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SELECT COMMITTEE ON MEDICARE

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SENATE

SELECT COMMITTEE ON MEDICARE

Tuesday, 26 August 2003

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

Senators in attendance: Senators Allison, 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.

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Committee met at 8.53 a.m.

FROST, Mr Brian Edward, Pensioner Group Representative, Public Hospitals, Health and Medicare Alliance of Queensland

SCHRADER, Dr Tracy, Member, Public Hospitals, Health and Medicare Alliance of Queensland (PHHAMAQ)

KENDELL, Mrs Kathryn, Coordinator, Health Consumers Network

HAWKSWORTH, Ms Gay, Secretary, Queensland Nurses Union

MOHLE, Ms Beth, Project Officer, Queensland Nurses Union

CHAIR—I declare open this hearing of the Senate Select Committee on Medicare and I welcome everyone here today. As you can see from our agenda it is very full. I am going to try to keep to time as much as possible today, so I request that the questions from our colleagues be as short as possible and the answers as succinct as you can make them without losing the import of what you need to say.

This hearing in Brisbane is the eighth of the committee's planned program of hearings around the country in relation to this important inquiry. Thus far, we have conducted an expert roundtable in Canberra as well as public hearings in Sydney, Newcastle, Melbourne, Perth, Adelaide, Hobart and, yesterday, in Bundaberg. I am sure that we will find today's discussions equally useful.

Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. The committee prefers all evidence to be heard in public but should you at any stage wish to give your evidence, part of your evidence, or answers to specific questions in private, please ask to do so and we will consider that request. Your submissions are before the committee, and I thank you sincerely for that. I invite you now to make a brief opening statement before we move to questions.

Mrs Kendell—I think it is fair to say that health consumers are concerned that valuable time and money is wasted putting out bushfires and reactively responding to crisis after crisis. This is how we view the government's proposals to fix bulk-billing. It will not achieve improvements and will make the system even more unmanageable. Earlier this month there was a proposal by 8,000 US doctors to abolish private health insurance and for-profit hospitals, transferring all Americans into an expanded and improved single-payer Medicare system. This is now also the official position of America's most prestigious worldwide distributed journal—the *Journal of the American Medical Association*. The contention is that the mix of private and public services in the US is costing some $200 billion, or 26 per cent of the health care dollar, in administrative costs alone.

In the US, health care became a lucrative commodity open to market forces. Americans now realise health care is not like other markets where competition can sometimes drive quality and lower costs. The forces that drive competition between health insurers are about avoiding unprofitable patients and shifting costs back to the patients and other payers. So why is the

government now considering solutions that invite and, in fact, pressure people to take out private health insurance to cover gaps in GP consultations? Does the government not realise the proposed $1 extra a week to insure the gap for all medical out-of-pocket out-of-hospital expenses will very quickly soar when doctors start charging blue-sky fees, knowing their patients' private insurance will pay for them? While the government is suggesting that gap cover will add only $52 annually to the current costs for private insurance, an American family of four pays as much as $US13,000 annually for this sort of coverage.

Over the last eight or nine years, millions upon millions of dollars have gone into the general practice evaluation program and divisions of general practice, where general practitioners receive benefits in addition to income from treating patients. These programs were driven by insiders pushing their own agendas. Perhaps the aims of these programs were wrong and perhaps some good was achieved, but overwhelmingly the opportunity through these programs to reform general practice as the cornerstone of effective primary care which has health promotion and illness prevention at its heart, has been lost.

The national summit in Canberra last week called for a complete reform and reorientation of Australia's health system. There was strong support for an independent national health reform commission. The government's proposals should be on hold until a national independent inquiry, looking into what the Australian community wants for the country's health system, what it is willing to fund and how best to achieve this, has produced an outcome. The community continues to be the forgotten stakeholder, disempowered and deliberately excluded from the health debate. Inward-looking power holders, politicians, insurers and provider groups control solutions. These power holders manage and manipulate information to protect and suit their own interests. There is a lack of open, honest and balanced information, and as a result there is massive public apathy and disillusionment.

The $21 million proposed for public education should be spent on citizens' dialogue; community values identification through deliberative polling; community involvement in the development of appropriate performance indicators for the health system; and citizens' juries or hypotheticals. The community could be an effective ally to all stakeholders. Lip-service and statements of principle about this have failed. Legislation is now required to lock the community in through appropriate structures and processes. This must commence with the Medicare principles. With the government's recent proposals, we are on the verge of losing these principles.

An example of just how cosmetic these principles are was cited in our submission, where the Mater Public Children's Hospital deliberately and cruelly chose to deny my own child medical care, which was required to overcome a very serious condition. That it happened was a tragedy for us and our child; that the health minister has repeatedly refused to investigate, stating that the hospital does not have to comply with Medicare principles, is a tragedy for everyone else, especially the children who must rely upon that hospital.

It is significant to note that the national health summit, attended by some of the smartest in health policy last week, gave recognition to this fact and agreed that a legislated national charter of consumer health rights is now required. We plead that, as one of the outcomes of this inquiry, there be a recommendation that no further changes that undermine the important Medicare

principles that we have are made until an inquiry determines what the community wants, what they are willing to pay for, and how they want to pay for it.

Ms Hawksworth—I appear with Beth Mohle from the Queensland Nurses Union. We are both registered nurses who share a great concern about the current direction of the Australian health system. I do not intend to revisit our written submission at this time, but I do want to highlight a couple of broad areas. Before outlining those areas, I wish to place on record that those concerns come from a different, but not inconsistent, perspective.

Our members, the nurses of Queensland, are important health service providers and they are also consumers of health services. They therefore have a dual stake in the issues that confront our health system. It is our view that nurses are a linchpin of the health system. They provide nursing care across all health settings, around the clock. As integral care providers in the health system, nurses have an invaluable contribution to make with regard to the formulation of health policy and patient advocacy. They can identify system problems and potential solutions. However, the current national shortage of nurses is impacting upon the delivery of health and aged care services in this country. Nurses' workloads have steadily increased in recent years and continue to do so as they struggle to match demand for services with supply of nursing personnel.

Nurses, as users of the health system, are increasingly reporting problems with the affordability of health care, as out-of-pocket expenses for consumers increase. For example, some of our members who have been injured at work and are awaiting workers compensation are reporting that they are unable to afford to pay for appropriate medical care or prescription costs. Delegates to our 2003 annual conference held at the end of July also overwhelmingly commented on the general issue of affordability of health care and called for a union campaign in defence of Medicare. For nurses, the defence of Medicare is an important equity and ethical issue. Value statement 3 of the code of ethics for nurses in Australia states:

Nurses promote and uphold the provision of quality nursing care for all people.

Our members are concerned that some of the current government's proposed changes to Medicare will undermine its fundamental integrity and will result in a three-tiered system with regard to bulk-billing. There will be differential treatment for those who are concession card holders, those with private health insurance and those in our community who are not concession card holders and who do not hold private health insurance.

In the time remaining, I will briefly outline some of those major issues of concern that are relevant to this inquiry. Firstly, there is the fundamental problem of the complexity of the agenda that your inquiry is examining and the time frame allocated for this inquiry. I can in no way do justice to the myriad of issues that must be considered by your inquiry in the time that I have available to me today. It is also our belief that your inquiry has an impossible task in this regard. That is why the QNU is calling for the establishment of an independent and inclusive vehicle that has the time and resources to properly consider all of the issues and engage the community in the debate on health needs and the expectations and the future of our health system.

The second point that I would like to make is that matters at the heart of the inquiry fundamentally deal with values. The nature of our health system defines us as a nation. Medicare

is more than a national universal health insurance system; it is a clear statement of values, founded on a commitment to a fair go for all in health care, where access to care is based on clinical need and not an ability to pay. Roy Romanow, who headed the recent Commission on the Future of Health Care in Canada, described the Canadian Medicare system as 'an expression of the double solidarity of Canadian citizens—solidarity between the rich and the poor, and solidarity between the sick and the well.' Our Medicare embodies a similar commitment to social cohesiveness, and we should not forget its importance in this regard.

It is important to remember that Medicare is also a core component of the social wage and has always been supported by the union movement. For example, the union movement, through the accord, agreed to a 2.6 per cent wage discount in 1984 to offset the effect on prices of the introduction of the Medicare levy. It is, therefore, an industrial issue for workers and their families and part of a compact between the government and the community.

The strong level of community support for Medicare is also an important issue for this inquiry to consider. We quoted some examples of polling on this issue in our submission. A news poll of 700 people commissioned by the ACTU and released in the last week highlighted that 71 per cent of the people polled would support an increase in the Medicare levy if this would ensure the continuation of bulk-billing. Another survey of 1,000 voters nationally found that 75 per cent of voters, including 69 per cent of coalition supporters, would prefer the government to spend money on services like hospitals and schools instead of tax cuts. The key here, of course, is ensuring that accountability mechanisms are in place to tie taxpayer funding to improving outcomes and access in areas such as health. We do not believe that taxes are a dirty word; they are a vehicle through which we ensure social cohesion.

Although there is a high level of community support for Medicare there is no doubt that there are problems in our health system that need to be addressed. We believe that our universal health system has served us well so far; it has certainly helped to contain costs and has delivered high quality care. However, there are problems with the system that must be addressed. Among those problems are, of course, the growth in out-of-pocket expenses for consumers, the timeliness of access to care, the precursors of interventions, the mismatch between supply and demand for services, the need for urgent and considerable improvement in health outcomes for Indigenous Australians, the lack of coordination of care, the lack of integration of health and aged care systems and our current system of health financing. Those problems are not insurmountable in our view, and our current Medicare system provides a solid foundation for reform. The QNU firmly believes that Australians want to see Medicare renovated but not demolished.

We wish to place on record our support for the communique for health reform released by the recently convened Australian health care summit of 2003. In particular, we support the statement of principles contained in the document. It is our view that this communiqué is an important document. It was a consensus view of over 250 leading consumers, doctors, nurses, allied health professionals and other health professionals, and that provides us with a clear way forward.

The QNU has called for a national independent commission of inquiry into the future of health and aged care in Australia. The Australian health care summit called for a national health reform council. Both vehicles aim to achieve the same objectives in our view. We based our call on the process of the Commission on the Future of Health Care in Canada that was completed at the end of 2002. The Australian and Canadian health systems share many similarities, but there are

also many differences. The Canadian inquiry was important in many respects. Commissioner Romanow made recommendations that were based on evidence and were value driven. This is a critically important point in our view—health care reform must be based on evidence and founded on values. In the Canadian review, the values were derived from a comprehensive community consultation process. Importantly, this community consultation process fulfils a number of purposes. It allowed the commission to ascertain the high level of support for universal health care in Canada. It also helped to identify problems in the current system and possible improvements. It also allowed the community to be informed about issues such as the cost of health care and the drivers for health care inflation and thus facilitated an informed debate about health care needs and expectations and how these are to be paid for.

If such a community consultation process can take place in Canada then it can certainly occur in Australia. We need a similar process here and one that goes beyond the Canadian government's brief and includes an examination of the future of health and aged care. This is particularly important given the ageing of the population. The QNU wishes to place on record that we oppose policy initiatives that will undermine the integrity, universality and ongoing viability of Medicare. We request that this committee ensure that there is no change made to Medicare until such time as a national independent inquiry into the future of health and aged care in Australia is established.

Finally, I wish to briefly address one aspect of the proposed amendments to Medicare—the incentives for GPs to employ practice nurses. While the QNU welcomes this specific reference in the package to nurses, given the important role that nurses play in our health system—and it is often overlooked—we make two comments on this particular proposal. Firstly, this is a subsidy provided to GPs to enable them to employ practice nurses and hence improve the efficiency and effectiveness of their practices. It is not a direct benefit to nurses as such. If, for example, the package included a subsidy in the form of funding to enable nurses to undertake refresher or re-entry courses that would enable them to take up employment in general practice it would be of direct benefit to nurses. As it stands, this initiative is a government funded subsidy to GPs to help them with their employment costs.

The other point that I would like to make on this issue is that the report of the National Review of Nursing Education predicts that 22,000 nurses will leave the work force over the next five years, and in the period 2001 to 2006 there will be 31,000 nursing vacancies in Australia, with almost three-quarters of those vacancies created by nurses leaving the profession. Given this, our question is: where are the practice nurses in GP surgeries going to come from? The QNU believes that practice nurses are a vital mechanism to improve coordination of care across the health continuum and they will provide clearly needed improvements in case management, especially for people with chronic diseases such as asthma and diabetes. However, there currently is no funded national strategy to address the existing and clearly worsening nursing shortage for the health and aged care systems. Without that overall strategy, creating opportunities for nurses in one sector will merely exacerbate shortages in other areas.

In conclusion, the QNU is an active member of the Public Hospitals, Health and Medicare Alliance of Queensland and supports that body's submission.

Dr Schrader—Good morning, and thank you for the opportunity to speak at this inquiry. I am representing PHHAMAQ. PHHAMAQ is a broad coalition of consumer groups, unions,

community organisations and health professional groups. I am the Doctors Reform Society representative on the alliance, and with me is Brian Frost, who is the Australian Pensioners and Superannuants League of Queensland representative of PHHAMAQ.

First off, I would like to comment on the composition and time allocated for groups speaking here today and at previous hearings. This committee's time has been heavily allocated to doctors' organisations. That the interests of doctors and powerful self-interest groups such as those within the private health industry take priority in health care discussions has been and remains a big problem. Community participation needs to be actively sought. This is a limitation of this Senate inquiry and its short time frame. Some members of the community and some community groups do not have the time or the resources that powerful lobby groups have to contribute to the process. This is one reason that we are calling for a broader, more comprehensive independent inquiry into health care policy, with the time and resources to actively engage the community.

I am a doctor myself, but I am not here to represent the interests of doctors; I am representing a group of organisations concerned with the Australian health system and universal health care delivery. We are all users of the health system. At some stage we will all need health care. Our own health and the health of others affect us all. This is why, under Medicare, health care is treated as a community responsibility rather than an individual user-pays system. It is something that unites us all. Everyone in this room would have a Medicare card. I know my Medicare card is always with me. This is the issue: Medicare belongs to all Australians, not just to health care providers or health care institutions. They are participants, but they should not dictate health care policy. Powerful interest groups should not hold sway over the interests of all Australians. Meaningful community participation is imperative.

We need to develop Medicare so it responds to the needs and wants of the Australian community. We believe health care is a public good and a community responsibility. We oppose the user-pays ideology and uphold the universal principle of health care according to need rather than just the ability to pay. This is best achieved through tax funded financing rather than private health insurance and user fees such as copayments.

Before finishing, I would like to make some specific comments on copayments, because there is a lot of misinformation about them. A lot of well-documented research has been done over many years in Europe, the USA, Canada and developing countries, and that research shows that health care copayments restrict access and place a heavier burden of cost on the less well-off and sick, without improving efficiency. Copayments disadvantage the less well-off and sick and benefit the wealthy and private health care providers, regardless of safety nets, tiered payments or other measures. The evidence is there.

Copayments are not a useful method of restraining excessive demand for health services. They do not diminish so-called frivolous or unnecessary visits. Research confirms that copayments affect access into the system with an equal negative effect on both so-called necessary and unnecessary services. The patient is generally not in a suitable position to judge what is a necessary visit. This can deter the use of appropriate health services and adversely affect health outcomes. In contrast, copayments improve access and increase use of services for upper income groups by deterring those with lower incomes. For people with the necessary resources, any form of partial out-of-pocket payment within a predominantly tax financed system allows the purchase of preferred access to a service primarily paid from the taxes of others. Introducing or

increasing user charges results in a redistribution of services away from those on low incomes towards the well off. Again, the evidence is there. We are already seeing this in Australia. For instance, there are now medical centres that have introduced a form of tiered payments, with better availability of appointments for so-called full fee paying patients—or the practice of giving appointments to paying patients, with non-paying patients having to wait. I would like to also submit a paper on copayments that has all the references in relation to this.

CHAIR—Thank you.

Dr Schrader—In conclusion, rather than allowing governments to enact piecemeal so-called reform, hacking away at the core of universality, it is essential that the health system in its entirety is examined, with active community participation. PHHAMAQ is calling for a comprehensive independent national commission of inquiry into health care in Australia. We need to examine underlying values, long-term goals and strategies to develop a national health plan for the provision of health care on an equitable and cost-effective basis. Finally, people want a universal health system. The Australian people like and want Medicare as it was originally envisaged. We want to be able to see a doctor without checking our wallets first. We do not want to have to worry about the cost and whether our health insurance is up-to-date and will cover what we need when illness strikes or when seeking routine health care. This costs money, but paying for it through our taxes is both cheaper and fairer than user-pays schemes. I would also like to mention that we have been collecting a petition—we have over 10,000 signatures—and that we are collecting stories and would like to give them to the inquiry as well.

CHAIR—In terms of the petition, are you presenting it to the inquiry today?

Dr Schrader—No, I will at a later date.

CHAIR—Thank you. In terms of the stories, we will receive those as supplementary submissions when you want to make them available to the committee. First of all, can I go to the question of community participation. I think that all witnesses here have made that comment strongly and the question of community participation has been raised by a range of other people as well. The Canadian model has been brought to our attention, and I thank you for talking to us about that as well. As you said, Dr Schrader, every single one of us carries around that green and gold card, but it is difficult to know how we organise and develop informed community participation in the discussion about health care—Mrs Kendell, you listed off a whole range of strategies. I am aware that some state governments have attempted to establish consumer networks or consumer organisations. Do any of you have a view about the effectiveness of a government—a state government, for instance or local government; local government in Victoria has done similar work, in fact—encouraging community information and then active participation and discussion?

Mrs Kendell—Several years ago, Health Consumers Network put in a submission for funding a consumer health advocacy. The government formed a steering committee, and I sat on that. We established a consumer health advocacy that was supposed to be funded for $2 million over four years. We established very clear objectives at the time, but unfortunately when you are funded by the government your ability to speak independently is extremely limited. The government would not put a grievance procedure within the service agreement for a decision to defund us, and therefore we had no protection. We were actually told that if we published any material

without running it by the government first we could be defunded. Certainly, we were defunded soon after the change of government—within three months of the coalition getting in. We know that there was very strong lobbying by the Australian Medical Association, who stated that there was a Health Rights Commission in this state and no need for a consumer body like ours.

We had actually started to make significant improvements. We had established a body of consumer representatives. We were training those consumer representatives, and we were holding workshops within the community. On one occasion we conducted a phone poll, which was widely advertised, and we received over 500 phone calls in a single 12-hour day of feedback from around Queensland. Normal, average, everyday consumers told us what they thought of the health system. It was that document that the government said we could not publish unless they approved it. It was immediately after that that we were defunded, without notice.

CHAIR—Was that the state government or the Commonwealth government?

Mrs Kendell—That was the state government.

CHAIR—At what time? What year are we talking about?

Mrs Kendell—I think we were defunded about four years ago now.

CHAIR—That just adds to the story of the need for there to be active participation from the consumer side.

Ms Mohle—There have been consultation processes undertaken by a number of state governments in recent years. In Queensland it was the Health 2020 strategy. It was a very important and worthwhile process to be involved in, but the difficulty is—and this is why we are calling for a national inquiry—that health issues cross state borders. There is a need for a consistent approach to this and a consistent approach to consumer input into this, so there is a great need for improvement in this area, in our opinion.

CHAIR—I appreciate you bringing that matter to the attention of the inquiry.

Senator HUMPHRIES—Mrs Kendell, in your opening remarks you made a comment about the danger that the gap insurance proposals in the government's package could lead to doctors engaging in what you called blue-sky charging of their patients.

Mrs Kendell—Yes.

Senator HUMPHRIES—So you see a danger there that, when doctors know their patients are privately insured, they will simply begin to charge higher and higher fees, reflecting that fact. You would be aware that the proposals are for the gap insurance to apply after $1,000 worth of out-of-pocket expenses have been incurred by a patient. Do you think it is likely that doctors would know when their patients were nearing that level and, therefore, know when to begin increasing their fees?

Mrs Kendell—I do not think it matters whether they know or not. There will be an attitude change that will come eventually—quickly—within the medical profession. Doctors are already

feeling that they are the poor cousins of specialists. I am aware of specialists charging $800 for a single consultation when Medicare for that consultation only pays $100. There is enough evidence, especially from America, that once there is the mentality that they can raise their fees without any barrier, that will happen. We sit here today thinking, 'Oh, it could never happen,' but the evidence in America—but also here—shows very strongly that many health professionals feel quite entitled to charge whatever they want. When you get a group of them charging really high fees, you will see other ones looking to them and thinking, 'I'm not making enough. I'll raise my fees.'

My husband has a cyst that keeps returning. About six years ago it cost him nothing to have it treated—it was bulk-billed. About four years ago it cost him $60. About three years ago it cost him $160. This year they wanted $1,000. In that short period that increase in cost has occurred. Each time he has exactly the same operation to remove the same cyst. I do not understand why the costs have increased so much.

Senator HUMPHRIES—But even before these changes to Medicare have been made these costs have been increasing. Isn't it possible that increases of that kind are a product of specialists becoming more expensive rather than of these changes to Medicare.

Mrs Kendell—No, I do not think that you should do things to make it easier for those things to happen. Knowing that these sorts things will happen means that you have a responsibility to put barriers in place to prevent them from happening.

Senator HUMPHRIES—The Queensland government submission before us today argues that there are not going to be many beneficiaries of that $1,000 gap insurance arrangement, because people will need to go to doctors quite a few times in a given year before they reach the $1,000. Assuming that is the case—I am not sure that it is—it will mean that the vast majority of people hit by the higher fees you say doctors will begin to charge will have no way of recovering those fees. The gap insurance arrangements will not help them in those circumstances. You will have transparency arrangements in the new package—that is, people will be able to pay at the doctors' surgeries for the gap between the scheduled fee and the doctors' fees. With that transparency and with the lack of capacity to go back to insurance, won't people begin to jack up when they see doctors increasing their fees in that way?

Mrs Kendell—People are jacking up now. It doesn't make any difference. Also, as I understand the publications about this gap insurance, it will cover all services—the rebate level to whatever the doctor charges and also diagnostic tests. I think that $1,000 will be reached very quickly. In my own family we do not actually have huge, chronic illness situations, but we have spent $7,000 in the last two years on medical needs. To get a CAT scan to look at a sinus infection, you have to pay $200, in addition to what Medicare pays. I had to have an MRI this year, and the charge for a brain MRI in the private system, after Medicare pays, is $500. That $1,000 will be reached very quickly, in my opinion, given the way I understand that it is going to be set up, which is that it will include all out of hospital Medicare gaps.

Senator HUMPHRIES—All right. If you do not think we should have a gap insurance arrangement, because that will, as you say, encourage doctors to charge more—even if the gap is not actually reached by a lot of the patients—and if you believe that the amounts being charged

by specialists are too great, you would presumably then argue for an increase in the general Medicare rebate to doctors?

Mrs Kendell—Yes, I would.

Senator HUMPHRIES—I think you have also said you are in favour of not having the 30 per cent private health insurance rebate remain in place; you would prefer to transfer that to the public system?

Mrs Kendell—We took out private insurance because of what happened in my son's case: the hospital told me to go back to my own country, even though I had lived here for 20 years. I became very frightened, because there is a standing threat by the hospital that if we ever return with our child they will send us out. So we have taken out private health insurance. I hate the fact that I have taken out private health insurance. I do not believe that it benefits us at all. I would rather see a system with proper controls in place—a public system that I can afford through my taxes and rely upon.

Senator HUMPHRIES—This question is to everyone on the panel. Assuming there are extra costs associated with the measures that you have suggested, such as increasing the rebate and so on, do you support measures like an increase in the Medicare levy in order to pay for that?

Mrs Kendell—Yes, I do.

Ms Mohle—Certainly, the polling by the ACTU that Ms Hawksworth referred to this morning shows that the community would support that, as long as there were accountability mechanisms there. That is exactly the reason why we want to have a broader dialogue about this. Certainly research undertaken by the ANU earlier this year attests to that as well—as long as there are accountability mechanisms and the increased taxes are tied to the provision of essential services such as health. I can, if you like, provide the committee with the ANU research that particularly mentioned Medicare. Certainly, from the evidence that is available to us, we think that would be supported. But we want to make sure that that is the case, by commissioning an independent inquiry on that and having a debate. That sort of broad ranging discussion informs the community as well. You can actually have a dialogue about what things cost and about how, if you do something, something else cannot get done. So, as well as being a discussion about values, it has an educative focus. That is our position with regard to the rebate.

Dr Schrader—Raising the Medicare levy is one possibility. But through the private health insurance 30 per cent rebate there is a lot of money there already, without taxes needing to be raised.

Senator STEPHENS—Ms Mohle, in your submission you talked about the need for a national strategy to address nurse shortages. What do you think could be in that strategy and why do you think it is important to have a national strategy rather than a state based strategy? I ask that because I am also participating in the Senate inquiry into skill shortages and future skills needs, and arguments regarding the issue of nurses have been very strongly placed there. Can you just elaborate on your concerns for a national strategy to address this issue?

Ms Mohle—Certainly. The QNU gave a submission on the national skill mix to that inquiry as well. Basically, the state governments in various forms—in Victoria, New South Wales and Queensland—have all had their own recruitment retention task force or their equivalent processes and they have been able to go so far in terms of the strategies they have been able to implement through those. There have been some improvements in Queensland because of our local recruitment retention task force, but it is a national problem and, by solving problems in one state, you create problems in another area. We noticed a big drift to Victoria, for example, when they implemented a lot of strategies down there that went beyond the strategies that had been implemented in Queensland.

There are also federal issues involved here. In the past there was federal funding for refresh and re-entry programs for nurses. Those are no longer funded by the federal government. We think there is a need to re-implement that. It is a national issue. Other countries have actually acknowledged it as a national crisis that requires attention. The US government certainly has. We think there is a dire need to focus attention on the issue so that there is a coordinated response from the state and territory governments.

Ms Hawksworth—Aged care, of course, is a national issue and funded by the federal government. That is an area of great concern—particularly at the moment. With all of that, it is impossible for the states to just deal with it in an isolated way, which is why it does really need a national approach.

Senator STEPHENS—The other part of my question was: what might actually be part of the strategy? I cannot remember whether or not in your submission to the skills inquiry you made some suggestions about how it could be addressed at a national level.

Ms Mohle—We made a detailed submission. Basically, we addressed the terms of reference of that inquiry but also gave our submission to the nursing inquiry. There was a wide range of recommendations with regard to strategy. I think there are over 60 recommendations that we would make in terms of how the issue can be improved.

Ms Hawksworth—One of the points we want to make is that there are many nurses not working in the system—still registered but not working in the system. Part of the strategy is to get those nurses back into the work force. We mentioned with the practice nurses that without that strategy of re-entry and refresher courses in the package that the coalition government is suggesting we are just going to pull nurses from other areas into that area. If part of the strategy were re-entry and refresher courses specifically for entry into the practice nurse area, it would not take from hospitals or aged care or other areas of dire need. Again, that is why there needs to be a national strategy.

Senator STEPHENS—Thank you very much.

Senator LEES—I have just a general question to any or all of you. You have all in various ways criticised parts of the package. Looking at it as a whole, should it be rejected now in its entirety?

Mrs Kendell—Yes.

Dr Schrader—Our view is that it is piecemeal and, yes, we need to have a—

Senator LEES—There is no part that is worth salvaging?

Mrs Kendell—There is a commitment to have more spaces available for medical students and nursing positions. We support those proposals because they help to address the shortage, but that is the extent to which we see anything worth keeping.

Senator LEES—So, if we reject the package in the coming months when it comes before the Senate, what do you predict will be the likely response of doctors and of patients generally and what will be the potential pressures on the public hospital system? Can I have some general comments about what you believe will be the outcome if the package is rejected in the Senate this year?

Ms Mohle—I guess it would be best to ask the doctors' groups that are going to appear later in the day about the reaction of doctors to rejection of the package. I think there was a recommendation out of the national health summit, for example, that the Australian health care agreement be renegotiated for another year to buy some breathing space to give proper consideration to it. I think that is what should be done. As people who have worked in the health policy area for a long time, we are incredibly frustrated by the piecemeal approach to health policy. We know that health is a very political area and that it is very loaded and quite difficult. Even the Commonwealth Minister for Health and Ageing herself has said that her package is not what she would have initially wanted. It was reported earlier this month that when she was addressing GPs in Perth she said that it was not the package she would have wanted. But political realities have demanded that there be certain concessions given to get it through the Senate and the like.

I think the time has come that we take a step back. Our health system is too important. It takes up too much of our GDP. It is a very expensive portfolio area to run. It is very important, as we have all said, for social cohesion. It is about the values that underpin our society—we feel that very strongly. We think that the time really has come to take some time out to have a comprehensive look at this. We think it will be time well spent, given that health costs are potentially going to increase significantly with the ageing of the population and given the technological drivers for health increases as well. That would be our response: we think that the health summit's recommendation that we have a year-long extension to the health care agreement is a good one.

Mrs Kendell—I just want to add that I have been working a stall to collect signatures. We have no problem with getting people to walk up to the stall and sign in support of Medicare. I would have spoken to at least 500 individuals during my time on this stall. I can tell you that there would not be a single person that I spoke to who felt that there was not a pressing need to address problems in the health system. I spoke to many people who said that they would be absolutely lost if Medicare disappeared or if their health care became more expensive.

It is difficult to get a lot of public participation when you hold big forums, because the public generally feel that the medical professionals control the debate and a lot of education and training needs to happen nationally within the community to encourage people to realise that they actually do have a voice in what happens in our health system. I think that historically over

the years this has been ingrained out of them. We need to do a lot of work to get people back into feeling that they can participate in this debate.

Dr Schrader—I would like to endorse what Beth said and say that the rebate for GPs, the way doctors are paid and the fee-for-service system are all things that have to be examined at some stage.

Senator ALLISON—I wonder if I can get a consumer perspective on bulk-billing. This committee has had contradictory advice and submissions about whether or not the quality of primary health is being compromised by bulk-billing's imperatives to get consultations over within eight minutes or 10 minutes. Do you receive any complaints from members about the haste with which doctors see patients and is there any evidence from your perspective of overservicing—that is, the doctor says to a patient, 'Come back tomorrow when we have the results and we can talk about them then'? Perhaps you can give the committee the benefit of your experience there.

Mrs Kendell—I can tell you that the general comment, the overwhelming comment, is that people do not get enough time with their general practitioners. Mistakes are being made. People end up in greater, harsher predicaments by ending up at the hospital because matters were not properly addressed by the GP in the beginning. General practice should be the cornerstone of our primary health care system. We do not have a primary health care system when GPs limit their time to six to eight minutes in a consultation.

Ms Mohle—I think that is the reason why initiatives such as the increased number of practice nurses and allied health professionals in general practice is an area that definitely needs to be addressed. There is basically very little case management and case coordination that goes on. The practice nurse positions that have been put in place in a number of general practices are beginning to do that. That is an essential issue that needs to be addressed. There needs to be a coordination of care across practice settings and a focus on primary health care rather than on curing people once they get into the acute care system. We can only stress again that there is a need for a far-reaching look at this whole issue and at new solutions. We will continue to get the same old answers to problems if we keep on asking the same people, and that is why we think we have to widen the debate on this issue.

Senator ALLISON—Leaving aside the work force questions for a moment—I know we cannot do that, but hypothetically speaking—it has also been said to us that doctors' efficiency and their capacity to bulk-bill under the current arrangement is enhanced by practice nurses, because they can take much of the pressure off the doctors. It has also been said that there needs to be a specialised training program for nurses who take on that role. Firstly, does the Nursing Federation support specific training for practice nurses; and, secondly, do you see that there is a need for an expansion of the practice nurse program to include all GPs everywhere?

Ms Hawksworth—In terms of the training, we do support that, in that the role of the practice nurse is an expanded role in some ways and there does need to be specific training for that. We have just recently profiled a practice nurse in our journal, and she also spoke at our annual conference. I have a copy of that. She believes that training is absolutely necessary. So that is coming from a QNU member who is a practice nurse in Rockhampton. We will leave a copy of that article with you.

CHAIR—Thank you.

Ms Hawksworth—What was the other part of the question?

Senator ALLISON—Do you believe that a part of the answer to the drop in bulk-billing is to have more practice nurses across the board and not just in those areas where there are doctor shortages?

Ms Hawksworth—We certainly see that as the answer where it is relevant. It may not be possible in every GP surgery, but certainly in the larger ones we would see it as extremely beneficial. We believe that nurses certainly undertake a major primary health care role. Certainly in those areas that I talked about—diabetes, asthma and so forth—the role of the nurse would be quite significant in primary health care and extremely beneficial both to the patients and to the GP practice, the doctor.

Senator ALLISON—I have a question about allied health. Your submissions talked particularly about dental health as being critical. Again we have had conflicting views put to the committee on dental health, with one suggesting that it ought to remain a state matter and that a strong public dental health service should be available, but not under Medicare. Would anyone care to give the committee a prioritised list of the sorts of allied health services that ought to be included under Medicare, if we accept that not all of them can be afforded?

Ms Mohle—The APSL and the DRS have some views with regard to some of these issues, but from our perspective the main ones are definitely dental care, podiatry, physiotherapy and, of course, nursing services. They are the ones that are glaringly obvious.

Dr Schrader—As we are saying this to an inquiry, I do not feel in a position to put a rank order. But the dental example is one that we face every day. As a GP you are giving stopgap treatment for people who cannot get dental care, so you are prescribing antibiotics and painkillers.

Senator ALLISON—I think we all accept that there is a great need for more funding for dental services, but, although I do not have the figures in front of me, if you look at the cost of including all dental services under Medicare, you are talking about a very large sum of money indeed—whether or not that dollar could be better spent on other services. The question is: do we keep the current system, fund it better and keep it as a public dental health service for those people on low incomes under the state umbrella or do we include it under Medicare?

Dr Schrader—Again, this is something that needs to be gone into in a lot more depth in a broader inquiry.

Ms Mohle—And the response to that has to be based on evidence. Those questions in relation to the privatisation of health care services are really quite complex.

Mrs Kendell—I just want to add that dentists charge far too much. I sat on the dental board of Queensland for four years. I have some real concerns about how they got into that position—being able to charge such extreme fees—in the first place. There is a real shortage of spaces in the dental schools. Young kids who want to be dentists do not have a hope because there are 25

places for 2,000 people who apply. It is ridiculous that we have so few dentists. It is a shame that they were ever allowed to start charging the fees that they do charge. That is what is going to make it so expensive to have dental care covered by Medicare. If there were a way—and I do not know if this is nonsensical or not—to open up dental school places for young people who wanted to be dentists and were willing to work in the public system for five or six years, you would definitely get students willing to go through that.

Senator FORSHAW—I have a question for the nurses. We have had evidence from various state governments—and I note that the Queensland government is to follow—that there has been a substantial impact on the services provided at emergency and accident services at hospitals as more and more people attend for very minor ailments that they could probably see their GPs about. According to that evidence, this is the result of a decline in bulk-billing and an increase in costs. We have also heard some people argue that this has not happened at all—a GP told us that yesterday, although I find it hard to see how a GP in private practice would necessarily know. What is the experience of your members—nurses—who are very often seeing them first and spending a lot of time with the people waiting around in emergency and accident centres?

Ms Hawksworth—Recently—in the last few weeks—we had a meeting of emergency department nurses from all the major emergency departments in Brisbane. The meeting was particularly about their workloads. There has certainly been an increase in that type of patient. But they are also reporting patients sitting in chairs who really need to be lying down in beds and patients who have drips sitting in chairs and that sort of thing. Certainly from our members' point of view there has been an increase. For example, a nurse told me that she had the flu at the weekend. She is also an asthmatic. By Sunday afternoon she knew that she needed antibiotics. She rang the local medical centres in her area and none was open; they had all closed by four o'clock on a Sunday. So she rang the after hours medical service and it was going to cost $220 to see a doctor on Sunday. She ended up having to go to the public hospital to get the antibiotics. As a nurse, she knew that she could not wait until tomorrow to get the antibiotics, because she had a chest infection and was an asthmatic. That is just one example—she told me that yesterday.

Senator FORSHAW—Dr Schrader, I would like to make a final comment in relation to your opening comments. I take your point that this is a huge issue and that one would always like more time. You have suggested a broad-ranging inquiry. This committee is operating under certain constraints, in that there is legislation that we have to consider. But I want to assure you that, at the public hearings we have had and in the submissions we have received, many groups, including unions, academics, councils of social service and consumers—a whole range of groups—have put a community perspective to us. It has not been dominated in any way by the medical profession, though they certainly have a right to appear before the committee, and an interest in doing so. I wanted to put that on the record to allay any concerns you might have.

CHAIR—In closing, I would like to thank the representatives of PHHAMAQ, the Health Consumers Network and the Queensland Nurses Union for your contributions today. If you have any further information that you would like to make available to the committee, please do not hesitate to contact the secretariat.

Ms Mohle—I will table the journal about practice nurses and also the research from ANU. Do you have a copy of the final Canadian report?

CHAIR—Ms Mohle, thank you. We do have a copy of that. I agree that it is a very important document. Dr Schrader, you also had a supplementary document you wanted to table?

Dr Schrader—I would like to table the communiqué that came out of the national health summit.

CHAIR—Dr Schrader, thank you. We also have a copy of that, but I accept that you would like to table it formally. Thank you all again for your contribution.

[9.57 a.m.]

CLEARY, Associate Professor Michael, Executive Director of Medical Services, Prince Charles Hospital, Queensland Health

DEETH, Ms Norelle, Deputy Director General, Policy and Outcomes, Queensland Health

EDMOND, Ms Wendy, Minister for Health, Queensland Government

OLLEY, Associate Professor, Richard Murray, District Manager, Royal Brisbane and Women's Hospital

CHAIR—I welcome representatives of the Queensland government. Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. The committee prefers all evidence to be given in public, but should you at any stage wish to give your evidence, part of your evidence or answers to specific questions in private, please ask and we will consider your request. Finally, for those of you who are state government officers, I point out that you will not be expected to answer questions which invite you to express a personal opinion on matters of policy and that you will be given reasonable time to refer questions to your superior officers or your minister. Your submission is before the committee, and I thank you for that. I now invite you to make a brief opening statement before we move to questions.

Ms Edmond—Firstly, I thank the Senate inquiry for giving us this opportunity. As a long-term health professional and Minister for Health for the last five and a bit years, I have a passion about health care. I have worked in many other countries as well as Australia and, from my experience, know that what we have is an excellent health system, and I think we are committed to keeping it that way. These are important matters to be before the public. For that reason, I thank you for having this inquiry in public in Brisbane.

The comments I am going to make to start off with will be supported by slides. This is really a quick overview to show why we believe there is a concern about health care and the provision of health care in Australia. These concerns are not new. I actually expressed many of these concerns in the lead-up to the signing of the last Medicare agreement when I was in opposition. The health care agreement in 1998 was signed about a month after I became minister, but I am well aware of the debate that led into that.

I am also well aware that at that time the Commonwealth said that once we had signed we could work out the program of reforms. That has not happened, and, facing the imminent signing of a health care agreement, we again find ourselves with the invitation to sign now and reform later. I have my concerns that those reforms will still not take place in the next five years, and I do not think we can continue to provide health services in the way we are and in a sustainable way into the future, with an increasing ageing population and the increasing expectations that are being placed upon health systems.

Category 4 and 5 presentations at emergency departments have increased unsustainably over the last few years, with a rise of 11.6 per cent over the four years to June 2003. Over that time we have seen bulk-billing rates decline quite dramatically, with a seven per cent decline in the three years to June 2002. We have a slide which clearly illustrates that. We have it in hard copy for the Senate inquiry; we will give you a copy of the slides, although we have a technical hitch with showing some of the slides today. The first slide shows a clear correlation between the decline in bulk-billing and the increase in presentations at emergency departments, which is totally irrefutable. I have heard some comments about other causes for that, but we have shown statistically, quite clearly, that that is the case. During this time we have also seen increasing out-of-pocket costs. Copayments in Queensland have increased by 21 per cent in the three years to March 2003.

I guess every state argues this, but we believe that Queensland is particularly disadvantaged for a whole range of reasons. We have lower MBS and PBS benefits than the national average—and again we have this detailed in data. It is rather hard to illustrate this without images. We also have, I think, one of the lowest rates of private health insurance in Australia. That has traditionally been the case and it is still the case, and we are seeing it declining at the moment. On top of that we have the highest rate of front-end deductibles, which means that most people go in to get the cheapest private health insurance they can, with the intention that they will never use it. In fact, we have shown statistically that people joined private health insurance not because of the rebate in the system but because of the penalties involved with higher taxation levels et cetera and the lifetime cover. As a result many of them took front-end deductibles and still use our public health system totally; they do not use their private health cover.

That is particularly the case in large rural areas. Perhaps the most anger I have received about private health insurance has been from rural areas where there is no access to private health facilities. The only access to health facilities is in the public sector, with our rural hospitals or GPs, so they are being forced in many instances—or they believe they are being forced—into taking out private health cover or paying higher tax penalties et cetera when they do not really have any option of using private health cover. So the anger about being forced into that situation has been expressed to me most vocally in rural sectors and semi-rural sectors. As you would be aware, Queensland probably has more people living outside the major metropolitan areas than any other state.

The high proportion of lower-income families in Queensland also impacts on the take-up and usage of private health cover. We show in the slides the percentage of lower-income families who are earning less than $26,000. Queensland has 25.3 per cent who are earning in that category, compared to an Australian average of 23.7 per cent. Again, many of those are outside the metropolitan areas. If we go back to the issue of private health insurance, Queensland currently has 62.4 per cent of front-end deductibles compared to an average of 59.2 per cent across Australia. Also, 40.8 per cent of the population are now privately insured—and that has been declining steadily over the last few years—compared to 43.4 per cent nationally.

Our PBS, as you see from the graphs, equates to an underfund of $37.8 million in terms of average PBS payments across Australia. That is significant in Queensland health terms. I could certainly, as a health minister, do quite a lot with $37.8 million, as I could with the MBS payments. If we received the average, we would get an extra $71.8 million—and again there are

many areas of Queensland that could benefit. We could put extra health services in with that amount of funding.

Our high Indigenous population is also something that impacts on our health service delivery. Queensland has 26 per cent of the ATSI population in Australia, yet we receive 14 per cent of targeted ATSI health funding. Most of our ATSI population, as Senator McLucas would well know, is in remote areas. So the cost of providing those services is particularly high when we are dealing with communities up in the remote areas of Cape York and the Torres Strait Islands and in other places such as Doomadgee, Mornington et cetera. The cost of providing services in those areas is extensive. There are no private GPs in those areas. We do have an arrangement in Cape York where we have a contract with the Royal Flying Doctor Service to provide GP visits to some areas. That is done in cooperation with the Commonwealth. Through cashing out some of the Medicare payments, some of those doctors are allowed to have limited GP Medicare claims.

Probably one of the biggest things we have seen in recent times has been the decline in GPs providing after-hours services. That has been for a whole range of reasons. I think one of the factors is social, and I think there is also a safety issue for some people. Sole practitioners are reluctant to provide services on their own after hours—particularly home visits. I think it has also been about the change to a greater feminisation of the GP work force. Certainly, we have seen a major drop. One of the things that repeatedly comes out is that it is just uneconomical to provide services after hours.

Of course, we have a quite artificially reduced number of GPs in the system. There has been a deliberate effort in the last few years to reduce the number of GPs by bringing in very strict trainee numbers, well below those that were anticipated at the time as being needed just for replacement. I believe this has really caused a fairly artificial shortage of GPs who are trained and qualified and have provider numbers in the system. There has been some relaxation of those rules in areas of need and in remote areas. I introduced a Doctors for the Bush program where overseas trained doctors working in remote areas would, with the agreement of the Commonwealth minister, be able to apply for general provider numbers after spending five years in a remote area and meeting their training qualifications or the equivalent.

Certainly, the number of GPs coming into the system has not kept pace with the growing populations. We see that in the surrounds of the city in particular. The outer city areas are the fastest growing areas in Australia, and there is a significant shortfall of GPs moving into areas such as the corridor running from Brisbane to the Gold Coast and the corridor north and the corridor west. We have had 40,000 people coming in over a few years to places in and around the Caboolture area, and there have not been GPs moving into those areas.

I acknowledge that there have been some arrangements at the Commonwealth level where they have put in benefits for those people. But it has been interesting to see that a number of those will actually benefit middle city areas rather than the city fringe areas where we have the most incredible shortfall. The other problem is that in these areas there are a lot of lower-income people who are working but are struggling to get by—they are not in highly skilled jobs et cetera, and they really rely on having GPs who bulk-bill or address their needs or recognise that they will not be able to meet the full copayment if they have a number of sick children.

It is interesting to note that one of the federal members on the north side has called for a hospital in his area as a solution to the shortage of GPs. He has put out a statement saying the shortage of GPs means that the state should build a hospital. That is a very inefficient use of hospital resources. It is probably a very expensive way of providing GP services and it is not one that I would support. I believe our health dollars are very precious and we should get the most benefit out of them by ensuring that we plan well and make sure that hospitals provide services that hospitals should provide rather than GP services. But I share his concern about the lack of GPs prepared to work in those areas and the lack of incentives for them to work in those areas.

One of the benefits—or drawbacks—of working around the world in health is that I have worked in the US and in countries such as Denmark and the UK. My experience in the US made me determined that I would never support a system that would lead to a situation where you have patients saying they cannot afford to have treatment to save their lives or their children's lives or where they have to sell their houses to pay for their children's treatment. Working in a cancer treatment area made me particularly vulnerable to that. You were asked if you could guarantee that somebody would be cured, because they were selling their house to pay for the treatment. In cancer treatment you cannot give that guarantee; it is impossible. I hope never to work for or belong to a health system like that in Australia. I am very committed to that.

Those are my concerns at the moment. I see increasing pressure on people to take individual responsibility for their health care rather than having care provided to meet their needs. It is based on whether they have the best health insurance and they can afford the extra payments. I do not want to see Australia go down that path. I am concerned that we are seeing an ideologically driven pressure to move more and more into the privatisation of health services and health service delivery. It is all very well to talk about safety nets and the provision of public hospital care for those who really need it. We all pay taxes, and then people start objecting to paying for a safety net system at the same time as they are paying large amounts for private health insurance and, on top of that, copayments. So cuts happen in those areas that general taxes go towards. That is what happens in the United States. People object to increasing public health care and improving the quality of it for those who are left behind. I have major concerns that that is the direction we are clearly taking in Australia.

The proposed changes to Medicare, I believe, will aggravate the current trends. I say that because I do not see them addressing the real need—the shortage of GPs. While I welcome the increasing number of medical student places—these were places that were identified by a report to health ministers several years ago as being necessary, to provide resources in the public sector to meet the growing numbers of people in the community—they are not over and above that. I am concerned at the way they are restricted and those restrictions will mean that few of those people will take their place in the public system—particularly full fee paying medical students who are unlikely to feel that they can pay back large amounts of debt by working in the public system. We already have a challenge providing high-quality staffing in our public sector with the salaries that we can afford to offer compared to the amount of money that can be earned in some specialties. I am sure you will have heard much about that before.

With regard to the Commonwealth government's A Fairer Medicare package, I accept that it attempts to address the decline in GP bulk-billing for concession card holders. But every GP I have spoken to has said that they use their discretion when they are charging gaps. Most of them

say that if they must meet the gap for all concession card holders they will then have to increase their general fees for everybody else and they will not be able to use that discretion.

Some of them have said they believe that some people who hold concession cards—for instance, people on seniors benefits who may be self-funded retirees—may actually have a better ability to pay a gap than a person on a single income with three small children who all have asthma at the same time. That is a concern. Hearing GPs talking about it, my understanding is that very few of them are going to be prepared to sign up, so I do not think we will see any real reduction in the pressure that we are under in our emergency departments.

I understand that some have argued that it is okay for emergency departments to deal with GP type patients as GP type services and the GP type patients are seen quickly and therefore they are not a real issue in the emergency departments. In Queensland, more than 60 per cent of visits to emergency departments are from GP type patients. While I accept that some of those patients, such as category 4 and 5, will need admission—just as some people who go to a GP in the suburbs will need to be admitted to hospital for various complexities or ailments—it certainly impacts on your emergency department if you have a lot of people who are waiting to be seen even for a GP type ailment. Certainly, that has caused significant pressure.

Queensland—in terms of meeting the demand for GPs—has over many years been underrepresented in medical student numbers, for a whole range of reasons. In recent times—since I have been minister—we have had JCU medical school come online, but its first graduates are not out yet. We have also seen the approval for Griffith Medical School on the Gold Coast, which will be starting to take students in 2005. That is a good step forward; it is significant. It will bring the number of Queensland's medical training places into line with our population growth and the other states. Previously, we have been significantly behind other states in the number of graduating doctors we have had and the number of places at university.

That will in the longer term help these trends but we must not also forget the changing work force in that we have now got many more female GPs. You cannot just count provider numbers when you are looking at the provision of services; you have to look at how many hours GPs are working. We are finding that women GPs take time off to have children. We are also finding that male GPs are drawing a line and wanting to have time parenting, too. There is a change in that it is no longer accepted that being a GP means a 24-hour-a-day, seven-day-a-week commitment. That is changing the role of GPs and how they deliver those services. I acknowledge that they need a life, too. It is unfair to expect them not to have a family life.

One of the issues that I would really like to raise is that I believe there are no real incentives in the current funding system for keeping people well and out of hospital or out of GP clinics or emergency departments. GPs, while they are being paid fee for service, are being paid for seeing sick people. Hospitals—and it seems this is not going to change—are paid based on the number of people they have in the hospital. I believe quite strongly that, if we are going to have a sustainable health system that can meet the demands of a growing ageing population and increasing technology et cetera, we really should be looking at focusing on keeping people well and out of hospital and not needing GP services.

I do not think we can continue to just treat people when they are ill. We really have to try and change that. But we also need to change the model of care so that it is more patient oriented so

that the funding follows the patient, rather than being locked into separate silos, which is an inefficient and outmoded model. We need whole episode-of-care funding so that the funding provided follows the patient from the GP to the hospital, out to community health services or to aged care or whatever is required.

That will only impact on that range of people who need that care. It is not going to impact on the person who, like me, goes to the GP twice a year when they get a sinus infection or something, but it is going to impact on a lot of people who take up a lot of our health resources—that is, those people who have chronic or complex health needs. I think that the model we have now could be made more efficient and deliver better patient-oriented health services. I will leave it at that. I am happy to have you ask questions of either me or any of our panel of experts, but I was just keen to put up the basics of where we are coming from.

CHAIR—Thank you very much, Minister. That will leave us the opportunity to ask some questions, and I appreciate that. I go to the issue of increased visitation at accident and emergency departments. Yesterday we were fortunate to go to the Bundaberg Base Hospital. I have to say that I was quite astonished at some of the figures they were providing to us, whereby, similar to the figure that you gave us earlier, they suggested that up to 70 per cent of visitations at A&E at Bundaberg Hospital were triage 4 and 5. That seems to me to be much higher than the national average, although I do not have evidence to support that. Do you have advice for the committee about whether or not Queensland has a higher visitation at A&E in triage 4 and 5 than the national average per head of population? You were talking about a causal link between low bulk-billing rates and high visitations at accident and emergency. It seems to me that the Bundaberg data certainly suggests that where you have a very low rate of bulk-billing—I think it is just over 40 per cent—and a very high rate of attendance at A&E. Are there other places in Queensland where that low rate of bulk-billing seems to indicate a high visitation at accident and emergency as well?

Ms Edmond—Bundaberg has had a serious shortage of GPs for quite a number of years. They have been trying to recruit. I know some elderly GPs there who have been trying to sell their practices or retire. I spoke to one about 18 months ago who is in his 70s and still practicing. He said that he really wants to retire but he does not feel that he can because there is nowhere for his patients to go because there is such a shortage of GPs in the area. I know that they have recruited some since then, but my belief is that they are still underresourced with GPs. You would have spoken to the division of GPs.

CHAIR—Yes, that is correct.

Ms Edmond—I think that they are still short, aren't they?

CHAIR—Yes.

Ms Edmond—That has certainly been the case. I think in Queensland people are much more prepared to come back to the public hospital system if there is not a GP, because of our long tradition: we had free hospitals with free GP care available through the hospitals from the 1940s, long before the original Medibank came in the 1970s. I grew up in Bundaberg in Queensland so I know it well. It was always there as a fall-back position in Queensland, which was not the case in many of the other states. I know that, in some of the other states, basically people went

without or ran up huge debts if they had to go to a private GP in those days. But Queensland did have that tradition and I think that still carries through.

A lot of elderly people, in particular, if they cannot get a GP appointment go to the hospital. And many of the people who are waiting in our clinics have tried to get a GP appointment and they all say they either could not get in to see a GP because they have closed their books and are not taking any new patients or they cannot get an appointment for a week, and, if you are elderly and sick, that is a long time to wait. So they just trot up to the local hospital because we will never turn anyone away. We do explain that we do prioritise and triage and, if it is a lower level of acuity and we have urgent patients, they may have to wait. We do explain that to them but we never turn anyone away.

Dr Cleary was an emergency physician by training before he took on health administration so, if you would like him to explain any of the emergency data or how that has changed, I am sure that he would be more than happy to do so.

CHAIR—It is that issue of the causal link between bulk-billing rates and attendance at A&E. Did you have any further comments to make, Dr Cleary?

Prof. Cleary—This is anecdotal evidence. In my experience, where I worked in Brisbane we had a number of bulk-billing clinics that worked very actively around the Royal Brisbane Hospital, so it was almost like a satellite around the hospital. Once those clinics had closed there was certainly, in my experience, an increase in the number of patients that presented to emergency departments for care. Over the years the emergency departments have introduced new and innovative ways of managing those types of patients because they are presenting and you do have to care for them and manage their problems when they present. Some of those innovative practices include things such as fast-track services, where people who are category 4 or 5 in the national triage scale can be managed very rapidly through the emergency department. Again, there does seem to be a significant number of those cases that have ailments that could be looked after in a general practice or in an emergency department. However, there are also a number of people that do require emergency department care.

Senator KNOWLES—Minister, are you going to sign the health care agreement?

Ms Edmond—That would be a matter for the government to decide. My understanding is that it is going to be discussed at the COAG meeting on Friday of this week and from there we will decide.

Senator KNOWLES—How much does Queensland stand to lose if you do not sign?

Ms Edmond—We will lose $9 million from day one. I should point out that the Commonwealth has already taken that funding out of our current payments in lieu of signing—they say if we sign we will get it back, but they have already taken that funding—and from then on we will be penalised by $146,000 per day.

Senator KNOWLES—Can Queensland Health afford that?

Ms Edmond—No, of course we cannot. Nor can we afford to sit back and get less than we would have got under the current arrangement rolled over. In Queensland's case that would be $160 million over the five years. It makes estimations that our usage is dropping. It makes estimations that the increase in health care costs is ½ per cent less than CPI when most fair commentators would say that the cost of health care is increasing at something like three times CPI rather than less than CPI. It means that the longer we go into the future agreement, the worse off we are going to be. One hundred and sixty million dollars may not sound very much to the Commonwealth, but in Queensland that would be the cost of running one of the new hospitals that we have provided, such as Redlands, for the term of the health care agreement. To us $160 million is critical.

Senator KNOWLES—How can you say that there is a decrease in funding when there is an actual real increase in funding on the table? Isn't that just juggling figures for a political purpose? Let us look at the reality. In your answer, can you also tell me what Queensland's commitment to increased funding over the duration of the agreement will be and whether that commitment in funding has been put in writing to the Commonwealth?

Ms Edmond—Yes, it has. The Commonwealth can look at our figures over the previous five years and see that we spent considerably more than the Commonwealth on providing public health services in Queensland. We have also rebuilt all of our health services in Queensland from the top of the state down to the bottom at a cost of $3.3 billion of state funding—not Commonwealth funding—to provide quality public health services to the people of Queensland that are on a par with anywhere in the world. What we have said is not that we will not get more money than we are getting now but that we will get less than if we rolled over the current agreement. In every agreement in the past there has been an acknowledgement that costs were going up and that there would be a need for an increase to the CPI adjustments and usage data. In this agreement there is not, and this is the first agreement that I know of in my many long years of health service delivery where the incentive to sign has been a vindictive cutting of funding rather than an incentive in some way with the boosting of services.

Senator KNOWLES—But you still have not answered my question as to what is the increased level of funding commitment by the Queensland government.

Ms Edmond—I am happy to table this. It shows Queensland's public hospital expenditure. It is on the public record. It was stated by our Treasurer at the handing down of the budget. We currently provide $1.582 billion compared with the Commonwealth's $1.352 billion. We will be increasing our payments to a total of $9.552 billion compared with the Commonwealth's $8.02 billion.

Senator KNOWLES—What percentage increase is that over the next agreement?

Ms Edmond—It is 7.9 per cent this year compared with the Commonwealth's 5.1 per cent. In average annual growth, it totals up over time to be a 6.2 per cent increase compared with the Commonwealth's 5.8 per cent increase.

Senator KNOWLES—How much does Queensland get out of the GST—considering that the Commonwealth does not get a cent of it?

Ms Edmond—That statement is not correct. My understanding is that Queensland and the other states only get back the proportion of the GST that is identified rather than also getting GST on the unidentified parts, which were previously called the black economy. I understand that one of the reasons for the introduction of the GST was to actually access taxes from people who previously were not taxed. There is an amount that comes back. This year it is in the order of an extra $50 million—not billions as the Commonwealth have said in all the propaganda they have been pumping out.

Senator KNOWLES—I do not quite understand your answer. Given that the states do get every cent of the GST—no matter what you might want to say politically, that is in legislation and so you just cannot pick and choose—how much of that which is going to the Queensland government have you earmarked or have you asked to be earmarked specifically for health?

Ms Edmond—The GST funding is for a whole range of services. It is not only for health but also for education and disability, both of which are areas where I understand the Commonwealth has said the GST should be paying an increased amount rather than the Commonwealth. I really do have some concern in that we are talking about Commonwealth money and state money, because to me it is all taxpayers' money. It is the taxpayers of Queensland who are paying the GST, so of course they should get it all back.

Senator KNOWLES—That is what you have been talking about.

Ms Edmond—It should not be even discussed. In fact, it should probably come straight to the state without the expense of going through another system. In terms of how much we are getting back, we have indicated that in health we have an increase of $1.6 billion over the next five years compared with about an extra $1 billion in Commonwealth funding.

Senator KNOWLES—But what amount has actually been earmarked or have you sought to be earmarked out of the GST revenue that comes back to the state?

Ms Edmond—If we were relying on the GST alone for our increase this year, we would be in a really sorry state.

Senator KNOWLES—That was not my question.

Ms Edmond—I am sorry, Senator Knowles, that you do not understand it. We increased our state budget by $300 million.

Senator KNOWLES—Do not patronise me. I am just asking a very simple question.

Ms Edmond—I am saying that this year the state, not health, got an increase in payments of $50 million due to the GST; we increased our health budget by $300 million. So, if I were relying on the GST increase alone—which is what I was trying to explain to you—I would have a major problem. I needed to come up with an extra $250 million.

Senator KNOWLES—Do you support the New South Wales government's line of increasing the levy?

Ms Edmond—Increasing the Medicare levy? We already have the highest-taxing federal government that I have ever experienced, and I think there is plenty of room within that to make sure that health is a priority. I think people pay their taxes to see service delivery. Everybody I know is quite comfortable to see an increase in funding coming to health. They rely on public health services; they see them, they actually like them and they believe they are excellent. We have produced data looking at satisfaction with our public hospitals that show an average satisfaction rate of 89 per cent. That is pretty impressive, and I think people want to keep it that way.

Senator KNOWLES—Why do you say that rural people have been 'forced' into taking out private health insurance, when no such forcing has ever been undertaken? I come from Western Australia, which is a big state; I know that lots of people in country areas in that state do take out private health insurance. I do not understand what is different in Queensland. People can go to private hospitals for elective surgery, and your own information shows how many private hospital admissions for elective surgery there are. A lot of people in country towns, if they seek elective surgery, will actually go to a private hospital by choice.

Ms Edmond—Firstly, let me comment—

Senator KNOWLES—There is no force; there is no compulsion.

Ms Edmond—It is not me who says that they are being forced; it is the people themselves—it is the people of Dalby, of Roma, of Longreach et cetera around the state. A lot of people in Queensland do not live in the capital city. I know Western Australia; I have been there and looked at your health facilities in remote areas. Not a lot of tertiary services are provided outside of Perth, so most people would rely on their being provided in Perth. But in Queensland we have services right up and down and around the state. We actually do cataract surgery in Weipa Hospital. We do elective surgery on people who live in the Torres Strait. In those places, let me assure you, there is not even a private GP, let alone a private hospital. In a lot of smaller towns around our state there is very good access to medical care but there is no private hospital.

Rural people, such as farmers, are the ones who are telling me that they believe they were forced into taking out private health insurance—and they say that they believe they were forced into doing it because, otherwise, they would have to pay an extra levy. So they feel that they had to either pay the extra Medicare levy in taxes or take out private health insurance. And, if they did not choose to access private health insurance at present but wanted to join a fund later when they moved or retired to the coast or that sort of thing, they then would have to pay a big increase in their premiums. Look at the people of Mount Isa, Longreach, Charleville and, as I have said, Dalby, Roma and Cooktown. I think it is pretty clear.

Senator ALLISON—Thank you for your stats on hospital services for the years 2001 and 2002. It is said generally that in the future—if this is not the case already—there will be more services being delivered out of hospitals, oncology being one example. You have provided us with a graph headed 'Private health insurance rebate and public hospital activity'. How do you see the trends over the next few years in terms of out-of-hospital services; will this make any difference to the services delivered in your public hospitals?

Ms Edmond—You have to look at what has happened to hospital delivered services over the last 20 years—and increasingly so over the last 10 years. We have seen the length of stay halve in the last 10 years; the average length of stay has reduced from seven to 3½ days. It has halved because of the way we are delivering services. I will ask Dr Cleary to talk about this and, as a health professional, I might too.

We no longer keep people in hospital for a long time; we actually treat them. Increasingly, acute hospitals will be areas of very short and sharp, very hi-tech and very costly intervention, and more care will be provided outside the hospital. There are good reasons for that occurring. One of my major concerns about the new health care agreement is that it does not recognise that and it is trying to lock us into only measuring those things that actually take place with people as inpatients in hospital. We now provided quite extensive dialysis. We provide dialysis in community health centres in remote areas, like on Mornington Island. We now provide an awful lot of outpatient based rather than inpatient based cancer care treatment and chemotherapies et cetera.

Senator ALLISON—But some would say that this package anticipates that precisely—it knows there will be higher costs outside hospitals and that the Commonwealth will have to pick up the tab. So the Commonwealth is already setting up a system whereby we can shift that cost to patients.

Ms Edmond—I do not see how you argue that, because these services are still provided by the public hospitals; they are not just counted as inpatient care.

Senator ALLISON—Let us take oncology: there are many more GPs now providing oncology services to patients who would otherwise be in public hospitals. Do you agree with that?

Ms Edmond—I do, but there are also a whole range of different levels of oncology carried out by specialists. In Queensland, while there are private specialists, increasingly those people are and will be public patients. In Queensland, we find that we are really pushing the envelope as hard as we can to provide services out of hospital. It means that you cut down on nosocomial infection rates and on—

Senator ALLISON—I understand there are good reasons for it. But I am asking in terms of what some might call cost shifting and what others might say is a sophisticated trend out of public hospitals—and that is a good thing and no-one is arguing about it. I am just interested in this graph, which you have provided, in terms of the number of services and what you see in the future. Will there be a steady increase similar to that experienced during the two years 2001 and 2002, or will it go down? Just what is your feeling for that trend?

Ms Edmond—I believe that non-admitted occasions of service will continue to increase. We have seen no indication that that will decline. That is part of a trend that has been going on for about 15 to 20 years and it has accelerated in the last 10, and I think that will continue. I would also point out that Queensland certainly has the highest rates of admission—I think it is to do with our rurality—in Australia. Of course, Australia has very high rates of admission compared to those of other OECD countries. So I think there is room for seeing that trend continue and for providing excellent care but for providing less of it on an admitted patient basis.

Senator ALLISON—You have given us good data on why Queensland is disadvantaged in dollar terms. The New South Wales government firstly calculated that the Hunter Valley region was missing out on $1 billion a year in MBS funds and then argued for some funding to be provided by way of a grant for after-hours services—I think they got $13 million, instead of $1 billion. Do you think a reasonable argument could be mounted that regions should all attract the same per capita funding for MBS and that part of that should be delivered in more innovative ways to make sure that there is access to primary health care in those areas?

Ms Edmond—I certainly believe that there is more room to do it in innovative ways. The trial in the Hunter Valley is one that we have looked at very closely, and I believe it has been successful. We have also had trials in Queensland. Again we have applied for things such as cashing out of MBS and PBS in our remote areas so that we could provide a package of care in those areas without worrying about which silo of funding it was coming from. I think that is something that we should look at more over the future. That is not about more money but about cashing out what everybody puts in so that we can provide quality care to people in remote areas. I am not sure that it should be done on a regional basis. I say that because I think, once you start doing that, you build in another range of inefficiencies.

Queensland runs, I think, the lowest cost health service in Australia. We do that by having centralisation to a certain level of a number of key areas so that we can maximise purchasing power et cetera. The states have a better knowledge of where certain innovative systems are likely to work and what the local arrangements are to improve those services. Rather than seeing direct funding on a regional basis, I really think it should be through the states. We are on the ground, we are providing the services and we have the people who are there.

Senator ALLISON—I have one final question. It was argued in Adelaide that for Indigenous communities, because they suffer such high rates of poor health—somewhere between times three and times five that of the rest of the population—funding should follow health outcomes. What is your view in Queensland with such a high Indigenous population? Do you agree with that, and is this a Commonwealth responsibility?

Ms Edmond—I do agree with that. We spend significantly more per head of population up in the north in Australia, where we have got the majority of our Indigenous people living in communities, than we do on a per capita basis in the south. I think the figure is about 1.7 times more. For our PHCAP funding, which is our expenses on Indigenous primary health care, the state puts in $1,573 per person and the Commonwealth contributes $268 per person, excluding MBS-PBS. I make that point because MBS-PBS are very little utilised in those areas. So that is a significant amount.

I have not got the figure for the averages across the state, but from memory we spend about 1.7 times the average—I am not sure if it is 1.7 times the average or 1.7 times the other two zones. We have three zones in Queensland—southern, central and northern—and I know that the northern zone is about 1.7 times, to allow for the rurality, remoteness and aboriginality in that zone, where there is a high level of remote communities.

Senator ALLISON—It is still not times three or times five, though.

Ms Edmond—No, it is not, although I have been to Indigenous communities in the Northern Territory and Western Australia, and I have going around ours in Queensland since 1990—I think that was the first time I went up to the remote areas in the cape. At that time they were delivering health services from shanties. We had virtually no qualified staff. We had one doctor in Cooktown, two in the Torres and one in Weipa. We now have, I think, eight doctors employed by Queensland Health in the Torres Strait, providing outreach community service to all of the Torres Strait as well, by flying out to see them. We have got two in Bamaga, two in Weipa, two in Cooktown—which is a significant improvement—and we have also got outreach services providing ENT services, ophthalmology services, diabetology services and child health services. We have got flying doctor services providing GP clinics for those who do not have resident doctors. The improvement we have made over the last 10 years is enormous; over the last five years it is considerable. I would be happy to take you up and show you. I am very proud of what we have done up there.

Senator ALLISON—Thank you.

Senator LEES—Do you think it would be better for specific patients, as well as taxpayers generally, if the Commonwealth took some of the pressure off doctors, did not worry about increasing after-hours rebates and simply said, ‘Okay, after eight o’clock at night we are going to fund, through the states, the public hospital system,’ and then employed doctors on a contractual basis? I do not know how far you can take the issue of triaging; it may be that a GP would not need to see some of the patients after hours. Would that be a better option than keeping a range of pressures on GPs—who, in some cases for home visits now, also seem to need some sort of security support services?

Ms Edmond—It would answer some of the questions, but it would not answer others. In some country towns the doctors have basically done that. They make the services after hours so expensive that no-one goes to them. I am thinking about one town in North Queensland where there are about 12 GPs, but you have to pay about $80 up-front for virtually the only GP service after hours. A lot of people cannot afford to pay that up-front. So they basically use the hospital now as a GP after-hours clinic. But that of course means that the doctors who are staffing the hospital are then doing a lot of after-hours work, and they have still got to front up and do their general work during the day, and do surgery or assist in operations and all the rest of it. And that causes increased pressure. So it would have to be done in a structured way that recognised that that was what we were doing.

We also have GP practices which have phoned the local hospital and asked them to fill out the part of the form for accreditation where they have to show that they have provided after-hours care. Some of them have actually rung the local hospitals and said, ‘Will you sign off that you’re providing the after-hours care so I can get my practice accreditation?’ I think that is a little cheeky and, again, it dumps an extra workload on the hospitals. Unless we do it formally and therefore fund the hospitals to provide that care we cannot do it.

It is the same with providing GP clinics in the hospitals. While it is a solution—if we can get the GPs; realising that there is a shortage of GPs, how many of them would be prepared to work in the emergency department for a salary is another question—we would have to allow them to bulk-bill or to charge, which is what happens in some of the clinics which are across the road from the hospital. We do not have any cases where that is happening within the hospitals, other

than in some of the remote communities where they are allowed to bulk-bill Indigenous patients through an arrangement with the Commonwealth. The fact that the Commonwealth is the main provider and funder of primary health care has been a recognised key principle of the health care agreements from the beginning. If you are going to shift that, you also have to shift some funding.

Senator LEES—Absolutely. That is what I am looking at. In other words, instead of the Commonwealth trying to put funds through individuals GPs in various ways, it might instead direct funds to you, and then you would, for whatever the cashed-out amount is, provide that service. Let me move on to look at prevention, an issue which has been raised before the committee time and time again. What is the best model to really refocus on the issue of prevention? Is it GP based, where GPs build around them a team of allied health professionals? Should it be through a public system that the states organise, such as community health services? Should it be hospital based? What do you see as the ideal model to refocus on prevention?

Ms Edmond—You have to look at prevention but you also have to look at early intervention. I think it is in early intervention that we could save funding by using other models and not necessarily always relying on doctors. Just this week, I have been up at a community cabinet meeting at Nambour, and a lymphedema clinic which a nurse is providing was raised with me. Lymphedema is something that can occur after breast surgery for cancer et cetera if the lymph nodes under the arms, in particular, are affected. That is just one example. She feels bad charging patients, because they cannot get a rebate. Yet really it is not something you need to go and see a GP for. It is unlikely that your GP is going be able to give you any support or advice. It is something that, if there were a change and a structure that allowed her to provide that service, could be done more efficiently and easily and done earlier—and, therefore, prevent some of the longer term issues and health risks involved with lymphedema. There are a range of areas where early intervention could actually save money, if it were more accessible through allied health staff or others—in this case, a member of the nursing staff who has specifically followed it up and trained herself in it. In terms of GPs being the best for prevention, we work very closely with the GP divisions to provide that care. I believe very strongly that we have to start putting a lot more focus on prevention. I am worried about how we are going to meet the demand of 40 per cent of the population having type 2 diabetes, with its complications, as is predicted.

Senator LEES—Looking at the funding model that we would therefore need, who would be the gatekeepers? Would it be through the hospital processes that you would decide whether a person needs a nurse practitioner or, as the Commonwealth has responsibility for primary care, should it be through GPs by, for example, in this package increasing the availability of nurses and nurse practitioners?

Ms Edmond—I think it could be done through that, but I do not think it will be done through that under the current arrangements. GPs say to me that they cannot use a nurse practitioner to really take any of the load off them. They can use them for support, but there is no provider number through which they can get recompense for a nurse practitioner seeing people and providing what could be quite extensive primary health care and prevention care. There are elements built in there, but they probably do not go far enough. If GPs could be fund holders for a range of services, such as physiotherapy or podiatry for diabetics, and provide that access, that, I believe, could be a very good preventive measure.

We have reduced admissions of patients with diabetes in the Torres Strait by 40 per cent and reduced the number of amputations by 40 per cent by being what I call 'aggressively' active in the primary health area. You can do that when the only providers are the state and it is basically a captive community—they are on the island and they are going to stay there. So when I say aggressive health care I mean that when they are passing people who know them in the health care business those people will say, 'It's time for you to have your check. We need to check that you are not getting into strife, that your blood sugar is fine and all the rest of it.' That has been a significant improvement. That information is documented. It has been in medical journals around the world—I am just trying to think of several—because we have reduced significantly the in-patient activity and amputations through aggressive primary health care.

Senator HUMPHRIES—Minister, you accuse the Commonwealth in this package of trying to cost-shift onto the states by virtue of the decline in bulk-billing, leading to increases in category 4 and category 5 ED attendances at your hospitals. Isn't it true, though, that over the last 10 or 15 years Queensland has been systematically cost-shifting onto the Commonwealth with respect to hospital services? Over that time there has been a serious cut in the number of public hospital beds in Queensland. Given what Senator Lees just described as the Commonwealth's responsibility for primary health care, doesn't that shift the onus back onto GPs? Don't you therefore have some responsibility for that cost-shifting?

Ms Edmond—The changes in health care modelling have been international, and the reduction in the length of stays has been quite dramatic over the last 10 years. I will ask Associate Professor Cleary to talk about this from his experience, but the days when people went into hospital for three or four weeks have gone. If you have a heart attack now, instead of being required to rest in hospital for three weeks you will probably be out in three days and much better for it—you will have less chance of a blood clot from lying in bed and all of those things. So the reduction in the average length of stay has been significant around the world and, increasingly, there are many things that you no longer need to be admitted for. For example, MRIs have replaced contrast media back imaging et cetera, which was previously a cause for admission. It is probably better to have one of the experts who has seen all of this happen as well to explain it. Associate Professor Cleary, would you like to comment?

Senator HUMPHRIES—Could I butt in? I do not think the committee would doubt that there has been a huge decline in the average length of stay—that is well-accepted evidence and, with respect, we do not need to hear that evidence. But isn't the other measure of what has been happening with respect to cost-shifting the fact that waiting lists have been increasing? Haven't your waiting lists increased dramatically in that 15-year period as well, while you have been cutting public hospital beds? Isn't that evidence that patients are in fact not getting better service but are actually getting a lower level of service, despite the cut in the average length of stays?

Ms Edmond—That is categorically untrue. According to the Productivity Commission, Queensland has the best waiting lists in Australia for elective surgery, and I can say that we have just recently pretty much reached our target of less than five per cent of category 2 patients waiting more than three months. We are doing increasing amounts of elective surgery. Increasingly, though, it is done on an outpatient basis or with the patient only being admitted for day surgery, and that is largely because of the changing models of health care. I am not sure if you aware of the number of procedures that are now done by keyhole surgery rather than requiring a stay in hospital of several weeks. Even my mother, who was 83, had keyhole surgery

for a gall bladder operation. Previously, that sort of operation would have required a stay in hospital of two or three weeks for somebody of that age. Associate Professor Cleary, would you like to comment on this too?

Senator HUMPHRIES—I want to move onto something else; I have only got a very limited period of time in which to ask questions. So, with respect, I do not think we need to hear that evidence. I think we accept that there has been a reduction—

Ms Edmond—It is just that your statement made it seem that you did not accept that evidence.

Senator HUMPHRIES—No, on the contrary, I was saying that there had been a rise in some categories of waiting lists over that 15-year period. That is still the advice that I have, and it indicates a lack of satisfaction.

Ms Edmond—I can say that there has been a rise in the number of services we deliver and in the number of people who are receiving those services—services such as angioplasty et cetera which were virtually unheard of 15 years ago. So there is an increasing range of things that people are having in the public system.

Senator HUMPHRIES—Thank you for that. The Labor states have been arguing pretty consistently that the Commonwealth's offer under the Australian health care agreement is a billion dollars less than it should have been under forward estimates. I do not believe that argument is true but assuming for a moment that it is, the Commonwealth has also proposed to spend an extra billion dollars—if you like, that same billion dollars—on incentives for GPs. Wouldn't you accept that, if we were truly encouraging preventive medicine rather than reactive medicine, we should be engineering a shift into the area of GPs and encouraging people's primary health care to be met at that level?

Ms Edmond—I go back to your introductory statement. The Prime Minister himself has said that that is true. I have seen that statement where he pointed that out. The health minister also pointed to the forward estimates last year when she told us how much the states would be getting. The amount that is being offered now is around $1 billion less than that. So I do not think we need to dispute that suggestion.

In terms of what is being spent, I do not think anyone disagrees that primary health care needs more funding and that GPs need more funding. I would argue that that should not come out of a public health system, because there is no evidence that the demand on public health systems has been reduced or that what is being proposed will reduce that any further. In fact, doctors around Australia have made it very clear that they do not believe it will have any positive impact on their care. Most of them are saying that it is an unworkable proposal and that they are not prepared to sign up.

Senator HUMPHRIES—Doctors have also argued that there is no evidence that there will be any likely increase in copayments if a copayment at point of service delivery regime is engineered. You say that there would be an increase of $20 to $25 in those circumstances. Can you give us any evidence to support that contention? On page 6 of your submission you state:

… doctors are likely to charge all patients—

that is, other than cardholders—

a co-payment that, on average, could be $20 to $25.

Ms Edmond—That is the information we have been given from discussions with doctors et cetera.

Senator HUMPHRIES—The AMA say the opposite. They say that the effect of the copayment arrangements that have been engineered could actually be deflationary. Which doctors have made that suggestion to you?

Ms Edmond—There has been quite a lot work in recent years on where health costs are or where fees are in relationship to CPI increases over time. Some years ago there was a Commonwealth funded study that looked at relativities between GPs and specialists. It made recommendations about what was the necessary level of fee structure for GPs that would give some guarantees of sustainability. That would be part of the basis on which we have based our arguments about what we see as the necessary fee to meet that requirement. The AMA has expressed a view that the standard consultation fee emerging from the relative value study should be set at about $50—which is consistent with what we are saying here when you think of a rebate at the moment of $21 to $23.

Senator HUMPHRIES—You are saying the copayment arrangement would lead to that increase in the fee. The doctors want more fees—that is true—but the copayment arrangement should not lead to that, surely.

Ms Edmond—Doctors are saying that, if they have to bulk-bill under the new arrangements—that is, bulk-bill patients who are eligible rather than those who they believe are needing it—they will have to increase their fees to more sustainable levels. The figure that has been put is $50: they will need to increase their fees to $50. If the increase—which I think is being offered to metropolitan based GPs—in the order of $1 is taken into account, that would leave a gap of $20 to $25.

CHAIR—I want to thank both Senators Forshaw and Stephens for accommodating the committee's shortage of time. Senator Forshaw has one question, which you may be able to take on notice.

Senator FORSHAW—A couple of the issues I wanted to go to have already been covered. However, page 7 of your submission states:

Queensland health has estimated the likely impact of these arrangements on the workload of public hospital emergency departments.

You go on to give some description of that methodology and how you arrived at the conclusion that there is a significant cost shift from the Commonwealth to the state. Could you give us some more detail about how you arrived at those conclusions? It may be useful if you took that on notice.

Ms Edmond—I can say straight off that the activity in Queensland public hospital emergency departments has grown from 674,000 to 747,000 patients over a couple of years. That is 10.94 per cent growth. That is way ahead of any population growth and is totally unsustainable. We believe it is plateauing now, but I think it is plateauing at a peak level. It has not dropped at all. We keep hearing how the private health system with the private health insurance subsidy has taken pressure off the public hospital system. We simply cannot find that in any of our data. We have seen that, yes, it plateaued for a small period and now it is going up again ahead of population growth.

Senator FORSHAW—Your submission says that, based upon certain assumptions, you estimate a doubling in activity. It then says:

> … there are two methods by which this additional activity can be costed, this fundamentally represents a significant cost shift from the Commonwealth to the State.

You then refer to the medical benefits schedule and the national hospital cost data collection, and you give some figures. If we could get some more detail by way of an explanation of how you arrived at those conclusions, that would be very helpful.

The other question I want to ask goes back to the issue of the increase in services provided at hospital emergency and accident centres for cases that might otherwise be treated by GPs. Do you have an estimate of the dollar cost of that, which would otherwise be picked up under Medicare? You may want to take that on notice. It is clear from the figures and the graphs that you and other state governments have given us that in the last couple of years there has been a surge, following on from other changes to client bulk-billing. I am wondering what the Commonwealth would be picking up through Medicare that the states are actually picking up through their public hospital funding—what that represents in financial terms.

Ms Edmond—I guess page 7 is outlining that, if we estimated the cost of that group of people being treated by a GP, it is in the order of $10 million. But if they are treated in the public hospital system, it costs about $55 million. The reasons for that are complex. I do not think that emergency departments are an efficient way of providing GP type services, with the overheads involved there et cetera. We have pumped in a lot of extra funding to emergency departments over the last five years to basically reduce waiting times for people, which have grown enormously over the last few years. That cost is not sustainable.

We cannot keep on putting a lot of money into providing very expensive front-end care to people who could be treated more effectively by their GP. Can I say that I think it is a better model of care. You are better off going to your own GP—who knows your health, who knows your family and your circumstances—to get that type of care and continuity of care than fronting up to emergency departments where you might see excellent specialists but a different one every time. They do not have your family history there; they do not know your personal circumstances. While you might get excellent care for that particular episode, there is not the continuity of care that is important, particularly with elderly or chronic care people. I am advised that these figures are extremely conservative.

CHAIR—Minister, we thank you and your departmental officials very much for your assistance with our inquiry. There are a couple of issues that have not been canvassed today, and

I hope you do not mind if we write to you about them to see if you could provide any further information to assist our deliberations.

Ms Edmond—Thank you; I have been pleased to have this opportunity. We are more than happy to help in whatever way we can. If there is more detailed information you would like, we are more than happy to provide it.

CHAIR—Thank you very much, Minister.

Proceedings suspended from 11.10 a.m. to 11.24 a.m.

BAIN, Dr Robert, Secretary General, Australian Medical Association

GLASSON, Dr William, President, Australian Medical Association

HAIKERWAL, Dr Mukesh Chandra, Vice President, Australian Medical Association

NESBITT, Ms Julia Margaret, Acting Director, General Practice and E-Health Department, Australian Medical Association

RIVETT, Dr David Christopher, Chair, Australian Medical Association Council of General Practice, Australian Medical Association

CHAIR—Welcome. Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. The committee prefers all evidence to be heard in public, but should you at any stage wish to give your evidence, part of your evidence or answers to specific questions in private please ask to do so and we will consider your request. Your submission is before the committee, and we have also received your supplementary submission. We thank you for both of those. I now invite you to make a brief opening statement before we move to questions.

Dr Glasson—I will make a brief statement to introduce our submission. At the moment Australia faces one of the worst doctor droughts we have seen for a long time, with declining access for patients to medical treatments in this country. The drought has been deliberately created by the federal government in order to try to restrict health care expenditure. Major policy changes are required if this drought is to be broken. Without stating the obvious, the current problems, particularly in relation to the work force, exist around previous policy which has aimed to restrict medical student numbers, doctor training numbers, access to provider numbers and GP remuneration and to increase regulation and red tape. Hence, the simple equation is: more doctors equals more patient treatments equals more costs—that was the philosophy, I suppose, on which all these decisions were made.

However, there are now widespread complaints about access to and affordability of the system. We feel that the government’s previous policies of the 1990s must be redirected, both to redress the underfunding which has existed for the last decade, or progressively over the last decade, and to try to really address the issue of work force. We figure that, at the moment, we are looking at something between a 10 to 20 per cent reduction in the appropriate level of GP numbers in this country. The AMA has put forward 16 drought-breaking recommendations, which you will find on pages 4 and 5 of the submission, which aim to address some of these problems. I would like to leave it there and answer questions.

CHAIR—One issue that I would like to go to first is evidence that has been given to us by non vocationally registered doctors. They have suggested a strategy that may be able to change participation by non VR doctors. They have suggested that, essentially, currently non vocationally registered doctors should be allowed to practice and the sunset clause that was in existence should be reinstated. Does the AMA have a view on what should occur for non vocationally registered doctors?

Dr Glasson—We came out with a comment on this yesterday, in combination with the Royal Australian College of General Practitioners. As you know, there are something like 2,500 GPs out there working in the non VR status, and we certainly have had significant representation from that group outlining their concerns. Their major concern, obviously, has been that their patients—and I remind people that rebates are for patients and not doctors—have been getting a progressively reduced rebate over the term of this VR, non VR status. We would certainly support bringing the non VR group into a position where their patients receive an equal rebate. Obviously, those doctors need to go through a process so that they are appropriately accredited. In combination with the College of GPs, we came out with a combined statement on this issue, which I am happy to give to the Senate committee.

CHAIR—Thank you, Dr Glasson. I suppose the issue that needs to be ticked off, on behalf of consumers, is that quality would not be compromised. Is that essentially what you are suggesting as well?

Dr Glasson—I think that is extremely important. Essentially, we are saying that the quality issue rests with the college. The college have to define and make sure they uphold the standards of general practice in this country, so we have turned to the college to give us direction as to how we should move forward to make sure that those who are accredited are accredited for the right reason. Our argument relates to patients. Certainly the AMA feels that it is unfair and unjust that, essentially, accreditation should somehow reflect a patient rebate rather than, necessarily, the standards that a doctor is required to hold.

Senator HUMPHRIES—What is the view of the AMA on what will happen if we have these copayment arrangements at the point where patients receive doctor services? You make the point in your submission that you believe that the effect of that arrangement could be deflationary rather than inflationary. Can you explain that statement?

Dr Rivett—Electronic allowance of patient claiming saves the patient considerable time in not processing their claim at the Medicare office and also in the transit time involved in doing that and in waiting for their rebate to come back to their cheque account. So streamlined billing is very patient friendly. It is also going to lead to large savings to the HIC in not processing these claims individually at a Medicare office and then forwarding them on to the HIC, so considerable savings can accrue to government. Our concern at the moment is the costs that will accrue to general practitioners. As the system is currently in the pipeline, it needs a lot of refinement. Some barriers have been broken. There has been a stand-off between the software providers and the department of health. This week, the minister for health announced that this has been broken and that funding will go to the software providers to facilitate such streamlined electronic patient rebates. So patients will be able to get their rebate by directly putting in a claim at the GP office with fairly simple software.

Previously we had great concerns because the costs were looking enormous for GPs becoming the Medicare office. Some of our concerns have been met; hopefully, this can be a win-win situation for patients, government and practitioners in the future. It is something that patients certainly want, and GPs will accept it if there is not an enormous cost burden. It certainly can be a huge saving to government. The last time we were given figures on this, which was about four or five years ago at an MOU group meeting, the savings put to us were at about $1.70 per Medicare item rebate, which is not insubstantial in the scheme of things.

Senator HUMPHRIES—A number of submitters to the committee have suggested that the ease of the copayment from the patient's point of view will lead to doctors increasing that copayment; it is an easy chance to get in under the radar, if you like. This morning, the Queensland government suggested that they thought that the copayment would become something between $20 and $25. Given the range and the strength of those views, are you still of the view that there would not be an increase in doctors' charges under the cover of this copayment arrangement?

Dr Rivett—Consumers become empowered once they reach into their pockets for a copayment. As somebody who charges copayments, I can tell you they demand far more from the practitioner. Instead of coming in on individual occasions with one or two items, they will come with a whole list of items and they will demand that they get quality service on that visit. We become much more interested as consumers if a copayment is raised. It is like free bread. If there is free bread out there in the shops, it is abused. It is the same as free medicine to some degree. I am not damning all consumers, but they certainly become a different consumer when they are reaching into their pockets. That would put all the balances in place to counteract any small increase in fees.

Senator HUMPHRIES—We have also heard a number of submitters, including again today, saying that copayments do not distinguish between those who are sick and those who are not so sick and that people will be discouraged from coming forward with genuine complaints as much as with hysterical or unnecessary complaints. What is your reaction to that argument?

Dr Rivett—GPs have always been very compassionate in their billing and have looked at patients' circumstances in the whole. They do not just look at patients' incomes. They look at their general health and how often they are going to be visiting them and they put a whole lot of factors into the equation when they make a decision about a copayment. It is multifactorial and varies enormously from GP to GP but, overall, there is great compassion from the profession. They do not want patients to be out of pocket to a large degree. They realise that they are going to hit a barrier as soon as they hit the pharmacy, finding copayments there.

Dr Haikerwal—I would like to add to both of those items. Regarding the copayment, there is a furphy that when you have access to electronic claiming and payment directly to the doctor's account there will be an inflationary effect and the copayment will increase. We are working in a competitive environment and, therefore, you have to make sure that your services are affordable; otherwise, people will not take them up. The second point is, of course, that if you are charging a copayment people will ask the question, 'Why are you charging me for a higher consultation?' That is another important fact.

The current billing mechanisms today allow for copayment to be made and for the doctor to take the green Medicare claim form to Medicare. If the account is paid, the patient's account is paid within three to five working days. So a lot of these things are already there. This is simply about streamlining the system for the patient and saving money for the government in double and triple handling of cheques and so on, especially where a cheque is not presented within 90 days and has to be re-presented.

On the issue of realising how people charge a copayment or not, there are multiple factors, including whether somebody is actually able to work the system and go to Medicare and get

their rebate or whether it is just too difficult for them because they have a mental health problem and so on and, therefore, you have made the decision to simply make it easy for them.

Dr Bain—The big issue around copayments is really the work force situation in the area. As the department's submission shows, once you get into areas where there is an extreme shortage of doctors the copayment increases. The availability of doctors in the region is really what drives the copayment situation.

Senator HUMPHRIES—You obviously do not see the rate of bulk-billing as a measure of the health of the system. You obviously have misgivings about the encouragements or incentives to bulk-bill which are in the government's package. What would you see as an appropriate measure of the system if bulk-billing rates are not measured?

Dr Rivett—I guess we want to see affordable access for all Australians to general practice care—that they can reach a primary practitioner without too many barriers. We want to see positive health outcomes for the nation. Some people certainly will still require bulk-billing under any system—if it is to be called 'bulk-billing'; we would rather see it be called 'compassionate discounting'. But the proposed system, with eight million cardholders—and with all GPs signing on to that system being obligated to provide free care under a Medicare rebate system that is riddled with inconsistencies and which does not reflect the true cost of care—is not a way forward.

Dr Haikerwal—The bulk-billing rate is not a reflection of any kind of health outcome; it is just the number of people getting a service that happens to be free at the point of use. If we look at health outcomes we see that there are a variety of other measures—including properly conducted studies, such as the BEACH study by the Australian Institute of Health and Welfare, which looks at outcomes such as the average length of time a doctor sees a patient for and the number of items dealt with during the consultation. The bulk-billing rate simply reflects a method by which patients are charged for the services provided to them.

Dr Glasson—I would like to make one last point on that. I personally do not bulk-bill people but I rebate a huge number of people. You might say: 'Why do you do that? It is very inconvenient for the patient.' I really believe that we have to send a signal that the service we provide actually costs something. I feel that by delivering an account to the patient they appreciate that the service was worth something. In reality, it is a pain for both my patients and my staff to do that, but I am in private practice and I have a business to operate, and it is essentially a decision between me and the patient for me to charge what the Medicare rebate gives back.

I think that bulk-billing sends the wrong signal. We are out there to provide a service. Lots of patients cannot pay a gap charge and we try to recognise that by accepting the full Medicare rebate as full payment. I would suggest to you that if you add those figures to the bulk-billing figures—and I understand that they are not included in the one number—you would find that more than 90 per cent of doctors are doing the right thing by their patients. They are trying to make sure that they are assessing their patients on compassionate grounds and making sure that services are being provided where they should be and at an appropriate fee.

Senator HUMPHRIES—The AMA seems to avoid making a comment on the question of whether to retain the 30 per cent private health insurance rebate. I have read what you said at page 7 of your submission. I do not know whether or not you commented on this in your supplementary submission, but you do not seem to say whether you are in favour of it or against it. Can I have a view about that from you now?

Dr Haikerwal—The AMA is very clear that the 30 per cent rebate for private health insurance is a central part of maintaining the private health system. This system allows over two million consultations to take place within that system. If you distributed that $32.5 billion to the public hospital system it would probably not allow that many services to take place. It is great value for money for the government because, although the 30 per cent is paid by the taxpayer, 70 per cent is paid out of post-tax dollars for everybody else. That represents pretty good value for money for the government and for the people of Australia.

Dr Glasson—We realise also that there has to be a balance between the public and private system. We are one of the great nations in the world, in the sense that we have, I think, a perfect model. The problem is that the system has been allowed to run down, particularly the public system, over the last decade or so. We must ensure that there is a balance between those two systems. My concern is that, if you remove the 30 per cent private health insurance rebate, the public system will not cope. We must ensure we maintain that balance.

Senator HUMPHRIES—Our terms of reference include the consideration of alternative models of health funding. Do you have a view about the Labor Party's policy for Medicare?

Dr Rivett—It does a little: it raises fees to 95 per cent of the MBS. But the MBS is what is broken through improper indexation over many years, and to try to then tag a little bit on to what is an improper amount to start with is not going to work. It is too little to address the needs of the system at the current time. Three large factors drive costs in general practice: we have an ageing population which takes considerably longer to service and which has many more needs, the number of therapies available to that population has exploded, and people's awareness of those therapies has also exploded. So we have a much better informed consumer population, many more treatment modalities which GPs need to be abreast of and a much bigger ageing population which is going to continue to grow in Australia. There is no easy way out of it without spending substantially more dollars to get a quality system in place.

Senator HUMPHRIES—If the opposition's policies were to be enacted as law, would your members be prepared to agree to bulk-bill universally?

Dr Rivett—The opposition's scheme does not require that. It is a scheme where you can make a decision individually with each patient, which is certainly preferable to the membership. The worry with the opt in and opt out scheme that we are seeing the government proffer is that it will provide a clear disjunction or split in health care, where we will see opt in practices providing for the less well-to-do and opt out practices providing for the others, and we will have two tiers of care in Australia. We will walk away from our universally funded health access, and I think that is not something that Australians want to see. Something Australians hold dear is the fact that we have a universal system where everybody chips in to support their fellows, rather than just the sick paying for their own care, which is what you have got in a user-pays system.

Dr Haikerwal—The paradigm that we are working in now is very different to the one in the early nineties. We have a group of highly trained GPs who are providing services of high quality, but also they have regained their self-respect. They now understand, with the findings of the relative values study, that their services are worth something. They are now prepared to say: 'I am worth something. The services I provide are valuable. This is the value I attached to them. This is what I will be charging. I may give a discount. The rest is between the insurer and the patient, and the size of the gap will depend on the size of the rebate that will come through the insurance system.' I think we are dealing with a different paradigm currently because of this high level of self-respect within the profession.

Senator STEPHENS—Dr Glasson, how would you respond to the suggestion that, contrary to popular belief, the relative values study did not find GPs should be remunerated at about $50 per consultation; that the findings were in fact based on GP value relative to specialists, whom many would argue overcharge—we certainly had evidence to that effect this morning? The Department of Health and Ageing have argued that the $50 figure is based on the AMA's modelling and suggested that there were inaccurate assumptions in that modelling.

Dr Haikerwal—If I may answer that, David Rivett and I both sat on the GP remuneration task force for the relative values study, so we could probably take that particular question on board. David might supplement what I say. David, would you like to go first?

Dr Rivett—The costs were not referenced against specialists; they were referenced against overseas doctors and also against like professional groups in the community. Five of those were chosen for direct comparisons, including, I think, chemical engineers, geologists, accountants and solicitors.

Dr Haikerwal—The figure that was widely quoted at the time of the release of the relative values study has been indexed based on the current rates of indemnity and other practice costs. That is how the figure that was quoted today of a $50 fee for a 15-minute consultation was derived—using the RVS methodology but indexed in today's terms.

Senator STEPHENS—Thank you. Your submission states:

The Australian myth that cost minimisation in primary care is fiscally responsible must be exposed and revoked.

How does the AMA suggest that funding could be optimally allocated so that there are better health outcomes and more spending on primary care given that we have a federal system of governance?

Dr Haikerwal—If you look at the overall levels of funding for things like primary care compared to tertiary care you see that the rate of growth of funding in the acute sector probably does not equate even to the rate for community care. That does not include general practice. So when you are dealing with general practice and community care, the support you actually have to have within the community to continue the trends of early discharge and of maintaining the care of older people in the community all have to be taken in the context of not just what Medicare is paying patients for the rebates for GPs in the community but also the level of supported care that is provided for that care to continue in the community. So you really have to actually measure those items rather than just individual parts of the budgets.

Dr Rivett—There can be a net gain to Treasury if the work force has its work life expectancy increased by better health care and better outcomes as the population ages. If people can be maintained in the work force for even an extra year on average because of improved health outcomes, that is going to reap substantial dividends for Treasury and reduce their payouts correspondingly. The notion of a healthy work force with a greater participation rate through their working life and a prolonged working life which they can better enjoy through good health need to be factored in. This has been looked at in the UK and in Canada.

Dr Bain—In our supplementary submission, we have tried to set out all the policies that were undertaken to try and restrict the GP work force, particularly through the latter half of the 1990s. There was a series of policies around restricting student numbers, training numbers and provider numbers. Wherever you looked, more regulations and more rules were put around the GP work force. What we know is that we have a very depleted work force which is going to get worse. I do not know whether the committee has seen the study by AMWAC, the Australian Medical Workforce Advisory Committee, on career decision making. It makes it quite clear that, particularly, male doctors looking for a remunerative career are not going to go into general practice, so we can look to a continuing decline in the GP participation rate. The GP drought is going to get worse, regardless of what we do. All we know is that there will need to be a lot of funding to redress all the funding that was pulled out in the latter part of the 1990s if we are going to turn that GP work force around.

Dr Glasson—The student bonding proposal will make it worse.

Senator STEPHENS—That brings me to my next question. You are quite critical of that whole part of the package. Do you see that there are some options that would increase the number of doctors?

Dr Glasson—I feel this is one part of the proposal that has absolute zero support across the medical community, and I think when you explain it to your colleagues in the house they too will agree that it is not going to solve the problem. If I thought it had any legs in solving the problems in the rural work force, or even the outer metropolitan work force, then you might give it some credence. The system whereby students receive a medical school place not on merit but basically on their desire to get a medical school place and then, supposedly, give six years of service back in 12 years time, we feel, is unfair, unjust and, as I have indicated, probably unconstitutional. What will happen is these doctors will buy their way out. They have their medical student position for the wrong reason. We are proposing that there should be a scholarship based system whereby students get their positions based on merit, after which a number of them are offered a rural scholarship, or a needy scholarship, which could pay part or all of their HECS fees and, for that, they do give a return of service, which we would like to begin more or less through their training.

In other words, if I were a young general practitioner in my training cycle, I could decide that I wanted to go and work in Longreach or the back of Bourke, because I would actually be returning my service and, in doing so, providing a service to those needy areas. I think that is a system that we should move forward on. I think it is fair and just, and, more importantly, I look at my rural colleagues and I say, ‘I think that will solve a lot of your problems.’

Senator STEPHENS—That is a very good sales pitch. I have a final question on the issue of the opting-in and opting-out requirements for HIC Online. We have heard quite a lot of evidence about the technology issues around that package. Dr Rivett said this morning that the software is now much more accessible. Can you tell me what your organisation's opinion is of the HIC Online proposal and the parts of the package that require you to opt in to actually be able to access HIC Online?

Dr Rivett—We have only had a detailed costing from one practice. Its costing ran to $70,000 a year when it had to employ an extra staff member, so the costs were enormous. It has to be streamlined and made a lot more user friendly, but with modern technology that should be quite possible in this day and age. It is something patients certainly want and will benefit from, and I think it will be patient driven. Even if governments think it is an evil step forward in the future, patients are going to demand it. It should be across the board for all patients. The ones who need it least are those who are currently getting compassionately discounted or bulk-billed; they do not need it. So directing it at practices which bulk-bill is really directing the emphasis of where it is least needed away from where it will do the most good for patients. If a practice is 90 per cent bulk-billing, it really does not need to offer this service to the remaining 10 per cent of patients. It is the other patients, who are wasting their time and hours in Medicare queues or their stamps waiting for a Medicare cheque to come back, who need it. We think it should be across the board to all Australia's populace.

Dr Glasson—Ultimately it should be a huge saving. The other thing I keep saying is that the more people who keep putting data in, the more likely they are going to get it wrong and the more it is going to cost. Essentially, if the data can be entered at the point of service—reflecting, obviously, the cost of that to the practice—that is the way to go. It is ridiculous that we have got to line up in queues. It is 2003, and everything—no matter what we are talking about in life—should all just be done online.

Dr Haikerwal—The Health Insurance Commission believe that you can actually hang on to the data and dial up, rather than actually go online with broadband. I think that is probably a fallacy and a false economy, especially in light of other components of the system—for instance, the authority prescription scheme and other such schemes—which, to work efficiently and effectively and get maximum savings for the system, are going to need a proper broadband connection. Of course, that means on the input side that there is a substantial cost involved and technology support and training are required.

Senator STEPHENS—Are you saying that this practice suggested that it was going to cost them $70,000 to opt in? Is that what you are saying?

Dr Rivett—Ms Nesbitt is the expert.

Ms Nesbitt—One practice priced their connection to HIC Online—every aspect of going online, including training time taken by staff—and that came out at $70,000. We have had other practices give us detailed costings as well, and we got costings of anything between $2,000 and $70,000. Around $30,000 seems to be the average, depending on your set-up. Basically, the costing depends on the status of your system and how much you have to alter. If you have everything that is compatible with HIC Online, it might cost you a few thousand to actually hook up. But, certainly, it will cost more if you have to re-network. The practice that we looked at had

to bring someone from a capital city in to re-network them, so the costs vary depending on what you have in front of you. There are also some incompatibility elements. A lot of practices have been moving towards what is called a thin client network and, in fact, that is incompatible with HIC Online. That then requires them to re-network to be compatible with HIC Online. We understand the department has also stated in the hearings that the costs were not modelled for HIC Online.

Senator STEPHENS—Is it possible for you to provide to the committee the range of costs and the issues involved?

Ms Nesbitt—Yes.

Senator ALLISON—Could I invite you, Dr Glasson, to expand on the comment in your submission that a program ought to be put in place to encourage GPs into rural areas. What would such a program look like and what do you suggest is the solution to this maldistribution problem?

Dr Glasson—As I keep saying, I was born in the bush and I work in the bush, and obviously the unfunded bonded scheme is not the way forward. I suggest that strategies relating to the student side of the equation, which in part have been addressed by this government by way of some of the scholarships already in place, could be the way forward. If those 234 places can be brought in as scholarship positions that will obviously be positive. From the point of view of getting doctors to stay in the bush—

Senator ALLISON—Excuse me, Dr Glasson, is that HECS fee relief or some other relief over and above HECS fees?

Dr Glasson—I think these days students are going to have significant difficulties paying for their medical courses, and a lot of them will be out there looking for ways of helping themselves through. I think if you could pay for their HECS fees that is all they really need from the point of view of saying: ‘Listen, I have had my HECS fees paid and I want to work in rural areas. Therefore, I want to go and return that service in the needy areas of this country.’ As I say, these areas are going to be more than just rural areas; they are going to be outer metropolitan areas as well.

Senator ALLISON—So that scholarship would bond them to rural areas? You would be happy with that approach?

Dr Glasson—Exactly. It would bond them to wherever the government of the day thought that the need occurred; that may be in rural areas or it might be in outer metropolitan areas of Sydney, I do not know. It should be targeted at those areas that are short of doctors—wherever they may be.

From the point of view of the doctors in the bush, there are obviously various reasons why doctors leave the bush and do not stay on. These reasons include issues relating to being on call, the inability to get away for continued professional development and the inability to recognise the profession of the spouse—that is one of the big reasons why doctors do not want to go to the bush in the first place. Their spouse either has another profession or is a doctor from another

craft group who cannot practice in that area. This is why I keep saying that we have to get doctors from the bush, train them in the bush and, more importantly, marry them in the bush. If you do that, you have a doctor forever. It is strategies like that—recognising and tailoring those jobs out there—that will ensure that the personal and professional requirements of the doctors are met, and then I think they will stay.

At the moment we are using a lot of overseas trained doctors to try and meet areas of need in the bush. Without our South African doctors in particular we would not have a medical work force in the bush. The trouble is the supply of overseas trained doctors, as you know, has dried up. In reality, we now have to grow our own and, importantly, make sure that those in the bush remain there. We can probably support them in their practices; infrastructure support in their practices is important. The cost of living in the bush is always much higher—you have to fly out, get education for your kids and those sorts of things. I think we need to get down to the nitty-gritty of what detracts people from the bush and try to address those issues. It is often very simple things like housing. People say. 'They would not fix up my house and I got cheesed off and I left.' It often little things like that that get on their nerves. I keep saying that in reality it is probably the most desirable place to practice medicine.

Dr Bain—There is one issue that we should mention to the committee and it is a cost free one—the Trade Practices Act. We still have very strong legal advice that doctors' rosters are illegal under the Trade Practices Act. The ACCC maintains they are not, but continues to prosecute people for rosters. It was picked up in the Dawson inquiry, which made recommendations about this. We hope that one day we will get some modifications to the Trade Practices Act that allow doctors to set up rosters for obstetrics and those sorts of things in country towns.

Senator ALLISON—Central to this inquiry is the question of whether doctors have an adequate salary or not. We have received various views—on both sides of the argument from doctors, I might say. Some of the statistics of the cost of operating a practice vary wildly. In fact, documents that you have provided, prepared by Access Economics—the study of community need and availability of GP services, for instance—say that the cost of a three-doctor practice is around $75,000, but the argument under the relative values study is that it is more likely to be $113,500. I think you say that it is higher than that in many instances. Do you have some advice for the committee as to why there are such variations? Are GPs poor business people? Should they be better trained in this business? Is that part of the problem? Have they just become grumpy because they are not very good at making their practices work efficiently?

Dr Rivett—The best figures are the RVS figures, and, for a two-man practice, the cost is $146,000 per GP. If we average them out across Australia, the average practice has about 2.2 or 2.3 full-time practitioners.

Senator ALLISON—How does that sit with the Access Economics study that I believe you commissioned which shows it is as low as $75,000 for a three-doctor practice?

Dr Rivett—I do not have the survey in front of me. I cannot imagine that. The lowest professional group for practice costs that I am aware of are psychiatrists with a figure of about $85,000. A GP could run a practice for $75,000 but it would be a no-frills practice—a run-down little shop somewhere away from a pharmacist and with probably lino on the floor and broken

kitchen chairs, which is not what we want to see. You cannot get quality care or work force morale being lifted to sustainable levels in those sorts of environments. GPs will certainly cut back and cut back to the bone to try and keep their doors open, but after a certain point they will just shut up shop and leave practice altogether.

Dr Haikerwal—The rule of thumb, really, is that your practice costs are about 50 per cent of what your gross billings are going to be. Obviously, if you are a one-man or a three-man practice, part of it is the actual flag fall of having a practice but, of course, part of it is going to be the number of people you are seeing that will increase your costs. The more people you see, the more costs will be increased because there will be increased staff time and increased consumables that you use in maintaining your practice. So there will be variations based on that as well. The answer to your question about whether GPs are good business people would have to be 'no', but there is a lot of work being done by the colleges and by the AMA to improve the quality of business management to improve the systems within the practice—that is what accreditation was partly about—so that people are able to concentrate on doing the medicine.

Dr Glasson—The difficulty with doctors is that they just want to see patients.

Senator ALLISON—And make a decent salary, presumably.

Dr Glasson—At the end of the day they wake up after 12 months and their accountant says, 'You're going broke.' The reality is that a large percentage of them do not have a clue, I do not think, about what is going on day to day because they are just at the coalface seeing patients. I do not think they base it on business models, and I suppose this whole scenario has made doctors realise that they are running a business model. It is a small business. They have significant overheads and those rising indemnity premiums that keep coming through the door are making them sit up and think. I think you are going to have a lot smarter doctors out there as far as the business is concerned as the realities of the last decade hit home.

Senator ALLISON—I have a final question. In Adelaide at the hearing we were implored to not improve the bulk-billing advantages in metropolitan areas because it was said that even more doctors, particularly from the remote areas, would flock to the cities and exacerbate the problem. You have rejected the government's proposal regarding the $1, $2.95 and $6.50. In terms of the increase in the rebate, what sort of difference do you think there ought to be between the most remote areas—or even just rural areas—and city-based practice?

Dr Glasson—You are talking about geographical rebates. Certainly the AMA does not support geographical rebates. If the government wants to move down a path of supporting differential rebates on economic grounds or whatever, that is their business. But at the end of the day our principle is that there is universal access to this system and it worries me that, once you start breaking it down into little groups, there will be a whole group of patients out there that not picked up by cards—these are the young families with two or three kids who are paying off a mortgage. They are the people who get burnt in this system.

Therefore we as an organisation argue strongly that there should be a universal level of rebate—I do not use the word 'bulk-billing'. It is clearly up to the government to decide what that rebate level should be—what they can afford to pay—and it is up to the doctor to decide what he or she needs to charge to provide that service. The smaller the gap between what the

doctor needs to charge to provide the appropriate service and what the government insurance arm or Medicare pays as a rebate, the more likely it is that the patient not going to be out of pocket—because the doctor will accept that as the full fee in a large percentage of patients. The bigger that gap is, the less likely the patient is not going to be out of pocket for that service.

Senator LEES—Firstly, back to Dr Glasson about marrying them off in the bush: we have heard evidence that once doctors finish university this is the time during their training that they often have more opportunities to socialise. Should we therefore be looking at the scholarships and the bonding—or the lack of scholarships and only bonding—to start during the training period rather than waiting until that person is fully qualified?

Dr Glasson—Senator Lees, I totally agree with you. At the end of the day, if you give someone a scholarship in Brisbane—a real scholarship—and you do not expose them to the bush at all, or very little, then I can tell you that what is going to happen is that they will do their residency training in Brisbane, end up marrying somebody in the environs of their own city, and it is then much more difficult to make a decision to go bush. I was a perfect example. I married a doctor from my year who was not really a bushie; however, I still go out anyway.

I think the Townsville experiment is going to be wonderful. I should not say 'experiment'; I mean the Townsville medical course that is running now. I am really looking forward to that first group of students graduating. What we have said to them up there, and what we have said to Queensland Health is: 'You make sure you have enough resident positions north of Rockhampton to put those doctors into. Do not bring them down to Brisbane and train them, I can tell you, because you will not get them back.' We want resident positions from Rockie north to Thursday Island, so that those young doctors are working in the areas where they were born, bred and trained, and hopefully they will marry and, therefore, be more likely to stay.

The other thing I should say is that, in my day, if you went and did work in the back of Bourke and you came down for a specialty training position in medicine or surgery, you got brownie points for doing that. The trouble now is that there is a perception, and if I go out the back of Longreach and do work for four or five years in general practice, I seem to get excluded from the schemes down here. So I think we have got to take it up with the colleges and also the state governments who fund these state hospital positions. If these guys do work in the bush, then they should somehow get some extra brownie points towards getting a job back in the training schemes.

Senator LEES—That was my next question, so I will move on. Given also that the level of training for rural GPs generally has to be higher, just looking at obstetrics and some of those other areas, are those training opportunities out there? Or are they at some stage still going to need to come into the city area? I am just looking at more flexibility in the package for when those six years are worked, how they are worked and whether we should have gaps in them somewhere.

Dr Glasson—I think the unfortunate thing that has happened, and it is happening right now, is that we are de-skilling our work force in the rural areas. In other words, a rural general practitioner used to do the appendixes, deliver the babies, reset the fractures et cetera. Because of issues of medical indemnity and for various reasons, we are actually de-skilling them of those skills. If we are going to send doctors out there to train with them, it is becoming more difficult.

I think we have got to try to redress that issue. I keep saying that, if we get the medical indemnity situation sorted out, it will really solve a lot of our problems from the point of view of our work force. That is probably the single biggest factor that is biting us. In reality, we have got to get more services in provincial areas where we can actually train these guys.

Dr Rivett—Indemnity is hitting hard there too. In New South Wales we now see the situation in rural hospitals where the Treasury managed fund is deciding what procedures rural practitioners should be performing, even if they have done them for 20 or 30 years. They are looking at their stats and saying, ‘Move all this to the city’, which is demoralising those who have been providing those services for many years—simple things like reducing a closed fracture on a child under an anaesthetic and other things that have been going on since rural hospitals were first put on the face of the earth.

Senator LEES—So you are saying that the health department is requiring now that public hospitals in rural areas do not do these things; they are in fact airlifting people to the cities?

Dr Rivett—The Treasury managed fund is imposing guidelines rather than peer privilege review groups, which has been the case in the past. Previously if you applied to do certain procedures at a rural hospital, it would be determined by a committee of your peers, skilled in that area, to see if you had the training and expertise to provide those services, and that would be kept a watch on. It could be referred to that committee. But to put it in the hands of an indemnity provider is another big step backwards for rural health, certainly.

Senator LEES—Moving on to the current issue before us, your additional submission at point 7 talks of support and practice nurses in all areas. I take that to mean city, outer metro, or wherever. What ratio would you recommend and should we also be looking at allied health professionals in that ratio?

Dr Rivett—The door has only just opened here. At the moment rural and outer urban GPs are provided with some funding towards a nurse one day a week per full-time practitioner basically. The funding in New South Wales, on our practice’s guess, is about $21 an hour and the cost of a nursing sister is about $30 an hour. It is a lift in quality but it is not something that GPs can make dollars out of. They are enormously useful for things like wound dressing but, again, the local hospitals and their district nurses can say, ‘We’ll shut our dressing clinics and refer them on to GPs.’ Then it becomes counterproductive.

We certainly need GPs working more with allied health practitioners, including practice nurses—not nurse practitioners. That would allow GPs to concentrate on the more difficult problems in the practice and not the simple problems. Practice nurses can be trained to do a whole range of activities and save the GPs time, make them more efficient and raise their outputs for the community so a lot can be gained. The other huge area where we ought to be working together is with pharmacists but we have the most restrictive trade legislation in Australia whereby pharmacists are prohibited from working in premises that are not owned and controlled by a pharmacist. How the ACCC could let that one go through their last review of this, the Wilkinson review, I cannot imagine. Because of financial pressures, GPs are grouping into bigger groups. That is going to be the way of the future and they need to work with allied health personnel more and more, including pharmacists. So there are lots of problems for the government to address.

Senator LEES—With regard to funding systems, we heard again this morning the department's wish that there was more emphasis on prevention. Do you see GPs as holders of the kitty, making decisions about things as broad as, say, dental or pharmacy services or whatever their patient may need in both preventive care as well as the treatment area?

Dr Rivett—Much as you might like to see GPs as fund holders, deciders of who gets what and being the official rationers in the system, it is a nightmare for general practitioners. As professionals, our role is to look after the patient before us and tell them what they can access for their care and how they can best obtain those services. If there is something that they should be having that they cannot get, we have to make them aware of that. We cannot just be rationers, otherwise we lose all credibility with our patients.

Senator LEES—On page 5 of your original submission, you say:

The proposed incentives are a fundamental change to the nature of Medicare as it applies to GP services, moving it from a universal payment system to that of a safety net system.

And you go on in the next paragraph to state:

...it moves the financial burden from the wealthier members of society to the sicker members of society.

Given that, and given the likelihood that the government is going to resist many, if not all, of the proposed changes to this package—and certainly, looking at your 16 points, it will not accept anything that extensive or which would cost that much money—do you believe that we should simply pass the package through the Senate anyway, or should we not pass the package through the Senate?

Dr Rivett—As the package stands, I would be very disappointed if it were passed through the Senate. I would certainly expect there to be some changes there, and the opt-in, opt-out clause is one I would certainly like to see go to free up provision of care and access for patients to all practitioners, not just those that opt in in a broadening of the safety net scheme so that there are tiers of safety nets, as proposed by the AMA.

Dr Haikerwal—I think that one thing that does not get addressed particularly often in all of this is the aged care sector, which is dependent on general practice services, especially in residential aged care facility type consultations. That area in particular is very much under the gun if this package goes through. We already have a large number of discrepancies in the way in which the package is handling GP services. We have seen these incentives probably not being of particularly great value for GPs, especially in metropolitan areas where those that are charging a gap will be charging between $5 and $10 for a cardholder and $10 and $25 for a non-cardholder.

Senator LEES—You are talking about the $25 as the gap?

Dr Haikerwal—Yes. I do not think that the financial incentives are much of an incentive at all. I also wear the hat in the AMA as the chair of the committee for the care of older people, and the real concern is that the ever diminishing number of people looking after our older folk in residential care will actually drop off dramatically too.

Senator LEES—After this package is implemented?

Dr Haikerwal—Yes, indeed.

Senator LEES—My final question—and I am sorry we are short of time—again goes back to your submission, where you talk about the package and say:

Nor will it benefit concessional patients in areas already experiencing low bulk-billing rates.

So is the reverse true that, in areas where there are very few concession card holders, quite a large number of people under the swipe system will perhaps be charged a $25 co-payment? In other words, in the sorts of areas that do not really have a problem at the moment, where there are probably a lot of GPs, will this package actually advantage the few people who will have to be bulk-billed?

Dr Rivett—It is a dream scheme if you have a small practice under the Centrepoint Tower in Sydney and you are dealing with business people who are all fit and healthy and coming in for check-ups, overseas travel and other things. It just hits the nail on the head for you. But, for the general practitioners out there servicing most of the population, it is not a way forward at all. In a few isolated cases, it will be very attractive to them.

Senator KNOWLES—I want to come back to the RVS. You have certainly suggested, more often than not, that the standard consultation should be $50. As you no doubt know, every dollar increase in the rebate equals a lot of money for taxpayers. How do you propose that the Commonwealth fund your proposals?

Dr Glasson—I will make a general comment. I am trying to say to my doctors at the moment: ‘Listen, you’re running a business. You’ve got to decide what you’ve got to charge to provide the service.’ It may not be $50; some people might say they can do it for $40 and others might say they can do it for $60. I do not know—they are running the business and they have to decide what they have to do. From the government’s perspective in saying, ‘How much can we fund Medicare, given we do not have an open-ended bucket of money?’ I think that is a decision for the government to make. I cannot pick a figure out of the air and say, ‘It should $30,’ or $35 or whatever. In reality you have to decide, as the insurer, what you can fund in the context of the overall budget. Regarding the figure that you pick—what you can appropriately fund—if the gap is not too great between what the doctor needs to charge and what we get back as an insurance rebate then you will find that the doctors will solve your problems, as I keep saying. They have always solved your problems, in the sense that they are trying to do the right thing by their patients. I think that is a roundabout way of saying that it is really up to the government to decide what it can pay and for us to decide how many patients we can give compassionate discounts to.

Dr Haikerwal—The true value of the service is what the RVS has talked about. People now agree that they will charge for their services based on that particular fee. In some parts of town you will get a discount and the full fee will be less than the RVS. The overall point is that there is a true value for that service, which has hitherto not been understood. If somebody is discounted down to the rebate rate, they are getting a 50 per cent discount, and they need to know that. If somebody is getting the scheduled fee, as per the Labor Party proposal, they are

getting a 40 per cent discount. But, nonetheless, people need to understand what the true cost of that service originally was.

Senator KNOWLES—With all due respect, none of that answers my question. The AMA is really asking for millions of dollars, if not over $1 billion dollars, worth of increased Commonwealth funding. My original question was: how would the AMA propose that the Commonwealth fund your quest to have a dramatically increased rebate level to match the RVS?

Dr Rivett—It has been substantially underfunded year by year. This is returning some of those cutbacks over the years. Last year saw a budget surplus of $4.2 billion, of which $2 billion was returned to taxpayers in small tax cuts. Major polls conducted by both the major media chains in Australia show that more than 70 per cent of Australians would have preferred that $2 billion to go to health and education. I think the people out there are prepared to reach in their pockets to maintain a universal health care system in Australia. As to whether a political party is brave enough to give them that option at an election is another matter. That it is certainly not for the AMA to decide; that is for the electorate to decide, and it is up to the political parties to offer them a choice.

Dr Bain—The AMA's view about access and affordability is that, under the current funding, access and affordability is declining. Doctors are voting with their feet and leaving general practice. The participation rate is dropping and people are not seeking to go into general practice as a career. We want to turn that around. We are not arguing about the level of funding; we are arguing about getting access to GP services for patients. That is diminishing and will continue to diminish.

Senator KNOWLES—Dr Bain, you have repeatedly—and, in my opinion, quite rightly—said that this argument is about access and not about bulk-billing. I come back to the question that Senator Humphries asked in relation to the alternative that is on the table at the moment from the Labor Party. Their quest is to have virtually everyone bulk-billed, or to a certain level, in exchange for an increase in the rebate. I am simply asking again for clarification, because I did not quite understand the response that you gave Senator Humphries. Is your quest for the increase in the rebate—which is really only being offered in an airy-fairy policy by the opposition—for 90 per cent and up to 100 per cent in exchange for a guaranteed level of bulk-billing? I also happen to subscribe to the notion that has been put to us by many witnesses that anything free is not necessarily valued. Will the AMA and its members be able to sign a pledge that, if such a policy is implemented whereby there are strings attached in exchange for the increase in the rebate, they will guarantee bulk-billing to a set number of people?

Dr Haikerwal—I think the answer to that would be a categorical no. We are in a paradigm now where GPs are much more full of self-esteem. They understand the value of their service and they are prepared to fight for that further. That was not the situation five years ago or 10 years ago. We are now seeing the situation where there is a true value placed on their service. With respect to your original question—that is, are we actually asking for the rebate to be the full fifty bucks out of the RVS—the answer is no. What we want is a recognition of the true value of our service. If the government does not want to raise the rebate it should say that the rebate is not changing. But it is not 85 per cent—which makes it seem that we are being extravagant in the way in which fees are being set—and it should simply be said that the rebate is no longer 85 per cent; it is actually 50 per cent in today's terms.

Senator KNOWLES—According to my knowledge, the AMA has been asking for a $17 increase in the rebate, which equates to $1.7 billion—85 per cent of $50.

Dr Rivett—When the initial RVS came out nearly four years ago it was costed then that total implementation over the relative value study findings—and it was not an AMA finding; it was a relative value study finding, held by government with AMA participation—right across the profession would be about $1.7 billion. That was the net cost right across the profession, not just for GPs. Some procedural fees would drop, consultant physicians would earn more, because they had considerable angst that they are underpaid, and GP patient rebates would also go up. So patient rebates for some categories would rise and in other categories they would fall, but the net cost would be around that figure at that point in time. That figure has escalated since then.

If the RVS were to be embraced as an ongoing route forward, it should be noted that the RVS was never finally concluded. Indexation was not looked at, which has been the bugbear of the whole system. Without proper indexation there cannot be a sustainable solution into the future. You have to have indexation that matches rising practice costs and average weekly earnings jointly; otherwise, we are just wasting out time putting in any solutions because they will be like bandaids on a dike—things will get worse. So indexation has to be countenanced, and it is not in either of these packages, which is a huge disappointment.

Senator KNOWLES—I have one final quick question. What is the RVS in relation to general practice and specialist fees?

Dr Rivett—It varies enormously from specialty to speciality. There is no uniform answer for that.

Senator KNOWLES—Wasn't there a huge increase for specialities vis-a-vis the recommendation for the GPs?

Dr Rivett—No. It is all based on the period spent in training and the other factors are put in there—for example, work life expectancy. With some careers you spend a long time training and then have a short working span and have to retire early—a bit like pilots have to do. Neurosurgeons and surgeons are not expected to work past a certain number of years. Different parameters were factored into it by the experts that concluded the RVS.

Senator KNOWLES—Dr Glasson, you might be able to fill me in on your speciality.

Dr Glasson—I am an ophthalmologist.

Senator KNOWLES—What were the recommendations in relation to you?

Dr Glasson—I numbered the items under ophthalmology that were going to be reduced. From the point of view of the consultation fee, there was a move to try to reduce, I suppose, the emphasis on surgical fees and put it more on consultation fees. So, at the end of the day, it probably was not going to make much difference to us. But there was a push to recognise the skills of consultation. That is always an issue between physicians and surgeons—that is, the fact that we do not necessarily recognise the mental capacity; we recognise more the surgical capacity in the rebates we give.

The reality is that what specialists have been charging as a consultation has grown even more out of kilter from the point of view of the Medicare rebate. So, again, specialists did not quite get caught in the GP downward spiral. But, having said, that there is a huge number of specialists out there who continue to accept the Medicare rebate and accept whatever the patient gets back from the health fund. The reality is that there is a huge number of specialists trying to do the right thing by the system and trying to look out for their patients but, at the end of the day, saying, 'If I'm going to provide a quality service, this is the fee I have to charge.'

Dr Haikerwal—The RVS methodology also had a different schedule base regarding the consultation items. So you did not have the situation that we currently do with a zero to five and a six to 19 type of scale. There were shorter time intervals which the RVS was modelled under. Those new items which have been modelled to a certain degree—and they are certainly not going to be taken any further without an increase in funding being available—show that you actually can give a better service if you model those times of consultation differently.

Dr Glasson—At the end of the day, if you recognise what the service is worth, we will then recognise what you can afford to pay. As long as there are sufficient safety nets in there, particularly the combined PBS and MBS, to make sure those people out there who really are in need—the chronically ill, the young, and the very old—are picked up in that system, then that may be a way forward. It is not for us to argue necessarily on amounts. I think that is wrong. All we can say is that the larger the gap between the recognised cost of the service and what the insurance company can afford to pay, the more the safety net has to make sure it kicks in to protect the people who need to be looked after.

Senator FORSHAW—I want to go back to your attitude to the ALP proposal. The proposal that the rebate would be lifted to 95 per cent and then eventually to 100 per cent has been mentioned, but there is another very important aspect or element to the ALP proposal, and that is to make incentive payments to doctors who reach certain targets in metropolitan, outer metropolitan and regional areas. Those payments, on the basis of the current target rate of 80 per cent metropolitan, 75 per cent outer and 70 per cent rural, would be $7,500 in metropolitan, $15,000 in outer metropolitan and $22,500 in rural areas—additional payments. When you add that to the further increase to 100 per cent, there are substantial amounts of money involved. What is the AMA's view of that total package, if you like, in terms of extra income that would be made available to doctors?

Dr Rivett—I was at a large GP forum in Sydney a couple of months ago and we asked for hands up for the government package, and there was an absence of hands; hands up for the Labor Party package, and there were about six; and hands up for neither package and I think there were about 250. So the Labor Party is certainly well ahead of the government, but—

Senator FORSHAW—Did they actually understand the full elements of the ALP package? For the last three-quarters of an hour or so I have noticed that when it has been raised there was only discussion about the increase in the rebate. It was put to you by the government senators that that is what the ALP package was, but there is that whole other area. Did they understand it fully?

Dr Rivett—It had been well explained in all the medical media for many weeks before that meeting was held, so I certainly trust that the ones that were there were politically aware and

came to that particular meeting because of that very focus, which was on discussing GP morale and how GPs can survive in the future. Eighty-five per cent of not very much is certainly not as bad as 95 per cent of not very much, but with inadequate indexation it is going to continue to be not very much. The whole system needs redrafting and shoring up with proper indexation and recognition of what a GP consultation costs and is worth to the community. Otherwise, you demoralise—

Senator FORSHAW—But you have once again talked only about the rebate. If they reach the target in a regional area of 70 per cent then, putting all that together, the additional remuneration for that doctor could be up to $38,000 or $39,000. There is a substantial component of $22,500 in additional payment to the doctor, over and above what happens with the rebate, if he reaches that 70 per cent bulk-billing rate.

Dr Rivett—It is an additional gross amount, presuming the doctor drops all gaps and does not factor in the gaps that he was charging previously. If he was charging gaps previously it may be a net loss. So the $22,000 is a gross figure and the outcome depends entirely on the bottom line and what gaps his population base is used to paying in the past as to whether he will be ahead or behind. It does not just equate to a better bottom line without factoring in all those drivers.

Senator FORSHAW—Have you actually done the work on that to try and find the net outcome?

Dr Rivett—I will wait and see what comes out of the Senate before I sit down and do all the complex figures.

Senator FORSHAW—That is a good point; it is the government's package that is before the Senate. Unless the government decide to throw out three-quarters of it and say, 'We think the ALP package is a good idea,' and then actually put that up or agree with our amendments or whatever, you might be waiting until the next election.

I want to raise another issue. Dr Glasson, it has been the AMA's longstanding view that it is not really keen on bulk-billing. You have said today that the relationship is between the doctor and the patient, that the patient has the relationship with Medicare and that the rebate is there for the patient—that is the fundamental philosophy of the fee-for-service model. Let us understand that there is no copayment at the moment; you either bulk-bill or the patient gets the account, pays it and goes to Medicare and gets the cheque and so on. Doesn't introducing a copayment actually substantially change that current dichotomy? In the future, doctors' incomes will be based upon a mix of accepting the Health Insurance Commission rebate over the counter through the swipe card and then the additional payment from the patient, and that is a fundamental change in your longstanding view that you need this separation. Do you accept that?

Dr Haikerwal—I run a practice in outer suburban Melbourne. We have probably a 70 per cent or 80 per cent cardholder population but we charge private fees. If somebody pays a full fee up-front then the paradigm we are talking about already exists—obviously they get their Medicare rebate into their account within three working days because we do all the paperwork for them. If they pay a gap, we wait about four weeks for them to get the cheque and forward it back to us—

Senator FORSHAW—With their cheque.

Dr Haikerwal—Yes.

Senator FORSHAW—That is right.

Dr Haikerwal—If that were streamlined it would mean that the HIC would save a bucket of money and the patient would not have to be bothered about queuing—

Senator FORSHAW—I understand those arguments; I do not think we need to go over them. What I am trying to understand here—you have repeated it today—is your longstanding view that the relationship in Medicare should be between the patient and Medicare unless you bulk-bill completely and accept the rebate. Now, you are saying that you like that part of the government's package which fundamentally changes your billing process. You will now have Medicare paying you and the patient a direct part of the bill. Firstly, doesn't that introduce a major change to your entire approach? Secondly, what will happen in the future? You will have two competing pressures in how you set your fees—that is, if you are not receiving enough from the HIC, the only option you have is to push up the copayment. Isn't that the logical outcome in the future?

Dr Rivett—We already have just those pressures; I do not think it is anything new. The patient rebate is the patient rebate is the patient rebate. How it gets to the doctor, whether it is done electronically in a streamlined manner—

Senator FORSHAW—Dr Rivett, with all due respect, unless you bulk-bill, you do not receive the rebate. What you get from the patient is payment of the total bill made up of two cheques: the Medicare cheque and the additional payment from the patient. That is how the system works. You have said here today that the rebate is for the patient, not for the doctor. You are now supporting a system which says that the rebate should be directed to the doctor.

Dr Rivett—The rebate is always for the patient. If the patient has paid their account in full, the rebate goes to the patient, without fail. It is not a change in the system; it is just a change in how it is processed and streamlined.

Dr Glasson—Senator, I see what you are getting at—

Senator FORSHAW—I know you can see what I am getting at.

Dr Glasson—and I am adamant. It is the same with private health insurance—no gaps. I totally agree that there is no different philosophy. If I receive a cheque from a health fund or a government agency, I am in part being paid by that. I understand what you are saying. What I am saying is that, if I give a patient an account at the front desk and say, 'This is $50, Mrs Jones; here is the gap; pay the money'—half of it is covered by Medicare, leaving a gap of $25—what happens to the Medicare component? She can line up at a Medicare office and send the cheque back to me. The patient still has the bill. If it can be handled electronically at the point of service and paid into the patient's account—that is, paid not into my account but into the patient's account—it would be one way of keeping my philosophy, so to speak. But if it is being paid directly into my account, I agree with you: I have trouble with that—do not get me wrong—but I am trying to make it easier for the patient, not make it more difficult for them.

Senator FORSHAW—You are also trying to make it a bit easier for yourself if you are not a bulk-billing doctor because, technically, what you end up with is, in part, bulk-billing. My concern is that, firstly, that is an acceptance of the part of bulk-billing that will ultimately benefit the doctor because they get their payment earlier and, secondly, you are now creating—you have used the term—'two drivers' of how you set your costs, rather than just one, which is what you charge the patient.

CHAIR—We are over time. I know that members of the AMA have to catch a plane. This will be the last answer from Dr Glasson, otherwise you will miss your plane, and then we will wrap up proceedings.

Dr Glasson—I am playing with semantics here and I apologise for that. But, at the end of the day, I give the patient a bill, the patient pays the copayment if there is one and then it is a matter of deciding how that money gets from Medicare back to me. It can be directed to the patient—and that is the way it is done now—and it comes back to me, or I can make it easier on the patient by having it directed into the doctor's account. I still have a philosophical problem with that—and I agree—because I think that, at the end of the day, I am responsible to whoever pays me. Whoever pays the piper calls the tune, I keep saying. If the government health fund is paying me, I have a responsibility to the government health fund. If the patient is paying me, my responsibility is to the patient. I accept your point, Senator, but I am trying to make it a bit easier from the point of view of that dear old lady who is trying to get her money back from the insurance company, which is Medicare.

CHAIR—Thank you, Dr Glasson, and members of the AMA for your contribution. Please do not hesitate to be in touch with us if you have further information for the committee. I hope you do not miss your plane.

Dr Glasson—Thank you very much.

[12.41 p.m.]

CLARK, Dr Stephen Leslie, Chief Executive Officer, Australian Divisions of General Practice

WALTERS, Dr Robert John, Chair, Australian Divisions of General Practice

CHAIR—Welcome. Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. The committee prefers all evidence to be heard in public, but should you at any stage wish to give your evidence, part of your evidence or answers to specific questions in private, please ask to do so and we will consider your request. Your submission is before the committee. Thank you very much for providing it to us. I now invite you to make an opening statement before we move to questions.

Dr Walters—May I first apologise for my deputy chair, Dr Vlad Matic, who is a remote practitioner in Walgett in far outback New South Wales. Unfortunately—one of the problems we will be highlighting later has struck—his overseas trained doctor colleague has had to return to Scotland urgently and Dr Matic has been unable to arrange a locum. As he is the only remaining practitioner, he clearly could not leave his patients.

As we have said in our submission, ADGP believe that health reform is urgently needed. We represent 121 divisions around Australia, as well as eight state based organisations. Their members are about 95 per cent of the general practice population. When I am talking about general practitioners or general practice, I will be reflecting the views of those divisions' members—general practitioners and general practices—through our membership, which is the divisions themselves.

We have to ensure that Australians can access high quality health care and get better health outcomes. We have to get more bang for our health dollar, which will be achieved through a greater focus on primary care, on the preventive, comprehensive whole patient care that can be delivered through general practice. Part of the problem is that primary care is not as dramatic a headline as MRIs or lung or heart transplants, but it is where the greatest difference to health status can be made. It is where huge financial savings can also be made. Good general practice saves dollars. We think that investment by governments, both Commonwealth and state, needs to be rebalanced to reflect that. It might also help if primary health care were better promoted by governments and if GPs were empowered and perhaps their image enhanced in their communities rather than general practice being the target, as it would appear—I will talk about this later—of A Fairer Medicare package.

We think the focus of the recent Medicare debate on bulk-billing has distracted the public's attention from the main game—that is, the need for substantial reforms that reduce duplication, reduce the cost and reduce blame shifting between Commonwealth and state governments, and that look at the health dollar overall and how it can be better spent. Bulk-billing does not relate to the quality of health care provided.

Divisions provide a unique infrastructure in health that bridges the Commonwealth and state systems. We think that this could be better utilised on a consistent basis across the country. We know that as a committee you have heard from a number of divisions about some of the innovative ways they have evolved the delivery of primary health care—from the Primary Health Care Access Program, to the cashing out of the PIP in the Northern Territory, to the after-hours work in Newcastle. We think this debate may be better served by taking a few steps back from whether the rebate should go up by $1, or $6, or $25, to get GPs to bulk-bill and looking at the whole system and how it can be rejigged so that GPs are better supported to do the great job that they are already doing.

Divisions are about building the capacity of general practice to improve the delivery of primary care in their communities. They do this in numerous ways: through running activities for general practice, and I heard you discussing with the AMA business education for general practitioners, and that is one way; through working with practices to implement more efficient systems, largely through IT and information management that impacts on both the clinical and business aspects of practice; through coordinating local practice nurse networks; through contracting allied health professionals; and through making arrangements between local hospitals and general practices.

The types of activities that divisions are involved in can vary from region to region, depending upon their local population needs and circumstances. The funding buckets available also vary depending upon their location—for example, access to the MAHS Program, which I am sure you have heard of, and practice nurse funding, which is currently limited to rural divisions.

With regard to the government's proposed Medicare package, ADGP did a national survey, which generated 800 responses. This is an almost unheard of number for this sort of thing, in our experience. It came back pretty overwhelmingly that GPs did not support it. They did not support the implied coercion in what they could charge which patients. Some bits of the package were supported more than others. There was a recognition, which we are grateful for, of some of the problems, but overall it was a pretty resounding 'no', because of the compulsion element. The results overall and on the individual components were attached to our submission, and I am sure you have seen that. A similar survey was done in regard to the ALP proposals and similar conclusions drawn.

GPs are offended by the fact that this so-called A Fairer Medicare proposal targets general practice. Nobody can find any price signals sent to specialists. While we recognise that they perhaps are a smaller part of the cake, we would have thought that, for equity reasons, price signals might have been sent to our specialist colleagues. This is not a specialist-knocking process; this is simply about equity—as this is called 'A Fairer Medicare'.

In conclusion, general practice is bleeding. We have a morale problem, we have shortages—the details of which you have heard, I am sure, on numerous occasions—we are reliant on OTDs, we are losing more doctors than we are training currently, and we are about to have large retirements in the baby boomer set, my set, many of whom (40 per cent in fact) have recently changed their retirement arrangements in view of the way general practice is going. We are losing some of our brightest minds from medical schools away from general practice, and we have that desperately sad situation where 80 per cent of currently practicing general practitioners

would not recommend general practice to their own kids. I am happy to take any questions, and my CEO will assist where possible.

CHAIR—Thank you very much. You said in your commentary that bulk-billing does not relate to the quality of the health care provided. This issue has been raised with us on a number of occasions in a number of different sets of words. Earlier, the AMA implied, but did not say, that there was a better quality visit between a doctor and a patient if there was a fee charged, but nowhere can I find any studies, any work, that have gone to the question of whether or not the quality of service is improved—I think you were saying that—if a fee for service is actually made. This is the first question I have: do you have any advice to that effect?

Secondly, I am a bit concerned that it seems to be implicit in what some doctors are saying—not you, I acknowledge—that somehow it is better if there is a copayment. I would imagine that the relationship between the doctor and the patient is at a higher level than simply whether or not the person has paid a copayment at the front counter.

Dr Walters—There are two issues to this. I think I heard the AMA discuss the concept that a service is better valued if a patient has to put their hand in their pocket. An argument could certainly be made for that. However, we are talking about the quality of care that is being delivered. What Bulk-billing, or rebate only, does is return to the doctor for their hourly rate, or for their remuneration, a lesser fee than they would receive if there was a copayment as well—clearly, there is extra if a copayment is made—and that puts pressure on the doctor to turn over a larger number of patients.

So a choice has to be made at some stage by the doctor as to whether they refer the patient or whether they carry out the service themselves. I can tell you from a cost-efficiency point of view, it is much more preferable that the GPs, many of whom are very skilled, carry out the processes themselves. It also indirectly puts pressure on something else that is very costly—that is, the PBS. It is a lot more time consuming to counsel people about healthy lifestyles—to go down the line of talking to people about diet or putting them on weight loss programs—than it is to perhaps prescribe a medication, such as an antilipid medication or something similar to that. We are talking about time pressures. We are not talking about the actual amount; we are talking about making general practices sustainable so that you can continue to run your business. Clearly, if there is a copayment then your income is increased. If your income is increased then you can afford to spend more time with individual patients.

CHAIR—But has that analysis been done in an academic sense—analysis that looks at, say, the potential for a bulk-billing doctor to make higher use of the PBS or to refer more readily? Has that work been done?

Dr Walters—I am not aware of any work that has been done on that, but certainly we could research that for you and find out if that is available and get it to you. I can take that on notice.

CHAIR—The second part of my question goes to a term that the AMA use—I am probably asking you questions that I wanted to, but did not get an opportunity to, ask the AMA—which is ‘compassionate discounting’. It is said to us by all the consumer groups who have come to see us, I think, that the thing that Australian health consumers value most is bulk-billing, that there is an understanding in the community that we have paid for our health care system either through

the Medicare levy or through our taxes and that the introduction of a payment at the point of service changes the relationship between the patient and the doctor.

Many doctors have said to us that they look out the window at what car the patient is driving in order to ascertain what to charge them. I am exaggerating there, but doctors are saying that they know how much to charge their patients because they have an intimate relationship with them. From the consumer's perspective, that changes completely the relationship over the doctor's consulting table. A consumer arrives wanting to have a discussion with the doctor about their health, but ever present in their mind is the question, 'What is he going to charge me?' Do you want to comment on the changed power relationship that results when compassionate discounting is brought to the table?

Dr Walters—My experience and that of many of the members of our divisions is that this is not the case—that is, having to contribute to health services provided by GPs is not a hindrance to most of our patients. In other words, the 'power relationship' is not used by general practitioners. On the whole, general practitioners are very compassionate people—you have to be to be in the business. Most general practitioners are more than happy to discuss arrangements and, as they get away from bulk-billing, are finding that patients appreciate having their GP discuss what the GP intends to charge. Anecdotally—though we could probably provide figures on this—a large number of the practices that have recently stopped bulk-billing have been amazed at how welcoming the patients have been of the new arrangements and how very few have left the practice, which I guess is the ultimate test.

They have been surprised and encouraged by their patients' reaction to a simple explanation of the fact that they cannot continue in general practice under the current arrangements—that what is provided in the rebate is totally inadequate to fund their general practice and that they will not be here if they have to continue to do that. That is certainly my personal experience, and it is the experience of a large number of general practitioners I have spoken to since I have taken on this role. I am sure that a number of people have presented evidence here, but I think a large number of the population out there who may not have presented evidence to you would have a different opinion.

CHAIR—Of the doctor population?

Dr Walters—Of the patient population.

CHAIR—That is potentially the case.

Dr Walters—Yes. I think that governments and political parties are running scared of this voter reaction to changes in bulk-billing. I know it is a very hot political issue but I think that, if you are brave enough to look at it and to poll the populace, you might find that the issue is not the bogeyman you think it is. What patients want is access to good quality care, from good general practitioners, in their community.

CHAIR—My analysis is that they want access, they want good quality care but they want it at an affordable price, and their understanding is that they have already paid for a good proportion of that through the Medicare levy and through their taxes.

Dr Walters—I think you will find that they want it at a fair price, and I think that the history of general practitioners is that they do provide it at a fair price. This concept that general practitioners are, under changes in arrangements, suddenly going to jack their fees up and make radical changes to their billing is just fictitious. It is not going to happen. General practitioners do know their patients well. They make constant allowances. They have been underwriting the ailing system for so long and they constantly go that extra yard on behalf of their patients. They are not going to suddenly change that doctor-patient relationship. I think that politicians—understandably, I suppose—do not fully understand that amazing thing that is the doctor-patient relationship.

CHAIR—I think that relationship is under stress—I think that is what consumers are telling us—because of the question of remuneration on the doctor's part and then the flow-on changes that occur with that relationship as the doctor changes his or her billing procedures. That is the point I am making. I recognise that there needed to be changes in the way doctors are remunerated. Certainly Labor's policy attempts to do that, as does the Liberal's policy to a lesser extent. It is that changed relationship that occurs at the point of the introduction of the gap that I am trying to get to.

Dr Walters—I guess what I am saying is that bulk-billing should remain as one of the options a doctor and patient have in deciding how that doctor is remunerated at the time. However, there should not be elements of compulsion there, and I think you will find that it is not the issue for many more of the consumers than perhaps you realise.

CHAIR—Thank you for that philosophical discussion.

Senator KNOWLES—Dr Walters, I noticed that you have appended the results of the A Fairer Medicare package survey. You said that you also surveyed the ALP package. Have I just missed the results of that, or should I have them here somewhere?

Dr Walters—I do not think it was attached to our submission, but we could arrange for you to have a copy.

Senator KNOWLES—That would be very useful. Dr Walters, do you know whether any work has been done by your organisation as to the number of visits each patient generally makes to your practices?

Dr Walters—We know that 85 per cent of the population will visit a GP every year. I think on average it is five visits per year—something along those lines.

Senator KNOWLES—For that 85 per cent?

Dr Walters—Yes.

Senator KNOWLES—So 85 per cent of the population will visit a GP five times a year or less?

Dr Walters—Eighty-five per cent of the population will visit a GP once in a year, and I think the average is five-point-something visits per year for the population. So some obviously visit a lot more than five times to give that average. That is the average.

Senator KNOWLES—What I am trying to find out—and I will probably have to try and get it from the HIC—is how many people visit a GP fewer than five times a year.

Dr Walters—Clearly, not everybody visits a doctor every year. Fifteen per cent do not visit a doctor every year. Some would visit once; some would visit 15 times. The average for the total population of Australia, as I understand it, comes out at five-point-something visits per year to a general practitioner.

Senator KNOWLES—Do you know how many people have left your member practices to go to a bulk-billing doctor?

Dr Walters—How many have left?

Senator KNOWLES—How many patients?

Dr Walters—No, I cannot give you figures on that sort of thing.

Senator KNOWLES—We have not had much evidence to suggest that people are walking away in droves because there is a gap to pay.

Dr Walters—That is exactly the point I was making to Senator McLucas. I believe that, in most cases, the strength of the doctor-patient relationship is such that when a doctor explains the situation to patients—and maybe in the past we have not been that good at explaining it, because it has simply been a matter of handing over a card—it puts out a price signal, in much the way that we are with the PBS now, to a patient who has not thought about what it actually costs to run a general practice, this little business in their community that provides them with such high-quality-service. When doctors make that explanation, we are finding—this is from all the information that I am getting—that the fall-out rate, the number of people leaving the practice, is minimal.

Senator KNOWLES—I have asked this next question before, and you probably heard me ask it of the AMA. Our terms of reference, as you know, are to examine alternatives. One alternative on the deck is to jack up the rebate in exchange for a prescribed number of bulk-billed patients. Given that eight out of 10 patients in Australia are already bulk-billed, do you believe doctors would sign a pledge, in exchange for a higher rebate level, that would guarantee bulk-billing to a prescribed level?

Dr Walters—Are you talking about the ALP's proposals?

Senator KNOWLES—Yes.

Dr Walters—As there are with the A Fairer Medicare package, there would be a number of practices where this would bring higher returns. Therefore, there would be some practices that

would do that. However, our survey showed that, in a similar way to the rejection of the A Fairer Medicare package, most practices believed this was not the answer.

Senator KNOWLES—Is the issue then for doctors still to be able to have the independence and the flexibility to charge what they perceive to be a fair amount, regardless of the A Fairer Medicare package or the carrot of ‘We’ll give you an extra big rebate if you guarantee to bulk-bill everyone’? Are the doctors just saying, ‘A pox on both your houses! We are going to do what we want to do, regardless’?

Dr Walters—I do not think they would be putting it quite like that, but they are saying that they, and the patient, should be able to decide what the value of a service is. Clearly, market forces apply. If a doctor is overcharging then patients will leave. If they do not feel they are getting value for money then they will leave. We are saying, however, that a straight fee-for-service approach, which is the preferred position for most doctors, is not the only way. We believe there are other ways of remunerating good primary health care.

Senator KNOWLES—What do you believe is the average out-of-pocket gap that people are paying these days for a short consultation?

Dr Walters—For an item 23 Australia wide, it is about $19. I know that in my home state it is significantly less, at about $14. The national average for out-of-pocket expenses, or patient contributions, is $19.91. In Tasmania, it is $14.66.

Senator KNOWLES—For a substantial number of people who visit the doctor less than five times a year, one might argue that $19.91 is not a huge out-of-pocket expense.

Dr Walters—One might argue that. Patients are clearly not arguing it, because they are paying it.

Senator KNOWLES—That is my point. Therefore, would it be fair to say that doctors look more compassionately upon those who are extensive users of general practice services and that, if patients have ongoing illness, terminal illness, very sick children or whatever, it would be wrong for anyone to suggest that the $19.91 will be charged ad infinitum regardless of the number of visits?

Dr Walters—Absolutely. There is no doubt that this is what general practitioners do all the time. They always have and always will. They look after the people who require a large number of services, the chronically ill. That is what we are talking about and why we are not advocating for the abolition, if you like, of bulk-billing. We are not advocating that there should not be other mechanisms available to provide remuneration for the doctors for these regular users.

Senator KNOWLES—In other words, for the average use of five visits or less, most people are looking at $200 a year—$2 a week or less—to see their doctors for a considerable time?

Dr Walters—That is what the statistics would imply.

Senator KNOWLES—Thank you.

Senator LEES—In your submission you have placed a lot of emphasis on teamwork and doctors working with allied health professionals and nurses. Could you detail that further and look at the structure of what you are recommending, particularly ratios of doctors to allied health professionals or doctors to nurses, and pick up some issues related to whether it should be in all areas of need, in all areas or, as is proposed, in outer metro and rural areas?

Dr Walters—We believe that the practice nurse initiative has been very successful. In this time of gross general practitioner shortages, we believe that an extension of that right across the system could help alleviate some of the problems by taking the pressure off general practitioners in the short term whilst measures are taken to increase the number of general practitioners in the community. The ratio would depend to a certain extent on the style of practice and on its location. However, utilised correctly, a ratio of one practice nurse to every two or three doctors would seem to be about right. However, the problem we have at the moment is that using allied health professionals within practices is an expensive business unless you are in one of the areas where it is subsidised. We think that there should be some consideration of being able to obtain remuneration for services performed by allied health professionals under the direction of the general practitioner—possibly even through the MBS as, I think, Professor Deeble mentioned at your roundtable discussion. There is the capability to do that.

Senator LEES—Could you also look at being paid to the practice—to, say, a three-doctor practice—what it would cost normally for the salary of your average allied health professional (I do not know what it would be; $40,000 to $45,000) and then leave to the GP as to what service, how much of the service, et cetera is provided?

Dr Walters—The Australian Nursing Federation is helping us with that research right at this time. We know that it costs around $50,000—it is probably a bit more than $45,000—to have a good practice nurse, to use that one as an example. Your suggestion is that practices be funded and then use those services. That is the type of system to an extent—although I think it is only subsidised at the moment—that is occurring in rural Australia and is being proposed for outer urban areas.

Senator LEES—So doctors would not have to look in on a patient; they could simply leave the triaging to the nurse at the front desk as to whether they eventually saw that particular patient or, indeed, the nurse gave the injection or fixed up the knee?

Dr Walters—Absolutely. Even the most conservative of general practitioners have come to the realisation that good primary health care is about a team approach. It is not only practice nurses but a number of other allied health workers that can assist in providing this to the community. At the moment the pressure on the general practitioners, where remuneration can only be obtained if the practitioner touches or is face to face with the patient, puts a bit of a skew on it and sometimes creates farcical situations.

Senator LEES—We have seen a lot of work done by hospitals on the impact of category 4 and 5 in terms of what is urgent and what is not. Have you done any work to break down category 4 and 5 patients into what percentage, on average, really should be seeing an allied health professional and what percentage of them could be very adequately supported by a nurse? In particular, what sorts of savings could be made in the preventive area if there were a regular

process of, for example, home visits by an aged care nurse, as far as the pressure on a GP practice is concerned? Has there been any research done?

Dr Walters—Again, I am not aware of any research. The questions that a number of you are asking are highlighting something that we are very keen to see happen—that is, the investment of a lot more money into research into primary health care. I am not aware of that, but there is no doubt that it could be better categorised. When patients go to emergency departments, for instance, they clag emergency departments up away from their real raison d'etre—and it does not provide patients with very good primary health care, I might add. With due respect to my colleagues who work in those emergency departments, because they are often either interns or specialists in other fields they do not necessarily provide top quality primary health care or, indeed, continuity of care, which is such an important plank of general practice. There should be research done into exactly that—and it would be a relatively easy thing to do, I would have thought.

Senator LEES—Looking through the various concerns you have raised in your submission, I see that on page 6 you have commented particularly about concerns relating to premiums and extending private health insurance coverage to the primary care sector and also relating to oversight that may evolve by the funders. I also noted some comments you made about the survey results from your members. If there are no substantial changes to the package, would you recommend that the Senate rejects it or passes it? What is your opinion on that?

Dr Walters—That is for the Senate to decide. The Divisions of General Practice are about improving the quality of primary health care, and I do not believe that passing this bill is going to do anything to improve the quality of primary health care.

Senator STEPHENS—Thank you for your submission. It addresses the terms of reference, and obviously, unlike some of the other doctors whom we have spoken to, you have actually thought through the longer term impacts of the package. I want to raise with you the issue that you mention on pages 5 and 6. You make some comments about the change to bulk-billing arrangements and you talk about some of the issues around technology and connectivity in rural and remote areas. In the final dot point on page 5 you say:

... patients facing a major health issue that requires substantial upfront costs over a short period are unlikely to be advantaged. The impact on fees and access in the long term will need to be closely monitored..

Can you describe what kind of patients they might be?

Dr Walters—We are relating there to the patient who is facing costs from other services, such as hospitals, specialists and so forth, not general practitioners. General practitioners would be incredibly advantaged, as would their patients, by having modern technology at the front desk at the point of service.

Senator STEPHENS—Information came from the AMA this morning that there have been estimates that it might cost between $2,000 and, from one estimate, $70,000 to implement the package. Do you have a sense of what your membership are thinking it will cost them to opt into the package?

Dr Walters—We do not actually have those figures. We have had these discussions before with the AMA. We believe that it is possibly somewhere in between those figures—

Senator FORSHAW—I think you are right so far!

Dr Walters—but it is probably not quite as far as the extreme figure of $70,000. It is going to vary depending obviously on geographical location, it is going to depend on what the general practices have already established in their practices, it is going to depend on the provider. However, I might add that it is an ideal area for divisions, because it is exactly our bread and butter to get in there and negotiate favourable deals on this type of thing on behalf of practices; to go in there and source the best and most practical way for this to work in general practice.

Senator STEPHENS—The other quick issue was about the point that you made on page 3 of your submission, which is your covering letter—that is, the comment you make in the first paragraph about the unworkability of the practice for after-hours services and the complexity of having doctors who opt in and doctors who do not opt into providing out-of-hours services. Would you like to elaborate on that issue?

Dr Walters—I can give you an example that I know very well. In my home town a number of practices cooperate to provide after-hours services—in other words, to provide cover for each other so that you are not working a one-in-two; you are working a one-in-six. However, the doctors often come from different practices and have different philosophies, and it would seem to us that one of the major impediments to this coercion would be the requirement to bill in a certain fashion after hours.

Senator STEPHENS—Is there a sense from your members that they would withdraw from those cooperative arrangements if that were a requirement?

Dr Walters—The cooperative arrangements are normally on an agreed basis. They do not agree on fees, obviously, because that would not be the way to go, but they agree at the moment that the treating doctor charges what he or she believes to be an appropriate fee. That is usual. If there were coercion, it may make doctors consider whether it was worthwhile. Probably GPs who are in those sorts of arrangements would be reluctant, however, to withdraw, because it is an expression of their preparedness to provide complete primary health care. But, again, we come back to sustainability, and we have got to say that at the moment it is not sustainable.

Senator ALLISON—Is there any data available through the Australian Divisions of General Practice or other bodies about the number of GPs who have closed their books and where this problem is most acute?

Dr Walters—We are looking at that at the moment, and we would be very happy to provide you with that, particularly in relation to the recent medical indemnity changes, which have caused huge upheaval in general practice land—in particular, with part-time practitioners who have left practice prematurely. Those practitioners were providing two or three sessions a week to allow a busy practice to have an occasional afternoon off. They would come on board for a week full time to allow someone to have the school holidays with their kids and would then disappear back into their semiretirement.

Senator ALLISON—I did not mean the GPs who are now not practising; I meant those who have simply said, ‘I’ve got enough patients. I can’t take any more’; someone rings and they say, ‘Go elsewhere. I’ve closed my books.’

Dr Walters—Sorry, I thought you meant those who had closed shop. That is on my mind, because that is what is happening as well. I do not think we have those figures, but it would not be difficult for us to survey through the divisions infrastructure, and we could do that for you. Let me just make a comment on that, however, and this goes back to the situation that I was talking about to Senator McLucas in the very beginning: the pressure is such at the moment, particularly in rural and remote areas, that general practitioners cannot close their books; they are the only game in town in some instances. The pressure is such that patients are appearing, whether or not they have an appointment, with urgent situations. General practitioners, despite what might be implied by some at times, do not throw out people who do not have a dollar in their pockets and who require urgent medical care—never have, never will, and do not do it at the moment. However, there are only so many patients that these hands can touch a day—and this comes back to the work pressure that I was talking about; the six-minute medicine much discussed—because we cannot just keep taking on patients.

Senator ALLISON—It would be interesting if you had some hard data on that question, because a lot of the submissions, particularly individual submissions, have talked about shopping around and getting a no from six, seven, whatever GPs in their immediate area—even beyond their immediate area. So if you do have some data on what you say—GPs taking people if it is an emergency—that would be interesting. This leads me to question your remark a little earlier: that patients will leave if they are overcharged. In a climate where it is very difficult to get to a GP, how likely is that? Are we going to see patients preferring to hang onto whatever problem they have and thereby incurring further health effects, or are they just going to find the money, even though they cannot afford it, by not paying for food or other necessities? How sure can you be, and what studies have you done that demonstrate this, that patients will vote with their feet?

Dr Walters—I concede that in areas of extreme GP shortage some patients may not have an option. But there is no evidence that I have seen that general practitioners—and I am talking about general practitioners specifically, and we could talk about the other later, if you wish—take advantage of that situation to charge unreasonable fees or put patients in the position of not having food on their table, as I think you said, for the costs of their medical services. In fact, I think that general practitioners have a unique relationship with their patients where—probably second to the patient’s family—because of the extraordinarily privileged position they are in, they know their patients' circumstances well. As I have said before, general practitioners have proven time and time again to be very compassionate, they have proven time and time again that they are prepared to underwrite the health system of this country, but they are not going to continue to do it—they are fed up and are not going to do it any more.

Senator ALLISON—Do you think there is a relationship between income and hours worked? In other words, if doctors were provided with a higher rebate, would they see fewer patients? Would they cut back from 60 to 50 hours because they could and their income would be the same?

Dr Walters—There may be some that would but, unfortunately, it is not so much income that doctors are striving for; it is seeing the patients, because of the gross shortages of general practitioners.

Senator ALLISON—You understand the policy that is behind that question: if an increase in the rebate leads to doctors seeing fewer patients, we exacerbate our GP shortage.

Dr Walters—No, because what we would do, hopefully, is make general practice an attractive option for doctors and medical students to come into. We are losing some of our brightest minds in medical school, who are saying, ‘Why would I?’ We have got some of the cream of the crop in general practice. We have some of the best medical minds in the country, but they are not going to do it if it is a constant battle to remain viable.

Senator HUMPHRIES—I will put to you a couple of questions that I put to the AMA. Do you think that doctors will take advantage of the copayment arrangements—the payment of the gap at the point where patients receive services—to increase their fees?

Dr Walters—I do not believe that they would increase them unfairly. If a copayment system were introduced—and I assume you are talking about outside any package—general practitioners would do what they currently do. That system currently exists. I can charge whatever I like.

Senator HUMPHRIES—Do you think that price signals tend in general to deter the sick as much as they deter those who are not so sick?

Dr Walters—I believe it is a bit of a myth that people who are genuinely ill are deterred from seeking general practice services. As I said before, I have yet to see evidence of people being deterred or turned away from general practitioners because of financial costs. I would like to see that evidence before I was prepared to accept that. I do not believe that to be the case.

Senator HUMPHRIES—Do you think that, if there were a gap insurance arrangement for patients who incur fees or out-of-pocket expenses of greater than $1,000 in a year, doctors would use that as an opportunity to begin to charge more of those patients and to take advantage of the fallback of insurance that patients had for out-of-pocket expenses?

Dr Walters—I think you would find that they would reach those limits, not from general practitioner costs but from other costs.

Senator HUMPHRIES—Given that that is the case, do you think that specialists would start to do that?

Dr Walters—I would like to think not but, unfortunately, I do not believe that our specialist colleagues have the same good record of taking into consideration the patient’s circumstances when it comes to charging their fees. As I say, I know where the specialist school is. I can go there and be one if I want to be one. I am not knocking specialists. I am simply saying that general practitioners have an extraordinarily good record of compassion in this area.

Senator HUMPHRIES—You argue for the integrity of the doctor-patient relationship to be the setter of fees—of what is fair between doctor and patient. That, I think, necessarily means that measuring bulk-billing rates as a sign of how well our system is providing affordable primary health care is less important. Our problem is what we use as an alternative measure if we are not using bulk-billing rates. You might want to take this question on notice: what alternative measures could we use to determine how fair, accessible and affordable Australian health care is if we do not use bulk-billing rates?

Dr Walters—I hope I have the question in my mind correctly. Outcomes are what we should be measuring, and they are measurable. We should be taking the blinkers off with regard to how we provide services that provide those high quality outcomes, particularly with the treatment of chronic disease. Fee-for-service is well adapted to acute medicine but there are other ways. You have heard some of them presented to you—for instance, after-hours care. For some of the Northern Territory medical services, there are other ways of providing that—for instance, through regional fund holding. The thought of that sends some people into states of apoplexy. I believe that these things, used appropriately in the right region for that community's problems, should be considered, along with a strong fee-for-service base. I hope I have answered that question.

Senator FORSHAW—I have just one question, and you may want to take it on notice. Do you have any statistics on the different ways that payments are made by patients to GPs? I am asking about what proportion of patients would pay with a credit card, cheque or cash at the time of service and what proportion would take the account away and pay it later, with a combination of a Medicare rebate cheque and their own payment?

Dr Walters—I think the HIC has all that data.

Senator FORSHAW—I realise that. I just wonder what your own experience is from your division.

Dr Walters—From what I have experienced as a general practitioner, arrangements are improved by total frankness about billing processes and by discounts for payment on the day. Patients often suddenly realise it is much handier for them to get cash back after they have a receipt from a general practitioner. I want to put in a plug for single point of service transactions, which benefit everyone. I heard you asking questions earlier of the AMA about why money should be paid directly into a doctor's account. Why not ask the patients what they want? If the patients opt to have that money paid into their account—

Senator FORSHAW—With respect, that was not my question, because that can happen and that is what bulk-billing is. My question was directed at how you justify or argue the philosophy of a doctor-patient relationship with respect to the fee and the patient having a relationship with Medicare, and then turn around and say that you want partial bulk-billing for patients if you support a co-payment and swipe card arrangement.

Dr Walters—We would say to the patient, 'The cost of your service is this much; the government has decided they wish to rebate you, the patient, this much; how do you want to collect that rebate? Do you want to sign for it to go straight to me, so the whole transaction is over? Do you want to collect the cheque and 'check it' or something?' I do not know why they

would want to do that. My choice would be to let the patient make the decision about that relationship, which is very definitely between the government and the patient. The rebate is between the government and the patient/voter, not the doctor.

Senator FORSHAW—I disagree if it ends up going directly to the doctor. You just cannot ignore the fact that that sets up a relationship between the HIC and the doctor. That does not exist now unless you have bulk-billing.

Dr Walters—The patient could choose each time how they wanted it paid on their behalf.

Senator FORSHAW—Sure, that is right.

CHAIR—I thank Dr Walters and Dr Clark from the Australian Divisions of General Practice. If you have any further information—and we have asked you some questions on notice—we would be very appreciative of your information and advice. Thank you very much.

Proceedings suspended from 1.38 p.m. to 2.37 p.m.

BROWN, Mr Nicholas Ian, President, Australian Medical Students Association

DEL MAR, Professor Christopher Bernard, Professor of General Practice, Centre for General Practice, University of Queensland Medical School

WATT, Dr Marli Ann, (Private capacity)

CHAIR—I welcome representatives from the Australian Medical Students Association and the University of Queensland Centre for General Practice. Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. The committee prefers all evidence to be heard in public but if you at any stage wish to give your evidence, part of your evidence or answers to specific questions in private, you may ask to do so and we will consider your request. Your submissions are before the committee, and I thank both groups for that. I now invite Mr Brown, first of all, and then a representative from the University of Queensland, to make a brief opening statement before we move to questions.

Mr Brown—Thank you for the opportunity to appear today. I obviously want to deal with issues specifically related to medical students as far as the government's new A Fairer Medicare package is concerned. The Australian Medical Students Association oppose the elements of the new Medicare package with regard to bonding of medical students. We think that this scheme does not necessarily target the real reasons why there is a doctor shortage in this country today. We also think that it has the potential to have further damaging effects on area-of-need communities as well as patients, doctors and medical students who will be involved in this scheme.

Firstly, it is great to see that the government is finally acknowledging the fact that there is a doctor shortage in this country and that steps are at least being taken to try to rectify that shortage. We think that there are other ways of increasing the medical workforce without having to resort to bonding and certainly without having to resort to this particular scheme, which is very different from any other bonding system that we have seen in this country before.

Basically, we think that the fact that students are asked to make decisions about their long-term career before they are even granted a place in medicine is wrong. We do not think that acceptance of a place in medicine should be tied to an acceptance of this contract—a contract which has very onerous restrictions and conditions placed on it. It would be very divisive amongst the student body and would create a subclass of medical student—those who could get into medical school with a normal position and those who had to resort to signing a contract to sign away their independence.

It requires students to be bonded to areas of need designated by the government once they complete their postgraduate training. It is important to understand that for most doctors this takes 10 or 12 years minimum, so in some cases you are asking 16- and 17-year-old students to sign a contract which will not affect them for well over a decade, and we think that aspect of the scheme is particularly unfair. We think that it is also unfair that there are no further incentives being applied to these students. The government says that getting a place in medicine is incentive enough, but we would reject that. There are 1,500 other medical students out there who

got their places without having to sign a contract, and if the government really is serious about addressing this problem we think it should make these 234 medical school places available free from bonds.

There are also issues regarding the legality of the contract. As yet, we have not seen a copy of the contract and we have not been consulted with regard to the exact contents and make-up of the contract. We feel it is very important as an association representing medical students and future doctors that we, along with other associations, get the opportunity to peruse this contract before it is presented to the students. There are obvious issues about being fully informed before students sign this contract. There are also issues surrounding the constitutionality of this scheme given the anticonscription laws in this country. We are still waiting further legal advice on that, but there has certainly been a big question mark raised on that issue. There is an issue with the enforcement of the contract regarding not just the constitutionality of it but also how the government intends to enforce a contract that is between the student and the government, when the government does not necessarily directly influence who does and does not get into medical school. There will have to be direct liaison with the medical schools. It is all very unclear and until the contract actually comes out and we see a physical copy of this contract we will not know exactly the details that we are dealing with.

Obviously, time is running out and our real concerns are that this is going to be pushed through without proper processes being followed so that we can stand up for the students who are yet to sign this contract. As is outlined in our submission, we feel that it is going to be damaging to the patients who ultimately will be serviced by the doctors in these areas of need. The doctors who do get through the system in 10 or 12 years time and who have not been able to buy their way out—if that is what they wish—will be disgruntled, dissatisfied and unhappy that they have to play by a different set of rules to every other doctor in the country. We think that patients deserve better than being serviced by a doctor who is unhappy, disenfranchised and dissatisfied. I do not think that anyone anywhere in this country would like to be seen by a doctor who does not really want to be there. That leads to issues of the quality of care, standards and access to a good health care system in this country.

The scheme itself paints rural practice in a negative light. By simply having to employ a big stick to enforce this, and to solve the problems, suggests that there is something wrong with rural areas and working in rural areas, and that is obviously not the case—I would like to make that very clear. Rural service does provide many greats opportunities for students and doctors but having to enforce such an onerous contract with a big stick and without any incentive paints a really negative picture of that setting. We would like to see students exposed to a positive image of rural Australia during their time at medical school and during their time training to become specialists and GPs. We think that is a much better way to entice students out into rural areas and areas of need rather than employing a draconian and onerous contract 10 years previously. That is unfair for the students and it is unfair for the patients they will ultimately be seeing.

I would also like to point out that, from a medical student's point of view, there are more disincentives to studying medicine today than there ever have been. We have an indemnity crisis, we have red tape, we have spiralling HECS costs, we have an increase in postgraduate education costs, we have a restriction on provider numbers and a restriction on college training places, we have increased workloads because of doctor shortages, we have increased demands for family life and a greater lifestyle, we have declining bulk-billing rates, we have decreased public

expenditure on medicine and now we are seeing an excessive and, we feel, unnecessary control on medical student places and on students trying to get into medicine. All these things will lead to fewer and fewer people wanting to study medicine.

Sure, today we may have a situation where far more people apply to study medicine than there are places for, but, if this trend continues, I think that, before long, fewer people will apply to study medicine. Of course, when fewer people apply, that also raises concerns about the standard and quality of medical education and, in the end, of the doctors the system produces.

We recently surveyed 1,000 medical students and found that 95.3 per cent of them would not have accepted this had they not been able to get the medical school places they already had. In the opinion of 98.7 per cent of respondents, it was unfair of the government to ask this of medical students, and 96.6 per cent of respondents thought that medical students would not have sufficient insight into their careers or career paths to make this decision at such an early stage. So you can see that a very high number—almost 100 per cent, in the high 90s—are saying exactly what we are saying on this issue.

We also asked them whether they would accept a financial incentive if it were offered, or whether that would make it more attractive. Ninety-four per cent of respondents said that it would make it more attractive, as would a reduction in the length of the bond period and being able to repay your bond as soon as you finish your internship year, instead of having to wait until you complete your postgraduate training. Even with those concessions, 71.6 per cent of the students still thought it was an unfair solution and would not have accepted it. So you can see that there is quite a large amount of opposition out there to this policy. Even with those concessions—even with things which most students say make it more attractive—the bottom line is that they are saying, ‘I still won’t accept it, because it’s not fair, and it’s not fair to ask students to do that.’

We would obviously like to see many other things done to try and address this problem. It is a serious problem, a real problem, and a solution needs to be found. It is a problem which probably has its roots many decades ago. As such, the solutions will also be very complex, and not the quick fixes that certain people are suggesting. It needs to be planned and thought out very well. We need to have multiple solutions to overcome this problem. That is the way I think we can best tackle it, and that is all outlined in our submission.

We would certainly like to see an extension of a lot of the existing schemes, including the RAMUS scholarship scheme for students from rural backgrounds, the John Flynn Scholarship and the HECS reimbursement scheme. All of these are Commonwealth-run schemes which provide incentives for students to experience medical practice in rural areas and we feel these give students a much greater opportunity of having a positive experience in rural areas.

We would like to see more funding for rural clinical schools. We are already seeing this from the government and that is great to see. We need more on this front. A group of students from the University of Queensland this year moved out to one of the rural clinical divisions and they want to stay there next year. But they are being sent home because they have to make way for the next lot of students. I suppose you could say that this is being too successful, but, when you have a group of students who are keen and enthusiastic and want to be in rural areas, it seems pointless to send them home to the city when there are no students to replace them. But, as part of the

rural clinical school initiative, the university has no choice but to send them home. That probably sums up everything I wanted to say.

CHAIR—Mr Brown, thank you very much. I now invite Dr Watt to make a statement.

Dr Watt—Thank you for the opportunity to appear and present my submission. Professor Del Mar and I will both say a few words this afternoon, but firstly I will give a bit of an outline. I am a practising general practitioner, currently operating in Brisbane, but most of my work has been in regional Victoria for the last 12 years. I am also currently studying for a Master of Public Health and have been fortunate enough this year to have a PHCRED scholarship. Also, with Professor Del Mar's department I am reviewing the evidence regarding patient linkages in general practice. I have been here this morning and heard the AMA's and ADGP's submissions, and I would like to say that I am also actively involved in both of those organisations. We realise that the committee has met with our colleague Professor Andrew Wilson at the roundtable discussions, and we would like to take this opportunity to clarify the main points of our submission and, of course, answer any questions.

Essentially, our proposal has really only addressed the last point of the committee's terms of reference, which is regarding alternative models of remuneration. There is no dispute that the access and affordability of general practice under Medicare needs to be reviewed and, indeed, even this morning this seemed to be the only issue that us GPs could agree on. Our argument is that there is no evidence to guide us in changing or implementing the most appropriate system in the current complex Australian general practice environment. We have suggested that we take our time to gather the evidence by conducting a national trial.

I heard both the main groups this morning being asked about what studies have been done, and I am not sure that the committee received an answer. I guess what we are saying is that, from a big picture perspective, there are international precedents for such national trials or even the systematic evaluation of natural experiments. Examples include the RAND Health Insurance Experiment in the United States, and there have been other national trials in Norway, Finland, Canada and even—more recently and closer to home—in Taiwan. In our paper we have nominated some possible variables that could be compared and analysed. These include the proposed A Fairer Medicare package incentives, the current blended system, capitation funding and even increased rebates, perhaps in line with the relative value study with direct billing.

These are only suggested variables, and certainly not the only ones that might be considered. Indeed, one might want to trial some of these, for example, in non-GP related primary care services such has allied and dental health services, with practice nurses and so on. Our contention is that we need evidence to determine the most effective, efficient and equitable system for the provision of general practice and primary care services in Australia.

CHAIR—Thank you. Professor Del Mar, would you like to make an opening statement?

Prof. Del Mar—I do not have much to add to that. You have already heard from Professor Wilson at the roundtable discussion and I think Marli has expressed our position extremely well. The only other thing I would like to emphasise is that this seems to be an ideal opportunity, when the delivery of services in primary care is under the microscope, to consider other factors that should be trialled, such as patient registration. This is an innovation that I think would be

welcomed by most of the medical profession, and it needs to be sold to the Australian public and the quite clear advantages which I think would be manifest from such a trial shown to the Australian public.

CHAIR—Could you explain patient registration? It is different to capitation, obviously.

Prof. Del Mar—Capitation is the way you pay people—the emphasis is on payment. Registration is about assigning people to a particular doctor so that patients have one doctor; they cannot just go free-for-all at different primary providers as they wish. That is the system which is used in much of Europe, and in other parts of the world as well. The advantages are that it means that the medical practitioner has to assume much greater responsibility for caring for their patient. If things go wrong, it is quite clear where the responsibility lies. The falling between two stools of responsibility, which so often happens in Australia, would be dealt with much more effectively.

CHAIR—Do electronic records fit? We have heard a bit about electronic records being a desirable component in delivering quality care and continuity of care. Does that fit necessarily with patient registration?

Prof. Del Mar—Yes, I think that electronic records certainly solve some aspects of the deficiencies of a service that is a free for all, such as we have. In terms of continuity of care, at least there is some continuity of information, even if it is not continuity of responsibility. I think that the advantage of a patient registration system is that it involves continuity of responsibility with a particular provider.

CHAIR—Your submission outlines an opportunity to do a series of trials that would take a portion of time. How long would that take?

Prof. Del Mar—That is a difficult question to answer because it depends on what the trial was specifically going to answer and how you would set it up. There are different methods of doing such trials. We are talking about the order of probably two or three years, I would think, before we would get meaningful data.

Dr Watt—There is evidence from some of the trials—for example, in the Scandinavian countries: Finland and Norway—that were done in the order of three years. They involved varying methods of remuneration: pure capitation, mixed capitation, fee for service, and just pure fee for service. That is the sort of order that we were thinking about, too.

Prof. Del Mar—One other thing to add to that is that sometimes the trial can be incorporated into the roll-out. Sometimes a trial is operated in one sector of a country—where the new model is introduced, data is collected about its introduction and the measurements that we are interested in taking—and, if that is going satisfactorily, that model can be rolled out, either modified or as it stands, to other parts of the country. If it is modified then more data is collected. It is spread across the country, with the correct model finally being identified. That is one method of doing such a trial. It is not that one trial is finished and then put into policy; it is rolled out so that the border between the trial itself and its roll-out becomes somewhat blurred.

Dr Watt—For example, in one area of Canada they evaluated the introduction of a copayment system and the effects on patient attendances at primary care physicians and accident and emergency departments, and the level of perceived health by the consumer. In Taiwan in the mid-nineties they evaluated the introduction of a national health insurance system.

CHAIR—What is your understanding of the community's acceptance of them being used essentially to trial a different policy approach?

Dr Watt—It was interesting that ADGP presented this morning the importance of explanations to consumers. Essentially, once they are informed and knowledgeable, that knowledge is power. Their understanding that it will help the system, which they see is flagging, would make the trial quite acceptable as well. It would need to be ensured that they were not disadvantaged by being involved in that. Certainly the evidence in the trials internationally is that the consumers loved being involved a lot more than the practitioners did. They felt that they were actually part of an answer, and that was further empowering them in the health policy development in their country.

CHAIR—Thank you. I appreciate also the references that you have made so that we can seek out further information from the trials that you have identified. Mr Brown, thank you for your submission as well. There are a lot of questions and issues that you have raised. I would like to ask you one question about a proposal that was put to us by the Aboriginal medical services of the Northern Territory who recognise, like you, that there is a problem in staffing general practice in regional and rural areas. Their option is to provide the individuals who have served a period of time—and they did not put a number of years on it—with preferential treatment in the allocation of provider numbers in areas that are highly desirable. So you could leave somewhere in a very remote part of Australia and basically get a provider number in the place of your choice—the North Shore of Sydney, shall we say. Does your organisation have any views about that as a solution to staffing regional Australia?

Mr Brown—Insofar as it provides an incentive for doctors to enter into the arrangement then, yes, certainly we would support that. It would not take a great change in thinking or in the approach to the way that some of the issues are being tackled to find a solution that would satisfy most of the parties involved and ultimately to end up with a good outcome. A similar sort of system was trialled with the teacher bonding arrangements of the seventies, I think, and certainly that provided an incentive. And any scheme to service areas of need would provide a reward for doctors who entered into it. I think it is a big step in the right direction. Anything that offers doctors something in return for the extra commitment they would make to the community, to their profession and to the government in terms of overcoming this problem would be taken up and seen as favourable.

Prof. Del Mar—This is not what I made my submission on, but I wonder whether I could comment on it.

CHAIR—Please.

Prof. Del Mar—There is a problem with the system that you are proposing, and the problem is this: if serving in rural areas is always seen as a second best option, we will be institutionalising a problem that will never go away. Perhaps that can be fixed by either creating

a gradient of incentives so steep that people are drawn there or—this would be the other solution—by creating equitable burden-sharing amongst the other sectors of the profession. The disadvantage in leaving it as it is, with the burden of the rural problem being shouldered mostly by general practice, is that general practice will always be a second-rate profession and that will be very serious for the Australian health care system. A strong, self-confident and self-reliant general practice work force is the key to a good quality Australian health care system.

If we end up with a system where people do not want to become GPs—this is where the rural burden comes in: 'You'll never get to work in a city; you've got a good chance of being shouldered off to the bush'—then that will become institutionalised. One way of dealing with that is to share it out, and a way of doing that is to ensure that registrars in all disciplines have to serve their time in the bush. So not only will general practitioners have to do it in the post-graduate area but also it will have to be done by those who are doing medicine, surgery, paediatrics and everything else. It sounds outrageous at first, but the converse is actually normal now—that all GP registrars serve their time in hospitals. There would be a lot of educational advantages in having specialty registrars doing their time in the bush, as well as solving this problem.

CHAIR—Would there be enough continuity of delivery under that model? I have not thought that through yet, but would there be enough continuity of service for health consumers in regional places?

Prof. Del Mar—I do not think that does solve the continuity of service aspect, but this is the training aspect and there is a lot of movement in the training anyway. There is also a continuity problem in the proposal that you mentioned regarding the Northern Territory, and so it does not solve that particular problem. But people in this work force area say that one of the problems is that people do not want to go to the bush because they do not know anything about it. The Commonwealth incentive in the past that has been extremely clever was to ensure that all medical students have some experience of the bush. In my view, that is enlightened and it is a good way to get people to experience it. But it is a very short experience—it is a month or perhaps two months. A few people can go on and do more than one month continuously and some people do two months continuously, but that is not compulsory. Of course some medical students spend as much time there as they can. But if people had to go and do a bigger slab of time—say, three months—as part of their registrarship, then there is a greater chance that some of those will discover the joys of living out of the city and end up wanting to live there.

CHAIR—And there are many.

Mr Brown—I would just pick up on something referred to by Professor Del Mar, and that is that, no matter what the solution, ideally it is better if such a system is entered into voluntarily by the students and the doctors. Anything that forces or coerces doctors into certain areas paints a negative picture. Professor Del Mar's idea of spending some time in rural areas during your post-graduate training is certainly worth looking into and investigating. Again there are issues with duration and what other requirements would be attached to it. But certainly I think the requirement for all medical students to spend some time in rural areas is a good one and is having the desired effect. As I mentioned, there is a situation in Queensland now where it is proving almost too popular. Obviously that will not be the case every year, but certainly that is a step in the right direction. If we can make those experiences positive, we will get students once

they graduate wanting to work voluntarily in areas of need and in rural areas. Certainly that is worth looking into.

Senator HUMPHRIES—Mr Brown, these days around Australia what is the average entry mark for a medical school?

Mr Brown—It varies depending on whether you apply for a graduate or undergraduate course. Graduate courses use the GAMSAT—the Graduate Australian Medical Schools Admission Test. For the University of Queensland, at least—I believe it is slightly higher in some other states—around 62 to 63 per cent gains entrance into medical school. For graduate courses there is also the requirement to have successfully completed an undergraduate degree. Some universities put a minimum GPA requirement on that; others do not. For undergraduate courses with direct entry from school, you have to sit the UMAT—the Undergraduate Medical Admissions Test. I do not know what the average marks for that are, but they are combined with your school leaving score—your ERP or TE score, or whatever the equivalent is.

Senator HUMPHRIES—For undergraduate entry I understand it is usually graduates from secondary school who have marks in the top couple of percentile who are eligible by virtue of their marks to get into medical school—it is something of that order, isn't it?

Mr Brown—That is correct. But quite a wide range of students—in terms of their ability—do apply. I think I know what you are getting at. One of our concerns with this scheme is that the top students, the bright students, will obviously secure their places in medicine; the group of students in the middle block will opt to try their luck again next year or they will go for the graduate course rather than have to enter into a contract which basically signs away their independence for a period of 10 or 12 years; and it will be the students at the bottom of the pile—and there is no way of guaranteeing that those students will have scores that put them in the top two percentile. If they are the only students left to fill these places, then they will fill the places. With all of the other disincentives that I mentioned before, I think you will start to see a shift in the type of people who start applying for medicine, and you will not necessarily be able to guarantee that they will be from those whose marks put them in the top couple of percentile every year.

Senator HUMPHRIES—Those who take up the bonded places by virtue of the system might not be those in the top two percentile, but they would be those in the next two or three percentile. You will not get people who have only enough marks to get into an arts degree suddenly ending up in law school because of this arrangement, are you?

Mr Brown—It does happen. Students who do not get into medicine do pursue other careers. It is interesting to note—this is another thing which is threatening the medical profession—that a medical degree these days is not necessarily a stepping stone to medicine. After graduating from medical school, many students may do one or two years in the hospital system and then they will get an attractive offer from a pharmaceutical company, a consultancy firm or a law firm. More and more students these days are being offered those packages and are taking them, because the realities of medicine, from when they first get into their course, are not necessarily what they thought they would be.

Senator HUMPHRIES—I put it to you that the fact that people are choosing other careers at the end of their medical degrees, that a wider range of options are being taken up by very bright students, does not alter the fact that you have to be among the very brightest—or among the best academic performers, at least—in any state or territory in Australia to have any chance of getting into medical school.

Mr Brown—Or law school.

Senator HUMPHRIES—Or law school—as a lawyer, I will accept that interjection. You cannot by any stretch of the imagination possibly be talking about getting people who are unsuitable to be doctors taking up these bonded places if they are what is on offer to them and they want to get those places.

Mr Brown—One would hope not. Certainly it is the case at the moment that it is the top students who get into medicine. Of course, with every entrance procedure you will have some who slip through the cracks, but you are quite right, looking at things from an average point of view: currently it is the top students, the brightest and the best, who get into medicine. What we fear is that, with the introduction of this scheme and a lot of the other disincentives that are facing students these days, that will slowly start to change. We want to make sure that does not happen. Whatever the schemes, for whatever the problems, they ought to be—and we want to make them—things that students want to be a part of, not things they resort to as last resorts or settle for because they cannot get the place they would prefer.

I think that with a few subtle changes and a few concessions we will be able to achieve something whereby students will actually want to enter into this scheme, as opposed to it being something which they settle for. By adding an incentive to it, by reducing the length of the bond, by allowing the students to start repaying their bonds as soon as they finish their intern years and, most importantly, by not tying their places in medicine to their contracts, I think we will start to see students really wanting to be a part of this program and this scheme—as long as it does not require them to sign a contract linked to their future careers, or their possible future careers, when at such a young age they may not have enough insight to do that properly.

We would like to see the extra 234 places made available so that the top extra 234 students are guaranteed of getting into medical school. Then the medical schools can say, ‘We have Commonwealth rural bonded scholarships available currently, and we have bonded medical school places which also carry an incentive.’ The students can in that way choose whether or not they want to be part of the system, without having to forgo a possible career in medicine if they do not want to take those schemes up. In a nutshell, we want to make this something that is desirable and not something that is just settled for.

Senator HUMPHRIES—I can understand that, and from the point of view of a medical student that would be a good thing to do if it made people happier about the experience. The critical question is whether people will take up the options that are being provided by the government if the package passes. Will you still get top quality students opting to take these bonded places—admittedly, as second best to an unbonded place—and do the time in rural areas? I ask you to look at it from a public policy point of view. The sweeteners you are talking about cost money and, if governments of any persuasion can achieve the outcomes without having to spend that money, you can understand why they would want to do that, can’t you?

Mr Brown—Sure. It may well be the case that they get enough students to fill the quota, even though there are risks associated with that, and it is impossible to know what the exact outcome will be until 10 or 12 years down the track—which is a problem. The other question that should be asked is: should students have to make this consideration in the first place? If the government were serious enough about addressing these problems—and augmenting the medical work force is certainly one of those problems—should students have to make such decisions at such a young age without any previous experience?

You talk about the cost of this scheme. One of the things we suggested was that the government makes these positions HECS free. Certainly, if that were the case, it would simply be a matter of $1.8 million in forgone revenue each year—which is a far cry from the $1 billion of the total package that is being spent. Sure, it is money—and a million dollars is not necessarily something to sneeze at—but in the scheme of things it is a very small price to pay for something which could be so much more effective and so much fairer for students and for the doctors that the students will become.

The issue is whether or not students ought to have to make these decisions. I think these positions should be made available; they need to be made available. Simply exploiting a student's desperation to study medicine is not a good enough reason to say, 'We'll carry them through anyway because it doesn't cost us anything.' I do not think that is responsible government. I do not think that is fair. I think that there are other solutions, fairer solutions and more effective solutions available.

Senator ALLISON—Have you seen the list of places designated for these bonded positions?

Mr Brown—The distribution within the medical schools?

Senator ALLISON—Yes.

Mr Brown—Yes, I have.

Senator ALLISON—You would acknowledge that they are not exactly all rural. In fact, I understand that one in Victoria is in Dandenong, which is all of a 40-minute drive from the GPO in Melbourne.

Mr Brown—You are talking about the areas of need?

Senator ALLISON—Yes.

Mr Brown—No, I have not seen those, but I understand that it is not just rural—that it is outer metropolitan, rural and regional Australia. We have not seen any of that documentation yet. We have not seen the contract; we have not seen the details. The government has said that an area of need for a neurosurgeon, for instance, may well be a metropolitan hospital somewhere. Certainly, a neurosurgeon would be pretty useless in a rural community where there are not the hospital facilities to support such a specialist. However, we are talking about the super specialties there—neurosurgery, microsurgery.

Senator ALLISON—I am just talking about GPs. Your platform is GPs, presumably.

Mr Brown—I certainly have not seen the list of areas.

Senator ALLISON—Would you change your mind if you discovered that quite a lot of these places will be quite close to cities, within driving distance of major metropolitan areas—which seems to be the preferred option for GPs?

Mr Brown—I do not think the issue is so much where the places are. I have said before that we would oppose this scheme even if it were metropolitan bonding. It is not so much that people are going to be sent to rural areas—there is nothing wrong with working in a rural area. The problems underlying this scheme are that students are being asked 10 or 12 years before—

Senator ALLISON—A Queensland student is not being told they have got to go to Dandenong or they have got to go Broome or somewhere. I understand there will be a very big list of places that are designated 'of need'. Students will have a choice among those places. Is that not right? Is that not your understanding?

Senator KNOWLES—And they do not have to stay there for the full period of time either.

Mr Brown—They have to stay in an area of need for six years.

Senator KNOWLES—That is right, but they do not have to stay in that area.

Mr Brown—The problem, though, is who knows what their situation is going to be in 10 or 12 years time? Who knows whether they will be married or whether they will have kids. I have not seen the list of areas. The students who have to sign these contracts in a few months time have not seen the list of areas either, and that is one of our real concerns.

Senator ALLISON—The health minister assures me that there is such a list. Maybe your organisation should contact the minister's office and ask if it could be provided.

Mr Brown—We, along with the AMA—we have been working very closely with the Australian Medical Association on this—have been contacting the department regularly and asking for all information relating to this proposal. As yet, we have not received that document.

Senator ALLISON—Perhaps the committee can take that up on your behalf.

Mr Brown—If you could, I would appreciate that. I still think the issue is that students have to sign away their independence.

Senator ALLISON—I think you have made that clear. It is hardly independence, I would have thought. Professor Del Mar, I am intrigued by your suggested trial whereby you would have patients registered with a GP. Presumably, there is some flexibility; they can move around if they do not like a GP, if the doctor changes or if they move to another area. Are you talking about a designated number of doctors for a given population, and would you draw a boundary around those designations? How in practice would it work?

Prof. Del Mar—Are you asking how the trial would work or how the new model would work?

Senator ALLISON—How the model would work.

Prof. Del Mar—I think you are asking me about how patient registration works.

Senator ALLISON—Yes.

Prof. Del Mar—Patient registration means that a patient chooses a doctor or they choose that doctor to be their provider of care for all care. If they need a referral, it is through that doctor. It reduces the activity known by some doctors as 'doctor shopping' in which patients go to different doctors for different perceived needs. What happens now quite often is that people will go to this doctor for that sort of complaint, to a doctor near work if it is just for a cold and they want time off and to the doctor at home if it is for the children and so on. The disadvantage of that system is that it results in fragmentation of care—which is the continuity thing we touched on earlier.

Senator ALLISON—Isn't it a fragmentation that patients are actually choosing? Effectively, they are choosing doctors. For instance, a woman may choose a woman for gynaecological issues but she may choose a local doctor, who might be male, for her children. Isn't this a legitimate choice?

Prof. Del Mar—It does limit choice. I am afraid that is one of the costs of it. But there are some advantages which many of us think outweigh that. The way that can be managed is to provide different units of different levels of care so that, for example, you would probably want to register with a practice. That is the most usual model. Within the single practice there might be a woman doctor and another doctor who specialises in skin cancer and so on and so forth so that people can get the doctor they want of that kind.

Senator ALLISON—Do you favour an idea—which I think was put to the committee in Perth—that we should simply divide up local government areas or areas of given population and say that there will be X number of provider numbers within that given population so that you enforce an equal distribution of doctors across Australia? I am sure Mr Brown would not like this idea. To your knowledge, has this been put into practice in any other country?

Prof. Del Mar—Yes, this is usual. This is what is normal in most places in the West outside Australia. Dr Watt and I are probably unusual in coming to this committee without a very fixed view of what we think should exist—perhaps with the exception of patient registration, which is a kind of extra layer. The point we have been trying to make in this is that we think that whatever model it is—and we can see the pros and cons of a variety of different models which may be more or less acceptable to the Australian population—whatever we do settle on, it would be good to trial it first before we enact it in policy. That is really the thrust of what we are saying. Rather than agonise through this sort of process or try to best guess which is the best method—and I have no doubt that you have had representations from people with all sorts of different models and views, and very strongly held views, too, I am sure—we could test it out in an empirical, pragmatic way.

Senator ALLISON—With a proposal such as that, which allocated provider numbers according to the population, you cannot just take a small area and do it, because you have still got all the doctors flocking to the North Shore of Sydney and wanting to stay there. Unless you

include the very populous areas in this experiment and clear out some of them—which I am sure would not be popular—you could never really know if it was going to work.

Dr Watt—Allocating provider numbers was not one of the variables that we suggested we investigate; we suggested that maybe patient linkages would be something that could be looked at. In answer to your question, I was in New Zealand a number of years ago to Building on Quality Project, which you may have heard of, that a number of Divisions of General Practice were involved in. In New Zealand provider numbers are allocated to a practice place. For example, when a locum goes in they take on that GP's provider number, so there really are limitations. They still have a crisis in meeting needs in rural areas. So there is evidence there in New Zealand that it has not been able to answer that. I know that it is a completely different country, with only 4 million people and about 60 million sheep.

I guess what we are saying also is that we do not know culturally in Australia, in our situation, in our federal system, what is right. We can say, 'In the UK, this is how they do patient registration.' In New Zealand, it is voluntary, and you can change every time you go to the doctor, but there are other ways of tracking what the duplication is and where the capitation payment goes to. They have 100 per cent patient choice every time they choose to go to the doctor in New Zealand, but they have patient registration. That is what I have been researching this year, and it is very interesting to see the different models in different countries and the levels of compulsoriness and choice, and the time periods between which people can and cannot change GPs. There is a lot of information out there on different approaches that we could be looking at here to see what is right for Australia.

Senator FORSHAW—I would like to follow up with you, Mr Brown, on the issue of bonded places, and I understand your opposition to it. You have put some propositions as to how that might be amended or changed. My recollection is that one of the proposals put forward by, I think, the AMA was that if you are going to have this scheme then maybe the bonded period—the six-year payback, if I can call it that—might start earlier and include the period of vocational training. Have you thought about that? I understand your principal position is that you do not like it anyway.

Mr Brown—With regards to this issue we have always said that, if we are to have bonding—and it certainly looks as if we will—let us make it a system which does work and is fair. Certainly, one of the concessions that we have looked at and requested is that after the intern year students are allowed to start repaying their bond. That has benefits in that it gets doctors into the areas of need much sooner, as well as allowing students to repay the time sooner, rather than having to wait so long.

Senator FORSHAW—What impact would that have on the final outcome? The period is six years—would it still be six years or are you saying that it could be reduced to three?

Mr Brown—We would certainly advocate a much shorter time. Three or four years would be the time that we would advocate—at the very least, the length of your medical degree. Some medical degrees are only four years currently, so repaying six years for a four-year medical degree does not quite seem fair. But I think it is accepted that if doctors have not had an enjoyable experience within a couple of years of arriving in an area of need it is unlikely that they will stay once the bond period is up. We need to start looking at more effective long-term

solutions so that doctors in areas of need are retained and do not only stay there while they are conscripted. We need to find ways of making them want to voluntarily live and work for extended periods in those areas. If doctors have not come to the conclusion that a place is where they would like to work and live within two or three years, an extra two or three years is not going to make a difference to the long-term outcome.

Senator FORSHAW—As I said, in your submission you have put forward some variations or modifications to the government's proposal. Beyond that, and beyond saying that if you do that some of the current arrangements—the scholarship system and so on—should be supported more, it would seem that they are not doing what they should be as there is still the shortage. Does your association have any other propositions? One could be: let's just have a massive increase in the number of medical places that are going to be funded through HECS. What else have you thought of?

Mr Brown—I would not go so far as to say that the existing schemes are not working.

Senator FORSHAW—I did not say that. There seems to be a recognition generally that there needs to be something extra.

Mr Brown—I suppose that existing schemes are limited in the sense that they are only so big. This is not really a student area, but one of the things that would see an increase in the number of doctors in rural areas and areas of need is a restriction in the provider number legislation—allowing doctors to do more part-time work or shorter periods of time in rural areas and allowing them to service those areas without having to wait or wade through all sorts of red tape for that to happen. The situation currently exists that for doctors to move around in rural areas they have to wait six to eight weeks for the paperwork to be approved on their provider number so that they can work in a new area. In many instances, doctors are only needed for short periods of time—for a couple of months—so by the time they have waited two or three months for the paperwork to clear they no longer need it. Greater flexibility for people who already are doctors and who have graduated to enable them to do part-time work, as opposed to full-time work, is certainly one way of addressing the problem in the interim while we are waiting for the extra graduates and extra doctors to come on line.

Senator FORSHAW—I have a question for Professor Del Mar or Dr Watt. You have proposed a trial, and it has been interesting to hear you this afternoon because you have raised some issues—some alternatives—that are a bit outside the square. Do you have any comments to make about propositions that go to salaried GPs? Some cooperative arrangements between state and federal governments using the public hospital system, and Medicare having salaried doctors in centres attached to hospitals and so on have been floated recently and have been talked about for some time. Do you have any thoughts about those sorts of models as distinct from just fee-for-service?

Prof. Del Mar—Yes. That is something that should be explored. I do not have any data on this but, anecdotally, I am convinced that there is a sector of the general practice community—GPs—who want to be paid a salary and do not want to become small businessmen. It is difficult for their needs to be met easily. They are often drawn towards entrepreneurial set-ups, which offer to look after the business side of things, but they find this intrudes on their professional

sanctity, and they do not like that. It may be that we need to explore salaried payments for GPs as one of the many options.

Dr Watt—I heard an interesting statistic the other night—do not quote me because it may not be 100 per cent correct. Two years ago, GP registrars were surveyed and 80 per cent said that they were not interested in starting their own practice. There is certainly scope in the new cohort of GPs that are coming through for alternative ways of practising. They do not necessarily want to go and work for big corporates and so on. Lifestyle issues and those sorts of things may augur well when looking at a salaried position where you can get holiday leave, sick leave, maternity leave and all those sorts of things which come along with a salary. I have talked to some GPs in the United States who are on salaries, are very well paid, have great conditions and are quite happy with it.

Senator KNOWLES—Mr Brown, do you plan to be a general practitioner?

Mr Brown—I have not made that decision yet. I recently completed my general practice term and, I have to admit, found it much more stimulating than I thought it would be.

Dr Watt—He is going into politics!

Mr Brown—I am certainly not going into politics. That is not to say that I thought it would be unstimulating, but it was certainly different from what I expected. The door is open—put it that way. I have not necessarily closed the door on anything yet.

Senator KNOWLES—Would you consider going into a general practice area of need?

Mr Brown—I think I would. I have always said that I would like to spend at least some time in a rural area, although the areas of need are not necessarily just in rural areas. You raise an interesting point, because I think that many students would like to spend some time in rural areas once they become doctors. Most people at medical school certainly have a fairly positive experience, albeit for a short time, during their rural term. I think that most students would certainly consider spending some time as a doctor in those areas, because most students acknowledge the fact that you get a much more varied experience in a rural area than you ever can in a major metropolitan teaching hospital. The problem, though, is that with lengthy bond periods, restrictions and onerous conditions being a factor in someone's decision-making process, with regard to whether or not they want to spend time in rural areas, ultimately they opt not to do so. If I had to choose between going to a rural area for six years or working in the city, I would opt to work in the city. That is not to say that I would not want to work in a rural area, but just not for six years.

Senator KNOWLES—You do not have to work in a rural area for six years.

Mr Brown—Okay, in an area of need.

Senator KNOWLES—But you can go from area of need, to area of need, to area of need. It does not necessarily consign you. This is where I think this whole debate has been so dramatically and emotionally skewed. All the students to whom I have spoken have said: 'Shock-horror! Am I going to be consigned to the bush for six years?' Heavens above! People

might get married; they might have kids. Do you realise that people who are married and have kids still actually live in the bush?

Mr Brown—Yes.

Senator KNOWLES—They actually live in outer metropolitan areas of Australia too. It actually works.

Dr Watt—But they have chosen to do so.

Mr Brown—That is exactly the point: it comes down to choice.

Senator KNOWLES—That does not mean to say that it is a dreadful option for people, although it is portrayed as such. I want to get onto another area, because time is short. Dr Watt and Professor Del Mar, in your submission you talk about general practice being in crisis. Honestly, I gasp every time that professionals use that term, because I think it demeans the excellence in Australian medicine. If we are to bluff ourselves into saying—as a certain witness in Sydney said—that we have a sub-Saharan standard of medicine in Australia, then I will go, 'Hee.' I think it is just ridiculous for us to even be talking about Australian medicine being in crisis. Given that you have said that it is, what are you doing to try and elevate the standing of general practice generally and rural general practice specifically—and I am now specifying rural as opposed to outer metropolitan—to a status whereby it is considered a specialty, which I believe it is?

Prof. Del Mar—I think general practice is in crisis, intellectually, and that is probably the context in which we wrote that. The data I would put forward to support that—I agree; it sounds like an emotive statement—is that, intellectually, general practice does not yet seem to be, nor is it seen to be, master of its own discipline. General practitioners, as a discipline, publish only one per cent as many papers per practising GP as do physicians—only one-sixtieth of the number that surgeons publish. Surgeons are not normally regarded as the most intellectually bright people in the discipline—

Senator KNOWLES—Is that because their patients are asleep?

Prof. Del Mar—It is because they are doers, not thinkers! And the figure is only 1/160th that of public health doctors. By those objective standards we do not seem to be formulating the intellectual property that is general practice.

Senator KNOWLES—As the University of Queensland what are you doing to elevate the standing of general practice to a specialty level? People go to a general practitioner for absolutely everything; they go to an orthopod for orthopaedics. So why are we saying that the orthopod holds a higher status than a general practitioner? I think that is absolute nonsense. I am not saying you are suggesting that—

Prof. Del Mar—Certainly not.

Senator KNOWLES—I am just saying that there is now a pervading feeling that somehow general practice is the last option.

Prof. Del Mar—I could not agree with you more, and that is exactly why I am so worried that, by creating a second option for GPs to choose, we are going to create a second class of graduating doctors who will end up working in the bush in general practice. That seems to me to be exactly the wrong policy for elevating general practice to a more desirable level. Whether we call it a generality or a specialty is not so important, I do not think, as—

Senator KNOWLES—Sorry for butting in again, but I am worried about time—I will get cut off. What are you doing, as the University of Queensland, to elevate the standing of general practice?

Prof. Del Mar—We have created a rural medical school, which has very high status within the health sciences faculty, in which there is a big investment in personnel, in the delivery of teaching in rural areas and in supporting research—the intellectual growth I was talking about—in rural areas. Similarly, the Centre for General Practice, which I am responsible for, is investing very heavily in research. We are trying to be seen as masters of our own discipline and trying to imbibe medical students, like Mr Brown here, so that they find it an intellectually exciting place to be.

Senator KNOWLES—Notre Dame has been given the new medical places, as you know.

Prof. Del Mar—Yes.

Senator KNOWLES—Its curriculum is going to be very heavily skewed to general practice to try and convince medical students that general practice is a viable option not only in a monetary sense but also in an intellectual sense and in every other component of work force satisfaction. Is that type of emphasis being placed on general practice in the universities here?

Prof. Del Mar—Yes. The amount of teaching that general practice is now responsible for has increased four or five times in the last 10 years since we have been revising the medical course and putting it in place. We are definitely moving in the same direction as Notre Dame and several other universities around the world which have a much higher emphasis on community teaching.

Mr Brown—As a third-year University of Queensland medical student who has just finished his GP rotation, I can certainly support what Professor Del Mar has said. As I mentioned, I had a very good experience with my general practice rotation.

Dr Watt—And as a GP, I take medical students in my practice, as well. On your question, the problem with general practice as a specialty, or wherever we are, is not only to do with the profession. It certainly is political, and you certainly see that when you do research around international health services where the status of primary health care physicians stands in those other countries. Even in Cuba, for example, the GPs and specialists all get paid the same amount based on their level of experience, yet the general practitioners get free housing because the service they provide to the community and the money they save the health system are acknowledged.

Senator KNOWLES—Maybe we could suggest that to the specialists in Australia!

Dr Watt—I would love that!

Senator FORSHAW—But isn't it also in the nature of the referral system?

Dr Watt—Absolutely.

Senator FORSHAW—You do not get to see the specialist without seeing the GP.

Dr Watt—Yes, you have to see the GP.

Senator FORSHAW—They are like a gatekeeper, ticket collector or whatever.

Mr Brown—I would like to pick up on one thing that Senator Knowles said. You are quite right: the word 'crisis' is bandied around quite a bit these days. But I do believe that some areas of the health care industry are in crisis, and there is a big problem out there with some GPs. It is not necessarily a financial windfall—you are not 'in the money', so to speak—as a general practitioner. Being a GP involves running a small business and you have many overhead costs. I know many general practitioners who are not earning anywhere near the amount that people think they earn or expect them to earn. Although we are not necessarily here to discuss doctors' earnings, I think that does reflect problems with regard to Medicare, schedule fees and those sorts of things. If you look in some areas, certainly the word 'crisis' is aptly ascribed—but it is probably not as widespread as some people would have you believe.

CHAIR—Mr Brown, Dr Watt and Professor Del Mar, thank you for your contributions this afternoon. I think it has been a very useful discussion around two questions that are very linked. If you have any further information that you would like to provide the committee, do not hesitate to contact us.

Proceedings suspended from 3.46 p.m. to 4.01 p.m.

ADKINS, Dr Peter Benjamin, President, Bayside Division of General Practice

KASTRISSIOS, Dr John Theodore, Vice-President, Queensland Divisions of General Practice

McBRYDE, Dr Ann, President, Brisbane North Division of General Practice

CHAIR—Welcome. Information on parliamentary privilege has been provided to you. The committee prefers all evidence to be heard in public but should you at any stage wish to give your evidence, part of your evidence or answers to specific questions in private, please ask to do so and we will consider your request. Dr Adkins and Dr Kastrissios, your submissions are before the committee, and we thank you for them. I now invite each of you to make an opening statement before we move to questions.

Dr Kastrissios—Thank you for inviting us to be present here today. It is a privilege to be here, and we are grateful for the opportunity to speak about the submission that QDGP has put forward. The issues we see are very significant. Whilst we have heard previous speakers speak about the crisis, we would like to see this as an opportunity to make significant changes for the long-term betterment of the health care of the Australian community. We see an opportunity here to provide our advice and experience in the area in which we work. We are the chief delivery mechanism for services in this area, and we think we have a very clear and lucid understanding of what the problems are and how best to assist in solving them.

The Queensland Divisions of General Practice has prepared its submission with a lot of suggestions that basically—without reiterating them all—suggest that, whilst there are many good points about the A Fairer Medicare package, the way it is proposed, the ‘all in or nothing’ solution and various other linkages that are made within it have the capacity to not assist the process in the best possible way and for the best use of the public funds. We would like to expand on that over time.

We also see the opportunity to improve the health outcomes by improving the quality of service that general practice can deliver. There are a number of different ways of doing that, and we have some ideas about how we can work together to better achieve those outcomes. We do not really think that these are addressed in the best possible way by either this package or the alternative packages proposed. We feel that we could do a lot better. I do not think there is any doubt that we feel that there is a huge potential for further erosion in the viability of general practice—the long-term sustainability of which is in question, despite what others might believe, for various reasons—and I think we can contribute to the discussion.

Dr Adkins—I welcome the opportunity to be present before this inquiry. The Bayside Division of General Practice operates in the Bayside region of Brisbane to provide advocacy and support for general practitioners. Through supporting general practitioners, the division has the principal aim of improving the health of the community. The majority of Bayside general practices are in urban areas; however, we have a smaller number of practices in the southern aspect of the region, and they are classified as both outer urban and areas of need.

The division conducted a survey in April this year to ascertain membership opinion on the federal government's proposed changes to Medicare, designed to address the decline in bulk-billing. We received responses from 31 of 46 practices, and those were analysed. Three practices supported the package, while 28 practices did not support the package. Despite the rejection of the package as a whole, GPs in the Bayside area supported elements of the package—namely, the ability to charge a copayment in addition to directly billing Medicare; assistance with employing practice based nurses in all areas, not just in areas of need; additional GP registrar placements in outer urban areas; subsidies to support the introduction of online claiming, which benefits both the patient and the government; and more medical school places.

The Bayside division feels that the profession and the government need to establish an agreement on quality care and develop a system that supports the delivery of quality care. This requires the development of a stronger medical benefits schedule which supports processes able to deliver quality care. For example, there need to be appropriate rebates for longer consultations to support the chronic and complex care needs of the population. We also support incentive payments under this system, but we would like them to be directed at those elements which cannot be delivered under a fee-for-service system, such as integration with other health service providers. The Bayside division also feels that greater investment needs to be made by government in assisting general practices to measure quality health outcomes. I am happy to answer questions on the Bayside submission.

Dr McBryde—Thank you for letting me come today. My division is Brisbane North, which is all the general practitioners practising north of the Brisbane River. That makes for about 720 GPs with a practice number of around 230. We have a mixture within that of probably almost every variety of general practice that there is, apart from remote and rural general practice. Our population is something like 520,000; that was in the last census and by now that would have increased because of the large growth corridor in the division's north.

I want to talk about two things today: the sustainability of general practice—I do not think there is a crisis yet, but sustainability is a big problem with general practice; and there are three areas that I want to talk about in that area—and also the potential of general practice, because I do not think we have really looked at what we can do in Australia to use the potential that is out there in general practice.

With regard to sustainability, I would like to talk about existing GPs. We have to retain existing GPs. You heard before that a lot of GPs—particularly part-timers and some of the newer graduates—because of the indemnity issue are leaving general practice and medicine. Possibly the main reason for that is the financial situation. Our division did a GP health and wellbeing project. There are about five major reasons why GPs are stressed and not happy with their situation, and by far the first one is financing. In Brisbane North we have five electorates, and we have seen a decline in bulk-bulling over those five electorates. GPs attempt to get that financing right so that they can give quality care rather than quick throughput of patients.

A second area that I think we need to look at with regard to sustainability is practice principals. One of the problems—and you heard this previously—is that two years ago 80 per cent of registrars surveyed were not interested in becoming practice principals. This is okay for those areas that have already got practice principals. For example, I practice in an area called Chapel Hill which, when I started up, was probably almost an outer metropolitan area. I have

been there for 26 years and now it is almost inner urban. But in areas like Mango Hill to the north of Brisbane not only do people not have any access to GPs but there are no GPs there. One of the reasons is that existing practice principals are not going to root themselves up from their practice and move out to those areas, and new graduates do not want to become practice principals either. So that is a big dilemma.

The third area we have to look at in respect of sustainability is new medical graduates. You asked Nick whether he was going to be a GP. Unfortunately, if you ask most medical graduates if they are going to be a GP, they say no. We have to make general practice exciting and fulfilling for those graduates. I want to touch briefly on the potential of general practice, because I think that, if we as a nation really wanted to put our efforts and our money into getting better health outcomes, this is the area to put them in. A good study by Professor Barbara Starfield, of Johns Hopkins in the USA, has shown that better health outcomes are achieved in a more efficient and effective way if there is a robust primary care system in place.

CHAIR—A question came up in the previous discussion we had with the university, relating to the data which says that 80 per cent of graduates do not want to become practice principals. One of the models that has been put to us, from a range of places, is the notion of salaried doctors working in areas where there is unmet demand. Does your division, or do any of the divisions, have a view about whether that is a reasonable way to solve the work force shortages in those places? If it is, then how could you structure an organisation to deliver that?

Dr McBryde—I think there are some GPs who would prefer to be salaried. A variety of people are GPs, so there certainly would be people who would prefer to be salaried. The problem for the profession is to decide who would employ those GPs. It might be state health authorities or it might be corporate bodies. Large corporate practices are not the choice of everyone. Maybe divisions are an answer for employing GPs in those areas where GPs are not willing to go as practice principals.

CHAIR—We have had no evidence from the corporate sector at all—and I do not know that that is particularly surprising—but, generally, people are not of the view that that is a desirable way for general practice to progress. Given that we have had no evidence to the contrary, that is all we have. How could a division assist in establishing such a model? Is the division an appropriate way to do it, given that you are on the ground in a regional area, you know your community and you know the tensions that may or may not develop out of establishing something like that?

Dr Kastrissios—I can answer this from my experience in the Logan Area Division of General Practice, which covers the area between Brisbane and the Gold Coast, a growth corridor. General practice numbers have been declining over the life of the division, while the population has been increasing at a fairly significant rate, well above the average for Australia. We have explored at a division level whether it is possible, desirable or otherwise to establish a general practice model based on the division's support—possibly with the support of others—using division resources to house and run a general practice with salaried GPs. There was a lot of discussion. It would put us into competition with the very same small business owners who are, in fact, our membership. That would create an interesting dilemma and conflict. It was not rejected out of hand, because, as you will find, general practices are very sensitive to the needs of the community. There is no doubt that, as a group, we put the needs of the community well above financial gain.

I can assure you that the division looked very hard at discussing with the membership about how this could be done. The fact is that we had no GPs to do it. We had no GPs who could see how it was any better. Whether the division could offer more money, a better lifestyle or better conditions was not in any way guaranteed, and we did not know how to fund it. Consequently, it has been left lying on the table. I think that is all I can answer you at this time.

I do not think that people are averse to it. I am sure many of you know how difficult it is to run a small business, particularly in recent times. General practice is very underdone in business principles and training. It has suffered enormously in the last five years because of that—not just from rising costs but from rising demands upon what it needs to do to administer general practice. There is extremely low interest in owning and operating a small business that has no profit margin or close to no profit margin.

When I was last approached by the corporates, they were struggling to find out why they could not make general practice run. When they asked me, it was quite obvious that they had not done their homework very well. We stayed open only because we did everything for nothing. I am talking in a business sense. I know we make money, but I do not think there is any margin there for the business operator. So to get a division of general practice to own and operate would be a challenge.

CHAIR—Have you done any business planning or any work on that that you would be happy to share with the committee?

Dr Kastrissios—I would have to go back to my board and find out how willing they were to share that. I cannot imagine why not—it is fairly obvious. The model for general practice in this sense would be the same model that every individual general practice shares—and it is no secret. Their operating costs—I am sure you have heard the statistics many times—are somewhere in the range of 33 per cent to 53 per cent et cetera. It goes on and on. Depending on the quality of the service you offer, the hours you open, the staff you employ et cetera, you can run it a particular way but there is no great secret in it. I am sure that when I take that back to my board we will be happy to provide the information, if we can.

CHAIR—Thank you. Dr McBryde, you referred to the health and welfare project of the Brisbane North division. Is that something you could share with the committee?

Dr McBryde—Certainly.

Senator KNOWLES—I want to come to the Queensland Divisions of General Practice submission where it states:

> There is no such thing as ‘free care’; bulk billing provides health care at no cost to the patient, but at considerable cost to the system.

It goes on to say:

> While incentives for GPs to bulk bill card holders will theoretically protect some vulnerable groups from unaffordable but essential health care, there are many others that will not receive such protection.

Why do you say that?

Dr Kastrissios—That is a good question. Since I was not directly responsible for that sentence, I struggle with it myself. I would imagine in this case that it relates to people who are unable to access bulk-billing, who are in this sense non card holders but marginal in their ability—

Senator KNOWLES—There is nothing in the package to prevent anyone from being bulk-billed.

Dr Kastrissios—Absolutely. I am trying to answer your question in the sense that I do not understand that either. It is not a reference to the package; it is a reference, I think, to the people who opt not to take it up. I do not think it makes sense. I agree with you.

Senator KNOWLES—Good. Your submission also states:

Increasing medicare rebates is a more equitable way of assisting all patients, because this then limits gaps for everyone.

What does the division believe that the rebate should be increased by?

Dr Kastrissios—Obviously the answer would be depending on what you thought you could bear, because we think that the average costs of a quality general practice service, lasting around 20 minutes, would roughly be around $45 to $50. If that were the rebate, I am sure that would be very acceptable to members of the community to whom the rebate should go.

Senator KNOWLES—A $45 to $50 rebate?

Dr Kastrissios—If that was the rebate the patient received because that was what the general practice was charging for that level of consultation, then that would be very acceptable. The QDGP does not have a particular view about what the rebate should be if it is bulk-billed—if that was the question—because that is not really a rebate.

Senator KNOWLES—What you are suggesting is about a $2.5 billion increase.

Dr Kastrissios—I am not suggesting it at all. I agree with you that the country cannot afford that.

Senator KNOWLES—For every $1 increase in the rebate, it is $1 million.

Dr Kastrissios—I am well aware of that, and I agree with you.

Senator KNOWLES—That is $100 million, sorry. Looking at that just blows my mind away.

Dr Kastrissios—I was not suggesting that.

Senator KNOWLES—That is encouraging.

Dr Kastrissios—If you asked a member of the public what they would like to pay for a high-quality service of any type, they would say 'Everything', but that was not the question.

Senator KNOWLES—No. I am looking at out-of-pocket expenses—and I pursued this earlier in the day. Many people only pay about a $20 gap, and many of them pay less. An overwhelming majority of Australians go to the doctor less than five times a year. Do you think that makes Australian health unaffordable to most Australians, bearing in mind that those who fall into the more chronic short-term or long-term illness categories are generally looked upon by medical practitioners in a more sympathetic vein?

Dr Kastrissios—In this case, I will go down to my practice level. At my practice level, that is a sustainable model, certainly in the short term and the foreseeable future. I think it is reasonably affordable, given that general practitioners, almost universally, consider the situation very carefully and are extremely sensitive to the needs of their patients. In situations where a patient is suffering through chronic illness or inability to meet regular costs, then they certainly do what you suggest they do. I think it is reasonably sustainable in the short term—that being somewhere in the next three to five years. Beyond that, I am not confident that the model will continue to hold up.

Dr Adkins—From my practice level—I work at Birkdale—one-third of our patients are charged a private fee, one-third are directly billed through Medicare and the remaining third are charged a discounted rate. In my area, the consensus from general practice is that a reasonable rebate would be at least $35, which is not as high as what John was saying.

Senator KNOWLES—It is $1 billion dollars.

Dr Adkins—Yes, it is a significant cost.

Senator KNOWLES—It does not sound much when you say it quickly, does it?

Dr Adkins—No.

Senator KNOWLES—A billion dollars. Part of our terms of reference is alternative policies. I notice that there has not been any comment in the submissions about the proposition that—and this is from the Labor Party, of course—in exchange for an increased rebate thou shalt be compelled to bulk-bill X percentage of patients. Do you believe that your colleagues would sign a pledge to do that?

Dr McBryde—I do not think they will. Having been in the profession for 26 years, I have seen what has happened over that time, and I believe that a lot of GPs have the same feeling that they cannot trust the government to increase the rebate or the bulk-billing rate in line with the CPI. I have actually got figures and graphs here that show that that has not happened.

Senator KNOWLES—To increase the bulk-billing rate?

Dr McBryde—If you are going to increase your bulk-billing rate over the next 10 years, to be able to sign on you have to have some guarantee of an automatic increase in the rebate. I do not think that the GPs will trust that.

CHAIR—Can I make a point of clarification on the Labor policy. You do not actually have to sign on. The amount of money is paid if you reach the threshold of bulk-billing, so there is no long-term commitment.

Dr McBryde—That is correct, but I think GPs will drop out if there is no increase guaranteed.

CHAIR—That is fine. It is a technical point, that is all.

Senator KNOWLES—But they still have to get to a certain level of bulk-billing, otherwise it is a case of ‘Sorry sport, you’re out of dough.’

Dr McBryde—Yes.

Senator KNOWLES—The issue that I wanted to canvass has completely gone out of my mind. What were you saying, Dr McBryde, about the way in which doctors were billing?

Dr McBryde—Did you mean in my division that they have dropped their bulk-billing rates from being above the national average down to below the national average in all the five electorates in the division to reflect their quality practice? The other thing is that even private billing practices have something like a 25 per cent bulk-billing rate even though they regard themselves as private billing, because of that discounted service that GPs do.

Senator KNOWLES—I would be interested in your comments on the rebate. My colleagues will be bored to snores to hear me say this again. In the last six years the rebate has gone up by 20 per cent, in the previous six years it went up by 9 per cent, and bulk-billing went up under 9 per cent and came down under 20 per cent. That is for a short consultation; it is five per cent and 26 per cent under a long consultation. What does government think would happen if the rebate kept on going up at that rate and when the doctors quite clearly then just stop bulk-billing?

Dr Kastrissios—I have been in this business for a while as well. I have been in the same practice for 17 years, and previously I worked in a bulk-billing practice. I have a strong sense from talking to lots of general practitioners about how they organise their business affairs that the billing and the rebate matter less and less to the actual health outcome they are looking for. We have been trained and consider ourselves to be one of the best professional work force units delivering health care anywhere in the world, and we are attempting to continue to do that. In my opinion the entire system is struggling—I do not want to say ‘in crisis’, not for maybe five or 10 years. My longitudinal view from being in the same room for 17 years is that there is a major difference in the last five years and a huge difference from 17 years ago about how difficult it is to manage people’s health outcomes.

I guarantee you that the issue is one of quality. GPs and patients want a good quality service at all levels, and they are prepared to either pay for it or not pay for it or whatever it takes, but that is what they want. GPs responsible for running their businesses make decisions to get that. They have discounted—and I will use that term—through altruism, clearly against the advice of every business adviser they have ever talked to. Their accountants laugh at them, their financial advisers and bankers mock them and their insurance agents scorn them. It is because they simply do not follow best business practices, and they are going out the back door in terms of sustaining the practice. They make an income but there is no capital to reinvest.

Senator KNOWLES—I have one quick, final question about the technology that is being used and is expected by everybody. Once upon a time if someone at the age of 90 wanted a hip replacement, they would be told, ‘Sorry, you are too close to slipping off the plate; that won’t happen.’ Whereas now the expectation is that everyone should have everything no matter what age or what circumstances they are in. How do governments now manage that demand for excellence in technology?

Dr Adkins—This is probably one debate that needs to be had in the public arena. I know it was tried here in Queensland a number of years ago. The community need to provide advice to government on the allocation of resources. Health resources are a finite quantity, and the general public have higher and higher expectations of them. They expect that anything can be achieved, but in reality there are only a limited number of resources to go around. The community need to be better educated in the fact that these are limited resources and to be part of a debate on what things are funded. I think the community expect that everything should be funded, and that is just not possible. That debate needs to be had, and it has not been had to date.

Dr Kastrissios—I spend a significantly increasing amount of my time managing that public perception. I run the line between being the patient advocate and also the system advocate, and I find it distressing and tense sometimes to explain the situation to people—as I did this morning. This morning I received two letters advising of orthopaedic outpatient appointments at my local hospital. The advice was: ‘We’ve written to your patient; they can expect an appointment in 26 weeks.’ I thought, ‘Well, 26 weeks is not too bad,’ but then I re-read the letters and both letters actually said 26 months, and I thought, ‘That’s probably not quite as good.’

I have to ring those people and say, ‘Can you put up with your shoulder pain and hip pain for another two years until you get your appointment in outpatients—not your operation; your appointment in outpatients? We need to manage what we can do.’ The frequency with which that occurs is distressing and puts enormous pressure on our staff who manage the patient’s distress and on the GPs with whom I work. I find it more and more difficult to do this job—and I love doing this job.

Senator ALLISON—I want to pursue the issue of scoffing and ridiculing with regard to GPs’ ineffectiveness in a business sense. Dr Adkins, in your submission you say:

> ... the current myopic emphasis on the general practitioner as the sole provider of medical services in the GP setting ignores the real benefits and efficiency gains offered by workplace reform and better utilisation of nurse and other support staff.

It seems to me from submissions that have been made to us, that practice nurses would be more than worth the investment in their salary. Can you indicate to the committee whether you think that is the case? As a division do you recommend to your doctors that they have practice nurses? Do you indicate to them how they ought to use them in order to better utilise them in terms of their financial benefits? What do you mean by workplace reform?

Dr Adkins—In my practice we have two nurses who work part-time and they are a valued asset of the practice. The difficulty is that the medical benefits schedule largely funds the work of the general practitioner—

Senator ALLISON—Sorry to interrupt you, Dr Adkins, but it is my understanding that, as long as the medical practitioner spends some time with the patient, the practice nurse can do the bulk of it, thus freeing up the doctor for other patients. Is that not correct?

Dr Adkins—That is not the advice that we have received from the Health Insurance Commission. We have had quite a strong debate in recent times about expanding the role of the practice nurse. At the present time, the GP or the medical practitioner is required to do the majority of the work. There cannot be efficiencies in practice and there cannot be workplace reform when the funding is just for one member of a team—it needs to be for the whole team.

Senator ALLISON—So that is the reform to which you refer?

Dr Adkins—Yes.

Senator ALLISON—Does the division have any ideas about the length of time a GP ought to spend in the presence of the nurse and what procedures the nurses could be relied upon to deliver themselves?

Dr Adkins—The division has prepared and put a number of submissions about increasing the numbers and role of the practice nurse in the general practice setting. The division is also very interested in education training programs and recruitment programs. At the present time there is a shortage of nurses and there is quite a lot of competition for nurses.

Senator ALLISON—I want to come back to this question, because it seems to me to be pretty interesting and we do not have a lot of information thus far on it. If this committee were able to make a recommendation with regard to practice nurses and what they could do, I think that might be useful. I am sure I speak for the rest of the committee members in saying that if you have a document which spells that out, it would be useful for us.

Dr Adkins—We would be happy to provide that information.

Senator ALLISON—Can you indicate how it was developed and where it has been in this whole debate?

Dr Adkins—The division was part of an application to develop an education and recruitment process for practice nurses. At the present time there really are no training programs specifically for general practice nursing. There is for domiciliary nursing and for nurses in hospitals but, within the general practice setting, there is no specific education and training program. The division, in conjunction with other divisions and Griffith University, has put a proposal forward to develop that aspect of training and recruitment.

Senator ALLISON—But it is one thing to talk about training; it is another thing to say, ‘What do we allow practice nurses to do and to attract a rebate for?’ Do you see what I am trying to understand?

Dr Kastrissios—Yes, there is a difference there. I will make a brief comment, and I know that Ann wants to speak. The question we have not yet discussed fully is whether we should get direct rebates for a nurse practising in the practice with no doctor participation, a limited amount

of doctor participation or any doctor participation. That debate has not been had amongst ourselves. What we would really like to do is move well away from the current principles which have taken us away from managing our practices.

The HIC attempts to micromanage our work practices. The Health Insurance Commission has specified in some parts of its documentation that practice nurses can do no part of any educative process and then allow the GP to claim a rebate. The HIC has since reversed that verbally, although we have not had a written reply, so that a trained practice nurse can contribute something and deliver some part of an education process and the GP can claim it. That is part of the EPC item problem in the provision of, say, an asthma Three-Plus Plan. But there is a bigger debate about whether you can receive a subsidy for a practice nurse, what level of supervision there should be or whether they should be able to practise independently within your practice. That debate has not been had fully.

Dr McBryde—I think one of the problems at the moment is that practice follows the funding instead of the funding following the way we should practise. Currently it is face-to-face fee for service in the main, and that can be very difficult. In some practices there are GPs who do every single thing, and a lot of that is nursing duties. If we could free up some of those duties and give them to an appropriate person within the general practice team, our work force shortage would start to be alleviated. That is the work force reform that we are talking about—that is, looking at what the general practice team looks like and who should be in it. In some cases it might be a practice nurse but, in another area, it might be a physiotherapist or an occupational therapist. It would be determined by the regional needs and certainly the general practice needs.

In our division we are currently looking at, because we know that general practice is very financially poor, something like a medical assistant—something which is being rolled out in the United States. Dentists have dental assistances; pharmacists have pharmacy assistants. It would be affordable for general practice to be able to have a medical assistant. But it is very early days and there is a lot of work that we have to look at. We have to look at what they would do, how they would be financed and what the political reality of it would be. That is the kind of reform that needs to be looked at.

Dr Adkins—At the moment we are saying that the GP is the bottleneck or the rate-limiting step in the provision of quality care in the practice. We would like to enlist the skills of other members of the practice to improve the quality and quantity of services that can be provided.

Senator ALLISON—That is certainly the view of some people who have made submissions. They have said, ‘We’ve got more than enough GPs; what we need to do is spread the load around and even find more appropriate professional groups to deliver on those services.’ So you do not disagree with that general proposition?

Dr Kastrissios—We do not disagree. The debate is in its early stage but there is a general feeling from the early debates that we have had that we as a group do not really support the provision of nurse services that are targeted to particular item numbers or particular services. In a particular practice, if the HIC were to delineate these particular services that would attract the funding, that would again hamper what could be a flexible model of care. We would like to allow general practice to do what it does best and innovate. I know that is a challenge for the funder but, if we go down the road of restricting what can be provided at an individual service

level, we are going to see services targeted in an entrepreneurial way to fit the funding, and that is not what we want to see. Again, we know what we deliver and we know how to get the best outcomes for the money we have.

Senator ALLISON—It is not all together clear from your submission, but I wonder whether you agree with the AMA on their rejection of any notion that private health insurance should move into general practice.

Dr Kastrissios—I will answer from a QDGP perspective, because we had some brief discussion on it. We are unclear as to what the outcomes would be and we are therefore fearful. Our relationship as GPs with private health insurers is often problematic in that we are forced to be in a patient advocacy role defending the person's claim, and it becomes extremely difficult to manage that process. We are small business operators; they are big corporations with teams of lawyers. We have experiences with private health insurance companies that are not always positive. I am therefore sure that most general practitioners—I am not saying the divisions of general practice here—would be interested in seeing the model developed further, but at this point I think we would reserve our judgment as to how effective it might be.

Dr McBryde—Some years ago I was in the United States, and they of course have hundreds of private health insurers, and in almost every practice that I went to I found that the general practice had to employ a full-time person just to deal with what can and cannot be done and to deal with questions with regard to what the claims are, how you claim it back and what will be paid. It is an absolute nightmare. I know it would be nice to have some finance from somewhere other than government and patients but, when you think about the negatives, it becomes a bit of a worry.

Dr Kastrissios—I recently attended a seminar with a practitioner from the United States. He suggested that, in his region of Florida, general practice routinely employed one coder and one staff member—two people—to handle the claims of the five or six HMOs, insurance companies, to which he was affiliated. He felt it was nightmarish. I do not know that that would be the Australian situation, but it certainly worries us.

CHAIR—Doctor, I think what you were saying was that advice from the HIC is somewhat conflicting in terms of what a practice nurse can do. Can you, at a later stage, point us to where—I gather advices from HIC are publicly available—we can have a look at that information, in order to talk with the department on Thursday?

Dr Kastrissios—We would be delighted to.

Senator STEPHENS—I would just like to take the discussion about quality a little bit further. I noticed in both of your submissions that you talk about improving and facilitating the integration of health services. Just as a point of interest, would the inclusion of a practice nurse as part of the Practice Incentives Program help?

Dr Kastrissios—It is certainly one of the models that we have considered might be applicable. It very much depends on what the nuts and bolts are. It depends a lot on what the restrictions might be and what comes out in the detail. I do not think there is any rejection. It does exclude, though, in some critical areas, people who have not signed up for other PIP

payments. To some extent, they see that as a bureaucratic hurdle in itself. However, if it were free from too much bureaucracy, from that perspective, I think people would probably support that. But that is again a personal view.

Senator STEPHENS—All of your submissions make the point about the complexity in compliance with the PIP. Are there obvious ways that it can be simplified?

Dr Kastrissios—I am a trainer for the EPC items and I can tell you that there are a dozen ways you could simplify it. If you had a red pen I could show you.

Dr Adkins—When you are looking at quality there is, by necessity, a need to collect additional information, which does incur an overhead. So there are additional costs in measuring quality. Some aspects of quality are very easy to measure, and other aspects of quality—probably the ones that we are all looking for—are very difficult to measure. There needs to be resourcing in that area to assist the general practice profession to measure quality outcomes.

We talked about how it is going to cost an extra billion dollars for rebates. The issue is: is the money that is spent actually making a difference; is it actually improving health outcomes? If you are spending money and you are really not going anywhere and you are not improving outcomes, that is not good for anybody. If you spend additional money on measuring outcomes and you do demonstrate that you are making a difference, then the money that is spent is worth while.

There are some aspects of the PIP that have been widely taken up and appreciated by general practice and there are other aspects of the PIP and EPC which have been dismal failures and have not been taken up by general practice. I think the message from general practice is that the GPs need to be involved at a micro level in finetuning and refining the programs that are put in place by government organisations and also that the profession needs to be more involved in the regulatory aspects of those programs as well as determining the criteria for quality outcomes.

Senator STEPHENS—Can you tell us which ones have been dismal failures?

Dr Adkins—The case conferencing has been one. The difficulty is that there are incentives for general practitioners to be involved in case conferencing with other health professionals but there are no incentives for professionals in the other private sectors or in the hospital sectors to be involved in those initiatives. Also, the logistics, particularly in urban areas, are quite difficult if you are trying to get three or four people together at the one time to talk about a clinical problem. That is a logistical nightmare. So, for that reason as well, the program has not worked.

In theory it is a great idea. In theory, it is about getting together a number of health professionals to talk about a patient problem, to come up to speed and to improve the communication for that patient problem but, in practical terms, it has not worked in the cities. It might have worked in some country areas where the number of health professionals is smaller and people know each other and value the information exchange more, but it has not worked in the city.

Dr McBryde—Everyone cites immunisation, but that is an outcome rather than a process. The outcomes are better for PIP, I think. I think the recall system for diabetes is another good one.

Where GPs can see that their patient has benefited by the PIP, they are happier to take it up even if it is more difficult. But when they cannot see the benefit of doing something, it just becomes another thing in their busy day and they just do not want to take it up.

Dr Kastrissios—In addition to holding a PhD, one member of my practice has an MBA and one has a computer science degree in addition to their medical degrees, and I have done extensive upskilling in mental health training. We do a lot of counselling and psychotherapy and we do a lot of fairly holistic care in asthma and diabetes et cetera. Even being a division chair, the QDGP vice president and knowing intimately what you have to do, I find it incredibly difficult to actually do it, because some of the design has been done by GP zealots—in all good faith and wonderfully constructive; somewhat modelled on junior specialist ideals. It is lovely to see, but it does not fit the workflow practices of the average GP.

The average GP constructs, for instance, a better outcomes in mental health care care plan in a sort of piecemeal way, which fits the nature of general practice, and they do not develop rigorous four-page documents on the one sitting. It does not fit the flow of general practice, and the uptake is therefore poor. I can give you example after example in every EPC and PIP model. We have had discussions with the HIC. They are exceptionally interesting people to work with, and we do not make very quick progress.

Senator STEPHENS—I have a question in terms of the technology issues. We have heard various estimates of the costs of opting in to the technology package. Other than just the online billing, to what extent would a technological relationship with the HIC improve the take-up of practice incentives or EPCs? Is technology going to make a difference?

Dr Kastrissios—It makes a huge difference. Information management is critical to progress, but the base work is yet to be done. There is a vast underspend, despite what people might think, in the peripheral areas of implementation of information technology at the general practice level. The systems that were bought three years ago are now ready to be updated and upgraded. There is no money to do that, and they will fall into disrepair. It is going to be quite interesting to see what happens in the next three years. I can guarantee you that the degree of technical expertise that you have to buy in to maintain a viable, secure private network in your practice has been underestimated by most general practitioners.

Three years ago, it took me—with a reasonable knowledge of an NT4 system—1½ days to set up HIC online in my practice with a PKI key. It took two senior IT technicians from Queensland Health two days to do it on one computer—one workstation. It was only because I was intimately aware of what I had to do and knew my system that I was able to do it. What the impact will be has been vastly underrated and the cost has yet to be ascertained properly. No modelling has been done. I have spoken extensively with HeSA and HIC online people, and I can tell you that they did not see that assisting that was at all a priority. They have moved it up the scale a bit, but we are making very slow progress there as well.

Senator HUMPHRIES—Because there has been a range of views by doctors, I have had a couple of questions that I have been putting to doctors' representatives, and I will ask you the same questions. First of all, do you think that doctors will take advantage of the patient copayment arrangements at the time of service—the payment of the gap between the schedule fee and the doctor's fee—to increase the size of the copayment to make up what I think you have

been describing as 'some lost ground' on the part of doctors? Do you agree with the view put to the committee that price signals by way of a copayment, for example, can deter the sick as much as those who are not so sick?

Dr Kastrissios—I think it is always a risk to answer the second part first. Deterring the sick in that situation is a theoretical possibility. In my practice it has not occurred. We moved to private billing for all patients—or 96 per cent of patients—a couple of years ago. We discount for the sick and we have made it very clear, through a practice that was transparent to people, that if they were ill and they had no funds they were still to come to us. It is my belief that that is what GPs would be doing. It is common practice as far as I know.

I certainly think some people will see the opportunity to make up the gap. We charge a gap copayment of $5 or $6, or less, to pensioners, depending on their frequency of visits et cetera and their needs. We often go through the rigmarole of giving them a stamped, addressed envelope so that when the doctor's cheque gets sent, most appropriately, to the patient they then send it to us. In fact, they hardly ever use them. Why? Because these pensioners take their time to come down the next day and bring it to us by hand. We keep saying: 'Don't do that; we don't need this. It's okay.' They are the most supportive. They have said to us time and again, 'Why haven't you been billing us?' It is the most rewarding experience of my life in that sense—in the financial sense—that this is from the people over whom we agonised for 10 years about saying, 'We're going backwards; what should we do?' Universally, we lost about 10 patients out of our 6,000 patient base. I do not know the answer for other people, but in our practice the experience was positive. We are humane—I do not want to use the word 'compassionate'. We are sensible people who care about the sick. That is why we do this. I could make more money bulk-billing—I can guarantee you.

Senator FORSHAW—The term 'copayment' gets thrown around a lot. You do not actually charge a copayment; you charge a total fee to the pensioner and you accept the Medicare cheque plus a small additional amount. I have a couple of questions. Firstly, in answer to a question from Senator Knowles in relation to a paragraph on page 3 of your submission, I think you said that you did not agree with it or you—

Dr Kastrissios—Did not understand it.

Senator FORSHAW—I actually did not find it hard to understand, but maybe I am misunderstanding it, given what you have just said. I took it from that paragraph that the proposal which promotes bulk-billing of health care card holders and concession card holders theoretically—you used that word—could give them greater protection, particularly if they are not bulk-billed at the moment, but that there are then a whole lot of other people who would fit into the category of low income or moderate income—just above that threshold of $32,000—who, if they do not have bulk-billing or they lose the bulk-billing that they might have now, might be disadvantaged.

Dr Kastrissios—Yes, they may be disadvantaged. In that sense I can understand it.

Senator FORSHAW—I think that is what that paragraph and the next paragraph say. You say that doctors use their own knowledge to assess who they might bulk-bill and who they would not. Okay, so that is clear. The second thing I wanted to ask you was with regard to your

proposition—I think this is what all GPs are saying—that if the schedule fee were higher and therefore the rebate, whether it is at the present 85 per cent or goes to 95 per cent or 100 per cent under our proposal, were around $45 to $50, it would remove a lot of the problems that doctors say they have because the rebate has not kept pace. Senator Knowles asked you questions about that and the response was that, to lift it to that level, would cost $1 billion or $2 billion—a lot of money. Do you know how much the cost is to the government—out of taxpayers' revenue—of the 30 per cent private health insurance subsidy? Do you know what that amounts to now?

Dr Kastrissios—I have read it—and Peter knows it.

Dr Adkins—I read it yesterday. It is a lot of money.

Senator FORSHAW—Yes. It is $2.3 billion and rising, because, as premiums go up, it inevitably goes up. And you know that that was introduced primarily to try to alleviate a problem that the health funds were having of declining levels of private health insurance. From what you are saying, I take it that if there is a problem which GPs are facing—

Senator KNOWLES—Do you have a question?

Senator FORSHAW—Yes, I do have a question.

Senator KNOWLES—It is just that the chair was wanting to finish at 5 p.m.

Senator FORSHAW—I got to start asking questions at three minutes to, and I will finish very quickly if you allow me to. Are you putting to us that trying to find the amount of money—similar to what was done with the private health insurance rebate—to deal with the issue of GPs' incomes would be a better way to go about it than the current package?

Dr Kastrissios—I would obviously be loathe to answer a question that is somewhat loaded; however, I will answer.

Senator FORSHAW—It is in your submission.

Dr Kastrissios—I realise that.

Senator FORSHAW—That is what you say.

Dr Kastrissios—The submission does say that it is a lot of money; it does not say, I do not think, that we suggest that it transfers to general practice necessarily. It refers to the concern that we have about the entire system. General practice—wonderful and marvellous as we are—cannot exist in isolation from the entire system. The concerns we have with the removal of that is that it would put increased pressure on the public hospital system, which would exacerbate the existing problems that we have. I have no answer for you. I would love to say to you—

Senator FORSHAW—I have not asked you whether or not you agree to take the money out of the health insurance rebate and put it here; I am asking you whether what you are putting to us is that there should be, as it were, a comparable increase. You actually say:

Increasing medicare rebates is a more equitable way of assisting all patients, because this then limits the gaps for everyone.

Dr Kastrissios—I think that an across-the-board increase would probably be a more equitable way of managing the current underfunding of the rebate. Whether or not that money comes from that other package is not something I would have understood or modelled.

Senator FORSHAW—And I am not asking you to.

Dr McBryde—If we can put more money into general practice and primary care—because I think general practice is part of primary care—hopefully down the track we will see some savings in the acute care sector, as indicated by overseas studies.

Senator FORSHAW—My final question leads on from that. Are you aware of the full detail of the ALP policy?

Dr Kastrissios—We believe we are.

Senator FORSHAW—An increase in rebates has been mentioned, but are you aware of the other component, which is payments in addition for all bulk-billed services once certain targets are reached?

Dr Kastrissios—We are aware of it.

Senator FORSHAW—Do you know how much it is worth?

Dr Kastrissios—It is a lot of money; it is up to $22,000 in some—

Senator FORSHAW—If the rebate eventually goes to 100 per cent, it could mean around $47,000 in a rural area when you put the two together—the increase in the rebate and the extra payment.

Dr Kastrissios—The only concern I have with your proposal—and I would ask you to listen to this carefully—is that, if you set targets that look at bulk-billing as an outcome, you will achieve those targets, and I am not confident that what we want in the community is more bulk-billing as an outcome. What we want is better health outcomes, whatever the method might be. I know, because I have worked in a bulk-billing practice. In fact, a couple of years ago I took a couple of weekends off from my practice and worked at a practice on the other side of town to experience the bulk-billing situation. I was asking people to sit down after four minutes because I had not even started to talk to them about their health problems. To some extent, it trains a generation of people to have a lower expectation of their doctor. I have concerns about the time that you can afford to spend with the patients. The time you have to spend with them is critical to understanding their needs, their psychosocial situation, their family and the impact of their disease on their lives.

Senator FORSHAW—We are running out of time. So you do not agree with bulk-billing in broad terms?

Dr Kastrissios—I have no problem with a low-cost health system that supports the poor, the disadvantaged and the unwell. Whether its name is 'bulk-billing' poses no problem for me.

Senator FORSHAW—Given that that is your position, why do you then support a proposition which is in the interests of you, the doctors, which is partial or hybrid bulk-billing which gives you the opportunity to bill the HIC direct for the rebate and collect the gap? That is what the online process is. You are actually saying that you support that as long as it benefits you. It is cherry picking, isn't it?

Dr Kastrissios—Only because it reduces the administrative burden for the practice, not because of the principle with which—

Dr McBryde—And the patients.

Dr Kastrissios—It is into patients, indeed. It is not the principle that it engenders the bulk-billing concept or the copayment concept. That has nothing to do with the health outcome. To us, the simple administering of a funds transfer has nothing to do with health. That is my key point to you. I really care about what happens to patients; I really do not care which way the money gets transferred to whom or by whom. In actual fact, it does not make a difference, does it?

Senator FORSHAW—It seems to.

Dr Kastrissios—Only apparently.

Senator FORSHAW—So you can take it or leave it?

Dr Kastrissios—I am happy for you to come to my practice some time and see how it works.

Senator FORSHAW—I have spoken to people in the practice that I go to, and it is a different perspective.

Dr Kastrissios—Maybe there are different practitioners in Australia.

Senator FORSHAW—There are.

CHAIR—I thank the divisions—Queensland, Bayside and Brisbane North—for presenting to us today. This is the conclusion of today's public hearing. I think it has been very successful here in Brisbane. We have done a lot of work. I thank everyone for their attendance and cooperation, and declare the meeting closed.

Committee adjourned at 5.04 p.m.