COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

SELECT COMMITTEE ON MEDICARE

Reference: Medicare

THURSDAY, 24 JULY 2003

MELBOURNE

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SENATE
SELECT COMMITTEE ON MEDICARE
Thursday, 24 July 2003

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

Senators in attendance: Senators Allison, Forshaw, Humphries, Knowles, Lees, McLucas, 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 8.51 a.m.

LITTLEFIELD, Dr Lyndel Kay, Executive Director, Australian Psychological Society

MARTIN, Professor Paul Russell, President, Australian Psychological Society

STOKES, Mr David, Manager, Professional Issues, Australian Psychological Society

CLARK, Ms Kerren, National Public Policy Officer, Australian Physiotherapy Association

MALONE, Mr David, Chief Executive Officer, Australian Physiotherapy Association

MICKEL, Ms Katie, President, Australian Physiotherapy Association

CHAIR—I declare open this public hearing of the Senate Select Committee on Medicare and welcome everyone here today. This hearing in Melbourne is the third of the committee’s planned program of hearings around the country for this important inquiry. Today’s hearing follows an expert roundtable held in Canberra and hearings in Sydney and Newcastle yesterday. I am sure we will find today’s proceedings and discussions equally useful. I welcome representatives of the Australian Psychological Society and the Australian Physiotherapy Association. Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you all. 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 you may ask to do so and we will consider your request. The committee has before it copies of your submissions, and I thank you for that. I now invite a representative of each of the groups to make a brief opening statement before we move to questions.

Ms Mickel—Thank you for the opportunity for physiotherapists to contribute to general discussions about the health care system, particularly today about Medicare. The Australian Physiotherapy Association have some key issues that we would like to place on the table for discussion, and I preface my comments by saying that we are committed to the continuation and improvement of the health care system that has both a public sector that is strong and vibrant and a private sector that is strong, vibrant and sustainable, and to Australian families having access to physiotherapy services both in the public sector and in the private sector.

There is now a need to diversify the concept of primary health care in Australia. Primary health care services for Australians are about more than doctors, nurses and pharmaceuticals. There is very strong evidence that physiotherapy interventions in a range of settings are the treatment choices that will produce the best health outcomes for Australians. Physiotherapy is a health science based on science and evidence. We have a very strong evidence base to present for you to see that physiotherapy interventions are not only efficacious but also cost-effective in a range of situations. We need to make sure that Australians are accessing primary health care services that are going to give them the best health outcomes. At the moment we are not seeing that happening.

An example of the concept of primary health care as it exists in Australia now is the Enhanced Primary Care program, a government initiative which was warmly welcomed by the health professions as a great way to have a multidisciplinary approach to primary health care,
particularly for older Australians and those living with chronic disease. But the doctor focus in primary health care means that in that Enhanced Primary Care program—which involves setting up care plans and case conferences with a range of health professionals to meet that individual person’s needs—only the doctor gets remunerated. If, for example, someone has osteoarthritis and needs a multidisciplinary approach to living with that chronic illness, they may need a physiotherapist, pharmacy interventions and GP interventions—but only the GP gets paid in that multidisciplinary team. So what do the physiotherapists do? Do they do it for free? Does the Enhanced Primary Care program work? No, it does not. It is not going to work as long as the doctor service is the total focus of primary health care.

We are disappointed that the proposed changes in A Fairer Medicare do nothing to address the current lack of physiotherapy services under Medicare and could, in actual fact, potentially exacerbate the inequities in access to these services. We see nothing there that provides better access for Australians. We have difficulty with the decision in A Fairer Medicare to commit to substantial increases in the numbers of GP registrars and nurses but not to addressing the significant and now critical shortage of physiotherapy services in this country.

I will summarise before going on to give you some more detail about our submission and our recommendation. In cases where there is clear evidence that physiotherapy interventions are more efficacious and more cost-effective than pharmaceutical interventions and surgical interventions, there should be access through Medicare item numbers for patients to access those services. The government needs to put its money where it can get the best result. But we would say that the narrow focus in the Medicare system on doctors as the sole providers of primary health care is denying Australian families best health outcomes and costing us money.

Prof. Martin—We have prepared a brief PowerPoint presentation, as we think it will probably be easier to communicate that way. I gather you have some handouts which have all the overheads on them. There is also a final page giving a bit more detailed information to support our presentation.

A PowerPoint presentation was then given—

Prof. Martin—We put a bit of thought into the title of this presentation. You can see we came up with ‘Cost-Effective, Evidence-Based Psychological/Behavioural Interventions and Medicare’. We really felt this most captured what we were arguing for. Our proposal is that Medicare be revised to include services provided by psychologists—to prevent onset of disease, effectively treat psychological and physical illness, enhance medical treatment, reduce the impact of disease, improve outcomes and save MBS and PBS costs. In many ways those dot points sum up the presentation so, rather than elaborating on them, let me move on and hopefully the elaboration will be there.

Cost-effective evidence based interventions are available for a range of health problems now. Depression, suicide, anxiety, stress and antisocial behaviour are the areas that most people associate with psychologists. By now there is an enormous amount of literature in these various fields. But we did also want to make the point that our work is relevant to physical health disorders for which changing behaviours like smoking, eating, drinking alcohol and inadequate exercise are risk factors. The point that we are trying to make is that many people are not aware that nine of the 10 leading causes of death in Australia are diseases for which the risk factors are...
related to behaviour and lifestyle. Of course behaviour is the absolute central concern of psychologists.

Obviously we cannot talk about all the different disorders, so I just want to pick two to give you some illustration. I have picked one from the physical area, heart attacks, and one from the mental health disorder area, depression. In the area of heart disease, the traditional major independent risk factors have always been considered to be smoking, high blood pressure and high cholesterol levels. Having said that, there has been literature for many years relating various psychosocial factors to heart disease—for example, stress, depression, anxiety and hostility: the so-called coronary prone or type A behaviour pattern. For many years the National Heart Foundation were reluctant to accept these as important independent risk factors. But in fact earlier this year they completed a very scholarly review of all the literature, and now the National Heart Foundation are saying that these risk factors—depression, social isolation and lack of quality social support—are as important risk factors to heart disease as smoking, high blood pressure and high cholesterol levels. If we look, then, at what psychologists can contribute in the area of heart disease, obviously the new psychosocial ones are very central to our domain. But smoking, eating, alcohol consumption and exercise are all behaviours, so they are also very central to the work of psychologists. Again, there is a huge amount of literature showing how we have developed interventions that can change these behaviours.

We have also put on the slide: ‘Improve adherence with medication-taking and compliance with rehabilitation programs.’ Psychologists obviously see themselves as part of a multidisciplinary team. We are not trying to push anyone else out; we are saying that we have something to offer as well. For example, in the case of the pharmaceutical industry obviously there have been new drugs developed over the years, which are huge improvements on ones of the past and very effective. But we would also point out that for them to be of any use people have to take them in the right quantity and at the right time. That is a behavioural issue, which is where, again, psychologists have much to contribute. We have also talked about the prevention of onset of heart disease and reducing the risk of further episodes, which leads to the subsequent slide.

Heart disease is the major killer in Australia. It is a disease of enormous significance and is one of the national health priorities. It is also an amazingly costly disease. These are just some of the figures—and you are probably very familiar with these—illustrating just how costly it is. We have picked just one recent study to illustrate our point. This study, which was done in the US and published in a very prestigious American medical journal, showed that psychological stress management halved the health care cost per patient compared with an exercise group and quartered the cost of usual care. That is showing it graphically—in other words, demonstrating that by using a psychological intervention there are enormous cost savings. This is taken from the same study: those who had the stress management training had 0.8 cardiac events on average in the next five years compared to 1.3 for the other groups. That is just a visual presentation of those results.

Moving on, there is an enormous amount of literature on depression. We know from numerous studies now that cognitive behaviour therapy, which is the mainstay of clinical psychology, is a more effective treatment for depression than medication. Combining the two also works well, but has no added advantages on simply using cognitive behaviour therapy. The literature shows that 12 to six sessions of cognitive behaviour therapy from psychologists is effective and
certainly costs less than medical treatment. ‘Costs less’ is not a casual statement; this has come out of a recent government study. We can talk about that more subsequently if you are interested.

So what are the advantages of including psychological behaviour interventions in Medicare? We would argue that very often the alternative to these interventions is medication. But they have many advantages over medication. For example, they are more cost-effective—they will reduce costs with PBS and MBS. They have more enduring benefits. In the depression area, for example, we know that 12 to 15 sessions of CBT has about the same long-term effect as drugs, providing people continue to take the drugs—but if they stop there is significant relapse. Finally, with the side effects, when you evaluate any treatment you focus on what you are trying to change—so if it is treatment for depression you look at what impact it has on depression—but you also have to look at unintentional effects. The unintentional effects may be beneficial or quite negative. Medication, everyone knows, often has negative side effects. When people look to psychological treatment, it is the reverse: they tend to have positive effects beyond what was targeted. I have mentioned improving sleep, which is a very common one.

There are other advantages that we see. Psychological interventions are preferred by a significant portion of the population. Many people are quite happy to take drugs but many of them are not. Many of them have very good reasons: they might have had a previous bad experience with the side effects. One of my recent research interests is postnatal depression. Most mothers who become postnatally depressed do not want to take medication because they worry about passing on the medication to the child by breast milk. Also, psychologists are widely available in both metropolitan and rural areas. The other health professions who most overlap in terms of what they offer to psychologists are psychiatrists, and we know that there is a real problem with access to psychiatrists, particularly in rural areas. We estimate there are about 4,000 to 5,000 psychologists, and they are well spread across metropolitan and rural areas.

In this submission we accept that psychology is very broad and not all psychologists are involved in providing services related to health—some are organisational psychologists or sports psychologists. We are of course only limiting this to those providing services in the health domain. But also psychologists have a range of qualifications. We are arguing for entry from the most highly qualified and that means people who in APS terms would be eligible for membership of professional colleges, which means a higher degree in a professional specialisation, supervisory experience, ongoing professional development and so on.

In relation to the way we see these services being provided, we believe we should follow the general model that access should be only via general practitioners. We believe, looking at the evidence based literature, that approval should be for six sessions in the first place followed by review, if necessary another six followed by review, and if necessary another six. There should be an absolute maximum of 18 because we do not believe there is any evidence that offering more than 18 sessions is an advantage.

We do believe now is the moment for change. In Australia more and more we are in this era of evidence based medicine. People only want to fund approaches that have proven value. Of course the same trend has happened overseas—in America and Europe. I want to emphasise that psychologists are totally committed to this approach. As a health care profession we are unusual. If you look at doctors for example, doctors have a very long tradition and history. They started as people out in the field trying to solve problems and help people with their health. Over the years
research began in medicine, people started training doctors, it came into universities and so on. Of course all that happened a very long time ago.

Psychology has a quite different history. We started off as an academic discipline around the end of the 19th century. It was not really until the Second World War that people tried to apply what we had learnt in our research, laboratories and so on. We really got going as a profession more from the 1960s onwards. For that reason when Medicare was introduced in 1975 there was very little evidence of psychological interventions that actually worked. But through the 1980s and 1990s an enormous number of techniques have been shown to be very helpful, and that is why we would argue it is time for change.

Finally, including evidence based interventions we believe will significantly improve the health of Australians in both metropolitan and rural areas. We believe it can be accomplished without increasing the cost of Medicare—in fact, quite the reverse. So we argue it will improve the system to include such interventions.

CHAIR—Thank you, Professor Martin. We now turn to questions.

Senator KNOWLES—I might just start with the physio submission. I notice that you have said that you are in favour of a mix of public and private commitment. Do you have any concerns about some proposals that are being put forward by certain organisations and political parties that the 30 per cent rebate should be abolished in its entirety or partially on ancillaries?

Ms Mickel—In the absence of any other policy that assists Australian families to access physiotherapy services in the private sectors and given that there is a huge burden on our physiotherapists in the public sector system, we support the 30 per cent rebate component that gives access for Australian families. However, we also acknowledge that that is not the whole solution to the problem and we are concerned about those families who are not in a position to access through the rebate and are not able to access the services either through the public system.

Senator KNOWLES—What would you see the net effect on your profession being if the 30 per cent rebate were chopped off ancillaries?

Ms Mickel—If the 30 per cent rebate were chopped off ancillaries, and if the approximately $60 million we estimate that would entail does not go into providing physiotherapy services somewhere else, we would see that as a very negative thing.

Senator KNOWLES—The proposition that has been put forward by other parties is that potentially the 30 per cent rebate would be chopped and ancillaries would be chopped—full stop, period—to give it to doctors by way of increased rebate. So the physiotherapists would miss out both ways.

Ms Mickel—They would. From my earlier comments, I think you would appreciate that the focus on the health care dollar being used to provide doctor services is not the only solution. There is undisputed evidence that physiotherapy management of osteoarthritis of the knee, as you saw in our submission, and incontinence produce better outcomes for those patients and are more cost-effective. Therefore, we would argue that they should be put onto an MBS item number so that people have access to them. They do not have that in the current system.
Senator KNOWLES—Are you aware that in the nurse practice program, where 457 full-time nurses can be put in place, a doctor can choose any health professional there—that is, if a doctor chose to have a physio instead of a nurse practitioner they can do so?

Ms Mickel—We are aware of that. Our concerns are that there is evidence that it has not been happening.

Senator KNOWLES—This program has not commenced yet. This is the new program.

Ms Mickel—The MAHS program was very specifically for more allied health services. In our opinion nursing is not allied health, yet in the last year, 30 per cent of the funding in the MAHS program for more allied health services has gone to putting practice nurses into general practices. We do not have a problem at all with practice nurses being put into general practice—it is absolutely fantastic for overworked GPs to be able to have that—but why call a program More Allied Health Services when it has not delivered? Only five per cent of that MAHS funding has gone to providing physiotherapy services, yet we are one of the biggest allied health professions in this country. So we are not seeing equitable access to physiotherapy services.

Senator KNOWLES—From what I understand from the figures, physiotherapy has about 5.5 million services generated, at a cost of $236.4 million per annum. Of course, that is in the private sector. There is much factual and anecdotal evidence that many low-income earners take out ancillary cover specifically to cover them for physio, dental and optical. Out of those three areas, where I believe there is a bit of a loose coalition in this matter, dental generates costs of $1.8 billion, optical $680 million and physio $236 million. That is a fair slice. If much of that were sucked out and put back into the public domain without corresponding money—because the money from the 30 per cent rebate under other proposals will go to the doctors—I would imagine there would be a serious decline in physiotherapy services and health outcomes for Australians.

Ms Mickel—we have certainly aired concerns that, if the 30 per cent private health insurance component that covers physiotherapy services is touched in any way, it must be put somewhere else into the system. Therefore we are totally opposed to those submissions and proposals from groups that suggest it be put into GP services and nursing services.

Senator STEPHENS—I will address my initial questions to the Australian Physiotherapy Association and come back to the psychologists later. I do not want you to feel abandoned. I think everybody appreciates the benefits of a multidisciplinary approach to primary health care. Going specifically to your submission to the committee now, I wonder if you can explain to the committee how often physiotherapists would be incorporated into an EPC team. I know that you argue in your submission that there is not much incentive for a physio to be there because there is no capacity for payment, but can you tell us how often a physio would be part of that team?

Mr Malone—one of the problems in answering that question is that the Department of Health and Ageing is not able to give you the details as to which other professionals made up, for example, a case conference team or a care plan team. All they can really tell you is how much money has gone to doctors. If you were to say to the Department of Health and Ageing tomorrow, ‘For each of the care plans that were funded in a particular area over a particular
period of time, can you tell us who the other two people involved were, other than the GP?’ my understanding is that they could not give you that information.

It is a program that is probably more accurately described as a program to support the general practitioner. That is one of the difficulties with this program: that you have a multidisciplinary approach which, there is evidence to show, will deliver a better outcome than a non-multidisciplinary approach, particularly with people who are aged with chronic conditions. People support that, yet the department will fund a general practitioner for engaging in that team. That is the limit of their funding and it is the limit of their data collection in terms of who has been involved.

Our anecdotal feedback from our members, and we represent over 10,000 physios in Australia, is that physiotherapists are often asked to be part of the team by the GP because there is a recognised need. But they cannot give up their time for free if they are in the private sector, and they cannot get themselves off the ward if they are in the public sector, because their workloads there are full. Our anecdotal information is that physiotherapists are often requested to be part of the team but cannot be involved. But like I said, we cannot tell you how many of the EPC care plans, for example, had a physio involved, because the department cannot tell us.

Ms Clark—We do have some strong evidence, though, that the program has been heavily undersubscribed. As Mr Malone has said, our members report to us regularly that the EPC program is not taken up. We have recently had a look at the budget figures from the 1999-2000 budget, and then the most recently released budget. In the 1999-2000 budget for the financial year 2002-03, $22.9 million was allocated to the coordinated care planning program, whereas in the most recent budget, for the 2003-04 financial year, there was only $15.3 million allocated. That represents a 33 per cent decrease in that funding.

We do not actually have the figures to show that the funding that was allocated in 2002-03 was not spent on EPC, but one would think logically, judging by that massive budget reduction, that those funds were not taken up. We think that demonstrates that the EPC program is not in fact working, and the reason that it is not working is that health care professionals other than general practitioners involved in that program simply are not being remunerated for their services and their contributions to the program.

Mr Malone—The only item category under EPC that has gone up is health assessments which, not coincidentally, is the only item where the general practitioner does not need to work with other professionals.

Senator STEPHENS—Can you just explain to me whether the EPC program is funded on each individual care plan submitted? It is not an allocated amount of funding to a practice; it is through the individual—is that how it works?

Ms Mickel—Yes.

Senator STEPHENS—You argue in your submission for new MBS item numbers for physiotherapy management. You identified incontinence, knee-joint osteoarthritis and back and neck pain. You suggested incontinence and osteoarthritis ahead of back pain, which I would have
thought would be the most common need for physiotherapy. Why did you opt for the first two as priorities over the others?

Ms Mickel—One of the reasons we are particularly passionate about incontinence is that it is a huge problem for a whole range of Australians, not least older Australians, who are more often admitted to residential aged care facilities as a direct consequence of incontinence than for any other reason. It was very important that we look at that issue. There is very little access for many Australians and there is very little knowledge and information out there about the efficacy of the conservative physiotherapy management of incontinence and knee-joint osteoarthritis. Knee-joint osteoarthritis is a huge problem for ageing Australians, with incredible mobility consequences which often see people taking the path into a loss of independence and the aged care process. We saw those, as part of the ageing Australia strategy, as being very important.

Ms Clark—The other aspect that is important for us is that both of those conditions are very easily diagnosed, and they are also readily managed with discrete interventions. The treatment of back and neck pain can be a considerably longer process. It is not so easy to say that physiotherapy is the intervention that will be required, whereas for the management of incontinence and knee-joint osteoarthritis there are quite distinct, clear interventions. Irrefutable scientific evidence demonstrates both their effectiveness and cost-effectiveness.

Senator STEPHENS—In terms of the numbers of physiotherapists in Australia, can you outline the qualification and accreditation process for your industry?

Ms Mickel—Physiotherapy is a four-year undergraduate course in nine universities throughout Australia. Physiotherapists graduate with a Bachelor of Physiotherapy. Those nine universities go through an accreditation process with their courses. Those courses are accredited and, therefore, those physiotherapy students graduate with competencies that make them registrable. There are eight state and territory registration boards, which then register those physiotherapists. The Australian Physiotherapy Association has mandatory continuing professional development. All members of the APA have to acquire so many credit points of professional development every year, and that is audited. We have nine clinical specialisation areas within physiotherapy, ranging from paediatrics right through to geriatrics, including gerontology, cardiothoracic, ergonomics and musculoskeletal physiotherapy. There are nine clinical areas of specialisation, and there is a specialisation pathway that physiotherapists can take to become specialists in those nine clinical areas.

Senator LEES—Following on from that question, how many physiotherapists do we have? I also ask the psychologists what the demand could be, if we were looking at both your submissions to make some recommendations in this area. You mentioned that your profession in particular was already stressed, particularly in the public sector and in actually getting people into the care teams. How many are now available and how many would be needed if, for example, there was at least one item number in both areas included in the Medicare schedule? Perhaps the physios could go first.

Ms Mickel—Thank you for the question. It is absolutely vital that there be a national study of the physiotherapy work force in Australia, because without that and without firm data we can only give you anecdotal reasons as to why there are shortages, where there are shortages et cetera. We are desperately in need of a national work force study that will give us the data so
that we can do the projections so that we can ensure that the physiotherapy work force of 2020 is adequate to meet the needs of Australian families. There are just over 12,000 registered physiotherapists in Australia at the moment. The shortages are critical in the area of geriatrics, which is a huge concern, obviously, because the Australian population is ageing. There are also shortages in rehabilitation areas, palliative care and paediatrics. As with other sectors of the health work force across the board, there are shortages in rural, remote and regional areas. But without a work force study we are unable to plan effectively for a work force that will be adequate.

Mr Malone—We base our anecdotal judgments on information like vacancy rates in the public sector departments. Many of our members manage large public teaching hospital physio departments. The vacancy rates are very significant—up to 35 per cent in some areas. In the job ads in our publications, about 10 people will be looking for a locum physiotherapist and there might be one available.

Senator LEES—Why aren’t there more places at universities?

Mr Malone—There are a number of answers to that question. Just to be brief, the biggest problem is the lack of clinical placements. That is a real issue. Schools of physiotherapy are constantly meeting with the APA and saying, ‘What can you do to help us find more clinical placements?’ As programs come along, like A Fairer Medicare, which increase the number of GP training places, unfortunately the flow-on effect is that hospitals turn around and say, ‘We’ve had to reallocate our distribution. We cannot fund somebody to supervise a physio student on the wards anymore.’ There is no shortage of people applying to do physiotherapy—it is one of the most sought after programs that school leavers seek to enter, and there is a huge number of people that cannot get into the course. At the university level, education funding is certainly an issue. But a bigger problem is placement funding. The hospitals say it is not their job and they cannot spare the physios to supervise the physio students, and the education department does not come up with the money, so consequently there is just not anywhere to put these students. That is our biggest concern.

Dr Littlefield—We are actually doing a work force profile right now with the Australian Institute of Health and Welfare. We also know that there are 16,000 registered psychologists in Australia, of which approximately 9,200 are members of our society. We are advocating that this form of Medicare item be accessible to only those psychologists who have high-quality, appropriate credentials. We know from our records that there would be about 4,000 to 5,000 psychologists who have those high-quality qualifications—and by that I mean postgraduate qualifications of six years, so master’s programs mainly, appropriate experience after that and ongoing professional development. We have a college system with which we accredit people when they meet certain high-level requirements. For this type of intervention the colleges that would be appropriate are clinical, health, neuropsychology and counselling. We have a fairly good idea of those numbers and where they are located across Australia from our membership databases. But to confirm it we are currently doing this work force profile with the Australian Institute of Health and Welfare.

CHAIR—To follow up on that question, you say in your submission, ‘in a large range of locations’—I would imagine that they are very much metropolitan based.
Dr Littlefield—Certainly most are in the metropolitan areas, as with all professions, but we do have quite a lot in rural areas and we do have that data.

CHAIR—You have that data about the spread of the 45,000—

Dr Littlefield—From our membership records we can identify people by postcode, so we know of the numbers in the rural areas.

CHAIR—Your members are by and large in the metropolitan area? That is not a criticism; that is just a fact.

Dr Littlefield—The majority are in the metropolitan areas but there is a good spread. Again, compared with psychiatry, there are far more psychologists in the rural areas.

Prof. Martin—To give an illustration, before returning to Melbourne recently I was in Armidale, New South Wales, which is a city of 22,000 people. There was one psychiatrist and about a dozen psychologists in the area. There being only one psychiatrist, the only intervention he could offer was drugs. He did not have time to do any other sort of work with people. You create the most unfortunate situation where people either go to the psychiatrist for drugs or to a psychologist, but as it is not subsidised by the government in any way, it is a very expensive alternative.

Senator ALLISON—Professor Martin, you make a good case for psychologists being part of the Medicare system but how would that work in practice? You also say that it is important for integration and that we have not seen that thus far. Does this mean we need a kind of triage system to look at what is appropriate for a psychiatrist to deal with and what is appropriate for a psychologist? You are all nodding, so I will take that to be a yes. Has that work been done? Is it clear where the lines of demarcation should be drawn?

Prof. Martin—No is the simple answer to your question. Obviously, there is overlap in what they do, but there are certainly differences, on average. Psychiatrists, reflecting their medical background, tend to use drugs as their primary form of intervention.

Senator ALLISON—I am talking about conditions, rather than treatment. Can you say, if someone is in the middle of a psychotic episode, that it is not appropriate for a psychologist to deal with that; that it is a psychiatrist’s job? Can we make a list of the conditions where a psychologist ought to be the treating person?

Prof. Martin—Lyn is saying that we can. We could certainly have a go at doing that. Obviously, it would not be an easy task, because there would probably be points of disagreement between the professions about exactly what their domains were.

Senator ALLISON—And possibly stages in the treatment of a condition where it might be appropriate to shift from one to another?

Dr Littlefield—Psychiatrists generally treat more serious mental health disorders—ones that need medication as well as other forms of therapy. But with a number of disorders you are talking about changing behaviour and lifestyle factors, so those disorders are particularly
appropriate to psychological intervention. There could be a system of referral based on that sort of dimension.

**Senator ALLISON**—Why not change the system so that psychiatrists can refer to psychologists, as GPs can refer to psychiatrists at the present time? Would that work?

**Prof. Martin**—That would not be the best model. I am not sure what the advantage would be of doing it that way.

**Senator ALLISON**—It brings you into the system without opening up the whole Medicare system to the ‘worried well’, coming to see you for minor problems, if I can put it bluntly.

**Prof. Martin**—Clearly, if there were an entry to the system, we would have to be very careful to make sure that exactly that did not happen, but I do not see that as a difficult thing to accomplish.

**Mr Stokes**—That is why we suggested that the GP might be the gatekeeper, as is happening in the Better Outcomes in Mental Health Care program, because that provides a broader spectrum of perception of the services that psychologists have available. Certainly, we need a gatekeeper function but it is a matter of whether the psychiatrist would be the only gatekeeper or just one of them. The notion in our presentation was that the GP might be that avenue of referral.

**Dr Littlefield**—I could see that the psychiatrist would work in the case of mental health disorders, but if it were in the case that we put for heart disease it would be an additional unnecessary step to go to psychiatry.

**Senator ALLISON**—I understand.

**Prof. Martin**—The overall point that I would like to make is that we certainly recognise that it would be a courageous decision by government in a sense to introduce new item numbers and have other professions involved in Medicare. We certainly recognise that any government is likely to want to reduce the cost of the system rather than increase it. We genuinely believe that it is quite possible to have a better system without increasing costs, but it involves being a bit more discriminating than the system is at the moment, because at the moment the system is a binary system and it is very simplistic. If you are a doctor, you get funded; if you are not, you do not. That is crazy and illogical. Governments usually—and I am not referring specifically to the current Australian government but to governments around the world—see one of the key ways of achieving quality as being through competition, but the current system is absolutely, completely and utterly against competition. For example, psychologists to a degree compete with psychiatrists. I say ‘to a degree’ because we tend to offer somewhat different things. Where is the competition when one gets funded and the other does not?

If you look at what is in the system at the moment, we are arguing, I guess, for an addition, but one could also argue for things being taken out. In our recent submission we talked about the fact that at the moment the system funds 50 sessions with a psychiatrist. As an evidence based profession, I can assure you that there is no evidence that 50 sessions is an advantage for anyone. So there are savings that can be made.
Senator ALLISON—Why fee for service, though? Why do both of your organisations come up with that approach? Why not have a better integrated approach which might see salaried positions in community health centres which might truly integrate with the medical work force? Isn’t a fee-for-service approach going down the same old path but including more people in the approach? Shouldn’t we be moving away from a doctor-medical centred approach to one which is a bit more holistic?

Ms Mickel—Senator, I think your point is interesting but the argument is really not about where it happens but that the access is there. What we would argue, with osteoarthritis of the knee and continence, is that through the Medicare system we can ensure that people get access to that treatment, which is more effective than surgery and drugs, and which costs less than surgery and drugs. As to whether that happens in a community setting, the quantum shift that would need to happen in the system to roll something like that out is very complex and very long term. What we have now is a health system where we have a critical mass of dollars.

Senator ALLISON—So you are not arguing against it—

Ms Mickel—No, I am not arguing against it.

Senator ALLISON—you are just saying that we cannot do it overnight?

Ms Mickel—Yes.

Mr Malone—The Australian Physiotherapy Association has a concern about some of these more recent models that have been rolled out where general practitioners can purchase services. For example, Senator Knowles was talking about the most recent program where there is a capacity for a doctor to purchase an allied health practitioner rather than, say, a practice nurse. It puts an awful lot of onus on and an awful lot of trust in the GP to be the best person to decide those purchasing decisions. General practitioners need to have a very broad range of skills. They are very time poor. Most GPs would be the first to admit that they do not have a complete understanding of every service that is available. They are not always the best people to make those decisions.

Senator ALLISON—Which leads me to my next question: what has been the trend over the last few years? You have put your case very well. I think people do understand it; I certainly agree with you. But what about GPs? Are they referring on to psychologists and to physiotherapists more than they did, say, five years ago? Is there any improvement in that respect or not?

Ms Clark—The only evidence that I have seen in that area comes from England; I have not actually seen any from Australia. The English evidence relating to physiotherapy is that there is a slight increasing trend, but there is also a great deal of variability based on the education and experience of the general practitioner. So, in summary, that is a difficult question to answer in terms of hard evidence.

Senator ALLISON—Your members must know where the referral is coming from?
Ms Mickel—Our members are first contact practitioners. Yes, they do work very closely with doctors—that is the tradition of physiotherapy and medicine and it will continue to be—but being first contact practitioners as well means that people do not have to rely on a referral.

Senator ALLISON—Yes, I realise that, but what I am saying is: can we see any change in GP behaviour?

Ms Mickel—We do not have that data.

Dr Littlefield—We have some data, because we run a referral service and in the last couple of years there has been a 75 per cent increase in that referral service.

Senator ALLISON—Is that from a very low base? How significant is this?

Dr Littlefield—Not very low, no—we are up to about 8,000 referrals a year, but there has been that 75 per cent increase and a lot of that comes from GPs.

Prof. Martin—As an academic I am always giving talks to general practitioner groups, divisions and so on, where I make a case for what psychologists can offer. The meetings always end the same way. The GPs say, ‘Why are you telling us all these things you can do? We know that; the problem is we cannot refer anyone to you because most people cannot afford your services because they are not subsidised.’

Senator ALLISON—This is really interesting. Is there any data on that? I guess the answer is no, but it would be useful if we knew how many GPs do not refer on because they know their patients cannot afford it.

Ms Clark—There is some Canadian information about that in relation to arthritis in physiotherapy. I believe there may be some other data available as well, but I have not seen any from any other country.

Prof. Martin—Certainly in Britain they have followed a route whereby psychologists now are primarily involved in primary care. In other words, they have changed the system to have psychologists working alongside GPs in their practices.

Senator ALLISON—Thank you very much.

Senator HUMPHRIES—I want to follow Senator Knowles’s question about the 30 per cent rebate and its possible abolition or removal and, as far as psychologists are concerned, how you might feel if that were to occur given that presently, through private health funds, a number of people do access psychological services. Do you feel that that would damage access by people to your services, if that rebate were to be abolished?

Mr Stokes—Can I say that obviously the amount that goes to psychologists is in no way the same percentage that goes to physiotherapists and there are significant caps on what psychologists’ patients can claim from their private health insurance but certainly, even though it is a small number, that would have an impact on private practitioners and we would be opposed to that notion, obviously.
Senator HUMPHRIES—And presumably your association would be concerned, as a result, by the proposal to do away with it?

Mr Stokes—We most certainly are.

Prof. Martin—Our concerns would be at two levels: for our profession, but also we would consider it a very unfortunate thing for the community.

Senator HUMPHRIES—I understand that members of your association have been involved in the Better Outcomes in Mental Health Care initiative, which involved about $120 million over four years. It does not provide the level of involvement and access to funding that you have been arguing for today, but I understand that about 70 divisions of GPs have employed psychologists and members of your association in developing mental health plans. Has that been a productive exercise? Do you see more of that as being a good thing to do?

Dr Littlefield—It actually is a really good start, in our opinion. The problem with the Better Outcomes in Mental Health Care initiative is that for the GPs to get into the incentive scheme, they have to do a level of training and to date there are only about 2,800 GPs who have actually done that level out of—I think—22,000 GPs in Australia. Unless the others do it, the access to the scheme is extremely limited. So, even though it is a really good start and they are working with psychologists and we are getting very positive feedback about that relationship, it still means there is only about 12 per cent of Australians who can actually get access through the scheme through the low number of GPs that will be funded.

Prof. Martin—It provides access only to very limited problems, because it is the mental health domain. Take, as an example, one of the reasons for heart disease. Talking about mental health versus physical health is a false dichotomy: health is health. Nevertheless, this scheme is about mental health and we see psychologists being able to offer a lot in areas like heart disease, cancer and so on.

Senator FORSHAW—Have either of your organisations done any work on trying to cost whether psychology or physiotherapy services or some, if not all, of them are covered by Medicare? Do you know how much that would ultimately cost in a net sense? You say they may replace some services that are currently performed by psychiatrists—and no doubt we might get a response from them one day.

Mr Malone—No, we cannot provide that data for you. We can do work on costing the physiotherapy component of treating a discrete condition—for example, osteoarthritis. We know what the services cost. We know what the best evidence says is the ideal number of treatments, on average. We know what the standard deviations are. We can tell you what the physio component is. The difficulty of giving you the net effect on Medicare is that it is very hard to tell what the current system is paying to people who have osteoarthritis. If somebody has a knee replacement, for example, there are lots of different costs associated with that. You have the pharmaceuticals, the surgery costs, the specialist visits and the in-hospital care, and it is very hard in the current system to pull out all that data and say, ‘This is what it’s currently costing someone to have a knee replacement or medical and pharmaceutical management of knee osteoarthritis.’ So getting a net costing is very difficult.
Senator FORSHA—It would be helpful if we could get some data on that. Whenever propositions are put up about extending the range of the operation of Medicare—and we accept that there are some very good reasons; we have heard this said in respect of dental services—there is also the issue of the financial impact. I think you wish to say something, Dr Littlefield.

Dr Littlefield—Again, we cannot give you an overall figure, but a very important project, funded by the Commonwealth government and called assessing cost-effectiveness of mental health disorders, is coming to a conclusion. Health economists have gone into the cost of psychological interventions versus the cost of medication and medical interventions for mental health disorders. They have figures on the savings when you use psychology for certain disorders. I sat on the steering committee of that and the figures will be published very soon, so there will be hard data.

Senator FORSHA—Can you take it on notice to provide the committee with that if it is published in the near future?

Prof. Martin—I have a small point before we move on. In the handout we gave you, you will notice that the final page has some extra information on (2). For example, in the physical domain the study from Lechnyr pointed out that there had been a 78 per cent decrease in the average length of stay in hospital, a 67 per cent decrease in the frequency of hospitalisation and a 49 per cent decrease in medical and surgical costs et cetera. We do not have an overall picture, but we have lots of bits and pieces of the picture, which I feel lead us to be able to say quite confidently that we do not believe adding psychology to the system will actually produce a net cost to the system.

Ms Mickel—Likewise we can give you the exact research findings—for example, in randomised control studies—where people had physiotherapy interventions and doctor-pharmaceutical interventions. The cost-effectiveness of those is there and clear, but in terms of putting it all together and putting figures on it, we are unable to do that. But if you look at our submission and the two specific areas that we ask for, those areas have evidence from the control studies.

Senator FORSHA—There is another issue to this—that is, the impact in respect of the funding that is currently covered through private health insurance, for those who have it. As we know, people can be covered for physiotherapy and psychology.

Mr Malone—An article appeared in the British Medical Journal in April 2003 comparing the cost-effectiveness of physiotherapy and general practitioner care for the treatment of neck pain—£447 to £1,379. It was one-third less expensive to have physiotherapy intervention, for a better outcome. So there are some snapshot studies like that, which are economic comparisons we can look at.

Senator FORSHA—What proportion of patients would be referred to physiotherapists or psychologists by GPs?

Ms Mickel—What percentage of the total number who receive physiotherapy are referred by doctors? I don’t think we have that data for you.
Senator FORSHA—Even anecdotally?

Mr Malone—Maybe one per cent, in the private sector—anecdotally.

Senator FORSHA—Psychologists?

Dr Littlefield—A smaller number, probably.

Mr Stokes—It may be 20 or 30 per cent at the most at this stage, but it may be growing with the Better Outcomes program.

Ms Mickel—We can tell you from our perspective that GPs refer more to physiotherapists—we know that through the division’s work—than to any other health professional.

Senator FORSHA—The point behind that is that it does have some relevance to people’s ability to claim through the taxation system once they get over the threshold. An issue that you refer to at a number of points in your submission, but particularly on page 9, is the proposed changes to Medicare as they would impact upon psychiatrists. As I understand what you are saying, there is currently a funding cap at 50 visits a year. What you are arguing—you might confirm it and make a comment—is that under the government’s proposals those costs could blow out substantially as a result of full cover for concessional card holders and also the out-of-pocket arrangements for both concessional card holders or private health insurance. Tell us what you are pointing to.

Mr Stokes—Our understanding is not that the session limit would change. We understand that remains. It is 50 at one rate and then 170 at a lower rate. That is the current system. What we are saying is that the gap measures both for the card holders and for private insurance will take away the dampening effect that the gap has provided on those services because now the government will provide it for card holders and the private insurance companies for their members. That will tend to produce, we think, a blowout in the process.

Prof. Martin—we would argue that already the system does not make sense. I do not know of any treatment given by a psychologist or a psychiatrist of more than 20 sessions where someone has been able to demonstrate that is the treatment of choice. I have no evidence of that at all. I do not know how anyone can justify funding beyond 20 sessions. Yet the irony is that it is being proposed to extend the level of support beyond that. That to me makes no sense whatsoever.

Senator FORSHA—If your services came under Medicare do you think physiotherapists and psychologists would bulk-bill?

Prof. Martin—we would be very happy with bulk-billing.

Senator FORSHA—for all patients?

Prof. Martin—I think the majority would. Obviously one cannot categorically say everyone would, because there may well be some exceptions, but I am sure the vast majority would.
Mr Malone—It is a very difficult question to answer. We do not know whether the bulk-billing rate is going to be set relative to market rates. If it is a reasonable fee, physiotherapists already have demonstrated that they have a strong focus on the community and lots of our members are participating in EPC for free.

Senator FORSHAW—I do not notice in the submissions any evidence or comments about what the fees are. You have mentioned psychiatrists, but can you provide us with a scale of fees that applies to physiotherapists and psychologists? I assume you have recommended fees from your organisations.

Mr Malone—We do not have a recommended fee structure. The ACCC does not like us having a recommended fee structure, but we can tell you what the market rates are.

Senator FORSHAW—That would be helpful, because it is also relevant to the level of refund you get from private health insurance—and from my personal experience with physiotherapists it is not that great.

Prof. Martin—Do you want that information now?

Senator FORSHAW—We are running over time, so it would be good if you could provide us with some written material.

Senator KNOWLES—I do not wish to delay the proceedings, but I did not hear the answer to Senator Forshaw’s question about whether you would be prepared to accept bulk-billing. Did I understand you to say that all psychologists would be prepared to accept bulk-billing as a payment?

Prof. Martin—I suppose the comment made by our physio colleagues was quite right, but I guess it depends a little on the level of fees set. I suppose my comment was made based on the assumption that a reasonable fee would be included in the system. That being the case, I am sure the vast majority of our members would be quite happy to bulk-bill.

Senator KNOWLES—What would you see as a reasonable fee, though?

Prof. Martin—We go through the same thing with the ACCC. The recommendation to members for a session of 60 minutes is $172, but we know from surveys of our members that the majority charge less than that. They charge less than that simply because, with the lack of support, the majority of people cannot afford that rate. We know that the majority of our private practitioner colleagues charge between $100 and $120 an hour.

Mr Malone—The market rate for physiotherapy for a standard consultation in Victoria is about $42, just to give you a snapshot.

Senator FORSHAW—Do you know how much they get back per visit from the funds?

Ms Clark—It varies.

Prof. Martin—From the insurance funds?
Senator FORSHAW—Yes, from the private health insurance funds.

Ms Mickel—About half.

Senator FORSHAW—That is my understanding, certainly with physio. I cannot talk about psychologists.

Mr Malone—It varies tremendously, depending upon what product you have from the insurer.

Prof. Martin—The funds vary and also it is not just a question of what they will pay per session, because a lot of them put a cap on the total amount and the cap is extremely low.

Senator FORSHAW—Which is the big complaint about private health insurance that I am constantly reminded about.

Prof. Martin—Sure.

CHAIR—I thank both organisations for their very useful contribution and for coming today. We could go on for much longer, but unfortunately time does not permit that. If you would like to provide further contributions to us, please continue to keep in touch with our secretariat. Thank you again for your contribution.
KIDD, Professor Michael, President, Royal Australian College of General Practitioners

WATTS, Mr Ian, National Manager, General Practitioner Advocacy and Support, Royal Australian College of General Practitioners

WRIGHT, Mr David, Chief Executive Officer, Royal Australian College of General Practitioners

CHAIR— I welcome Professor Michael Kidd, Mr Ian Watts and Mr David Wright from the Royal Australian College of General Practitioners. Information on parliamentary privilege and the protection of witnesses and evidence has, I understand, 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 you may ask to do so and we will consider your request. The committee has before it a copy of your submission. I thank you for that. I now invite you to make a brief opening statement before we move to questions.

Prof. Kidd—Thank you very much for the opportunity to assist you in addressing this very important issue for Australia. The RACGP has 10,500 members. It is the largest medical college in Australasia. The RACGP is responsible for setting and maintaining the standards for high-quality clinical practice, for education and training, and for research for general practice in Australia. We advocate on any issue which affects our ability as general practitioners to deliver a high-quality service to our patients, the people who trust us for their primary medical care, and to our communities.

The craft of general practice is an inspiring and fulfilling discipline to which many bright, compassionate Australians aspire. International evidence shows that meeting the need for continuing care of the whole person—being a specialist-generalist—makes a substantial contribution to the health of any nation. Australia’s general practitioners can be proud of our contribution. The vast majority of general practitioners work continuously to enhance the quality of care we provide. Most of us have moved to have our practices accredited. Most of us engage in continuing professional development. We have embraced information technology and moved down the path to make the most effective use of new technology in our clinical care. Many of us are looking for new ways of working with our practice nurses, our practice managers and other practice staff to ensure that the best use is being made of the whole general practice work force team.

However, the sustainability of high quality general practice is facing a serious challenge in Australia. The rising costs of sustainable general practice, aggravated recently by the rising medical indemnity costs, have not been met by rises in the subsidy paid by the government to patients. This has placed our patients—our public—in a precarious position. As a result many GPs are faced with the choice of compromising the quality of care we provide or compromising access for our patients. Faced with this dilemma, many GPs charge copayments as a means of protecting our ability to sustain the high quality of care we provide. We know from international
research that cost is a leading reason why some Australians are unable to follow their GPs’ advice.

We know from Australian research that the perceived cost of seeing a GP is related to the community’s perception of a general practice’s illness care, rather than being wellness oriented. It is short-sighted for governments to allow financial and other barriers to high quality general practice access to increase. General practitioners across our profession are profoundly disturbed by the growing problems with access for the community. We fear that the people who need our care the most—those with the greatest need for continuing whole person care—will be let down by the inadequate funding now provided in rebates.

The RACGP believes that governments must ensure universal access to general practice for all people in Australia. The RACGP believes that the operation of the Medicare benefits schedule can be improved with some restructuring. This would require attention to the work force implications and would need financial investment. However, I commend to you the detailed deliberations of the attendance item restructure working group. The RACGP would be happy to provide you with the two background papers we prepared for this group. Both addressed making the MBS more quality focused.

Amongst those likely to face substantial barriers to seeing a GP are families with young children. Enhanced funding of consultations for children is likely to reduce these barriers and the potential financial impact on these young families as outlined in our submission. We know from the developmental health literature that this access can make an important long-term contribution to the health of these individuals and to the community more generally. Our funding system is limited by its ability to reward preventive care activities. This is one way of doing so.

Strategies such as this and the introduction of the biennial health check for Aboriginal and Torres Strait Islander people, which we strongly endorse, move beyond arguments for improving the operation of the MBS that are based on geography alone. Overall though, the MBS needs to be kept simple.

We are particularly concerned that single people are comparatively disadvantaged by the requirements of the safety net, both as it exists now and with the changes proposed. Many of the most vulnerable people with high health care needs in our communities are single, including many people with mental health problems, drug and alcohol problems, the homeless, the widowed and so forth. The RACGP believes that consideration must be given to making a means of having the safety net as a real safety net for all Australians, including single people. They must therefore have a lower threshold to meet than family units.

The challenges of meeting the needs of disadvantaged Australians and recognising service provision based on quality, not volume, mean that non fee-for-service models do need to be considered. The model of rural retention grants has very low red tape and is working. The judicious use of non-volume payments in conjunction with, not instead of, fee-for-service payments has merit. However, we do not want any review of the PIP to throw the baby out with the bathwater and risk valuable elements such as the teaching payments which are essential to allow us to actually train the next generation of doctors for our discipline. There must, however, be robust dialogue about the PIP, its role and its requirements. It is absolutely clear that attention
to the financial arrangements of general practice will not alone address the challenges of maintaining access for all Australians.

The RACGP has been calling for and supports the introduction of more general practice registrar vocational training places. However, governments must take seriously the changes in work force participation, the demand for longer consultations, which we know produce better quality outcomes, and more non face-to-face work, which we are seeing in the general practice work force, in order to maintain the safety and quality of the primary medical care provider to our communities and also to meet their needs, as often disenchanted older GPs are leaving our craft.

The RACGP’s position is that Australia has an ethical obligation to train enough of our own doctors to meet our own community’s needs. We should not rely on our relative attractiveness as a destination to attract overseas trained doctors. We must not rely on the medical school outputs of developing countries to meet this country’s work force needs.

However, it is important to ensure that general practice is an attractive career choice for our existing medical work force and our most able medical graduates. Currently, the environment of general practice, its unnecessary historical Cinderella status, its relatively poor funding, its work force pressure, its inflexible geographical training arrangements and the red tape all make the choice of becoming a GP less attractive. The RACGP strongly opposes the proposed bonded medical students scheme. We believe that it is more appropriate to bond the money to rural and regional locations as the site of medical training and to support these locations to provide attractive opportunities for training and retention of the work force.

Determining the availability of training options based on work force considerations will undermine general practice as a career choice for medical students who have recently graduated. The bonding of students and registrars in training runs a risk of compromising the quality of training. Even when educational and work force needs can be met without compromise, the RACGP believes that bonding will make general practice, especially rural general practice, less appealing to these students. Many bonded students will train in high-income procedural areas and pay off their bond. This will result in a net decline of general practitioners in areas of most need through the very policy which, it is claimed, is aimed at increasing them. Australian general practice must be both accessible and sustainable. I look forward to responding to your questions and exploring the issues as one important step to ensuring that Australian general practice remains accessible and sustainable.

CHAIR—Thank you, Professor Kidd. I want to pursue one issue that you raised—that is, the point you made about there needing to be longer consultations. I think that concurs with evidence we had yesterday from Professor Marley in Newcastle. His contention was that, if doctors essentially billed under the appropriate item number—that is, level C—more regularly, then they would be able to completely bulk-bill and get a reasonable level of remuneration. Is that the point you are making as well?

Prof. Kidd—The point I am making is that, from the evidence, we have support for better outcomes from longer consultations. That is self-evident if you think about it. The more time that we are able to spend with our patients—particularly those with chronic health care problems and co-morbidities, which involves a large amount of the work that we do—will enable us to spend
more time, address more health care concerns and, very importantly, add in that preventive health care component which we believe should be a part of every consultation between Australians and their selected GP. There are studies which show that general practitioners do underestimate the time of consultations. Our computer systems are allowing us to better judge now than ever before how long consultations take. However, I do not think it is the whole answer to the problem.

CHAIR—I think the point that has been made to us on a number of occasions is that general practitioners are a little bit embarrassed to bill someone on a level C consultation. There is a reticence to bill someone as a level C, and that embarrassment could be part of the funding problem that we are getting to. Do you have any notion anecdotally or any evidence that says that doctors are undercharging?

Prof. Kidd—We know that different practices address this in different ways. We have practices where patients, if they believe the problems they are presenting with are going to take more time, are encouraged to book a longer consultation and therefore will be charged a longer consultation fee. However, often it is not until someone actually gets into the consulting room that it is clear how much time is needed. The concern we have, however, is that, with the declining general practice work force, our ability to undertake longer consultations is being put under very significant pressure—and that is a serious concern.

CHAIR—Of course, there is no point taking longer if there are more people out there in the waiting room.

Senator KNOWLES—I want to come to the issue of bulk-billing. I am a little fascinated with some of the things in your submission. We have a fair bit of evidence that people do not trust you guys not to jack up your copayments and, blow me down, I pick up your submission and you do not trust yourselves, because you reckon you are going to do that. That flabbergasts me somewhat. Why is it that GPs are not prepared to bulk-bill all concessional card holders full stop?

Prof. Kidd—The first issue is about trust. We know that the Australian public do trust their general practitioners. I believe that we are one of the most trusted groups in the community. The issue about bulk-billing individual patients is up to an individual practice. Every practice is different, every practice services a different population of Australians and the ability to pay varies greatly from practice to practice. I work in an underprivileged area—an area of need. I have large numbers of patients on low incomes and those people are bulk-billed. But it is an individual choice and a decision made by each practice. What we do know is that the current level of rebates are not providing sufficient remuneration to allow us to continue to deliver the high-quality care which we believe the Australian community needs, expects and deserves.

Senator KNOWLES—that is nice, but it does not answer my question. My question was: why cannot all concessional card holders be bulk-billed? If it is linked to the rebate—and my colleagues will start sighing in a minute, because this is a question I have asked everyone but have not yet got an answer to—why have you, among others, linked the rate of bulk-billing to the rate of increase of the rebate when the rebate for a short consultation in the last six years has increased by 20 per cent as opposed to nine per cent in the previous six years under the previous government and, for a long consultation, the rate of rebate has increased by 26 per cent as
opposed to five per cent in the last six years of the previous government and yet the rate of bulk-billing has gone down? Yet you come before us and say, ‘Jack up the rebate and we will increase our bulk-billing.’ We have jacked up the rebate but you have decreased your rate of bulk-billing. It still comes back to my initial question: why cannot all concessional card holders be bulk-billed, especially with the incentive?

Prof. Kidd—We have seven million concessional card holders in Australia—a large proportion of the population. A large amount of the work which Australian general practitioners are carrying out is with concessional card holders. The difference that we have is that the rebates are not allowing us to be able to meet our practice costs. Practice costs have risen dramatically and the recent rise in indemnity premiums has increased costs as well. The value of the rebate is not meeting GPs’ needs to be able to provide a high-quality practice. Again, it is an individual decision. We have many practices which do bulk-bill all health card holders; we have others who have made the decision that they can no longer afford to do that. The RACGP has produced a private billing education kit to allow our members to look to see how they can best fund providing a high-quality service to their patient population. We have had 300 practices get hold of that kit over the last three months—practices concerned about the sustainability of continuing to provide high-quality service with the current rebates.

Senator KNOWLES—Is bulk-billing some concessional card holders used as a ‘traffic-calming’ device—trying to get some of the regular attendees who come through the door to be less inclined to come through the door if it means paying a copayment? For example, they might come in regularly for a bit of a chinwag as opposed to a real medical problem and the doctors are stretched and say, ‘Well, this person needs to be deterred a little. We will charge them a copayment.’

Prof. Kidd—A lot of people come in to talk to their general practitioners because they need to. That is a very important component of the service that we provide to the Australian community. Counselling is very important. We have a very large morbidity with mental health care problems in Australia, as you are aware. People do present with real medical problems. I am not aware of any evidence to support the contention that we are using bulk-billing in the way that you describe.

Senator KNOWLES—It just does not seem logical. You say that the funds coming from government are not providing enough income for practices these days and that they have not kept pace when, taken as a whole, including the fee for service and practice payments, the average government benefit per GP service has moved slightly faster than the CPI. You are telling us that it has not moved faster than the CPI. The evidence does not support the claim. We have an increase in the rebate, which is the focus of everyone, and a decline in bulk-billing. We are saying that anyone can still be bulk-billed—anyone at all. But you are telling us that it is not even likely that GPs will agree to bulk-bill all concession card holders, let alone anyone else.

Prof. Kidd—Each practice will need to look at the proposals put forward in the budget and each practice will have to decide whether it can afford to take on the proposals which have been offered. The feedback that we have had from large numbers of our members from around the country is that the figures just do not add up and the proposals being offered are not doing anything to assist in supporting the sustainability of high-quality clinical care in general practice.
Practice costs have risen way above CPI, particularly with the rising medical indemnity costs which we are faced with.

**Senator KNOWLES**—The inflation line, I noticed this morning, has been zero in the last quarter so that is an encouraging thing. Can we assume that we will probably see more GPs bulk-billing in the future?

**Prof. Kidd**—I think the pressures we are seeing in general practice and the challenges for us to deliver a sustainable, high-quality service probably indicate that that is unlikely.

**Senator KNOWLES**—I could go on forever but I have one last question. In your submission you say:

... bonding is certainly not supported by the RACGP.

And you said that in your oral evidence. You go on to say:

Rather than bond more students, we need to bond medical schools to local rural communities.

We have the cheek to criticise the Irish for doubletalk but you are saying there, ‘We don’t agree with bonding unless it is bonding there.’ What we are saying is that people are going to be bonded to go to areas of need. Areas of need are not only in rural communities. Areas of need are in outer metropolitan areas as well as regional areas—so why just focus on rural communities? And what on earth would make you think that by some stroke of imagination doctors would go there and stay there if there is not some bonding arrangement?

**Prof. Kidd**—Thank you for defining the areas of need because that was not outlined at all in the budget papers. We assume areas of need are rural and remote areas and that some of the underserviced outer metropolitan areas in Australia have also become areas of need in recent times. We know that the areas of need cover the entire continent and include many inner city areas as well, where we have patient populations who have very high needs for high-quality general practice services. We also know that there have been some very successful initiatives of the government to look at training in rural areas and their success in retaining people to work in rural areas. We have the university departments of rural health, the rural medical clinical schools and so forth. We are proposing not to bond the students but to take that money and bond the universities to provide the training in those areas where we would like those doctors of the future to settle, practise and be engaged with those local communities.

**Senator KNOWLES**—So the students can go there, get trained and move off back into the cosy suburbs once they are qualified?

**Prof. Kidd**—People will make their own decisions, as we all do in life, as to where we relocate during our lifetimes. However, we have some evidence to show that if we train people in rural communities a more significant level of those people will stay there. Similarly, if we take people from rural communities and train them, more of them will stay in those areas, or at least have some of their practice career working in those areas. So why not use the initiatives that have been successful? We have no evidence to show that bonding our students in this way will produce the outcomes which it appears are desired.
Senator KNOWLES—Even if they get a cash windfall for doing so?

Prof. Kidd—We believe that many of these students are going to train in high-income procedural areas and pay out their bond. Under the bonded student scheme, these students do not receive a cash windfall. They are not getting a scholarship during their training. They are the same as all the other students coming in. There is a lot of confusion between the Medical Rural Bonded Scholarships Scheme, where students get a scholarship, and the bonded student scheme, where students pay HECS. These students end up with either a huge debt or having to work out the bond at the end of their vocational training.

Senator KNOWLES—I fail to see how your proposition is actually going to get people into areas of need—having training places in areas of need that do not keep them there.

Prof. Kidd—we have some evidence to show that training people in areas of need will result in some of those people remaining in those areas.

CHAIR—I am aware of some evidence, especially from James Cook University, on that matter. If you could provide that evidence to us, that would be useful.

Senator STEPHENS—Professor Kidd, in your submission you address the issue of the role of nurses in general practice. You seem to have reservations about the role of nurse practitioners who—we have heard in other evidence—are playing a vital role in providing services, particularly where there are few doctors. Can you elaborate on your position, and tell us why you have these concerns that you have touched on in your submission?

Prof. Kidd—RACGP strongly supports the role of nurses working in general practice—working as part of the general practice team, working with general practitioners and other members of our team. We welcome the practice nurse initiatives—the increase in the number of practice nurses—which were announced in the budget. We are concerned that they are restricted geographically. We believe that we need to be encouraging practice nurse involvement in all general practices across Australia. We strongly support the primary health care team approach. We believe that there is very strong evidence to show that nurses working with general practitioners can actually produce significant improvements in health care outcomes. Our concern is about nurses working alone and working in isolation from other members of primary health care teams, which is the nurse practitioner model.

Mr Watts—the evidence reported in the British Medical Journal—a summary of the nursing research—suggested that nursing research does not have large enough numbers to be powered sufficiently to detect whether, for example, there are underlying incidents of adverse events not detected by nurses within that practice model. The question is: is the evidence robust enough so that the model is safe as an independent model as opposed to a collaborative model? That is why we have argued for research in the Australian context.

Senator STEPHENS—While I understand your point of view, I would suggest to you that there have been other people who have given evidence to the committee who say that your concern about nurse practitioners is really just about income protection and that nurse practitioners are playing a critical role as part of a general range of models of service delivery. We heard, as an example, that in New South Wales a specialist nurse practitioner in the mental
health area was providing a level of care in a rural community that they would not have had unless that model had been implemented. So I assume that you support nurse practitioners as part of an overall scheme of primary health care.

**Prof. Kidd**—We support general practice nurses working as part of our team in general practice. It is not about income protection, it is about quality care. It is about ensuring that all Australians have access to high-quality primary health care services wherever they happen to be. We have based our submission on evidence from the medical literature which was available to us.

**Senator STEPHENS**—What about the nurse practitioner issue—the nurse practitioner model as part of an overall scheme? In your submission you do not support nurse practitioners per se. Would you acknowledge that they do play a vital role in the overall primary health care scheme?

**Mr Watts**—Our college’s formal position statement acknowledges a role for nurse practitioners but not an unsupervised, independent role for them, working as independent practitioners outside a collaborative arrangement. There is evidence to suggest that the studies are too small to know that that is going to be a safe model—working absolutely independently.

**Senator STEPHENS**—Are nurse practitioners being used in Victoria in the same way that they are being used in other states?

**Prof. Kidd**—We are a national college. I am actually based in New South Wales, so I cannot answer that question.

**Mr Watts**—There is variation across the states. I am not familiar with the state by state situation.

**Senator STEPHENS**—That is fine. The other part of your submission that interested me was your comment about the college participating in the attendance item restructure working group. Can you elaborate on that working group—some of the key problems that you addressed, what kind of recommendations you were supporting and when that report might be available to us?

**Mr Watts**—There are a number of problems with the structure of the Medicare benefit schedule, one of which is that it effectively penalises longer consultations. On a fee-per-minute basis, it is better to do a six-minute consultation, whereas the international literature would suggest significantly longer consultations than that. So the attendance item restructure working group has been looking at how you might structure a schedule to decrease the disincentive to long consultations, given we know their value in providing high-quality care. The working group has been in operation for over 15 months and has looked at the ways in which that could be structured into a schedule.

The trade-off to those sorts of structural arrangements is that you can end up with a schedule which is very complex and that creates a red tape problem and a problem in that certain activities are inappropriately better rewarded. So the recommendations of the attendance item restructure working group are around decreasing the disincentive to long consultations without disincentivising short and appropriate consultations. The implications of that, though, are that if we move to slightly longer consultations we will aggravate the access issues for Australians. So
we have had to look at those trade-offs and issues. With respect to the way in which you fund the components of a fee structure—for example, flag fall, the way in which the payments are weighted for length of time—the four GP organisations have worked very closely together to come to grips with those issues in a joint committee with the department.

Senator STEPHENS—What about the timing of that report—its availability?

Mr Watts—We have submitted the penultimate draft of the report. The foreword has been written by the independent chair, Professor Justin Beilby. We are now waiting to have discussions at the collegiate council level of our organisation. We expect that the report will be released imminently. We are not able to provide you with the report but we can provide you with two detailed pieces of work that we did—a summary of the research on quality of consultation and length of consultation, and a report on literature about intensity and complexity of consultations and the implications for the structure of a schedule. We are happy to provide those because they are in the public domain.

Senator STEPHENS—Thank you. I have one final question. Also in your submission you identify the fact that in the past three months approximately 300 GPs have requested an educational kit developed to assist general practitioners to assess their ongoing ability to bulk-bill. Is it possible to provide the committee with a copy of that kit?

Mr Watts—Absolutely.

Senator ALLISON—Professor Kidd, I want to ask you about your own practice. You practise in a low-income area and some people you bulk-bill and others you do not; is that correct?

Prof. Kidd—The practice where I work is unusual. I bulk-bill everybody. I have a high number of patients with significant chronic health care problems and comorbidity, as I work with a lot of people with HIV, hepatitis C and mental health problems.

Senator ALLISON—Mr Wright, are you a practising GP?

Mr Wright—No.

Senator ALLISON—Mr Watts?

Mr Watts—No.

Senator ALLISON—Okay; I will ask this question elsewhere. I am interested in your argument—and it is consistent with so many others we have spoken with—about isolation being a major problem, particularly in regional areas and in areas that are not even all that remote. Doesn’t that suggest that, in places where there will not be a lot of GPs whom you can join as part of a team, having allied health professionals, including nurse practitioners, would be an appropriate model for providing support for GPs? Professor Marley yesterday in the Hunter Valley region said to this committee that the demographics, the ageing nature of GPs and the propensity to move out of general practice into other specialisations and so forth meant that in the next decade there will be a very serious problem regarding access to GPs unless we embrace allied health professionals in a much greater way than we currently do.
We heard this morning that there are some moves for GPs to refer patients to physiotherapists—small gains—but of course physiotherapists are not covered under Medicare. What happens in your practice when someone on a low-income who comes to you because you are a bulk-biller comes in with a soft tissue injury? Do you refer them on or are you more inclined to medicate them than perhaps the alternative, which could be longer term better treatment?

Prof. Kidd—There are so many questions built into that question. I will cover the issue of professional isolation first. That is a serious concern. It is one of the reasons why we have a college. Our college has been around for nearly 50 years and we aim to build up that collegiality between general practitioners. One of the great benefits of divisions of general practice has been the ability to bring together doctors in geographic areas and to overcome some of that professional isolation. We value the team and we value—

Senator ALLISON—But we are talking about a team of doctors rather than a team of health professionals.

Prof. Kidd—No, the general practice team. It is not the general practitioner team; it is the general practice team.

Senator ALLISON—How does the division bring in other health professionals? This has not been made clear to the committee so far.

Prof. Kidd—Our divisions in Australia are divisions of general practice—they are not divisions of general practitioners; they are divisions of general practice.

Senator ALLISON—That is my point. You talk about teams of other GPs. What I was trying to suggest to you is that there is evidence that in the next ten years there are not going to be enough GPs. Even if they talk with one another, they are not going to do the job.

Prof. Kidd—The general practice team needs to include others apart from just general practitioners. That is why we support the practice nurse initiatives. We have a number of initiatives which have placed other allied health care workers within general practice settings as well, with significant benefits. You heard about some of those today. It is a real difficulty for people on low incomes to access allied health care services in many parts of Australia. We believe that is a problem that needs to be tackled. Many of our patients do not have the capacity to pay for private services. Many of them do not have the capacity to insure themselves to be able to get some assistance in gaining access to those services. Many of our publicly funded services are extraordinarily stretched, particularly in providing mental health care support and physiotherapy, which you were looking at earlier today. So it can be extremely difficult to get in.

Senator ALLISON—Does that lead you to suggest that there should be a provider number for those allied health professionals or that we should expand the publicly funded community health centres and other avenues for those services to apply? Does the college have a view on that?

Prof. Kidd—Our view is that we have a problem. We have a problem with regard to access. We have people who are unable to access these services, and that is a problem for the entire
community. The solutions we find to address those problems are going to be multi-tiered, just as the problem is multi-tiered. We are not putting forward in our submission any specific solutions.

**Senator ALLISON**—So you are not opposed to one or the other by way of expansion?

**Mr Watts**—Given our experience, there is clearly a risk that private health professionals will be funded at a discounted rate of 50 per cent if they go onto a schedule funded by the government. For us, the mechanism is of much less concern than the overall funding of the increase in allied health services. It is clear, for example, in the work that I did in our coordinated care trial in Brisbane that one of the limitations was that GPs were not able to refer to allied health professionals because there simply was not a work force or because there was an inaccessible work force for financial reasons. There is no question that the college supports better access to evidence based allied health care.

**Senator ALLISON**—Thank you. I also want to go back to practice nurses for the same reason that I gave earlier. You say that there is no evidence in Australia, we need the evidence, we need to look at the context here and we cannot rely on the UK. What is the difference between Australia and the UK with regard to practice nurses? Isn’t one of the problems that we just do not have enough practice nurses here in order to do a study to know whether their work is safe and effective?

**Prof. Kidd**—There is a difference between general practice nurses working with us in our settings and nurse practitioners.

**Senator ALLISON**—Yes, nurse practitioners—and if I said the wrong thing I apologise—those who are separate from doctors.

**Mr Watts**—I think the answer is yes, that there is simply not enough work done on a research basis in Australia to know.

**Senator ALLISON**—You have already said that in your submission. You refer to a UK study, but you say that it is in a different context. I am asking: how is it different?

**Mr Watts**—It is not a UK study. It is a summary of nursing research published in the *British Medical Journal*, so the research reviewed is not only British research. It is true that the structural arrangements are different in Britain and in Australia, and that is one of the issues that one would need to take account of in deciding appropriate primary health care models, but it is inaccurate to say that it is a British study. It is a study published in Britain that reviews a number of other studies.

**Senator ALLISON**—Okay. My second point was that there are so few nurse practitioners, so would a study be meaningful or should we focus on making sure that the training for nurse practitioners is such that major problems could be overcome?

**Prof. Kidd**—Certainly, the area of training for nurses working in general practice with us is an area of major concern to our college. We currently have a project, working with the Royal College of Nurses, looking at the educational requirements of practice nurses and at how we are going to be able to develop the capacity to train the number of practice nurses that we believe we
are going to need in order to build up our primary health care teams and in order to meet, as you say, the needs of the next generation of Australians.

**Senator ALLISON**—You might want to look at the *Hansard* from yesterday, because the Hunter Valley region is actually developing—from scratch, they say—their own practice nurse training program. They say that the nurses who have come on board have very little understanding of what it is to be a practice nurse.

**Mr Watts**—That has certainly been our experience in the consultations we have had to date right across Australia.

**Senator LEES**—I was also going to ask questions in that area, but I think Senator Allison has covered that ground. I will just move on and look at some evidence we had this morning from Professor Kidd and in yesterday’s hearing—and it is in some other submissions—that GPs are spending more and more time doing things other than face-to-face consultations. Have you done any research on that? Could you give us a list of what those things are? For example, yesterday the eventual description was that they were not so much general practitioners as general specialists and they had a lot more reading to do and phone calls, et cetera. Have you done any research on what GPs are now being expected to do compared with what they did 10 or 20 years ago?

**Prof. Kidd**—I can certainly outline to you the tasks we are required to undertake. Is there any research available that we can provide to the committee?

**Mr Watts**—The Attendance Item Restructure Working Group looked extensively for international and national research on the nature, scope and scale of non face-to-face work. There is none. There was no authoritative work that we could rely on in our deliberations. One of the strongest conclusions and recommendations that came out of that group is that there be a well-structured, authoritative study commissioned. Anecdotally, everybody says it is increasing and, anecdotally, everybody says it is more complex. Some of the research suggests that non face-to-face time is proportionate to face-to-face time. As we increase our face-to-face time to meet more complex needs, the non face-to-face time increases proportionately. But there is no strong authoritative evidence about that, and there certainly is no strong Australian study.

**Prof. Kidd**—It is a very important issue, though. What is the work that Australia’s general practitioner work force is doing? The changing demographics of our general practice work force are changing the involvement in direct clinical work. Over time, that is likely to change further. We have more people working part time; we have more people taking time to raise their families and working part time in practice. A large number of non-remunerated clinical tasks are carried out without a patient present. But we have also had a major increase in the number of GPs who are involved in teaching, in research and especially in the very good work that is being done by divisions of general practice in increasing the population health focus of our primary medical care services.

**Senator LEES**—But there has been no study we can look at to see where this is going. We have been given examples of doctors who are frequently on the phone to patients because they know the waiting room is full—so they might be able to talk to Mrs Smith on the phone. We have been given other examples where people, instead of coming in for a script, simply say to
the pharmacist, ‘Yes, make up those Webster packs just like you did last month for Mr Willis.’
You are saying that no research has been done into exactly what takes up the time now in the
average day of a GP?

Mr Watts—Some work was done for the Productivity Commission study of compliance and
administrative activity. But it took a very particular focus—not on the range of quality activities
needed by GPs in the consultation process. It focused on the administrative area and red tape.

Senator LEES—If you come across anything, I am sure the committee would very much like
to have it.

Mr Wright—I would like to clarify something on that, because I might be able to add some
information. In my previous position I worked with AGPAL; I have joined the college very
recently. AGPAL is the accreditation body of general practice. In Australia there are
approximately 6,000 practices—

Senator LEES—They are accredited?

Mr Wright—No, about 85 per cent are accredited, of which AGPAL has undertaken about 80
per cent, or just over 5,000 practices. I believe this figure of 23,000 general practitioners in the
country who are actually working in general practice is a bit of a furphy. Practitioners pay for the
accreditation process according to the sessions they work within the practice. It is a much better
figure of the sessions actually being done, which contributes to the time in the practice. I can get
access to those figures, which might be of assistance.

Senator LEES—Yes, thank you. In terms of those 6,000 practices, they vary from one GP to
a dozen or more. That is right across various models of practice?

Mr Wright—that is right.

Senator LEES—Any data you have on that would be helpful, thank you. You mentioned the
cost of indemnity. Do you have figures to show how much it has risen, where it is now at and,
again, how doctors work out how much they pay, given that we have had such a wide variety of
eamples of what doctors do with their time? Do they pay a general amount per year, does it
depend on how many sessions, or whatever?

Mr Wright—it has risen quite considerably. The non-procedural GP was paying about $2,500
about three years ago. I think that amount has probably trebled.

Senator LEES—Would you take the question on notice and come back with some specific
details, or any research that you have done, or perhaps some examples from a particular practice,
on what the various GPs are doing, depending on whether they are involved with the divisions or
whether they are just involved in the practice, or whatever else they are doing with their time.

CHAIR—Mr Wright, do you believe that the information from the accreditation agency is
more correct than the data we get from the department—and from the AMA, for that matter—
about what is the effective full-time GP group that we have?
Mr Wright—The department used to contact me for information, if that answers your question.

CHAIR—Is the data from—

Mr Wright—That is on-the-ground information: not billing indicators, but actual work within the practice.

CHAIR—That would be very useful. Thank you very much.

Senator HUMPHRIES—I could not see in your submission a direct comment about the level of the rebate. I assume you want an increase in the level of the rebate. Is that the case?

Prof. Kidd—The rebate is currently not set at a level which is supporting the sustainability of high-quality general practice.

Senator HUMPHRIES—So that is a ‘yes’, is it?

Prof. Kidd—You can take that as a yes.

Senator HUMPHRIES—Right. What level do you think the rebate should be set at to provide quality care to patients in Australia?

Mr Watts—I think the question is more complex than that, in the sense that our college is supporting a process which says, ‘We need to look at what we can afford as an Australian health care system.’ To set the rebate at a level which would fully fund access to every general practitioner for every Australian, which is the sequel to your argument, is a significant challenge.

Senator HUMPHRIES—Government has to set a rebate; it cannot decide it wants to set a rebate at different levels in different states. It has to set a rebate across the country. The AMA has made a quite explicit suggestion about what the rebate should be set at. Does the Royal Australian College of General Practitioners not have a view about what the rebate should be in order to reflect the value of the work that the doctors do?

Prof. Kidd—The Royal Australian College of General Practitioners sets and maintains the standards for high-quality clinical care in Australian general practice. We have a role in advocating on any issue which affects our ability to deliver a high-quality service. Our focus is on the quality of the service which is being provided by Australia’s GPs to the Australian public, on the standards of care and identifying when our ability to deliver that quality care is being compromised.

Senator HUMPHRIES—You must have an idea, though, of how much that is worth, how much it costs doctors to deliver that level of care, surely?

Prof. Kidd—Sure. The best work on that which we have available to us, and available to you, is through the relative value study.
**Senator HUMPHRIES**—So, on the basis of that study, what would you say should be the level of rebate that the federal government sets?

**Mr Watts**—That study suggests that at today’s prices the rebate would have to get close to $50 for a standard consultation.

**Senator HUMPHRIES**—So you would support $50, is that what you are saying?

**Mr Watts**—That study would suggest that that is what is required to fully cover practice costs.

**Senator HUMPHRIES**—That was not the question, though. You are a professional organisation and, frankly, I find it hard to believe that you do not have a view on this subject. Do you think that $50 is what doctors are worth for a consultation?

**Mr Watts**—Absolutely, because that is the best authoritative information that we currently have about what it takes to sustain a general practice.

**Senator KNOWLES**—So, if for each dollar increase in the rebate it is $100 million to the budget, what is the cost of your proposition?

**Mr Watts**—I think there are two questions here. Senator Humphries asked a question about what GPs are worth and what the nature of the cost is.

**Senator HUMPHRIES**—Okay, I think I am going to get as much as I can out of that question. Can you tell me why we cannot get a commitment from doctors to at least agree to bulk-bill all concession card holders in Australia? We can debate the margins of whether there are people who should be in that category or are deserving of also getting that concession or not, but let us put that to one side. Can we at least agree that those who hold concession cards are worthy recipients of the benefits of bulk-billing and that everybody who holds a concession card should be bulk-billed by their doctor when they go to see them?

**Prof. Kidd**—The Department of Health and Ageing is currently conducting a series of workshops around the country to try to answer that question which you have put. Each general practice in this country needs to determine for itself what income it requires in order to continue to be able to provide a sustainable, high-quality service. Our members have responded; they have done the figures and they have looked at the proposal which was put forward as part of the government’s A Fairer Medicare package. Large numbers of our members have come back to us and said, ‘The figures don’t add up, the figures are not here to allow us to move to that model which has been proposed.’

**Senator HUMPHRIES**—Isn’t that a debate, though, about whether the bulk-billing rate is sufficient to cover doctors’ costs? That is what that debate is about. Surely, you concede that whether the rate is high enough or not, the patients deserve access to bulk-billing. The patients should receive that, no matter where they might access a doctor in Australia.
Prof. Kidd—The RACGP’s position is very strong. We support universal access to high-quality general practice services for every person in Australia. The government has a responsibility to work with the profession to ensure that we are able to provide that.

Senator KNOWLES—Yes or no? Will you support general practitioners bulk-billing concessional cards? Yes or no? This is about the fifteenth time this same question has been asked, Professor Kidd. Can we just have a categorical answer. Will the GPs support bulk-billing concessional card holders? Yes or no?

Prof. Kidd—Senator, it is a question which does not have a yes or no answer.

Senator KNOWLES—Yes, it does.

CHAIR—There is no point arguing, Senator. I move to Senator Forshaw.

Senator FORSHAW—Can I ask for clarification of this issue: you have been asked some questions about what the level of the rebate should be. Are you actually talking about the level of the rebate based upon 85 per cent of the schedule fee, as it is at the moment, or are you talking about what the level of the schedule fee should be for a standard consultation?

Prof. Kidd—It is the level of the rebate. We could have a very lengthy debate about the schedule fee and what it means.

Senator FORSHAW—There is an alternative proposal put by the Labor Party which would see an increase in the level of the rebate over time to 100 per cent of the schedule fee, which is another way of looking at what happens to the level of remuneration for doctors on the basis of bulk-billing. I have a couple of other questions and you may wish to provide us with some information by taking this on notice, if you need to supply more detail. What is the current cost to the GP of vocational training and registration?

Prof. Kidd—Work has been done on this as part of the work with the Productivity Commission in looking at the red tape review of general practice. I do not believe we have the figures with us.

Senator FORSHAW—Take it on notice.

Mr Watts—Can I ask you to repeat the question? I think you were asking about vocational training.

Senator FORSHAW—Vocational training and registration.

Mr Watts—I want to clarify this because there are a number of different costs for a number of different things. If you are asking about the cost to the GP of undertaking vocational training, that is one question. If you are asking about the cost of accreditation, that is an activity undertaken by a practice. It is a different set of costs and we can certainly look at that.

Senator FORSHAW—I am happy for you to give us as much information as you can with respect to costs associated with vocational training.
Mr Watts—I am just trying to clarify that the question is about vocational training.

Senator FORSHAW—And practice accreditation, and registration as well.

Prof. Kidd—Is it vocational training or is it compliance with continuing professional development for established GPs in order to maintain vocational registration?

Senator FORSHAW—I would include all of those. If we are going to have the evidence before us about costs that GPs face in running a practice, whether it is a single practice or a multidoctor practice, it would be good to have as much of that as you can give us. Also in your submission you refer to the scheme in New Zealand—the New Zealand reducing inequalities contingency fund. Could you expand on that? This appears on page 7 of your submission, talking about retention payments in rural locations and also extending the model to other workforce locations.

Mr Watts—We have not seen a lot of the details of the health inequalities contingency fund, but it is a model that takes account of the burden of illness in the practice population and weights the payment to that health inequality of the practice population. So it is a fund that is a non-volume payment in the sense that it is not a fee-for-service payment. It acknowledges that some practices have a differentially larger health inequality or health burden within their practice.

Senator FORSHAW—If you are putting that forward as something that should be considered, we would need some—

Mr Watts—We are putting forward the principle that we strongly want the health system to support the addressing of health inequalities, and that is one strategy used internationally.

Senator FORSHAW—Any information you can provide to us on the New Zealand fund would be useful. In appendix 2, page 14 of your submission you indicate, both in respect of medical school placements and general practice registrars, that the government has got its sums wrong or that you question the government’s sums with regard to increases in medical school places and GP registrar training places. Could you expand on that?

Prof. Kidd—We looked at the dollar amounts that were allocated to each of those items in the budget proposal, and we equated it to the current costs of training our medical students. The figures did not seem to add up. We were just pointing that out in our submission and in our response to the package at the time.

Senator FORSHAW—to put it in layman’s language: the amount of money that the government is allocating will not deliver the number of places the government is saying will be able to be funded by that amount.

Prof. Kidd—I imagine that is a debate that the government will have with the deans of the medical schools to ensure sustainability of the medical school training.

Senator FORSHAW—You obviously continue to support fee for service—that is a constant theme in your submission, the AMA’s and others. I have always wondered about this: how does a multi-doctor practice work in terms of fee for service as against the total running of the practice
with all of the costs? You can correct me and explain to me briefly: do the individual doctors get remunerated according to the number of patients they see within the practice? Is that the sole criteria, or does it operate on some sort of partnership, such as in legal practice, where every member of the practice draws a base payment and then they divvy up the profits at the end of the year? How does it work?

**Prof. Kidd**—There is a range of business models in Australian general practice. You have mentioned some of the models. We have models of partnerships, associateships and employer-employee relationships. It differs depending on the individual practices. This is a private system, but it does have an impact when it comes to the distribution of the funds coming into the practices. One of the difficulties with the PIP program for many of our part-time members is that people are engaged in these activities but are not necessarily seeing the financial benefits from those programs.

**CHAIR**—If you are able to provide us any further information about practice structures on notice, or if you have any data on that, it would be useful.

**Senator FORSHAW**—I constantly hear about fee for service, and it seems to me that it is about fee for service in a doctor-patient relationship. It may not—and from what you just said it certainly does not—reflect the way in which a lot of medical practices are actually operating as business units. In fact, you are picking up models such as salary arrangements even though there is this constant rhetoric about having to maintain fee for service.

**Prof. Kidd**—A large number of our practices are direct fee for service. So it depends on the models. We will provide you with the details of how some of those models work from our training and support literature for people setting up practices.

**CHAIR**—Thank you very much to the Royal Australian College of General Practitioners for your contribution to our inquiry. Please do not hesitate to provide us with any further information that you think would be useful, and we will do the same. Thank you very much for your contribution.

*Proceedings suspended from 11.10 a.m. to 11.25 a.m.*
GRIGGS, Mr Dean Francis, Municipal Public Health Planner, City of Darebin

HURLEY, Mr Bruce Donald, Chief Executive Officer, Darebin Community Health Service

CHAIR—I welcome representatives of Darebin City Council and Darebin Community Health Service. Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. The committee prefers that evidence 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 you may ask to do so and we will consider your request. The committee has before it copies of your submissions, and I thank you for those. I now invite each of you to make a brief opening statement before we move to questions.

Mr Griggs—Firstly, thank you for the opportunity to speak to the inquiry today. It will be great to have a conversation about the submissions we have already made. I will elaborate on that. It is worth revisiting why Darebin City Council and Darebin Community Health are involved in the issue of Medicare and bulk-billing. We see our role, particularly as a local government, to be an advocate for our community and, where possible, to facilitate community awareness and involvement in issues that affect them. The proposed reforms to Medicare place the health of our community, we believe, in jeopardy, and that is why we are involved.

The Municipality of Darebin is characterised by high levels of chronic illness, particularly diabetes and cardiovascular disease, high levels of socio-economic disadvantage and an ageing population. Quite simply, we are concerned that, under the proposed changes to Medicare, those people who are part of our community who do not qualify for a health care card will not have access to bulk-billing and basic medical care. The statistic to support this view is that in the city of Darebin 15 per cent of people living below the poverty line—that is, they earn under $32,000 per year—do not qualify for a health care card. Under the proposed Fairer Medicare package these people will be forced to pay to see a GP, and I am sure that there are many communities like this throughout Australia. We believe that the federal government should reinvigorate bulk-billing to again make it accessible for all people in our community and not go down the path of making it just a safety net for people on a health care card and receiving government benefits.

The proposed changes are of major concern because, as we know, World Health Organisation research indicates that people on low incomes are most at risk of serious illness and therefore most in need of doctors. There are many people like this in our community in Darebin. We believe the Fairer Medicare changes will undermine and dismantle the basic principles of Medicare and that we will have a user-pays, US style system. As a local government, the City of Darebin has been active on this issue for some time now. In December 2002 we were prompted to do our own research by anecdotal evidence that bulk-billing was declining locally. We found that there were as few as eight bulk-billing general practitioners out of the 50 practices surveyed. This will only get worse in the coming years, we believe, if the Fairer Medicare package is introduced.

Since our submission was put to the Senate inquiry there have been some local developments in our community that I would like to inform you about briefly. On 20 June this year we held a public meeting which 250 people attended. The meeting was organised by Darebin City Council,
the local federal MP, the member for Batman, Martin Ferguson, the local state MP, the member for Preston, Michael Leighton, and the Preston Reservoir Progress Association. Since this meeting the Darebin ‘Defend Medicare’ campaign has commenced, with a core group of 30 members looking to educate the community about the need to reinvigorate bulk-billing. This campaign will conclude when and only when Medicare is again a sustainable way for people to access universal medical care. Bruce Hurley would like to make a couple of comments about Darebin Community Health.

Mr Hurley—I will give some background to any questions that might arise from the submission. Darebin Community Health has three sites. Those sites either have a medical practice or had a medical practice. It is interesting to reflect on each of the three sites. The Northcote site had a medical practice for a number of years, and we closed it two years ago because it was not financially viable. All our medical practices are bulk-billing practices and the percentage of health care card holders varies between 70 and 75 per cent. The East Preston practice has been going for 25 years. It is also struggling financially and struggles to attract GPs to what is a bulk-billing practice. It is currently cross-subsidised by other programs. Hence, we have to have fewer physios or whatever to cross-subsidise the medical practice at East Preston. It is currently running at a 10 per cent loss.

There is a new site called the Panch Health Service. Perhaps foolishly, we have just started a medical practice at the Panch Health Service. The reason for that is the bulk-billing service opposite Panch Health Service no longer bulk-bills, and one of the doctors there wanted to continue to bulk-bill. His particular client group used the fairly large methadone practice; about 25 to 30 per cent of the clients were on a methadone program and that was no longer acceptable. In a sense it was no longer commercially viable for the bulk-billing practice, so he moved across the road and established a practice in the Panch Health Service. It is just a couple of months old. We will obviously also be concerned about the financial viability of that practice. It is coming from the perspective of a bulk-billing practice in an area of high need. We put an emphasis on quality—as I guess all GP practices do—so we find it almost impossible to make the medical practices financially viable in that kind of situation.

We are obviously concerned about the new package proposed—that, in an area like ours, which is a disadvantaged little suburb in Melbourne, the consultation reimbursement will be increased by $1. We certainly do not see that as enabling us to make the practices financially viable. Some of those middle disadvantaged suburbs in the metropolitan area do not have the advantages of being in the inner city and do not attract the higher subsidies that outer metropolitan and rural areas do. To be frank, there is not a lot in the package for us.

CHAIR—Thank you, gentlemen. I want to go to the issue of timeliness; I think you refer to it in your submission. Do you have any reason to believe that concession card holders in a participating practice under the government’s proposals will have a more difficult time getting appointments when they need them than those people who will be gap payers? I am referring to the article that was in one of the papers recently about how, if you were prepared to pay, you could see a doctor now, and, if you were a person who could not pay a gap, your ability to see a doctor in a timely way would be delayed. Do you have any evidence or any reason to believe that that could occur in your local authority area?

Mr Hurley—It does not affect the practice that I manage. It is fully bulk-billed.
CHAIR—I am referring more broadly.

Mr Hurley—However, I am well aware of the finances of practices. Because it is very difficult to make practices financially viable, inevitably there will be pressure to have a higher proportion of clients who are able to make a copayment compared to those who do not make a copayment. It is almost self-evident that that would be the case.

CHAIR—As a practitioner, obviously, timeliness of primary health care or general practice services is extremely important. The other worry that has been put to us is that people will make a decision not to attend if they have not got that money in their pocket.

Mr Hurley—Once again, that is a very real problem. It is a problem that is beginning to be experienced now with the decline in bulk-billing. That group is the group that Dean referred to—in Darebin, the 15 per cent of people who earn less than $32,000 but are not eligible for a health care card. Certainly, that is a real concern.

Mr Griggs—Certainly, we believe it is those people who cannot access or would find themselves waiting longer to see a GP who often find themselves in emergency departments in state government run hospitals, inappropriately waiting for medical care there, when they cannot access a GP, either during business hours or particularly after hours. That is also a trend that we are seeing. I do not have the figures here but there is certainly data to indicate that those people are attending emergency departments in state government run hospitals. Also, on the bulk-billing issue, given there is a decline in bulk-billing doctors in our municipality, those people who are eligible for bulk-billing or who are health care card holders would have to wait longer and longer because there are a limited number of doctors.

Senator HUMPHRIES—You talk in your submission about the proposals for the safety net for concession card holders. With respect—and I am talking particularly to the city council—you seem to misunderstand what the safety net proposals are all about. You talk about the federal government turning Medicare into a safety net. In fact, the safety net proposals that are being discussed are really directed at people who have out-of-pocket expenses with respect to Medicare. It is designed for people who meet a certain number of costs in a year, find the costs have mounted up and have a safety net cut in so that either 80 or 100 per cent of their out-of-pocket expenses are recovered above a certain threshold. With respect to those provisions, what are your organisations’ views? Are they good or bad?

Mr Griggs—Can I clarify: are you talking about the safety net provisions for people who claim more than $1,000 in out-of-pocket GP costs?

Senator HUMPHRIES—That is for people in private health insurance. There is that provision. There is also an equivalent provision for people not in private health insurance who meet out-of-pocket expenses for their ordinary care and who, at present, can only recover the difference between the Medicare rebate and the schedule fee, which could be quite a small amount of money. Under the new provisions they can recover, above the threshold, 80 or 100 per cent of their total out-of-pocket expenses. What is your view about that?

Senator FORSHAW—Senator Humphries might tell you the full story: it is for people who hold a health care card or a concessional care card. It is not for everybody.
Mr Griggs—So that only applies to people who are health care card holders?

Senator FORSHAW—Yes.

Mr Griggs—I suppose the concern is that that then leaves a significant number of people in the population who are just over the line, who do not qualify for a health care card. They would still have a number of out-of-pocket costs that they perhaps may not be able to afford.

Senator HUMPHRIES—Surely you would concede that giving some people at least access to that benefit is a good first step; it is an appropriate thing to do?

Mr Griggs—I would concede that it is a good first step, but I think there are a number of other steps that would need to be taken.

Senator HUMPHRIES—You do not make any comment in your submission about term of reference c(ii): the idea of patients being able to make a payment at the time of consultation for the difference between the schedule fee and the rebate. So patients, particularly those in lower socioeconomic categories, might be able to go to a doctor and pay only the difference between those two amounts and not have to worry about carrying the cost of that until they can get to a Medicare office and recover the rebate. What is your view about that proposal?

Mr Hurley—I think it is likely that that out-of-pocket expense will continue to rise. I think that in the last six or seven years it has risen from approximately $8 to $13, and I think that under the scheme that will continue to rise. That is the main concern. Given that they have to pay, that is a better system, because it is less time consuming in their not having to go back to the Medicare office and not having to carry the extra cost during that time. However, the concern is the continuing rise—and I think that under this system the out-of-pocket expense would rise more. But, given that you have to make a payment, it is a better system.

Senator HUMPHRIES—Doctors have made it fairly clear today and elsewhere that they are not guaranteeing any containment of those rising costs, unfortunately, but I take your point that, if you have to pay it, that is a good way to pay it.

Senator ALLISON—Mr Hurley, I would like to know a little more about your practices, if you can expand on what you have already said, particularly the practice which now resides at Panch. Did you need to reach some agreement with the Commonwealth about the MBS being provided for doctors who are in a hospital setting?

Mr Hurley—Panch Health Service is more akin to a community health service than a hospital setting, so the short answer is no. In community health centres a number have GP practices. It is state government policy that those practices need to be self-supporting from Medicare funding. As I have indicated, because the practices struggle to be financially viable, there is a level of cross-subsidy that occurs from the state funds to the Medicare run practices.

Senator ALLISON—I am not sure I understand how that works. The community health centres are state run and set up by the state?

Mr Hurley—State funded, yes.
Senator ALLISON—In what sense are they state funded?

Mr Hurley—There is a committee of management, an incorporated organisation. The bulk of their funds comes from the state government.

Senator ALLISON—Of what?

Mr Hurley—Of Victoria—the Department of Human Services.

Senator ALLISON—What do the funds from the state government cover?

Mr Hurley—The funds from the state government are basically for allied health services—physiotherapy, podiatry et cetera. Most of them have a large public dental service within them—social workers, counsellors and so on.

Senator ALLISON—Okay. For GP services, what does that represent as a proportion of all of the consultations or all of the services you provide? Is it roughly half, more than half, a quarter?

Mr Hurley—They would be about a 10th.

Senator ALLISON—Okay. And your other services subsidise the GPs?

Mr Hurley—Yes, they do. That is contrary to the state government position, so it is an awkward position to be in.

Senator ALLISON—Are your doctors paid a salary, or are they simply paid whatever the bulk-billing rate is for the consultations they do?

Mr Hurley—Yes, there is a range of methods. We are able to choose the method by which we pay. In trying to attract doctors, we offer them a salary, a percentage of income earned from Medicare, or a casual rate, so we have three choices. The preference is for a salary, but we need to attract GPs so we give them those choices.

Senator ALLISON—Can you tell the committee which model, of all those you have described, is the most sustainable model in terms of what is viable?

Mr Hurley—From my experience, the preference would be to have a basic salary and then with some additional bonuses depending upon money earned, as a kind of combination of salary and some throughput measure. In the existing climate that is what we have found the best, under the existing health care system, in attracting doctors and being able to retain them and still have a sense that they are in a salaried position in a multidisciplinary community health centre.

Senator ALLISON—Can you tell us the level of that base salary and then what proportion above that is dependent on, presumably, productivity—that is what you are talking about?

Mr Hurley—Yes—it is uncomfortable, perhaps, to use that word. The average salary for a GP in my community health centre, with all benefits added in, would be approximately $95,000 a year.
Senator ALLISON—That is all up?

Mr Hurley—Yes. That is including superannuation, the benefits of salary packaging that we are able to give—if you add all those benefits in it would come to about that.

Senator ALLISON—These GPs are full time in your community health service?

Mr Hurley—They are both full time and part time, but the $95,000 figure is a full-time figure.

Senator ALLISON—I understand. How successful have you been in this model in integrating GP services with allied health professional services?

Mr Hurley—I think that is a success. As it is based in a service that has a range of allied health services there is a fair level of integration and the doctors are working as part of a team. I think that is particularly important in some areas that we would specialise in. Partly because of the locality we have a specialisation in refugee health and it is important to work with other health professionals and interpreters. In the methadone program I mentioned it is important to work with drug and alcohol counsellors to support the people on that program.

Senator ALLISON—What difference would it make to your community health centre to have Medicare coverage of, say, psychology, physiotherapy, dieticians, dental? Would you like to prioritise those and tell me what is the most urgent?

Mr Hurley—I think there needs to be a fair amount of thinking done on the primary health care system in Australia. There could be an hour’s speech about that. Coming back to your question, I think it is important that those professions are covered in a Medicare agreement. I would caution against it being the same system or identical to the system of payment to GPs, but I certainly see that there is a responsibility on both the Commonwealth government and state governments—one on all governments—to provide adequate basic health care services in all areas. I guess the one that gets the most coverage, because there is a really high demand and need for it, is dental. I am sure people are aware of the waiting lists of two to three years that were exacerbated by the Commonwealth government axing the Commonwealth dental program in the 1990s.

Senator ALLISON—What is your waiting list for dental services—how long?

Mr Hurley—Ours is one of the best in Victoria, so it is certainly not typical. It is 10 months for general care, for general treatment. But I understand the average in Victoria is a bit over two years, and of course in some areas it is as high as three years.

Senator ALLISON—If I can just clarify: you are suggesting free for service is not an approach that you would recommend by way of including allied health professionals—is that right?

Mr Hurley—Yes. The state dental system works well at my centre and the actual cost per treatment—this data is available—is considerably less than that in the private sector. I also think
there is more chance of making sure that dental clinics are opened in areas of need, that there is a better distribution—and there are those difficulties with GPs.

There are a number of difficulties that I think are inherent in the Medicare system that need to be thought through, so I certainly would caution against replicating the Medicare system for the dental and other professions. I do not think it is a particularly good way to contain costs or to get an equitable distribution of the profession, and I think that you are more able to ensure what the kind of treatment is—for instance, in dental, we do not do crowns and bridges: there is a certain kind of treatment that is not done, where you really have to look at the greatest good for the greatest number and you need some kind of controls in place, I believe, if it is being taxpayer funded.

However—just to expand on it, because I think it is an important area—there are elements in the dental area, and it works well, where in fact the centre is reimbursed for the treatment that is performed. So there is an element, if you like, of a fee for service. There need to be the right financial incentives to get good productivity but at the same time to get a quality service that is targeted to the people that you want it to be targeted to.

Senator ALLISON—Thank you very much for that.

Senator STEPHENS—Thank you, gentlemen, for your submission, which is quite an interesting model in terms of the range of models that we have been hearing about throughout our discussions on this issue. The role of local government is a very interesting perspective that I would like to pursue today, if I could. Yesterday we heard from some people in regional New South Wales about the very competitive nature of attracting doctors to areas of high need and, perhaps, a thin market. I was quite alarmed by some of the evidence that was provided to the committee yesterday about the highly competitive nature of trying to attract doctors and the kinds of packages that were being offered by local governments and local communities, often with quite considerable pressure on the communities’ other resources, to attract a doctor into the community, some of whom have not had doctors for perhaps two or three years. Can you make some comments, first of all, on how you have attracted doctors to your centres and what you think is the role of local government in this whole process?

Mr Griggs—I will speak about the role of local government and then perhaps Bruce can talk about attracting doctors to the centres. We have certainly been alerted to the fact that in Darebin, in particular, there is a shortage of doctors in the northern part of the municipality, particularly in Reservoir. That has come to our attention via the Division of General Practice that we have been working really closely with. We have a great relationship with the local division and a number of local GPs. I suppose, in terms of local government’s role in general, we have been fortunate enough to have that relationship with the local division and to have a discussion locally about work force issues with doctors and, perhaps, how they can be attracted to the municipality.

Darebin Council has not really had much of a role in that as yet but we have, in a way, been proactive in opening up the discussion about Medicare, bulk-billing and work force issues for doctors for the local government sector. We actually sent a letter, from our mayor, to the 78 or 79 other mayors in Victoria asking them to have a think about the issue of Medicare. We are happy to have a conversation with them about it in terms of the role local government can play in facilitating local conversations—between local government, local divisions of general practice
and local community health centres—as a model for talking about the issue, looking at what the issues are locally in terms of a decline in bulk-billing, a decline in local doctors and how that can be addressed by those players. We have also had some preliminary discussions with the Municipal Association of Victoria to look at what local government can do, acting on behalf of its community, to make sure that it has an appropriate number of doctors for the number of people in certain municipalities. That is very difficult in rural and regional areas, given that there are such work force shortages even in metropolitan areas, but local government is a good platform for those discussions.

Mr Hurley—From a GP practice point of view—and I think the same applies to private GP practices in middle and outer metropolitan suburbs in disadvantaged areas—if you have a bulk-billing practice it is very difficult to attract doctors. We have gone through several unsuccessful recruiting campaigns, as have other private GP practices. The main site of Darebin Community Health is East Reservoir. East Reservoir comes up—depending on what social disadvantage indicator you use—in the top three or four within the state in terms of disadvantage, and it is very difficult to attract doctors if it is a bulk-billing clinic. The nature of the area is also a factor, and the finances are such that doctors tend not to live in disadvantaged areas. It is hard, and more often that not we have vacancies.

Senator Stephens—What is the turnover of doctors in your centre? How long have you been able to keep them?

Mr Hurley—We have five doctors. Three-fifths of the doctors are long-serving doctors and the other couple of positions tend to turn over. Once you have a doctor who is committed to that style of practice in that kind of area, then they often do stay. That has been our experience for quite some time. In terms of the other questions that senators asked about being in a multidisciplinary setting, there are some gains for doctors working in that kind of setting. We have some doctors who have been there for eight, 10 and 11 years. It is very difficult to get up to our full quota of long-serving doctors.

Senator Knowles—Can you explain to me your statement at the bottom of page 1 of the council submission about the rebate being at the same level for so long?

Mr Griggs—From what I understand, the rebate for general practitioners has been $25.05 for some time now. From what I can gather, from the research we have done and from some of the submissions you would have heard, that is not a sustainable rebate for general practitioners to continue practise.

Senator Knowles—That is a different answer to a different question. You say here that the rebate has been at the same level for so long. Can you explain what you mean by that?

Mr Griggs—I am not quite sure how long the rebate has been set at that level, but I would imagine it would have been for longer than two years or so.

Senator Knowles—Would you be surprised to know that it has risen 20 per cent in the last six years as opposed to nine per cent in the previous six years under the previous government? And for long consultations it has risen by 26 per cent under the current government, and by five per cent under the previous government. I am asking you, as I have asked everyone else, to
explain your assertion that the rebate needs to be increased to increase bulk-billing when, in fact, the rebate has been substantially increased for both short- and long-term consultations and bulk-billing has gone down. I would be interested to know why you make the claim and the nexus.

Mr Griggs—The claim is not based on what the increases have been to make it $25.05; the claim is that $25.05 is not enough, regardless of the increases that have led to it being at that level.

Senator KNOWLES—But your claim is that it has not gone up.

Mr Griggs—Then that claim is wrong.

Senator KNOWLES—I also ask you to explain which federally funded national dental health program has been closed, as you state on page 3. ‘None’ is the answer. There has never been a federally funded dental health care program. It has been the responsibility of the states since 1901.

Mr Hurley—with due respect, in the 1990s—I cannot remember the exact dates but it commenced in the late eighties, around 1987 or 1988 but do not hold me to that, ceasing around 1993 or 1994—there was a Commonwealth dental program.

Senator KNOWLES—No, in the mid nineties, the states were lagging so far behind that a top-up was introduced by the federal government to accelerate the rate of delivery of service to a particular target by the states. It was never undertaken by the Commonwealth government; it was simply a top-up to get them back to where they should already have been. That was Labor Party legislation and policy that went through at that time. Once the Commonwealth helped with a top-up and the target was achieved, funding ceased. You are claiming that there was some federal dental program. There has never been any such thing since 1901.

Mr Hurley—Coming from the perspective of a service provider, there are a couple of things we need to say. The primary health care system suffers in terms of the divisions between state and federal. That is not an easy one to solve but it does suffer because of that. In terms of an agency perspective, we had funds coming in from the Commonwealth dental program in the nineties, and that was appreciated. I am not an expert on it. I have skimmed some documents which say that there was some legislation or other—in 1948 or something like that—which said there was a joint responsibility between the Commonwealth and state. I am not an expert but I recall that back there somewhere. The overall point I would like to make from an agency perspective is that there is a joint responsibility of state and federal government for health, including dental. Not just under the Liberal government but under all governments there have been long waiting lists for public dental services. With respect to the GP rate it is true that there have been increases but during the last 30 years the actual rates have not on average kept up with inflation.

Senator KNOWLES—Medicare has been in existence for only 20 years. Since Medicare has been in, when you include fee for service and practice payments, the funding to general practice has kept marginally above the CPI. So I do not know the basis on which you are making that claim.
Mr Hurley—I did not hear the submission from the Royal Australian College of General Practitioners, but certain studies have been done—I do not know what the last well-known Australian study has been—looking at the costs of running a GP practice in 2003 as compared to previously. From where I sit, I know that the income of GPs in the practices I have been connected with has not kept pace with inflation during that 30-year period.

CHAIR—What you have just said has been confirmed by a range of other witnesses. Senator Knowles has asked this question, in the same form, of a number of witnesses and that has been the tenor of their response as well—that technology and the cost of delivering service have changed over time. So to compare those periods of time on a notionally equal basis is not able to be done.

Senator KNOWLES—It is able to be done because technology has enhanced the more rapid delivery of services. Coming back to the dental program which you say was there, because you say that this should be a Commonwealth and state responsibility, are you aware that the states have said to the Commonwealth that they want to devolve their dental responsibility to the Commonwealth? They want to absolve themselves of the responsibility they have had since 1901 to the Commonwealth.

Mr Hurley—I am not up-to-date with the discussions between the Commonwealth and state governments. Getting back to the central point, there is a responsibility of governments for a public dental program, and a disadvantage in our current system. From a service provider’s and a citizen’s perspective, it would be nice if we were able to overcome some of the fragmentation that occurs with parts of the health system residing with the state and parts of it residing with the Commonwealth. There seems to be a fair amount of discussion in terms of cost-shifting and so on. It is complex.

Senator KNOWLES—in your statement under ‘Private health insurance for out-of-hospital, out-of-pocket expenses,’ you say:

This means that those who do not qualify for government benefits are required to have private health insurance to see a doctor.

Where on earth have you found that?

Mr Griggs—I imagine that would be in response to the private health insurance proposal that, if those people who do not qualify for health care cards incur up to $1,000 worth of out-of-pocket expenses, they can then apply for private health insurance.

Senator KNOWLES—‘Can’—you are saying it is compulsory. At the moment, if a catastrophic event occurs and someone incurs out-of-pocket, out of hospital expenses for continuing oncology work, specialist visits or whatever, they have no mechanism whatsoever to cover those expenses. This is saying that if you want to cover for that possibility, for $1 a week you can take out that cover. You do not have to—you can carry on exactly the same way as you are now. But if you want to take it out, you can. Why do you say that it is going to be compulsory? Have you told that to the people of Darebin?
Mr Griggs—No, I have not told that to the people of Darebin. If people have incurred those out-of-pocket costs, then why wouldn’t they take up the incentives that are put to them by the federal government? I think it is an unusual incentive, in that people would not really want to take out private health insurance. But if they do incur those costs, it will be an option to them through the A Fairer Medicare package.

Senator KNOWLES—That is right. Isn’t it a good thing that they have an option? If a family has an ongoing medical need—say someone has cancer—at the moment they cannot insure for out-of-pocket, out of hospital expenses. Isn’t it fair to say to someone, ‘You can’t do it now, but under this you can do it for $1 a week’? It doesn’t matter whether their expenses are $2,000, $3,000 or $10,000 for ongoing treatment; they can take out of hospital, out-of-pocket expenses cover.

Mr Griggs—In a sense that institutionalises a two-tiered system, where people either need to have private health cover or cover for out-of-pocket GP costs, or qualify for bulk-billing—

Senator KNOWLES—This is not for GP stuff. This is more for oncology, specialist treatment or things like that where there is a huge, ongoing, out-of-pocket expense for catastrophic events. It is not compulsory; it has nothing to do with income. It is about a person having the option to cover themselves for catastrophic events or ongoing medical treatment.

Mr Griggs—I think it has quite a bit to do with income, because if people on low incomes who do not qualify for health care cards are given the option to take on another out-of-pocket expense, such as $1 a week—which may be a significant amount of money to them; it may not be to other people—that is another cost that will be incurred.

Senator KNOWLES—So you would prefer to have them have to pay the out-of-pocket expenses, which could be $10,000, $20,000 or $30,000?

Mr Griggs—No, I would prefer them to have universal access to bulk-billing.

Senator KNOWLES—But they do not have that now.

Mr Griggs—They do not have that now?

Senator KNOWLES—They have never had that in the past and they do not have it now. You would prefer those people—instead of giving them the option of forking out $1 a week—to pay out any amount of money.

Mr Griggs—I would prefer them to have better access to universal bulk-billing. I would prefer them to be bulk-billed and I would prefer them to have better access.

Senator FORSHAW—So they do not have the problem in the first place.

Senator KNOWLES—It never happened under the Labor government.

Senator HUMPHRIES—It does not cover those costs.
Senator FORSHAW—Senator Humphries, what was that interjection?

Senator KNOWLES—It has never been thus.

Senator FORSHAW—Senator Humphries, you just said that it does not cover those costs.

Senator HUMPHRIES—The out-of-pocket expenses.

Senator FORSHAW—I just want to clarify this. The government’s proposal for $1 a week insurance—and that figure is pretty rubbery—is only applicable when you reach the $1,000 threshold of Medicare covered services only. It does not cover all out-of-pocket expenses for all medical services, which is the impression being given here. I want to raise the issue of the dental scheme. I have heard on a couple of occasions this week the suggestion that there never was a Commonwealth dental health scheme. I find that amazing. Are you aware that the scheme that was introduced by the Keating government in 1993 provided $100 million per annum? You have to answer yes or no.

Mr Griggs—Yes.

Senator FORSHAW—The abolition of that scheme when the current government came to office in 1996 cut off any opportunity for such funding to continue into the future. Secondly, are you aware that currently under the Commonwealth’s 30 per cent private health insurance rebate the Commonwealth contributes in another way to dental coverage, by giving $340 million as part of that subsidy to private health insurance funds?

Mr Griggs—Yes, I am aware of that.

Senator FORSHAW—The point is, Mr Griggs, the Commonwealth government already picks up a responsibility for dental care.

Mr Griggs—Correct.

Senator FORSHAW—I note also that the Commonwealth government is very happy to say to the states, ‘We will take over all your industrial relations powers and beat up on workers,’ but they are not too interested in dental health, it appears from what is being said here. In respect of the surveys that you did, are you aware of the proposal that will require all doctors within a medical practice to opt in before the practice will be entitled to receive funding under the general practice access scheme?

Mr Griggs—I am aware of it. I have not given it detailed thought.

Senator FORSHAW—The government is saying that it will provide funding as an incentive to practices to bulk-bill concessional card holders, and there are different rates depending upon whether it is city, outer metropolitan or country. There is a requirement that, before a practice can access that funding, every doctor in the practice will have to opt in and bulk-bill all of their concessional card holders. What is the view of GP practices in your area?
Mr Griggs—I cannot say, unfortunately. I am not quite sure what the view of the local division of general practice is on that or the view of local doctors, so I cannot really speak on that.

Mr Hurley—in the practice I am involved in they will all opt in. Their main concerns—and this was raised briefly in our submission—are that the $1 is such a small payment, and that a proportion of that would be taken away in administrative costs.

Senator FORSHAW—What has the impact of declining bulk-billing rates been on your community health centres?

Mr Hurley—I guess it is the same with bulk-billing practices. In the Batman area it is not as significant as in some other areas. However, because there is also a shortage of GPs, a consequence is that people have to wait longer, as Dean mentioned. It has been said that some people go to the emergency department, and certainly there is some evidence to suggest that. People have the option of either waiting, going to the emergency department or not going at all. There are two reasons: one is the drop in the number of practices that are bulk-billing; the other is the shortage of GPs in highly disadvantaged areas.

CHAIR—Thank you very much to Darebin City Council and Darebin Community Health Service for your evidence today. Please remain in contact with the secretary. If you would like to provide us with further information, please do not hesitate to do so.
[12.17 p.m.]

BEAUMONT, Ms Marilyn, Member, Victorian Medicare Action Group

WALKER, Dr Christine, Member, Victorian Medicare Action Group

WILSON, Mr Rod, Convenor, Victorian Medicare Action Group

CHAIR—I welcome representatives of the Victorian Medicare Action Group. 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 you may ask to do so and we will consider your request. The committee has before it a copy of your submission. I now invite you to make a brief opening statement before we move to questions.

Mr Wilson—Thank you for the opportunity to speak with you. Just a brief history of the Victorian Medicare Action Group: we are a coalition of organisations such as Community Health Services, Women’s Health Victoria, Health Issues Centre, Victorian Council of Social Services, a number of churches and a lot of consumer groups. We have 150 or so members who are just average people from the community—service users and peak organisations throughout Victoria. We formed our group some seven or eight months ago in an attempt to engage the community and politicians in the process of discussion about improvements to health care services and particularly GP services. We were prompted mainly through our concern at the decline of access to GP services and bulk-billing services, in particular the increase in presentations to emergency departments of hospitals as a result of that, and as advocates for the health and wellbeing of our own communities.

Today we would like to put a human face on what is happening in health care by relating some of the consumer stories we have accumulated over our period of existence. These are simple stories about people in country Victoria and metropolitan Melbourne who are struggling to meet their health care bills and what that means for them. There are people like Andrew in Bentleigh, who is struggling now to see a doctor at all. He has a wife who is dependent on him and who requires intensive support and care and he finds himself unable to access a GP in his local community. Stuart from Mitcham claims he is almost bankrupted by the costs of his health care. Whereas previously he had access to bulk-billing services, now that the GPs in his area have changed their billing practices he can no longer afford it. Ever time his wife has an asthma attack now, Stuart calls an ambulance because he cannot afford to go to the doctor.

There are people like the woman in Echuca, who tells us that none of the doctors in her area now bulk-bill. She has been sent a letter from her local clinic saying that she is not to return until she pays her bills. She has two disabled children and is extremely concerned about what she can do. A woman from Melton tells how she dropped something on her foot but put off going to the doctor because she could not afford to pay the fees. She almost died as a result of not getting early enough attention for her medical conditions.

Part of what the Medicare Action Group does and what we want to do today is convey to you simple messages about what consumers are experiencing. We do not pretend to be experts on health policy. We are providers of health services in our local areas and we are here to tell you
the stories of people and to put a human face on this debate. We see it in our own services. People tell us their stories all the time. One person told us that they can no longer access a GP service in their country town because the service does not bulk-bill. They owe the GP money and they now have to go to a welfare agency to get a referral to go to a GP practice. These stories are coming up more often. The Medicare Action Group is trying to communicate those issues to politicians and key decision makers, and to work with communities to help them respond to the lack of basic health care services in their areas.

CHAIR—Do either of the other participants wish to add anything at this point?

Ms Beaumont—the other side to the stories we are hearing comes from organisations that work in areas of disadvantage, such as those working with homeless people. Those GPs who do bulk-bill talk about experiencing what is called ‘bulk-billing burnout’ because the most chronic, the most complex and the highest need cases gravitate towards those GPs who bulk-bill—in communities where they exist. The lack of equity in doctors’ handling of the chronic and the well is causing extreme problems. Another side of it is high service users, such as women, who use GP services when they are well, for contraception and screening. Many women who are on low incomes do not fall within the health care card area and are concerned about the high cost that they will experience through using services as well people and also using services for the people they are caring for.

They make up a big segment of the population, and I think that some of the ways forward do not deal with the variations that people experience through life—that is, they can be in the work force, have an illness and be out of the work force and then possibly have to go onto a health care card—and perhaps those variations are not picked up in some of the policy ideas that have been put forward.

Dr Walker—the Chronic Illness Alliance undertook a survey in regional Victoria to collect information for its own research purposes, and the draft results have been made available to you. We found something like 400 households that had very serious chronic illness such as Crohn’s disease, multiple sclerosis, cystic fibrosis and cancer. Of those households, we found that 65 per cent had access to a health care card but only 35 per cent had access to bulk-billing. We were interested in the whole range of copayments that people in regional Victoria had to meet, and when we added up all those copayments we found that in some instances people were spending something like 21 per cent of their total income on their health related costs. We also conducted focus groups with people from the Bendigo area, the Gippsland area and the Western District, and we found a range of stories very similar to the ones that Rod was recalling. The issue was that bulk-billing was extremely important to people. If they could not get bulk-billing, that was just another one of their barriers to accessing health care.

CHAIR—Thank you, Dr Walker. You have provided the draft results of your survey on a confidential basis. Is that correct?

Dr Walker—Yes.

CHAIR—Thank you. We will receive them in that fashion. Can I go to the question that Ms Beaumont was raising—that is, the shift in the role of GP services from essentially preventive health care, especially with women’s health, to curative. What is the net effect of delaying
attendance for preventive activity? Has any work been done on the cost of delaying those services? What happens when women do not go for a pap smear, a breast check or whatever?

Ms Beaumont—Groups in the population who do not have access to additional money at a time when they need it are trying to get into public health services in any way that they can. You can find evidence of people using ambulance services when earlier on they could have used a general practitioner services. So the ambulance service is used inappropriately. The public hospital emergency type service usage is going up in an interesting way. I understand that Sunshine Hospital, which is in the northern suburbs of Melbourne, has had an increase of 18 per cent over the last 12 months in the number of primary care type patients trying to access public hospital services for GP type services when they could not get them locally. I am not sure about screening rates, but more people are using the public screening services.

The recent debate about access to emergency contraception and whether it should be through GP services has been interesting. A significant percentage of the population said that a pharmacy should be able to provide it because they would not be able to get into a bulk-billing GP service in order to access it in a timely way. ‘Timely’ means that you might avoid the need to go into quite an inappropriate abortion service, for example. I think that is an important process for young women in particular. They have been very vocal about the need to be able to access that during an increased range of hours on a seven-day-a-week basis. GP after-hours type services are very limited and nonexistent in some communities.

Mr Wilson—Some surveys we have heard about indicate that young women are staying away from GPs, particularly in country Victoria, at quite a high rate just due to the fact that they cannot afford to access those services. Those young women not accessing GPs in the way that they need to has huge social implications for those country towns and those young women.

CHAIR—And were they mainly for sexual health services?

Ms Beaumont—Yes. In many cases the communities we are talking about that have no access to bulk-billing also do not have a good community health service so either they pay to go to the GP or they go to the emergency department of the local hospital, which is often run by the same group of GPs, who deny access there. So they have to travel down the road for some hours to get to a public hospital emergency service that will see them. That is quite inappropriate for essential services.

CHAIR—For essentially a GP type service, yes.

Mr Wilson—Our observation of the way the system is working is that people will attempt to find somewhere that can meet their needs and usually they are not the appropriate provider of the service. We are now getting stories that some maternal and child health nurses are having to do work that GPs would normally have done because maternal and child health nurses are at least available and accessible. So the system gets skewed. Emergency departments of hospitals are one, and local government services that provide HACC services are another. People find their way around the system, but a lot of people find their way to inappropriate, less qualified and less competent services.
Senator KNOWLES—I noticed you were sitting in the audience before so it will come as no surprise to you that I ask this question about your submission. On page 1 you say:

Clearly the current rebate provided for GPs is not adequate to maintain a bulk-billing practice.

Would you care to explain to me why you think that jacking up the rebate is going to provide more bulk-billing?

Mr Wilson—My organisation is a provider of bulk-billing services, so we know how difficult it is to run a bulk-billing practice. Like the previous speaker, we find we are having to subsidise our bulk-billing practice from other state government funds.

Senator KNOWLES—How about the practice payments and so forth from the federal government as well?

Mr Wilson—It is just not enough.

Senator KNOWLES—But you just said to me that you only have to top it up from the state government funds. That is not exactly true, is it, because it is topped up by a lot of federal government funds through practice payments and other incentives?

Mr Wilson—No, the practice incentive payments are not nearly enough to meet the costs of running a bulk-billing GP practice.

Senator KNOWLES—But they are there, aren’t they?

Mr Wilson—they are there, yes. There are all sorts of payments available to GPs—EPC items—enhanced primary care items—and all sorts of blended payments. But all the information we get from GPs says it is not enough to sustain a bulk-billing practice. If it were, a lot of GPs would still be in bulk-billing practices—they would be providing them. Drive around Melbourne and see how many bulk-billing signs you can see. They do not exist. GP practices are stopping bulk-billing. The figures indicate that.

Senator KNOWLES—Mr Wilson, did you hear the figures I cited earlier about the increases in bulk-billing in the last six years vis-a-vis the previous six years?

Mr Wilson—we are totally in accord with the AMA on this. We believe that the cost of running a GP practice is very similar to the sorts of costs the AMA has said. So it is not surprising to us. The increases in bulk-billing rates have not nearly kept pace with the costs of running a practice. Yes, they have increased, but not nearly at the pace that they need to. I am surprised you asked the question, because it is obvious that GPs are voting with their billing practices. They are passing the costs on to consumers.

Senator KNOWLES—I am asking you why your colleagues have reduced bulk-billing when the rate of the rebate has dramatically increased, and increased the rate of bulk-billing when the rate of the rebate went the other way? Now you say to us, ‘Increase it more and we will bulk-bill more.’ I could not get out of the RACGP this morning even the most remote commitment that they would guarantee bulk-billing of even concession card holders.
Mr Wilson—Our view would be that it is a mistake to leave the market to the GPs. This is a Commonwealth government responsibility. Why would you leave the responsibility of running the system to GPs? This is a public health system. From our information, the public wants the government to take a hands-on approach to making sure that they get adequate services to publicly funded GP services. It does not surprise us that the AMA says that they are dodgy about getting back into bulk-billing. But it is not the AMA's job, nor is it the doctor’s job to require bulk-billing. It is the government’s job.

Senator KNOWLES—The AMA only represents about 28 per cent of doctors, so that is just a view. I am saying that the rate of increase of bulk-billing has gone down when the rate of the rebate has gone up.

Mr Wilson—It is a very simple economic argument that the costs of the increase in the rebate have not kept pace with the costs of running a practice. All of the research shows that.

Senator KNOWLES—When the increase in the rebate was less, bulk-billing went up.

Mr Wilson—We are not a doctors group. We are saying that the research we have seen indicates that the cost of running a practice has increased at a far greater rate than the rebate has. It is a very simple economic argument.

Senator KNOWLES—It was interesting yesterday. We had evidence in Newcastle that if doctors bulk-billed everyone, they would actually make more money.

Mr Wilson—We are not arguing that bulk-billing per se is the answer to this issue. We are saying that a national primary health care policy is required. Funds pooling is required between the Commonwealth and the states and a far more sophisticated level of thinking needs to occur in relation to this. Obviously bulk-billing has become the cornerstone of our primary health care system. However, a lot more thinking needs to be done by the Commonwealth government to come up with a system that is going to work long-term. We have to get back into bulk-billing, but there are a lot of other things we have to do as well.

Ms Beaumont—The other point about this is that bulk-billing only gives access to general medical providers. There is a range of other providers that people want access to in a primary care sense. That is why there is the need to think beyond the cost of a GP service. Even fee-for-service is very oppositional to dealing with complex care across a range of providers. The evidence is that people cannot get access to services in a primary medical service. Whatever the reason for it, there is diminishing access to primary medical services.

Mr Wilson—The number of people attending GP practices in this country is declining. They are not all of a sudden getting better—they are staying away.

Senator KNOWLES—Why do you say on page 4 of your submission that the impact of allowing only health care card holders to access taxpayer funded health care will create a two-tiered system? Where does it say in any utterance that only health care card holders will be able to access taxpayer funded health care?
Mr Wilson—Our understanding of the A Fairer Medicare package—you might be able to correct us on this—is that those doctors that sign up to the package, which we understand will not be very many, will be able to bulk-bill health card holders and others. Basically, those who do not have a health card will pay a fee for service. Others will be able to take out private health insurance. I am happy to be corrected if I have misinterpreted the package. That is my understanding.

Senator KNOWLES—But doctors will get an additional payment on a sliding scale, depending on their location, if they bulk-bill concessional card holders. There has never been a plan, and there is no plan at the moment, to prevent doctors from bulk-billing anybody else at any time. So the assertion that only health care card holders will have access to taxpayer funded health care is a very inflammatory statement and frightening to a lot of people out there, coming from people like you.

Mr Wilson—I will tell you what is very frightening: when you cannot afford to go to a GP in the first place. In fact, what is very frightening is what you are proposing. We believe the market has already spoken; the GPs have already spoken. They are already instituting a user-pays system. That is what is happening on the ground at the moment. People are staying away from GP practices because they cannot afford to pay.

Senator KNOWLES—But why do you say that only health care card holders will get it?

Mr Wilson—Your proposal is just institutionalising that. It is sending a message to GPs that user pays is the way to go. If the community accepts that, then well and good—that is fine—but let us not disguise with some other language what is going on.

Senator KNOWLES—Why do you say that only health care card holders will have access to the health system?

Mr Wilson—that is happening more and more, and your proposal will institutionalise that.

Senator KNOWLES—that is just dreadful, coming from an organisation like yours. That is an appalling statement.

Senator ALLISON—for a start, they are the only ones who get the extra $1.

Mr Wilson—What is in the package for anyone else?

Senator KNOWLES—that is an appalling statement. That is a blatantly political statement.

Ms Beaumont—Would you like to hear more from us?

Dr Walker—People in regional Victoria reported having to beg—as they said—to be bulk-billed. Part of the problem is that we are moving back into the situation where the GP decides on who deserves welfare. That is certainly happening in country Victoria. We hear stories about that in Melbourne too.
Ms Beaumont—We have evidence of a health system that needs serious attention to take it into the future, but it must be built on what I think the public understood about Medicare—that it was simple, that everybody had equal entitlement and that, if you have money on top of that, you could go out and buy beyond that. People have gone out and bought beyond that for a long time. It is about being simple and everyone having equal entitlement to the basic access. Putting in layers of complexity, making some entitlement to the service in a certain way and another entitlement in another way, is confusing to people. The other element of it is that there is no evidence that that type of approach to segmenting entitlement actually works. Of the models I have been looking at, the US system is probably the best example of it and it does not work in terms of equity of access.

The other element of it is: why would you bring in private health insurance to cover this area? It does not work in the acute hospital system. It has not helped in decreasing the demand on the public hospital system in the state sector. The private health insurance industry are in it for profit. They will skim off the easiest people to see and we still will not have a private health insurance system that will deal with the complex, the people with high needs, the people who are difficult to treat and the people who might bring embarrassment to a service. Those people will not have access to private health insurance. They may be able to afford it—we do not know—but the private health insurers will not be looking to that group as a good group to cover. Also, do you take it out at the point of critical need? Do you take it out at the point of diagnosis of cancer? I do not think the insurers would be interested in that. How the private health insurance end of it would work is a big unknown. It will not stay at the level of $1 a week for very long because that has not been the history of private health insurance in other areas.

The complexity of what is being proposed is very difficult to explain in terms of the problems that we are hearing about. We are not politically aligned. All we want is a system that works, that is cost-effective, that the community can afford and that the community can access at the right level at the point in time that they need it.

Senator ALLISON—The recommendations you have made in your submission seem to me to be very interesting. The first one is that doctors should be selected into medicine from a broader representation. Can you expand on the reason for that recommendation and on how it might work?

Mr Wilson—The entry point for medicine is very high, and subsequently you are drawing on a particular group of people. We do not see why there should not be more GPs drawn and trained from a broader cross-section of backgrounds—particularly rural backgrounds. We know that the federal government has tried to do some things in this area, and that needs to be progressed and pushed. Basically, we need to attract a more diverse group of people into GP services. I suspect it is more about education policy than about health care policy.

Senator ALLISON—It would appear that the recommendation is in line with the government’s proposal in respect of new places being made available. Are you saying something more than that? Are you suggesting that perhaps there be a bonding arrangement that comes with the provider number for GPs? Are you suggesting that we divvy up the whole country into areas and that we provide a licence for GPs for each of those areas?

Senator FORSHAW—A bit like real estate agents.
Mr Wilson—The basic thrust of what we are saying is that we train GPs at a huge cost to taxpayers and then we allow them to work wherever they choose to work, whereas they are basically a public health service. It is terribly important that we get those GPs where they are required. Whether it is a licensing scheme or some sort of bonding scheme—however it works—this is one idea that we think is worth looking at. Certainly, the distribution of GPs is a huge issue. Why do we spend a lot of taxpayers’ money training people to provide core services for communities and allow them to go and work wherever they choose? It seems to be a very odd arrangement, particularly when the health of the community is so affected by the lack of GPs in certain areas.

Ms Beaumont—I do not know why we, as a community, would balk at an equal distribution of provider numbers across the country. I think that would be incentive for people to go and work in certain areas. I do not know why we balk at the constitutional barriers to setting fees and things like that, which is said to be the civil conscription clause. I do not know why we say, ‘Well, that exists and it should be there and will be there for ever.’ We have to think beyond those elements of Medicare that were part of the original design and take it into a new future. In terms of the provider number issue, if it is only for medical service provision then we should think beyond that. We should also think beyond the idea of a provider number and beyond the idea of fee for service. I think the community health model is a good one. It brings together a whole range of service providers and determines where they will be provided.

Mr Wilson—I think that Recommendation 3 is more what we are interested in, which is funds pooling. Previous speakers have spoken about that, and there are very good models in Victoria where we have been able to pool state and federal government funds in the local community clinics, which work extremely effectively. There are not enough of them and they are not well enough resourced but they work very well. Despite the efforts of all levels of government, on the ground these clinics actually pool funds. This did not happen consciously—the government did not say, ‘Look, we have to get these funds pooled at a local level.’ The providers themselves figured out how to do it; how to run GP practices with allied health services, drug and alcohol services and all sorts of support services—HAC services, et cetera. We are saying that those sorts of models—and they are empowering the community—are managed by local communities in local areas. We think they fit very nicely with the Commonwealth government’s philosophy of putting responsibility back onto communities for taking care of themselves. The concept of giving funding to communities to look after themselves and taking responsibility for their own community is one which, we think, fits very happily with that sort of philosophy. We are promoting that as the solution.

Senator ALLISON—You might be interested in yesterday’s hearing in the Hunter Valley where the divisions of GPs got together with the hospital to provide after hours service, pooling together a whole range of funds and influential people. The pooling model could be worth looking at.

Dr Walker, I am interested in your evidence. My conversations with GPs suggest that they are opposed to the concession card holder definition—those people for whom, if doctors bulk-bill them, receive an extra dollar or whatever on the consultation. They say they are much more selective than that: they identify people’s chronic illness, those who need to come on a regular basis, low-income families where children might be sick, and age pensioners. But they do not like this idea of concession card holders. It leads me to this question: you said that the
experience of your members is that they have to beg to be bulk-billed. Are they asked whether they are on low incomes, in your experience? Would you like to see a sign in the waiting room saying ‘We bulk-bill aged pensioners and those with chronic illnesses’? How do we take this out of the realm of doctor paternalism?

**Dr Walker**—I think the challenge is to not end up with bulk-billing as a quasi welfare system. I am interested in what you said at the beginning, because my discussions with GPs have shown that they are often uncomfortable at having to decide who should get their services at the bulk-billing rate and who should not. That is partly the problem. People with chronic illness have enormous needs which go beyond just medical services and services from the PBS. We need to be thinking beyond that to things like funds pooling and so on. Quite often people will go for medical services because there are no other services available. They might need something that is not medical but because that is the only thing available in their town or their suburb, or because the doctor is the gatekeeper for another service, then they will go to it. That is quite an expensive way to operate. I am not sure if I entirely answered your question.

**Senator ALLISON**—Not quite.

**Mr Wilson**—Maybe you would like to come back to that point. I suppose what we are saying is that really the outcomes of GP services and health services need to be tied to health outcomes. If there is a percentage of people in the community that have asthma, epilepsy or some other chronic illness, the performance of the GP should be tied not to throughput but to how they affect the health and wellbeing of that community. There are all sorts of measures that can be put in place to make sure that GPs are based not on a clinical throughput model but on a model that maintains the health and wellbeing of communities. While we continue to have a throughput model of health care, where people pay fees for services, we will continue to have groups in the community that miss out, because there are lots of really difficult people out there who need really intensive care, and it does not pay for GPs to look after them at the level that they need to be looked after. We are certainly advocating tying government funded services to health outcomes rather than to measures of throughput.

**Senator ALLISON**—Diabetes is a chronic illness, as you would be aware. Professor Marley from the University of Newcastle said that there was evidence in the UK that we will never solve diabetes for people until we bring dieticians into the equation, but doctors just will not and cannot do it. Mr Wilson, you have made it clear from the point of view of your community health centre that you think bringing allied health into the tent is important. Can I ask you, Dr Walker, to comment on chronic illness. What you would give priority to in terms of funding for allied health groups?

**Dr Walker**—I would not give priority to any particular disease group. We have the national health priorities, which means that people who are not part of those health priorities tend to miss out on a range of services. I think we should be basing priority on a level of need. We should be looking at illness in terms of how it affects the individual, and what they need in order to improve their health so that they can optimise the quality of their life.

**Ms Beaumont**—The question of which type of allied professional to be added to the provider number with doctors is difficult. What came to my mind when I heard the question was that I might put counselling in there—no cost or low cost early counselling—which enables the person
with chronic and complex problems to better negotiate either way through the system and get access to information and, therefore, access to other services. Would it be a physiotherapist as against a dietician? I do not think there is an answer to that.

**Senator ALLISON**—The reason I ask is that we currently have optometrists and psychiatrists under the umbrella. One of the terms of reference of this committee is to look at that whole question. The message you are giving us is that a community-based system in which all allied health professionals are on a needs basis is a preferable model to further provider numbers.

**Dr Walker**—That is the value of funds pooling as opposed to a fee for service. The GP is the gatekeeper to a whole range of other services too.

**Mr Wilson**—There is not a Commonwealth set of services that sit over here, a state set of services that sit over there, and the local government sitting somewhere else. The reality is that a lot of these things come together on the ground. We need to institutionalise that. We need to require them to come together and not just let them come together on an ad hoc basis. If we required state-funded and Commonwealth-funded services to work together on the ground, we could do a lot better than we are currently doing. That is why we say that a national primary health care policy is one of the things that is desperately required.

**Senator STEPHENS**—Thank you for your submission. It brings the consumer’s viewpoint to the debate. Dr Walker, concerning the issue of people living with chronic illness in your alliance, you have provided the results of your survey and a publication, which are useful. Is the alliance a national alliance?

**Dr Walker**—We are incorporated in Victoria. We started off as a Victorian alliance, but we are moving towards being national. We represent quite a number of national bodies now—the Australian Crohn’s and Colitis Association is one example.

**Senator STEPHENS**—I found it useful to try to distil the policy options in your submission down to how they would actually affect people on the ground. Your case studies were quite useful in trying to see what the implications would be. Using your first case study about the mother with her three children in a large town in regional Victoria as an example, have you had an opportunity to consider the government’s A Fairer Medicare Package and the Labor Party’s alternative proposal and then determine what is going to be better for this woman with her three children in that very distressing situation? Have you had a chance to compare the two proposals and see if one will deliver some benefits over the other?

**Ms Beaumont**—The message that federal policy is about improving access to bulk-billed services is an important one. With regard to the other message about a range of different options being available depending on whether a patient is a health care card holder or whether they access private insurance, a person who—like the woman—is on a low income, is not a health card holder and has a couple of kids may stop work and go onto a health care card as an option. That would enable them to access those GP services that did agree to bulk-bill—and we do not know that they will because there is no message that bulk-billing is the federal policy direction. The strong message of improving access through improving bulk-billing is a very important one for those communities that have no access at the moment.
Mr Wilson—Our interpretation of the two packages would be that one is sending a message to GPs about moving more to a user-pays system, if you like, and that is a philosophical argument. It is a values based argument about whether we believe that people want to pay for their services through their taxes or whether they want to pay for them at the point of service usage. What we are saying in our submission is that by and large the feedback we get is that people want a taxpayer funded health care service that meets their basic requirements. To the degree that the Labor Party’s policy is about support of public health services, we applaud it. And, to the degree that the coalition’s policy is about user pays, we have concerns about it. Having said that, we like the Democrats’ policy a lot, which is about development of funds pooling in community health services across the country—we think that has a lot more to do.

We are engaged in a community debate here, which I think is a good community debate—we are not shying away from it—and it will come down to the values of people in local communities. Do they believe that the packages that have been offered will actually deliver for them? I say to you all that, in our experience, what will keep happening is that consumers will continually tell their stories about how they do not access these services until the system changes, until the community requires it to change. People keep coming to us and saying, ‘Have your heard our story?’ And that is going to keep happening. Let us have the community debate; that is what this process is about. It is a values debate about whether people want taxpayer funded health care services or whether they want a user-pays system. I think this woman obviously would prefer a taxpayer funded health care service that she can access for herself and for her children.

Senator Stephens—Thank you for the comment. I appreciate that there is a philosophical debate and an ideological debate underpinning the two options that I have alerted you to, and you have talked about the Democrats’ package as well. None of us is shying away from the fact that continuing to fund a primary health care system is hugely complex and difficult and is going to be increasingly expensive. There is never one simple solution that can take the thread. In respect of your recommendation 4, which is about providing an integrated whole-of-community, whole-of-government approach to primary health care and to community health care in all its guises, I would suggest that there are many examples of integrated community service delivery models that are out there in a range of areas. Can you provide the committee with anything that takes your recommendation a step further, and starts to think about the intricacies and the relationships of the Commonwealth-state issues that you have identified here in terms of funding and mandates?

Secondly, I want to go to the issue of community participation in the decision making process and the role you are advocating here for community committees and community decision making at a local level. It would be useful to know whether there are some opportunities that you might be able to point us to where that is successfully occurring and whether it is in human service delivery or some other delivery.

Mr Wilson—I think our view about the complexity of the system is that we have too many levels of government, basically. We are not proposing today that we do away with any. It would be really good to have health care services delivered by one level of government. The transactional costs of three levels of government delivering health care services in Victoria must be huge. Alternatively, there could be an independent commission to run all health care services, similar to that which currently exists in Canada. I do not think anybody in the community doubts
that that needs to happen. I have not heard anyone say, ‘Whatever you do, let’s make sure that we keep having every level of government in the health care field.’ People are always saying, ‘Let’s rationalise it,’ so we believe that should occur. Whether it be state, federal or whatever is irrelevant from our point of view, it needs to be rationalised.

In answer to your question about community participation, the Victorian community health model has existed for a long time, despite efforts from different governments to get rid of it. Its strength has been in its base in the community. One of the reasons that successive governments have been unable to get rid of it is a fear of the fact that people actually relate very well to being a part of a health care service in which they have some say in how the services are delivered. It does not do enough and it is not well enough resourced, but the model works and it works very well. In Victoria, the state government appoints some members to the boards of community health services and the members elect some members. It is there to see. I am sure there are other models in other areas where community participation works well in the delivery of health services. Primary health care is a tiny percentage of the budget. It would be good to have the community involved in the delivery of those services.

Ms Beaumont—Before you take the opportunity to have a discussion about a particular model of community participation that would exist in Victoria that we could point you to, we will come back to you on that.

Senator STEPHENS—Dr Walker, there have been some comments in previous hearings about the way in which patients access health services, in the sense that if they have a particular need—and I am thinking of someone who has a chronic illness—they will have developed a relationship with a doctor who is their primary care provider and who is maintaining continuity of care about their particular illness, and if they have other non-chronic illness related issues they will go to another clinic to get in quickly for a doctors certificate or whatever. Is that the experience of your membership? Are they able to make that choice? I am really trying to understand how someone with a chronic illness is cared for in our health system.

Dr Walker—Our experience has been that people with serious chronic illnesses prefer to access specialists, and they would like to be able to stay with the specialists. But that is not really possible because of the referral system. The other thing is that people with serious chronic illnesses are also very loyal to their hospitals and to their health services. Some of them would really like to be able to access a whole range of allied health services through the hospitals. That is something that disappeared in Victoria in the 1990s. If people with chronic illness had their choice, they would really like to have some central access point where they can get specialist services and primary health care services all in the one place. What people really complain about is the business of having to travel from one service to another, and the fact that that is quite often an uncoordinated process.

Senator HUMPHRIES—I have a couple of questions. Your first recommendation says:

The ... Group would propose that entry into medicine be reviewed to ensure broader representation made much easier than it currently is.

What do you mean by that?
Ms Beaumont—That was a question asked earlier.

Senator HUMPHRIES—I am sorry, I did not hear it.

Ms Beaumont—Just to talk about that a bit more, the evidence is that people talk about wanting to access somebody of their own culture or of their own socioeconomic group and for certain services women prefer to see a woman provider. So there is this demand for a wider range of people coming through in medicine, including increased numbers but also increased diversity to reflect the diversity of our community.

Senator HUMPHRIES—Is there the danger that as you target particular categories and say you want Indigenous doctors, doctors from non-English-speaking backgrounds and so on you could generate a situation where people see an Indigenous doctor and say, ‘He had a lower entry mark than other people—he is a sort of token member of the profession,’ or someone in one of those other categories suffers the same problem? Is that a danger?

Mr Wilson—We are not proposing to get into education policy on this. What we are saying is that, from our experience and knowledge, there is a lack of diversity of representation in GPs, it would be good to broader it out and that may help in terms of distribution. We know the Commonwealth government has made efforts to recruit GPs from country areas and things like that. Maybe we need to do more of that kind of thing. Maybe we need a greater diversity of people who are GPs. The education issues are really not our area of expertise.

Ms Beaumont—Maybe the entry point to medicine is the point that is wrong. I think the example some years ago in the Hunter Valley where they targeted mature age entrants and developed a school around those entrants created quite a different graduate to those that went from school to university and straight into medicine and did not have a lot of life experience. How doctors communicate with people is the area that most people complain about. The mature age entrant with a lot of life experience has a completely different way of communicating with the service user. It is those sorts of things that need to be thought about.

Senator HUMPHRIES—I see some problems with that recommendation and with the one about licensing for particular communities, in terms of practicalities. I take it you have not fleshed that out to any great degree, so perhaps we will have to leave that on the table.

I want to ask Dr Walker about the survey you have given us. I was just a bit surprised to read—perhaps I misunderstood it—that the survey demonstrates that 72 per cent of households had one chronically ill person and 23 per cent had two chronically ill people in the household. That seems extraordinarily high. Was the survey catchment restricted to certain sorts of people?

Dr Walker—Yes; it was a targeted survey and, from that point of view, the results are quite skewed. The way we did it was to send the survey out through our member organisations and, because of that, it was the people with the most interest who responded to it. That definitely is a limitation.

Senator HUMPHRIES—It is a self-selecting survey?

Dr Walker—Yes.
Senator FORSHAW—Can I just clarify this, because I am not sure if we got it all at the start: I understand that you each have a professional background in medicine or in health. Is that correct?

Ms Beaumont—My background is in nursing.

Mr Wilson—My background is in health care management, essentially.

Dr Walker—I am a health sociologist.

Senator FORSHAW—I think it is important to get that on the record.

CHAIR—I thank the Victorian Medicare Action Group for your presentation today, and I apologise for the delay.

Proceedings suspended from 1.14 p.m. to 1.51 p.m.
PIKE, Ms Bronwyn Jane, Minister for Health, Victorian Government

BROOK, Dr Christopher William, Executive Director, Rural and Regional Health and Aged Care, Department of Human Services, Victoria

CHAIR—I welcome the honourable Bronwyn Pike, MP, Minister for Health in Victoria, and Dr Chris Brook. Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you.

Ms Pike—Thank you very much, Senator. I thank the committee for the opportunity to make a presentation and then have a conversation about these very important issues. We have provided you with a copy of the presentation. I will move through it very quickly and will not cover all the material here.

Victoria is very concerned about proposed changes to Medicare, for a range of reasons. Fundamentally, we believe that the universal character of Medicare, as it was originally envisaged, has served this country very well for a number of years. The characteristics of Medicare are that there is universal access to medical and hospital care for all Australians, that the funding of public hospitals is shared between the states and the Commonwealth, and that the Commonwealth funds general practice.

After 20 years we find that there have been a lot of changes. Public hospitals continue to provide universal access but the balance has shifted between the states and the Commonwealth, and in Victoria’s case we now fund over 50 per cent within our public hospital system. A declining proportion of people have access to GPs. Particularly in outer suburban and rural regions, there has been a significant decline in bulk-billing and after-hours availability. On the hospital side, we have seen increasing pressure on our emergency departments, with an eight per cent growth per annum in those departments. Two million fewer Victorians were bulk-billed over the last two years and we can provide numbers which show that decline right across all of the electorates. We know that after-hours access is also declining.

When we turn to the impact of that on the public hospital system the figures become alarming. We have seen a rapid growth in primary care patients presenting at emergency departments and that is growing at an average of about 6.5 per cent per year—or 25,000 patients per year. But in those areas where there has been a greater than average decline in bulk-billing and after-hours availability, there has been a commensurate increase in growth in primary care patients. So the outer metropolitan hospitals in Victoria are seeing a greater than average growth of the category 4 and category 5 patients.

In addition, out-of-pocket costs to patients are increasing. The copayments have increased more than the CPI in 32 out of 37 Victorian federal electorate areas. We believe that the proposed changes are an invitation to doctors to increase the copayments and demand more and more from their patients. The recent introduction by one practice, which many of us will have read about in the Herald Sun, of giving people the opportunity to receive faster service or enabling people to jump the queue is a very bad precedent. We note that there have been public comments which, in a sense, condemn this practice. On the other hand, the proposed policy
changes open the door to this kind of practice, and we think it will become more and more a feature of our health system.

We also note that specific groups in the community other than low income earners are finding it much harder to access GP services. Only an estimated 16 per cent of GPs now provide services in residential aged care facilities. I was recently out in the Werribee area to the west of Melbourne and I met a group of aged care providers who said that it is almost impossible now to get a GP to come to a nursing home. We know that higher copayments will mean that many poor people will avoid going to the doctor and in many places in country Victoria access to bulk-billing is almost impossible. All our good work in terms of prevention, early intervention and screening programs is now vulnerable, as people choose not to go to a GP.

Doctors are very concerned about the fact that Medicare rebates have not kept pace with the services that doctors wish to provide, and certainly about their capacity for appropriate remuneration. There are increasing practice costs, rising medical indemnity costs and increasing red tape and compliance costs. Recently we met with a rural doctors group, who told us that doctors, particularly in rural areas, have not overwhelmingly welcomed the proposed changes to Medicare. They said that only 15 per cent of doctors in rural Victoria would be availing themselves of the opportunities in the Medicare reform package. Whilst it has been touted as a proposal to address the declining rate of bulk-billing, doctors are not convinced that it will really achieve the required results.

We are concerned about the potential development of a two-tiered system, entrenching discrimination against low income families—a system with access to GPs based on an ability to pay, with bulk-billing only available to concession card holders. In poor areas, the incentives are insufficient for GPs who have high levels of patients with concession cards. As we are advised, many GPs will choose not to participate in the new scheme. We certainly believe that the way that the whole new package is structured does not provide the appropriate incentives to maintain the universal character of Medicare.

I want to make a couple of comments about the work force strategies in the Medicare package. Whilst we welcome additional medical places, Victoria needs over 60 extra doctors urgently. The bonded character of the additional places makes them quite limited. It is going to take 10 years to train these doctors, so it is not addressing the issue we face now. It is the same for nurses and allied health workers.

We believe that the proposed changes to Medicare will aggravate current trends, promoting a rapid decline in bulk-billing. They will not do anything to address after-hours GP services and in fact will introduce new barriers and reduce access, particularly for the chronically underserviced members of the community. In a sense, there are disincentives for GPs to service these vulnerable groups. As health minister here in Victoria, I say that all of this is going to further increase the demand for public hospital services through primary care type patients presenting at hospital emergency departments.

In summary, we are being squeezed from both sides. We do not believe that the changes will provide greater access to medical services—in fact, quite the contrary. Those people will continue to present at emergency departments. That is how we are being squeezed on that side. On the other side, the Commonwealth took the $918 million directly off the top of the AHCA,
directly out of public hospitals. So we have more patients of a medical type coming through and a billion dollars less nationally to be able to deal with those patients. In the case of Victoria, there will be $350 million less in the public hospital system over the next five years than was there under the previous AHCA. That is equivalent to the loss of funding for an entire public hospital, such as the Maroondah Hospital.

Chair, in these brief comments I have tried to make it very clear that we certainly oppose the nature of the changes to Medicare. We are very concerned about the potential impact on other aspects of the health system, particularly the public hospital system. We are very concerned that the funding was taken out of the hospital system to fund the reform. It is not new money at all. We certainly believe that the Commonwealth needs to restore access to general practice through increasing the rebates to doctors and providing further incentive payments to GPs in rural and outer metropolitan and undersupplied areas.

My final comment is that we are very keen for the Commonwealth to re-engage the states in our work that was begun on the reform agenda, which sees greater attention given to the interface between the public hospital system and general practice in the community. Thank you.

CHAIR—Thank you, Minister. The question that has been posed to this committee about which we truly cannot get a real understanding of the real effect is the potential for there to be an inflationary effect through the introduction of this package, both for health consumers and potentially also for state governments such as yours. That effect may be delivered through doctors choosing not to participate in the proposal or, for those who do, there is potential also for increased costs to families who do not have a concession card. Has the Victorian government done any analysis of what the inflationary effects are for those two groups—consumers and the state government? You have already told us about increased attendance at emergency departments; do you know what the impact will be on your hospital system and also on your community health system, which seems to be a different model from those operating in other states?

Ms Pike—To comment broadly, by making it quite explicit in the new package that bulk-billing is really there for concession card holders and pensioners only, the door has now been opened for GPs to recover the costs that they need to recover to earn an appropriate wage and to meet the requirements of their practice, and to do that by directly charging the consumer. That in itself means that there are no limits or bounds. But the way that the package is structured gives another means of incentive. We know that when people reach $1,000 of expenditure, they will be eligible for a copayment funded through the private health insurance scheme. In fact, on ABC radio, on The World Today on 30 April, a GP being interviewed said:

What’s the point of keeping my fees down? Why would I want to sign up to bulk bill when I can charge a standard fee of $100 for a consultation ...

To that, everyone would say, ‘That’s terrible,’ but think it through. He goes on to say:

... and know that eventually the patient is only going to be paying $20 out of their pocket?

In other words, he is saying, ‘If I can rush my patient through so that they reach that $1,000 level, if they are a high-using patient with a complex issue or a family with a number of
members, I can charge them more up-front, recoup that money, get them into the private health insurance rebate so that they get the copayment through their private health insurance, and therefore then draw down those additional resources.’ That is inflationary by nature because it means that there are no bounds to the resources that can then be pulled out of the system. Chris might want to make a few more comments about that part of it.

Dr Brook—we have made no detailed analysis of what the inflationary impact would be. I think it is very difficult to do so because of the uncertainty about whether the package will proceed and, if so, who would accept it. The only comment that I could make in relation to the inflationary aspects directly on our health care system is that, as the minister has stated to you, we are seeing a significant increase in presentations of triage category 4 and 5 patients in emergency departments. This has increased more over the last two years than in any other period.

Senator KNOWLES—Do you have a graph of those tendencies that you can provide?

Dr Brook—we do, yes.

Ms Pike—we publish a quarterly hospital services report and we can provide that to you. We have all that information.

Dr Brook—to the extent that there is transfer from general practice, particularly out of hours, which the package does not address, that is a direct cost to us in addition to the indirect costs to the community through increased outlays.

Ms Pike—you mentioned community health. As people are unable to find a bulk-billing GP—a normal general practice—they will turn to every other part of the system where free health care is available, and community health is one of those areas. But community health itself is being squeezed, and many GPs are not choosing to work in community health settings because the amount of reimbursement that is available to them really is not an adequate wage.

CHAIR—I understand that you are conducting an inquiry into the impact on your community and public hospitals of the diminishing access to after-hours services in particular and to bulk-billing general practitioners. Can you tell us about when that inquiry began and when it is expected to be completed? I am interested for the purposes of this inquiry.

Ms Pike—that inquiry is a reference to one of our parliamentary committees, the correct name of which I will remember in a moment. They have already begun to consult with people within the broader community, and I can seek advice as to when they intend to report. I anticipate it will be within the next 12 to 18 months. I do not think it is a short period of time. I will provide you with more information about that.

CHAIR—Thank you.

Senator KNOWLES—This inquiry, of course, is about not only the A Fairer Medicare package; it is about other proposals that are on the table. Can you tell me how the Labor Party package will solve your hospital problems, your doctor problems, your after-hours problems and your dental problems?
Ms Pike—We are of the belief that we have to have the closest alignment between the cost to GPs of delivering a service and the amount of rebate that is available to them. The reality is that the rebate has not kept pace with cost for doctors. Their incomes are declining to the point where some practices are not viable. Strategies which fundamentally address that rebate and provide incentives for bulk-billing irrespective of people’s particular financial capacity will address the issues for doctors—in other words, will provide less of a green light to larger and larger copayments and will provide less necessity for doctors to make unpalatable choices, such as choosing to give people who can pay more a faster service than those who can pay less or who are seeking a bulk-billing service.

My understanding of what is being proposed by federal Labor is that it is an underpinning of the universal character of Medicare by a greater level of reimbursement to doctors and by incentives for people to treat more and more bulk-billing patients in those other areas. We think that any proposals that enhance access to primary health services, such as those provided by GPs, will assist us in reversing the trend for category 4 and 5 or primary type presentations within our emergency departments.

Senator KNOWLES—You believe the increase in the rebate is the be-all and end-all to all problems here in Victoria. You have not mentioned dental, but I butted in—I acknowledge that. So the increase in rebate is basically the sole policy position that is being put out by the Labor Party?

Ms Pike—No, there are other positions that are being put out by the Labor Party. I do not have a copy of the complete package here. But I want to talk about the rebate because we can actually show a direct correlation between the decline in the availability of bulk-billing services and the increase in presentations to the emergency departments. That decline in availability, if you ask general practitioners, is due to the fact that the rebate has not kept pace with costs. Doctors would clearly like to be able to bulk-bill many more members of the community than they currently do or to at least keep copayments to a minimum. But as the copayments get bigger and bigger, and as bulk-billing becomes less and less available, people will seek alternative free health care.

Senator KNOWLES—Then why has bulk-billing gone down as the rebate has gone up? The rebate over the last six years for a short consultation has gone up 20 per cent and for a long consultation has gone up 26 per cent, and bulk-billing has gone down. Under the last six years of the Labor government, the short consultation rebate went up by nine per cent, and the long consultation rebate went up by five per cent. Bulk-billing went up under the lesser increases and down under the bigger increases. Could you explain to me why you now believe that an increase in the rebate is going to solve the bulk-billing problem?

Ms Pike—I would like Chris to add something to my comment, but it has to do with the relative growth in the cost of the provision of health care. We have seen an escalation in those costs. There are three components to cost increases in health: the first is the rapid ageing of the population, the second is the higher level of utilisation of services through advances in demographic technology, and the third is the CPI and the cost of living. You would have to weight those relative increases in the past against the respective increase of cost in the provision of health care. The reality is that health care costs have now increased beyond the CPI—in fact, to the point of well over eight per cent.
Senator KNOWLES—Can you explain to me why, since the introduction of Medicare, with the fee-for-service and other practice payments, it has kept remuneration above the CPI, when you make the claim that it is below the CPI. The evidence does not support what you have just said.

Dr Brook—I am happy to answer the question in part. It is always difficult, if not impossible, to answer a question which chooses particular time periods for specific reasons clearly to support or not support particular claims. In the submission to this inquiry Deeble does make the point in his very comprehensive document that, over the life of Medicare, it is true to say that the rebate has held pace, more or less, with the CPI. However, that is practice revenue, not income. As the minister has said, practice revenue is not the same as income, and costs in health do not move in line with the CPI. They move significantly higher than the CPI in all aspects, including salaries and wages for health workers who are not medical practitioners working in general practices elsewhere, and in terms of consumables, equipment and the like. In the last 10 years, for all but two years, the rebate level has been below the CPI. But, in a sense, all of that—with respect—is irrelevant.

The fact is that there is a growing gap between what general practitioners think they should be earning, what they are receiving as rebates, and what they are prepared to charge. As long as there is a gap between what a pretty important part of the market thinks is its perceived appropriate remuneration level and a constrained rebate, then choosing the general economic CPI is not helpful. One would need to look at something that was much more closely weighted to a health CPI—if there were such a thing—and that has never previously been accepted by the federal government. Or you would have to look at the real issue: what GPs think they should be earning—their target figure is $48 for all consultations—and what they are receiving in terms of rebates. If that gap is widening, then, where the market permits, people will move away from taking the lower price and going to a billed price.

Senator KNOWLES—I find it very touching that people are defending doctors’ incomes when they are 4.7 times average weekly earnings. It is interesting that the CPI is considered irrelevant when put in that context, but the argument has been used by many people, including yourselves today, in a global sense. So when it is pointed out in a global sense that the information is inaccurate, we then have to redefine it.

I come to the area of dental health. The Victorian Auditor-General’s report on community dental services stated that what the Victorian government said they were doing and what they were actually doing were not the same. There was a mismatch between the government’s stated priority for rural health promotion and the mix of services delivered. Worst of all was the VCOSS analysis of the 2003-04 health budget. They said it showed that in reality the Victorian government had allowed their funding in this vital area to decline by 1.3 per cent. Minister, can you explain to us why dental funding has gone back by so much in Victoria?

Ms Pike—It is true that the dental health system is under pressure here in Victoria. The Commonwealth made a determination in 1997 to withdraw its funding from the publicly funded dental health scheme and at that time, under the previous government, the numbers of people waiting doubled within a few months. Since coming to government, this government has attempted to peg back that growth in the waiting list. In our first term of government we put in significant additional funding and we continue to increase the funding to dental health. Whilst
VCOSS claims that there has been a reduction in dental health funding, that is not entirely accurate.

**Senator KNOWLES**—The Auditor-General claims the same, though.

**Ms Pike**—The Auditor-General, with respect, does not claim the same. It is an argument that says that in one term of government, over and above your base, you put in an additional, say, $40 million—I think it was thirty-something million dollars that we put in, in our first term—and then in the second term you say you are going to put in an additional $20 million and then somehow that is interpreted as a cut. It is not a cut—it is a lesser rate of growth, but it is not a cut. It is important to make that distinction.

The Commonwealth had a successful public dental program for a number of years. The funding for that was in the forward estimates right up until 1999. So it was not to be a short-term program, as some people would like to claim; it was always intended to be an ongoing program. Now it is costing around $350 million a year under the private health insurance rebate scheme to contribute to dental services, so we do not believe it was even a good value for money decision for the Commonwealth to pull out of the public dental scheme. We are aware that we have a backlog. We are certainly aware that there is an issue here—

**Senator KNOWLES**—A 24-month waiting list now?

**Ms Pike**—Again, it is important to look in perspective here. As soon as the Commonwealth pulled out their funding, under the Kennett government the numbers doubled within the first six months because they did not reinstate additional funding. Our government has reinstated funding and we are slowing the growth of the waiting list. We know there is a lot more work to be done but at least we are putting in resources, which was not the case under the previous state government. We think that dental health is as much a part of people’s health as mental health and the primary and acute care system, and we believe the Commonwealth should share this responsibility with the states, as it did in the past.

**Senator KNOWLES**—Minister, has it ever occurred to you—crossed your mind—to put the $52 million that you have allocated for a trade union building accommodation fit-out into health? The fit-out in this trade union building—a bit like Centenary House in Canberra—is, I understand, going to comprise two office towers, a fitness centre, a swimming pool equipped gym and a range of restaurants, bars and shops. That is a very large amount of money. Has it ever crossed your mind that maybe the bureaucrats could stay where they are and the $52 million—that is the largest item, I believe, in the budget in this type of the area—could be put into dental care?

**Ms Pike**—I am sure that all governments make determinations about priorities and it probably would not be very helpful if I open up that conversation regarding the current federal government’s priorities too. We can all play that game. It is not a very helpful pathway to be walking down—

**Senator KNOWLES**—You are directly responsible for your portfolio, Minister, and I notice that you have refused to answer it. You are responsible for the expenditure. I would have thought you would have said, ‘Premier, I need that in dental health.’
Senator ALLISON—Minister, firstly, thank you for appearing before the committee. It is rare for ministers to do so and it is always very productive when they can. Leading on from that last exchange and concerning the reforms that you are discussing currently about the interface between public hospitals and general practice: are you confident that the current relationship between the Commonwealth and states is such that innovative proposals might get up successfully and that we can look a bit outside the square, as it were, to find solutions to some of the more serious problems? The reason I ask this is because we have just been in New South Wales in the Hunter Valley and have heard about some proposals which work extremely well—after-hours services for GPs in conjunction with hospitals and the health service in the region. Do you see that as a way forward? Should the Commonwealth and states be working together to find solutions to some of these quite difficult problems?

Ms Pike—Twenty-six different health groups have come together to form a coalition under the leadership of Professor John Dwyer in New South Wales and they are pushing the Commonwealth and states in this very direction. We know that we have to look much more closely at the connections that are right across the health system. Over 12 months ago, on the initiative of the Commonwealth minister and with full agreement from all the state health ministers, the Ministerial Conference set about a reform agenda. There were nine working groups set in place. Two very critical aspects of the reform agenda were the interface between the emergency departments of public hospitals and general practice and the connection between the acute system and the aged care system. Currently 621 people in our public hospital system have been assessed as eligible for a nursing home. They are using acute beds. They should be in a nursing home but there is nowhere for them to go. So that interface is critical.

We understood that the work from those nine working groups would inform the next AHCA agreement. The states have all been extremely disappointed that that work has now been put to one side and the offer for funding under the AHCA agreement has taken no account of some possibilities for genuine reform of the system, which I think the community is asking for. We certainly are asking for it as well. Just to hear me talk about the connection between what is happening to bulk-billing and GPs and what is happening to the emergency department surely must drive people to realise that we have got to get these interfaces right.

Here in Victoria we are engaged in some very innovative programs to try to break down the hard lines between the acute setting and other places where people’s health is sustained. Our Hospital Admission Risk Program has had $40 million of additional funding in the first round and is seeking to manage people with complex and recurring medical issues so that they do not come bouncing back into the acute system all the time. We have seen some terrific results from that program and we have lots of projects funded across the state. We are also involved in interim care, in the growth of the sub-acute system and in finding more appropriate places than just the very blunt instrument of an acute bed to care for people. Dr Brook will add to that.

Dr Brook—Thanks, Minister. We aspire to see the best utilisation of all resources to achieve maximum health benefit. The relationships we tend to find ourselves in with the Commonwealth are what may be called boundary protection, more than anything else. I am sure the Commonwealth would say the same thing about its relationship with the states, so I do not suppose one could ever call it a one-way street. It does mean, however, that it is incredibly difficult to engage in innovation, except in small pilot arrangements.
Like other states, we have a number of small pilot arrangements, some of which are of exactly the sort that you have described. For example, the after-hours GPs triage service in the Grampians demonstrates the benefit of telephone triage services, but it is only ever going to be a pilot because there is no enthusiasm for providing that kind of extremely valuable service to the whole community. In many respects, we are at the point where we would prefer to see some larger—if smaller scale—reforms to just a whole bunch of pilots. But that seems to be the way the Commonwealth has rolled out any kinds of reforms over recent years. We would much prefer to see an end to endless pilots, trials or whatever which do not lead on to anything else.

**Senator ALLISON**—Do you think that is because they are not properly evaluated or is it because with each one we can make yet another announcement about a new pilot program? In your view, is there proper evaluation of those programs? Is that the issue?

**Dr Brook**—I think it is a mixed bag of things. Pilots and trials are always good generators of activity, and the result may be the activity itself. Sometimes there have been very detailed evaluations. For example, the coordinated care trials did not demonstrate the financial benefit that people had hoped they might and therefore fell by the wayside, notwithstanding that no-one really looked at or took seriously the apparent dramatic improvement in service quality and experience of the people who went through the coordinated care trial programs. There are different agendas at play as well.

In addition to the reforms the minister has talked about, we try very hard in the broad area of primary care to bring together parties irrespective of funding arrangements so that we have a state wide primary care partnership program with 32 different primary care partnerships across the whole of Victoria. In a sense, that is a state wide trial and it is in some places going much better than in others. That is designed to create relationships and then to simplify relationships between different participants in primary care—predominantly HACC providers, aged care providers, GPs and our own community health providers.

Through that, we have been able to develop a single initial needs identification and service coordination template tool, which has greatly simplified the assessment requirements of people in those areas where it has been fully implemented. It has greatly simplified the assessment requirements and the continuity of care for people who are coming into a system but who may have previously had five or more separate assessments and five or more different service templates. I cannot say to you that that is universal in its application in Victoria, but it is in some places and it is a terrific advance. That is in a sense standing outside the square and asking, ‘Irrespective of who funds these people, can we bring them together around a clinical service concept, improve their care and send that communication tool with them as opposed to it being locked up in local government or locked up in a community health centre and not travelling with the patient?’

**Senator ALLISON**—What about the suggestion of witnesses this morning—you would not have heard it—that for primary health care, including HACC services and the like, we pool the funds that are contributed by Commonwealth, state and local governments? Is that too radical? Do you think we could see a future in which a health commissioner might independently determine the distribution of funds for primary health care? Could Commonwealth and state governments trust in a process like that?
Dr Brooks—Funds pooling is nearly always raised as an end in itself in discussions surrounding health financing. Perhaps I have been a bureaucrat too long, but I take a somewhat reserved view about the advantages of funds pooling. It is certainly not an end in itself. Funds pooling without very clear attention to what services you are providing and the nature of those services is just a different way of paying. Certainly, however, the concept of greater flexibility between funding sources is critically important, and that is something that we aspire to, though I think we, like everyone, are always accused of having too many divisions. Unfortunately, there is this other concept called accountability, and the two must go together.

Ms Pike—What we have done to better manage people without making them jump from a local government system to a state-funded system to a federal system is through the kinds of collaborations that Dr Brooks has spoken about through the Primary Care Partnerships. In our own system—and the heart program has been a good example of that—rather than having a culture of referral which says, ‘I want to work out who I can send you off to,’ it is about identifying someone who will actually take a major case management responsibility role. They will have the capacity to get services from the system and will be accountable and responsible for the long-term maintenance of someone with a complex issue so that that person does not just bounce around the system.

Senator STEPHENS—Dr Brooks, going back to your response to Senator Allison’s question, it has been said in other places that governments have more pilots than Qantas. You made the comment that pilots and trials are often more about the activity generated itself rather than real outcomes. I assume that the Primary Care Partnerships strategy has an evaluation strategy planned as well. Although that is about service delivery and improvements in standards of care and quality, is there as part of that evaluation a cost-benefit analysis?

Dr Brooks—Yes, there is a substantial evaluation which has been contracted to La Trobe University. Hal Sverrinsen is leading the evaluation and he has already produced a preliminary evaluation of the first phase. Reforms like Primary Care Partnerships are not easy, because by nature you are asking people with almost no additional resources to voluntarily come together to produce a benefit that they have to work fairly hard to achieve. It is a slow and difficult exercise. In the first instance we probably had too many participants and have somewhat restricted participants since that time because that was the best way to do it.

That evaluation is not primarily designed to look at cost-effectiveness, but it is already in a couple of the local government areas where the use of the service coordination templates and needs identification tools have been universally applied. It has already demonstrated a significant benefit, particularly to HACC providers, who find that they are spending much less time seeking repeat information and are able to receive information from community health centres or from GPs. At this stage that is only anecdotal and we cannot prove it until we have much more experience with it, but it is certainly part of the evaluation that we are looking at.

The benefit for GPs I could not comment on in the same way. What does seem to be the case for GPs in successful PCPs is that they now know who alternative service providers are, whereas previously they may not have know, because this is accompanied by a very detailed service mapping exercise. They now know who alternative providers are, they have the capacity to immediately refer and they have a tool for referral that does not involve them having to ring up...
and wait for substantial periods on the phone to talk to the wrong party. So for them there is a distinct efficiency benefit, insofar as we can tell.

**Senator STEPHENS**—In his evidence on Monday, Professor Deeble spoke to us about the issue of technology impacts. He made a comment that over the past decade there has been a 50 per cent increase in admissions or procedures following visits to doctors. He related that to a whole range of issues, including indemnity issues, but also to the fact that the technology is there for quick diagnosis, confirmation of diagnosis and much quicker access to information that will help to treat an illness in its early stages. Given the different mix of public and private hospitals in Victoria and your community health services, can you make some comments about the kinds of impacts that technology has had on the whole Victorian health service? Are you seeing that level of increase in admissions or procedures?

**Ms Pike**—My initial comment would be that the community often thinks that when we get some new technology or medication that means people are going to be fixed up more quickly and will spend less time in hospital and that somehow that will mean there is a decrease in costs within the health system. In fact, increased use and availability of technology is one of the key cost drivers within the health system because there is far greater utilisation of the resources that are there and, of course, that means we are keeping people alive and managing chronic illnesses et cetera a lot more effectively. That is a broad comment that can be made.

**Dr Brook**—I do not know that I have quite understood where Professor Deeble was coming from. In commenting on technology I have to be careful not to give a philosophical answer, but the health care system that we sit and look at today and that we manage is dramatically different from the health care system of 10 years ago and, in turn, dramatically different from the health care system of 20 years ago. I think that is something which is not as clearly understood as we would all like and is certainly not clear in the broad community’s perspective. Technology is probably the single largest driver of change in health care, save only for population growth and ageing; and the capacity to apply technologies to increasingly older and sicker people doubles, if not exponentially increases, the effect of those two things. It is the reason predominantly why acute hospitals are and will increasingly be places where only very sick people are or should be, and only for the briefest possible time, in order that those highly expensive and technical places are used for that purpose—that is, a brief technological intervention.

That does not mean to say that people should not have or do not need care beyond an acute hospital episode, but it means that we have to redesign the system—and we are in the process of redesigning the system—so that those who require continuing care for a period do not receive it in that enormously high-tech, much shorter length of stay, acute facility but in a subacute restorative or recuperative facility—sometimes previously called a rehabilitation centre, which is not a good term in some senses—or at home with appropriate supports. It is the ‘at home with appropriate supports’ that most worries us in terms of this whole debate about Medicare and primary care. We need to be investing far more than we do at the moment, in our view, in people who are going to be at home with a variety of chronic illnesses and disabilities.

One thing I can say confidently is that we are investing and have invested very significantly in that beast called subacute. I can say without hesitation that Victoria has a very comprehensive and well-developed subacute care system which I do not think is replicated elsewhere in this country. It has been a very conscious, very clear agenda of ours to understand precisely what the
care needs of people are and to ensure that that very high-tech—and indeed it is very high-tech—is only the beginning. Things like robotic surgery, nanotechnology and the whole new world of gene technology and targeted treatments are only just beginning. This is a constant process that will keep happening over the next 20 years.

Ms Pike—Adding to Dr Brook’s comments, it is the primary health area that we know we have to reinforce and strengthen. We know there is a rise in depression and mental health issues and it is GPs and their capacity to diagnose and then to connect with appropriate community based supports who are absolutely critical in our early intervention and prevention in so many of these areas. Yet these are the very groups that are, in a sense, being undermined by the proposed changes where we should in fact be bending over backwards to shift our health dollar the other way in everything that we do.

Senator HUMPHRIES—Having heard the New South Wales government submission to this committee on Tuesday and now the Victorian government submission on Thursday, I sense a great deal of attempting to cost shift over to the Commonwealth for matters which are really the responsibility of states. Coming back to the issue of dental care, with the exception of that quite specifically targeted dental program the Commonwealth funded a few years back, dental care has always been the responsibility of state governments. Can you really make a case for saying that the state of the waiting lists for dental care in Victoria today is somehow a matter that can be laid at the foot of the Commonwealth government?

Ms Pike—My view is that these are shared responsibilities—

Senator HUMPHRIES—It has never been shared really.

Ms Pike—and in the referendum of 1946 it was made very clear that the public of Australia saw these as shared responsibilities. The state of course recognises that we are not wanting to shift the cost to the Commonwealth at all. We understand that we have an obligation in the provision of all sorts of health care and I made it clear that the states’ contribution in the case of public hospitals has gone well over the 50 per cent of the shared responsibility that is there. So we are really asking the Commonwealth to be part of the dental health system as it was in the past so that the state does not have the full burden of that responsibility, because we recognise that dental health is as much a part of people’s health as mental health and health within the hospital system. I think I have made it clear that we have worked hard to stem the tide of the growing waiting lists. We know there is more to be done and we would invite the Commonwealth to share that responsibility with us.

Senator HUMPHRIES—Talking about waiting lists and hospitals, in fact the Commonwealth has shared responsibility with Victoria. You have had an increase in funding over the period of the last Australian health care agreement. You put your own substantial amount of money into hospitals, I understand—I think you have talked about a billion extra dollars into hospitals—yet waiting lists in Victoria have gone through the roof. Comparing the first quarter of 1999 under the former government and the first quarter of this year, your waiting lists for people for elective surgery have gone up by 20 per cent, the number of people on waiting lists longer than ideal has gone up 84 per cent, and the number of people staying more than twelve hours in hospital emergency departments has gone up 170 per cent. With these proposals, aren’t you really expecting the Commonwealth to come in somehow and bail you out
of a problem which appears to be of your own making with respect to the mismanagement of the many extra dollars—many of them Commonwealth extra dollars—into your public hospital system?

Ms Pike—I will draw your attention to the latest hospital services report here in Victoria. I am very happy to provide a copy for you which shows that on every indicator waiting lists, 12-hour waits and ambulance bypass are down—

Senator HUMPHRIES—When?

Ms Pike—and that is a direct result of the strategic interventions of this government. I also draw your attention to the Duckett report, which analysed the state of the Victorian hospital system in 1999, and determined that our public hospitals in the metropolitan area were technically insolvent. This government has been investing resources—as you said, $1 billion in our first term and another $1 billion in this term—and that investment is certainly bearing fruit. As I said, on every indicator we have seen significant turnarounds in the hospital system. I do not actually have in front of me the report that you have there. I would be interested in the figures that you are comparing because, since the reporting time of this government—not the report that referred to the previous time—we have seen a decline in waiting lists. From a comparable period, our hospital services report shows that our indicators are good. I further point out that the rate of growth offered by the Commonwealth under the previous Australian health care agreement was 28 per cent, whereas the rate of growth that Senator Patterson and John Howard want us to sign up to on 31 August is 16 per cent in Victoria’s case. At the same time, Senator Patterson has acknowledged that the health care CPI runs at twice the rate of normal CPI and that the cost of health care growth is at least 7.5 per cent because that is how much she granted the private health insurance funds.

Senator HUMPHRIES—I am interested in and look forward to seeing the figures on waiting lists that demonstrate that they are lower than the ones that you inherited. The New South Wales government indicated that it would fund the sorts of things that they were bidding for in health. You have your own wish list here on the last page of your submission. They would fund their wish list through an increase in the Medicare levy. What is the Victorian’s government view about that?

Ms Pike—At this stage, we have no predetermined position for a mechanism. We do believe that the increase in rebate to doctors is critical. We do not believe that that increase should come at the expense of the public hospital system. The mechanism for funding that is a matter for the Commonwealth.

Senator HUMPHRIES—You do not have a view about it, or you do not support the New South Wales position?

Ms Pike—We have not made a determination at this stage. We don’t support or not support.

Senator FORSHAW—I was going to invite you to answer Senator Humphries’s question regarding waiting lists again so that he heard it, but I think that he has got the message. Minister, you have covered all of the issues that I wanted to ask questions about except I wanted to draw
your attention to another observation made by the New South Wales government in their submission:

Public hospitals are also experiencing huge increases in the demand on emergency departments—

you have already dealt with that—

and for other services delivered on an outpatient basis such as chemotherapy services. Private health insurance arrangements do not cover non-admitted patient or emergency department care and so private hospitals rarely provide this care.

They went on to make the point that there is an increasing demand upon the public hospital system to provide a service where the patient with a need for ongoing treatment, such as chemotherapy, no longer gets admitted. That is something that is not therefore covered in funding arrangements. Could you comment on that in terms of the Victorian experience?

Ms Pike—Briefly—I will ask Dr Brook to fill in some more details—this is where the reform agenda that Senator Allison was talking about is so critical. We know that we want to shift people from institutional settings—from an acute hospital or whatever—and provide services closer to where they live, even within their own homes where we possibly can. But the rigidities of the current funding models and the places where we, as a public system, can recoup reimbursements do not facilitate a reform agenda to move health in the way that we think is appropriate. So we would concur with the observation made by New South Wales and say that the scenario has many similarities here.

Dr Brook—Growth in emergency admissions is not a feature of this submission because it focuses on primary care, bulk-billing and the rebate. But in another submission—which I am sure we will happily share with you—relating to hospital demand in Victoria, what has happened in this state over several years is that we have faced enormous increases in demand, particularly for medical patients with complex and chronic needs requiring admissions through emergency departments. In our metropolitan hospitals with emergency departments, particularly outer metropolitan hospitals, we are still seeing an eight per cent increase each year in medical patients, mostly, if not exclusively, elderly patients with complex needs, who require admission. That is an extraordinary demand to place on any hospital system. That is, in part, why there are stresses in this state’s hospital system, as indeed there are in the each state’s public hospital system.

That eight per cent increase every year in emergency medical patients requiring admission does cause stress in terms of other patients that may otherwise be accessing the services. That is not a group who carry private health insurance or who, if they carry it, use it. They are not people who are going to private hospitals instead of public hospitals—the growth in private hospital admissions in this state has been almost exclusively day surgery and elective surgery. So that complex chronic group is increasingly becoming a greater part of our business. They are people who are very complex and difficult to treat. They stay for very long periods of time—much more than the average length of stay. That burden alone is pretty extraordinary.

In the non in-patient area it is also true that there are big increases in demand. The biggest single increase in demand that I could reflect upon would be for renal dialysis services, where
the rate of growth is just phenomenal each and every year. That is a tragic thing in its own right and reflects the need to get right on top of diseases like diabetes, but it is a huge cost and treatment driver for us. Likewise, oncology services—although there is a distinction between the New South Wales way of counting oncology services and Victoria’s way of counting oncology services; we count them as in-patients, they no longer do so, so that does tend to slightly distort figures of public hospital utilisation. Nevertheless, those services are paid for in both systems, one way or another. Those sorts of things are great costs to us. At the end of the day, of course, we provide the expensive and difficult to find treatments too.

Senator FORSHAW—That was a point that they made as well. This is relevant not just generally in the context of the whole issue of health care but in terms of private health insurance, the rebate and the question of what private hospitals are doing in this area. The answer is: little.

Ms Pike—There is a claim of course that you do not need to give as much money to the states to run the public hospital system because there has been an increase in demand in private hospitals. It is true there have been more patients going to private hospitals. In Victoria’s case we also have had a massive increase in people going to public hospitals. But as Dr Brook is pointing out, the complexity and the kinds of patients that we are seeing mean that when you put that weighting on as an overlay then the argument that you can somehow shift funding from the public system because the private system is picking up the lion’s share does not hold water at all. It is just not true.

CHAIR—Thank you very much, Minister and Dr Brook, for your presentation today. I appreciate the time you have been able to give us and I apologise for going over time. It is an indication of the quality of the discussion. Thank you very much.
[3.05 p.m.]

**RICHARDSON, Professor Jeffrey (Private capacity)**

CHAIR—Welcome. Do you have any comments to make on the capacity in which you appear?

Prof. Richardson—I am the Director of the Health Economics Unit, Monash University. I am speaking here today as a private academic.

CHAIR—Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. The committee prefers that all evidence 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 you may ask to do so and we will consider your request. We have a copy of your submission, and we thank you very much for that. I invite you to make a brief opening statement before we move to questions.

Prof. Richardson—I request that I be allowed to speak a little longer than suggested, the reason being that at the time of my submission I was exceedingly busy and was not able to put in a full submission. I would like to elaborate on a few of the points as briefly as I can. I have tabled some additional data. I apologise if the committee has already received it. However, I think it is important data. It is fairly up to date. I received it from the department of health this morning, so it is quite timely.

I want to make a series of fairly brief points on the terms of reference and then a couple of general points at the end. The first one is with respect to term of reference (a): full-time general practitioner incomes. That is part of the data I have just tabled. I have given you two pages in reverse order. The first of them looks at the current income of GPs and specialists through time. One of the interesting points in there and in the next piece of datum is that the income received by general practitioners is not just from the Health Insurance Commission as fee payment. These days, there is an additional $20,000 per general practitioner being obtained through additional payments such as the divisions and the practice incentive payments.

The more interesting graph is the one entitled ‘Ratio: fee income to average weekly earnings’. This shows the income of general practitioners and specialists relative to average weekly earnings. The income of general practitioners and specialists has been divided by average weekly incomes and indexed so that in 1984-85 the index number is one. If the index rises, that means that medical incomes are rising above those of the rest of the community relative to the baseline. What you will observe is a remarkable constancy in the level of income. For example, in 1984-85 the income for general practitioners was $103,700 or 4.98 times average weekly earnings. By 2001-02, gross fee income was $215,000—4.63 times average weekly earnings. Including PIP payments, this rises to $235,000 or 506 times average weekly earnings, virtually an identical figure relative to the community. So this throws into some question the impression that the terms of reference convey—and which is very commonly conveyed in the press—that there is a problem with respect to general practitioner incomes.
Another interesting statistic is that in 1984-85 the copayments that were being received by general practitioners were 10.6 per cent, in addition to the rebate obtained through the Health Insurance Commission. In 2001-02 the latest data showed that figure to be 10.8. So there has been virtually no change in the relative position. In contrast, specialists have increased both their incomes and their relative position to the rest of the community. So my first general point is a concern over the data which dominates the debate. Taken overall, the data do not reflect any form of crisis. There are distributional concerns, but not about total income or service use. That throws at least into question the existence of the general practitioner shortage itself. It is not a topic which I follow in detail, but I am not aware of hard evidence that demonstrates either the shortage or its distribution.

For example, in 1984—the first year for which we have comprehensive data—the supply of general practitioners was considered almost universally to be excessive; we perceived there being an oversupply of general practitioners. Since that date, the general practitioner supply has gone up by 16 per cent, and the use of their services has gone up by 24 per cent, both relative to population. Yet we now perceive there to be shortage. There has been a dramatic increase in specialist services. Between those two years, the specialist supply rose by 63 per cent and the use of specialist services rose by 99.7 per cent. This indicates that general practice was doing a smaller percentage of the total medical work and that specialists were taking a larger relative load. General practitioner services have increased, yet we still talk about a shortage. So the first key point that I want to make is to focus on the evidence of a shortage and the problems that involves.

Term of reference (d) refers to the question of whether or not dental and allied health services would increase cost effectiveness. The answer to that is fairly simple: selected services would be highly cost effective. You would need to distinguish between those that were and were not, but it is indisputable that some of these services are cost effective. However, the true issue here is whether or not we wish to include, as a social objective, services such as dental in the scheme. That is not a technical question that can be answered by cost-effectiveness ratios or economic evaluation. It is a social question of whether or not we wish to do that.

Term of reference (d) also refers to the range of options we have for changing the system. That is too big a question for me—and possibly even for this inquiry—to address in full, except to say that there is enormous flexibility in what we do. Sooner or later, Australia and other countries are going to have to grapple with the fact that we will be providing services only when they are medically efficacious and when we want to encourage their use. That would imply use of service after they have been fully evaluated, which is not what happens at the moment. We can contemplate a fee regime in which the fee falls as quantity goes up. That is a volume/price trade-off. It occurs in Canada and West Germany, and it occurs by specialist group—if a particular group of specialists increase their service use too much their fee falls. We can contemplate—in fact, the government is contemplating—different rebates for bulk-billed services from others. I will return to that. It is also possible to contemplate dramatically different rebates in underserviced areas. If you took equal spending on every Australian as your benchmark, in a geographic area where there was half the use of services you would expect, if that benchmark was accepted, double the rebate. So there are powerful reasons for differentiating the rebate by geographic area.
Term of reference (c) refers to the proposed policy of the government. I will simply summarise what was in my article in my submission. In that, it says that the short-run effects are likely to be comparatively minor. It does not destroy Medicare; there will still be universal insurance and universal access to hospitals. In the longer run, it creates a mechanism which makes it far easier to transfer expenditures out of the government scheme and into the private sector. It does that fairly simply. It has separated a rebate for health card carriers from the rest of the community. They can therefore index the rebate for card holders and allow the rebate for the rest of the population to stagnate—and there are a host of ad hoc reasons that could be given for their stagnation. Practice costs rising for doctors when the rebate was not rising would make the abandonment of copayments inevitable. That would be unpopular. As the copayments rose, there would be a demand for insurance cover, hence the importance of the reinstatement of insurance in the market for out-of-hospital medical services. So it sets up the structure whereby a later government could starve the public non-cardholding part of the scheme of funds and force the transfer of expenditures from the public to the private.

So the real issue that we are looking at is not one of the capacity of the country to continue with the existing scheme. I think it is really about the redistribution of income. When you have a rebate from the government it is tax financed and that implies a cross-subsidy from the wealthy to the poor, from the healthy to sick. The present changes would increase private health insurance in the longer term and so the 30 per cent subsidy will go to those who have private insurance, and that is by and large the wealthier parts of the community. It will decrease the size of the rebate within the government sector. That rebate is, once again, paid for by the wealthier parts of the community. So this transfer will result in a smaller cross-subsidy of the poorer sections of the community for two reasons: more of the government subsidy will go to the wealthy who have private health insurance and there will be a smaller general rebate for Medicare patients, that is, for the part of the health scheme which is financed through taxation.

I would like to make several other general points fairly quickly. The first is also in my article. This is in ideological terms the significance of what has occurred is that there has been a change in the value system underlying Medicare. I think that is a reasonable interpretation of what we have seen. There are two quite distinct value systems which get confused in Australia so it makes it quite hard to separate them. One of them, which is associated with the left wing and the Labor Party traditionally, is what Europeans would call ‘solidarity’—sometimes called ‘communitarianism’. This is a social philosophy that says that certain commodities, certain activities, should not be part of the economic reward system—defence, law, public parks et cetera. The second value system is the liberal, libertarian value system which says that individuals should look after themselves as far as possible and the government will step in as a safety net. The implication of what has occurred is that we have set up a mechanism for transfer from the system of solidarity through time to a more liberal, libertarian social welfare system.

My second general point—and the issue that has been raised in the terms of reference, but much more generally—is about the viability of Medicare, general practice, and bulk-billing, which has been raised from time to time. There is a very simple response to the issue of liability of any of those three: we can do what we wish. Those that tell you it is inevitable that something is going to happen, or that we have no choice but to do something or other, are mistaken. In Australia we spend an average amount on health for a nation of our size but, importantly, we spend less through the public sector than most other countries. We have low taxation. We have the flexibility within our system to do as we choose to do. We are talking about choice; we are
not talking about inevitabilities. When we are told that we ‘must’ do something to Medicare, that is verbal camouflage for another objective. So if we wish to preserve bulk-billing that is something we could do. It is a matter of social choice; it is not something that an economist or any other analyst can say without resort to their own personal values.

Talking about values, my next general point follows on from this. Bulk-billing has been one of the objectives of government in the past—that is, it reduces financial risk and it gives access of a particular sort. There is no reason why we should not continue doing that if we were prepared to pay for it. So the theme is choice and whether we are willing to pay. But, in particular, this is an example of where I think the structure of our analysis and approach to questions is back to front. We should be deciding first our objectives and then seeking to implement them. What in fact we seem to be often doing is being driven by the interests of particular groups and, in particular, the income of the various provider groups. So we are not looking at social objectives and saying, ‘How do we achieve them?’ Rather, we are taking those issues that impact upon vested interests—and I do not say that lightly.

If bulk-billing is an objective, it is perfectly legitimately for us to pay for it, to pay more for it. But that has not been the presumption. The question in our analysis has been: is this fair to doctors and how will it impact upon doctors and, of course, access to patients? We have not viewed it, as I think we ought to be viewing it, as an objective in itself—assuming it is an objective in itself. If it is, then we say, ‘This is what we will pay for.’ That means doctors may or may not like that but we are the buyers or the government are the buyers and it is for them to say what the product is. The objective is social values, the product that the society wants, rather than the objectives of the medical profession and others.

My last general point, which is an extension of that last one, is on the nature of the debate that we have had, and have always had, in Australia. I think it is true that the agenda has been set very largely by interest groups. It is to do with the distribution of income between doctors and others, the income of private insurance companies and the extent of the subsidy from the healthy wealthy to the poor sick. A lot of the issues which the inquiry is about are issues that can be informed by existing databases: what is doctors’ income, what is the effect of bulk-billing, is it viable following through time—the sort of data I gave you at the beginning which is generally not brought into the debate. That is highly undesirable. Australia has one of the best data systems in the world. A large number of the questions that this inquiry is looking into could be answered without controversy by inquiring into our databases. This ought to be something which a society would be monitoring all the time. We have invaluable data on who gets services. We could ask what the consequence is of those services. We could ask what the consequence is of those services. We could be asking on a regular basis about issues of access, outcome and cross-subsidy, the issues which unfortunately are not routinely collected and distributed. Our agenda is set by assertion, anecdote and self-interest. Given the databases we have and the importance of these issues, it is foolish to ignore the evidence that we have.

But it is worse than this. It is not simply a matter of the distribution of income where we are ignoring our data. We have got, from occasional ad hoc studies, some information that suggests that there are some spectacular faults in our system which are simply ignored as the agenda is taken elsewhere. Most notably, the Australian quality of hospital study in 1995, re-evaluated in 1999, suggests that 2,000 to 3,000 Australians are dying each year as a result of errors that should not have been made. There is an error rate of over 10 per cent for admissions into hospitals or episodes of hospitalisation. Probably one of the largest health hazards in Australia is
that our hospitals are, to a very large extent, not safe. This issue is totally ignored, politically and in the community. It is an issue which you would have expected would have sent a shockwave through the community and been the subject of ongoing parliamentary debate and for there to have been a repetition of the study on an annual basis. Committees have been set up, but it is a non-issue in terms of the public debate. Work that I have personally carried out has demonstrated quite spectacular differences in the rate at which services are provided in different parts of Victoria—we have a tenfold variation. There is no interest in that issue, either politically or within departments. A further study looking at patients who have had a heart attack when they are admitted to a private hospital found they are between two and three times more likely to have a high-tech intervention, angiography or revascularisation. That data exists. We did one study that was ignored.

So overall we are not using our data. It is spectacularly, almost criminally negligent to ignore the data that we have. We have the capacity to ask what is happening and what is the result of that, we can track people who are underserviced or overserviced and see what has happened; we choose not to. Rather, the agenda is concerned with the distribution of income and the distribution of control in the health system. The former issues, I have suggested, ought to be the subject of ongoing, continuous monitoring.

In Australia we spend remarkably little on using this data. It is collected and, to a large extent, ignored. We put no funds, or minute funds, into health services research—that is, the issue the Senate is presently investigating and the subject I have just been commenting on. In contrast to that, the largest funding body in the United States, the National Institutes of Health—and it is only one of several large funding organisations—spends, in Australian dollars, between $2.5 and $3 billion every year on these issues. If you adjust for their GDP in America, that would translate in Australia to about $120 million. If that sounds a lot, it is about 0.2 of one per cent of the health bill.

At the moment we would be spending significantly less than 0.1 of one per cent of the health bill. You would be hard-pressed to find any other industry in Australia or elsewhere that spends such a remarkably small amount on finding out what it is doing and the consequences of its own actions in the marketplace. Looking at that statistic alone suggests that to a large extent we are not interested in finding out about the health of the population. Rather, the agenda is being driven by income and distribution and income and power.

CHAIR—Thank you very much, Professor Richardson. You have raised a whole range of questions that are germane to the purpose of the inquiry. Could I start by asking you about the point you made that if preserving bulk-billing is a desirable goal—and I personally believe it is—it is simply a matter of choice. You described the philosophical point of view that we, as politicians, bring to that question. It was put to us on Monday, I think—you have made the point more clearly—that that has started to occur, that the bringing in of these proposals is not the point of change of mind by government, that the government has, over a period, been progressing a notion that bulk-billing is not a desired thing. Would you agree with the notion that the government has sent a message to the medical profession to say, ‘We would prefer if you did not bulk-bill.’

Prof. Richardson—I cannot comment on what the government’s motives are—I am very hesitant there—I can only comment on the effects, and the effect of the legislation that has been
Medicare proposed would be to encourage doctors to cease bulk-billing for other than card holders. There would be a strong incentive, as compared to the present system, to add a copayment. The most obvious of the measures is that doctors who are bulk-billing their pensioner patients will be able to direct bill the Health Insurance Commission and charge their patient out of pocket over the counter. That is important. Under the present system there is a deterrent to charging above the rebate because you inconvenience your patient. If you charge 5c over the rebate, the patient must then go and get it reimbursed. That inconveniences them. So bulk-billing does not just give a lower price; it gives greater convenience. Now that convenience factor is being removed, so that makes it much easier to actually charge directly without the patient noticing. So the incentives have changed—whether or not that is the government’s intention, I will not speculate.

Chair—It is probably a bit unfair to ask you that question. It has been put to us that the projected bulk-billing rate, if this package were to be adopted, would sit around 55 per cent. Has your institution done any work to predict what that eventual bulk-billing rate might be?

Prof. Richardson—There is no methodology which can give us that data. It has to be somebody who is familiar with the system making some sort of guess based on their feel of what has happened in the past. We have not really got a historical precedent for speculating on that. Almost certainly the rate would drop significantly—given that all card holders would be bulk-billed—and a very small percentage of the remainder bulk-billed. Fifty per cent does sound like the order of magnitude you would be expecting.

Going back to my earlier statement on bulk-billing, there could not be a stronger contrast between the Australian approach and the Canadian approach. As you probably know, we adopted most of our medical system from Canada. That is where bulk-billing originated. In Canada, where the attitude of solidarity is much stronger, there has been a presumption that bulk-billing is desirable and it was for the opponents of that to demonstrate its lack of desirability. In Australia the question has been set in a different way, reflecting, I believe, the difference in the agenda that we have always pursued. It has been assumed that bulk-billing is dangerous or undesirable and it has been for the advocates of it to show it to be worthy.

Chair—The other part of the question about the decrease in bulk-billing goes to your point about the data we have available. There has been a suggestion that the proposal from government will be inflationary in terms of patient costs—out-of-pocket costs for patients who are not concession card holders. There are two parts to this question. The first notion is that the uptake of people who are going to be participating in practices, from a lot of the evidence, is very low. That is predatory. We do not really know what the uptake may or may not be. The second notion is that for those patients who are not concession card holders, their patient costs—and I think you agree with this—will grow. Is there a way that we as a committee can get a notion of what those inflationary effects will be? Can you do modelling that takes you to that answer?

Prof. Richardson—We have no statistical analysis in Australia which would allow you to make a confident prediction. I think—this is another example of where our analysis is woefully inadequate—our unit is the only group which has done comprehensive analyses of fees. But that is unfortunately cross-sectional—that is, across the country—and the relation between the cross-section and the time series is quite difficult, so quantifying would again be some sort of guess. It would depend very much upon the ability of people to reinsure once we had reached the $1000
out-of-pocket. If that were reduced in subsequent years, as soon as a majority of those insured were getting a rebate through private insurance, then you could expect the inflation to be quite significant.

Perhaps I should add as a footnote that, while it would be significant, I do not think you would be correct in concluding that the health of the population would be jeopardised. There would be certain individual cases where the lack of access would do this. People who are sick generally get to the doctor and they can still do so via the public hospital. So I think we are looking more at the extent of the redistribution of income than we are at the health of the nation.

CHAIR—Regarding your point about reinsurance for the gap of the $1,000, it has been put to us that that is what is called catastrophic insurance and that it will only capture a very small number of people who have had quite horrifying events happen to them and that it is not a safety net for the general population.

Prof. Richardson—If the general population gets sufficiently sick to get into a private hospital, they would find $1,000 was the entry fee rather than a catastrophe. I do not think that is a correct perception. People, when they get significant sickness, would pass the threshold quickly. But far more importantly, that notional $1,000 does not have to stay at that level. Next year it could be reduced to $200—it could be progressively reduced. Alternatively, if it simply sat at $1,000, general medical cost inflation through time, which is part of general inflation, that $1,000 would be reached more quickly.

We have a structure—that is the important issue—which allows private health insurance to be re-established, and there is a mechanism by which that could occur. If we ask the Productivity Commission to look at private health insurance, they would be almost certain to come to the conclusion that there was no need to have unwarranted regulation if private health insurance was in the market. Cut out the regulation and let it insure all health care costs. It goes against one of the principles of economics to have ad hoc interventions such as a $1,000 threshold. So it would be very easy to argue that, in the interests of deregulation and competition, we should remove that $1,000. It is a structure that we have established. The removal of the $1,000 is easy and its significance is small.

Senator HUMPHRIES—In your article in the Financial Review in May, you talk about the inflationary effect of allowing people to insure for the entirety of their health needs rather than just above a certain threshold. You say:

In subsequent years, health funds might be “deregulated in the interests of competition”—that is, allowed to offer full insurance cover.

You then say that will have an inflationary effect on prices. What you say is perfectly true and would be recognised widely as being true, which raises the question: why would a government choose to do that? Isn’t it so obviously the case that, because it would add to inflation, it is extremely unlikely it would ever occur?

Prof. Richardson—It would be part of a process of transferring responsibility for health from the government sector to the private sector. There would be an inflation of fees which would then justify less intervention by government. A higher percentage of the doctor’s income would
be coming from the private sector. It would be part of the transfer of responsibility from one to the other.

Senator HUMPHRIES—Surely, if fees rose so dramatically as a result of full insurance taking place, it would make that insurance less affordable and it would push the responsibility back onto the shoulders of government to provide for those people who could not afford that greater insurance.

Prof. Richardson—Not in the short run. Eventually that could occur, and the safety net would certainly pick up people if they got into sufficient difficulty. We have had a number of precedents in the past of policy being driven by extremely short-term objectives. One example of that was when the medical rebate for private services in hospitals was reduced from 85 per cent to 75 per cent. That had a one-year objective of bringing down government expenditure in that year’s budget, but the long-term effect was the beginning of the inflation of private health insurance rebates. So for short-term gain you can structure private health insurance so that they can provide medical income increments rather than the government providing them. You would hope that would not happen. I am saying that that is a structure which can allow that to happen.

Senator HUMPHRIES—Okay. You are making an assumption about the motivations of governments, I suppose. We can all make our own assumptions about that. In criticising the idea of a copayment when paying the doctor’s bill, you say:

... patients presently see the total bill and will recognise (more or less) excessively high charges.

I put it to you that when people get their doctors’ bills at the moment they do not necessarily recognise, relatively speaking, how high the charge is, because they do not know in 99 cases out of 100 what proportion of what they have just been presented with is going to be refunded under the Medicare rebate. All they know is that they have a bill, they will pay the doctor and at some point they will get a refund from Medicare. This is obviously not for bulk-billed patients. Couldn’t you say it was the case that, if people could see in front of them the actual difference between what the Medicare rebate is and what the doctor is charging, you would have a more powerful health consumer because they are in a position to see what they are personally putting into the doctor’s pocket?

Prof. Richardson—I am not sure I follow your argument fully. Are you saying that, when they get the bill at the moment, they do not necessarily know what the division is going to be and that in the future they will see the division? I think that is a legitimate point to make. Which way it will go on balance is hard to say. I would not put a great deal of store on that argument one way or another. I think it is a fairly small point. So I would accept your argument; it is possible. I guess I was speculating—and this is not based on hard evidence, so this is a personal speculation, having thought about the issues for some time—that a very large percentage of individuals will tend to pay comparatively little attention to what they are not being charged immediately. They will take notice of the copayment, and that will be what provokes some sort of response.

My view is partly influenced by the New Zealand experience, where that scheme did occur. New Zealand economists argued—and they did not have hard evidence—that their system was in effect setting up a market in the copayments, and the reimbursement through the government was totally ignored in the process and almost invisible. We had in New Zealand, firstly, a rebate
and, secondly, a market determined fee. I guess that New Zealand experience is the only evidence we have.

Senator HUMPHRIES—You speak in your article about the shifting of costs from the private to the public sectors. You might be aware that Professor Harper from the Melbourne Business School has done an assessment of the effect of the Howard government’s reforms on private health insurance. He apparently concludes that, in 2000-01 alone, private hospitals in Australia performed procedures that would have cost the public hospital system around $4.3 billion to perform. In other words, had the private sector not carried out its share of that total hospital workload, public hospital outlays would have been about a third higher in real terms. Have you seen that work and, if so, do you have a view about it?

Prof. Richardson—I have not seen the work. Yes, I do have a view about it. There are a couple of qualifications. First, if the private sector is operating efficiently and is taking over from the public sector in terms of health and the distribution of health, it is not an issue which is very important. It is, rather, an ideological issue about which sector you wish to pay and to provide the health service. The second caveat is that the research we have done suggests that you get a different type of service in the private hospitals now than in the public hospitals. I referred to that in my opening remarks—that in the case of heart attack you are two to three times more likely to receive a high-tech intervention in a private hospital. That is of significance for the public sector, and it is quite contrary to the common view. It implies, just making the arithmetic simple, that if you transferred 10 per cent of the patients from the public sector to the private sector then, assuming the same sort of behaviour across the board, you would have to transfer not 10 per cent but 20 or 30 per cent of the doctors from the public system to the private system. So in those areas of medicine where there is already a shortage of doctors, transferring 10 per cent of the patients and 20 per cent of the doctors to the private sector would have a very adverse effect on the public sector. So it is not totally neutral when you simply switch patients from one side to the other.

Senator HUMPHRIES—On the other hand, you have private investment through premiums at work in the private sector, which you do not have in the public sector. That would put less pressure on the public hospital system in another way, wouldn’t it?

Prof. Richardson—that is not correct. It is certainly true that people who take out private insurance pay more than those people who do not and so are injecting more money into the health system. As they are paying more, there is no doubt that an equity case can be made for returning funds to them. My position has always been that it is a government decision whether or not we subsidise private health insurance. It is not an issue of economics. Sorry: could you repeat the last part of your question?

Senator HUMPHRIES—You said it would be more expensive for the same service to be provided in the private sector. I do not have any evidence to contradict that, so I will accept it for the moment. In the private sector you also have private investment through premiums, which you do not have in the public sector. Surely that offsets to some extent that greater cost, if indeed there is a greater cost.

Prof. Richardson—Yes. I apologise: it has been a very long day for a number of reasons, not just for the committee. The additional point there was that the problem in the public system has
nothing or very little to do with the decline that was occurring for some time in private health insurance. The reason is that, during the whole period of the decline in private health insurance, use of private hospitals was booming. What happened in the private sector cannot be directly linked to what happened in the public sector. The private sector was booming at the very time when private health insurance was in decline—basic but not extras private health insurance.

The problems in the public sector were entirely—I think I can say that without any qualification—a result of the budget caps which were put in place by respective governments. Back in the 1980s, there was a universal and correct, I believe, perception that public hospitals were inefficient. Governments had very few methods for reducing inefficiency other than putting a budget cap on, limiting the budget. This was done not just in Australia but world wide—that is, public hospitals were squeezed. That squeezing was what caused the problems in the hospital system. Nobody knew just how far you should squeeze the hospitals. The hospitals turned to the press immediately and tried a political solution rather than an efficiency solution. I think the consensus now is that the public hospitals were probably pushed rather too rapidly, but the ‘problem’, the cause of what happened in the public system, was entirely what happened to their budgets and had very little to do with the change in private health insurance. Certainly it was not connected to the decreased use of private hospitals during that period.

**Senator ALLISON**—This is a fascinating presentation and different from anything we have received so far. Can I ask you about the economics of looking at groups of people or geographic sectors of Australia that are under-serviced, as you identified them. Yesterday we were in the Hunter Valley and the argument was put that the area was under-serviced by $1 billion a year in terms of health services. They successfully argued for, I think, $15 million from the federal government to put in an after-hours program for GP services. The view was that the only way they got that far was by community pressure and if the community had not been part of this process it would not have happened.

You say it is peculiar—that is my word, not yours—that so many studies show that there are inadequacies in our health system but no-one seems to care about them. Is the problem that our community is not sufficiently informed about the issues to put that pressure on health administrators, politicians and governments? What is the problem in Australia? Is it that we have what you describe as a criminally negligent approach to what are glaringly obvious problems either with service levels or with standards of health care? Where have we gone wrong?

**Prof. Richardson**—I am not a sociologist. There is no doubt we have gone wrong in our perception of the priorities. One of the contributory factors—it is a symptom, I guess—is the issues that are picked up by the press and sold. To me it has been utterly startling that over a 15-year period we can have the press continually following the very simple story that there has been a decline in private health insurance, which means a decline in the use of private hospitals, which means an increased pressure on the public hospitals. That story has been around for 15 years, and for the full 15 years it has been contradicted by the data. It is not a matter of assessment; it is just hard data.

I am totally bewildered that our press is so obdurate that it continues telling wrong stories year after year while the data is there for anybody to see and it is very simple data. There may be such a rapid turnover of journalists that they never have time to understand what they are writing about. Certainly in departments of health the turnover is astonishing. To have any sort of
corporate memory of the issues is quite unusual, at both state and Commonwealth level, and increasingly, the health bureaucracy and elsewhere has been politicised and so it has been focused upon issues of political interest.

Another bewildering case would be the episode of privatisation. I think every state in Australia looked at it and many acted upon it, but there has been no evidence that any place in the world—and this is a subject I have followed with interest—has actually demonstrated the superiority of the private hospital sector. At best, there is not a great deal in it; at worst, there seems to be a marginal increase in the cost of such hospitals, especially for profit—they are good at making profits—but in terms of the overall importance of the issues in the health sector it is monumentally underwhelming. It really is not a big issue. If anything, private hospitals are probably not a good idea in terms of the limited data we have, yet that was able to capture the agenda of departments of health for half a decade or more. I am sorry, I am not giving you an answer to it; I am simply saying it is bewildering—I am thinking on my feet, sitting down.

What I would point to is this astonishing lack of research that we do. This sort of data is generated by the Australian Institute of Health and Welfare; it goes no further. Occasionally an underfunded academic—I have no-one specific in mind—may try and research this, but it is very difficult to do the research with no resources to do it. So there is not a constant source of people pushing forward the evidence. I think any sensible country that was concerned with its health services would have one or more institutes whose tasks included informing the public regularly, through reports, of what was happening over a wide range of issues that affected their life and the quality of their life, but in Australia we have not done that.

Senator ALLISON—You say we need to set objectives and that this government’s package appears not to have any—or at least they may be hidden. What would we need to do if our objective was to return to the peak of bulk-billing, which was over 80 per cent? Do you have any advice for the committee on how that might be achieved?

Prof. Richardson—It would be very easy to achieve it. You would increase the rebate on bulk-billing and not on other services. If a social objective is bulk-billing then it is perfectly sensible, in fact you would expect, that the customer would pay more for what they want. We seem to be more concerned with equity to doctors or a structure which doctors approve of than we are with paying for what we want—assuming bulk-billing is what we want. So if the government says it wishes to have bulk-billing, it simply pays more for it and less when a person does not bulk-bill. You could change the differential until you achieved whatever target rate the government had decided. You could of course go to the Canadian extreme, which was simply to legislate, under the Canada Health Act, to prohibit it, but if you took the former route and had a differential in the rebate then you have allowed for flexibility.

Senator FORSHAW—Given that you have said that what happens with private health fund membership does not necessarily automatically reflect what happens in private hospitals—I forget your words but you said that they had been working at full capacity all through the period of declining rates of membership—do you have data which shows the impact of the 30 per cent rebate in terms of the private hospital system as distinct from private health fund membership? In response to the groups—and there have been many of them—that have said us, ‘It is inefficient; get rid of the rebate and put the money into other areas of public health or health care,’ the government has said that if you do that it will have a catastrophic effect on the
operation of the private hospital system. That presupposes that the rebate had an impact on the system when it came in.

Prof. Richardson—I have not looked at that data. The data is readily available and it is something which I would have thought the Commonwealth would have submitted to the committee. It is one of those pieces of information that you would expect to be readily available and produced on a routine basis. Every state collects comprehensive information on hospitalisation. It is not something that I have been researching recently. Yes, the data is there.

My assumption would be that it has not had a dramatic effect because the private hospitals would have been operating at reasonable capacity. In the longer term what has happened will ensure their market. There could have been a fear that their market would not be sustained through time if the decrease in private health insurance had continued. The measures that we saw recently—lifetime community rating and the subsidy—were preventative measures to stop a subsequent decline if the insurance continued to fall.

When I give talks on private health insurance I have an overhead slide which says that the echidna, the platypus and private health insurance are Australia’s entrants in the world’s strange but true contest. I then go on to say that we would win even if the platypus and echidna were not there. Because of the levy that we put on the wealthy, for a family with an income of over $100,000—or rather less than that—the price that a family pays for its private health insurance is negative. At the end of the year you have more money in your pocket if you buy private insurance than if you do not buy the insurance. I know of no other product in the world that has a negative price. But there is a degree of equity, because if you use your private health insurance then you will be out of pocket financially in a way that you will not be if you do not have insurance. So you are paid to have insurance but you are penalised if you use it.

Finally—and this is rather more complex—the lifetime community rating has a very bizarre twist to it which suggests that we have forgotten what the insurance was for. Before we had that lifetime community rating, people would consider the next four or five years when thinking about whether it was a good idea to take out insurance. In other words, they considered the uncertainty or the risk of what would happen in the next two, three or four years. Insurance is insurance against risk. What the lifetime community rating has achieved is that people now have to worry about the uncertainty of the next 20 to 30 years. We have increased the risk. So in order to increase insurance membership we have increased the very thing that insurance is designed to reduce—that is, risk. That suggests that our objectives have been forgotten as we pursue another agenda.

Senator FORSHAW—Thank you for those very interesting comments. In the Financial Review article you say there is a ‘final intriguing question’ and point out that the main focus in the government’s package is on increasing the bulk-billing rates for concession card holders and health card holders, which you say on the figures is to ‘solve a problem that does not seem to exist’. In response, I have become increasingly aware of situations, particularly in rural areas, where there might only be one or two doctors in the town and they are ceasing to bulk-bill concession card holders or health card holders. This has consequential impacts on those people in terms of distances to travel if they want to go to a bulk-billing doctor in the next town. So I think there is a problem, but I can see what you are getting at. It is really looking at the small end of the overall problem of declining bulk-billing rates. I invite you to comment further on that.
Prof. Richardson—I guess this is yet another example of the extraordinary neglect of data. Information does exist which could answer the questions about how many health card holders are not presently bulk-billed but the data is not currently available in the country. We have chosen not to collect it or look at it. Rather, we have allowed the agenda to be generated by anecdote and interest groups.

GP income, at least in gross terms, for a full-time GP has not declined relative to average weekly earnings—that is the data I have given you. It is possible that general practitioners have become disgruntled for other reasons. There are a lot of problems with general practice. In particular, they may be disgruntled because they would be aware of the fact that specialists’ incomes have risen and they may very well benchmark their own objectives against specialists rather than against the rest of the community. But the final comments there were just an example of, or pointing to, the lack of data.

We have launched into the possibility of legislation without checking the data. So there is a question mark about the objective we are seeking if we do not bother to get the information which is justifying the changes. Certainly, where we do have data for those people above 65 or 75—and we do not know whether they are card holders or not because that has not been separated out—the level of bulk-billing remains very high. But there are undoubtedly cases where you will get exceptions. We have allowed doctors to do as they wish in this country, and there will be exceptions and anecdotes. I fear that we may have legislation driven by anecdotes rather than by the evidence that exists, which we choose not to look at.

Senator FORSHA W—It would be reasonable to assume, wouldn’t it, that if we just left the situation as it is and did nothing about bulk-billing rates generally, which are in decline, then it would progressively lead to more difficulties for people in all income categories, including concession card holders? I take the point that those rates may still remain higher than the general rate but, in the absence of doing anything or only doing something that is effectively targeted at one group, it is not going to improve the situation.

Prof. Richardson—It is a legitimate inference that, if the decline in bulk-billing continues as it has done in the last few years, eventually we will see the card holders in trouble. Just how far the decline in bulk-billing would go without this legislation is unclear. It is not true that private general practitioners have had catastrophic reductions in their income and that therefore this reduction in bulk-billing is a response to those catastrophic decreases. To the contrary—the evidence I have put shows that, relative to the rest of the community, GPs on the latest data were getting almost exactly the same as they were in 1984. They may be disgruntled but that is not such a decline—or not a decline at all—that will necessarily drive bulk-billing lower than it is at the moment. So whatever the cause of their disgruntlement, it is not a major decrease in income.

Senator FORSHA W—I probably should have addressed this next question to other witnesses as well, particularly those from the profession. Do you have any comment about the impact of one doctor’s practice or a medical practice in a town or region on what other practices do? In other words, do they say, ‘Because Mr Smith down the road bulk-bills everybody, the rest of us can increasingly let him pick it up’?

Prof. Richardson—It is a very good question and one that I would like to do the research on. It is an important question. It has never been looked at in Australia. My prior expectation would
be that there would be a significant effect, especially in a fairly closed area. But, no, we have no data. The formation of fees for general practice has not been properly studied. Certainly the impact of other practices close by can be studied. It has not been.

Senator ALLISON—Can I just clarify that the GP income figure on your graph includes all income—it is before expenses are deducted—or is that personal income for GPs?

Prof. Richardson—that is gross income. It is generated by the bills that go to the Health Insurance Commission. That has not taken costs into account. I suppose I should have drawn attention to that. An important caveat is that if costs could be shown to have risen disproportionately—that is, more rapidly than average weekly earnings—then that data would be misleading. General practitioners’ net incomes would have fallen. But I have not got data—I do not think data exists—on the change in general practice costs through time. That is another area where we could have data but do not.

Senator ALLISON—It is, of course, what they argue—that costs have risen beyond CPI and the adjustment that is made.

Prof. Richardson—it is an area that needs hard data rather than anecdote and speculation, I think.

CHAIR—Thank you very much, Professor Richardson, that has been useful to the inquiry. If you have further comments or data to provide us with we would be very appreciative. Likewise, we may contact you for comments about specific questions. Thank you for your time this afternoon.

Proceedings suspended from 4.05 p.m. to 4.18 p.m.
DEANS, Mr David Randall, Joint Chief Executive, COTA National Seniors Partnership

REEVE, Ms Patricia Doris, Director, National Policy Secretariat, COTA National Seniors Partnership

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 you may ask to do so and we will consider your request. The committee has before it a copy of your submission and we thank you for that. I now invite you to make a brief opening statement before we move to questions.

Mr Deans—First of all, if I can just explain the unusual name: it is two organisations coming together, heading towards a merger next year. It is Council on the Ageing, which is COTA, and National Seniors Association, and this time next year we may be able to come under a different name, who knows. We have been in partnership now for approximately six months. As an organisation we have in excess of 270,000 members—that is, people over 50 years of age—and that makes us the largest organisation of seniors in Australia. We carry out a lot of policy work. All our work is, of course, based on that membership and we get information from the grassroots around Australia; we have offices in each state and territory. The membership comprises people in the work force and people who are in retirement: self-funded retirees and those on a pension or part pension. The partnership was formed last December, in 2002.

On our submission on Medicare, we see Medicare as an important pillar of social protection for all of the community, including those people aged 50 years and over. We note that Australia has excellent outcomes in health care by international standards and we believe Medicare is a linchpin in achieving this success. We believe that Medicare is sustainable, fair and a responsible policy. Medicare is used and valued by older Australians. That is very important for us as an organisation representing that age group. In particular, seniors place great importance on the bulk-billing component. Finally, we believe Medicare has an important role in protecting against, and redressing, disadvantage.

CHAIR—Ms Reeve, do you have any comments?

Ms Reeve—No.

CHAIR—In your submission you say:

We question whether linking access to bulk billing to concession cardholders will achieve access, affordability and quality for these people—

you are talking about your constituency, aged between 50 and 64—

who may have limited incomes but who are not holders of concession cards.

Would you like to expand on that point?
Mr Deans—We see it as a bit of a hole in the model. Many of these people are retired, and in fact a lot of people in Canberra would be like this. They have gone into retirement aged 54 years and 11 months, they are not entitled to any benefits at all and their income does not necessarily give them the health card that goes with low incomes. We believe that is an issue that needs to be considered. All other concession holders and people of that age will benefit from the new package.

CHAIR—Do you see that there would be an increase in costs for that part of your constituency?

Mr Deans—An increase to government?

CHAIR—No, an increase in patient costs, in health costs.

Mr Deans—There would be, I would imagine. Currently they are not benefiting from it anyway, but I think if you set up a model where concession card holders receive that benefit, then this is a group of people who are in retirement whose income is on the borderline, because they do not necessarily have a lot of income, and they will be paying when other colleagues of the same age who may be unemployed will have the health benefit card and will get bulk-billing.

CHAIR—Could you extrapolate the situation of those low-income earners to other low-income earners who are not seniors? One would expect they would also have higher costs relative to their current health care costs.

Ms Reeve—Although our constituency is people above 50, it is clear that in many aspects they share characteristics with people in earlier age groups. We do see that that is a likely outcome, but we were not advocating specifically on behalf of that group. We are interested in the wellbeing of the whole community, but we have tried to confine our comments to those who are over 50. I think there is a concern still about whether access to bulk-billing will follow the concession card holder, so if you are a concession card holder you get bulk-billing if your GP is prepared to do it. That does not address the costs for other low-income people. We do not have evidence but there is some concern that costs for people not on concessions may go up and they may have a larger gap payment.

CHAIR—As a result?

Ms Reeve—Yes.

Senator KNOWLES—It is interesting, just on that point, because as you know there is no prohibition on people being bulk-billed who are not on concessions. What is your experience with—how would we describe it—the benevolence of doctors? With people who are over 50, low income and not on concession, do the doctors look at those people and treat them with sympathy or do they just say, ‘Too bad’?

Ms Reeve—Our impressions would be anecdotal, and impressions, but I would think that people experience very mixed reactions, depending on their GP. I do not know that there would be a general trend.
Mr Deans—I see it as changing over recent years. From my discussions with our membership as well as with the medical profession, I think there is less of that—as doctors may well put it—charity to that age group. I think that is a concern, that in fact the medical profession is changing in its make-up. I think that certainly, as the population ages, the medical profession is going to have to come to grips with that very issue. But obviously something needs to be done to ensure that they have the time—and therefore they are paid for that time—to service those people of any age but particularly those who are the older group in the seniors group, if you like, in retirement.

Senator KNOWLES—I notice you support and welcome the greater technical efficiency in the direct payment of rebates to GPs, and I can understand why. Senator Humphries was talking to one of the previous witnesses about the price signal that people would get under that proposed scheme that they do not currently get when they are just given a total bill. Most people do not know what it is made up of—they do not know how much is the rebate and how much is the gap. Do you believe, by having that price signal in the direct-billing situation, that people will have a better indication and understanding of what the gap is? Instead of it just creeping up, and they are not too sure whether it is creeping up because of a combined thing, they will be able to see from visit to visit whether or not the gap is actually increasing, because that is all they are paying and they are not having to run around to the Medicare office?

Mr Deans—I think seniors generally would understand very clearly what the gap is, if it changes—and certainly we do support just paying the gap and having the doctor claim the $25.05. I think they are very conscious of what they are paying and in fact the difficulty for many seniors is, of course, that it is not standard. If you go to several GPs for some reason—you might be moving interstate or travelling—that is not a standard fee, and I think that is the great concern to people. But I am sure, currently, they see it when it comes back in the cheque—if that is what they do, if they get the refund sent to them—and I think they have a good feel of what the gap is, of what the amount over the schedule fee is.

Senator KNOWLES—But under this proposal it will be an immediate reckoner, won’t it? So that if they went last week or last month and there was a gap of $5 and the next time they visited it was $7 or $10, to me it would be a more transparent thing to be able to say, ‘Hey, hold on, just a minute—I only paid $5 last time, why are you charging me $7 this time?’ Whereas when there is a rigmarole involved in running around and paying the whole amount, it is less clear.

Mr Deans—First of all, Senator, if you can direct me to the GP who is only charging $5 or $7, we will communicate that to our membership because—

Senator KNOWLES—They would all flock there.

Mr Deans—That is right—they would get a lot of clientele. I think you are right: you mentioned a trigger, and that is probably right. It is a smaller amount of money that people are paying and they may well see that change. I am not quite sure what they will do about it though, because people have a lot of confidence in their GPs. They do not want to move, so they are captured.

Senator KNOWLES—There is a lot of reverence for medical practitioners, isn’t there?
Ms Reeve—There is a lot of attachment. That is often a good idea because you get a more comprehensive view of your health situation if you are attached to one person over time. The other issue about change for the much older part of the population is that many of them do not have the ready means of getting around to wide choices of GPs. Unless they are in a small geographic area where there is an incredibly wide choice, they are locked in by the practicalities of where they can get to in a reasonable time of travel—what is on their bus run. The price signals are important but there are other things that also happen that constrain people’s choices in terms of costs. Certainly some of the information that we are getting back from members is that there are quite large geographic areas where it is difficult to find anybody that bulk-bills. So despite the figures of the averages across the country, the distribution of that bulk-billing of GP services is of interest because it appears that it is quite patchy.

Senator KNOWLES—I will just ask one final question: in your opinion, is access more important than bulk-billing?

Mr Deans—I would want to take that on notice. It is very difficult to answer off the cuff because I would think that, except in rural and regional areas of Australia, the majority of Australians have access.

Senator KNOWLES—It has been put to us, if I may just interrupt there, that there is no point in worrying about bulk-billing if you do not have a doctor to go to.

Mr Deans—Most certainly. The package does, of course, include a plan to solve that problem. But the feedback we have had in Canberra is that basically you cannot get bulk-billing. That is probably an overstatement, but Canberra is a market where you cannot go and get bulk-billed.

Ms Reeve—They are two necessary conditions. If you do not have a doctor at all, the issue of bulk-billing seems a bit remote. But if you do not have access because you cannot afford it, that is also an issue. They are both important considerations, rather than being alternatives.

Mr Deans—We see access as critical. Every Australian should have access to medical attention if they require it.

Senator KNOWLES—Some of the high retirement areas are the very areas where doctors are hard to find.

Senator ALLISON—I note that you welcome what has come to be known as the swipe card approach at surgeries and clinics. Have you had a chance to consider, as many other submissions have, the inflationary tendencies that are likely to arise from that measure, or do you not see this being an issue?

Mr Deans—We certainly have not considered that issue. It has not come to our notice from our membership that that is seen as an issue.

Senator ALLISON—If there was evidence that patients not paying up front would cause doctors to increase their fees—because it is not so difficult for people to find $5 or $10 as it might be to find $30 for paying the full amount up front—would you still be in favour of it, or could you imagine another process which might overcome that inflationary aspect?
Mr Deans—One personal comment on that matter is that doctors tend not to keep their debts themselves; they off-load them to collection houses or they sell them for two per cent or whatever it is, so they do get their money. There is no reason unless they are getting very busy and they cannot take any more customers—one way of controlling that is increasing the price. If that happened, certainly we would be one organisation that would be very concerned about that.

Senator ALLISON—One of the terms of reference—and I note that you have said you are not in a position to answer this but I am going to ask you anyway—is to look a bit outside the current Medicare square, which has optometrists, psychiatrists and GPs in it. The question is whether other allied health professionals should be part of that. It also involves looking at, depending on which camp you are in, practice nurses and nurse practitioners being much more part of our overall primary health care system. Yesterday we had before us some older women who were uncertain about that idea of going beyond GPs as their first port of call. What do your members think about that? Do they still see GPs as the centre point, if you like, or the main person to whom one goes in cases of sickness?

Ms Reeve—We have not tested that through the membership, but it did actually come up in conversations. We have been having the first national policy council of our new organisation over the last 2½ days, and it came up over lunchtime today. People were floating that around. It was something people certainly did not have a single view on, but they were pondering at the table what the impact was and what sorts of things nurse practitioners may or may not do. I think it will be some time before people will decide. It is mainly a matter of the confidence people have in who is doing them.

Mr Deans—I will add to that. I think that there should be some testing done in the area of nurse practitioners because—and you have obviously had personal experience—they do do a lot of the work anyway. So why not recognise that? It would also make it easier in regional and rural areas to have that professional person. We have had brought to us over the years the issue of the use of Medicare for dental and other allied services. The question that has always come back is: can we afford it as a country? It has never come through as a policy because, without knowing exactly what it might cost, although we know that has been done over the years, it was not reasonable to ask for that.

Senator ALLISON—I do not have graphs in front of me, but I think the data shows that the over-50s are more inclined to have health insurance than younger groups. You nonetheless say that the proposed extension of private health insurance to GP gap payments is a limited value initiative. Is that a view that is expressed by those people that already have private health insurance amongst your members, or is that just the conclusion you have drawn from looking at the package?

Ms Reeve—The latter. Certainly a lot of our members do have private health insurance and feel they have no option but to have it because they lack confidence that they could get access to public hospital services when they need them. So in many cases they feel that it is a forced choice rather than a consumer driven choice. I think the point we are making is that for some people the $1,000 itself is difficult, but that is not something that we have tested with the membership.
Senator FORSHAW—When you indicated at the outset that you represented senior Australians aged 50 and over, I thought, ‘I’d better join.’ I had better tell my local golf club, because they will not let me play in the seniors until I am 55. Your membership includes those aged 50 and over. You gave us some figures regarding income distribution for 55- to 64-year-olds on page 7 of your submission. What proportion of your membership would be earning a full-time income where they still have a family and dependants? I would have thought that there would be a substantial proportion from 50 maybe through to 55 and even 60 that would fall into that category. I am trying to work out how to say this without saying the wrong thing. It would tend to skew the data, wouldn’t it? You are covering a range of the age profile that clearly embraces not only people who are retired superannuants, pensioners et cetera but also people who are still actively in the work force—or, hopefully, in the work force—with all the responsibilities that they have.

Mr Deans—That is interesting. Our membership has changed over recent years. You would expect that with the so-called baby boomers coming through. The oldest baby boomer is 57; the youngest is around 40. So we talk about the baby boomers, but they are not one group. The oldest could be the parent of the youngest. In our membership, you are right: some families have three generations who are members of COTA National Seniors Partnership. Someone might be in their 90s, and the others would be aged around 70 and 50.

However, the average age of our membership is in fact 61, and so sometimes we are mistaken for an organisation of older old people. We may well have started off as that many years ago, and in fact 90 per cent of the people who join our organisation each month—about 5,000 people—are under 64; in other words, they are in the work force age group. We, too, hope that they are all employed, but we know that they are not, unfortunately. So it is difficult to just state some figures here and accept that it suits all of the membership. We do have people who are self-funded retirees independent of any social security benefit, and then, of course, there are people who are fully dependent on social security benefits.

Senator FORSHAW—That is not to say that the points you make are not relevant, because we know that people in the work force who are over and under 50 are also concerned about what is happening with bulk-billing and Medicare and are affected by it.

Ms Reeve—Although we have a large membership—and so, given the timelines that are put up for us, we try to test all of these issues with membership—we are actually not just representing the interests of members; we are representing the interests of the total age group. A lot of the work in this section has been drawing on contact we have had over the last six months with almost 1,000 mature age unemployed people. So we found the ABS data a bit startling: that so many people—33 per cent of the age group—were on government pensions and allowances.

We would not want to see disincentives to getting into work, because for most of them the reality is that they are going to have to take part-time work and not have a good income. We would not want to see losing your bulk-billing concession being a deterrent to taking up work that might become available. Our interest is in what sorts of things need to change—and a lot of them are around age discrimination—and what other sorts of mechanisms may lock people into poverty traps and into remaining on pensions and benefits. It is difficult anyway for that age group: the average unemployment time is somewhere around two years. So it is a very difficult
time of life. As you pointed out, numbers of them still have dependent children—so it is quite a tricky time.

**Senator FORSHAW**—That is very helpful; thank you.

**Senator STEPHENS**—Thank you very much for your submission, which does provide us a very different snapshot of the world and your constituency. Can you enlighten me a little bit about your recommendations. You have one recommendation about resetting scheduled fees, and you suggest that they should be related to performance outcomes. Can you tell us what kinds of performance outcomes you believe GPs should be assessed against in relation to those fees.

**Ms Reeve**—I think we were actually more recommending setting up a body to examine that and do that, rather than thinking we had all the answers ourselves. We did think that if to a large element you have public support for GPs’ fees, it is not exactly a private industry and so it would be reasonable to look at performance standards. You might even look at polypharmacy and all those issues that come up, or they might just be in the administrative areas. Our major point was that data suggests that the scheduled fee may not be adequate to sustain doctors in a way that would enable us to maintain bulk-billing, and we find difficulty, as a consumer organisation, when we have governments and groups like doctors’ associations just arguing with each other backwards and forwards about whether things are sufficient or not sufficient. So we are saying that perhaps there should be a mechanism set up with an independent body with terms of reference so that they can examine these things and make recommendations on them. It is more a concern to get some standing, so that the community can have confidence in what underpins the recommendations on scheduled fees.

**Senator STEPHENS**—Thank you for that. Just one final quick question that you might be able to help me with, given your constituency base: do you have any comments, or have any of your affiliated organisations made any representations to you, on the issue of the availability of Medicare benefits to veterans and the difficulties that they have in some circumstances?

**Mr Deans**—Is that because the veterans may be in a better position than the normal person?

**Senator STEPHENS**—Yes. Obviously it is not an issue that has been raised with your organisation or you would have understood exactly the complexity of the situation that veterans are in. It is really fine—I just wanted to know whether or not that had been raised with you, given the age group of your membership, that is all. Thank you very much.

**Senator HUMPHRIES**—I commend you on the point you make, first of all, about GPs in rural and regional areas. You make the point that initiatives to encourage GPs to set up practice in such areas would not be sustainable without measures to improve the overall economic performance of those areas. That is a good point which I do not think many other people have picked up on, and I commend you on that. I was looking through what you were saying and trying to piece together a picture of how we should deal with the issue of adequate funding of health services, based on the problems that you raised. You said that you did not support the targeting of people with concession cards, for a variety of reasons, including that it could motivate people to stay within the concession category. But you also warned about the danger of not providing subsidies for people who might be sick, because people might not want to attend doctors if they had a cost to meet in doing so.
It has been put to the committee that some rationing of health services is necessary given the political equation in this country that people are prepared to pay less amounts in tax and things like that. If you had, for argument’s sake, only the billion dollars or so which the federal government is proposing to spend now on these initiatives, and assuming that was the extent of tolerance of the taxpayer to fund health needs, how would you spend that billion dollars differently to meet the objectives and address the concerns you have raised in this?

Ms Reeve—If we were the government, we would be deciding how many millions or billions, wouldn’t we, and wrestling with the other things? As for the testing of the Australian community and taxation, there are a number of reviews on it. You might want to do more research on it and test that out. It is difficult to see whether rationing gets the services to the right people, and that is also a huge issue.

Mr Deans—You need to put access next to the rationing issue. If rationing affects access we would obviously be very concerned about that. If the rationing is related to overservicing, you could understand that. I do not think we could comment on how we would spend the billion dollars, Senator, because we have not done any work on that. You then go back to square one and say all the billions of dollars are in the total model and what you would come up with as a model might be the more appropriate way to start if you are looking at how you might spend the billion dollars differently.

Ms Reeve—Some of the rationing in the system already results in some practices that I do not think would be supported by the majority of the Australian community. We had some reported at our meeting this week where people over 75 who have a stroke are being denied access to stroke units because they have just decided that people over 75 will not have access.

Mr Deans—They are too old.

Ms Reeve—The huge discriminatory practices against older people are usually disguised a bit better than that, but they are there and they are real in terms of access to intensive care units and hospital and rehabilitation services sometimes on the grounds that it would be an apparent waste of money because they are too old, even though we cannot know that the 75-year-old might still be 25 years away from death. Suddenly these things are happening. As my colleague said, if the rationing is designed to deal with overservicing or unnecessary servicing that is one thing, but if it is just depressing use because people cannot afford it or they cannot manage the system I think that would not be acceptable.

CHAIR—On behalf of the committee, thank you very much for your submission and for making yourself available today. We will keep in touch with you, and if you have any further comments please do not hesitate to bring them to our attention. That completes our hearings here in Melbourne. It has been a long and very instructive day and I thank everyone for their participation.

Committee adjourned at 4.54 p.m.