places where you have one doctor for one nurse and others where there are two to one. What ratio does the AMA recommend in terms of the amount of nursing or allied health professional support that doctors need?

Dr Bain—We do not have a recommended ratio. Every doctor that has one nurse will tell you that they wish they had two.

CHAIR—On this point of practice nurses, we will have Senator Knowles—

Senator KNOWLES—No, it was not actually on practice nurses; it was something that Dr Bain said about higher bulk-billing rates in lower socioeconomic areas. The evidence that was given to us this morning by the department said that there was a clear link between higher bulk-

billing rates and where there are more doctors than for rates in lower doctor occupancy areas. I do not understand the link between what you have just said and what they said.

Dr Bain—The top table on the fourth page—the pages are not numbered—says 'Bulk-billing varies little by SEIFA area', which shows that the bulk-billing rate is a little bit higher in the lower socioeconomic area but it really sticks about the same. The point that was made in presenting that slide is that there was really not much difference in bulk-billing right across the SEIFA range. If you looked at that graph by itself, that is what you would think. If you adjusted it for the number of doctors per head of population, you would find it would come out quite differently.

Senator KNOWLES—The other graph there says there is a strong link between the supply of doctors and the bulk-billing rate. So capital cities have a very high bulk-billing rate whereas the country areas and outer metropolitan areas have a considerably lower level.

Dr Bain—I think that is what I am saying. This table shows that there are quite high bulk-billing rates in the highest socioeconomic areas. That is because more doctors live in those areas and there is more competition between the doctors. If you look at the bottom end, the lower socioeconomic areas, you will see a high bulk-billing rate. It is not because there are plenty of doctors competing—there is a shortage of doctors in those areas; it is because of the low socioeconomic status of the patient group they are dealing with. That accounts for the high rate of bulk-billing in the low socioeconomic areas. So we are mixing supply and demand effects.

Senator KNOWLES—Exactly.

CHAIR—I think we have two questions that we are trying to discuss at the moment. I would like to complete the discussion about practice nurses and then maybe move to the discussion that we were having there. Is there anyone who wanted to talk more on practice nurses and their usefulness?

Mr Gregory—Practice nurses are valued, I know. But I want to make the point that they extend the ability of doctors to see patients or to do better things with the existing number of patients but they will do nothing, as far as I am aware, to provide doctors where there are no doctors. I wanted to make two points after Philip's presentation. The first of them is crushingly obvious, but I have got to say it, and I may well say it again after lunch—that is, the bulk-billing rates as currently defined cannot be increased where there are no doctors and will be very hard to increase where there are few doctors. Lest it be thought that I think that this debate about the bulk-billing rates for general practitioner services is actually the right debate—and I know that it may be what the select committee is going to focus on—I agree with what Philip said this morning, in part, when he said that part of the debate is in the wrong place. Rates of bulk-billing of doctors' fees are not the only potential—or, indeed, always the best—indicator of access to appropriate primary health care. So practice nurses are good, they help doctors to do more or do better, but they will not, as far as I know, help doctors in any way move to areas where there are currently no doctors, and that is a key issue.

Prof. Wilson—I think the issue is more complex than that. Gordon, I am sure that you do not mean to convey the impression that it is not an important component, because in rural and remote areas we know that one of the major issues for doctors is the issue of professional

isolation, issues of there not being other people around to support them—and that includes other allied health people. These things are important components of what makes a rural service viable. I cannot help but feel that in that situation practice nurses can help that viability, that desire to remain there.

The other thing is that from a consumer perspective, particularly in rural areas, where the work force is predominantly male, nurses can offer a balance, particularly for women, who may want to have some sorts of service provided to them by another woman, and nursing is still largely female dominated in that regard. I think there are other opportunities around practice nurses which are only really just starting to be explored in Australia in terms of what they can do in this situation and the ways that they can make general practice more viable but also more enjoyable in terms of some of the things that are there.

Mr Gregory—More viable or sustainable where they are in practice, but I see no evidence that it will help doctors to decide to practice in a town or a place where they are currently not practising. That is the point I am making.

Prof. Wilson—I think the issue here is that if you are going to attract doctors to rural areas one has to think about the whole package of things that you are offering in that situation. The tendency is to focus on trying to recruit a doctor in isolation. We have seen situations where extraordinary salaries have been offered to general practitioners, or even specialists, to go to rural areas, and they do not want to go there because these other things are not there as well. So I think one has to think about the whole package of things and not just the financial remuneration for the doctor in that regard.

Prof. Hall—On practice nurses I want to make two points. One is that so often when we talk about work force issues—and we are doing it now with doctors, general practitioners—we do it in isolation from the rest of the system. I think we should not forget that we have a very real crisis in nursing in this country, which is unlikely to be solved quickly. The idea that we might just move nurses wholesale into supporting general practice may well not be viable, given the other components of the system. The other is to go a little bit more broadly and say that we talk about the viability of general practice but we really have skirted around the issue of productivity and productivity improvements in general practice. Practice nurses are one component of that. I think there are enormous differences in general practices and how efficient they are. We see very little data on it. Some of those differences may well be explained by differences in structure if you have got a rural or remote location where you are going to support a smaller practice, but what about in the cities, where we still see big variations in the number of practitioners in a practice? Is anybody—indeed, is the AMA—able to produce data on any productivity gains or productivity efficiency differences across general practices? Surely what we should be supporting from public money is efficient practice, not any style of practice that people like to have.

Mr Davies—I would like to acknowledge Mr Gregory's comment that you cannot bulk-bill if there is not a doctor there. I think I did mention in my presentation that we have seen an 11.4 per cent increase in numbers of full-time workload equivalent GPs in rural areas over the past five years, which I think is significant. It is also notable that 4½ per cent out of that 11.4 per cent has occurred in the last year, which suggests that we may even be getting slightly better at moving doctors into these currently under serviced areas.

I recently had the opportunity to speak to the Rural Doctors Association about the government's rural health services package, which is multifaceted and, indeed—in line with Professor Wilson's comment—is not just about financial support. It provides support over a broad spectrum. If I remember rightly from the presentation I gave, there are at least 14 different components which are pumping either in cash or in kind support to those rural GPs. No-one would deny that we still have a way to go, but I think we are at least heading in the right direction in that area.

I have a quick observation on Professor Hall's point. No-one would want to deny the situation we have with nurses around the country, but, while I am not aware of any empirical evidence, certainly anecdotally there is a view that the nurses who are drawn to work as practice nurses in general practice are to some degree from a different pool of labour, because it is work that is very different to conventional acute hospital work. Although I cannot quote evidence on this, there is a view that we are not actually cannibalising the hospital work force to quite the degree that one might at first think.

CHAIR—It is a matter of degrees, I think.

Prof. Sainsbury—I want to make some comments about the whole issue of the sustainability, equivalence and context of general practice, to some extent outside the issue of bulk-billing and fees but on the general level of perceived dissatisfaction of GPs. It is something I think is patently obvious. I want to emphasise that, as far as the rural and remote issue is concerned, it seems clear that there are different problems here. And if you have different problems you need different solutions. Some of them may be the same, but we need to be quite clear that we need to be thinking about the issues of rural and remote areas quite differently from the way we think about problems with general practice in urban areas. That is my first point.

My second point is about practice organisation. We have talked about practice nurses and other allied health staff potentially assisting with workload and with creating an environment in which practice could be more stimulating. We have talked about group practices and the advantages in terms of quality, efficiency and comprehensiveness of care. I would support both of those moves. But a point that I seldom see raised in any discussions about dissatisfaction with general practice—and I hope that non-medical people in the room will not be shocked by this—is that, although I have not seen any evidence, anecdotes and discussions with colleagues tell me that many general practitioners find general practice boring. This is an element in dissatisfaction. Fundamentally, you take pretty intelligent, motivated people, you put them through a long educational process that is extremely stimulating and very gruelling and then you put them out into practice. For a while it is quite interesting and it fulfils the need to pay off a mortgage and the need for intellectual stimulation and procedural challenge. But after five to 10 years it all becomes very repetitive. You can look at the journals and see discussions of heart sink patients and one thing and another. This is one of the problems: general practice can be extremely tedious, repetitive and boring, and this accounts to some degree for the level of dissatisfaction.

I am making the point—and others have made this point—that we must not only look towards the level of remuneration. We are hearing that GPs are quite well paid in many ways, but they feel badly paid. We need to be looking at this broader context of practice. Things like allied health staff, group practices and the stimulation associated with the work all need to be taken into account if we are to create viable general practice in Australia.

Ms Stratigos—I would like to follow up on what Professor Sainsbury said by introducing a reference to another subgroup of general practice, which is procedural general practitioners—those who provide, amongst other things, obstetric general surgery and anaesthetic services, which are mainly only used these days by GPs in rural and remote areas; these things are not generally done by GPs in cities. This is a factor in job satisfaction because we know from research that procedural medicine is often an attraction to go into general practice in rural and remote areas because you can do it then. Just to support what has been said, the procedural rural work force is a very fragile part of the medical work force. Its numbers appear to be declining, at least partly for surgery. It is ageing very quickly. This brings me back to the point about nurses. When we are talking about practice nurses as being necessary for support and perhaps as an attraction for rural general practice, we also have to look at the supply of other highly skilled nurses—for example, theatre nurses and midwives—because without that level of skill in the nursing work force in rural and remote Australia we cannot have rural procedural practice. Therefore, we have to look at the teams as a very wide group when we consider this issue. Perhaps we are looking at new models of practice, certainly for rural and remote Australia.

CHAIR—I will call Senator Barnett next and then we will move to Professor Wilson and then to Professor Deeble. We should then have pretty well wrapped it up.

Senator BARNETT—I wanted to follow up on a comment made by Mr Gregory about overseas trained doctors. I have received the same advice that he has received about the 2,000 overseas trained doctors out there who are not currently in the system. What are the obstacles? What are the obstacles to the OTDs being registered? Perhaps the department or the AMA might be able to respond to that. What role does the Australian Medical Association play? How many of them are undertaking the exams each year? How many of them are actually registered and have been introduced into general practice? Can we seek some clarification about the overseas trained doctors? Obviously if they were allowed to be introduced there would be an injection of quite a number of doctors. There are 16,700 full time equivalents out there at the moment. So there is a substantial number of doctors who could be included in the system. Would Mr Gregory, the department or the AMA be willing to respond to that?

Mr Gregory—Those are good questions, and I will wait for someone else to give the answers.

Prof. Wilson—I can perhaps shed some light, although possibly not a lot of light, on this. In my previous role as Chief Health Officer in New South Wales perhaps the two least memorable aspects of my role were, firstly, in relation to the Sydney water crisis and, secondly, in respect of dealing with the overseas trained doctors who were on hunger strike on the steps of parliament. I had quite a lot to do, in New South Wales, with trying to sort through the Australian resident overseas trained doctors. I spent a long time in consultation with them. The first thing to say is that, to the best of my knowledge—and this is despite work that we try to do—the figure of 2,000 keeps floating around. I know of no real basis for that figure of 2,000. It keeps on re-emerging everywhere, but when we tried to track it down to give it some substance—that was two years ago—we were unable to substantiate it in a solid way.

Senator BARNETT—What figure are you aware of?

Prof. Wilson—All I can say is that I think it is less than that, based on the number of people that we could actually trace through various organisations and based on the fact that the bulk of

them are probably resident in New South Wales and Victoria. But, as I say, the figure is very rubbery.

The second thing is that, through that process and having to deal with a multitude of cases, there were clearly situations where there were a number of Australian resident overseas trained doctors that I believed suffered discrimination through a whole range of processes. Some of those were structural. For example, Australian resident overseas trained doctors who complete the first part of the AMC examination have a very high success rate of getting through to the second part of the AMC examination, but the difficulty is finding enough training places each year, enough examination places in that second part, for them to get through. So there is a structural issue there that hinders them. There appeared to be some issues, which there have now been major attempts to try and address, around the processes that the professional colleges had for accreditation, particularly of specialists, in that regard.

Having said that, there was also a substantial proportion—I will hazard a guess, and, please, this is a guesstimate, that it would be about a third—that would have difficulty. It is probably impossible for them to meet Australian standards by even the most generous allowance in terms of that situation. They had major problems because of language and the types of training systems that they had come through and—a factor which is frequently forgotten—because of the period of time in which they had been out of practice, which impacted very much on their currency and their likelihood of ever being able to get back into the work force.

Senator BARNETT—Do you have any evidence to support that claim?

Prof. Wilson—That last claim?

Senator BARNETT—Yes.

Prof. Wilson—As I say, I am basing this on an assessment of working with the doctors and of working and being involved in the registration process in New South Wales. I am being up front with you here: this is based on my personal experience of dealing with this group and working with them in the knowledge that I wanted to see more of them come through, because it was in our interest to do so.

Senator BARNETT—So you are saying they can do the exams, complete the exams, but then an obstacle is provision of training places. Who is responsible for the provision of the training places?

Prof. Wilson—It has been difficult for the AMC to find enough places. It is not so much training places; this is actually examination places, for people to be able to sit the examinations in hospitals where they can actually do them. There has been a problem in just finding places that have been prepared to do it.

Senator BARNETT—Have you discussed it with the AMC?

Prof. Wilson—Given that I have been out of that for two years, I think that the committee should really put that question directly to the AMC. The AMC has been trying to address this

problem, they are well aware of it, and I think it would be inappropriate for me to comment on that.

Senator BARNETT—I look forward to that.

CHAIR—Thank you Professor Wilson. Ms Walker has been looking for the call for some time. I would like to close this session just after 11 o'clock. I know there are a number of people who still want to make contributions. Maybe you can wend your way through another issue to cover the matters that we need to talk about.

Ms Walker—I think the point that Dr Bain picked up is important, about that chart that Philip Davies put up which says bulk-billing rates vary little with socioeconomic status. When I saw that, because we do a lot of work in that area, it did not make sense to me. I just want to say a couple of things that I have thought very much about. First of all, John Deeble said that bulk-billing was put there to try to make sure that the poor are being helped. Now that graph actually tells you that it does not do that—if it is correct. Also it is in contrast to what the previous graph says, which looks at it by region, because from our work—and we do it at the individual level, the socioeconomic status bit, not at the broad geographic level, which tends to blur things. We know that most of the rural people are lower in socioeconomic status than the urban ones. The next graph then goes in the other direction. So my suggestion is that perhaps if socioeconomic status could be looked at at the level of the individual patient, rather than at the level of some sort of bland geographic area, we may get quite a different picture. But it is worth looking at because, if that is correct and bulk-billing does absolutely nothing or very little for the poor, maybe that is the wrong way to try to support poor people who have bad health.

Senator KNOWLES—Isn't it more important, therefore, that concession card holders are the ones who are given bulk-billing and the doctors then get an incentive to bulk-bill the concession card holders, or low income people?

Ms Walker—Yes, or some sort of more specific targeting. But I do not think—

CHAIR—The same question went through my mind when I saw that graph in the document. Mr Davies, why did we decide to identify SEIFA by postcode, given that postcodes do not necessarily contain the same number of individuals? It can be quite misleading in some respects, because of the averaging within the postcode.

Mr Davies—Undoubtedly, postcodes are a somewhat crude way of doing this. The sort of analysis that Ms Walker has described would enable us to take this down to a finer, more granular level of detail, but it would still be sample based so there would still be statistical uncertainty in any such results. I think there is a recognition that SEIFAs are designed to be reasonably heterogeneous in terms of socioeconomic status. I am sure we can all think of areas where one side of the street is very upmarket and the other side perhaps less so but, as a way of averaging and with the data that is routinely available within the department and the Health Insurance Commission, that is the best level of analysis that is available. It does indeed show that uniformity.

Going back to Professor Deeble's earlier comment, to some people—and I think I said in my presentation that it depends on your view of fairness—that uniformity may be a sign that

Medicare is achieving exactly what we wanted it to do, which is that everyone is roughly equally likely to be bulk-billed. That is certainly the case when you look at it by SEIFA. But then you go back a couple of diagrams and you see how the bulk-billing rate varies by geography, by rurality, and, even if the SEIFA diagram is a source of some comfort, by the same token the geographic gradient should be an equally strong source of discomfort.

CHAIR—I would like to pursue that matter. During estimates we talked about whether or not we collect the data to be able to link whether or not a patient is bulk-billed with their economic status. I think you have told us in the past that that is not possible.

Mr Davies—The problem is that patients are not bulk-billed; services are bulk-billed. Part of the anomaly and something one could argue A Fairer Medicare seeks to address is the fact that the same patient could be bulk-billed for a service one day and not bulk-billed for another service—even a very similar service—the next day.

CHAIR—That is the point that Ms Walker and I are trying to address.

Mr Davies—That does make the analysis of bulk-billing for individuals very difficult, because bulk-billing is not an attribute of an individual; it is an attribute of a service.

Prof. Deeble—It is an attribute of a doctor and neither of the others. I would like to point out that there are two separate questions: the geographic and the socioeconomic. I think Philip Davies has made a very good case for some differential benefits and differential charges by geographic area, but that has got nothing to do with the other changes, which are more to do with socioeconomic changes. You are talking about two different things, as I said in my submission. The geographic distribution of doctors and access to services geographically is one question; access to services by people, with or without charge, is another one. They are not related. You can do anything you like to encourage more doctors to go to the country—just spend more money on them if you think that will help—but there are other changes proposed which have to do with basic control principles of Medicare and have nothing to do with whether you spend more money in the country. I imagine that the committee will have no objection at all to anything the government wants to spend on country doctors.

Proceedings suspended from 11.05 a.m. to 11.22 a.m.

CHAIR—We now move to session 4 which is to do with access to general practice in Australia and the role and importance of bulk-billing. I call on Professor Andrew Wilson to start the discussion.

Prof. Wilson—I thank the committee for this opportunity and I thank you on behalf of my two colleagues, with whom I have had lots of discussions about this, Professor Del Mar, the director of the Centre for General Practice at the University of Queensland, and research associate Dr Marli Watt, who also helped us put together our proposal. In making these comments, I think it is important to say that one of the reasons we are interested in making a submission is that the Centre for General Practice has as one of its major areas of interest the application of evidence based health care in the general practice setting. One of the things that interested us in looking at this process and the proposed changes was the extent to which there

was or was not evidence—and mainly there was not evidence—to support a lot of the changes to existing practices or the changes that are being proposed.

That is one of the reasons why we have suggested that, in thinking through any of these changes and talking about the financial implications for a very large slice of the health funding in Australia, we should perhaps try to look more closely at the evidence base for what we do. Where we have a situation of equipoise—that is, where we do not actually know what is right or what is wrong and what the outcomes might be in terms of health benefits for Australia—maybe we should put something in place to try to investigate that further. That is the background to the comments that I would like to make now.

I would also like to make a couple of comments about the nature of general practice consultation, the way in which it is changing and what the implications are. I stress again that it is important when we think about general practice to recognise that it is not one thing. There is a great deal of heterogeneity in the way that people practise and in the environments they practise in. Although we talk about dissatisfaction among general practitioners, not all general practitioners are dissatisfied. Many of them have very rewarding practices, and some of the groups that you might least expect to be satisfied are among some of the most satisfied, certainly in terms of their clinical work. There is, we believe, evidence suggesting that the complexity of general practice morbidity is increasing and changing over time. There are some pretty obvious reasons for that. One is the ageing of the population and the associated larger group of people who have multiple comorbidity as part of their care. There is an increase, as part of that, in chronic disease. Really, one of the thrusts that the health system has to come to grips with—and it currently does this very poorly—is how to manage chronic disease better.

Lastly, there are changes to patient expectations of what happens in the consultation process. A large section of the consumer movement, or patient population, is much more educated and has much higher expectations. Philip Davies referred to some of the aspects consumers expect from it, but it also relates to the types of things they look for in the consultation process. There are also changes in the types of things that people bring to general practice, with a much larger focus on psychological illness and disability in general practice.

There is some evidence—not a lot, but some—that the quality of general practice care is related to the length of consultation. In fact, the submission that you have received from the Royal Australian College of General Practitioners summarises a lot of this quite nicely. Most general practitioners want to provide quality care. But they also have income expectations, as do the rest of us. Logically, you could say that bulk-billing arrangements which under-remunerate for a particular service will encourage what I call poor, high-volume practice. There is an incentive in place, when the remuneration provided under bulk-billing is poor, for people to churn patients through, to see patients more frequently, to call them back where they can on a telephone basis and to not spend that time which is needed to deal with the more complex patient environment within general practice. We believe that that sort of arrangement is probably inconsistent, to some extent, with health care needs. If nothing else, we have to look at that level of remuneration if we want to promote better quality care. I totally agree with John Deeble's earlier comment that we are not in a situation where we can through some sort of process enforce quality in the provision of health care. That is true across the system, and it is not just related to the legislation; it relates to the whole nature of medical consultation. But you can

certainly put things in place which encourage poor practice, and situations which encourage high-volume work have that potential.

We also would like to suggest that the current system of open patient choice of doctor, which is strongly supported by consumers—it is one of the things which people like about the current Medicare arrangements—may not necessarily be the best thing for health care overall, given the potential for it to produce inefficiencies. If people do move from doctor to doctor, you will see retesting when it is unnecessary and a breakdown in continuity of care—and we believe continuity is an important part of the proper management of chronic disease. It is also not a reality in many places where the choice of doctor is pretty limited anyway.

What about changing the situation at the moment? Is there any evidence of what copayments and changes to bulk-billing will or will not do, as the case may be? Our reading of the literature suggests that the introduction of copayments is more likely than not to lead to reduction in general practice use. Depending on the size of the copayment, that may be a relatively short-term phenomenon, but we believe that that will occur. We also believe, from our reading of the literature, that this effect is likely to be the greatest among those who are most disadvantaged—that they will be the most impacted by those sorts of arrangements. So, if you are having copayment, the nature of the safety net arrangements is absolutely critical in terms of not further disadvantaging those people who most need those services.

It is surprising that it is not actually clear what the health consequences of that reduction in servicing might be. Particularly in Australia we do not—and we almost started on this discussion before—have very good data at the moment that relates individual outcomes to the systems of care that they are being managed under. It is possible to do it; other places have done it. There is a very nice study from Canada which I was reading this week which looked at the health outcomes of total coverage—full insurance—versus non full insurance situations, which they did through record linkage, that clearly shows an advantage in that particular environment. Our reading of it would suggest that those activities under an increased copayment system which are most likely to be impacted will be in preventive care. That goes back to the original Rand studies in the early eighties, where that was one of the clear things that were impacted by levels of service charge. I think there is some evidence that it may impact on chronic care but, as I say, we do it so badly now anyway that I think we need to look at how we might improve that.

Going back to Professor Deeble's comments right at the beginning, I think we can say there was an extraordinarily high level of bulk-billing rates. John indicated that the target level that was seen as desirable was 80 per cent, and it certainly got very close to that and was maintained at that level for quite a long period of time. So I do not believe that there is a major opposition in the community or in the medical community to bulk-billing per se. What I believe is that, at the moment, the remuneration that goes with that is less than adequate and therefore is a major disincentive for people to continue that.

The last comment I would like to make is that if one looks at the current funding environment within Australia for health care one sees that it is very fragmented and some components of it are relatively inefficient. I think this is very nicely illustrated for you in the submission from Waterhouse and Hindle, which makes a comparison of the Australian and Canadian systems in that regard. It is quite confusing to consumers, even to the extent that there is a significant number of Medicare rebate cheques, for instance, which are never cashed. So I think if we are

looking at any sorts of changes we should try and ensure that we do not introduce yet another level of complexity in the funding arrangements. There is confusion for consumers with the arrangements as they are at the moment. I will end my comments there. Thank you.

Senator KNOWLES—Professor Wilson, I note that in your submission you made various claims that the universality of Medicare should be maintained by increasing the rate of bulk-billing. I am just a little concerned that history is being rewritten in some of this area. The universality of Medicare never included universal or compulsory bulk-billing. Why is your submission really focusing on that area, when it was never thus?

Prof. Wilson—That does not necessarily mean that the government should not consider the full range of policy options available.

Senator KNOWLES—Are you honestly suggesting that we should have bulk-billing for all?

Prof. Wilson—I am suggesting that there are other approaches, such as you have in Canada, where there is a process whereby the whole of the community can claim all their services.

Senator KNOWLES—With no out-of-pocket expenses?

Prof. Wilson—With no out-of-pocket expenses.

Senator KNOWLES—Is that what you are advocating for Australia?

Prof. Wilson—I am saying that I think we should take an approach which says: 'Do we know which one of these approaches is best, which one will produce the best health outcomes, which one will produce the changes?' We do not know the answers to those questions, so if we are going to launch into a change let us try to do it in a way in which we can try to explore some of those issues.

Senator KNOWLES—What I am trying to get to the bottom of is this redefining of the word 'universality', because so much has been written—ill informed nonsense in the papers, quite frankly—about the universality of Medicare including bulk-billing of everybody. It has never been thus and is unlikely to be thus.

Prof. Wilson—I think that is what Professor Deeble made clear this morning about the intent of the program. I think it was an excellent introduction he gave us on the history of Medicare, and it is always useful to have people who have had the history and are able to recount it for us.

Senator KNOWLES—I have looked at those comments contained in your submission and put them in tandem with further comments you made in your submission about the low-income earners spending a higher proportion of their weekly income on health care than higher income groups do. I do not think that anyone would dispute that, while the lowest income quintile does spend the largest proportion of income on health care, it spends the least in dollar terms. Conversely, those people on the highest income quintile spent the least on health care as a proportion of income but they also spent the most in dollar terms.

Prof. Wilson—Does that surprise you?

Senator KNOWLES—No, it does not surprise me at all. But what does surprise me is that in your submission you tend to have this focus that, somehow or another, the low-income earners spending the highest proportion of their weekly income on health is somehow wrong, when it is just a fact of life that in some of these things, because they are on a low income, they are going to spend a higher proportion—but the lowest value in dollar terms. That is why I come back to the point of trying to focus on a measure where low-income people are supported in trying to achieve less or no out-of-pocket expenses, which is surely a very important measure.

Mr Gregory—On this issue, I do not know anybody who thinks that universality means that everybody should have it free. Universality is a principle. Some people have been pleased to say that universality is Australian in the sense that it is about a fair go. What that means is that the aspiration is that everybody should have—

Senator FORSHAW—Access—isn't that the word?

Mr Gregory—equivalent access, equivalent options.

Senator KNOWLES—That is exactly right.

Mr Gregory—And we say, of course, that we understand it will always be mediated by the decisions of general practitioners, in this case. But I think universality is not about everybody getting it free; it is about having one system which provides equivalent access for—these are the words that I have seen recently—low cost or free. I have no objections, like you, if people who can well afford to pay, pay. The other thing I want to say about universality is that—I was going to mention this after Philip's discussion, where he listed three or four principals—it is a first-order principle, and the others are second order. By that I mean that universality is what actually brings about some of those other principles we admire so much.

It is administratively low cost because it is universal. It is simple for both doctors and consumers because it is universal, because there is not a choice of products. It is fair because it is paid universally through the tax system, and therefore it is progressive. I think universality is the key principle that determines some of the other things like low cost, fairness and simplicity. I think we should see them not as four equal principles but as universality—which I stress again does not mean free access to everybody, and not to me—and a number of other principles that are then determined by universality. That is why so many people want to retain it as principle.

Senator KNOWLES—Unfortunately, the debate has headed, quite wrongly and quite mischievously in my opinion, towards universality and free access by all through everyone being able to access bulk-billing.

Mr Gregory—You might be right—

Senator KNOWLES—It is quite mischievous. I come back to the question that I asked Professor Wilson about the importance of that low-income group. The measures contained in the A Fairer Medicare package which are specifically directed to low-income people are surely important in addressing any out-of-pocket expenses for many of those low-income people.

Prof. Wilson—I think there are two issues, at least, in relation to the questions that you are asking. One is the issue of what the low-income group is spending on health, whether that is an appropriate amount and whether they are getting the appropriate service to meet their needs for what they able to pay, or whether, in fact, they are paying what they can pay and still have unmet needs. That would be something that would need further exploration. The second issue is question of what is the fairest way to achieve a balance in terms of the contribution. One approach is through having differential copayment based on a doctor's decision about how much a patient will pay. Another is through a system which is, if you like, more universal: through what goes through from the taxation process. I think this was what Professor Deeble was referring to in response to what Philip was saying before about those two different issues.

I come back, however, to the point we were making in relation to this. I am not necessarily suggesting that copayments are a bad idea. I do not know the answer to that. I have tried to look at the effect of them where they have been introduced. If we are going to make these sorts of changes, let us try to understand what the consequences might be in terms of health. I am not sure that we know the answer to that.

Senator KNOWLES—But you are talking about copayments. I am talking about the other end of the scale: the direct initiative to reward doctors for bulk-billing concession card holders and low-income earners and the safety net measures and so forth that are in place. I would have thought, as a consequence of your submission, that that would have been a logical conclusion. Also, you mentioned the option of doctors trying to decide who would make a copayment. If we are talking about red tape being lumped around doctors' necks, I would have thought it would be a shocker to say to a doctor, 'Thou shalt decide who has what capacity to pay what copayment.' I think that would be frightful.

Mr Gregory—There are two ways I want to respond. As soon as you select any group you lose universality. I have tried to explain why I think it is essential we do not lose universality. The government's current package selects a particular group, cardholders. A lot of people have shown a lot of evidence that card holding is not a good proxy for financial need.

Senator ALLISON—Bulk-billing is central to this whole inquiry. We would not be here if we not looking at a reduction from 80 per cent to 69 per cent in recent times. Leaving aside this legislation, are we looking at a steady continuation of that decline? What is the view around the table? Are we heading down to 40 per cent or 20 per cent? Maybe the AMA could kick off the answer to this. Are we seriously dealing with a crisis, or would the system maintain its universality if we proceeded along the same lines we have been going on for the last couple of years?

Dr Bain—Our evidence is that as the real value of the rebate declines, which it has been doing over the years, the level of bulk-billing will drop with it. Under A Fairer Medicare package, the real value of the rebate will continue to sink and we expect that bulk-billing would continue to sink with it. As the participation rate falls, and there are fewer full-time equivalent doctors, that would also tend to reduce the rate of bulk-billing. I would also pick up Professor Wilson's point that as you add another layer of complexity to it you make the whole thing less attractive.

There are two aspects of A Fairer Medicare package. Firstly, doctors who used to charge a copayment on weekends or after hours, if they opt-in, will no longer be able to do that with

concession card holders. Doctors who opt-in will not be able to charge a copayment on Saturdays, Sundays or in the evening. So the incentive to be open at those times would be reduced and we expect that there would be a fall-off in the services that will be offered after hours by doctors who opt-in.

The other thing is that individual doctors do not opt-in and do not get anything out of this—whole practices have to opt-in. For practices that mix and match, with maybe a female GP coming in on Wednesdays to see female patients—which is happening more and more now; practices tend not to be just one doctor sitting there for 50 or 60 hours a week but a mix and match of doctors—every doctor who attends that practice will have to be prepared to sign-up. Getting a practice to sign-up to the package which might have seven or eight doctors rolling through it in the space of a week, and their locums and everybody else associated with it, will add a layer of extreme complexity to the whole exercise. We think that both of those things—the whole practice having to sign up, and the inability to charge a copayment to concession card holders on weekends or after hours—will be a real disincentive towards offering services.

Mr Goddard—I have a couple of questions. One is about the nature of a 'crisis', and the use of that word, and that has been discussed by John, among other people. If we use as our definition 'a situation of absolute awfulness', that is probably not the situation yet. The *Macquarie Dictionary* defines it as 'a turning point'. In that sense, we are in a crisis situation. We are at a turning point; we have to find some answers now.

My second question is whether the decline in bulk-billing will continue, and at what sort of rate, if we do not do something fairly decisive. The question I would ask is why would we expect it not to continue if we do not do something fairly decisive? Having spoken to a number of GPs whom I have known for a long time and I think are telling me the truth, I suspect that it may be that we could see an acceleration in that rate. It may be, if the anecdotes I am talking about are more general, that there is a cohort of practices out there that have been holding on to bulk-billing, or a high level of bulk-billing, and are starting to say: 'It is just not an option any longer. The things which are being proposed do not answer our objections.'

The other thing that has been put to me is that, once things start to unravel in a fundamental sense, sometimes the rate can be fairly uncontrolled. I can see no reason to believe that the rate should not, at least for the time being, continue at the current level or maybe something more. I can certainly see no reason it would stop at 69 per cent.

CHAIR—Professor Deeble, you made some comments in your submission on that.

Prof. Deeble—I want to offer a few facts in relation to Professor Wilson's statements about the responsiveness of demand to prices. The best data on this came from a big American experiment that said the effect of copayments on use is not very high. It depends upon the size, of course, but, nevertheless, it is not an extremely high effect—about 30 per cent—that is, if you put up fees by 10 per cent or introduce a copayment of 10 per cent, you will get about a three per cent reduction in use. That certainly does fall a little more on low-income people. But if there were a system that protected the very low-income people, that would answer that. But the reduction was quite random. It is often said that, if you have a charge, services will be used more efficiently; well, they were not. The essential services fell in use just as much as the unessential services.

If you want to be risk averse, in the sense of 'do no harm' rather than 'try to do some good', then, because they are random in their effect in relation to need, charges do have an effect—they may harm some but not do much good to others—but it is not huge. My main concern about charges is the effect on the type of service that people will get. If you really wanted to encourage bulk-billing of the disadvantaged, I would pay doctors more than they would get from charging patients. But under the proposals, and this is true of all the proposals, they will still get less—that is, a doctor will get more money from treating a non-concessional patient than from treating a concessional patient. If you really want them to treat the concessional patient, you pay them more, not less. I have experience of the old Pensioner Medical Service—probably most of you were not alive when it operated. About 60 per cent of the GP fee was the amount charged to pensioners, and discontent was rife, and it was rife for 30 years. Doctors all complained that they did not get paid enough, and pensioners did not get a good service either. In some respects, I think the thing is reversed.

Mr Davies—I am a little bit concerned at what might be a couple of terminological inexactitudes creeping into the discussion. Correct me if I am wrong, Andrew, but from some of Professor Wilson's comments, I sense there could be a view that the government is planning to introduce copayments. I think the message has been very clear all along that there is nothing in this package that requires or justifies the introduction of gap charges. I hope you will agree that some of the data we put up in our presentation showing the net—and I emphasise 'net'—additional income to practices who participate in this scheme probably would support the view that the scheme itself would not justify a move to introduce copayments.

The second point is that I have picked a couple of people referring to the end or the decline of universality. Once again, bearing in mind Professor Deeble's very early and very important point that the MBS is an insurance payment to the patient, under A Fairer Medicare that payment remains universal and it remains uniform. For all Australians who are entitled to the MBS, the level of rebate paid to the patient remains the same and it remains uniform. The incentive payments are paid to the practice. One might argue that that is a pretty fine distinction to be making, but it does remain the fact that the insurance coverage is universal and payments under that insurance coverage are uniform.

Prof. Hall—I want to reflect on the discussion as it has been evolving as well. Perhaps I will start off with this issue of universality, because I think the word is being bandied around with no clear meaning or idea about what it implies at all. It is interesting that the Canadians have just had a big inquiry into their health system, and Commissioner Romanow was able to come out of it at the end and say, 'This is what all Canadians want from their health system: they want solidarity, they want direct-billing,' as they call it. It will be interesting to see if you can do the same, Senator, after your hearings around the states, but I suspect not. In Australia I think we have a much more complex and multifaceted society in terms of social aspirations, so I do not think there is as clear an issue.

The other reflection I would make on the Canadian health care system, though, is that there are enormous variations from province to province, unlike the much more uniform system that we have here. So you can well argue that the fact that which state you live in does not affect your entitlements under the Commonwealth programs is, in fact, a very positive aspect of universality that other systems which claim to be universal do not have. So there are many different shades of meaning, and if we are going to argue about it we have to have some clarity. My own argument

in the Australian context would be that we are about not erecting substantial barriers, particularly financial barriers, to access for people to use health services.

The next issue in terms of bulk-billing is that we keep focusing on this headline rate when, if we are not going to accept 100 per cent bulk-billing as a social objective, we really need to talk about who gets bulk-billing, for what services and under what circumstances. I know there has been one study done, although it would be quite old now, of how people use health services, and some people are quite discriminatory in how they use health services. They go to bulk-billing clinics for things that they regard as minor, and they might rush in on the way to work to find out if they can get antibiotics for a sore throat—

CHAIR—Hopefully not!

Prof. Hall—and for their more complex conditions they prefer to consult someone with whom they have a longer and ongoing relationship. So we actually need to know, if we are going to have sensible debate about what this should be, not just who is getting bulk-billing but under what circumstances and what they are choosing. And indeed, in spite of my colleagues' emphasis—such as Professor Wilson's emphasis—on continuity of care, sometimes the patients do not want it. They choose different practitioners under different circumstances.

I also want to make a point about copayments. I will not reiterate what John Deeble has said, but we do know a lot about the effect of copayments. There are two major studies. There is the Rand study, and the other evidence that is really important in this area comes out of a Canadian province, Saskatchewan, before the introduction of the Canadian Medicare system, where they introduced copayments and saw that initially services went down. They stayed down for the poor; they went up for the rich. So overall utilisation of services went up slightly, but they got a much greater variation in their distribution. We need to take that into account.

We are talking about rebate levels whereas, really, we need to be focused on all the payments that are going into a practice so that we are talking about practice income and not just rebate levels. Indeed, part of providing incentive payments is to move away from the incentives that are in fee-for-service, which are just to provide more services. Indeed incentive payments may well change that balance. The other issue I would raise is that we need to be very conscious of what the incentives are at the margin. It is not just about what are the incentives for bulk-billing patients or about raising copayments—we need to be really specific about what is the marginal incentive for the doctor. When the next concession card holder comes in, what is the incentive to treat that patient?

My final comment reflects on Dr Bain's point about why all doctors in a practice have to maintain the same practice style. It would seem to me that in almost every other service industry we have seen a move away from solo practitioners and cottage industry into a much more corporate—and I do not mean that in the for-profit sense—organisational structure. We have already had some of the little evidence there is presented to us today that that provides better economies of scale in general practice. It may well be arguable that it can improve quality of care as well—for example, through continuity of availability of patient records to different practitioners. I would suggest that, a priori, there is a strong case for asking doctors to act as firms rather than as individuals.

CHAIR—Where that is possible.

Prof. Hall—Yes; with the proviso about smaller practices.

CHAIR—Can I come back to Mr Davies's point? It is an issue that has been raised in a range of the submissions. You say that there is nothing in the government's plan to encourage increases in gap payments. What has come through very clearly to me is that lots of people are predicting that there will be an increase in gap payments as a result of A Fairer Medicare. What modelling was done? What work was done to try to assess whether there would be an increase in gap payments for people who are not on concession cards?

Mr Davies—The modelling is summarised in the table I showed earlier. It shows that the vast majority of practices who participate in this scheme will be financially better off without making any change to their current gap-charging policy. That provides no financial imperative or financial justification for them to introduce or increase their gap charges. They will make more money by virtue of participating in A Fairer Medicare.

CHAIR—And did you test that in some way? You have a model, but how did you test it?

Mr Davies—It is an axiomatic view that if this gives them more money then it does not give them any justification to introduce or increase gap charges.

Prof. Deeble—Do they need it? Do they need the justification for increasing their gap charges?

Mr Davies—I cannot speak for individual GPs.

Prof. Sainsbury—My response is pretty much the same. I wanted to ask the question you asked, Madam Chair. Surely, simply demonstrating that by adopting a package most GP's incomes will increase provides no evidence whatsoever that they will not try to increase their incomes even more by another measure, the other measure in this particular case being increasing what they charge non-concession-card-holders. There is nothing to stop them doing that and, indeed, from many of the submissions to the committee that I have read I agree that it seems likely that the bulk-billing rate for concession card holders will be seen as the standard base level. It will be seen not so much as an insurance payment as a welfare payment, and GPs will be perfectly at liberty to charge non-concession-card-holders whatever they wish.

Senator KNOWLES—As they always have been.

Prof. Sainsbury—Indeed, they always have been. But with these measures they will be able to take the money that is being offered with the package and run, and they will also be able to increase the amount they charge non-concession card holders by even more and increase gap payments. I personally believe that that will be the likely scenario.

Mr Schneider—But that is also an argument for saying we should not increase the rebate across the board. If a doctor is going to exploit the system by charging someone who is not a concession card holder more under this system, there is no reason why they would not try to

increase it even more under one in which the rebate was increased across the board, if greed and avarice are their motivation.

CHAIR—I do not think we are suggesting that, Mr Schneider.

Mr Schneider—For years the medical profession has effectively played Robin Hood. It has always charged the person it believes can afford more more than the person it believes cannot afford to pay more. That has occurred through bulk-billing or through any other system. I can see nothing in this package that would promote the idea that a doctor who is getting paid more for his concession card holders should not reverse the arrangement for a change and use that to cross-subsidise those people on slightly higher incomes which take them out of the concession area. Doctors could bulk-bill those people and continue the practice of charging the people they think can afford it whatever they think the market can bear. That is no different from the current system or any other system we have unless we are prepared, as was raised earlier, to go down the path of trying to control doctors' fees.

Prof. Deeble—I think there is an invitation for doctors not to increase the rate of the patient charge, which on all services is now about $43 a visit—and that is not just at level B; it applies to all the services—while the benefit is about $28. So there is a $15 copayment for the ones who are patient billed. I would not expect that to rise; I just think more people will pay $43, because that is what lowering the bulk-billing rate will achieve. It can be shown—and I think I showed this in my submission—that logically doctors would maximise their incomes by going to the rate that is expected, which is about 55 per cent, and charging the uniform $43 to everybody else, although I am sure that they would modify it a bit.

Despite my argument in that direction, I have to make a small counterargument because something very strange has been happening. Although bulk-billing has fallen from about 80.5 per cent back in 1996-97 to the present sixty-eight point something—most of which occurred in the last year or so, which is an interesting phenomenon—if you look at the Medicare statistics published by the department you will see that the ratio of benefits to fees charged has hardly fallen at all. They did not start to fall until this year. There was a decrease of about eight percentage points between 1999 and 2001, and the ratio of benefits to fees charged fell by only one per cent. I deduce that a lot of doctors stopped bulk-billing but they did not charge the patients any more. They were keeping their options open to raise charges later on. I am sure that the government possesses this information. They could use it to say that that is what will happen. They could say that doctors will not bulk-bill because they do not trust the government. They will keep their options open but they may not charge the patients any more than the benefit. I do not know about that. I think it is unlikely but I have to allow the possibility that that could happen because it has happened to some degree in the past couple of years. If you look at the aggregate bulk-billing statistics against the average coverage you will see that has not changed nearly as much. I cannot be sure of what doctors have been doing.

Senator FORSHAW—I will address these questions to Mr Davies. Following what Professor Deeble has just said, and without getting into this continuing debate about what universality and bulk-billing mean, if we accept that there are two issues at the moment about bulk-billing—first, the decline overall in the level of bulk-billing services and, second, the fact that we are finding more and more doctors who are not providing bulk-billing even for concessional health card holders—the government says that part of its package is aimed at the second group, the health

care card holders, low-income people, welfare recipients and so on. What does this package do in the government's view to the overall bulk-billing rate? In other words, what does it do to promote the concept that we should try to get those national bulk-billing rates back up to what they were—namely, 80 per cent? In other words, in respect of those who were bulk-billed in the past but who will now not be in the category that the government has targeted, will there be an increase?

Mr Davies—I can only really reiterate the point I have made, which is that there is nothing in the package that justifies no longer bulk-billing anybody who is currently being bulk-billed. What there is in the package is—

Senator FORSHAW—I am asking the reverse in terms of the overall position—not the concession card holders alone, which Senator Knowles has raised, but overall.

Mr Davies—The same applies. There is nothing to justify ceasing to bulk-bill people who are currently being bulk-billed, be they concession card holders or not.

Senator FORSHAW—I am not asking you that. This government introduced a scheme which they said had the deliberate purpose of lifting the level of private health insurance coverage in this country, which they said had reached a crisis point and that the overall level of coverage was too low. They introduced a scheme to lift that rate. I am asking you what is in this package that would lead to an increase in the overall level of bulk-billing services across the entire community universally to the sorts of levels they were at before?

Mr Davies—There is no implicit or explicit target level for bulk-billing—there never has been. As a think I explained in my presentation, it would be very difficult for a government to achieve any target level, ranging from 100 per cent downwards. What we do know is that, to the extent that concession card holders are not currently being bulk-billed and to the extent that they are able to access participating practices, there will be an increase in the bulk-billing rate for those concession card holders.

Senator HUMPHRIES—I am a bit mystified about the basis on which some people are pronouncing that bulk-billing is dead and that there is a crisis in the system. I have seen, for example, your comments about the low rate of bulk-billing. Bulk-billing stood in 1992 at just over 70 per cent. It is not a great deal below that today. I do not recall anyone administering the last rites to bulk-billing back in 1992 under the former government when it was as low as 70.6 per cent. The Medicare rebate for a standard consultation has risen by 20 per cent in the first six or seven years of this government whereas it rose by only nine per cent over the last six years of the former government. The average gap-payments for GP visits went up significantly more under the former government than they have been rising under this government. So what is it in the announced package of measures that does not address the real problems of the kind that have been acknowledged in the present operation of Medicare? What more do people see needing to be done to deal with those key problems of lack of access in rural and regional areas, shortage of doctors overall and administrative problems in the way people make their payments?

Mr Gregory—That goes to the question which is the focus of this hearing. I think we are all here because we are interested in providing primary health care to people in need. We are focused on only one of the main questions, bulk-billing, when it seems to me that the real

question is how do we change the structure and funding of our health service so that everybody has access to whichever primary health care provider is best equipped to intervene in whatever condition they have? That is why the National Rural Health Alliance, for which I work, believes there is a two-stage process. First of all, we should be assuring a universal system, and I say again, not just because it is nice and Australian and a fair go, but for all sorts of practical and administrative reasons as well. Any system other than a universal one would be partial, less fair and more costly. So the first thing is to assure universality.

Then the second thing to do is about the sorts of things we were discussing before tea—that is, changing the shape of Medicare so that it actually provides, through a universal insurance system, access to not just doctors and those who work for them in their practices, in their surgeries, but whoever it is that provides the best intervention for their condition. Of course, this immediately throws up fears about cost blow-outs, so it needs to be constrained. Perhaps it needs to be capped, perhaps prescribed for certain areas. It is ironic for me, as a rural advocate, to be saying 'Preserve universality at all costs,' because the reality is that it is mediated by people who in many rural and even more remote areas do not exist. So what I am saying is, even though it is not universal for remote people—because they do not have doctors and they do not have pharmacists either, so they do not have access to the PBS either—universality we believe is a principle worth fighting for and retaining. Once we have done that, we have to move on and change the shape of Medicare so that people in remote areas can get access to some publicly funded primary health care intervention, which probably will not come through a doctor.

Senator BARNETT—A lot of discussion has been had in regard to the level of the rebate. The AMA in its submission has recommended $50, I understand, rather than $45. What is the cost to revenue? Can we just get some clarification on that, in terms of every dollar increase in the rebate? If it were $50, can you advise us what the cost to the taxpayer would be?

Mr Davies—Certainly. In very broad terms, a dollar on the rebate costs the taxpayer $100 million a year. So to put the scheduled fee—which I think is the argument on the part of the AMA—up to $50 is about a $17 increase in the rebate, so we are talking about $1.7 billion per annum of additional taxpayer funding to deliver rebates at the level the AMA is suggesting is desirable.

Dr Madden—I did not want to come in on that issue about elasticity, because I could not contribute to it, but I do want to comment on the third dot point on the table, about public hospitals. The whole point about rural access, I think, is relevant to that. During the morning tea break the staff kindly distributed a table with a cover sheet to show where it came from. There has been mention of the Medical Workforce Advisory Committee, to which this was attributed. I was a member of it. In fact, Robert Bain and Jane Hall are also members. Let me just say something about that. That is an AHMAC committee, with a wide variety of people on it, and it is charged with looking at the adequacy of the work forces across the medical profession and not, as some seem to think, at the number of places in medical schools. We did give some advice, which Mr Davies referred to, which has been accepted by the government, but that generally has not been part of the terms of reference. We are currently doing a GP review and, for my sins, I have been put onto that review by the main committee—which is a very difficult role.

This table I have distributed came from the last review, published in, I think, 2000. The reason I have distributed it is that it shows you, if you go across the columns from capital city out to remote areas, how things other than Medicare become more and more important. Overall, there is about an extra 30 per cent of services provided that are funded other than through Medicare or not funded at all. In capital cities it makes a difference of about 15 per cent, and clearly Medicare is the major issue. When you get out to the remote areas the other services—and particularly those provided through public hospitals—about equal the Medicare services. So there is another system out there that you have to look at as well. And of course, at least in the public hospital system, there are no charges for access to that.

The reason I wanted to say this is that this table—the chart that the department distributed earlier—says at the bottom that it excludes workers compensation claims, payments through public hospitals and so on. That is more than a footnote; it is actually a very important issue and becomes much more important as you go out into the rural areas from the cities. So I think this needs a lot more analysis. Unfortunately, the AMWAC study will not be finished until the end of year, as always, so I can only table these numbers, which are a couple of years old. But I doubt that the overall pattern has changed dramatically.

Mr Ford—I want to add to the discussion about bulk-billing and demand in hospitals because I think it is a really important issue. I am particularly familiar with the Victorian public hospital emergency figures, but I suspect they are fairly similar, particularly on the eastern seaboard. I know that in Victoria from June 1999 to June 2002—they are the latest figures—emergency demand in metropolitan public hospitals has increased by around 15 per cent. Not all of that demand is from people whom we call bulk-billing patients. In fact, emergency demand is increasing across the board, from the most critical care needs through to the most minor cases.

I think the important point to make is that increasingly there are people presenting to emergency departments who might have otherwise gone to see a GP. Another important point to make is that, while there actually have not been many studies examining the relationship between GP access and emergency demand, the studies that have looked at this question have shown that people usually identify three reasons when asked, 'Why did you come to the emergency department rather than visit your GP?' The first reason is access. That relates particularly to accessibility after hours and on weekends, when GP practices are closed. More and more GP practices are nine to five operations.

Another point that people often raise is the cost. Emergency departments are free; you do not have to pay. As long as you are prepared to wait, you will get seen. You might have to wait eight hours, but you will get seen. The third thing that people often say is that it is because the range of services in a hospital is much more comprehensive. If you go to a hospital you will get everything. You will be seen by a doctor or a nurse and you will get an X-ray, blood tests et cetera. The range of services you will get if you front up to an emergency department is very comprehensive. They are three really important reasons why people would go to an emergency department rather than a GP.

Senator ALLISON—As far as I know, it is not true that people get services at emergency departments. I have heard increasingly that when people are finally seen, after waiting for hours, they are told to go to their GP in the morning.

Mr Ford—That does happen, but emergency departments should not do that. I have done studies in emergency departments and I have seen emergency doctors or the triage nurse say, 'You would be better off going away and going to your doctor tomorrow'. If you go into an emergency department you can demand to be seen, as long as you wait. But the other does happen.

Mr Schneider—I will add to that with an anecdote told by Bernie Amos, who used to be the head of the New South Wales Department of Health and was the administrator of Westmead Hospital in Sydney. He established two bulk-billing clinics across the road from the hospital to try to relieve the load on the emergency department. When patients came to the hospital who could be dealt with by a GP, they were referred across the road, where it would cost them nothing. The clinics were open 24 hours a day, with no waiting. He said most of the patients declined to go there, because they wanted to be in a hospital where there were 'real' doctors. I think that attitude is true in many of those who go to emergency today.

Mr Davies—I would like to table one more piece of evidence on this particular issue. One does hear anecdotally that more and more patients who could go to a GP are now choosing, or being forced, to go to public hospital emergency departments. I am obviously concerned at that assertion. We have pulled together some data that shows the share of public hospital emergency department services by triage category and how it has changed over the past four years. I say 'how it has changed' but it is remarkable how little it has changed. If you look at categories 4 and 5, the lowest acuity presentations, you see it was just over 60 per cent in 1998-99. That is from adding up the top two portions on the graph that is being passed around. In 2001-02, it was around 60 per cent. Certainly the evidence on a national basis tends to give the lie to the view that there has been a big increase in the number of patients with minor problems receiving services in public hospital emergency departments.

CHAIR—Mr Davies, I am not very good at adding up bars. Could you give us that data in numbers?

Mr Davies—We will get that over lunch for you. It will be four years of percentages.

Senator ALLISON—Is the data broken down into areas where you might understand certain factors? This is an average so presumably it evens things out. There is plenty of evidence to suggest that when bulk-billing goes from an area there is an increase at the emergency departments of the hospitals in that general area. Can you look at individual hospitals? Can you relate it to the access or otherwise to bulk-billing in the area?

Mr Davies—I can certainly ask that question for you, Senator, and see what the answer is. As you pointed out, the point is that over that same four-year period the national bulk-billing rate has declined. To the extent that these are national figures, if the assertion is true, one would expect to see that national decline in the bulk-billing rate reflected in a national shift in this balance of triage categories.

Senator ALLISON—That is providing that there are certain patient groups that remain the same. It depends on some heterogeneity of the figures, which may not be the case for a reduction in bulk-billing.

Mr Ford—I was not saying that we have seen an increase in triage 4 and 5 and a relative decline generally; we have seen an increase in all triage categories. But when you ask the 4 and 5s why they are going, they cite the reasons I gave before. We are not seeing a relative increase in triage categories 4 and 5 in respect of the other categories; we are seeing an increase in all categories.

Senator KNOWLES—What is the lowest acuity?

Mr Davies—Five.

CHAIR—Mr Davies, between now and after lunch, could you explain what the five triage categories are? Instead of listing the services in each category, could you give the actual data? You have been describing relative change and you assert that there is none. I would like to look at the total number of events rather than at the separation.

Mr Davies—The point we are trying to make here is the relative point and that is that there has been no evidence of emergency departments increasingly substituting for general practice over this period. That would have changed the relativity. However, we can produce the actual numbers as well.

Mr Gregory—I want to re-emphasise a remote area aspect of this hospital utilisation. I would hate there to be any residual sense that the disproportionate use of hospitals by health consumers in remote areas is a good thing in terms of health interventions and health outcomes. The evidence is that it is a bad thing. People go to hospitals in remote areas because there is no-one else to go to. Whatever part of the hospital you go to, it is not a good place to get health promotion advice. It is also not the place to go if you have depression or a mental illness. The evidence is clearly that good primary health care is better than a hospital in terms of health promotion and illness prevention—but if your leg is falling off, I guess a hospital would be pretty good.

CHAIR—It is now time for us to move to session 5 and we are only half an hour behind. I suggest that we work from now through to 10 past one and try to cover off the matters that we want to raise in terms of what will occur under the government's and the opposition's proposals relating to the rates of bulk-billing, concession card holders and patient copayments. I invite Professor Hall to make some opening remarks to lead us into this session.

Prof. Hall—As I was asked to do this only about five minutes ago, they will be very brief opening remarks.

CHAIR—We are looking for brevity when we are this far behind.

Prof. Hall—The first point I want to make is that one of the problems we have every time we have a debate about the Australian health care system is the lack of evidence. Some of it is lack of data, but a lot of it is lack of use of the data that are available and lack of independent analyses. I want to make the point that for the last three to four years the National Health and Medical Research Council has been sitting on millions of dollars which are supposed to be used to promote work in this area. We still have to see even a call for expressions of interest on this. I think the issues that we are dealing with are very important. This country lags behind the rest of

the world in its investment in health services research, and it hampers our ability to deal with these really important policy issues. That is my hobbyhorse.

It seems to me that what we are talking about now is how we get some sort of increased payments for general practitioners. We know if we are going to have increased payments somebody has to pay more. What we have to do is look at what are the options for people to pay more and what are the options for then getting that money through to the service providers. We have talked a bit this morning about some of the options for getting it through to the service providers, such as general increases in rebates, targeted increases or incentive payments around concession card holders. There are different incentives if we go for different sorts of payment mixes. What we have not talked about so much is how we might raise the additional money. There seem to be two ways we might go. We could go for increased copayments, where people who are subject to the copayments will be paying more money—and they are likely to end up being the better-off people, as they are going to be much less resistant to price increases—or we could go for taxes. We could also talk about how the tax system should finance increases in health care expenditure. One of the things that is never mentioned is the role of the Medicare levy and the fact that, in a usually progressive tax system, we have a really flat rate tax that could be either made much more progressive or rolled into the progressive tax system. That is another way of us looking at how we raise the money.

I will not go through the issues of how we might pay people differently. What is clear is that it is quite possible for there to be pressures to increase levels of copayments in the system. Again, what we have not addressed is the role of insurance in the government plan and how that will affect the likely pressures on copayments. There are two ways insurers might work. They might become very passive conduits and pass on inflationary increases to the consumers and the funders of health insurance—which of course are the government now—or they might become much more active managers of at least the costs of the system if not the overall care of the system. We have not yet seen evidence in Australia of insurers taking on that role, although I believe—and I am sure Mr Schneider will correct me if I am wrong—that they are interested in taking on that role. If they do take on that role then we need to have a much wider discussion about the role of private or voluntary health insurance and where it sits in the system. It would seem very peculiar, if we expect them to exert a primary influence on cost and utilisation level controls, to have them funding a very small part of the overall payment for each service. We know that if we have multiple payers in the system we are likely to have much more administrative overhead. It just costs more to have more payers. More systems have to be set up and more sorts of checking routines.

I want to go back to a point that I made this morning, too, and say that I think that what we have seen with the rise in bulk-billing rates is the outcome of price competition among doctors that has been driven by the increase in numbers. I could argue that we could probably increase the bulk-billing rate by flooding the market with doctors. But what will that do? It does not solve the maldistribution problems. In fact, the imbalance in distribution between rural areas and city areas has been made worse by the increase in the doctor supply and it will certainly drive up total health care expenditure levels.

Is that better or worse? If you are a conventional market economist, you would say 'If consumers use it, they like it. Therefore, there is an increase in consumer surplus. The market must be right.' If you believe there are information problems and consumers have problems in

judging the value of services, and indeed they might not be the most appropriate people to judge as individuals what a societal contribution to services should be, then you are into a debate about what the appropriate level of servicing is.

I think also, sitting on AMWAC, what bedevils our discussions about numbers every time is understanding what appropriate utilisation levels should be. We know in this country, as we know from the evidence in every other country, that we see enormous variations in practice patterns and in utilisation that are not explained by differences in patient morbidity or any other indicator of need. What we just see is variation and we do not know what the right level is. I think we are going to keep having this sort of problem, and certainly changing bulk-billing levels, changing doctor numbers and changing all sorts of things does not seem to reduce that variation; it just moves everything up or down, with the distribution of variation still being there. I guess what I have done is to introduce some more complex problems but, if we want to look at the costs and benefits of changing the system, we have to tackle those issues to some extent.

Senator ALLISON—Can we ask the department the question that Jane suggested first up about the NHMRC and why it is that we are not getting good research advice about health policy through that agency?

Mr Davies—In my role I do not have any direct responsibility for NHMRC but obviously there are other people within the department who do have some oversight of the workings of NHMRC. As we know, NHMRC has its own independent governing council. I think that is probably a question you would have to pose in another forum.

Prof. Sainsbury—I would like to comment—and Professor Wilson might want to comment as well; he was on NHMRC until a year or two ago. I am currently on NHMRC. For the committee's information, in March or April there was a workshop in Canberra called by NHMRC that was specifically focused on it taking a more active role in the development and funding of health services research. Jane is quite right, of course—it has been on the agenda for some time and not much seems to have happened, but there does seem to be a determination to lift the game a little in that particular regard in the near future. That is just for the information of this committee.

Senator KNOWLES—I want to come back to the issues that Senator Humphries raised earlier, that there are claims—and Professor Sainsbury is one who made them again today—that there is a possibility that gap payments will be increased under this package. I did not gather any answers to questions that were raised by Senator Humphries and I want to specifically ask participants why there would be a belief that there could be increases in gap payments, when over the last six years the rebate has risen by 20 per cent, compared to nine per cent under the previous six years of the Labor government, and the gap payments have risen by 53 per cent under the coalition but rose 60 per cent during the last six years of the Labor government. I find that very difficult to come to grips with, that suddenly there is a claim being made now that there is a greater risk, when history is showing that the rebate has been higher and gap payments have been lower under the coalition government, and now people are saying it is suddenly going to be reversed. Why?

Prof. Deeble—I will take an honest guess. It seems to me that a number of things are happening. The gap payments have been constrained by the expectation of people that they will

get bulk-billing and by the expectation that those gap payments will not be very large. The disapproval of those gap payments, in a sense, by a government which has tried to maintain bulk-billing as a significant selling point for the system has influenced the amount that doctors charge. They are not immune to social pressure. But—and this relates to some of the things that Jane was saying—if there is an invitation saying 'It is now all right. In fact, we will give you our blessing to go and get what you want to get from your patients,' then I believe doctors will. They have an income target, and I think the GPs have a case—they have always argued that they have a case. It is not easily measurable, but they have a case. Whether or not they have a good case is irrelevant; they are going to raise their charges.

Senator KNOWLES—But there is nothing contained in the package—

Prof. Deeble—What is contained in the package is approval for doing so.

Senator KNOWLES—There is—

CHAIR—Let Professor Deeble finish.

Senator KNOWLES—I am just trying to clarify that Professor Deeble is saying there is something in the package that will specifically accelerate gap payments.

Prof. Deeble—More people will pay gap payments—the same gap payment, if necessary, but more people will pay gap payments because the strategy that is best for the doctors under the government's proposal is to drop to bulk-billing at the target level, which is the concessional level, and charge what they want for the other patients. They have established a fee of about $43 and the AMA's target fee is $50. What makes you believe—what makes anybody believe—that if there is no pressure to reduce or limit those charges they will not move to as close to $50 as the market will bear? I cannot imagine why they would not.

Jane raised a question about who is going to pay. I take it as read that general practice is going to cost more. I take it as read that somebody is going to have to pay more. I take it as read that the GPs are in a position to get the income increases they seek. If that is not the problem, then why are they dropping bulk-billing? It is a question of who is going to pay. Either the patient pays or Medicare pays. Nobody else is going to pay. There is a difference in approach. If Medicare benefits were raised, it would cost more to government but no more to patients. If the government basically holds its benefits constant, then it will cost patients rather than government. But the amount of money is likely to be very much the same. In answer to your question, I think that doctors are invited to.

Senator KNOWLES—I do not see anything in the package, and that is why I am asking all the participants. Professor Sainsbury, you might like to comment on this, because you made the claim that copayments would inevitably go up. It has always been thus that doctors can increase their charges. It is worth noting that general practitioners are, I think, currently on about 4.7 times average weekly earnings. I raise the question again: what is there in this package that is going to do it? Why is there a so-called nexus between the level of the rebate and the level of bulk-billing? There has been no indication that raising the level of the rebate by the $17 that the AMA is wanting, at huge cost to the bottom line of the budget, is going to increase the level of bulk-billing and decrease any possibility of copayments.

Dr Bain—Can I start with a correction? The AMA do not have a policy—although Mr Davies said it—of seeking a rebate of $50.

Senator KNOWLES—I thought you were seeking an increase of $17 in the rebate?

Dr Bain—No, that is not for the rebate.

Senator FORSHAW—That was the scheduled fee. It is a bit of a difference.

Dr Bain—We are saying that the schedule fee should be set at about what the relative value study says. We spent seven years working with the government on the relative value study and that came up with the figure of about $50. That is where the schedule fee should be. Whether the government can pay 80 per cent, 50 per cent or 10 per cent of the schedule fee is another issue but we are saying that the schedule fee should be where the RVS says.

Senator BARNETT—What do you think it should be?

Dr Bain—The rebate?

Senator BARNETT—Yes.

Dr Bain—I do not have any particular view on the rebate. The AMA does not really push the rebate—they think doctors should charge what they think they are worth. I want to come back to whether this package will have an influence on the level of bulk-billing. We think it will, because the package says that the government is not going to implement the RVS. When I joined the AMA, we surveyed all GPs in Australia, both members and non-members. There was a very high expectation that there would be a quantum increase.

Senator KNOWLES—The AMA represents only 30 per cent of GPs, does it not?

Dr Bain—It represents between 30 per cent and 40 per cent of GPs. We say that while we represent them all, only about 30 per cent of them pay.

Senator FORSHAW—That is not bad, for a trade union!

Dr Bain—The point is that there was a very high expectation that there would be a quantum increase in the rebate, as a consequence of the relative value study. Now that the government has sent the message that it is not going to implement the relative value study in any way, shape or form, the message we are getting back from the members is that they know they are on their own and that they will have to find ways of funding their own practices because it will not come via the rebate. The message from A Fairer Medicare package is that, from the government's point of view, the RVS is dead. We believe the consequence of that will be that a lot of doctors will increase their charges, as John Deeble has said.

Senator KNOWLES—Why would they take such action when the rebate has been increased by 20 per cent in the last six years and was increased by only nine per cent in the preceding six years?

Dr Bain—The point about the relative value study—and it is a joint government and AMA study—is that it shows that the schedule has got a mile behind any sort of realistic measure of—

Senator KNOWLES—But it is ahead of the CPI. Since 1984 it has been ahead of the CPI.

CHAIR—Thank you, Senator Knowles, for making that point. Professor Sainsbury, would you like to speak?

Prof. Sainsbury—The questions you pose, Senator Knowles, are legitimate and I might try to answer them not in political terms but in the context of trends over time. What we saw after the introduction of Medicare was, broadly speaking, a steady increase in bulk-billing which presumably reflected the fact that GPs were happy to bulk-bill and patients were happy to be bulk-billed. Broadly speaking, that arose out of a constellation of policy factors. We have seen in the last few years a reversal of that. There is a steadily declining rate of bulk-billing which presumably reflects, from what we have been told, not so much patient dissatisfaction with bulk-billing as GP dissatisfaction with bulk-billing.

So in partial answer to your question 'Why now, if not then?' the situation is fundamentally very different—rates were increasing then, and now rates are decreasing. This is a reflection rightly or wrongly—as others have said, regardless of the CPI and the relative value of the gap and one thing or another—of what the GPs themselves perceive the situation to be. There is a strong argument that GPs are no worse off now financially or very little worse off than they were, and that they are still getting a good income. But they perceive themselves to be hard done by and underpaid. That perception is the difference between then and now, and it is being borne out in their behaviours of increasing bulk-billing and now decreasing bulk-billing.

There are two elements in the increasing gap payments and this has been highlighted as we have gone along. One is that the average amount charged as a gap—where a gap is charged—could increase more.

Senator KNOWLES—We could get rain in Canberra next week too. This is just crystal ball gazing.

Prof. Sainsbury—Yes. I am just saying, though, that there are two elements. Firstly the amount charged, where a gap is charged, could increase; and secondly, in concert or independently, the number of people who are charged the gap could increase. Both of those possibilities are there. They could both occur or neither, or one and not the other. Now, is it likely that either or both will happen? In terms of the actual average gap, then yes, I think it is quite possible that that will increase, the reason being that the GPs feel there is a justification for charging a higher gap than is the average gap at present—as evidenced by what the AMA says, by what the relative value study indicated and so on. So they have some justification there for charging more than they do at present. There is also a justification, I would argue, in the fact that the way that A Fairer Medicare package is set up—with the rebate being for concession card holders et cetera—very much establishes that as a welfare benefit to poor people. 'That is the minimum,' it is saying, 'that we will do for these poor people who really need a bit of a hand, and for everyone else you can charge extra.' And that is where you can argue that GPs will extend the charge of a gap, whatever the gap is, from the current 69 per cent of services to the 52 per cent. They will increase for the 17 per cent of people between the 69 per cent and the 52 per

cent—the people who are likely to get it because they are concession card holders—and that 17 per cent of people who currently are not being charged a gap will now be charged a gap. I think you can make an argument that the situation is different now from six years ago. And secondly, there are arguments that both the average gap will increase and the number of people who are charged the gap will increase. So overall the gap will increase.

Senator KNOWLES—But that could have happened already. If it was going to happen, it could have happened.

Prof. Sainsbury—Well it could, and it has happened to some—

Senator FORSHAW—But it has happened in another way, because what has happened, particularly in the last 12 months as Professor Deeble said, is that doctors have used the device of opting out of bulk-billing to increase their incomes. In other words, as you decrease the number of patients that you bulk-bill, you actually increase your income, and you do not have to see any additional patients because you are no longer accepting a rebate as full payment. And that is why I go back to the question that I asked of Mr Davies. The answer, I believe, to Senator Knowles' question—one of the answers—is that if there is nothing in this package that addresses the issue of the declining availability of bulk-billing for the general population, as distinct from the concessional card holders, then the package does nothing to lift bulk-billing rates over all. And as you say, you set up the construct—if you like—that there will ultimately be two groups of patients. There will be concession card holders, who will be entitled to absolutely 100 per cent bulk-billing. If it is directed there the package—I will at least acknowledge this—would try to get doctors to start bulk-billing those health care card holders again that they previously did bulk-bill and have now stopped doing, particularly in rural areas. So it looks at them, but it does nothing about the rest. That is the issue. It is not a question of what happened six or 10 years ago, because in the first period of Medicare the medical profession opposed Medicare for years and years. Eventually, when it recognised politically that it was in to stay—when the coalition decided that it would stop telling people that they did not really like it—you saw bulk-billing rates increase. It became a fact of life. Now it is heading in the other direction.

Mr Davies—As a precursor, I have to comment on Dr Bain's use of the relative value study. The assertion that the relative value study concluded that the schedule fee for the standard MBS GP service should be $50 is, I am afraid, simply not true. That argument is rehearsed at some length on page 22 of the department's submission; I will not go over it again now. The assertion that the relative value study was a process where assumptions were fed in and out popped an answer saying $50 should be the scheduled fee is simply not the case. I have a couple of other points. I think Professor Deeble was claiming that if GPs think they are worth $50 they will charge $50. That probably ignores the effect of markets and competition.

Prof. Deeble—I do not have a lot of confidence in that.

Mr Davies—Certainly there is ample evidence from the fact that the bulk-billing rates in well-serviced inner city areas is already very high that, in fact, GPs in those areas are not able to wantonly charge whatever they think their services might happen to be worth. That goes partly to Dr Sainsbury's point as well. I would like to table one more bit of pre-prandial evidence. A lot of submissions and, I think, some of the interventions in the last session have built on the argument that if we increase the rebate then bulk-billing will be restored or gaps will be reduced.

I have three more graphs which I would like to table—with your agreement, Madam Chair. The first is a simple comparison of the GP bulk-billing rate against the standard rebate for item 23, expressed in nominal terms. It shows that the last three or four years, which has been the period when the rebate has been rising at the fastest rate since the establishment of Medicare, has been the period when the bulk-billing rate has been dropping at the fastest rate. That tends to give the lie to the argument that if we were to increase the rebate then bulk-billing rates would go up.

More tellingly, I have a couple of other graphs to table which look at the impact of a couple of other changes where rebates have been increased significantly. The first looks at radiation oncology. Between 1998 and 1999 there was an increase, by eye, of about $8 in the rebate for a couple of radiation oncology items. The logic that underlies the case that if we increase the rebate, gaps will go down or bulk-billing will go up does not seem to hold up in this case at least, because despite an $8 increase in the rebate the average gap per service appears to have remained totally unchanged. The increase in the rebate has all been absorbed in the form of additional income to radiation oncology service providers.

We see a very similar thing in the case of obstetrics. In fact, this case is even more telling. The average rebate has, again, in two consecutive years increased significantly but, lo and behold, the average gap charged has also risen across those two two-year periods. I venture to suggest that taking those three graphs together—and this may sound counterintuitive—raises the question of whether an increase in the rebate is actually going to flow through to a reduction in gap charges or an increase in the bulk-billing rate.

Senator ALLISON—Mr Davies, I have had a look at page 22 of your submission. You say:

... modelling by the Department of Health and Ageing, based on the same technical reports—

that is, the same ones used by the AMA—

but using different assumptions, showed that ... general practitioner attendances were under-funded to a small degree.

Can those assumptions be provided to the committee?

Mr Davies—I will certainly see what material we have on that whole RVS issue. I think one of the points made there is that the RVS showed that, if anything, there was some slight under funding of GP services and some slight overfunding of other non-GP specialist services. It would be interesting, if he were here, to see what Dr Bain thinks the 60 to 70 per cent of his members who are not GPs would feel about implementing the RVS as interpreted.

Senator ALLISON—To clarify, your statement a little earlier was that subsequent changes in various programs that have been provided made up that small difference you have identified.

Mr Davies—Basically, the rebate is not the whole story in GP remuneration. As Professor Deeble said in our first session, a lot of other funding streams contribute to GPs' practice revenue.

Prof. Deeble—I do not think that you get it up just by increasing the rebate across the board—those days have probably gone. In both the government's and the alternative government's proposals, the higher payments are linked to achieving certain levels of bulk-billing. It is not too difficult to construct a system in which the highest incentives are where you want the bulk-billing level to be, and they are starkly different. The same amount of money is involved but there is quite a different outcome in terms of whether the government or the patients pay. But I agree with you that a general increase in the rebate is now a lost cause. I do not think that it was always a lost cause. I remember talking to the secretary of the department in 1996, when they froze the GP rebate. I said, 'You'll lose them,' and he said, 'No, we won't,' but they did. This could have been mitigated to a good degree if the response had been a little more flexible in terms of the rebate over the last few years. But that is water under the bridge.

I do not think it shows very much when you look at the very big items where the patient contribution is largest. They are basically in those specialties that work in hospitals and, therefore, work on private patients in hospitals who have an additional level of support from the private health insurance funds. For instance, it is true that the rebate for an obstetrician is now about half the fee. That would not bother me too much from an insurance point of view, because there are only 220,000 such occurrences and they occur, on average, twice in a lifetime to half the population. I would pay them anyway. I cannot see that that would actually contaminate Medicare's other operations to the slightest degree. I do not know why we fuss about an item which is a few million dollars in a billion, about maintaining the principle that we cannot give one doctor group more than another.

As for the analogy, why things change—why there are different outcomes across the specialties—is the product of a lot of other things. It really does not show what would be the outcome for GPs, and GPs are all we are talking about.

Senator STEPHENS—I do not want to interrupt the flow about the concession issues but I want to go back to your presentation this morning, Mr Davies. You raised three issues: lack of fairness, costs adding up and inconvenience. We have talked a lot about the lack of fairness but I want to focus on costs. You presented the slide showing how up-front costs can be a barrier which generates additional time costs and how it is no longer technologically necessary. Can we move to the proposals for direct bulk-billing and the implications for costs, access, administrative efficiency and possible inflationary pressures on patients' out-of-pocket costs that will arise from the introduction of the proposed swipe-card system? I thought that Professor Hall might have had some thoughts about that issue. What do you anticipate will be the impacts of having doctors install that technology in their surgeries? What will it mean in technology costs for the system?

Mr Davies—It is very closely related to the question that we have already canvassed: will the package, if implemented, lead to new or additional gap charges? That issue is tied to access to the technology. In that regard I can only repeat my previous statement that nothing in the package requires or justifies increased charges or the introduction of gap charges and I will continue to say that.

The other facet of that is that, for those patients who do face a gap charge, there is a very compelling argument that, at long last, they will be able to settle their account with the doctor and walk away from the practice, and that will be the end of the transaction. The current two-

stage process of leaving the doctor and then, either the same afternoon or later in the week, finding your way to the Medicare office simply to get back some money that you have already paid will come to an end. For those people who access participating practices and do have a gap to pay, the process that it is fair to say many patients find somewhat baffling and frustrating will come to an end. From the doctor's point of view, there is also the fact that the rebate payment will be credited to their practice accounts significantly more quickly than is currently the case, which obviously has some cash flow benefits for those practices. We have not costed those but they are obviously part of the overall picture.

Senator STEPHENS—That is much more what I was asking. I think everybody understands the two-stage process and that it is pretty unsatisfactory for health consumers, but I am much more interested in what it means for the practice to participate in this direct billing technology. Mr Gregory may have some comments about it. We have seen what has happened in the rollout of the Job Network and the technological difficulties that have been incurred in regional and rural areas so similar issues would probably be raised in relation to this.

Mr Davies—There is provision in the package, as I am sure you are aware, for payments to participating practices for the IT costs of signing up to HIC online. They are $750 in urban areas and $1,000 in rural areas. Our view is that, for those practices that are already at a reasonable level of computerisation, those payments will be sufficient to meet the software and hardware required to access HIC online, as it is colloquially known. But there is recognition that in rural and remote areas, no matter what you have sitting on your desk, if you cannot communicate across space then you are going to be limited. I do not have the figure offhand but I can certainly get it for you. There is provision in the package for support for the cost of broadband technology for those remote areas. Indeed, in addressing that issue, Health will be working in a broader context with other government initiatives to roll out broadband access into those more remote areas.

Senator STEPHENS—That information would be very helpful.

Mr Davies—It is $9.2 million, I have just been informed. That is for the broadbanding.

Senator STEPHENS—I take you back to a comment you made in response to a previous question. Did you say that the department has not modelled what the cost of investing in the technology might be?

Mr Davies—We believe that the figures of $750 and $1,000 will be enough for those practices that are already computerised to add the extra functionality they need to access HIC online.

Ms Stratigos—In the amount of money you suggest is available for practices in remote areas to get broadband, did 'rural' just slip away from that sentence? This is quite an important issue. For example, we are told by rural doctors that they just laugh at $1,000. In fact, we recently saw a quotation for $30,000 for a practice to upgrade itself to broadband. As you are aware, you are not just paying for the technology; you have to pay for the travel and accommodation of the people who are going to do it, and so on. So is there provision for the actual cost of providing broadband and the related technology? If there were not, clearly doctors in rural and remote Australia would be puzzled by the advantage of this offer.

I would like to raise another point: if the technology were available to a practice in rural and remote Australia if they opted in to the system, in terms of increasing the supply of doctors in rural and remote Australia, would it not be a good initiative to provide this technology to all practices in rural and remote Australia, regardless of their uptake of the current proposal?

Mr Davies—I think there are a few questions there. Firstly, is it remote and rural? I do not have the exact wording of the government budget statement in front of me, but I think it is probably safe to assume that $9.2 million is to facilitate the extension of broadband into areas where it is not currently available, which I would suggest is probably a reasonable working definition. I think it is important, as I mentioned earlier, to recognise that we are not here talking about setting up broadband for health and then going and setting up broadband again for some other government initiative. This is an issue where there is potential for synergy across government initiatives. As I mentioned, we are working with other government departments and government bodies to have an integrated approach to this broadbanding issue.

As regards the $750 and $1,000, the view is that for those practices that are already computerised—and I think the figure is about 75 per cent—those sums will be sufficient to make the necessary upgrades. Regarding your final point about providing this technology to non-participating practices, I suppose that at the end of the day one has to say that this is all part of an incentive package to get practices to behave in a particular manner, therefore there is a logic to making it available to those practices who come to the party, as it were. Having said that, of course, if one gets broadband access to a particular remote community then I think the potential to allow some people and not others to access it would be practically and technologically quite difficult—but I am no expert on broadband technology.

CHAIR—Senator Barnett wants to make a couple of comments—I said that we would break at 10 past—and I will accept that very briefly.

Senator BARNETT—Thank you, Chair. Because this session relates to the importance of the different policies from the different political parties and as a senator representing regional Australia, I would like to hear some views on the proposal to have a two-tier system—under Labor's proposal—whereby you have a lower bulk-billing rate in regional areas. Certainly, my constituents feel like second-class citizens. I would like to know the views of the participants around the table on setting up a two-tier system where you have a different bulk-billing rate for regional Australia compared with cities in Australia.

CHAIR—It is probably more than a two-minute question. Mr Gregory, do you want to answer that?

Mr Gregory—It was not more than a two-minute question but it might well be more than a two-minute answer.

Prof. Deeble—Having a different target rate for bulk-billing across the country—higher in the city. I suppose it is a matter of saying—

Mr Gregory—Can I escape by saying that—you have heard me say it twice already—the alliance for which I work wants a universal system; we do not want to divide people up at all. Having said that, we recognise that both the government package and the opposition package do

have differential consideration for rural and regional areas, as you say, and it is hard to be in the position that I am in and not welcome that because we are always asking for differential treatment. The case has been made this morning on many different grounds, in many different ways, that rural and remote areas are different and so require a different set of solutions.

I do not think it is for me to comment particularly on the opposition's proposed package, except to say that presumably it is based on pragmatism. Because rates in rural and regional areas are so low I can only assume—I do not know—that the opposition has set that lower rate because it would be an improvement on what the current situation is, and maybe there is some intention to move to uniform rates later. I have no idea.

Mr Goddard—I am speaking as somebody who, like you, comes from Tasmania. It seems to us that there is a need to treat rural and remote questions and Indigenous questions with a different set of policies from those used for the inner cities. Having said that, it seems to us that the package that you are talking about is a substandard way of doing that. It is a way of doing that, but it is a substandard way. The history of trying to deal with all of those issues—rural, remote and Indigenous—is littered with failures of policy. It seems to us that if you are going to have any success in addressing those issues then you need a much more complex approach, a much more cohesive and comprehensive approach, than simply talking about rebate levels and so on. Rebate is part of it, but it is only part of it, and I suspect that if that is all we do then we are not going to get very far. Surely a better way of doing it would be to say, 'Okay, this is what a service ought to cost,' and pay accordingly, then look at policies and packages on top of that to address those areas of special need, which would be much more complex than simply talking about rebates or bulk-billing rates.

CHAIR—We are over time.

Mr Davies—Can I just clarify for the record that the broadband infrastructure support is indeed focused on rural and remote communities.

Proceedings suspended from 1.18 p.m. to 1.58 p.m.

CHAIR—Travel commitments on all of us require that we complete at 5 p.m. We understand that some people will have to leave early, and we thank you for the contribution you have been able to make. We have three sessions left to cover in the time remaining. I suggest we go through session 6 as described and amalgamate sessions 7 and 8, given that we have covered some of the issues in both of those sessions—probably not to the depth that we would all like, but at least we have gone to the issues. Then we will have, potentially, 20 minutes or so at the end in which we will have an opportunity as a group to identify those issues that have not been canvassed well enough or which need more research. We will move now to session 6, outcomes under the government's proposals for safety nets and private gap health insurance. I welcome Mr Goddard to introduce the session for us.

Mr Goddard—I will address two issues here. The first issue is the nature of safety nets in a universal system and what a safety net is. The second issue is private gap insurance. The role of safety nets is inextricably linked to copayments and a lack of access and a lack of equality of access. The more satisfactory access is, the less need there is for a safety net. However, safety nets become essential if there is going to be a significant level of copayment or out-of-pocket

expenses. The concern is for those who just fail to qualify for these sorts of concessions. The Consumers Health Forum did some interesting research about five years ago on the safety net and its impact on copayments in the Pharmaceutical Benefits Scheme. It found that the people who just fell outside the concessional safety net scheme were substantially worse off, even though they had nominally higher incomes, than those who were covered by the concessional scheme. That is always one of the drawbacks with any scheme that falls short of universality. There are always going to be people just over the edge who fall outside and who tend not to be identified as needy, but who can quite often end up being far more needy than, for example, pensioners, the unemployed or the underemployed.

From the consumer's point of view, the other drawback of safety net schemes and entitlement schemes is that they tend to be complex. First of all, you have to know that you are entitled to these things. You have to organise your life in such a way that you are able to do the paperwork and make the claims. Some people do that but some don't. The people who do not are not necessarily the people—or their families—who do not need that claim. Getting back to the principle which we heard about this morning of simplicity of administration, simplicity for the consumer and simplicity for the doctor, the more safety nets you have, the more complex the system becomes and the more it fails the principle of simplicity.

This morning we talked about the role of copayments, out-of-pocket expenses and price signals in terms of reducing demand. There is no question that they do reduce demand. Professor Deeble gave evidence that they tend to reduce demand less effectively and less powerfully than some advocates might expect, but they reduce demand in an indiscriminate way. They reduce demand from people who you want to be going to the doctor and who you want to be seeking those services and they reduce demand from those people who you do not want to be going to the doctor.

There is a lot of advocacy for price signals in health—for seeking health service to reduce unnecessary demand—but there is a difference, perhaps, between a price signal, a copayment and a revenue raising measure. One of our doubts about price signals is the tendency of governments to see them as potential revenue raising measures. Once that happens, what was seen as a price signal to control unnecessary demand becomes a revenue raiser. It fundamentally changes its purpose and, because the consumer has to pay more, it becomes more of a potential barrier to seeking necessary treatment. Therefore, safety nets are desirable and necessary if you have copayments, but wouldn't it be nice if we did not need them? That is our position.

It has been proposed that these gap insurance products would cover consumers for anything more than $1,000 in out-of-pocket expenses in a year. A premium of $50 per annum has been suggested. There are two questions: first, fairness and coverage. Such a measure is unlikely to be taken up by everyone who does not qualify for a health care card. Therefore there is a question of equity on this measure. Secondly, there is the question of how practical it is. There is a substantial opening for moral hazard—for instance, for doctors, and specialists in particular, to structure their charges in such a way as to bring people up to the $1,000 threshold quite quickly so that they could then claim on the insurer. To the extent that that happened, it would put quite a lot of pressure on the insurer and quite a lot of upward pressure on premiums. The extent to which this is doable within a relatively small premium is of course essential to the practicality of the scheme. We believe that there is serious question about the extent to which that is deliverable.

Senator HUMPHRIES—You said that the more satisfactory the access the less the need for a safety net. I do not really understand that. Surely a safety net is about morbidity. If you had a bulk-billing doctor on every street corner you would still need a safety net for people who are very ill and who have a higher call on the services of doctors than others. Isn't that the case?

Mr Goddard—If you have universal access to GPs and if you are going to a bulk-billing doctor who bulk-bills you every time you go—it doesn't matter how many times you go—in that situation the closer we come to that situation surely the less you are going to call on the safety net. The fewer the out-of-pocket expenses for any consumer the less you are going to need a—

Senator HUMPHRIES—That is not really about access; that is about the charging policy—

Ms Walker—What you are saying is that, if it is free, it does not matter.

Mr Goddard—Yes.

Prof. Wilson—I have a couple of comments about safety nets and their features, and especially about the PBS, which I believe it is important that we bear in mind. The PBS has a very sophisticated way of capturing information. In terms of the safety net scheme, once a patient registers with a pharmacist they can be captured from a range of other pharmacists. If they go to other pharmacists they can be registered as part of the system. However, as I understand it, we do not have that technology in place at present to do that with the other arrangements. We can learn from the PBS system, which is fairly well advanced in terms of the technology that underlies it.

Senator ALLISON—But is it not also the case that the PBS safety net is very significantly underclaimed?

Prof. Wilson—I am sorry, but I do not know. That might be the case.

Senator ALLISON—Does the department know? Can you tell us whether the PBS safety net that is in place for concession card holders is underclaimed?

Mr Davies—I cannot answer that at the moment, but I will get an answer for you. Professor Wilson is right: it is a different mechanism. The safety nets we are talking about in this context for MBS would all function behind the scenes at the Health Insurance Commission. However, in response to your more general question about whether the PBS safety net is underclaimed, I will undertake to get you an answer.

Senator ALLISON—It is not all behind the scenes, is it? People still have to keep their receipts and have to initiate the—

Mr Davies—I believe—

Senator ALLISON—No? I can see heads shaking in the background.

Mr Davies—One of the problems I am aware of in relation to the PBS safety net is the need to establish what a family unit is, or a claiming unit for the household. A lot of families have one

Medicare card with all the family members listed on it. That makes accumulating costs during the course of the year easy. That means that the HIC can trigger notification once you reach a threshold. However, I understand that a lot of families choose to have separate Medicare cards for different family members. In that case, there is an active task required—

Senator ALLISON—Of the patient?

Mr Davies—Of the family to bring together their accumulated costs.

Ms Walker—A few years ago when I worked for the department on the PBS, the officers told us that, on the basis of some broad statistics that were available, they suspected that a number of people did not claim although they accumulated over time. They did some inquiries and that seemed to have been due to the fact that a lot of people did not understand the system and they did not know that they could claim. Whether it is still like that now, I do not know.

Prof. Hall—The issue is that when you have a safety net that requires an individual to take an action—and that is what the PBS does; you have to notify the pharmacist that you are likely to be in it—it requires that action. There are always going to be people who do not understand, who do not know and who do not realise or just never get around to it. It may be the people who are least likely to understand the system who are in most need of the safety net provisions. If you could have something that was much more automatic, you would have more confidence in the safety net covering all the people it was targeted at.

Prof. Sainsbury—As I see it, there are fundamentally different safety nets. The PBS is a safety net of compulsory payments made when you pick up your script—your $3.20 or your $22.70 or whatever it is at the moment. You pay that—that is the up-front payment you make when you pick up your script—and when you reach the safety net level you can start to recoup that, whereas what was being discussed with GP billing is that the safety net would be for the amount over and above the rebate rate. That could be anything—it could be $1 or $50 per service. So it is a fundamentally different thing. One is the basic cost which the government then covers the rest of, and the other way round is the complete reverse. I just wanted to make that distinction.

Prof. Hall—But that is not the safety net provision. What we were talking about is what triggers people to become eligible to attract the safety net.

Prof. Sainsbury—I appreciate that as well.

Prof. Wilson—You are required to register with your pharmacist but in fact you do not need to do that. The system, as I say, is quite a sophisticated system that could be set up in a different way, but it has developed over quite a long period of time. At the moment, your pharmacist will ask you or you can tell your pharmacist to check that. Most pharmacists if you are seeing them regularly will know to set the process in place.

Ms Walker—Now that it is essential to have your Medicare card when you collect your pharmaceutical drugs, it would be possible to automatically collate that. My understanding is that the problem is that the Medicare cards do not link the families, which is what Phil Davies was talking about. But it is not impossible to get that going.

Prof. Hall—If you need your Medicare card every time you go to a pharmacist, you are less likely to have all your family members on one card, because they have to carry it around with them.

CHAIR—Which raises the whole question of what a family is and whether it is equitable to have a family and an individual with the same threshold. That is a different question, but it is still a question in my mind.

Ms Walker—If I can just talk about some of the work we have done here, firstly, Professor Deeble said that Medicare was intended to be an insurance for those people who happen to be sick. I think the safety net should be there for that reason. If you have a huge accident with lots of costs, or you get into trouble, with co-morbidities, the safety net will limit the amount so that people will be paying an amount that is not impossible for them. The other thing I would like to talk about is some work we did, on the PBS again, in relation to how the burden is distributed across all these copayments. We found that concessional patients on average pay less than two per cent of their after-tax take-home income. For general patients, the average goes up to about four or five per cent. But for the poorest of the general patients, when we divided the population by five, in 2000 it was about six per cent. That is for a family and we are talking about their after-tax income. It is starting to be big. But then we did some projections to 2005 on the basis of the already announced increases in copayments, which were then CPI-related, and it was getting to about nine per cent. That is a huge amount for a relatively poor family. So it is important to remember that if we keep doing that for every part of the health system it is going to amount to huge pressure on a small group that is just missing out on concessional status.

Mr Goddard—We tend to discuss these things in isolation but, of course, the consumer does not see them in isolation—they are all costs of seeking medical care. Inevitably there are disincentives to seeking needed medical care. They all add up.

Prof. Deeble—It seems to me that this is really a case of having two-bob each way like we have done for 30 years. We say, 'We will have bulk-billing and that will make sure that there is nobody in need,' but then we say, 'We will not achieve that, so we will have something else.' Safety nets are about the most inefficient, complicated, expensive and, in a sense, unmanageable way of handling those costs.

I am not concerned so much about the costs for GPs, because to run up $1,000 in GP visits, even for a family, you have to have a very sick family. It is not going to be in pathology or radiology, where the bulk-billing rates are up in the 80 per cent area. It is going to be in specialist care. This is a safety net for specialist care. This is doing what the government proposed to do a couple of years ago, but which it withdrew from because the GPs did not like it much. I think you have to face what this safety net is about. It is not actually going to be about GP use. It is going to be about specialist use, because that is the only way you are going to get up to $1,000. So it is introducing, under the guise of a change in GP billing related to a relatively small drop in bulk-billing for GPs, a principle of a safety net which will extend to the whole of Medicare. Now my concern is about what that will do for the charges at the other end—that is, what it will do for charges at the specialist end because, if that is backed by a safety net which is more related to them than to GPs, I fear it will push up the specialist charges. I know that the funds, Russell, are doing that now, and they may be containing that fairly well, but another safety net on top of that will release that pressure even more. Can you answer that?

Mr Schneider—Yes, I was just going to wait for someone else, John, but I can. I think there are two issues here which interlink, in relation to the insurance safety net as distinct from the government one, and those are equity and practicality. The equity one is that these charges are already being made. There are people who are very, very sick, who are having to incur quite considerable charges in a whole range of areas, but I agree with you it is principally in the area of specialist services—although you may rack up a few visits to GPs before you get to $1,000. I simply take the point that these people are in a position where they have to meet that cost and I do not think it is equitable to deny them the capacity to be able to insure for it.

Secondly, I think the other thing we have to remember is that the way medicine is being delivered today is quite different from the way it was 20 or 30 years ago. It is quite illogical now to confine the operations of the health insurer to the boundaries of the hospital because there are many services which can be performed, probably more safely and better, outside hospital than inside hospital. But the way the system works at the moment is that we have a very perverse financial incentive which encourages both the patient and the doctor to admit the patient to a hospital facility—which the doctor may own, in the case of a day surgery—rather than to provide that treatment outside. And it is very easy for the patient to agree to that because, apart from the fact that they will do it because the doctor has recommended it, there is a financial bonus to them: if they are admitted as an insured patient all their costs are covered. So they have a gap cover for the agreed amount the specialist charges for the very expensive inpatient admission, but they cannot be covered for the same treatment outside hospital. This is true in areas like oncology, chemotherapy and others. So it would seem to me that, apart from some of the other issues, this is a way of trying to get to grips with the way health care is changing and, at the same time, provide the capacity to some possibly limited extent to remove some of those perverse financial incentives which actually add to costs.

Prof. Deeble—Actually, a lady having even a normal delivery with a specialist obstetrician will just about get to the safety net on that one thing. I do not know whether that is the intention, but that is the effect.

Mr Schneider—Well today she should be covered, or pretty well covered, under a gap cover arrangement.

Prof. Deeble—If they are covered under gap cover arrangements, where do they fit for the safety net?

Mr Schneider—That is recovered.

Prof. Deeble—So it becomes a recovered cost and not answerable in the safety net?

Mr Schneider—No, I would think that that would not intrude into the safety net. If the benefit is paid, that is not part of the safety net.

Prof. Deeble—But if you are not privately insured, you will end up going into the safety net on having a baby.

Mr Schneider—Well, not unless you have private health insurance.

Prof. Deeble—Anyway, these are just mechanics of the thing.

Senator ALLISON—Is it possible to ask at this stage about the modelling, either from the department or from you, Mr Schneider, on the $52 or $1 a week premium? How confident can we be that that is a long-term level for the premium for this?

Mr Schneider—I do not think I could be confident about anything in the long term in the health care sector.

Senator ALLISON—Well, let's try the medium term then.

Mr Schneider—In the medium term I have no reason to dispute or question the government's figures. All things remaining relatively equal, there is no reason to believe that $1 a week is an unrealistic figure. I cannot commit individual funds, who have to look at what their position is like in relation to their own membership base and what they believe is their risk exposure. If you look at the numbers in total, there is no reason to question them.

Senator ALLISON—So it was the government's modelling that set it up and they checked with you to see if this was okay?

Mr Schneider—More or less, yes.

Senator ALLISON—Is that modelling available?

Mr Davies—Probably not.

Senator ALLISON—Why would that be?

Mr Davies—The reason for that is that we think it is really quite important that Mr Schneider's members determine their own premiums based on their own analysis. We would not really want to be seen to be setting the market rate in detail.

Prof. Deeble—I do not know why not.

Senator FORSHAW—I would like to ask a few questions regarding this. Firstly, I would like you to clarify, Mr Davies, precisely what is meant by coverage for out-of-pocket expenses. Are we talking about the difference between the rebate and the total charge of the doctor, or are we talking about the difference between the rebate and the scheduled fee? My second point picks up on the comments by Professor Deeble. One would assume that it would take an awfully sick family to reach $1,000 worth of gap expenditure during a year for GP services. I would have thought there was data available through the tax system to at least get some hard figures on just how many families—or individuals for that matter—would have that amount of expenditure each year on GP services. We know that once they get over the $1,500 threshold of additional expenditure or out-of-pocket expenses for medical services generally, including pharmacy, optical, hospital costs et cetera, they can claim a tax rebate of 20 per cent of that additional expenditure. Surely somewhere there is some data about the component that reflects GP services—which I would have thought is pretty small compared to how those figures would add up through other expenditures that are not covered, such as dental costs or whatever.

My third point is on the practicalities of how the system would work, and this has already been touched upon. At the moment, if you are claiming through private health insurance for other expenditures you can either submit the account or pay the account and submit the receipt. If you are claiming through Medicare for GP services, specialist services et cetera, you can do the same: you pay the account and get the rebate or you submit the account to Medicare, wait till the cheque comes back and then pay. Whichever way it works, there is data available within the system that tells you what your out-of-pocket expenses are. The data is collated each year and provided to people for their tax returns; both Medicare and the private health funds do that. But under a system whereby you go to the GP, swipe your card and pay the difference, what data collation system will operate? Presumably, Medicare will not have the record of what the doctor has actually charged in total—will they?—to provide that data to individuals so that they know if they have finally reached that $1,000 figure and can put a claim in? I put it to you that what happens in the pharmaceutical area is that a lot of people assume they are never going to reach the limit and so do not bother about it. I know people in that situation. A lot of pharmacists are not forthcoming in telling you what your entitlements are, and a lot of people use a whole range of different pharmacies. So that scheme has a lot of difficulties. Can you comment on that? Other witnesses might also like to make a comment.

Mr Davies—Your first question is an easy one—what do we mean by out of pocket? There is this very important difference: for the two safety nets we are talking about—the $500 one for concession card holders and the $1,000 one for everyone else—it is total out-of-pocket spending. Unlike the current safety net, which as I explained this morning only considers payments up to the scheduled fee, these policies accumulate total out-of-pocket costs to measure your progress towards the threshold, be it $500 or $1,000, and once you have reached it, they cover your total out-of-pocket costs beyond that threshold. The current safety net only looks at the gaps and even when you have triggered the safety net, it still only reimburses the gaps, which is why we do have people who are facing these quite significant costs. This is largely due to above schedule fee charging and, as I think a couple of people have observed, it is not really going to be general practice that pushes you certainly over the $1,000 threshold.

Anyone who spends more than $1,000 out of pocket is either visiting a reasonably expensive GP at least once a week or is using specialist services. Our analysis shows that the two most prominent services that tip people over the $1,000 are radiation therapy for people with cancer and psychiatry. Both have this characteristic of being specialist services that have protracted courses of treatment. As for the likelihood of someone getting there purely on GP services, I suspect the numbers exist somewhere but it would be a very small number. I think that answers your second question.

Senator FORSHAW—Yes.

Mr Davies—Your third question about how to know when you have reached the $1,000—

Senator FORSHAW—That is in regard to the system of swipe cards and just paying the extra. In other words, how is the HIC now going to ensure they know what the doctor has actually charged?

Mr Davies—For every MBS transaction, the HIC knows the full charge levied by the doctor, which is how we can do modelling on current levels of gaps and so on. It would be no different

under the new arrangement. The HIC would be able to monitor total out-of-pocket spending as it grew during the course of the year.

Senator FORSHAW—They do know because the whole account has to go through Medicare one way or another. It might seem like a stupid question but there a lot of people out there wanting to understand how this new system will work. You go into the doctor, you swipe your card, you owe an extra $20 or whatever it is, and you pay that. What is the requirement in the future, under this proposal, on the doctor to advise the charge provided for each patient service rendered?

Mr Davies—That is the case at the moment and that will not change.

Senator FORSHAW—That is because the account goes through Medicare. In the future, the account will not go through Medicare for a lot of people; what will go through Medicare will be the swipe. Tell us how it will work.

Mr Davies—My colleague Mr Maskell-Knight can fill us in on the technical details of how the money goes round.

Mr Maskell-Knight—My understanding is that one of the requirements for the new regime where the Medicare card is swiped in the doctor's surgery is that when the claim is transmitted to the Health Insurance Commission, the doctor will also have to say what the total fee charged was.

Senator FORSHAW—That is the answer I was looking for.

Dr Bain—Very briefly, doctors, like obstetricians, sometimes charge a booking fee or other fees that never find their way to the HIC. Also they will provide an account, but they will say to the patient, 'If it's paid within a certain amount of time, I'm prepared to accept substantially less.' So the records that the HIC have on the total costs are actually quite inaccurate.

Senator FORSHAW—We will make a note of that.

Senator ALLISON—I did not think that was legal.

Dr Bain—I think obstetricians and so forth at the beginning—

Senator ALLISON—What about GPs?

Dr Bain—No, not GPS.

Mr Schneider—From our perspective if it is not illegal, it should be.

Senator FORSHAW—Mr Davies, I assume that it follows that, as you said, you cannot tell the funds what they will ultimately charge for this product—you have suggested $50—but you equally cannot tell them where they could set the safety net figure, or is that a different situation? We know that with hospital coverage there is a range of products out there which differ as to what excess people might have to pay.

Mr Davies—That is certainly not a risk with this proposed product in that there is a uniform threshold and a uniform requirement for full coverage beyond that threshold. That will apply to all funds that offer this product, which will make it more comprehensible than some of the hospital tables currently are.

Prof. Deeble—The existence of a safety net which is going to be funded by the patient but with you giving a private insurance rebate means that the size of it does have some financial implication for you. To what extent do you believe that the existence of that safety net will alter the department's and the government's view about what the comprehensiveness of the fee ought to be, or the rebate ought to be?

Mr Davies—You may know what my answer is going to be but I do not understand the question.

Prof. Deeble—Are you going to leave the fee alone and say that the safety net can look after the gap?

Mr Davies—Do you mean the MBS?

Prof. Deeble—Yes, the MBS. There is a clear option here to say, 'We in the government and in the department know that there is a safety net which people pay for. So we can let the gaps grow a bit—we can freeze our rebate—and we know that it won't hurt anybody very much, and the rebate and the safety net exist for those people who are hurt.' And you do not pay the full amount of that; you pay only 30 per cent of it.

Mr Davies—You say that increasing the fee would not hurt many people. Surely it would hurt all but 30,000 people who reach the threshold. I think the view that the government could let the vast majority of the population suffer that on the belief that slowly a 30,000 cohort would grow is a little imaginative.

Prof. Deeble—It has happened.

Senator ALLISON—Following that point, what is the plan for the rebate? By what will it increase over the next few years?

Mr Davies—I am not aware of any new policies in that area. There is a current policy on indexation.

Senator ALLISON—How does that work?

Mr Davies—The MBS rebate, the rebate level, is indexed to one of the standard government indices which all have strange acronyms—in this case WCI5, wage cost index 5.

Senator ALLISON—One of the arguments we constantly hear is that doctors are moving out of bulk-billing because medical indemnity insurance and locums are so expensive. Does that indexing system take into account those costs?

Mr Davies—WCI5 is a hybrid index of wages and costs. To the extent that things like locums are a labour input, one would expect that changes in locum costs would find their way into the WCI. One of the tables I tabled this morning gives a rough breakdown of the input costs to a typical general practice.

Senator ALLISON—You had what seemed to me to be a fairly small figure, and we are, after all, going back to 1999-2000. Has that figure increased? Can you answer that question about whether this WCI5 picks up on insurance?

Mr Davies—Does it pick up on insurance generally or medical indemnity?

Senator ALLISON—Medical indemnity.

Mr Davies—In the sense that it is inflation within the general economy then insurance would contribute to that.

Senator ALLISON—No, it is quite specific. Medical indemnity is rising at a faster rate than household insurance.

Mr Davies—In the sense that medical indemnity is a component in our national spending, it will work through into the overall index. We do not have a specific index that reflects changes in medical indemnity and automatically maps those through to the MBS rebate.

Senator ALLISON—Can I ask why not?

Mr Davies—Because the increase in the MBS rebate does not happen on an itemised basis. These different items in that table will all inflate—or even, in some cases, maybe reduce—at different rates. So the approach that has been in place for many years is just to apply one index from the standard range of indexes.

Senator ALLISON—What studies has the department done of actual costs over time, so it can check with WCI5 to see whether it has actually kept pace?

Mr Davies—The reason the date I provided is almost four years out of date is that we do not routinely examine the cost structures of general practices, or any other medical service provider for that matter.

Senator ALLISON—But you have 1999-2000 figures. Where did they come from?

Mr Davies—This was a one-off survey. I have a copy of the report for you here. This was a one-off survey carried out as part of the modelling underpinning the relative value study.

Senator ALLISON—It did not occur to you that, at this time when this is central to the government's package, it would not be a timely exercise to investigate again whether the rebates keep pace with the costs of doctors?

Mr Davies—We heard from two of our experts this morning, Professor Wilson and Professor Hall, who made two significant comments: firstly, what is an average practice? That was

Professor Wilson's comment. These are an average make-up of costs. Professor Hall commented that there appear to be wide differences in the productivity of GPs and other medical service providers. So to actually say that there is an absolute cost structure—

Senator ALLISON—There are some absolutes with medical indemnity insurance, surely. There is not too much variation between what one GP is charged and what another is charged.

Mr Davies—Yes, and we do know that the typical premium for a non-procedural GP would be about $4,000 a year.

Senator ALLISON—That is about twice what it was in 1999-2000.

Mr Davies—I am told that that is in New South Wales; other states may be lower than that. Yes, that is about twice what it was estimated to be at the end of 1999, but it is a doubling of a very small component of the overall cost structure. It is an increase, according to these figures, of less than $2,000 in a total cost structure of $127,000. In percentage terms it is a very small increase in those input costs.

Prof. Deeble—That is hardly likely to justify a big fee rise—and it should not be used for that, either. Is it not true that, eventually, in those high indemnity cost specialities, if you are going to maintain the rebate as a constant proportion of the fee and the indemnity costs are fed into the fee—that is, the costs are passed on to the patient—the Commonwealth will be paying the indemnity costs? You must be, eventually. Through the rebate, you will be.

Mr Davies—Your own description, Professor Deeble—the government does not pay doctor's costs, the government pays insurance to patients.

Prof. Deeble—Who do you write the cheque to? No. You will eventually, if the patient gap is not to increase, be meeting whatever the proportion is—85 per cent—of the increased cost. It has always bothered me that the government is treating medical indemnity as something to be handled by Treasury and not the department of health, because it actually will be paid by the department of health. Otherwise, you are just going to make the gap widen and the patient will pay it. You can be certain that the doctor will not pay it. That is just a comment on the way in which these things must take place.

Mr Davies—Going back to Senator Allison's earlier line of questioning, we estimate that the average increase in GPs' indemnity premiums in New South Wales is $2,000. For a GP with a typical workload, that equates to an additional cost of 32c per consult. So, arguably, it is not material in the scheme of things.

Senator HUMPHRIES—Mr Goddard, you said that it would be nice if we did not need safety nets. The ACA submission to the inquiry suggested that there should be an increase in the Medicare levy in order to put more money into the system. I think you have also recommended the abolition of the 30 per cent private health insurance rebate on ancillaries. Is that right?

Mr Goddard—Yes.

Senator HUMPHRIES—Would you see that money going towards widening the safety net or increasing levels of bulk-billing in some way through higher levels of incentive? How would you see that extra money being spent?

Mr Goddard—That section of the submission should be read as one way of doing it rather than as the universal answer to everything. The reason for writing that section was that those on my side of the argument believe that the 30 per cent rebate is an inefficient way of getting the outcomes and therefore that we should find another way. That is a complex argument and it has had any amount of rehearsal. Those of us who have been arguing that have failed fairly dismally to argue how that might be done. Getting away from the rebate is going to be far more complex than bringing it in. Those of us who have been arguing for that have failed to argue the detail.

We have also failed to argue the detail of what will happen in its absence. If private health insurance will not be capable of funding private hospitals in the future, how are private hospitals going to be funded? A number of economists have said, for instance, that it would be more efficient for the government to fund private hospitals directly, and there are some advantages in doing that. But we have left it as a one-liner. We have not put forward any proposals or options for doing that so that people can look at them. That is really what that section is about. It does not pretend to be a finished model. It is one possible way of doing things. Really, it is illustrative of the need for us to take the argument a little further.

Senator HUMPHRIES—You do not seem to be quite clear on whether you are recommending an increase in the levy or the 30 per cent rebate.

Mr Goddard—We certainly think that reallocation of the 30 per cent rebate will not solve all the problems facing health funding. As costs increase, those costs have to be found somewhere. That is what that is about.

Senator HUMPHRIES—In your opening remarks you said that it would be nice if we did not need a safety net. What can I take from that? Are you suggesting that we increase the level of bulk-billing somehow? Obviously, you are not advocating the removal of the safety net.

Mr Goddard—Certainly, the more bulk-billing you have, the less you are going to need a safety net. It was actually a fairly simple point.

Senator HUMPHRIES—How would you achieve that? How would you spend those extra dollars you are talking about raising?

Mr Goddard—In our submission one of the key points is that the rebate needs to be indexed regularly according to real costs so it never falls behind again. Senator Knowles made the point this morning that the falling behind is not the work of one government or the other and that is absolutely correct. This has happened over a long period of time. Quite clearly, that needs to be funded from somewhere. You could fund it from other areas of government expenditure, from an increase in the tax base or from the rebate. My point is that there would be a lot of people with dibs on that $2.4 billion if it were spent somewhere else. I do not have a finished model for precisely how that should be divided up. I think that is something we should be arguing for. In the longer term, we are going to need to raise more money to pay for health.

Ms Stratigos—I would like to follow the point made by Senator Allison about whether the rate of indexation reflects the actual costs of general practice. There is quite a distinct discrepancy between the type of costs incurred in rural and remote general practice and the costs incurred elsewhere. People who live in rural and remote areas face higher costs in terms of communication, transport and so on. However, they also face some specific costs. As I mentioned earlier, proceduralists hardly exist in urban Australia. I think the BEACH study states that about three per cent of procedural medicine is practised in cities. Most proceduralists working in rural and remote areas are up for higher medical indemnity and we see anomalies like the government's present policy which is subsidising specialist obstetricians for 80 per cent of their premiums, but only 50 per cent of premiums for key obstetricians. That seems to us to be a rather strange and inexplicable difference. There are also other higher expenses. For example, GPs in rural areas may have to purchase equipment, such as X-ray equipment, which is readily available in hospitals or other services in cities. The issue that Senator Allison raises is particularly crucial for rural and remote areas of Australia.

Senator STEPHENS—I want to focus on the gap insurance. Several submissions, including yours, Mr Goddard, raised that issue. In your submission you say that insurers would have little or no control over these rising costs—that is, the inflationary rise of copayments—other than to pass them on to a dwindling pool of customers. Dr Bain says that the AMA's comment is that the risk in the safety net is that it moves the financial burden from the wealthier members of society to the sicker members of society. This might allude to a point made by Professor Hall this morning about two studies into copayments. Is there any evidence about health insurance products that gives us any comfort or any indication that doctors are less reluctant to charge higher copayments if they know patients can take out gap insurance?

Prof. Hall—I cannot give you a direct answer to that question but I will try to get as close as I can. Two important studies have been done on the effects of copayments. One is the RAND Health Insurance Experiment, which took place in the early 1970s and which Professor Deeble referred to this morning. They randomly allocated families to different levels of copayments in six sites, from memory, across the United States. They showed that the higher the copayment the less people went to the doctor; in particular, the less the poor went to the doctor and the less they took their children to the doctor for things that could be easily fixed, such as middle ear infections. However, once you get to the expensive end of the system, copayments tend to cut out in most systems anyway. Certainly, in these systems, part of getting families to enrol in the experiment was that nobody would be out of pocket more than they would have been before. There was no less use of hospitals or less use at the expensive end. One of the problems with the RAND Health Insurance Experiment, though, was that for any doctor the effect on their practice of having somebody with a different level of copayment and changing their utilisation level was minimal, so we did not see how the doctors reacted to that.

The other important study is the Saskatchewan study. It was more by way of a natural experiment, which perhaps provided much more important evidence in this field than trying to run controlled experiments. Copayments were introduced after a period of them not being there, prior to the introduction of Canadian Medicare. Use by the poorer groups in the community went down. After an adjustment period, use by the higher income groups went up. They are the two studies that I referred to this morning.

What is interesting to look at more in the current debate is what has been happening in the United States, particularly around managed care. There are two cost drivers in the US health care system that do not seem to apply in many other systems. The US spends 14 per cent of its GDP on health care. There seem to be two areas where the extra money goes: higher incomes for doctors and far more administrative costs of running the system—that is, simply what the doctors have to do to claim things and what patients have to do to claim things. The bulk of the system costs a lot more to run and doctors get more out of it. That suggests that where you have insurance there is much more ability for providers to increase the amount of rent in an economic sense—the amount of money they can take out of the system.

The other interesting thing about the US system harks back to some of the lessons around health maintenance organisations that came out 10 to 15 years ago. It is exactly the same experience. The rate of costs in America goes up faster than anywhere else and something changes. In the mid-70s when HMOs took off, there was a plateauing of those costs and then it took off again. We have seen exactly the same under what is called managed care—which some of my colleagues would call managed costs—where there is an immediate impact on the system, there is a plateauing and then it takes off again. My interpretation of that evidence, which is supported by a certain amount of game theory, is that if you introduce a big enough shock to the system everybody is so worried that they stop. They work out what they are going to do, then they work out how the new system works and they are off again. I think that is the evidence that we have. Does that answer your question?

Senator STEPHENS—That is useful. Do you have a different viewpoint, Mr Schneider?

Mr Schneider—It is probably true that wherever you have a third party payer there is always an opportunity for the provider to charge more. To a certain extent, if there was no cap on bulk-billing it would increase charges too, but it is capped by paying a certain amount. I would have thought the defect with the proposition put forward is that the doctor does not necessarily know which patients are insured and which ones are not, nor do they necessarily know what the level of reimbursement is going to be. So I think that is the first sort of check or balance that I would put into this system.

Secondly, I think I could say that if this scheme comes about, if either the health insurance industry or the health insurance commission discovered that the medical profession was exploiting any arrangement which was intended to cover catastrophic illness, I would be back in this room as quickly as I could possibly be, seeking some further refinement of the legislation to reduce the prospects of that continuing. Perhaps we could then have a discussion about what sorts of systems might be put in place, but at this stage I think I am fairly confident that there are sufficient checks and balances in the system to preclude the sort of abuse that would concern all of us.

CHAIR—Mr Davies has a very tiny comment.

Mr Davies—To reiterate a point Mr Schneider has made, another bit of health-insurance jargon is: 'This product is catastrophic cover.' It is a premium which the insurance people call a high deductible premium: you have to have paid $1,000 out of your own pocket before you become eligible to claim under these policies. We estimate 30,000 people per annum will benefit from that and for those people it is a very valuable product, but actually I know that is

substantially less than one per cent of the population. So the opportunity for doctors, particularly specialists, to increase their fees in response to the existence of this product seems to me extremely unlikely. They will not know who has already crossed the threshold, because they have no way of knowing that. All they can do is increase their fees across the board in the hope that the 0.25 per cent or whatever who are covered will willingly pay their suddenly inflated fees. So I think that the catastrophic nature of these policies makes their impact on possible medical inflation very limited indeed. That risk I think is minuscule. As Mr Schneider has said, I think society as a whole—and, I am sure, the groups representing medical professionals—would take a very dim view of anyone who sought to manipulate their fees to take advantage of those very few people who would be claiming under these policies.

CHAIR—Thank you, Mr Davies.

Prof. Hall—I am sorry, but I think it is not unknown for the medical receptionist or the doctor to ask you what your insurance coverage is—but that is not actually what I was going to ask. The $1,000 is very blunt: for some people that is a lot of money; other people would spend that for lunch—some of the people I know! I never have time for lunch; I work too hard. It is actually quite a blunt tool, in terms of targeting the people who perhaps need the most support, and I wondered if there had been any consideration given to varying levels?

Mr Davies—The main driver was, I guess, that broad number of how many people would cross the threshold. If you hit $1,000 in one year you are probably unlikely to hit it for a few years prior or subsequent to that, so maybe—notwithstanding the cost of a good lunch in Sydney—it is not an unreasonable threshold.

CHAIR—We will move now to session 7. Professor Sainsbury, I would like you to introduce alternatives for reform of Medicare and to canvass in particular the dental and allied health professional issue.

Prof. Sainsbury—My comments are really only by way of introduction rather than having any conclusion. I think the question is: should Medicare be extended to a broader range of services provided by a broader range of professionals? I would like to take us back to the question of what this is all about, why are we here and why do we give a damn about all of this? It is not just about the appropriate rate of bulk-billing—whether it should be 60 per cent, 70 per cent or 80 per cent—or whether we should pay for services provided by doctors or acupuncturists. The issue is, it seems to me, that in the 20th century—and now in the 21st century—it became a legitimate function of government to maximise the health of the population. Providing health care—and I include in that health protection, health promotion and the treatment and management of illness—is a legitimate function of government. Before the 20th century not much could be done anyway. I know there were doctors, but they did not actually achieve much. It was only when we developed effective remedies for things and, perhaps 50 years earlier, effective interventions to prevent things happening, that it became important for government to become involved. Before that it was all just a bit of voodoo really.

But we have now accepted that this is a legitimate role of government for a variety of reasons. One reason is that we want to maximise human capital. That might be to fight wars. I do not make that comment flippantly, because in Britain certainly, and here as well, one of the things that highlighted the poor state of health was recruitment for the Boer War. Whether it be for that

reason or that we simply wish to demonstrate what a caring, humane society we are, or that we do not want to offend our sensibilities by seeing sick people lying about in the streets, or because we perceive that there is some sort of social contract that we owe to each other as individuals or that the government and the population owe to each other, there is now a legitimate interest in promoting health.

We have realised increasingly that that is not done just by these people called doctors. We have a much broader view now of what health is all about—what constitutes not just illness but 'dis-ease'—and, as a result, we are forced to think about what other services there are in society, or are potentially available in society, to protect against illness, promote health and treat 'dis-ease'. It seems to me that if we look at it like that—at what we value in society, the effectiveness of interventions, the desire to get value for money and to implement cost-effective interventions, as well as promoting human rights and a humane approach to life—we have to broaden our view of what we want a health service to do in a country where the government has a legitimate role of custodianship.

The burden on health services is now not so much from acute illnesses—particularly, infectious diseases—but more from chronic illnesses and complex illnesses. And the population have come to expect a broader range of therapies—people do go to acupuncturists, chiropractors, psychologists and social workers. So it is appropriate that we think not just about whether we can afford to pay anyone other than doctors and whether they will all just rip us off, but rather about what is the function of a health service in society. I would strongly support consideration of these issues.

To close, I will point out, as some of the submissions point out as well, the gross anomaly of dental care not being included in a health system as though the mouth and teeth are different. To me, it was ludicrous when the Commonwealth dental health program, which was costing I think $100 million a year, was abolished—a program that did provide some form of dental care for poor, disadvantaged people who often had bad oral health. What we have now with the rebate is the government spending $300 million to $350 million a year subsidising dental care for people who have health insurance. Notwithstanding that some poor people do have health insurance—there is no doubt that higher uptake rates of health insurance occur in wealthier people—the government is in effect now providing a subsidy for wealthier people to have dental care and not providing a subsidy, in broad terms, for poorer people. So I certainly think that we should be thinking about whether dental care is included in some form of health scheme. It is only in light of those broad comments that I wish to introduce this session.

CHAIR—Thank you very much, Dr Sainsbury. The issue of dental care has come through in a lot of the submissions and is certainly one that I would like to canvass as well. Does anyone have any comments to make on why the mouth dos not belong to the Commonwealth but, rather, to the states?

Senator KNOWLES—It has been the responsibility of the states over a long time, other than for a short finite period when the Commonwealth picked up the lag of the states and then the states carried on. I would like to ask a question about that, because the number of people with ancillary cover continues to rise—as at March 2003, it was 41.4 per cent of the population—and the professions of dental, optical, chiropractic and physio account for 70 per cent of ancillary benefits. What worries me—and it comes back to Mr Goddard's contribution—is that abolishing

the 30 per cent rebate will affect a whole range of people, including low-income earners. People like Mr Goddard and I think Dr Sainsbury are saying the same thing. You want to abolish the 30 per cent rebate where a million people earning less than $20,000 are getting the benefit of the rebate—so they will lose about $750 a year—and at the same time you are saying, 'We don't care about that; we'll take that away from you and we will also increase the Medicare levy.' I find that absolutely and utterly contradictory to the benefit of the low-income earners.

Prof. Sainsbury—I do not believe I did actually advocate that the rebate should be abolished. I just pointed out what I thought was an anomaly in what had happened in dental care. I am happy to have a debate about the rebate, but that is not what I was actually proposing. I was merely drawing people's attention to the broader aspects of health and the broader aspects of health and illness care that are available in society these days, and we ought to be looking at it holistically.

Senator KNOWLES—Mr Goddard mentioned the abolition of that. When you put together the abolition of the rebate for ancillaries with an increase in the levy, the people who will be the hardest hit will be the low-income earners.

Mr Goddard—As I said, that list there is one conceivable way of doing things. It should not be read as being the universal answer to everything. The point I was trying to make is that, as we move away from the rebate, we will have to have a program of putting other things in place. Maybe getting rid of the rebate up the top is the wrong way of going about it, but the point I am trying to make is that if we are going to talk about moving away from the rebate then we have to have a coherent plan to put other things in place as we go along. It is not a simple process.

Senator KNOWLES—That is exactly right, and that is why I am asking you the question: what is the plan other than to increase the levy and abolish the rebate when to abolish the rebate would increase premiums by 43 per cent? I just find it breathtaking that you have a million people earning under $20,000 who have private health insurance and you want to scrap the rebate and increase the levy.

Prof. Deeble—The main problem with Medicare covering the industry is its basic uninsurability. It does not come randomly. Initially, it was always considered—and this was considered in the early 1980s—that there would be a backlog and that that backlog would be quite large. It was also difficult to verify the need for it. There were no clear ways of controlling it, so most private insurers, quite rightly—and Medibank Private did when I was there—always had limits to stop the backlog being treated all at once.

It has to be said that insurance works for best for things that are episodic and unpredictable. Dental illness is slow: it is not episodic and it is not unpredictable, because you know you have it for quite a long time. You do not suddenly discover that you have a dental problem. It should be treated, but it should not be treated within an insurance approach. It should be a program that is different from an insurance concept, because it just does not work that way. That is why it was never added.

Senator LEES—What about public dental?

Prof. Deeble—A public dental program is more effective because the insurance approach just does not fit the uncertainty that is supposed to surround these things. Dental care is not like that.

Senator FORSHAW—What about the preventive public health approach, just as when we fluoridated the water supplies?

Prof. Deeble—That is the best thing you ever did.

Senator FORSHAW—Yes, but I mean in terms of an option. It has been put in another inquiry, one that is looking at poverty and financial hardship, that regular dental check-ups prevent problems in the future; they have a beneficial effect on the total health of people. We all know that dental problems can lead to all sorts of other problems in the body, which then get treated by doctors and specialists. So is there anything wrong with the concept of Medicare covering at least some element of dental expense, even if it were just an amount that covered a check-up or something like that?

Prof. Deeble—No, none at all. But it would not be an open-ended insurance commitment, which it is for almost everything else. Medicare covers whatever medical care is given. It covers, to the extent that it can and does through the public hospital, whatever hospitalisation is given.

Senator FORSHAW—But the point I am getting at is that Medicare also covers when people go to the doctor just for a check-up.

Prof. Deeble—There is no reason why is should not. But it probably would not be possible to say that you will get a benefit for every procedure for every dental condition that might arise.

Senator FORSHAW—Yes.

Mr Gregory—I understand what Senator Knowles has reminded us about in relation to the teeth and the mouth having been a state responsibility for all but two or three years. But this issue is so important. The evidence is incontrovertible that it is a serious issue that the health status of teeth and mouth is poor in Australia, especially among people in rural and remote areas and other people who are deprived. To inject a bit of passion into the debate, after all these years I am still hopelessly naïve. This is too serious an issue for anybody to say, 'It's your job. It's not our job.' A lot of sensible people, many of whom are collected together under a new organisation called the Australian Health Reform Alliance, are taking just this view: that there is right now a major opportunity for us to convert this hopeless naivety, which some people will accuse me of, into action.

As we all know, the Commonwealth is currently trying to give the states and the territories $42 billion, and the states and the territories are saying, 'It's not enough'. This is a crystal clear and obvious opportunity for those two sets of jurisdictions—the Commonwealth on the one hand and the states and territories on the other—to get together to agree to do some things on matters like oral and dental health. I understand that it has not traditionally been the Commonwealth's role. I simply assert, with as much passion as I dare, that it is far too serious an issue not to have the Commonwealth exercise leadership. Whether or not that leadership comes down to spending money is a later question. It is my belief, and the belief of many other people, that the existing negotiations on the health care agreements should be used as the sort of opportunity where the

Commonwealth and the states can sit down, look at each other and sign up to some commitments on things like dental health, which are too important to shift costs and plans about.

Senator KNOWLES—I could not agree more and if that is the case, how much would you suggest that the Commonwealth's contribution to the states should be decreased, if the Commonwealth were to take on the responsibility? They cannot have it both ways: they cannot get the money for dental—

Senator ALLISON—It is done through the rebate.

Senator KNOWLES—and then say, 'We're not going to spend the money; it's going to be your responsibility.' I do not like the finger-pointing either, but it is a real problem.

Mr Gregory—If the Commonwealth seriously believes this, why did it not consider saying that one of the key requirements to signing up to the health care agreements will be a commitment from the states and territories, if the Commonwealth believes that the states and territories are resigned to doing it? Why was it not a schedule attached to the health care agreements? It was an opportunity.

Senator KNOWLES—The department can correct me, but I do not believe that the states at any stage said to the Commonwealth, 'We want you to take on our responsibility for dental care.' Is that right?

Mr Davies—I am not aware of such a request having been made, Senator.

CHAIR—We can certainly ask the states later.

Senator KNOWLES—It is too late; they have signed the agreement—game, set and match.

Prof. Wilson—I would like to make a brief comment about the dental issue and then I would like to talk more broadly about the allied health and other issues. As someone who had responsibility as part of their portfolio for a public dental program in New South Wales and spent a long time fighting to try and get some additional resources at state level for oral health, I do believe we need to find a way to provide a better public sector access program for people. This is a condition which is probably, of all the conditions in Australia, the most strongly socio-economically related. The people who have the worst oral health are the most disadvantaged in the community. I agree that we do need to look at the public health approaches but some of the groups which have the most dental disease are those who are least likely to be able to get, for instance, fluoridation. I do not think fluoridation exists in any Indigenous rural and remote community in Australia and many rural towns do not have fluoridation. It is certainly a major factor, although there are also some other notable population centres, like Brisbane, that do not have fluoridation and should have. That would be a major factor which would very much help the socio-economic gradient in dental care, if we could get that in place. Having said that, there is a large amount of dental disease in the community, and we need a strategy to deal with it. The Commonwealth funds, when they did flow, were a very important part of doing exactly what Professor Deeble suggested—that is, the catch-up phase. In New South Wales, which is the only place I can actually speak of with some certainty, there was a very significant shortening of that backup queue of people. I believe that even if there were a short-term five-year program, you

could make the public dental program work much better in Australia if we had some catch-up phase to do that work.

I would like to move on a little and talk more broadly about the allied health area. I think it is extremely commendable that the Commonwealth government, in relation to rural and remote areas, has started to think more broadly than general practice and has started to think about the whole primary health care process in rural areas. Part of that, as we discussed earlier today, has been driven around a recognition that attracting doctors to rural areas is not just a matter of finding the doctor and offering them money but offering them the right context. I think, however, that we need to start thinking beyond just rural and remote areas when we think about access to allied health.

In Australia somewhere between one in 10 and one in 20 Australians within five to 10 years will be suffering from diabetes. If we are going to provide proper care for them, we need to think about how they can get appropriate access to things like nutritionists, podiatry services and the other services, which we know are essential to providing good care for people with chronic illness. We must think about the prevalence of osteoarthritis and other arthritic and musculoskeletal diseases in general and the increase in these diseases with the ageing of the population. These are conditions where you need access to physiotherapists and other medical services for treatment. I do not have a particular view about how we achieve that access, but I do think that, as a nation, we have to think about how we are going to provide efficient access to those services. We have to get around some of the historical issues around public funding flowing only through the doctor. We have to think more creatively about how we fund these services so that people can have access to that sort of care.

Senator LEES—I have a question about the public dental program. Are we looking at somewhere around $100 million for just a basic public dental program nationally? There was some work done on that, was there not?

Prof. Deeble—That is what it was.

Senator LEES—Are we beyond that now?

Prof. Deeble—It would be more than that, and I do not think that met all of the requirements anyway. I am not a dental expert, but I would have thought that extending the school dental service up to about 18 years of age—and that is a preventive service—should cover the period of puberty and adolescence where most dental conditions are likely to be worst.

Prof. Wilson—The problem is that dental disease gets established in childhood and never gets remediated properly. So what happens is that patients get emergency restorative dentistry in the meantime; they do not get oral health care over that period of time. So the problems are established and, once they reach adulthood, you have to do something about it early.

Prof. Deeble—I would have thought that something in order of $200 million to $300 million is a realistic figure for an effective dental program to that point. That is not a large amount of money; it is less than others. It is a matter of prioritising: whether that would be more effective in raising dental health than giving people money to have their teeth fixed up indiscriminately.

Senator HUMPHRIES—You are saying that it would cost $200 million to $300 million for a dental program for under-18s?

Prof. Deeble—That is to extend the program and cover the lower income age which you were talking about.

Senator HUMPHRIES—Does anyone have an estimate of the cost of a comprehensive dental program a la a Medicare style program for dental health?

Prof. Deeble—It would be 85 per cent of whatever you pay dentists now.

Senator HUMPHRIES—This is a fairly significant question.

Dr Madden—The total expenditure on dental services in Australia is about $3 billion. We have figures for the last year which show that total government spending was $600 million. So governments, Commonwealth and state together, are only spending a little over 20 per cent, and that includes the rebate—although that figure probably does not take into account the effect of the rebate for the full year; it might be a little bit more than that. If you start to look at an 85 per cent rebate on $3 billion then instead of $600 million you are talking about something in the order of $2 billion. That is a big program.

Senator HUMPHRIES—Do you have a figure for how much we spend on allied health costs as a nation?

Dr Madden—No, not in such a nice way unfortunately.

Senator BARNETT—Is it possible for that to be done in terms of the different parts of the allied health industry? What is important is that we know how much this costs. The second question is then: who actually pays? Senator Knowles made the point earlier that this has traditionally been a state responsibility. Is there any possibility of obtaining that research? We have a figure of $3 billion for dental services. Can we get figures for the other services?

Dr Madden—There is some work being done to develop the collection of data on community health, but it is not in place at the moment. We would really need that before we could give a decent answer. It may be possible to make some estimates, but from the statistical system you will not be able to get that data in the reasonable term.

Mr Schneider—I would estimate it, based on our expenditure, as being somewhere between $5 billion and $7 billion.

Dr Madden—No, it is not that high.

Senator FORSHAW—That is all the allied health professionals that are covered through ancillary insurance?

Mr Schneider—Yes.

Dr Madden—With dentistry.

Mr Schneider—But it would be primarily dental, chiropractic, physiotherapy and optical services and non-PBS pharmaceuticals.

Dr Madden—Can I make the point I wanted to make? The point of those numbers that I just gave is that about two-thirds of the expenditure on dental services in Australia at the moment is out of pocket. So if you are going to do anything substantial about dental services you have to immediately look at the supply side. Dental services are the one area where we have had substantial excess inflation in costs in Australia. The reason health is only nine per cent of Australia's GDP is not because we are underserved; it is because the cost of the inputs is relatively low here, particularly when compared to the US. But in dentistry we have had very high inflation of costs. A lot of it has been driven by public health requirements of dentistry and so on—infection control and all those sorts of things—not just dentists driving bigger and bigger BMWs. It is a very serious issue, and you cannot really talk about substantial change in dentistry without looking very closely at the supply side. That is possibly something governments can look at with rather less heat—that is, at doing something about expanding the number of people in the dental industry. It is not only dentists; there is a whole range of dental professions. I should also emphasise the public health issues here that can be dealt with through the extension of fluoride—that is a really important issue.

Prof. Deeble—The only other point I would have raised is that in relation to the ancillaries everybody equates Medicare with the fee-for-service private practice reimbursement system. But it does not have to be that system. For many years there were things called health program grants which could be given to all kinds of different organisations. It does not have to be a private practice fee-for-service system; it can be about any group that provides ancillary services to any other group.

To give you an example, one of the general practice divisions in Northern Queensland has a practice division which is the professional group and it has formed another company which provides the ancillary services to the members of that general practice division. That division could get a health program grant—it is just that it does not fit the private practice fee-for-service model, which seems to have got everybody's attention to the exclusion of any alternatives, although the legislation exists for it.

CHAIR—I might pursue that further; it is of interest to me.

Mr Gregory—I wanted to make a small party political broadcast on behalf of allied health professionals. It has been pretty well done around the room, actually, and that is good, but it is so important to the alliance that I will do so, with your indulgence. It is very brief—Andrew Wilson, in particular, has done a very good job. Among the National Rural Health Alliance's 24 member bodies are two representing the interests of allied health professionals and allied health organisations.

The National Rural Health Alliance is continually frustrated that allied health is either missing from considerations of health reform or misquoted in them. In too many instances allied health seems to be defined to mean practice nurses, as it was in the budget papers, and sometimes dentists. Practice nurses are not allied health professionals and dentists and community pharmacists do not like to be called allied health professionals. The importance of allied health professionals can be clearly stated by reference to some of the critical roles and functions they

perform in health care. There is the work of OTs after stroke; podiatrists in the care of diabetics; speech pathologists working with children with a disability and with patients after stroke; physios in pain relief and palliative care; radiographers in diagnosis and screening; oral hygienists; psychiatrists and social workers in mental health; dieticians in preventing illness and establishing lifelong healthy habits; and ambulance officers and paramedics in accidents and emergencies, especially in the golden hour after the accident. The alliance for which I work would like to see greater attention given to the primary health care contributions of these and other allied health professionals. I am right up to date with the difficulties the department has in terms of defining allied health, but the plea from the alliance is that if it cannot be agreed what it is meant by the term 'allied health' then can it at least be agreed that it does not include practice nurses?

CHAIR—Thank you, Mr Gregory.

Senator ALLISON—I want to pursue the question of other fund's models of delivery. Professor Deeble said private practice is one. Can we look at other ways in which GP services might be delivered by salaried GPs, GPs in community health centres and GPs attached to hospitals? I think Mr Schneider said this does not work, but I have heard of other examples where it does. Certainly some hospitals that I know of are looking at this question right now. I probably should have raised this earlier, but it is an important area that we have not touched on so far.

Mr Schneider—I think that is a very constructive suggestion. I was actually smiling, looking at my friend Dr Bain, and wondering how the AMA would react to any suggestion of departure from fee for service.

Senator ALLISON—We know the AMA will hate it, but we will talk about it anyway.

CHAIR—I suggest we note that as an issue that we have not canvassed today and look for any submissions or comments during the course of the next 10 days of deliberations. There is another point I want to canvas, and I acknowledge Mr Gregory's comment about practice nurses not being allied health professionals. The issue that is raised regularly with me is that, with practice nurses being used in general practice, some services are almost wasteful of doctor time. For example, where you have a patient who is due to have their annual flu injection, that person does not necessarily—and it is doctors who are telling me this—need to see the doctor. We know that person needs the flu injection. Why do we waste that health professional's time—the doctor's time—when we just need to give the person the flu injection, and probably the practice nurse is the best person to do it? But, for that doctor to be paid, the doctor has to see them. That is a question that I do not think we can canvas now, but I note that it as an issue in terms of good use of public money that we should canvas at some point in the future.

Proceedings suspended from 3.37 p.m. to 3.55 p.m.

CHAIR—I call the meeting back to order. Mr Davies, you have a document which goes to the relative values study?

Mr Davies—I now have two documents. The first is the technical report on the relative values study, in response to Senator Allison's request. It is a very dry and technical document. I have

enough copies for all senators to have one if they wish or alternatively I could just supply one to the secretariat.

CHAIR—Could you supply one to the secretariat; there has been request that we might precis it.

Mr Davies—Also in response to an earlier request from Senator Allison are detailed data on the public hospital A&E occasions of service. It is not entirely self-explanatory but, if I table it and people have questions, we could return to it later on. Would that be helpful?

CHAIR—Thank you very much. We now have half an hour that we can allocate to session 8 on alternatives for reform of Medicare and alternative funding models. By the nature of this discussion, we have canvassed quite a bit of this session already. What I would like to do at the end of the discussion in session 8 is to ask each member of the panel to make comments that will provide further direction to the committee. I would like to canvass issues that you do not think we have canvassed today as well as any gaps in knowledge that you think may exist, to inform the deliberations of this inquiry. So am giving notice now that in about half an hour we will run around the table and ask for your comments in respect of those two items. I would now like to invite Mr Ford to make some opening comments on the final session for today—alternatives for reform of Medicare: alternative funding models.

Mr Ford—I thought I would spend a little bit of time focusing on a few points, particularly private health insurance, the 30 per cent rebate and the relationship between it and hospital demand. This is an important question because, as has been mentioned before, in Australia we spend nine per cent of GDP on health care. It is always a question of how we best allocate scarce resources; this is a key public policy question. When the government introduced the 30 per cent rebate for private health insurance, one of the reasons it did that was to introduce a balanced system which would ease the burden on Medicare and the public health system and give Australians greater access to private hospitals. There are a couple of things that it is worth saying about that. The first thing is that the last budget paper showed that the Commonwealth spends $2.26 billion per year through the 30 per cent rebate. That has been estimated to be the equivalent of all Commonwealth subsidies to the mining, manufacturing and primary agriculture industries, so it is a lot of money.

The rebate had two major objectives. The first was to encourage people to take out private health insurance. The argument, which I have summarised in my submission, is that the rebate was not the policy that encouraged people to take out private health insurance. In fact, the argument has been made by a number of other people that it was a lifetime health cover. If we look at the dates, there is some evidence to support that argument.

The 30 per cent rebate was introduced on 1 January 1999, when 30.2 per cent of the population had private health insurance. Nine months later this figure had risen to 31.4 per cent. A couple of weeks later the government announced Lifetime Health Cover, and within a similar nine-month period the proportion of the population with private health insurance rose from 31.4 per cent to 43 per cent. People might remember the ads at the time, with the umbrellas—the ‘run for cover’ ads. Such was the rush for people to join private health insurance companies that the deadline was extended from the end of June until mid-July because insurers were overwhelmed

by numbers joining. The argument is that it was lifetime health cover at no cost which got people into private health insurance, not the 30 per cent rebate.

The other argument about the rebate is that it would reduce pressure on public hospitals. But in fact the point has been made before that during the period of the rebate demand in public hospitals has increased over the same period. Demand for total hospital separations has gone up; emergency demand and elective surgery have all grown. While we have seen more people being treated in private hospitals, we have also seen more people treated in public hospitals over the same period. Interestingly, throughout the late 1990s when the proportion of the population with private health insurance was declining, we were still seeing increases in private hospital admissions. I think it is important to point out that there is not necessarily a relationship between the rebate and private hospitals nor between the rebate and people taking out private health insurance. Rather, I think it is probably fair to say that Lifetime Health Cover has been the thing that has pushed people into private health insurance.

The question is: if we have this $2.26 billion, where should we spend it? I do not want to spend too much time on that because I think we have done that in a lot of detail today and I know that there is going to be an opportunity for members of the committee to make some more points later on, but I guess it is worth pointing out that one of the areas that my organisation thinks that we should spend this money on is targeting GPs who bulk-bill patients. We believe that, if we raise the rebate to GPs who bulk-bill all patients, that is a real, universal incentive. What is the true cost of a consultation? We have discussed that a bit today. There are various estimates, but I think it is probably very important that the Commonwealth committee researches to find out what the true cost of a standard GP consultation is so we know what we are actually talking about.

I think it is also really important that we increase funding into public hospitals. Professor Duckett and Dr Terri Jackson have estimated that, if all the Commonwealth subsidies to the private health sector were transferred into public hospitals, we could treat an extra 1½ million patients per year, so there is a significant number of patients that would benefit from that.

We have talked today about primary health care. I am not an expert, but it seems to me that we do not really think about primary health care in the same way as we think about public hospitals. If you think about a public hospital, you get a whole gamut of services in a public hospital. There are doctors, nurses, social workers, OTs, physiotherapists, social workers, pastoral carers et cetera. But really when we think of primary health care our conception of it is limited to GPs. I think it is important that when we think about primary health care, as other members today have mentioned, we think about that more broadly.

I think it is also really important to go back to dental. When the Commonwealth public dental scheme was cut, I know in Victoria the average waiting period for public dental care had dropped to roughly 12 months. Now in Victoria—and I am not sure about the other states, but they are probably similar—the average waiting period is around two years. Indeed, in some areas in Victoria like Horsham, in country Victoria, there is a four-year wait for public dental. It seems to me that both the Commonwealth and the states need to sit down and look at this issue and say, 'We do indeed have a crisis in dental care.' The argument has been made before: why do we treat the teeth separately? The whole body, it seems to me, goes into see a doctor and I think teeth should be included in that as well.

The final point I want to make is that I would urge all sides of politics, at both the state and Commonwealth levels, to accept that when we are thinking about reform of the health system—as the committee is doing today—it is really important that we consult widely and invite contributions from all groups including doctors groups, consumers groups, groups with chronic illness and groups with special needs. I think a really important objective—particularly when we are talking about things such as Medicare that are really important—is that we have wide consultation and that all points of view are taken into account. That is where I would like to kick off the discussion.

CHAIR—Thank you, Mr Ford. Are there other contributions or comments from other participants?

Mr Schneider—I think one of the things that tends to be overlooked in discussion of the private health insurance rebate is the very significant effect of community rating in the Australian health care system. Australia's health insurance system is unique virtually throughout the world, with the exception of the Republic of Ireland, in that Australia is the only country which actually provides bona fide community rating for health insurance. Community rating means that everyone, regardless of their means, age, sex or state of health, is entitled to the same benefit at the same price. What it does, in effect, is bring in a large pool of people who are healthy, whose contributions to the pool subsidise those of the sick. That instantly leverages a lot of money from people who would otherwise spend it on other things, I suppose, and certainly would not spend it on their own health care because, by definition, they do not need very much. But it is a way of encouraging their contributions, which are based on the possibility of something happening, into a pool which is guaranteed to fund that for those people who are almost certain risks.

We tend to overlook that when we talk about the rebate, because what the rebate actually does is produce even more leverage for the financial impact of community rating. Every 30c that the government puts into the private health insurance system via the rebate turns into a dollar to be spent on the health care system. You cannot get that sort of leverage from taxation; it just is not possible. I certainly would not support any argument for a rebate in a risk rated system, but a community rated system and the rebate together—the link of the two is very important—mobilise a lot more money for health care for all levels of society than taxation can, or than governments seem prepared to do via taxation. So I think we should take that into account in any discussion of the rebate.

Secondly, I think there has been a little bit of mythology about the impact of lifetime health cover in terms of participation rates. I have no doubt at all, and no-one would dispute, that the very significant increase in private health insurance numbers took place in the period about a month before 30 June 2000 and the two weeks afterwards, during which the amnesty period was provided to allow those people who had missed the boat to be covered. But I do not believe—and I was pretty closely involved with these things—that it would have been possible to have got that sort of participation rate at the prices that would have prevailed at that time without the rebate. Around 1997 or 1998 an organisation called TQA Research—Tony Quint and associates—which does a two-year survey of the health insurance industry and has built up a reasonable track record on assessing likely trends in the industry, determined that the attrition that was taking place would require a minimum 30 per cent reduction in the price of health insurance to be stopped or turned around.

The moment the 30 per cent rebate was introduced, the erosion stopped and turned around. I would draw your attention to the fact that, several quarters before the 30 per cent rebate was introduced, the government did experiment with a means tested rebate, but it failed—it increased participation rates for one quarter only. After that, the trend resumed its downward path. The rebate instantly turned things around. Funnily enough, if you track the curve to today, you would have almost the same participation rates today that you would have from lifetime health cover. It is just that lifetime health cover was able to shift things forward and move it faster. Indeed, one wonders whether any government would have been willing to introduce lifetime health cover without the attraction of the 30 per cent reduction in the price achieved by the rebate.

That is really all I wish to say about that, but I would pose the question: what would happen if the rebate was removed? I think it goes without saying that it would instantly increase the price of health insurance, and not by 30 per cent. If you do the maths, it would actually be in excess of 42 per cent, simply because of the oddity of mathematics. It would be a very savage percentage increase. Health funds would have no choice but to make allowance for the attrition that would inevitably take place there. The inevitable assumption must be that the first to go would be the best risks. They would make the logical decision that, given that they are healthy, they do not need to be paying for it, and they would carry their own risk. Therefore, the actual impact on price is more likely to be something like 50 per cent. The inevitable impact of that, of course, would be that those on the lowest incomes would be the least able to maintain their insurance. Almost by definition, those people are retired. Most of them are over 65 and many are over 70. They would instantly fall out of that system and back into the public sector. You can imagine the sorts of demands that that would impose on the public hospital system.

Based on some demographic work we have done, this year there are going to 2.2 million admissions to private hospitals by insured patients, compared with 1.5 million admissions in 1998, the year before the rebate was introduced. That is an increase of almost 50 per cent in admissions—an increase of 700,000 people—compared with the pre-rebate period. While some of those people might be going to hospital for fun, I would suggest that most of them are going for very good reasons. Inevitably, those people would have found their way either into a public hospital bed—possibly ahead of someone who would otherwise be in that public hospital bed, because their acuity would be greater—or, at the very least, onto a public hospital waiting list. I think that that argument speaks for itself. I think it is quite clear that we have seen a significant increase in private sector utilisation and it must be assumed that that has taken a considerable load off the public sector. Even if public sector admissions are increasing, they are not increasing by anywhere near as much as they would have been without the 30 per cent rebate.

Senator KNOWLES—Mr Ford might like to comment on that response, because it was exactly the question that I was going to ask him. Would lifetime health cover have been as successful without the 30 per cent rebate? What would have happened to the incremental increases had there not been the 30 per cent rebate and increase in PHI in that time?

Mr Ford—I do not link the two. I know that Russell likes to link them. He has a good reason for linking them: the 30 per cent rebate is essentially a subsidy. But I do not link the two. I think they are two separate things. I think that lifetime health cover was the policy that pushed people into private health insurance.

Senator KNOWLES—It was not the $750 that they get back each year or that they do not have to pay each year because of the 30 per cent rebate? Your information is completely different to mine if you believe that. When people get their statements, as they have in the last couple of weeks, and they see what they could have paid and what they did pay, they will say 'That is rather nice.'

Mr Ford—I am looking at when lifetime health cover was introduced. I have no doubt now that, if we got rid of the 30 per cent rebate, people would drop out because, as Russell said, premiums would rise. But the important point is that we were told when the rebate was introduced that it would ease the burden on premiums. They have increased every year. Private health premiums are rising and we are paying for it through the 30 per cent rebate.

Senator KNOWLES—Don't you see any correlation between premium increases and utilisation?

Mr Ford—My argument was that people join private health insurance because of lifetime health cover, not the rebate. The percentage of the population with private health insurance hardly moved when the rebate was introduced. When lifetime health cover was introduced it rose from over 31 per cent to 43 per cent—a really dramatic increase—because there were the 'run for cover' ads. People were told, when they saw their tax agents, that they could get a reduction in tax by joining up, because of the tax penalty of lifetime health cover.

CHAIR—I will ask the question the other way. Mr Schneider said that if you removed the 30 per cent rebate there would be a reduction in the number of participants in private health. If you removed lifetime health cover, what would happen?

Mr Ford—I think that question is difficult to answer. However, there are a number of young, healthy people who have the cheapest private health policy because that costs less than the penalties through lifetime health cover. So I would imagine that people would drop out if we got rid of lifetime health cover as well.

Mr Schneider—I do not wish this to be a two-way debate, but I think there would obviously be some attrition if lifetime health cover were removed. I do not think it would be anywhere near the same numbers as would be the case if the 30 per cent rebate were removed.

CHAIR—Is that because of that cohort of young, healthy people?

Mr Schneider—Yes. The hard thing is to get people into the system. Once they are in they tend to drop out, all things being equal, at a fairly slow rate. The moment you increase the price, you almost force people out. Our retention rates have been pretty good. We have found that whenever we can hold the rate of increase close to the CPI people tend to retain their insurance. In fact, over the last four years the actual increase in private health insurance rates has been consistent with the CPI. It has been just a dash over the CPI in the last year. Whether that can be maintained in the future will depend a lot on overall health care costs. I would think that the impact of the withdrawal of the rebate would be far more dramatic in terms of drop than the elimination of lifetime health cover. Certainly, I would not argue for the removal of lifetime health cover.

Mr Ford—I do not want to make this only two-way. I wish Professor Deeble were here. His analysis shows that private health insurance is not necessarily price sensitive but it is very income sensitive. In other words, the higher the income you have the more likely you are to take out private health insurance. Once they have private health insurance, people on higher incomes in particular have less sensitivity to price rises. I acknowledge that if we got rid of the 30 per cent rebate people would drop out. Of course they would.

Senator KNOWLES—How about the one million people earning under $20,000 who have private health insurance?

Mr Ford—I am sure that people would drop out. I am not saying that no-one would drop out. My point is that it was lifetime health cover that pushed people in. I think that that is a really important point to make.

Mr Gregory—First of all, I congratulate whoever did the seating arrangements for this afternoon. It is unfortunate that Russell and Greg are sitting next to each other. The National Rural Health Alliance, for which I work, does not have a position on private health insurance, but I have two comments to make. Firstly, if it is all about doing something for the public hospital system, which is what most of its advocates end up saying it is, then it is a very indirect way of doing that. If one wants to do something for the public hospital system—if that is what it is about—then it would be much more effective, all things being equal, to divert the money directly to public hospitals. Secondly, although the National Rural Health Alliance does not have a position, it is not particularly excited by the policy, because the uptake in rural areas, as Russell well knows, is significantly less. My figures are not as good as yours, because I do not have your figures, but my figures suggest that on average seven per cent fewer people take out private health insurance in rural areas than in cities. Some estimates have been done about how much. Again, this is another of those deficit arguments about how rural areas are missing out on the rebate, compared with the situation that would apply if it were distributed on a per head basis. Those are two comments for Russell, really.

Mr Schneider—On the second point, a more accurate statement is that private health insurance numbers in rural areas are lower if there is no private facility. In those areas where there is a private hospital or a private facility of some sort, participation rates are actually quite high.

Mr Gregory—But, as you know, outside of Perth there are two private hospitals in the whole of Western Australia. Western Australia is a big state.

Mr Schneider—There are not many people outside of Perth.

Mr Gregory—I care about the few there are.

Senator STEPHENS—Mr Ford, taking Mr Gregory's point, would you be able to enlighten us about this? Anecdotally we hear a lot of stories about the numbers of privately insured patients who use public hospitals but do not advise that they are privately insured. Are you able to provide us with any indication of how often that happens?

Mr Ford—I have heard estimates, but I cannot recall them. I think it might vary between seven and 17 per cent of admissions, but I might be totally wrong.

Mr Schneider—I do not say this with disrespect but I think it may be a bit of a furphy that people have been trying to run an argument on. I think the percentage is probably very small. Although, I would qualify that by saying that they have Medicare entitlement anyway, which they are entitled to use, and I do not think anyone would suggest that be taken away. If you think about how the system works, most of those admissions, if they do take place, would be in accident or emergency circumstances where the patient comes through casualty and is not given the option of choosing their doctor. In some cases, indeed, they are given the option of choosing their doctor by being given a list of those doctors who are on duty on the night and those who are not, and they are asked which one they would like to choose. When they do that, they are charged. So I do not think that is a very fair way of treating the insured patient who is not given the opportunity to make a bona fide choice.

All elective admissions are organised outside the hospital; they are organised in the specialists' rooms. That is where the option to be a private patient or a non-private patient is made. I very much doubt that most specialists would willingly admit an insured patient as an uninsured patient, on the presumption that it would cost them money. If on the other hand—and I have always wondered about this—their financial arrangements with the public hospital mean that it is more financially attractive for them to treat a Medicare patient than a private patient, they may actually make that arrangement. One of the things that might be asked by the committee during its deliberations is what are the financial arrangements for the treatment of Medicare patients in various hospitals in different states. That may well create another perverse incentive in the system.

Mr Gregory—I wonder if you would comment on my first point about a less direct route.

Mr Schneider—Again I think the problem is that it ignores the impact of community rating. The government could simply put the money into private hospitals, but it would not have all the other money that is mobilised by those people who are not insured. So it would still have to find the money from taxes. It would actually have to tax more those people who today are not insured, to allow it to continue to put money into the system that is currently coming from people with insurance.

Mr Gregory—Is that where your 30c converts to a dollar figure comes from?

Mr Schneider—Yes. I do not think there is any more powerful leverage in the health care system than that.

Mr Davies—I would like to make a couple of very brief observations. Firstly, I think it probably would be helpful if we put the 30 per cent rebate versus lifetime health cover argument to bed because this is, essentially, an evidence-free zone. We cannot separate the two. We introduced lifetime health cover in a world where there was a 30 per cent rebate. We have not conducted a controlled trial, so it is impossible to say what the impact of lifetime health cover would have been had there not been a 30 per cent rebate in place. I would suggest that that is ultimately an arid topic for debate. The reality is that we went into the sequence of rebate and lifetime health cover, and it is methodologically impossible to untangle the impact of the two.

There is another aspect. At various times during the day we have heard people talk about some fairly abstract concepts that health systems give us in terms of social solidarity, feelings of wellbeing and so on. There is also an argument that choice is a good thing to have in a society. Obviously, by facilitating access to private health insurance, we are facilitating choice in how and where people access health care. If you subscribe to the view that choice is a good thing to have in society, maybe there is merit in investing money in increasing choice as well.

CHAIR—I was looking for the section in your submission where you canvass the rebate or lifetime health cover, but I will find that later.

Prof. Sainsbury—I do not think that it is all about public hospitals. I will go back to my introductory comments of the last session: it is about how we are to ensure the best health for Australians in the most cost-effective way. That is what it is all about. Then it comes down to whether we are spending the money in the best way to get the best value for money. For me, that is what it is all about; it is not just about more or less for public hospitals. That may be part of the debate but it is not by any means the whole of it.

The private health insurance rebate did not increase the dollars that the public directly invested in private health insurance. This can be quite easily demonstrated arithmetically. If we say that the uptake rate was 30 per cent before the rebate and that it was 45 per cent after the rebate was introduced, and if premiums stayed the same, that was a 50 per cent increase in the amount of money that went into the funds. Right? But 30 per cent of the total amount is now provided by the government, which is just about the same amount as the extra money invested by the public directly. The extra money that went into the private health insurance funds as a result of the rebate was not money that the public invested out of their pockets in totality; it was money that the government put into the private health insurance funds, if you look at it in that total sense—a very poor way of investing government money.

That leads me to my next point. The issue is not 'what about the people who earn less than $20,000 a year?' although they are, of course, a concern. The issue is: how can we most effectively spend taxpayers' money to protect and promote the health of the poorest in society—and the middle and the richest? Is subsidising those people who earn under $20,000 a year to allow them to purchase private health insurance the most cost-effective way of improving their health and treating them when they are sick? Sure, it may be a tough political decision to take away the money that is being given to voters under the terms of the private health insurance rebate, and that is a political decision for politicians and for the electorate. But we should not confuse that with whether it has drawn money from the public into private health insurance and we should not confuse it with whether it is a cost-effective use of public taxpayers' money to give it as a subsidy to the private health insurance industry and then to private health care providers.

My final comment is that, sure, choice is important in society; it is something that we tend to value. People should be allowed to choose private health care if they so wish. But, again, the question becomes: if you want to choose private health care, why should the rest of society subsidise your choice to have it? By all means have the choice but do not subsidise it. It should be a choice that people freely make and pay for from their own pockets, and not that those who choose not to have it subsidise your choice to have it.

Senator KNOWLES—Conversely, those who choose to have it subsidise those who do not choose to have it, do they not? It has to cut both ways.

Prof. Sainsbury—Why is that?

Senator KNOWLES—By natural extension, it has to cut both ways. Those who do have private health insurance are not only subsidising themselves but also subsidising those who do not have it, by subsidising the private hospital system, the Medicare system and the whole system.

Prof. Sainsbury—I do not quite follow your argument.

Senator KNOWLES—They both pay taxes.

Mr Schneider—They pay taxes.

Prof. Sainsbury—Indeed.

Mr Schneider—The privately insured person pays taxes for services that they do not use.

Senator KNOWLES—That is right. They pay taxes.

Mr Schneider—They choose to use other services, which makes way for those who are not privately insured to use the services.

Senator BARNETT—The important question from Senator Knowles, if you do not mind my asking, Professor Sainsbury, is: what is the impact of those using the private hospital system on the public system? Can you answer that? Is there any impact, in your view, on getting people out of the public system into the private hospital system? Under your scenario, I assume you would say there is no impact.

Prof. Sainsbury—I do not think I would be quite so categorical as to say there would be no impact; I think that would be folly. I am certainly not convinced by the arguments advanced by the private health insurance industry and the Private Hospitals Association that the rebate or the increase in the uptake of private health insurance has taken any great pressure off the public hospitals. What the insurers and the private hospitals tend to do—indeed, some politicians tend to do it—is to tell us how busy the private hospitals are. Being busy is not the same as taking pressure off the public system. There would need to be evidence demonstrated—

Senator BARNETT—You are an expert; what does the evidence say of admissions to public and private hospitals in the last few years?

Prof. Sainsbury—That they have both been increasing overall, apart from one year when public hospital admissions did not increase, and that in percentage terms there has been a greater increase in—

Senator BARNETT—Do you know what the extent is?

Prof. Sainsbury—The figures are on the page from the recent publication that Russell has. It says that between 2001-02 separations in public acute hospitals increased by 2.6 per cent and in private hospitals they increased by 9.5 per cent. That is in the recent publication from about a month ago. Of course, that is three or four times the percentage increase but that percentage is on a much lower base. The question asked earlier was about absolute numbers and not just percentages. Again, it is not simply a question of whether it has or has not taken pressure off the public hospitals. The question is also whether this is the most cost-effective way of providing the services to people who are now receiving them? Could that $2.5 billion a year have been better spent to provide hospital services or any other services to improve the health of the Australian population?

Dr Madden—That is terrific—I rarely get a chance for a commercial. The publication that you are referring to is *Australian Hospital Statistics*, which was released on 30 June. I will leave it with the committee.

CHAIR—Thank you.

Dr Madden—It is available on our web site. There is much data in the report to advance both sides of the argument.

CHAIR—That is very politic.

Dr Madden—My reason for intervention was just to come back to Senator Stephens' comment about the people in public hospitals with insurance. We used to collect data on that but the data was so meaningless, because of the issues that Russell referred to, that we stopped publishing it. We thought we were misleading people. I think the key thing is that people who go into public hospitals, whether or not they are insured, have a right to be there, and asking them a question that is irrelevant to their being there is not a helpful thing to do. So that is why it is not in the statistics.

Ms Walker—I have something to say on that point. NATSEM are currently having a very large database set up from New South Wales health data on hospitals, both public and private. We have this data on a patient basis so we do not have the separations type of problem and therefore can do considerable analysis of distributional impacts. We are adding costs to that as well and having a private health insurance model based on regressions and what has happened in the past. We are going to link those two together so that we can see the impact. We are initially aiming to have that done by December. We are going to study the impact of both the 30 per cent rebate and lifetime cover on public and private hospital population changes.

Coming back to how many people have health insurance in public and private hospitals, out of this dataset we will be able to analyse that. On the New South Wales hospital database some people declare whether or not they have private insurance, but that is known to be an underestimate. Because we also have the total population in the private health insurance model coming out of Russell's data we will be able to impute across the system how many have declared it. So there will be some information on it, although it will be an estimate.

CHAIR—And that will be available in December?

Ms Walker—We will keep working on it so interesting things will come up. If you are interested, we could send the committee copies of the papers we are doing on this project. It is moving very fast. We are planning about four papers which will come out between now and December.

CHAIR—Thank you; that would be useful.

Mr Davies—I promise that this is the last document I will table but, to help the committee with its deliberations and to save the committee the trouble of ploughing through Dr Madden's extensive publication, we have put together a very simple summary of the growth in private hospital separations by the main diagnostic categories. You might find this quite interesting. It shows that a lot of the growth in private hospital separations has been in some fairly heavy-duty diagnoses. This is quite useful data so, with your permission, I table that as well.

CHAIR—Thank you. Is that by percentage or by raw number?

Mr Davies—It is by raw number.

CHAIR—We know that there are increased attendances in both the private and public sector. When the community affairs committee has talked about this issue at estimates it has often been identified that the sorts of procedures that are occurring in the private sector are what the minister called delayed procedures: procedures that were not absolutely essential but, given that the person now had cover, the person thought, 'I might as well go and do that.' So it is the type of procedure and the growth in those procedures that, to really get to the issue of where the growth is and whether there has been any benefit to the public system, we need to get a good analysis of. We are now 20 minutes from closing.

Senator FORSHAW—I would like to add one comment to something that the states have argued in their submission, and you have heard about this from me before. Looking at the 30 per cent rebate, the growth in private health insurance and what has happened with admissions to private hospitals is not really the best comparison—and I am not sure what is—because there are other factors. For instance, it is not just private health insurance that is covering costs in private hospitals; Medicare is doing that as well.

As the states would argue, what private hospitals do not do—and this is in addition to the point Senator McLucas just made—and that public hospitals do is all of those procedures or services that are done without a hospital stay necessarily being involved and which of course are not subsidised, if I can use Senator Knowles's words, by Medicare in the same way that, through the agreements for funding for public hospitals, things are covered in hospital admission. At the end of the day, private hospitals essentially deal with people who are admitted to hospital for a stay. The public hospital system deals with a lot of people who come in the door in the morning and go out in the afternoon or at some point during the day. It is a whole other set that I think has to be factored into this debate: if you reduce pressure on public hospitals by increasing private hospital admissions. It goes then to the question of funding for public hospitals.

Mr Davies—I think I am right in saying—I look to my colleagues—that a same-day service in a public hospital would still count as a separation. So those would be included in the data for both public and private. But, moving down another level to outpatient treatment, earlier this

afternoon someone made the point that—and this is bringing us right back to one of the things A Fairer Medicare is trying to address—we do have this anomaly whereby you can insure for admitted private hospital treatment but your private health insurance cannot cover non-admitted treatment. As more and more services can be delivered outside the hospital setting, that is exposing people to increased financial risk which they cannot insure against.

Senator FORSHAW—It is a whole other debate but it is relevant, and my point goes to the issue of how the states are funded for public hospitals in terms of the health care agreements. There are a lot of things happening in public hospitals that are not happening in private hospitals which are not funded.

CHAIR—We might close that session now and in the remaining 15 minutes or so ask each of you to address the two questions that I posed earlier—that is, what issues haven't we canvassed today, and what gaps in knowledge do we have that we need to redress in order to truly make good decisions in the next few weeks?

Ms Walker—One thing that we have not talked about which I think is terribly important is the way we are going into the future. I remember John Deeble mentioning that already in the sixties people could see that costs would increase as technology advances. But we had a quantum leap in the possibilities with the mapping of the human genome and the first types of medical breakthroughs are now occurring because we can now keep alive people who would have died—cancer patients treated with Gleevec et cetera. A lot more are expected to come and are coming—I have followed that for a few years—and the pace at which they are coming on is a lot faster than we expected. A futurologist, Tom Kirkwood—the BBC was covering the issue—expects that people will live 20 years longer. That has an impact on the health service.

I do not think we have talked about whether, if we are going to change the system, it will be able to cope with that later on. Who is going to pay for it? Gleevec, for example, is for leukaemia. It costs $50,000 a year, so individuals cannot pay for it. But are we going to subsidise? How many are we going to subsidise? And for how long, given that people live for so long? So I would have liked to have seen a little more discussion. To me it suggests that we have to move towards user-pays because you cannot collect that extra amount of money out of general taxes. But we have not really discussed it.

In relation to the gaps in knowledge, I agree with Professor Jane Hall that there is now a lot more data around than there was earlier and we have not really mined it properly. So I would like to see the possibilities of getting the data and linking it so that we can see how sectors impact on people, and not just separations and things like that. That is my main one. It is a big job, although it does not sound like it.

Dr Bain—I think that we have done a pretty good job in covering it today, but one area that is perhaps a bit underrepresented in the debate is the outer urban area. The GPs in outer urban areas are by far the most depressed GPs that we see. If you have a breakfast meeting with a doctor in, say, Frankston or another outer urban area, they will tell you that they are bulk-billing—they feel obliged to, because of the nature of their patient load—and, judging by the cars they are driving and the clothes they are wearing, they are not making much money. Their waiting rooms are full when they open at eight o'clock in morning. Some of them have to close at lunchtime and

physically stop more people from coming in, when there are mothers outside with kids and so on. It is just a very tough scene.

I agree that rural and remote health is a problem as well—it is a very serious problem—but we see the outer urban one as very hard going. For whatever reason, rather than start charging that group, the doctors will move to a higher socioeconomic suburb. There are jobs for GPs wherever they want to go—there are jobs for doctors advertised in Double Bay every week, if they want to go there. I would really recommend that the committee have good look at what is happening in places like Western Sydney and outer urban areas.

Senator KNOWLES—Isn't that why access is more important than this whole silly debate about whether Medicare and bulk-billing should be at 70 per cent or 80 per cent?

Dr Bain—Access is much more important. We hardly ever get a complaint about a GP's charge. We constantly get complaints that someone could not get access for their mum when she fell over, or for their children or for whatever reason, and they ended up going to some hospital somewhere and waiting for hours and hours. Access is much more important in these areas. I am sure that the fee is important for lower socioeconomic groups, but 90 per cent of complaints that we get about GPs would be around access problems.

We all agree that access and, to some extent, affordability are real problems and that we have a very run-down work force with a falling participation rate. The real challenge for all of us in this debate is: how do we fix one without making the other worse? This is the problem we have with A Fairer Medicare. Some of the key features of the Medicare package are the very things that doctors say are causing them to drop their participation rates. That is the difficulty. People can try and grab doctors and force them into some mould and the model might look good, but, if we lose two or three hours a week in the average participation rate, we are back behind where we started from.

Mr Davies—I would just make a final point of clarification and one suggestion. Firstly, I want to highlight a comment that Professor Deeble made earlier on. At one point, he seemed to be expressing surprise that A Fairer Medicare had ventured beyond general practice, particularly through the safety nets, into covering the costs of other specialist and diagnostic services. I was a bit concerned that he and maybe others were seeing A Fairer Medicare as solely about general practice. I hope you will recall that, first thing this morning, we explained that many more specialist and diagnostic services are now being provided in the private sector and therefore A Fairer Medicare needs to, and indeed does, also address the costs of those services. So A Fairer Medicare is not solely about general practice.

The other point is that someone in the last session—I have forgotten who it was—suggested that the department should be working out the cost of a standard consultation. I think Dr Bain himself said that he would not wish to venture what the cost of a standard consultation should, would or could be. Again I would draw your attention to one paragraph in our submission on page 22 where we argue that whether there is any such thing as a correct fee is arguable. The fee a doctor charges can and does vary widely and it relates to a number of factors, including the input costs of the practice; the efficiency of the business operations—a point which Professor Hall has referred to—the level of demand and supply within the local marketplace, as evidenced by the close relationship between bulk-billing and the supply of doctors; the style of practice;

and, indeed, the personal views of the doctors on what is an acceptable fee for patients and what is an acceptable income for themselves and their partners in the practice. So I think that any notion of an appropriate or standard cost or fee is a somewhat spurious line of research to pursue.

Mr Ford—Some of the things we have not talked about today, but which are important, focus on the role of GPs. We have spent some time talking about primary health care more broadly but not about how that can work to improve the health of Aboriginal people and disadvantaged groups. I would urge the committee to explore that within its terms of reference if the opportunity arises. The other thing that I think is worth exploring, which again we have touched on today, is the touchy but really important issue of Commonwealth-state relations and cost shifting. We have explored issues around dental care and the relationship between bulk-billing and emergency demand, and I think those things are really important to explore as the committee goes around the country.

Mr Schneider—There are probably many things, but I have jotted down just two thoughts. One is that we seem to have accepted fee for service as being an inevitable part of the system. I wonder whether it would not be worth exploring some form of capitation, perhaps, as an option for those doctors who wish to provide cost-free services to their members without going through a fee-for-service system. Another issue which I touched on and think is still quite relevant is the perverse incentives which currently apply in the insurance market which act as an incentive to admit someone to hospital rather than treat them outside. That is an area which probably cannot be dealt with in the context of this legislation or this current inquiry but which I think would be a valuable thing for as to look at for the long-term future of the health fund industry.

The other one I think that is very important in terms of the gaps in knowledge is the unfortunate fact that most data, particularly in relation to public sector activity, is very out of date. Richard's organisation does a monumentally good job in providing that data and pulling it together. It is through no fault of his own that we have to wait for quite some time to see what the statistics are. That makes it very hard for policy makers or legislators to get a feel for what is happening in real time and therefore it makes it very difficult to adjust policy to what is actually happening today. All we can do is rely on almost ancient historical data. I know that 12 months to 18 months may not be bad, but it is still a bit risky to make a decision about what is going to happen tomorrow based on that. Even such things as the Australian Bureau of Statistics surveys on health are lacking in some of the detail that they might give, including the surveys they used to have in relation to the demographics. The committee might like to consider, as time goes by, recommending that that be resumed to provide all people concerned with more up-to-date information.

Prof. Sainsbury—In terms of what is not covered, we have touched on many things. I would like to endorse Greg's comments, in some ways, by encouraging the committee, when framing its report and response to the particular terms of reference, to think of health and its promotion—not just about illness and its care—and to consider all the people who provide services that protect and promote health and all the various elements of the service that fund it, and to examine to what extent the Commonwealth and the states could work together, better than they have in recent years, to focus on improving health and health care services. So remembering to see it in the big picture is the point I would like to make in terms of coverage.

On the subject of missing data, Professor Hall pointed out to me that maybe my comments about the NHMRC could be interpreted as me saying, 'It's all under control; don't you worry about it.' That really was not my intention at all. I feel very strongly, as Jane does, about the issue of health services research and priority-driven research. On the subject of missing data, you might consider writing to the NHMRC and asking what they are doing about funding health services research and priority driven research—what programs and plans they have in place to stimulate that and to address the issues in the longer term that we have now identified as a shortage of data to help us with policy making at the moment.

CHAIR—We may do that. Thank you.

Mr Goddard—One of the things that we have barely given more than a mention to today is the management of chronic illness in general practice and primary care. I have a personal experience of this. I was diagnosed with HIV about 15 years ago, so I have been living with chronic illness in general practice for that length of time. I have done a lot of policy work and I know a lot of good doctors in that area. Unless we are able to treat chronic illness adequately in general practice, we are not going to treat the people, because there are nothing like enough specialists to do that job. Just because a condition is complicated, like mine or hepatitis C or depression, does not mean that we can deal with more than a fraction of people with that condition outside general practice. It is much more cost-effective generally to do it in primary care than to do it in hospitals or to seek specialist care every time, yet the present funding models tend to penalise doctors who get involved in those areas. It is very difficult for a doctor to claim anything like the amount of time they actually spend with a patient with a chronic or complex condition. The Health Insurance Commission, they tell me, simply will not allow it because it falls too far outside the average. I agree with Dr Bain that the practice incentive road to dealing with that is not a bad idea in principle, but in practice it has a lot of holes in it. For one thing, there are an awful lot of patients and an awful lot of conditions that simply are not covered.

GPs who treat chronic illness are among the best people we have. But if a doctor in a particular practice can see only two, three or four patients an hour and cannot claim for that sort of time, that is a pretty substantial disincentive to get involved in that kind of treatment. We as a community, and sometimes as a health system, are demanding a level of expertise on top of what we demand from the average GP to treat those particular disease areas. In my own case, most states—certainly the larger states—demand continuing medical education, regular updates and standards. Exams have to be sat every year, for the GPs treating people with HIV to maintain their prescriber rights for the section 100 highly specialised drugs program drugs, and yet those people are given no financial incentive at all, no financial assistance, even in getting to the CME sessions. As a patient, that is not in my interest.

That is an extreme example, but we do and should demand more of a doctor treating a lot of patients with depression or one who has a semispecialisation in diabetes or a whole range of conditions, yet not only do we not recognise that but we actually penalise them. That seems to me to be worth looking at. Perhaps a simpler way of recognising and providing that incentive and the realistic return for the doctor would be to recognise longer consultations—something closer to the time they spend with a patient—rather than going down the practice incentive route.

CHAIR—Senator Forshaw has to leave; he has to catch a plane. We are now over time, so it would be good if we could keep our comments as discrete as possible.

Mr Gregory—This is an exciting opportunity for us to get things right, because—let us face it—for much of the last 30 years Medicare has not been on the political agenda. Now that both sides of politics are happy to talk about it, this is an opportunity for us to retain Medicare as a universal health insurance system and to improve it. The alliance for which I work is a rural group, but we acknowledge the outer metropolitan areas as being in severe need—we do not work for them but we are an organisation based on social justice and equity, so we are very happy to see what is happening there. It has been very gratifying today to hear many references to how rural areas are different and how rural and remote areas have needs.

I want to have two bob each way on bulk-billing. Do not forget, please, that bulk-billing rates in rural areas are very low. They are less than 50 per cent in many rural electorates, and at that level it means that they are actually impacting on the ability of people to get care. On the other hand, as I have already said a couple of times today, bulk-billing is only part of the question, because the real question is how to provide primary health care. In order to address access to a doctor, who is at the heart of primary health care, we need to do something about bulk-billing, and there are proposals around for a rural consultation item number which the committee will, no doubt, look at.

Also, we need to work on what John Deeble described as quite a separate set of issues—that is, those relating to the work force. We will not get bulk-billing rates up until we get the doctor work force situation sorted. As I have said two or three times already, I want to see Medicare changed so that it provides access to other primary health care professionals in all areas—in rural areas, because it is essential and because it is the only way we will have any access, and in urban areas, because it is a very good idea in terms of interventions and the efficaciousness of care.

My first second and third points are: maintain universal Medicare and continue to amend its shape—this is not new; enhanced primary care is a changing of the shape—so that it will soon accommodate other providers; and use opportunities like the health care agreement still being negotiated to connect and to leverage off each other the Commonwealth as between the states.

I acknowledge very briefly my friend and colleague Joan Lipscombe for helping to look after me today.

I end by listing a couple of gaps in knowledge. We in the alliance would love to know precisely what we mean by ‘a level of necessary health services’; how to ensure access when there are no or few doctors; and how we can better target health funds to those in need. We would love to know the distribution of total health costs by region and socioeconomic status. We would like to know more about what health services people in remote areas actually get and by what means they do so because, in the data sense, remote areas are doubly difficult because of small numbers and so on.

Ms Stratigos—I have four brief points, most of which have been raised. First, when looking at the supply aspects, which we have agreed are germane to levels of bulk-billing, we have mentioned fee-for-service in relation to the remuneration of general practitioners. Dr Bain and

Mr Goddard have referred to special incentive payments, which are the other component of remuneration. This needs to be fully explored, because it would seem to me that this might be another area of difference between urban and rural practice, which we have not had time to touch on today. I am no more courageous than anybody else when it comes to talking about the cost of a standard consultation, but we have agreed that we need to introduce a note of realism into the patient rebate for services and the opposite of missing data. In a while the Rural Doctors Association may have some research available, which may be able to illuminate this, and I hope that we can get it before the end of your inquiry.

We have talked about the way in which we may need to apply solutions differently in different environments. The rural consultation item numbers issue, which is the basis of our submission, is something that we have not had time to talk to today. I hope that when you are in regional Australia you will see that it gets an emphasis. The fourth thing that we have raised but have not had time to go into is different models of delivering GP services. Nobody thinks that any incentive is really going to make a significant increase to the rural medical work force in the short term—it cannot—so we have to look at different ways of delivering primary health care services led by GPs.

Dr Madden—The information system used in Australia has stood up fairly well today. The main issue is to analyse some of the data rather than try to collect more of it. There has not been any mention of the BEACH study of general practice activity, which is available to tell you what GPs do—the patients they see, the reasons for the encounters, what they do with patients and so on. Unfortunately, that survey does not include a question as to whether the particular consultation is bulk-billed. I could go into good reasons about why that is not there but there is still a lot of information about what GPs do.

I cannot let the day finish without commenting that there has not been any discussion about particular groups who do not necessarily have concession cards, particularly Aboriginal and Torres Strait Islander people. It is a practical issue and I know the department is aware of it but it is something that you need to explore.

I make a final plea. To go back to what Russell Schneider said, if there were one piece of data we would like, we would certainly like the states to provide quarterly aggregate data on what happens in their hospitals, simply counts of separations by public and private. We have had very little cooperation from them to date in getting what seems to be simple data that would go with the PHIAC data on insured patients to give a much more up-to-date view of what is going on in the hospital system. It should be easily done.

Prof. Hall—As I have to leave in about two minutes to catch a plane, I have a very strong incentive to be brief. I have four points. First of all, from what we have heard today, there is no justification for a target bulk-billing rate. There may be justification for 100 per cent bulk-billing, which is what the Canadians have adopted, but there is no justification or rationale for anything less than that.

The second point is that, if I were a member of the committee and I wanted some more data to help inform my deliberations, the most important data, which is potentially obtainable within the time frame, is information about who is being bulk-billed and for which encounters by socioeconomic status, where the changes have been in bulk-billing and how they have affected

different groups. That really means trying to push for more data at the individual level rather than trying to use proxy indicators such as geographic region.

My third point—again thinking as though I were in the committee's shoes—is where we go in terms of what this is likely to do to costs and utilisation in the system. The key issue here is whether GPs are income maximisers or target income achievers. There is conflicting evidence on this and I do not believe that it is resolvable. We will never have the depth of data that will allow us to resolve that issue, so I do not think it is worth wasting time on it. In policy terms, we know that if we have more doctors we have more services. If we have been successful in controlling costs, if we remove some of the checks and balances in the system—to some extent we have done that by restricting doctor numbers—what will that do to costs, utilisation and what sort of utilisation?

My fourth point is about the long-term consequences for other changes in the health care system. We have had a bit of talk this afternoon about what a health care system should look like. Nobody would design a health care system from scratch that looks like the one we have now. Mind you, they would not design it to look like any other health care system in the world, either. We are prisoners of our history and of what is politically feasible, and we have to think about where we want to go from here and how we can get there. One of the most important issues in that is the role that private insurance plays in the overall scheme of things. To see it only in terms of private hospitals or only in terms of gap payments is to miss the picture of where we want to take the health system more broadly, which will take a longer time.

CHAIR—I thank all of you for your contributions today. I think we have done a reasonably good job of canvassing what is a very complex and not easily explained expenditure of money that will deliver quality health services in Australia, and certainly that is the aim. We are very grateful for the time you have given us and for the thoughtfulness of your contributions. This is not the end of our relationship with you as individuals. Please do not hesitate to make further comments to us if you hear things from other parts of our inquiry, or if you want to make any further comments generally. I know that we will probably catch up with people from your organisations around the nation, if not with you. I look forward to continuing the discussion, so to speak.

Committee adjourned at 5.12 p.m.