COMMONWEALTH OF AUSTRALIA

Proof Committee Hansard

SENATE

SENATE SELECT COMMITTEE ON HEALTH

(Public)

THURSDAY, 5 FEBRUARY 2015

CANBERRA

BY AUTHORITY OF THE SENATE

[PROOF COPY]

INTERNET

Hansard transcripts of public hearings are made available on the internet when authorised by the committee.

To search the parliamentary database, go to:

http://parlinfo.aph.gov.au

SENATE

SENATE SELECT COMMITTEE ON HEALTH

Thursday, 5 February 2015

Members in attendance: Senators Cameron, Di Natale, McLucas, O'Neill.

Terms of Reference for the Inquiry:

To inquire into and report on:

a. the impact of reduced Commonwealth funding for hospital and other health services provided by state and territory governments, in particular, the impact on elective surgery and emergency department waiting times, hospital bed numbers, other hospital related care and cost shifting;

b. the impact of additional costs on access to affordable healthcare and the sustainability of Medicare;

c. the impact of reduced Commonwealth funding for health promotion, prevention and early intervention;

d. the interaction between elements of the health system, including between aged care and health care;

e. improvements in the provision of health services, including Indigenous health and rural health;

f. the better integration and coordination of Medicare services, including access to general practice, specialist medical practitioners, pharmaceuticals, optometry, diagnostic, dental and allied health services;

g. health workforce planning; and

h. any related matters.

WITNESSES

OWLER, Associate Professor Brian, President, Australian Medical Association

Committee met at 08:36.

CHAIR (Senator O'Neill): I declare open this public hearing of the Senate Select Committee on Health. Could I have one of the committee members move that we allow the media to record proceedings.

Senator McLUCAS: Certainly. I am happy to do that.

CHAIR: I welcome you all here today. This is a public hearing, and a *Hansard* transcript of the proceedings is being made. The hearing is also being broadcast via the Australian Parliament House website. Before the committee starts taking evidence, I remind all witnesses that in giving evidence to the committee they are protected by parliamentary privilege. It is unlawful for anyone to threaten or disadvantage a witness on account of evidence given to a committee, and such action may be treated by the Senate as a contempt. It is also a contempt to give false or misleading evidence to a committee.

The committee generally prefers evidence to be given in public, but under the Senate's resolutions witnesses have the right to request to be heard in private session. If a witness objects to answering a question, the witness should state the ground upon which the objection is taken, and the committee will determine whether it will insist on an answer having regard to the ground which is claimed. If the committee determines to insist on an answer, a witness may request that the answer be given in camera. Such a request may, of course, also be made at any other time.

I now welcome Associate Professor Brian Owler, President of the Australian Medical Association. I invite you to make a brief opening statement, and then the committee will ask questions.

Prof. Owler: I am a neurosurgeon but also, of course, President of the federal AMA, and I thank you for the opportunity to provide a statement to the committee this morning. I understand the committee is interested in the $5 cut to the Medicare rebate, the proposed freeze to indexation of the Medicare Benefits Schedule and, in particular, the government's process of consultation through both sets of co-payment proposals.

Let me start with the consultation process. I think it is fair to say that the government has not consulted with the medical profession—certainly it has not consulted with the AMA—in relation to either the first or the second co-payment proposal. I am pleased that the new minister is now embarking on a process of consultation and that it appears to be a constructive process. That is something that we welcome.

The lack of consultation really means that the decisions that were made in relation to, in particular, general practice were made on the basis of anecdote, personal assertion and, in particular, ideology. When you do that on the basis of no evidence and no data, ideology becomes the natural enemy of logic, common sense and, unfortunately, moderation. I think that is how we ended up with the poor proposals that would have very significant impacts not only on general practice but on, I think, the health care of Australians.

There have been a number of reasons given for the co-payment proposals that were put forward. One of those, of course, is a price signal. The very basis of a price signal can be one of two things. It can send a message about the value of the service that is being provided but it also sets up a barrier to care. For primary care, for general practice, where people access their first point of care, having a barrier makes no sense in terms of making our health system better and looking after the health care of Australians.

The other issue has been about the sustainability of our healthcare system. The data will show that our spending on health care is sustainable. The percentage of GDP that we expend on health care overall as a nation is on the OECD average and we get very good results for the amount of money that we spend. It has been rising perhaps one per cent over a decade, but you would expect that as a nation becomes more prosperous. Health is a superior good. We should be spending more of our GDP on health care as this nation prospers. The percentage of expenditure as a proportion of the federal budget on health care has remained stable—in fact, it has fallen. It was around 18 per cent in 2006-07, it went down to just over 16 per cent; in the MYEFO figures from last year it was 15.9 per cent. So we are spending less on health care overall.

Let me return to general practice, and particularly the impacts of indexation and the $5 cut to the rebate that have been proposed. This is not about the sustainability of Medicare—this is about sustainability for many general practices. We need to have viable and sustainable general practice. General practice costs the government a very modest amount, particularly for the outcomes that we receive, and this cut to the Medicare rebate represents a disinvestment in general practice. As I have said on many occasions, every country in the world knows that investing in primary care, in general practice, is about making sure that we keep people well and we keep them in the community, out of expensive hospital care. That is the answer to a sustainable health care system and it is important that we start to invest in general practice. The cuts are not about doctors' incomes—the cuts are

about the viability of practices, particularly those practices servicing low socioeconomic communities where the ability of people to pay out-of-pocket expenses is limited. It is the ability of those general practitioners to employ practice nurses, to provide services for their patients and to provide the sort of comprehensive quality health care that we need. There are things that we can do better. I think we can improve general practice and I think we can get better value for money. I know our general practitioners are more than willing to participate in those sorts of initiatives.

The Medicare rebate has been falling in real terms over decades. It is not indexed at the rate that is required; that is why we have had injections of practice incentives and other initiatives—team care arrangements, chronic disease management plans—that have supported general practice. The indexation freeze will mean that the Medicare system essentially will be dismantled, because as the rebate falls in real terms and remains at the same level, it means that the Medicare rebate no longer reflects the cost of providing the health care and it certainly does not represent the value of the health care that is being provided.

The other issue with MBS indexation, and it is one that I think has been particularly overlooked by this government, is the impact it is going to have on out-of-pocket expenses for specialist practice. We have to remember that the MBS indexation freeze which goes to 2018 is right across the board. All the private health insurers have a no-gap or known gap schedule. That is indexed in line with the MBS schedule.

Last year, in the last round of indexation, Medibank Private did not indexed their schedule and said that they would not do so until the government indexed theirs. The other health funds indexed their schedules, but it is hard to see them continuing to do that and absorbing the costs associated with indexing their schedules as the gap between the MBS schedule and their schedules continues to grow.

About 89 per cent of hospital services are actually performed and provided as a no gap arrangement. If the schedules for private practitioners or specialists continue to be frozen, it will mean that fewer people will participate in the no gap or known gap schemes. That means that, once you start to charge more than the schedule, the out-of-pocket expenses for patients skyrocket.

I want to give you an example. The MBS item number for craniotomy for removal of tumour is 39709. The MBS schedule fee is $1,586. So normally the patient would receive $1,190—that would be covered by Medicare—and $396 of the schedule is the extra, which is usually covered by the health fund. Health funds have their own schedule. For Bupa—and I just picked Bupa out of the air; I could have picked any of them—it is $2,586. That means the health fund covers $1,396 and the patient has no out-of-pocket expenses if that doctor participates in the no-gap schedule. However, if that schedule is frozen for four years, the doctor may decide to increase their fee, perhaps by four per cent, or $114, to $2,700. If the schedule is frozen, Medicare will still provide $1,190. The amount the health fund covers falls back to 25 per cent of the schedule fee, so it falls back to $396 and the patient is out of pocket $1,114. So a modest increase of $114 means that the patient is out of pocket not only $114 but $1,114. That is the sort of impact that these changes are going to have on the out-of-pocket expenses of patients seeking care within our medical system.

One final point I want to make is that the government has already made many cuts to the healthcare system. They are included in the amount that is supposed to go to the Medical Research Future Fund. Some $15 billion worth of cuts have already essentially been made through changes to public hospital funding, programs and agencies. That amount will be available for the Medical Research Future Fund, but we still do not have that set up. I think there has yet to be enough attention paid to the impacts that these changes are going to make on our public hospital system, either the direct changes to the funding of the public hospital system or the deleterious effects that these changes are going to have on general practice for people who then have to access hospital care in the future.

Thank you. I am happy to take questions.

CHAIR: Thank you very much. I might commence with a question and then I will move to my colleagues.

Senator CAMERON: Chair, just before you do, could I ask if Professor Owler has his opening statement in a written form? I would be interested in having a look at the detail of some of these figures that you have quoted, if it is available.

Prof. Owler: My words were not exactly written words. I have a summary here, but I can certainly provide you the numbers that I ran through.

Senator CAMERON: That is what I would be keen on.

Prof. Owler: No problems at all.

CHAIR: If you are happy to share it now, the secretariat will use your summary sheet to assist us in our questioning this morning. Then we might have something fuller from you later on, but we will also have a transcript, of course. That summary now would be extremely helpful, if you can manage to share it with us.

Prof. Owler: Yes. No problem.

CHAIR: My question goes to the issue that has exercised so much of the political energy and the goodwill of the AMA and it regards the abandonment at the last minute of the $20 consultation fee that was to be implemented for every Australian. Can I ask what the impact of that would have been and the process the AMA has been through? Could you put some words on the record with regard to that?

Prof. Owler: Sure. These changes were the third component of the co-payments announcement mark 2. They were the changes to the level A and level B consultations. They came as a complete surprise, and I have to say the amount of feedback that we had on that initiative in particular exceeded the feedback that we have had on just about anything else. I think a lot of people felt very insulted, particularly experienced GPs, who were saying, 'We can provide quality care in eight or nine minutes.' The issue is not whether it is 10 minutes or above.

I think what needs to be recognised is that quality should not necessarily be directly linked to time, but that is essentially what that proposal did. Of course, the level A rebate is defined as a simple matter. The rebate is $16.95, compared to a level B, which essentially provides for a consultation where there is a history taken, a diagnosis made and a treatment plan provided, which covers the vast majority of consultations. That rebate was $37.05. With the $5 cut to the rebate which was due to come in on 1 July, the rebate for a level A consultation would have fallen to $11.95.

CHAIR: How could the government come up with this sort of arrangement? How could it get to the point where they made a decision without actually speaking to you? Have you ever had that experience prior to this particular instance?

Prof. Owler: I think co-payment mark 1 and co-payment mark 2 were both instances where the announcements were made without any consultation with the medical profession. The announcements in the budget, I have to say, were a complete surprise. While we had speculation in the media from the Christmas before, the extent of the co-payment proposal mark 1, which included, remember, pathology and diagnostic imaging as well as going right across the board for general practice, took everyone by surprise. It was such a large extent. There were other things flagged in the Commission of Audit, but there was never any consultation process, any meaningful discussion about what would be included in a co-payment proposal or—the most important thing—the impact those proposals would have not just on general practitioners but on patients and our healthcare system.

Regarding co-payment mark 2, again we found out 20 minutes before the announcement was made. In fact, I was in the United States—

CHAIR: Twenty minutes!

Prof. Owler: in Chicago, in my hotel room, when the phone rang from the minister stating that these were the changes about to be made. But there was absolutely no consultation with the AMA. I understand you will hear from other groups as well. I suspect no-one else had any consultation about the impact of those changes.

At the end of the day, the people at the coalface who are actually doing this work know what impact these changes are going to have. We heard back from our GPs, who were able to articulate very clearly what the impacts for their patients and their practices would be. The fact is that many GPs just do not have the capacity to absorb those sorts of cuts. They are not going to start to spend an extra four minutes in the consultation so that they can get above the threshold. GPs do not work like that. Of course, if they did that, it would mean fewer appointment times available for patients and that would have an impact on access to services.

There are many people who cannot afford to pay large out-of-pocket expenses visiting a GP. While the AMA has always said that not everyone should be bulk-billed—there are people who can afford to be privately billed; we have always said that—we know that there are many vulnerable patients in our community who would be adversely affected by those sorts of changes, and that is why we oppose them so strongly.

Senator McLUCAS: Thank you, Professor, for appearing before this committee again. I want to go to the comments you made about consultation. You said that previously there had been none, and I think that is very clear, but that now the new minister is attempting to sit down with the AMA, and that is to be applauded. Can you give the committee an understanding of the nature of that consultation and the parameters of the discussion that you are having?

Prof. Owler: The discussions are reflected by what has been said on the public record already—that is, the minister is seeking information from not only the AMA but also other groups and individuals. She is trying to get across the portfolio, not just in terms of the issues for general practice and co-payments and funding, but across the portfolio generally. I was pleased that the minister was able to reverse those level A and level B changes, because it did create the environment where we could have some constructive discussions. The minister has said that the co-payment proposal remains the government's policy and they are committed to the price signal, but she is obviously open to listening to the views of general practitioners and doctors right across the country. I think that is the process that she is going through.

We have provided our views, which I have already talked about, about the need for investing in general practice. Certainly we are opposed to the $5 cut to the rebate and the freeze on indexation. That process is an ongoing process. While we welcome a very constructive dialogue with the minister, at the end of the day our response will depend on what decisions are made by the government and what the final policies end up being.

Senator McLUCAS: So to recap: are the conversations being held in the context of the same funding envelope? So the proposal to provide a price signal—I do not agree with that, but the government are saying that they need to put a price signal on it—with a co-payment is still within the policy of the government and that moneys to be cut, there is no other way to say it, particularly from the primary health sector are to go to the Medical Research Future Fund. Are they the consultation parameters?

Prof. Owler: I think it is fair to say that there are no hard parameters to the discussions at this stage. The government are clearly looking for savings, not just in health but across the board. They have flagged savings that they want to achieve. The discussions have not been around, 'We have to get to a particular dollar number by some other method'. My point to the minister and publicly has been that we should not consider the health system in silos; we need to make sure we consider the health system as a whole and how changes in one area, such as general practice, can have adverse consequences in other areas. We need to start considering things as a whole rather than just look at individual numbers. I have also said publicly that one of the reasons we are in this mess in the first place is that the changes that were flagged were always designed as fiscal measures, they were never viewed through the prism of health policy and I think that has been the failing of both sets of policies.

Senator McLUCAS: The government say very clearly that Medicare is unsustainable, that the reason we have to do all these things is because the current funding for health services in Australia is—they use this language of 'unsustainability'. You have used two measures in your opening address today to say that spending as a percentage of GDP has remained static—that is, growing one per cent in 10 years—but the percentage of the federal budget is static if not tipping downwards, frankly. How more clearly can the AMA say that this question of unsustainability is actually a furphy?

Prof. Owler: This is the narrative that had been built up by the government well before the last budget, that it is unsustainable and something has to be done. But the figures that were used by the previous minister of around 263 million free visits a year to the doctor were for a number of services, which included pathology and diagnostic imaging as well as the different services that GPs provide. It has nothing to do with the number of consultations, nothing to do with the number of actual visits to the doctor. When you look at the numbers in raw terms—and the government always uses raw figures when it is talking about the expenditure, because they sound like big numbers, and no-one has any context to put such large numbers into some sort of perspective, particularly when you look at the differences over a 10-year period—in fact the growth has been quite reasonable. I do think we can actually get more value for the dollar that we spend. We know that there is waste in the healthcare system. You would expect that, with such a large system. There are things that we can do to make things better. We can look at the number of tests that we order and the way that we order tests. There is a lot of appetite and enthusiasm within the medical profession to tackle these issues. Sometimes you actually have to invest to get those initiatives in place. There are a whole range. But the area that is the most modest area of expenditure, which is certainly not growing at an uncontrollable rate, is primary care and general practice. The most expensive part of the healthcare system is our hospitals, and that is because of, mainly, technology.

Senator McLUCAS: And an investment in primary care will eventually mean a reduction in the expensive end.

Prof. Owler: Exactly. As I said, every country in the world is tackling this problem. This is not new stuff. We know that we have an ageing population. We know that there is a growing burden of chronic disease. When people get over the age of, I think, 65, a lot of people have four or five chronic diseases, and these have to be managed. If they are not managed properly, that is when people end up in hospital. If we can keep people well, we can keep them in the community. The only way we are going to do that is by having strong general practice and primary care.

Senator McLUCAS: Thanks, Professor.

Senator DI NATALE: Professor Owler, I was not sure if I heard correctly. The changes to level A and B consults that were announced by the government—the first you heard of those was 20 minutes before they were announced? We have had so many iterations of this. I am not sure which one we are talking about. So the changes to level A and B consults—when did you find out about those?

Prof. Owler: I was sitting in my hotel room in Chicago just before the minister made the announcement, I think with the Prime Minister. I obviously did not see the press conference because I was overseas, but that was the first that we had heard about it. People sometimes criticise the initial response of groups like the AMA and others, but that is because in the first 24 hours we were still trying to work out what those changes actually meant and listening to our membership. Our membership came back very clearly in response, but that was the absolute first we had heard in relation to that. The rhetoric was that it was about tackling six-minute medicine, but I do not see how a proposal that has a 10-minute limit has anything to do with six minutes. It absolutely made no sense at all.

Senator DI NATALE: While they have dropped that proposal, they have continued on with the proposal for a reduction in the rebate of $5. The other part of the package was the freeze on indexation. You focused on that in your submission. My reading of the freeze is that it is as significant and possibly more significant than the $5 reduction in the rebate. We are freezing Medicare rebates out to 2018. I cannot see how a number of practices are going to continue to be able to bulk-bill if we freeze not just GP rebates but all rebates out for that period of time. Would you say it is as significant an issue as the co-payment proposal, in your view? Does the AMA treat that as seriously?

Prof. Owler: Absolutely. First of all, yes, it is across the board. The dollar figures are actually higher in terms of the amount that is potentially coming out in terms of savings. It is the analogy of the frog in the boiling water. It is one of those slow-burning things. You do not know until the last minute what the impacts are going to be. As I said, the impact in terms of having no relationship between the actual rebate and the cost of providing the services but in particular the value of the services being provided—that is what we are going to end up with. If people continue to bulk-bill on that basis—and this is not just applying to non-concessions over 16; this is right across the board, remember—then people are going to have to start to privately bill not just the non-concession patients but also those people on concessions and children as well.

Senator DI NATALE: Why has the debate been dominated by the $5 co-payment and we are not hearing much about the freeze in Medicare rebates? As you say, it is across the board. Over time, it will have a more significant impact than the co-pay. Why aren't we hearing more about it?

Prof. Owler: To be frank, it is of those things that I think people do not understand. Freezes were introduced, remember, by both sides of politics, so people have been less willing to talk about it. This is a real issue for not only general practice but also specialist practice. That issue, in terms of going away from the no-gap schedules and people having to pay much more out of their own pocket, is a real problem. We are going to see people dropping out of their health insurance because they are unhappy about out-of-pocket expenses. That puts more strain on our public hospital system. Health is a very complex area. Once you make these sorts of changes, it can have really far-reaching consequences. The $5 cut is something that people can understand. People can grasp it and they can see it. The indexation freeze is often thought of as a bit nebulous and that it probably has more to do with doctors' incomes, but it actually has to do with the whole healthcare system.

Senator DI NATALE: The minister has said that she is going through a consultation phase, but the government has also said that they are still committed to the $5 reduction in the rebate and the freeze. Have you discussed both of those issues with the minister? Do you see that there is any room for negotiation on either of those issues?

Prof. Owler: We have always said that we do not support any cut to the rebate. As I said, the rebate has been falling in real terms over time. This is not the time to be disinvesting in general practice. The proposal that is put by the government is just a complete shift from the government taking responsibility to straight onto the patient. The GP ends up just being the middle man. We have outlined our views on the indexation as well. The minister is on the record as saying that continues to be their policy, but she has said that she will continue with the consultation and has stated that she is happy to reassess those policies in view of the consultation process. For the moment they remain the government's policies.

Senator DI NATALE: It seems to me that, if you are going to consult with people but you are going into it with a fixed position on things like a $5 cut in the rebate and a freeze in indexation, it renders the consultation meaningless. Are you comfortable that there may be room to move on both of those issues?

Prof. Owler: I think there is room to move. The government has already shown that it can change—not easily, but it can change. It is also fair to say that this minister did not come up with those policies. They are policies developed by the previous minister. I do not think the consultation process is meaningless. The meaning will come out of the results of the consultations and any revision of the policies that is announced by the government subsequently.

Senator DI NATALE: So you are optimistic there could be a shift in both of those areas?

Prof. Owler: I am optimistic. We have until 1 July for those changes to come in, so we do have some time. The minister now has some time to go through that process. We also have a budget coming up in May, which is something that we will be watching very closely for the impacts on health, to see that there are no new nasty surprises that we spend the next 12 months talking about. The minister does have to be given the opportunity to have the consultation process, but obviously, at the end of the day, it depends on what the minister and the government decide are their policies going forward.

Senator DI NATALE: Without wanting to go into the detail of the consultation, what framework is there for those meetings? Are you meeting regularly? Do you have an ongoing structure around that? How is it working?

Prof. Owler: I have had fairly open contact with the minister. We have met on three occasions. In fact, we met her for the first time only several hours after she was sworn in as minister. I certainly have been grateful for having fairly direct access to this minister. I think that is a good thing. Although we do not have regular meetings set, we have been able to schedule meetings as required.

Senator DI NATALE: Can I just squeeze in very quickly. The means-testing proposal was floated by, I think, Mathias Cormann in an interview. He suggested that Medicare would be means tested. Has that been discussed in any of the meetings with the minister?

Prof. Owler: No, it has not.

Senator DI NATALE: Just lastly, there has been a lot of discussion about leadership at the moment. If there happened to be a new Prime Minister and you had to have a discussion with a new Prime Minister, what would your key message in health be for a new Prime Minister?

Prof. Owler: I think that whoever is in government or whoever is Prime Minister needs to consult with the profession and go away from being driven only by personal assertions and ideology and get back to looking at evidence and data. As I said before, the ideology that has driven most of these proposals has ended up becoming the natural enemy of common sense, moderation and logic. We need to get back to talking about good health policy and map out a program of how we are actually going to make our healthcare system better not only for general practice but across the board and to make Australians healthier and safer as well.

Senator CAMERON: In your discussions with the new minister have you been able to identify what the real reason for this chaotic approach is? Is it still a budget emergency? Is it sustainability or is it that you need to force more costs on an individual? What are the reasons?

Prof. Owler: I think that is a good question. We know what the narrative of the government has been. It has probably been characterised by all of those at various stages. I do not agree with any of those reasons. As I have said, yes, while we have a deficit, mainly driven by problems with revenue, the expenditure particularly in primary care and general practice is not unsustainable and it is not out of control. We do not believe in the idea of a price signal. Where people can afford to contribute, I have no problem with people making more of a contribution to the costs of their health care. But we do not want a price signal because a price signal essentially sets up a barrier to accessing health care. Particularly in primary care, the first step when someone has a problem is the key to prevention and the key to chronic disease management. That is not where we want a price signal.

That is one of the problems that we have had in justifying the changes that have been made. One issue that we still have is the Medical Research Future Fund. We all want a Medical Research Future Fund. I have done research, I have written many scientific papers from written grants and have sometimes been unsuccessful. It is very frustrating. More money for research would be great, but it should not come at the expense of sick people going to the doctor.

I think one of the worst things that we have had over the past eight months or so is this process of having researchers out there lobbying, ignoring where the money is actually coming from and essentially pitting researchers and GPs against each other. I think that has been a terrible episode. I think we should establish the medical research fund, because we actually have about $15 billion in savings over the next six years, which has essentially already been passed. There is no reason why the fund should not be in existence as we speak. It has been held hostage over the co-payment and I think we need to get away from that.

Senator CAMERON: So, fundamentally, this is about austerity? It is about budget cuts? It is not really about the future of health in this country; it is a bottom-line budget cut, isn't it?

Prof. Owler: I would agree with that. I think the proposals that have been made, as I have said, have all been fiscal. They have all been about saving money. No-one would introduce those measures if they were to look at the impacts through the prism of health. I think one of the most disappointing things over the past 12 months is that we have just had no health policy developed in this country. We need to get back to talking about how we are going to make the health system better. I am pleased that the new minister appears to be embarking on that process, but I think it has been a disappointing 12 months from that perspective.

Senator CAMERON: It is okay to say that the minister will engage in consultation, but if the fundamental position from the government is that you have to take money out of the health system and put it into budget repair, as the rhetoric goes, you are never going to reach agreement on that, are you?

Prof. Owler: As I have said, we do not agree with a cut to the rebate and we do not agree with the indexation freeze. I am hopeful that both sides of government, both sides of parliament and everyone in parliament will actually come to the same conclusion. We need to ensure that everyone opposes the freeze to indexation. We need to ensure that everyone opposes the $5 cut. I am hopeful that, through the process of consultation, by listening to GPs, groups like the AMA, the minister will actually come to the same conclusion. I think that is an important part of the consultation process. As you have alluded to, consultation is great but it is also the outcome that matters at the end of the day.

Senator CAMERON: We have been conducting these inquiries around the country. The latest round of submissions that we have have been consistent with the submissions we have had all through this inquiry. Do you get any feeling as to why the government do not understand what every other government in the world understands and that is primary care is absolutely essential? If they understood that, they would not be going down this path. Have you ever got any idea as to why they do not understand this?

Prof. Owler: I think that is a question for them.

Senator CAMERON: But you are dealing with them.

Prof. Owler: We were happy to help come up with something that was better. We were asked by the Prime Minister to come up with an alternative proposal. If there was going to be a co-payment proposal, we came up with one that at least protected general practice and that provided some investment and protection for vulnerable patients. But that was not good enough because it did not save enough money. It became clear to everyone that this was not about introducing a price signal; it was about saving money. I guess that has also been clouded by the idea that they were not cuts because the money was going into Medical Research Future Fund. Where is the fund? The whole fund seems to be an accounting trick to make the overall debt look better.

Senator CAMERON: So you are still none the clearer. Do you think it is a budget issue? The issue of sustainability and the medical research fund were just thrown out into the political ether, weren't they?

Prof. Owler: Yes.

Senator CAMERON: It is like one of the planes taking off from Baghdad airport and the foil getting thrown out, so people talk about something else and not the cuts? That is the impression I have got, anyway.

Prof. Owler: I think so—and an ideology that people should pay every time that they go to the doctor. I think that ideology has got in the way of common sense and good policy.

Senator CAMERON: The medical system is not a pure market-based approach, is it? It is not a market in the normal sense, is it?

Prof. Owler: There are many things that work like a market but, in fact, you do not necessarily want it to work like a market. You actually want people to access care. One of the problems we have got in this country is that we do not get people going to the doctor enough, particularly to their GP.

CHAIR: Which is why we have so many public health education campaigns to get people to go to their doctor.

Prof. Owler: That is right. Males, particularly in their 40s and 50s, are probably the worst offenders. You almost have to drag them kicking and screaming to the doctor. We need to be trying to encourage people to access their general practitioners, go and see them, have health checks, make sure there are interventions to tackle issues such as smoking and obesity and alcohol use, make sure their blood pressure is looked after and make sure their cholesterol is okay. That is what GPs do. They try to keep people healthy so that they do not end up having a heart attack and going through the hospital system, having bypass surgery, primary stents, ending up on all sorts

of medications and not being able to work because they have heart failure. GPs save the health system money in the long term.

Senator CAMERON: Going to that point, we had submissions from a group of doctors in Newcastle. As I am sure you are aware, over 130 doctors came together in Newcastle to look at these issues. Again, they made a similar proposition to this committee—that Medicare is being not only dismantled but destroyed. That Medicare will be destroyed is the argument from all of those doctors in Newcastle. That will have huge implications for fairness and equity in health care in this country. If that submission is correct, we should not pass any of this legislation in the Senate, should we?

Prof. Owler: No, absolutely not. But one of the problems that we have is how you are going to stop the freeze on the indexation, because as I understand it that does not require a change to the legislation. In fact, it does not necessarily require anything. That is a real challenge. It is not just about the $5 cut. I think we need to make sure that the indexation freeze is also taken off the table not just for GPs but right across the board.

Senator CAMERON: So communities around this country should be very concerned about the sustainability of their local GP practice under this approach. They should be concerned about whether they will still have access to GP services, because this policy could drive many, many GPs out of business.

Prof. Owler: Particularly those in lower socioeconomic areas that are serving underprivileged areas. That is one of the major problems with the issues of inequity that I think many of these measures have. They should be very concerned. They are very concerned. We have members of the public telling us that, and I am sure you have had many people writing to each of you, as have the members of the government.

CHAIR: Thank you very much, Professor Owler.

Prof. Owler: My pleasure.

CHAIR: You have given a great deal of clarity, once again, to the arguments we have heard about sustainability arguments from the government actually being a lie. From your evidence today we have begun to hear the stories of the impact on real people, and we will hear more about that coming up shortly. We will conclude hearing from you this morning, but you did indicate the goodwill of the AMA on advancing policy. You have had pretty much a shut door so far. In keeping an eye on the transparency of the process going forward, this committee would also be very keen to hear any suggestions you are putting to the government. One thing we need to do is put out to the public these sort of conversations, particularly given the turmoil that we see the government in at the moment. I think the public deserve this information as the process advances. If you could assist us by providing the committee with some information on a regular basis on how things are going, we will transmit that in a public way.

Prof. Owler: Thank you.

BURGESS, Dr Zena, Chief Executive Officer, Royal Australian College of General Practitioners

JONES, Dr Frank R, President, Royal Australian College of General Practitioners

[09:23]

CHAIR: Welcome. Thank you very much for joining us this morning. I invite you to make a brief opening statement and then we will continue with questions.

Dr Jones: Thank you for asking us to contribute to today's discussion. Thank you, again, behalf of my college for the opportunity to appear before the committee to outline our views on the proposed changes to Medicare. I think my colleague Dr Bastian Seidel, who you met through your inquiry when you were in Tasmania, informed the committee about the role of the college when he appeared before you last November. So I will proceed with sharing our perspectives regarding the current situation.

It is quite clear, to state the obvious yet again, that a strong primary care section in general practice has better overall health outcomes. A regular place for medical care is associated with a fourfold reduction in hospitalisation. Increased continuity of care leads to higher patient satisfaction and almost halves emergency presentations. When an admission does occur, the length of the stay is halved. General practitioners are clinical experts in providing personalised, high-quality care. General practice is a medical specialty in its own right and the only specialty with continuation of care at its core.

Australian general practice patient services have been unfairly targeted by the government to find savings within the health budget. GPs and practices are now faced with an ethical dilemma of providing ongoing quality care balanced against practice business imperatives. Please remember that most general practices in Australia operate as small businesses.

The government's changes in December lead to an unprecedented protest from GPs. Thousands of GPs contacted the RACGP with concerns regarding the changes and requested advice on how to implement them. Nearly 47,000 patients, GPs and other medical specialists signed our petition to the health minister. Others wrote to their MPs and displayed posters in their waiting rooms informing their patients of the impending changes. We do not often mount campaigns. We are an academic college. But this situation warranted an immediate response.

Needless to say, the college and its members do not support the changes. We have provided a submission that provides more detail on our issues with the model and the process used by the government to arrive at their budget measures. I would be happy to take questions on that submission. But first I would like to address the area for real reform and real areas for savings that do not threaten the sustainability of the primary health care sector or target the most cost-effective part of the health system.

There has been absolutely no debate about the cost of specialist services or hospital based care. Further health savings could easily be achieved through improved chronic disease management, amendments to the prescribing authority hotline, reducing hospital admissions through better investment in primary care and addressing duplication and inefficiencies in the current system. Quality can be promoted by reconfiguring the GP MBS attendance items to encourage in-depth consultations about diagnosis, therapeutics and prevention—the three areas that GPs are experts on. Voluntary patient registration as part of an implementation of the medical home will transform the way GPs practice and result in better health outcomes for all Australians.

We are operating in a very complex health environment. Life expectancy is increasing. The population is ageing. Chronic diseases are becoming more prevalent. New technologies are increasing the effectiveness of care but also increasing costs. Short-sighted changes will not respond to these challenges constructively. Our recommendation to this committee is that the government needs to take the time needed to undertake comprehensive consultation with the profession through the GP college, our colleagues and our patients.

Our college represents 29,000 GPs. We have recommended to government that it place a six-month moratorium on the proposed changes and establish a GP health reform expert group with representatives that include GPs, patients and representatives from the government. While I have had brief discussions with the minister since she took charge, the changes to the time for consultation went off the table. I understand that consultation will end in a couple of weeks, and this is simply not enough time to analyse and identify the serious implications of these changes and will likely result in more budget measures that damage the most effective part of Australia's health system. I have appreciated the opportunity to talk to you. I am happy to take any questions, thank you.

CHAIR: Dr Burgess, do you want to add any comments at this point?

Dr Burgess: No.

CHAIR: Dr Jones, there were a number of very important issues that you raised there, but can I take you to the final comment that you just made. We have heard this morning from the AMA, and it has been on the record on multiple occasions around the country, that consultation has been the thing that has been missing that has led to the most egregious decision making, which has everything to do with dollars and nothing to do with health policy. In your closing comments, you just said that you expect the consultation to go for only a matter of a couple more weeks prior to the government firming up, once again, another position, having already declared that they continue to remain committed to a price signal. Is that correct, and could you expand on that?

Dr Jones: Sure. We have had very brief contact with the minister, purely because of timing issues. We are meeting with her next week. Briefly we met her last week at United General Practice Australia, and she was very much in the listening mode, and that was good to hear, but the indications were that there was a time limit on the consultation process. I can give you no more information than that.

CHAIR: So there is a time limit on the consultation process with the new minister, but we do not know what the time limit is.

Dr Jones: Correct.

CHAIR: But you also said in your opening evidence that you thought there should be a protracted period, a moratorium of six months. Is that correct?

Dr Jones: We have asked for six months so we can all sit down and see what the implications of all the proposals actually are.

CHAIR: What we have seen so far is policy made in a vacuum, without consultation, and this brief period to make more policy, from a government that has a pretty bad track record—let's face it—should be of some concern to you and your members.

Dr Jones: It certainly is. As I say, we think that what we need to do is be able to advise government on the implications of policy changes. Their policies seemingly have been made on the run, with no consultation. Like my colleague Professor Owler, I also received a phone call about half an hour before the announcements were made. There was no consultation with our college or our members whatsoever.

CHAIR: This government is into pretty short time limits, isn't it: no consultation prior to the budget announcements, half an hour before they gave version 2 in December, and now, again, time limits on their consultation with the experts in the field.

Dr Jones: We believe so. We believe we have some positive solutions that can help government, and we are absolutely willing to talk.

CHAIR: Thank you very much for putting that on the record. Could I just go to the opening comments that you made about the better health that is achievable. You talked about a fourfold reduction, a halving of emergency and higher satisfaction rates. Could you take me to those two particularly: the fourfold reduction and the halving of emergency accesses if we maintain a proper primary healthcare system without a price signal.

Dr Jones: Certainly. There is very good evidence within Australia and overseas. You have to pick winners. The high-cost end of the system is hospitals. The high cost is within the emergency departments. We know that if you pick the winners, reduce emergency presentations, reduce admission and reduce time in hospital then you can save money. That has been well documented. It is evidence based. We know that. The question earlier on about government was: do they actually hear what we are saying about the efficiencies of primary care? I think they maybe hear but they do not listen. This message is so strong worldwide. The literature is so strong worldwide: if you have a strong primary care system, it is going to save money downstream. There is absolutely no question.

CHAIR: But the government have ignored that to date?

Dr Jones: Seemingly, yes.

CHAIR: Would you say you are concerned that they still might not hear it, considering we have heard that they continue to be committed to a price signal?

Dr Jones: Minister Ley, in our brief discussion last week, did acknowledge that countries with strong primary care did save money down the track. I am not sure whether she has taken it on board and what she is going to do, but she has certainly heard that message loud and clear.

CHAIR: But she remains committed to a price signal?

Dr Jones: As far as I am aware.

Senator McLUCAS: Thank you very much for appearing before the committee. I also want to talk about the consultation process. Did the minister indicate why there was a two-week limit on the consultation going forward?

Dr Jones: Two weeks?

Senator McLUCAS: Sorry, you said the consultation would end in a couple of weeks.

Dr Jones: That is our impression: that there would be a time limit on the consultation.

Senator McLUCAS: Did the minister, or anyone, indicate why there would be an end to this consultation?

Dr Jones: No. As I said, we have suggested at least a six-month moratorium so we can sit down and discuss this.

Senator McLUCAS: I have a question similar to one that I posed to Professor Owler: can you give the committee an understanding of the parameters of the consultation? Is the minister saying certain things are on the table but certain things are definitely off the table? You seem to be telling us that the minister has said very clearly that a price signal needs to be conveyed. That to me is a co-payment or a tax. So that issue is still on the table. I am just trying to work out what is in and what is out at the moment in terms of the consultation.

Dr Jones: At United General Practice Australia last week she said the same words—that Medicare was not sustainable, and the way they felt that they could do it was with their price signal. Now, that needs to be debated and discussed. I have just tried to outline the implications to you, as Professor Owler has. It will have huge implications for general practice. GPs will be faced with the ethical dilemma of whether they take a cut in their fees—especially after 1 July with the indexation.

By the way, the indexation for General Practice has been frozen for the last 18 months, as is. And now we have another three years ahead. This will put enormous pressure on general practices to provide quality care. It is about quality care. It is not about the numbers coming through; it is about the quality that we provide for our patients. And we know that if you invest in general practice, and prevention particularly, we will save money. People's outcomes are better; their health lifestyle is better. We know this.

Prevention is often forgotten in this discussion. When I see a patient I do three things. I make a diagnosis, I decide on therapeutics—that may be medication or it may be referral elsewhere—but also embedded in my consultation is prevention. Every single patient I see—every presentation—has prevention as a part of the consultation.

Senator McLUCAS: Coming back to the parameters of the consultation, the minister is saying that she is of the view that Medicare is unsustainable. That flies in the face of the evidence that we have heard from yourselves, from the AMA and, frankly, from almost every witness that we have spoken with. How do we make it plain to this government, or are they just not listening?

Dr Jones: It comes down to your ethical and philosophical point of view. Countries like Australia are relatively well off. It really reflects that fact that we have to have compassion and look after the more disadvantaged patients—people in our society. There is no question about that. We also know that if you invest in health—the social determinants of health are really important—you have a healthier population and a healthier workforce. So it flows on; it is an economic no-brainer.

Senator McLUCAS: I agree. Thank you.

Senator DI NATALE: Thank you very much for your submission. I want to go to a couple of things that were announced. I will go to changes to levels A and B—the short consultation change. I will be honest—possibly to my detriment. When the change was first announced my reaction was not, immediately, that this is a terrible proposal. It was that we want to encourage quality in general practice and we need to think carefully about ways of doing that. And at least we are opening up a debate. The position I came to was that, while the debate was being framed in terms of quality, it was really about cost saving. But at least we have opened up the space to talk about quality. Can you see any merit in a proposal that does change the way we incentivise quality—if, for example, we made changes to short consultations but we reinvested that in, perhaps, rewarding for longer consultations or other parts of general practice to reward quality, there might have been some merit to that proposal?

Dr Jones: I think, like yourself, that many colleagues did not realise the repercussions when the first announcement came out. But on the next day, very much there were repercussions.

Senator DI NATALE: I learnt very quickly, from my general practice colleagues, that they were not enamoured of the proposal.

Dr Jones: I think the evidence that time based consultations improve quality is relatively poor. It is not good but there is some evidence. In our modelling for government—this is one of the discussions we wish to have with them—we wish to remodel the ABC system. We have some ideas and we have done some financial modelling as well. Tagged on to that—very importantly—is improving the quality of care.

We have a proposal whereby the items of service would be reframed, if you like, and it would encourage longer consultations and disincentivise superficial consultations. Tagged onto that—very importantly—are payments for practitioners to provide quality care, for practices to be able to enable practitioners to do that, and, thirdly, reflecting the complexity of the local demography. We have modelling along those lines. So I think that we do have some potential solutions (a) to improve the health of the population, which is by far the most important thing, and (b) to help this government out of the dilemma that it is in.

Senator DI NATALE: The temptation for me is to focus on how ridiculous some of these proposals are, but I would like to explore perhaps a more constructive line of questioning. When you talk about remodelling to reward quality—we do have practice incentive payments, for example, which attempt to do that, and we have some item numbers around care planning and so on that are an attempt to move away from just fee-for-service to look at rewarding quality in general practice—are you talking about an expansion of practice incentive payments? Are you talking about changing the way we do our care plans? Do you want to perhaps elaborate a little bit more on that?

Dr Jones: Yes, I could certainly provide detail if the Senate are interested down the track, but, basically, certainly the Practice Incentives Program needs to be looked at very carefully. There are certainly some efficiencies and changes that could be made there. We would see the PIP thing continue within our new model but again reflecting the actual payments to practices, not just the practitioner, because the systems need to be in place. General practice is complex. We have to have appropriate recall systems. We have to have nurse practitioners. We have to have our nurses involved in all this. So it is not just straightforward A-B-C-D medicine. We have embraced teamwork in general practice. We do believe that the general practitioner is central to that, obviously. One of the things that disincentivises doctors from employing nurses is, for example, the nurse payment. It is very difficult to employ nurses with the change in some of the governments—in recent times, the Practice Nurse Incentive Program, for example. That has gone. There are lots of ideas that we have on which we would love to sit down with government and give them some solutions.

Senator DI NATALE: Let me ask you about a submission we received from the Hunter General Practice Association. They focus on unnecessary spending on pharmaceuticals, investigations and so on—what some people will call medical waste. Do you have a view on whether there is scope to achieve savings in those areas—

Dr Jones: I do indeed.

Senator DI NATALE: and what sort of framework would enable us to achieve that?

Dr Jones: I think there is a whole scope of efficiencies there, if we are talking money. For example, if I refer a patient to the emergency department and I have actually worked up a patient already with various blood tests, they are usually repeated.

Senator DI NATALE: Yes.

Dr Jones: That is one simple example.

Senator DI NATALE: Yes.

Dr Jones: General practice can also do things so much cheaper. There is a four- or fivefold difference. For example, if you take a skin biopsy in general practice, it is about $62. In hospital it is about $290. It is the same procedure. So there are huge opportunities for us to look at the whole system.

Senator DI NATALE: We keep hearing about that. There are countless examples of where we can get those efficiencies, but we are not doing anything about them just yet. We can have a conversation about it, and I know that in other settings there have been initiatives set up to try and do that. But how do we go from talking about the problem to actually starting to put some of this into practice?

Dr Jones: I guess it is a little bit like when I teach my registrars. I teach my registrars to have a conversation with patients, not just a consultation, so I think maybe now we need to have a consultation with government so that there is actually an outcome and not just a conversation. There are multiple examples that we as a college can provide to government where there are cost efficiencies. Again, I say that reducing disincentive via general practice is really not the answer to Australia's healthcare problems.

Senator DI NATALE: Let me ask you the same question I asked the AMA president. We could have a new Prime Minister next week. If you had one thing to say to an incoming Prime Minister about health care, what would it be?

Dr Jones: Countries with a strong primary healthcare system have better health outcomes.

Senator DI NATALE: They would argue they are strengthening our primary health system at the moment.

Dr Jones: Well, unfortunately, by the looks of the dollars and cents, they are not. There are multiple examples we have just given you.

Senator DI NATALE: Thank you.

CHAIR: So the core message is: don't touch Medicare. It is sustainable; leave it alone—at the very least. Don't break what's not broken.

Dr Jones: Absolutely.

Senator CAMERON: Welcome, Dr Jones. I think you have been a bit diplomatic this morning in some of your responses, where you said the government have 'seemingly' ignored the importance of primary care. All of the submissions we have are that there is no 'seemingly' about it. They have ignored it. Have you got a different view? Are you being diplomatic?

Dr Jones: As I say, we are an academic college at heart, but I believe that the College of GPs now has to be involved in anything that impacts on the quality of care that I can provide for my patients. There is no question that the proposed changes will cut general practice and its services and quality. Really, that is from my point of view as a GP. I have been a GP in my town for 30 years. On the quality I will be able to provide for my patients with these rebate cuts, we will have to have a serious look at our numbers in my practice and how we actually charge patients. The day of the announcement of the change in the A and B, when I received the phone call from the minister, we were having a practice meeting about how much we were going to have to charge our patients to continue. That is how close it was: three hours.

Senator CAMERON: We have not spoken about another issue. The whole system is very complex, and it is not just GPs; it is the hospital system and it is the university system that supplies the doctors into the system. What are the implications of these cuts to income for GPs coupled with an increase in costs to be educated to become a doctor? Has there been a discussion about that?

Dr Jones: This discussion is not about income; however, I can tell you that general practitioners are the lowest paid speciality in Australia. With these proposed cuts again threatening the viability of practices, why would a young doctor choose to be a general practitioner? It is going to make it very unattractive. You might as well go and be a salaried doctor in an emergency department, where you know what your income is. Who is going to want to come into general practice with all this uncertainty? So it will definitely have an impact, and we certainly have feedback from younger doctors about—

Senator DI NATALE: Do you mind me interrupting? Have you got any data on what this is doing for young doctors going into training at the moment?

Dr Jones: I can take that on notice. Certainly we have verbal responses from young GPs saying, 'Why would I bother?' We can certainly take that on notice.

Senator CAMERON: Dr Jones, you said that when you see a patient you do a diagnosis. That is the first thing, I think, and then you do therapeutics, and then prevention underpins. Is that correct?

Dr Jones: Yes, absolutely.

Senator CAMERON: If you look at this in the context of the political task to deal with Medicare, would you agree that the government's diagnosis is wrong and that the therapeutics they are using are the wrong therapeutics—

Senator McLUCAS: This is too poetic.

Senator CAMERON: and that prevention is not being done, surely?

Dr Jones: Generically I would say that is probably correct.

Senator CAMERON: Yes. So they are just not being professional about this?

Dr Jones: I do not think I should comment on that.

Senator CAMERON: Why not?

Dr Jones: Well, I think that their job is to govern the country. They have been elected by the people. That is what their imprimatur is.

Senator CAMERON: Okay. The Newcastle GPs have given very good and detailed practical submissions—not to say that all the submissions have not been practical, but these are the guys and women at the front line. They say in their submissions that the proposals for no indexation and the $5 co-payment are ill considered and have not been modelled. They say they will make Medicare unsustainable and in the long run will increase government costs, create barriers to care, create workforce shortages, put patients at risk and reduce infrastructure in the primary healthcare system. Have you got any difference on any of that analysis?

Dr Jones: No, I would agree with all of that.

Senator CAMERON: If you agree with that, what are the implications of Medicare being unsustainable?

Dr Jones: The implications are that you will have worse health outcomes. People will present to their doctors late, potentially more unwell, potentially requiring more investigation, potentially needing more hospital referral and emergency department presentations. The on-costs are huge. It costs $400-odd to see a patient in casualty for a semi-emergency. It costs $37 to see a general practitioner who is used to dealing with undifferentiated disease and using fewer and fewer tests.

Senator CAMERON: Senator Edwards, one of my colleagues, a Liberal politician from South Australia, says basically that if people are sick they will find the $5—it is a cup of coffee. But it is more complex than that and it is not just $5, is it?

Dr Jones: It depends on the maturity of our society—whether we believe we should have universal access to health care or not. We should have absolute equity to everybody, for sure. As a college of GPs, we have never been opposed to the fact that GPs can charge what they feel is fit. That is their own professional prerogative. Certainly, we have to protect our disadvantaged. We are altruistic. That is what we do. That is why we are doctors—we care for people.

Senator CAMERON: What would be the implications in rural and regional Australia?

Dr Jones: I am a regional GP. Very, very much. I work in a very low-socioeconomic area. We have a lot of opiate abuse, for example, and methadone—

Senator CAMERON: Can I just ask you where you come from.

Dr Jones: Mandurah, in Western Australia, an hour and a half south of Perth. We have a lower socioeconomic mix—social class 4 or 5. We have a large methadone-prescribed population. There is no way in the world that those guys have money to buy their drugs, but if we do not look after their problems to keep them away from drugs, if we start charging them, there is no way in the world that we are going to reduce the opiate abuse. So we bulk-bill them. That would be a really tough call for us in our practice.

Senator CAMERON: This is an interesting point you make. Drug abuse creates other social complications, such as crime.

Dr Jones: Of course.

Senator CAMERON: So this could actually increase the incidence of crime amongst addicted Australians, because they are just not getting the proper treatment.

Dr Jones: That is quite possible. We know there are social implications of health. If you do not get the things right at the start, the whole thing roller-coasts. That is a very simple example. There are multiple others.

Senator CAMERON: I have done a lot of negotiations over my career as a union official but, when you sit down at negotiations and there are polemics and you are poles apart, you are not going to come to an agreement fairly quickly. It seems to me that the organised labour in the medical area are poles apart from the government on this issue. All of the submissions say this is bad policy and it has huge implications in a whole range of areas. If there is a time limit on the process, how do you think we are going achieve a proper outcome?

Dr Jones: I think all we can do as a medical profession is present the facts as we know them and be sure that they are evidence based. It really is up to government at the end of the day what they do with that. They are the elected government. In all the submissions you have heard we think this is bad policy, it is not good for the health of Australia and it is going to have ongoing costs. How much clearer do we have to be?

Senator CAMERON: Has either the previous Minister Dutton or Minister Ley given you any evidence of the unsustainability of Medicare?

Dr Jones: No. We have read about it, but personally, one to one, no.

Senator CAMERON: So they just make assertions, do they?

Dr Jones: It is only what I have read in the press releases that they have made about Medicare. In one-to-one conversations that has not been talked about.

Senator CAMERON: Do you agree with the AMA submissions that per capita the actual expenditure has gone down?

Dr Jones: There is certainly good data on that. We have good data on that as well. If you actually look at the graph, it is very simple. GP co-payments are there and hospital payments are up there. It is a very simple graph, and I am sure you have seen that.

Senator CAMERON: I know that some of the GPs have said that you should look at the hospital system for savings. We need to be a bit careful about that as well, so we do not create a push into the hospital system to defund aspects of the hospital system, don't we? It is not a simple issue. It has to be evidence based, doesn't it?

Dr Jones: Health care is complex. Every country in the Western world is struggling with the fiscal responsibilities of its ageing population and its chronic disease. When I was a younger GP it was relatively straightforward. My patients are incredibly complicated now. My cohort of patients have grown older with me. Most of my patients are over 60 or 65. They have at least five to seven medical diagnoses; they are usually on about five to 10 different medications. It really is a different ball game these days. So general practitioners basically are now the expert general doctors of the 21st century. We know that if you invest in that it will actually save money in the hospital system. It is a complex discussion. The states fund their public hospitals; the federals fund Medicare. That is a political dialogue that really needs to take place about that system, because there is such a lot of duplication there. Again, it is not my brief today to discuss that with you.

Senator CAMERON: As a consumer or a patient—there are all these different things you called them—

Dr Jones: We call them patients, actually!

Senator CAMERON: As a patient you go in and you are thinking about medical issues. Do you think the population really understands that these are small businesses and they have all the pressures of small businesses, or do they see it purely in medical terms?

Dr Jones: I do not think they understand—but some do—the actual business implications. We know that intuitively patients know that GPs do a great job, and intuitive GPs do too. The problem with general practice as opposed to certain other specialities is that measuring outcomes is quite difficult. If you are a cardiologist, you know that if you put X number of stents in, you are going to get X number of good results. My patients might have seven interrelated medical conditions.

You mentioned research earlier on. In Australia, all the research funds primarily go into hospitals. Less than three per cent of medical research in Australia goes into general practice, and we see 85 to 90 per cent of the population annually. Now, if you are going to talk about research, let's talk about the money that goes into general practice. But, again, that is not our brief today.

Senator CAMERON: I want to come back to perceptions and understanding the practicalities of dealing with this issue. We have to try and deal with the issue. Have you seen any evidence that the government, the minister or the minister's staff understand the complexity of providing care while keeping a sustainable business? Has that fundamental issue been engaged with effectively by either of the two ministers we have had?

Dr Jones: I have not had that conversation with Minister Ley. We had a brief conversation with Minister Dutton. He understood the fact that health is important. He understood that putting some money into—

Senator CAMERON: Well, that is really good for a health minister—to understand that health is important!

Dr Jones: Indeed. He did understand that primary care is efficient but he also said that he wanted a price signal.

Senator CAMERON: Yes. So it is simply this ideology that you have to treat health care as a purely market-based issue.

Dr Jones: That is the impression that I was left with, yes.

Senator CAMERON: If they do that, then they do fail to understand the health, social and economic implications of what they are doing, don't they?

Dr Jones: Well, one would think so.

Senator CAMERON: Okay. Thanks.

CHAIR: Dr Jones and Dr Burgess, you would be aware of the *Medical Journal of Australia* article by Lourenco, Kenny, Haas and Hall, the most recent summary of concerns regarding the impact of changes to Medicare bulk-billing. It says:

… caution is needed when considering changes to GP fees and Medicare rebates because of the many possible paths by which patients' access to services could be affected.

And we have heard a little bit of that from you this morning.

I want to close with two questions. Firstly, the process by which the government was about to bring in the changes to levels A and B was by regulation, which was to get around the Senate. That should only be done in the most extraordinary circumstances and it should be done after consultation. We have established this morning there was no consultation. These processes reveal the arrogance of the government towards the profession and particularly the Senate.

Dr Jones: And patients.

CHAIR: And patients, at the core of it. Given the track record of this government and their very unusual way of manifesting their understanding of 'consultation', the concerns that you raised about only two weeks of further 'consultation', could you put on the record what it will mean, what it will look like on the ground, if the proposed changes that you have seen so far from the government go ahead? What will it look like in your practice, and how will it affect your capacity to run an effective business? This is a government that says it is the friend of small business; but, frankly, from every conversation I have had with doctors who run those small businesses, and practice managers, they have never, ever experienced such a tsunami of change as that foreshadowed prior to this last backflip by the government. So there are two angles there: the business angle and the impact on patients.

Dr Jones: I think it will be gradual. If it goes ahead on 1 July, I think most practices will sit down and refashion their business models. They will actually see what impact it is going to make on their practice. I think over a period of time people who continue to accept the rebate—I would rather use that term than 'bulk bill'—will find that their income will go down by between seven and 10 per cent. That is our modelling, approximately. It is going to be an individual practice and practitioner decision whether they do that.

CHAIR: So you think some practices will just hold out and continue to look after people?

Dr Jones: They will have to monitor it, because they have got to pay their staff and their mortgages; like every other business, they have to do that. They will monitor it very carefully. I suspect that most practices will do their sums and there will be a patient contribution.

CHAIR: So that will essentially change the way that Australians interact with their doctors?

Dr Jones: Yes.

CHAIR: You will have to have money in your pocket if you are sick because you will need that to access your doctor?

Dr Jones: Yes.

CHAIR: That is your prediction if the government continues?

Dr Jones: If it continues. It may not happen straightaway; but, over a period of months, after 1 July, if practices are doing their monthly financials, they will soon find out what is actually happening from their business model, and I think they will have to change.

CHAIR: So this is a government intent on destroying businesses and health at the same time.

Dr Jones: It certainly does not bode well for the future general practice of Australia if this position is maintained.

CHAIR: Thank you very much, Dr Jones. As I indicated to Professor Owler, given the uncertainty about the status of the government at the moment and the tenuous nature of the conversations which we might hope are happening—consultations seem to be occurring—this committee would be very happy to take submissions from you about the things that you are advancing so that we keep some of this conversation in the public place rather than behind closed doors.

Dr Jones: Sure. Thank you very much for your time.

CHAIR: Thank you.

JOHNSON, Ms Jennifer, Chief Executive Officer, Rural Doctors Association of Australia

[10:01]

CHAIR: Welcome. I invite you to make an opening statement and then we will follow with questions.

Ms Johnson: Firstly, I would like to table an apology from our president, Professor Dennis Pashen. He is unable to be present today. He is doing some locum work in Tasmania but he is going to be in Canberra next week and quite regularly thereafter. Senator O'Neill, he has an appointment to see you next week. We are also quite happy to organise appointments with other members of the committee at mutually convenient times. I point out that I am not a clinician, but if I cannot answer questions I am certainly happy to take those questions on notice.

I will confine my opening remarks to some commentary on the recent announcements regarding proposals for the MBS system and the various other changes that have happened over the last few months. The Rural Doctors Association of Australia is strongly committed to the provision of quality health care and the improvement of health outcomes in rural and remote communities. We welcome the intent in the recent announcement of the Minister for health to consult widely with stakeholders.

We believe there is a general willingness in the rural doctor community, in particular, to engage in discussions about future sustainable funding models which will promote accessible and high quality health care and sustainable rural practice. However, the consultation is really important because it is necessary not only to obtain a variety of perspectives, because none of us is experts in everything, but also to minimise the potential for perverse outcomes. I think that is really important.

We believe that a number of factors must be taken into consideration during these discussions, and I will summarise them briefly. Firstly, rural health outcomes are poorer—and I do not need to elaborate on this. We put some more statistics in our submission, but I am sure you are all well aware of that. Secondly, quality primary care provides a very strong return on investment for the healthcare dollar—and, once again, I will not elaborate on that in my opening statement. I am sure that there have been lots of stakeholders who have made that point.

New funding models must incentivise and reward quality of care. In addition to sustaining the longer term sustainability of Medicare, funding models should focus on quality rather than throughput and reward doctors who provide the services that are needed in their communities. This is especially important in rural communities, where we need to get the focus away from just having any doctor in the community for the sake of a number to having appropriately skilled and supported doctors who can provide the services that are needed in those communities. They must also build community and workforce capacity in terms of both numbers and skill sets. Once again, this is really important in rural communities, where medical services are very important in the social and economic fabric of those communities.

Detrimental impacts on rural practices will also flow onto other healthcare services in rural communities. I think this is an issue that is largely ignored. Rural doctors traditionally provide a range of primary and secondary care services and some tertiary care services. For example, a rural doctor who is working in his or her general practice will also most likely be providing visiting medical officer services to the local hospital. They will probably be providing mental health services and counselling, they will be teaching medical students and they will be providing after-hours and emergency services. They may be providing more advanced procedural services.

For this reason, there must be a holistic approach to developing and analysing the impact of the proposed policies. For example, if a rural practice is forced to close or it loses a doctor because of economic circumstances, then that will flow onto the local hospital, which will have less doctors to fill its after-hours rosters and to provide emergency and secondary care. This in turn will compromise the ability of communities to access after-hours services. It will lead to a downgrading of services in the hospital and then we get into that awful downward spiral. The unfortunate end point may be a total downgrading of services to those rural communities. Practices may be forced to cut back on staff and that not only impacts on service delivery but also has broader economic and social implications for the wider rural community, as I previously mentioned.

Economic fragility and uncertainty in rural practices limits the availability of training posts for GP registrars and students. This is another really important aspect. This is counterproductive, because fewer opportunities to experience rural general practice will reduce our potential pool of future rural doctors. The evidence is strong that students from a rural background and students and junior doctors who have positive and longitudinal training in rural areas are far more likely to go back and practice there.

General practices are also small businesses. Rural practices, in particular, tend to be more economically fragile. Because of their circumstances, they are less able to change their business models and particularly to change those business models quickly. Rural doctors often take significant business risks and they make considerable personal

investment in these practices. It is quite often difficult to recoup that investment. It is not unheard of for doctors to not be able to sell their practices and to just walk away from them if they have to leave.

The proposed freeze, for example, on the indexation of MBS rebates will make it even more difficult for rural practices. Many will need to pass on additional costs to patients. We then look at the combined impact of a co-payment and a freeze on MBS indexation, given that—say, in three years' time—it is going to result in a much, much larger out-of-pocket cost to patients than simply the co-payment alone. We cannot really consider any policy in isolation, particularly when it comes to rural areas, because it is a complicated network of service delivery and funding models. The current atmosphere of business uncertainty is making practice owners more reluctant to make significant practice infrastructure investments, particularly in rural areas. It is also making practices far more cautious about employing staff and particularly about employing GP registrars. This is something we are really concerned about.

This flows onto my last point, which is that general practice and particularly rural general practice must be an attractive career option. We are very concerned that the current atmosphere of uncertainty is deterring medical students and junior doctors from a career in general practice. Certainly, we are more concerned that the funding models will really deter them from rural general practice. The proposed deregulation of higher education may also have significant negative impacts not only on the capacity of rural and remote students to undertake medical degrees but also on workforce distribution. It is quite likely that students are going to choose to work in more lucrative aspects of the medical profession rather than in general practice and certainly in rural general practice. I am saying that purely from a business perspective, because we working very hard to make sure that rural general practice is seen as a strong and interesting career option for medical students. There has been a lot of good work done in that area. It would be a pity to be taking backward steps when we are just seeing positive progress.

There is also a strong need to provide prevocational exposure to rural general practice for interns and junior doctors, because they spend those years mostly in hospital based environments in larger metropolitan and regional areas. The previous Prevocational General Practice Placements Program provided them with that important exposure. We do desperately need a replacement for that program.

Just to summarise quickly: we believe that the circumstances and needs of rural communities and rural medical practices must be given particular consideration in the development of new policies and funding models. These circumstances include generally poorer health outcomes, maldistribution of medical workforce—and we are talking both geographically and in terms of skill sets—and the ongoing difficulties in accessing healthcare services in many rural communities.

It is important that the rural incentive programs, which are very welcome, are continued and we have supported the adoption of the modified Monash model as a new rural classification system that will be used to determine levels of incentives. We believe that is a positive step forward. Thank you.

CHAIR: Thank you very much, Ms Johnson. Can I just ask for a bit of an outline of the degree and nature of consultations you have had with the incoming new minister.

Ms Johnson: We have met with the new minister on one occasion to date and we have certainly flagged our willingness to engage in further positive and productive discussions. As I mentioned before, I think that there is a general willingness for the general practice community to engage in discussions about what funded models should look like into the future. We meet regularly also with the Assistant Minister for Health, Senator Fiona Nash. We are obviously willing and ready to engage significantly into the future, if that opportunity arises.

CHAIR: You have already been having regular meetings with the assistant minister, Senator Fiona Nash—

Ms Johnson: Absolutely.

CHAIR: Throughout the period since the Abbott government has come into being?

Ms Johnson: Yes. We have had regular meetings.

CHAIR: Would you call them consultations?

Ms Johnson: Yes, I would.

CHAIR: So there has been a degree of consultation that has been going on?

Ms Johnson: In terms of opportunities to put forward our policy, I have to say that the announcements regarding the MBS rebates, those sorts of issues, were a complete surprise to us as I think they were to most people. The government's intention to make those announcements was not flagged with us beforehand, so we had no idea.

CHAIR: So you must be a little concerned about the word consultation, given the fact that you are the first person actually to say to us that you have had consultations on a regular basis with a member who lives in a rural

area—now we have a minister who is from a rural remote area. In light of the fact that you have been having consultations, yet they went ahead with the extraordinary changes to policy—which we have heard this morning are based on ideology, anecdote and personal assertion rather than fact—how can you have any confidence at all that consultations moving forward will be any different?

Ms Johnson: We are just waiting to see to tell you the truth. In the consultations we had with Senator Nash, because obviously we had no idea that the Medicare announcements, for example, were even on the agenda, we have very productive consultations around the rural classification system, the need to design incentives to make sure that they were going to the areas where they were most needed with those issues. So we are hopeful and, as I said, we have made it perfectly clear that we are willing to engage in consultation.

CHAIR: So we have heard this morning about the primary healthcare access and the determination of the government to continue to advance a policy of a price signal and a claim about sustainability that is a lie. They are still going to push ahead with a price signal. Do you have any sense that in the forward consultations there will be any change to that policy about sending a price signal and getting between people and their GP?

Ms Johnson: I think that the minister has made clear that she is committed towards a price signal, and that is as much as we know.

CHAIR: Given that the government is committed to a price signal—and you have spoken about the already significant challenges for access to healthcare in the regions and remote areas of Australia—how can a price signal be at all palatable to GPs who practise in the bush?

Ms Johnson: I am not saying that it is, by any means. Once again, this price signal needs to be taken into consideration, in regional areas in particular, with all the other aspects. We have already stated that a co-payment—a price signal, for example—will probably impact more severely on rural doctors and rural communities. We know that rural patients are far more reluctant to seek medical assistance. That is for a number of reasons—one of which is access. Most times, they obviously have to travel much further to see a GP. We know that economic and social circumstances are quite often poor, and particularly economic situations. In rural communities that might not necessarily be reflected in eligibility for, for example, healthcare cards. So quite often in farming communities you will have people who are asset rich, for example, but cash poor.

One of our concerns is that, because rural doctors are integral parts of their communities, there is going to be increased pressure on them to waive putting increased costs on patients, because they know those people personally and they are aware of what their personal circumstances are. They are the people they meet in the street every day. It is going to put a lot of personal and business pressure on rural practices.

As I pointed out, the other issue is that the totality of the cost. There would be the price signal but the fact that the MBS indexation is frozen will mean that maybe in the first year the out-of-pocket costs will not be so great but, by the time the third year comes around and practices are forced to pass on those costs to their patients, the payment may be more significant.

CHAIR: So the gap between patients in the bush seeking care and their doctors is already larger than that for their city cousins and what is proposed by the government in terms of a price signal will further that gap and very certainly impact negatively on their health outcomes?

Ms Johnson: We are certainly concerned about the impact on access, and obviously health outcomes in rural communities are very strongly dependant on access.

Senator McLUCAS: Thank you very much for appearing before the committee today. I think you have covered the consultation issue fairly well. I come from a regional centre but grew up in a town of 1,000 people where there was one doctor. Over time we have seen, particularly in cities and regional centres, that the number of practices have coalesced and you are getting larger practices. That is good, because you can then have the capacity to buy in other types of services into a larger practice. But, if you take a town of 1,000 people, you probably have a one-doctor practice. Can you talk to the committee about the different business model that that small one- or two-doctor practice has compared to a larger practice where you may have five, eight or 10 doctors and allied health providers, practice nurses and probably someone like a practice manager. That does not happen in the little 1,000 person town. I am trying to understand the level of disproportionate effect on those small one- and two-doctor practices compared the larger practice.

Ms Johnson: As I mentioned, certainly the smaller the practice the more economically fragile the practice. The tradition used to be that a doctor would go out to a rural community and his or her partner would become the de facto practice manager, because there was nobody else available. I think that still happens to a certain extent. I think it impacts particularly on overseas trained doctors with very little experience who go to rural communities, and they are sometimes expected to run a general practice as part of their work in those communities.

The business of running a general practice, as I am sure you are aware, is becoming more and more complex. Not only have we the incentive programs, which, in themselves, require quite a lot of extensive knowledge and administration to make the most of, but also there are lots of red-tape requirements—reporting requirements. So what happens is that rural doctors, quite often, particularly in small practices, actually end up doing a lot of that stuff themselves, as well as attending to what is quite often a very busy practice load and after-hours workload.

That is the other issue. Having come from a rural area myself, I can remember that we would sometimes have to sit in the waiting room—and people did it quite happily because they understood what the burden was on the doctor, but it was not uncommon to go or to ring up and be told: 'No, Doctor is out at an emergency; ring back in three hours time and we'll see how they're going.' That doctor would then, let us say—having maybe been up half the night delivering a baby—get to their practice at nine o'clock, see a full workload of patients, go off to see outpatients at the hospital at lunchtime, and then attend to heaven knows what during the day. That is a huge load, both personally and professionally.

I think one of the important things that we have to do is to look at different models and, particularly, to look at ways in which we can make one-doctor towns into two-doctor towns, or improve the support base, because the other thing that has been shown is: that is a significant deterrent to attracting younger doctors to rural and regional areas. You get a critical mass and people are more inclined to go.

Senator McLUCAS: Have you said these sorts of things to Assistant Minister Nash?

Ms Johnson: Yes. We have. These views are always brought out in our submissions.

Senator McLUCAS: So she knows—

Ms Johnson: Yes, I think she does.

Senator McLUCAS: that the proposals that the government has put forward will have a disproportionate effect on rural doctors?

Ms Johnson: We have made that view quite clear. We have made that view clear in the media. We have made it clear in a number of meetings that we have held with elected representatives in parliament.

Senator McLUCAS: Have you done any modelling on it? I am not talking about the health outcomes. I am actually thinking about the small business considerations around a one- or two-doctor practice in a regional town. It is a hard thing to do—I understand that—but have you done any work on trying to work out how disproportionate the effect on a small practice would be compared to a larger practice? I am not saying that it would not be impacted as well—

Ms Johnson: We have not done any specific modelling in this instance. A number of years ago the Rural Doctors Association of Australia, in conjunction with some other stakeholders, completed a very large project on viable models in rural general practice. I think that the principles around that are still valid. I think the work definitely needs updating, but it is work that would be quite worthwhile to do, I believe.

Senator McLUCAS: Thank you for your evidence today.

CHAIR: Thank you, Senator McLucas. Dr Di Natale?

Senator DI NATALE: Thank you very much, Ms Johnson. There has been a lot of work done in trying to recruit young doctors into rural environments. It is a tough gig, and workforce challenges are ongoing. Have you got any anecdotal evidence to suggest that some of the changes occurring in general practice are dissuading new graduates from deciding to embark on a career in general practice in a rural or regional environment?

Ms Johnson: I think that, because most of those announcements have been recent, it is a little bit too early to tell. What is concerning for us is that we have had reports from rural doctors who say, 'I do not know if I'm going to be able to take a GP registrar next year,' or, 'I used to take three GP registrars; I'll probably only take two.' There are a number of reasons for that. One is that there is this whole atmosphere of business uncertainty. People are not willing to make new investments because literally they do not know what their source of income is going to be or the quantum of the income from that source. That is largely determined by the government, through the MBS rebates—particularly for practices that rely on bulk-billing.

CHAIR: Was that exacerbated by the determination under Minister Dutton to push ahead with that regulatory change that was held up at the last minute? Is that critically a part of this increasing business uncertainty in the bush?

Ms Johnson: I think there is a number of factors there that all contribute to the uncertainty. The fact that there have been changes announced and then more changes. People at the moment are just waiting and seeing. That is unfortunate—

CHAIR: We are all waiting and seeing.

Ms Johnson: If you are looking on from the sidelines, that, combined with the announced changes to GP-training arrangements and the abolition of the PGPPP, will deter some medical students from choosing General Practice as a career at a time when we really need to be focusing on continuing to grow our own medical workforce and when we are starting to make significant progress through rural-training pipelines towards attracting and retaining young, highly skilled and motivated doctors to the bush.

Senator DI NATALE: To carry on from that, the outcome for patients in a regional or rural or remote community is that they will not be able to see a doctor. If they need to see a doctor, they are going to have to wait longer and/or face higher out-of-pocket costs. If we train fewer doctors, that is the reality for someone living in an environment like that.

Ms Johnson: Absolutely. Even though we are making strides, the maldistribution is alive and well. As I also said, we need to get past this place where any doctor is good enough in a rural community. Rural people are entitled to the same access and standard of health care as their urban counterparts. There is a special and wide range of skills that are needed in rural areas. It is a great investment in the long term, but we need to work on it.

Senator DI NATALE: The government has said that if you do not like their proposals, you should come up with new ones. Have you suggested anything to the new health minister that may provide savings as well as improving the quality of care?

Ms Johnson: We are certainly actively working on some options and we will be putting them forward to everybody. Once again, I have to stress that it is really important that these conversations include a wide range of stakeholders—we all have different perspectives. In order to avoid as much as possible unforeseen and adverse consequences, we need to have a broad range of perspectives and stakeholders really need to be brought on board. I think there is a willingness there for dialogue.

Senator DI NATALE: That is the sense I get, too. Do you have any suggestions? Rather than looking at primary care and the language around price signals—which, we have heard a million times, is not going to do anything to improve the sustainability of health care but just shifts the cost onto patients—what would you do? If there were a few things you could change in health, what would you do?

Ms Johnson: We would certainly be looking at ways in which to reward care quality and continuity of care. Rural practices do a lot of that already, and that is really important. Perhaps item descriptors that focus on quality care rather than throughput—maybe some sort of blended funding models—

Senator DI NATALE: Let's explain that for people who are not clear about blended funding. Are you saying fee for service could be one part of how doctors earn their income but it should not be their only source of income?

Ms Johnson: It may well need to be, and it already happens to some extent with rural doctors who also obtain income from providing state based services to rural hospitals. It may also mean looking at the way in which the funding is provided for longitudinal care of chronic disease. That is one issue. We have, together with the AMA, often looked at the rural rescue package, which we are in the process of updating. There are loadings for the isolation in which a service is delivered and also the complexity of that service, so you are rewarding doctors who are providing the services that are needed in the locations where they are needed. There are a number of options around that. Obviously, there are other areas of the healthcare system where there is a potential for quite significant cost savings as well. Particularly in rural areas, it really has to be a holistic approach. Rural health services are just like a big jigsaw puzzle: if you take one bit out and you are left with an incomplete picture and possibly an incomplete range of services.

Senator CAMERON: Ms Johnson, you indicated that your organisation had some discussions with elected representatives in the bush. Do you represent rural and regional?

Ms Johnson: Yes, we represent regional, rural and remote doctors.

Senator CAMERON: How many engagements have you had with elected representatives on a formal basis?

Ms Johnson: We have had regular meetings, as I said, with Senator Nash. We have met with backbenchers, we have met with senators, and we also met with the Minister for Small Business to talk about the issues that were impacting on rural practices as small businesses. We have met with both members of the government and members of the opposition to put forward our views and to obviously advocate strongly for high-quality health care in rural communities.

Senator CAMERON: Given the outcome of the last election, you would have met predominantly with National and Liberal Party members in the rural and regional sector?

Ms Johnson: We make a point of meeting with politicians, elected representatives, of all political persuasions to get our message across.

Senator CAMERON: That is not the point. I am not accusing you of bias or anything. I am just saying that the practical implications of the last election are that, predominately in rural and regional Australia, there are Liberal and National Party members. That is the point I am making. It is not about any bias or anything like that. Do any of them get it?

Ms Johnson: They are aware of the difficulties in accessing health care. I am quite sure that they are aware in their local communities. We have encouraged our members to contact their local MPs with their concerns. I am sure they do. I am quite confident that a number of them have raised those concerns.

Senator CAMERON: In public, have you seen any comments on this from any of those coalition MPs in rural and regional Australia, defending Medicare?

Ms Johnson: I am not aware of a lot of the public announcements, but, as I said, we have made our concerns known privately.

Senator CAMERON: Wouldn't you think that one of the tests of how effective your consultations and lobbying have been is whether a coalition MP comes out and says, 'Rural and regional doctors have got this right. We just can't continue down this track'? Wouldn't that be the test for how effective you have been?

Ms Johnson: We do obviously work very hard to be effective and to advocate for our members and for our communities.

Senator CAMERON: They do not get it, do they?

Ms Johnson: I would not say that.

Senator CAMERON: In your discussions with either the junior minister, Senator Nash, or the rural and regional coalition MPs, have you been able to understand what this is all about? Is it about a budget emergency? Is it about sustainability of the system? Is it about a medical research fund? What is your understanding of why this massive attack on Medicare is being undertaken?

Ms Johnson: The very clear and consistent message that we have been given is concerns about the ongoing sustainability of the healthcare system, and that is why we have been saying that we are certainly prepared to engage in productive discussions to make sure that the healthcare system is sustainable going forward.

Senator CAMERON: So do you disagree with the AMA? Does your organisation have a different view from the AMA, the Newcastle doctors groups, the college, consumer groups and the academics that have given us evidence to say Medicare is perfectly sustainable? Do you have a different view on that?

Ms Johnson: No, we do not have a different view. I think what we are saying is that we would consider any number of proposals, but they must be considered holistically, particularly in light of the way in which services are delivered in regional, rural and remote areas.

Senator CAMERON: Yes, because one of the arguments we have heard is that, if you put the co-payment in place, if you are in a metropolitan area there is another option for a patient. That other option is to present at the emergency area of the hospital. In a rural area—I used to live in Muswellbrook—if I could not afford to go to the local GP, it would be the same GP I would present to in the emergency at Muswellbrook hospital.

Ms Johnson: Yes.

Senator CAMERON: So that is an avenue that is not available to many rural and regional Australians, isn't it?

Ms Johnson: That is another issue that we also made. Another point that we made post budget was the fact that any increase in presentations to outpatients and emergency in rural areas is going to result in one of two things: it is going to result in the local doctor being called away from his or her practice or being called after hours—so it is going to mean an increased workload—or it is going to mean, unfortunately, emergency transfers, which come at an enormous cost.

Senator CAMERON: Has Senator Nash confirmed that this is about budgetary issues in your discussions with her?

Ms Johnson: I do not recall Senator Nash specifically making those comments, but certainly the general impression that I have received in our discussions is that the major concern is the ongoing sustainability of our healthcare system.

Senator CAMERON: Has she presented any evidence at all about the unsustainability of Medicare?

Ms Johnson: I have to say that we have not really discussed the sustainability of Medicare per se specifically with Senator Nash. Our discussions, as I said—before the budget and before this last round of announcements—have been focused on rural, regional and remote incentives. As you are aware, there was a lot of work around that. We have made our concerns known to Senator Nash about what the impacts may be, and I am sure that she has taken that on board.

Senator CAMERON: So you have done that one on one?

Ms Johnson: Yes.

Senator CAMERON: And she has not been able to advise you as to why in the view of many of the submissions we have, even from the AMA, this could destroy Medicare? You have not raised that with her?

Ms Johnson: We have not raised specifically the issue of the ongoing sustainability of Medicare. As I said, we have provided her with our responses to these announcements and to the budget announcements when they were made.

Senator CAMERON: Do you agree with the proposition that the policies that the government is promoting could destroy Medicare?

Ms Johnson: I have to say that I do not think that as an organisation we have discussed that in any specific detail. Given the fact that I am the chief executive officer and obviously very keen to reflect our policies, it is not something that I would be prepared to comment on at this stage.

Senator CAMERON: Given the importance of Medicare to your members, do you think that you may now—after hearing the AMA, reading the submissions from the Newcastle doctors and looking at the college's submissions—want to raise the issue of the future of Medicare with the assistant minister?

Ms Johnson: This is certainly an issue that is, as I said, on our agenda and we are engaging in some more detailed policy work to actually put forward some proposals that we see would promote and ensure the provision of continuity and quality of care in an economically sustainable way.

Senator CAMERON: If Medicare collapses all the incentivisation that you are talking about would be really under a cloud, wouldn't it?

Ms Johnson: Obviously one of our considerations would be maintaining Medicare.

Senator CAMERON: Yes. Do you intend to continue to raise these concerns with rural and regional members of parliament? Would your members have some plan to actually get a change in this destructive policy?

Ms Johnson: We will be continuing to raise these issues. We will be continuing to meet regularly with elected representatives to put forward our policies and certainly to advocate for our members and for our communities.

Senator CAMERON: Given that the minister has not been in a position to tell you whether it is a budget emergency, sustainability or the research fund that is creating this chaotic position, have any of the local members been able to advise you as to what this is all about?

Ms Johnson: Well, once again, as I said the response from members was consistent. My recollection of their response was that there were concerns about the sustainability of the healthcare system and that measures were important.

Senator CAMERON: That was assertions from them, was it—no evidence; just assertions?

Ms Johnson: Yes.

Senator CAMERON: Okay. Thanks.

CHAIR: I want to ask for clarification of a couple of things. Firstly, 'regularly meeting' what does that mean—weekly or monthly?

Ms Johnson: No. We have limited resources, particularly in terms of getting our president and whatever to Canberra. We would aim to have our president down here every couple of months and then we would organise some meetings as people's times permit.

CHAIR: Okay, so every couple of months. I note that Dr Jones in his evidence this morning alerted the committee to the reality that there may be only two more weeks of consultation with the new health minister before more policy seems to be ready to be formulated. You are talking about preparing documentation. Do you have an appointment to see the new minister within the next two weeks?

Ms Johnson: No, I was not aware of those timeframes.

CHAIR: So is that a concern to you, Ms Johnson?

Ms Johnson: We have made it quite clear that we think it is important that extensive consultations take place before any new policies are developed. Obviously we would be concerned if that did not happen.

CHAIR: In the evidence you gave this morning you indicated the interconnectedness and the perverse outcomes that have been delivered by the policy that has been made thus far. What sort of a timeframe would you like? We heard from the RACGP this morning that they thought a six-month moratorium on any further decisions needed to be called as a minimum to allow for a reasonable period of consultation. Do you share that view?

Ms Johnson: I do. I think our members would share that view. These are important decisions. If, as I said before, we are going to consider how all the issues interrelate and get that rural perspective then we would need that length of time.

CHAIR: So predominantly regional, rural and remote communities that are represented in large part by Liberal-National Party members need to let their minister know very promptly that two weeks is a completely inadequate timeframe to give consideration to the impact of policy making on them, their health and their families in the bush.

Ms Johnson: Certainly I think we need much longer than two weeks to consider new policies and certainly what their implications might be.

CHAIR: Thank you very much, Ms Johnson.

Proceedings suspended from 10:44 to 11:01

ALEXANDER, Dr Graeme, General Practitioner, Claremont Village Medical Centre

BONNEY, Professor Andrew Drummond, Roberta Williams Chair of General Practice, Graduate School of Medicine, University of Wollongong

KAMERMAN, Dr Ian, Private capacity

PEARCE, Dr Colin James, Clinical Director, Charlestown Square Medical Centre

TERRY, Dr Richard, Practice Principal, Whitebridge Medical Centre

VAN LEEUWEN, Dr Fiona Joy, Vice Chair, Hunter General Practitioners Association

Evidence from Dr Alexander was taken via teleconference—

CHAIR: I am very glad to welcome GPs who have kindly given up their valuable time to speak to us today. Your experience at the patient coalface is very valuable to the conversation that we need to have at this time. We are delighted that you are able to join us and we have an hour allocated for this conversation. We will have many, many questions for you.

I would like to offer you the opportunity to make a one- or two-minute opening statement to get perspectives across the range and then we will go to questions. I will commence with Dr Alexander and ask you to be very mindful of the time: one to two minutes.

Dr Alexander: I will be very mindful of the time. I sent in a submission which I think covers this. I work in a large general practice which I run in a low-socioeconomic area with 12 other doctors. We add up to six full-time equivalents. We have a practice we are very proud of. There isn't anyone in the room there—and I am sorry I am not in that room but it was a bit short notice. As a GP, I would rather talk to people face to face.

I am not going to talk for long, because I have tried to educate politicians, journalists—you name it—over the last decade. The most effective thing I find we do as GPs is to have politicians and therefore decision makers asking questions of us rather than us telling them.

I commend the committee's decision to listen to grassroots general practice. There is no better example of the consequences of the failure to do this than the policy fiasco of the past few months. I encourage questions and questions about solutions.

CHAIR: Thank you very much, Dr Alexander.

Senator McLUCAS: Dr Alexander, I remember sitting in your surgery about 10 years ago and you explaining how Medicare worked to me. It is nice to be back with you again.

CHAIR: Professor Bonney, would you like to make an opening statement?

Prof. Bonney: It is really two statements, one as an academic and the second as a GP.

CHAIR: Thank you.

Prof. Bonney: The first is that internationally we know, and there is no doubt, that jurisdictions with strong primary care also have lower costs and reduced rates of health expenditure increase. At worst, in comparisons among countries in Europe, strong primary care is associated with lower levels of health expenditure increase even if the baseline healthcare costs were higher in the first place. So there is no conflict between seeking to contain costs and improve health outcome, providing that it is recognised that serious policy investment in primary care is the vehicle.

Seeking to contain costs by providing price signals via increased co-payments will not achieve either cost containment or health outcome goals, especially where such measures disproportionately weaken primary care. The current evidence and my experience anticipate that the result of increased co-payments will be reduced access for those most in need of care, later presentations of illness, and unplanned admissions to hospitals with ensuing higher healthcare costs. In the longer term, the disinvestment in primary care, in my belief, risks creating structural weaknesses in the health system which could take a decade to reverse.

In my own experience in a town of 3½ thousand, where I bulk-bill 80 per cent of my patients because they are either unemployed or on sickness benefit, I know full well what the outcome will be if, over the next four years, there is a freeze on Medicare and our practice is unable to sustain that level of bulk-billing. It will be that those patients do not present to us when they need care; they will present 20 kilometres away at the local hospital and have higher healthcare costs as a result and poorer health outcomes for the community.

CHAIR: Thanks very much, Professor Bonney. Dr Kamerman?

Dr Kamerman: As doctors, we are very aware that the human body is a complex system. Changes brought about by disease or injury can often bring about both predictable and unintended outcomes. So as a doctor it is certainly no surprise to me and certainly my colleagues that small changes to Australia's health system that are designed to bring about an outcome will also produce multiple significant unintended and adverse outcomes. In essence, you cannot just make one or two changes. The whole system may well come crashing down.

The recent mooted changes to Medicare payments for general practice were introduced without any consultation with the profession by the government or by the department. As a doctor who believes in evidence based medical practice, I believe it would be logical to fund Australia's health system on the basis of the evidence that exists that will provide the best health outcomes for the health of Australians: the triple aim of efficient, effective and better care for individuals. Given that general practice in primary care has an overwhelming degree of evidence behind all of the above, it is highly illogical for the government to seek to remove billions of dollars of Medicare funds from general practice over the course of the next few years and to do it selectively to general practice.

I would like to talk further about the aspects of the business of general practice. To cut the talk short, I suppose it is a concern to me as a business owner and operator as well as a GP that there is no funding now, essentially, to support the actual practice of general practice. Certainly it is marginal at the moment, and, with the changes to indexation, the gap between expenses and income is going to increase from marginal to about $100,000 a year that I am going to need to make up in costs and income in my practice. Either I am going to have to put staff off or I am going to have to increase patient fees to do that over a period of time. Currently, my non-concessional patients pay a $35 gap. That gap is going to increase to about $60 or $65 if I am going to stay afloat as a business. It is certainly much more than what has been talked about as the cost of a latte. Either that or I am going to need to cut out bulk-billing altogether.

The last short point I would make is that I am really concerned about the effects on GP training. I think this is all going to be a huge disincentive to doctors wanting to do general practice. I do not think, though, that the government and the department have looked at funding for GP training. Certainly these Medicare changes will impact on training practices significantly. And I do not think anyone has actually surveyed the Australian public as to whether they are prepared to pay a co-payment for the cost of training a GP in my practice.

CHAIR: Thank you very much. Dr Van Leeuwen?

Dr Van Leeuwen: It is my honour and privilege today to represent the newly formed Hunter General Practitioners Association as its vice-chair. Many thanks for the opportunity to address this inquiry. I wish to apologise on behalf of our chair, Dr Tony Isaac, as he could not attend today. I also wish to acknowledge Dr Lee Fong, who, as our secretary, has contributed in a major way to our submission and papers.

I and my colleagues Dr Colin Pearce and Dr Richard Terry represent three of the major practice styles that deliver the majority of care in this country—that is, solo GPs, corporate groups and small to medium-sized GP owned practices. We in the Hunter region have a history of involvement in innovative solutions to the wicked problems that health service delivery throws up at us. We have a gold standard after-hours service. We have been instrumental in bringing integrated, clinician led health pathways to Australia from our colleagues in New Zealand. And we have formed an alliance framework between the local health district, the Little Company of Mary Mater Hospital and the Medicare Local, to name a few.

We recognise that our current systems are flawed. We are not here today purely to criticise and bemoan the status quo but to engage collaboratively to seek improvement and, to this end, efficiency, care provision that leads to good health outcomes for our patients, and a healthy, sustainable workforce. These initiatives must include targeted education and continuous quality improvement to be a part of our business as usual.

Redesigning health is like building an aeroplane in the sky. Our patients, our community, are our passengers. They rely on us to build it well and, as crew, to keep the plane in the air and to land it safely. We do not have all the answers, but, if we are the crew and our passengers, our community, our patients, collaborate strongly, we are a highly skilled force to be reckoned with, full of hope, passion, commitment and possibility. The plane we build together will do the long-haul flight and land our patients safely. The risk of getting this wrong is real, but the risk of not embracing innovation and collaboration is much greater and the cost much higher.

In conclusion, we urge against any further erosion of what is an essential part of the Australian healthcare system—that is, general practice. We urge against proceeding with both the GP co-payment and the freeze on MBS rebates. Limit the damage with regard to both financial and human currency. Instead, use our collective knowledge and experience to help to begin to craft a health system that can improve the patient experience and improve the health of all Australians. We want your help to rebuild the trust. Please let us use this opportunity to

take the first step towards working in partnership with grassroots general practice for a health system that will meet both the healthcare needs and the financial challenges of Australia for generations to come. Please find our submissions as tabled.

CHAIR: Thank you very much, Dr Van Leeuwen. Can I say for all of us that we are very impressed with the quality of the submissions, and we sincerely thank you for the effort that you went to in preparing them and getting them to us. Dr Terry?

Dr Terry: Just to get my statements in perspective: my other two interests apart from being a solo GP of some 32 years standing are that I teach medical students within the practice, and I have a particular interest in targeted educational programs for GPs. I commend the members of the Senate have a look at one of the programs I have developed about preventing hospital admissions in a primary care setting, which is a 10-week program. That is a good example of what GPs on the ground do, not in liaison particularly with the college; it is just something we do ourselves.

I would like to thank the commission for their excellent interim summary that they put out. It was interesting to read that, seeing that they listed a large number of peak bodies who had not been consulted around these health changes.

CHAIR: Dr Terry, are you referring to our interim report that we tabled?

Dr Terry: To your own interim report, yes. I thought it was an excellent summary.

CHAIR: Thank you.

Dr Terry: And I think that, in the same way as the science of climate change is in, the science of general practice and primary care is in. Anyone who has spent more than a couple of dozen—or at least a couple of dozen—hours actually taking the time to read the various submissions by the various health institutes around the country would quite clearly say that not only was general practice not overfunded but it is probably underfunded, and it should be the major part of the solution.

What interested me in solo general practice was how many practices in Australia are actually represented by solo GPs. Numbers are really hard to find, and I will give you some stats that I did find. The total number of GPs in Australia, as far as I can see, is about 43,000. It is interesting that the RACGP, who presented here earlier today, say they have a membership of 28,000 GPs and, by their own admission, they are an educational body. That leaves at least 15,000 GPs in the community. Essentially, taking both of those numbers into account, there are 43,000 grassroots GPs who represent thousands of patients who have not been consulted on these healthcare changes.

From the Primary Health Care Research and Information Service coming from Flinders University, I was able to drag out figures from 2010-11, and it is interesting when you do the math. It seems in 2011 that 35 per cent of the total practices—that is, the bricks and mortar we walk into, the buildings—were actually inhabited by solo GPs. Even if that data has dropped now, which I suspect it has, it could still be 20 to 25 per cent of practices which are solo GPs.

I would just like to draw attention to the financial vulnerability of solo practice. I have been in solo practice for a long, long time, and for the last 10 to 15 years we have suffered a lack of indexation medical rebates—10c a year on some rebates. Many of us in solo practice have stayed in practice for the love of our patients, because our actual remuneration, which is the money left in the pot at the end of the day, has been going down as the cost has increased. It is hard to gauge. Certainly if that Medicare level B fiasco had gone through, you would have seen practices dropping by their thousands, because you simply would have had to close the door because you could not afford to keep it open. I think that the co-payment and the lack of indexation again have the similar effect.

CHAIR: Dr Terry, I might just interrupt you there. We will get some more evidence from you as we go, but I just want to go to Dr Pearce, and then we will come back to a more fulsome conversation.

Dr Pearce: Madam Chair, thank you for the opportunity to address this inquiry. I have submitted my opening address really as a document. It has very similar messages to the other submissions that you have heard summaries of.

In summary, the doctors who I represent all believe that the proposals of no indexation and the $5.00 co-payment suggested to keep Medicare sustainable will in fact do the very opposite: they will make Medicare unsustainable. They need to be taken off the agenda. And we are here as a panel today to discuss the reasons why that should happen and to come up with ways for health funding and better solutions.

Having said that, on my 4½ hour drive here last night I came up with a little answer to a question that has been going around in my head since chairing a meeting, which is: why do GPs feel so insulted and undervalued by

being given this legislation to cope with? And I thought of a big company analogy, and most people involved in any big company will understand this. The company is called 'Health'. We have a huge number of consumers—probably 20 million; I am not sure of the population in Australia now. They have a very high expectation of what health they want delivered. That starts a preconception in this country, and it goes to the last breath.

The executive of the company, Health—the CFO, the CEO and the chief operations officer, who would probably equate to the Treasurer, the Prime Minister and the health minister—decided that Health is not sustainable. They need to reduce the spend on Health, or it is all going to fail. They decided to attack GPs without consultation and simply just offer them the legislation, saying: 'As of this date we are going to do this; as of this date we are going to do that.'

How did GPs react to that? It is like a performance review without the opportunity to speak for yourself. On one hand, they say: 'You're doing a great job—you spend $5.1 billion of $62 billion health expenditure, and that expenditure has not gone up in 10 years. We really respect how efficient you are. But do you know what? Our hospitals are bleeding—they are bleeding money. You have only got to look at the graph presented by the RACGP to realise that. So what we have to do is get you to work harder. You need to be more efficient and you need to collect money from your patients on our behalf to try and make this sustainable.'

In response to that the GPs said at the meeting, 'We have three options. It is like any bad relationship—we can absorb the pain and just try and put up with it and hope that we survive and get what we can out of the relationship while we are still in it; we can leave the relationship'—and leaving the relationship will be to retire early if you are an elderly GP—'move sideways and retrain or forget Medicare completely and just charge what you think what you are worth, which is going to create huge barriers, or not join the profession in the first place'—and we are all going to have workforce issues with that; 'and the third option is to negotiate and try to save the relationship, which is worth saving.' Really, I think that is why we are all here today.

CHAIR: Thank you very much for a well-articulated summary of the situation which we find.

Senator DI NATALE: You are a marriage counsellor now, aren't you?

CHAIR: I think the funding for marriage counselling has been withdrawn, hasn't it?

Senator DI NATALE: That is true.

CHAIR: So we are in all sorts of bother at a whole lot of levels. Some of the language that we heard in your opening submissions was about feeling insulted, the break of trust and about illogical action not based on evidence. All of these are things that we heard in our 15 inquiries prior to the interim report—which I am very pleased that you have acknowledged. It is a very good record of the perspectives across the country. Despite the fact that it is on the record, though, we still have a government that continues to say that we must send a price signal. So today we are particularly keen to hear what it means on the ground. We have heard some commentary on the business impact, but I would like to ask a really basic question. Has the current uncertainty around policy had impacts already on the health outcomes of your patients? Have you seen reticence to seek help? Have you seen concerns amongst people? Have you already seen an impact of flow to emergency? Would someone like to take that question? I see Dr Van Leeuwen is nodding and then we will hear from Dr Pearce.

Dr Van Leeuwen: Interestingly, the week after the budget announcement we had a 20 per cent reduction in patient attendances. This quite possibly has started to return back to baseline but it has taken a long time and it probably has not completely resumed where it was.

CHAIR: Is that of concern to you and why?

Dr Van Leeuwen: It is of concern to me because, even though we know that we can gain further efficiencies from our consultations, healthcare is now so complex we need to supervise patients regularly—their managements and their treatments—and treat them opportunistically and preventatively.

Dr Pearce: I would concur with that. There were actually three periods of reduced demand on appointments. Probably the government thought, 'This is great; this is working.' But in actual fact it means that people are avoiding care because of price points. People do not really fully understand announcements. The budget announcement in May said that there was going to be a $7 co-payment. We were inundated. Our secretary spent seven or eight phone calls each day explaining that had not come in yet. There was a drop in appointments. My appointment times went from about a one- to two-week wait down to about a three- or four-day wait.

CHAIR: As you say, though, the government thinks that is good. What we want to understand from you is why you think it is bad.

Dr Pearce: Take a simple example of a child with an ear infection. You have a new parent and they have a one-year-old child with an extreme fever. Those kids look sick, they do not want to eat, they are pale and they are

very hot—and the parents are extremely anxious. I think the people who are being least acknowledged in all of these debates are actually middle-income earners who do not have a healthcare card. So they are new parents and they have got lots of costs. If they come and see me I am going to charge them. Co-payments have existed for years. They were $10 about 10 years ago and they are now $35. So we get a 50 per cent rebate. If they come and see me, my general policy would be—unless I feel very sorry for them and I can see their financial distress—to charge them a gap of $35. So for a standard visit it would be $70. In about eight or nine minutes, I could very adequately assess that child, work out that they did not have meningitis or urinary tract infection, find the focus for the infection, treat that appropriately, and reassure the parents and prevent them from presenting to hospital.

Now, if you take it on the other side, they say: 'I don't actually need to see Dr Pearce today. The kid's really sick. Maybe we should go to the emergency department.' In their mind, they are doing the mental arithmetic: 'Well, that's $35 to see the doctor. He's going to prescribe some antibiotics, because the child's under two and is septic or very sick from the ear infection, so that'll be another $15. Then we've got to get some Panadol or some Nurofen; there's about another $20.' These are parents earning a middle income, with no other subsidy, and they are faced with a bill of $120, out of their pocket, when they pay tax, and they expect some form of medical insurance for that tax. So, they present to the emergency department, where it is all free. But, in reality, as we have heard earlier, it costs $500 for that encounter. So, you are looking at a cost to the government of $37 to pay me to assess that child efficiently versus $400 for them to present to the emergency department. Of course that $120 or so that those people are going to have to pay to see me becomes a price barrier. There is no other way to look at it.

Prof. Bonney: Perhaps I might add to that. The premise of the price signal is that people are unnecessarily seeking health care and that it was for trivial reasons and therefore it was a waste of the taxpayer's money. We know health-policy-wise that the things that improve overall health outcomes are four components of primary care. The first is access to care, and following on from that, once they are in the primary care system, is continuity, comprehensiveness and coordination.

But perhaps I could just illustrate two cases from my own practice within the last fortnight. We are in a small town, and we are under-doctored, so my waiting time is two or three weeks, or longer. And to try to improve access, because we are dealing with so much chronic disease, we have an hour walk-in clinic in the morning. So, if there is an acute problem, you can just turn up and we will see you. That might take only three or four or five minutes, particularly if it is for a work certificate or something, where we can usually knock it off pretty quickly. But, of course, people just turn up because people do not go to university to learn medicine just so that they can manage their families. So, within that walk-in clinic, the people turning up just for things like, 'I'm a bit worried about this, Doc' included two patients who had lost sight in an eye because of diabetic haemorrhages and a fellow who had a lump in his groin, which turned out to be lymphoma. They are all things that obviously are going to take longer than five minutes. But just having a walk-in clinic so that people can access care when they need to means that people with very significant, serious things can have those picked up and dealt with quickly. Now, if we had just standard appointments at standard rates, I am not quite sure when those folk would have turned up. But by improving access to care—because patients do not understand sometimes when they truly are ill—you can prevent an awful lot of grief and mortality down the track.

The other thing is that about 10 per cent of my patients are Aboriginal. Those folk do it very tough, and a copayment for my Aboriginal patients would significantly restrict their access to our care. And I know just from prescribing and medication that the Close the Gap incentive, such that Aboriginal patients do not have a copayment for their medications, has made a huge difference. But, prior to that, we would just keep a stock of medication, because the next question I would ask after trying to sort out what was the problem would be: 'Have you got the cash for the medication? And, if you haven't, then let's sort out some samples for you until you have the cash to be able to do it.' It is a very, very real need.

CHAIR: I want to ask some questions about turning the GP into the financial counsellor as well as the doctor, but I am mindful that Dr Alexander is sitting there at the end of the phone, and I am very aware of the demographic of large sections of the Tasmanian community. I just want to invite you to make comments in light of what has just been said.

Dr Alexander: We have seen a massive impact from these changes that were overturned and the changes still being threatened down the track. I work in Tasmania, in a lower-socioeconomic area. Tasmania has the worst-performing health system in the country, full stop—probably with the exception of some of the Aboriginal areas. We have the worst performing public hospital. We have the oldest population and the most diseased population. So the rest of Australia should be looking to Tasmania to see what the future problems are that we are going to face in health care.

There have been huge outcomes from these proposed changes by the government. I am just going to point out: it is disappointing that there is not a government member, as far as I can gather, there today. There should be. This should be beyond politics. We have been waiting, and Senator McLucas will probably back me up on this, for years for a non-political health policy. We need to talk more about health care than Medicare. Health care is what we are after. With this hearing coming up, I decided to look at some of the literature that backed up the value of general practice. It dawned on me, after some hours of looking through endless surveys about the value of general practice, that the decision makers—the politicians, the health departments—know our value. It has been told; it is there in black and white; it is everywhere. I did not choose in my submission to endlessly put how valuable we are as GPs because everyone knows this. The problem we have is that, despite the decision makers knowing it, we do not understand, as GPs, why the policies simply come out to undermine general practice. That is the problem this committee should be looking at. Why do we have the evidence but come up with policies in completely the other direction?

There is another devastating flow-on from what we have had to deal with over the past few months—that is, the morale of our existing workforce and particularly our young workforce. I was encouraged to go to an AMA meeting—I am not an AMA member, I am not at college member for reasons I can happily go into—and I tried to encourage young GPs to also go to this meeting. We had two doctors under the age of 45 at that meeting, and the average age was over my age and over 60. The damage this is doing to our workforce is an ongoing damage while we do not get these issues resolved. Hopefully the government will particularly withdraw the two policies we should be looking at, which are the fixed rebate and the $5 co-payment. It is so easy to explain the damage they will do; it is just the basics of health care. It is affecting the morale of our workforce and we do not understand—I would like to ask the four senators, if I am allowed to ask a question: we do not understand why there is this disparity between the evidence and the policies that come from all parties—

Senator McLUCAS: That is our question, Graeme!

CHAIR: We have the same question. We are getting the evidence and we are hearing you loud and clear, and we keep asking why the government continues to move in this direction. I also note that there have been a few comments here about the department and their role in consultation, which seems to have been absent as well. The department will be joining us later this afternoon and we might have some questions about that. I will go now to Senator McLucas with some questions to follow on.

Senator McLUCAS: Graeme, that is our question as well. We have had evidence from the AMA and from the RACGP, and everyone who has come before this committee makes the case that we actually do not—there is this 'problem', this 'dreadful unsustainability' that they are asserting. I think that every witness who has come before us has said that there is no problem. Dr Van Leeuwen, you said the system might be flawed but it is not unsustainable. All of our witnesses have said we can do things to fix this, to fix the system we have that we call Medicare, but that essentially it is a good system. Dr Terry, can you talk to me about a concern I have about the disproportionate effect on small practices? I was very interested in your comment that 35 per cent of GPs are operating in single practices. That is much higher than I thought it would be.

Dr Terry: It surprised me—that is from 2011—but as I said I suspect that is a lot lower now because of the fact that more people have been forced out of practice. There are a lot of people my age, in their early 60s, who could walk away from general practice now—and may have to because of the cost of general practice. In my practice, I could have four or five doctors working in my building as it is big enough; it is totally equipped in all of the surgery rooms. But the amount of money, proportionally, that it takes for me to run my surgery, being a sole practitioner, is much higher. Again, the rural doctor people talked about this earlier on; it is particularly hard in the country.

If I could just read one little email—I moderate an email mailing list from GPs as well as being on the national doctors email list, and there has been massive debate among the list, massive debate, about this—one of the GPs said: 'The Senate needs to know that, if the current trend to freeze Medicare rebates and remove the item numbers continues, there will be a point reached where there will be a massive exodus from bulk-billing patients. GPs are now close to that point.'

The point I would like to make is that we do not want to be forced down this road to a user-pays system such as exists in America, where 'user pays' is synonymous with 'medicine for the rich', and the disadvantaged and the poor do not get access to health care. One of the powerful things about Medicare, I think—and it is a cherished institution in our society, by both doctors and patients—is that it already has the infrastructure set up; it is a manageable thing. The people within it have to be accountable, and it is actually equitable. But we do not want to be pushed to the point where we have to charge people to survive.

Senator McLUCAS: I find it quite extraordinary that, at the moment, America is trying to establish something that looks a little bit like Medicare, whereas our government is actually trying to—

Dr Terry: Trying to dismantle it.

Senator McLUCAS: move us toward something that looks a lot like America's system.

Dr Terry: Yes.

Senator McLUCAS: Professor Bonney, you made a very clear statement. You said that you know that, if there is a co-payment, people will not come—it was a very unambiguous statement—and that they will go to the hospital 20 kilometres away. How do you know that?

Prof. Bonney: From 23 years practising in my town and understanding the demographics of my town. The town, proportionally, is of significant socioeconomic disadvantage.

Senator CAMERON: Excuse me, Professor Bonney, what is your town?

Prof. Bonney: Culburra Beach, which has a population of about 3½ thousand, just out from Nowra, on the New South Wales South Coast.

CHAIR: It is a typical sea-change town on the eastern coast, and many such towns have large, ageing populations.

Prof. Bonney: Yes, that is completely correct—and a high Indigenous population. Also, rent is cheaper than it is in Sydney, so if you are really doing it tough in Sydney then it is a bit of a bolthole. So we just know that folk will not turn up. People ask if we bulk-bill. We know that from the folk who do not get their medications made up because they do not have the money, for example, or the people who do not attend specialist appointments—and that is huge problem for us, getting people to see specialists, because a significant number of specialists do not bulk-bill, although an honourable minority do, and I congratulate them on that. But co-payments make a big difference to access to care.

Senator McLUCAS: Yes. Going to that other issue, about attendance, Dr Van Leeuwen, you said there was a 20 per cent reduction in attendance, but I think a lot of the other doctors said that it just meant that the time to attend was shortened. We asked this question of the department and the Department of Human Services, and they produced data that said that there had been no reduction in attendance over the month following the May budget last year. But I think that now explains it: people just did not have to wait so long. Instead of waiting three weeks to see the doctor, you could get in in 1½ weeks or something like that. So I appreciate the other evidence but I appreciate yours as well, Dr Van Leeuwen.

Dr Van Leeuwen: From a small-business perspective in that setting, the fixed costs remain fixed; the income changes. We have been encouraged to employ nurses to work in a team-care environment. Then income is drastically changed, so small businesses are left with responsibilities to our employees and staff.

Senator McLUCAS: Yes. Thank you.

Senator DI NATALE: I just want to thank you all for attending. We do not do enough of this, talking to people who are at the coalface, whose lives are affected by this and who are in direct contact with patients. Well done to the secretariat and to Senator O'Neill for making sure that we actually heard from GPs. It is terrific that you were able to come. I want to put to you a couple of arguments for why these changes are necessary—arguments that I do not support. One of them is, of course, that people who have the means should pay for their health care. Why is it that a millionaire should not be faced with an additional co-payment? I just want to hear a response.

Dr Terry: The reality is that we already charge people who can afford it—the gap in my surgery is $37, I think—but that is a very small minority of people. Healthcare cardholders or people who are actually employed but on a low income you might charge either nothing or $15.

Dr Pearce: I was going to say the same thing, except I would like to qualify it a little bit more. I think we are all responsible GPs here. We book our time in 15-minute average appointment times. Some of those take six minutes; some of them take 15 minutes. They are all level B consultations, or standard complex consultations. We have a similar gap for people who do not have a healthcare card of about $35 or $36—thereabouts. Our policy at the moment is to bulk-bill healthcare cardholders. But, if you look at Fiona Van Leeuwen's argument there, costs remain the same. So, if I am booking four appointments per hour and I happen to see four healthcare cardholders per hour, at the moment I get about $45 per visit, which is about $180 per hour for the allotted time. Forty per cent of those billings go to the practice, to look after—

Senator DI NATALE: Overheads.

Dr Pearce: Yes. Seeing private people, it is $280—a big difference. So we are actually already discounting. Why is it that there is such a big disparity for us when we have fixed costs and we are offering the same care? What will happen if this model continues and this gap grows bigger is we will be offering people two different levels of health care, because we will not be able to give people who do not pay that $37 gap the same level of time allocation. We are going to have to see them quicker. They are not going to have as much explanation, or we are going to have to charge them a similar amount, so their costs are going to increase. Do you see my argument there?

Senator DI NATALE: Yes, sure. You do not have to convince me. I am just interested to hear how you respond to some of these arguments. The other question is about unnecessary visits. We keep hearing that we need to put a price signal in place because some people are going along to the doctor just to have a chat with them. Why should we be paying for that?

Dr Terry: There is a very small group of people who have unnecessary visits and they often have anxiety or stress related type conditions and they need to come more often. There are, paradoxically, some unnecessary visits because it is cheaper to come to the doctor to get a script for paracetamol or some other drugs on concession than it is to go and buy them from a chemist. But the vast majority of people who come to the doctor do not come very frequently. They will only come when they actually need something.

Senator DI NATALE: Getting back to your point, Professor Bonney, the whole point of having a medical degree is that you learn the capacity to distinguish between what is necessary and unnecessary. That information is not in the hands of most ordinary people.

Prof. Bonney: That is correct. In most situations, GPs have waiting times for standard appointments of several days, which really negates the whole argument of trivial visits. They are not spur of the moment decisions or for minor things. If people have to book in advance and wait, then typically that has already sorted out people who need to be at the doctor's.

Senator DI NATALE: Dr Kamerman, in your paper you highlighted the impact of some of these changes and said that the combination of the changes to the level A and level B coupled with the changes to indexation would have resulted in a gap of $250,000 per year in your practice. Can you explain to me how you got to that number?

Dr Kamerman: The A and B had the most significant effect. We figured that, if we did not make any changes to staff wages or staff numbers, we would be dropping something like $15 per consultation for the shorter ones, and we worked out the percentage of consultations which were under 10 minutes, which was about 25 per cent.

Senator DI NATALE: Which is pretty close to the average.

Dr Kamerman: So we were looking at those sorts of figures. Then we worked out the effect of the loss of indexation. We worked out that probably about seven per cent of our total income would just be frozen.

Senator DI NATALE: So you have calculated the changes to indexation. That would cost you $100,000 per year?

Dr Kamerman: Yes, by the time we get to 2018.

Senator DI NATALE: I suppose it would be worth me pointing out that the changes to indexation have had bipartisan commitment. They were introduced by the previous government—I am sorry to say to my Labor colleagues—

CHAIR: For a short period of time, not for four years.

Senator DI NATALE: That was a policy that was introduced by the previous government and has been continued now to 2018.

CHAIR: Four years.

Senator DI NATALE: What are your options in those circumstances? Indexation, it appears, is something the Senate does not have any power to change, although we are looking at that. The issue of indexation means that you have got two options. One is that you will increase the out-of-pocket gap to $60. So you are saying there that a visit to your practice will cost now $100?

Dr Kamerman: Yes. Basically, if I make no other changes at all to my costs, that is what a non-concession card holder is going to have pay if I am going to continue bulk-billing the rest of them.

Senator DI NATALE: And that is just to maintain the level of income you have got at the moment?

Dr Kamerman: Yes. That is just to break even.

Senator DI NATALE: So $100 a visit. Have any of the other practices done similar modelling looking at what, under the changes to indexation, you will need to start charging non-concessional patients?

Dr Pearce: I did a rough spreadsheet on that. I modelled it on a five-doctor practice, which is an average practice. I worked it out per doctor. With the $5 co-payment in 2015, per doctor it would be a $18,750 reduction in income based on 50 per cent bulk-billing and 50 per cent non-bulk-billing. This is per GP. The non-indexation in that year in its true sense would look at about $6,021 per GP. In a five-doctor practice in 2015 that would be a $51,000 reduction in service fees. That is the usually 40 per cent retained by the practice for service fees.

In reality though non-indexation is a double whammy because we are all going to increase our private fees by between one and three per cent. There was a very good article printed in *The Conversation* this morning that tried to extrapolate that. In fact, if inflation is running at two per cent, so we miss out on two per cent indexation with the Medicare levy, and increase our private fee by two per cent, in actual fact the patient is slugged by four per cent non-indexation in their rebate, if you get what I mean. I do not think that has been taken into account either. It is significant. This table I can submit as evidence. It is hard to explain.

Senator McLUCAS: Dr Kamerman, what is the tipping point in your practice? If you are going to say to a person $100 is what you are going to have to be charged to come, I suggest that that would mean that patients will just say, 'No, I can't afford it.'

Dr Kamerman: Certainly from a practice perspective my tipping point will be 1 July. We will not be able to continue to bulk-bill patients at that stage—

Senator McLUCAS: At all?

Dr Kamerman: At all.

Senator DI NATALE: What about the $5 reduction in the rebate?

Dr Kamerman: I will give you my perspective of the $5 reduction in the rebate. I currently bulk-bill the disadvantaged, who are supposed to be protected. The loss of indexation is going to hit us very quickly. Already we are marginal, so I will start going backwards from 1 July. I am going to have to stop bulk-billing and if I am going to stop bulk-billing it is not going to be a $5 gap for disadvantaged people. It is not worth me charging $5; it is not viable. It is going to be something like a $25 or $30 gap.

Senator DI NATALE: Let us just explain that. You are saying that, because of the changes to indexation that are already biting and will only get worse over the next few years, you will not be able to bulk-bill even non-concessional patients and the impact of that is that you are not going to increase it by a small amount. You have to go to the trouble of collecting a payment from patients and you have to deal with some people who will not pay, bad debts and all the stuff that goes with that—the administration costs and so on. You are suggesting that even concession card holders are going to be faced with at your practice an out-of-pocket $20 to $25.

Dr Kamerman: The message we are getting from the government, very clearly, by these changes is that bulk-billing is finished as far as a source of income for general practice, if you actually—

Senator DI NATALE: Let us be clear about this: for everybody. The government keeps saying they are going to protect concessional card holders. Why is it that these changes do not protect concession card holders?

Dr Kamerman: Because the rebate is frozen. If we got indexed rebates, at least I would know that I will be able to marginally cover cost increases over time even though the inflation on medical equipment—the fall on the Aussie dollar is certainly going to blow out some of my costs. Unless there are wage presses—and I have got a big practice; I have got a 15 doctor practice, so I have got to pay payroll tax as well. Thankfully—again, I am sorry, I do not want to be political—superannuation increases have frozen, because all those things keep biting into the costs of a practice. Yes, I have got an integrated team care practice. We have got nurses, we have got dieticians and we have got psychologists in the practice, so it is not a simple operation. It is actually a reasonable sized business, and for me to have close to $1 million worth of capital invested and get no return, I would have rocks in my head being a practice owner.

CHAIR: Can I be really clear about this. Come 1 July, if I am a concession holder and I show up at practices around this country—because I am sure, Dr Kamerman, you are not on your own in this—and I am the mother of the child that we heard about earlier. I am a young parent. I have a concession card and I show up. I am going to have to pay a gap regardless that will be much bigger than $5. Is that correct?

Dr Pearce: That is correct. Unless out of our social conscience, which the government seems to be preying on, we can see that there is desperation in your eyes and we can decide to bulk-bill you. But if we do that, then we cross that point where practices are not sustainable and then the government precipitates this thing that I have written in my submissions, which is that infrastructure will just disappear—

CHAIR: That means there will not be doctors to go to—

Dr Pearce: Doctors on this panel will walk away from their practices and then the government is going to have to become involved in providing the infrastructure for which primary health care can deliver health services. At the moment we have got a huge investment in infrastructure which has got to remain viable. What everyone is saying here is that, with all of these little bites that have been happening over the last 40 years since Medicare came in, every little bite, we have reached the tipping point. This is the tipping point. Unless we change our billing procedures, unless we actually look at ways to change our business model to make our practices sustainable, the people that own infrastructure—be they GPs or corporates—will no longer be able to make any profit and, as a result, the infrastructure will be walked away from. It will be sold. It is an unsaleable item, because it is non-profitable, and the government will have to step in.

Dr Van Leeuwen: Just in terms of savings, nobody actually mentions the fact that GPs quite often choose, as do we in our practice, to charge a person less on a healthcare card for the same consultation, considerably less for the same rebate. We accept how much less per consultation?

Dr Pearce: A 50 per cent discount.

Dr Van Leeuwen: A 50 per cent discount. If we were selling a pair of jeans we would not say, 'Hang on a minute: tell me how much money you've got and I'll charge you $5 and you $25.' Medicare does have this component of relying on the goodwill of human nature to support it, and the true cost of a consultation, unfortunately, because the environment in which we work today is not the environment in which Medicare was born, is very marginal when it comes to providing service.

Dr Terry: Just one quick comment I was going to make. If you look at all the statistics about the age of general practitioners, there is a very large number of GPs who are 50 or over 60 now. Given the problem with the loss of income, there could be quite a large number of older GPs who will say, 'Well, it's just time to hang up the shingle, because it is no longer profitable.'

Senator DI NATALE: You basically charge your non-concessional patients a lot more, or you start charging your concessional patients. That is really the equation, so either way someone is going to have to—

Dr Kamerman: Or we close.

Senator DI NATALE: Or you walk away. If you are at an age where you are contemplating retirement, you might bring that on by a few years.

Dr Van Leeuwen: There is one other thing, which of course is just to reduce your staff. Instead of encouraging your clinicians to work at the top of our scope, we would have no practice nurses and very few administrative staff. So you can wind back the clock 25 years and go to one GP seeing one person for 15 minutes.

Senator DI NATALE: That might sound attractive to people who think administration is where we should not be spending our money. But let's be clear what that means. It means no recall for people who need their vaccines done, it means no regular diabetes checks and making sure people are recalled for all sorts of health conditions. That administration is not just—

Dr Van Leeuwen: It inhibits modern care.

Senator DI NATALE: When we are talking about the increasing burden of chronic disease, those staff that you are talking about are critical in terms of chronic disease management.

Dr Van Leeuwen: Absolutely.

Senator DI NATALE: I suspect you will not get much disagreement about the level of concern that we feel here in terms of the impact this is going to have on patients and, of course, doctors. But governments keep saying we want to hear alternatives. Do you think there is an appetite within the general practice community to start looking at how we better reward quality and outcomes and how we better look to reduce wasteful spending? Is that a conversation that you think people on the ground are really ready to have? Or is it just, 'We've had enough of this. Leave us alone'?

Dr Terry: We have had a lot of discussions about this. I would bring you back to that graph that the RACGP put in their submission. It shows that our costs have stayed fairly static and the cost of the hospital system has gone up. We have sat down as a group and looked at large number of areas we could help make changes in. There is the high PBS expenditure on lots of drugs—the pharmaceutical benefits cost. There have been recent articles in the press claiming that Australia is overpaying up to $1.3 billion compared to other countries and asking why we can't adjust our pharmaceutical costs. I think general practice would sit down and we would look at the areas we can actually make a difference in, such as do investigations need to be done and can we reduce pathology costs—all those sorts of areas.

Senator DI NATALE: I thank the Hunter association for the submission on that.

Senator CAMERON: I do not want to get any of the detail at the moment, but could you provide the secretariat with the details of your 10-week program?

Dr Terry: It is already in the Hunter GPA submission. It is on the back page.

Senator CAMERON: Dr Kamerman, we had some discussion previously about Tamworth in relation to bulk-billing. I received correspondence from a Tamworth resident complaining bitterly about not being able to access bulk-billing and the cost of medical treatment in general. It is not just about the cost of bulk-billing in Tamworth; they have to go to Newcastle to get a specialist, and transport costs and all of that are added on. Rural and regional health costs per individual are quite high. That is a fact, isn't it?

Dr Kamerman: Absolutely. Once you add in the distance and the travel time, it is increasingly high. In a lot of states, rural emergency departments are not funded by the state government. Consequently, doctors generally have to bill them privately or bill through Medicare, which is just bizarre. I could not imagine this happening in any city metropolitan large emergency department.

Senator CAMERON: Professor Seidel, who has given evidence to the committee, came back with the results of some investigation he has done in Tamworth. There is one area that bulk-bills everyone, and that is the Aboriginal medical service. There are three that do not routinely bulk-bill. However, they offer pensioner rates. One is in the process of changing its policies so that a selected number of GPs will bulk-bill. Three others do not bulk-bill but will do it with discretion. One other did not respond but, on their website, they say that all consultations have to be paid for at the time. These changes are going to make that even worse.

Dr Kamerman: Currently, our practice is one of the largest practices in town. We have got a policy. We used to routinely bulk-bill concession card holders. Some of the doctors stopped doing it, so it was only half our doctors and all the registrars that were bulk-billing concession card holders. Come July 1, we will be stopping it altogether and that will only leave the Aboriginal medical service. I do not know how they are going to continue to operate with a frozen rebate for 2018.

Senator CAMERON: So Indigenous health could suffer. Your local member is Barnaby Joyce.

Dr Kamerman: Correct.

Senator CAMERON: You are not doing a 'Barnaby' on us, are you? You are not saying there is going to be a $100 lamb roast and there is absolutely no chance of that ever happening. This $100 co-payment is a real issue, isn't it?

Dr Kamerman: It will not be a $100 co-payment; it will be a $100 fee. If these changes are not reversed, I just do not know how to make ends meet or I am going to have to close the doors and that is not really good for anyone. I would rather keep trying to get the business up and running and continue to operate.

Senator CAMERON: And you have got one of the biggest practices in Tamworth, so this may even be a bigger problem for some of the single practitioner doctors that do not have economies of scale.

Dr Kamerman: That is right. There is certainly lots of evidence that you get economies of scale around a five- or six-doctor size. Smaller than that you tend to run into trouble with costs: staff and infrastructure. If I was in my former practice, which was in Bingara, a town of 1200, 150 kays north of Tamworth—

Senator CAMERON: I have been there.

Dr Kamerman: a great town—I would have closed my practice and just walked down to the hospital and opened my practice from there and just used the state government rates and seen everyone through the emergency department. It would be the only viable way of keeping on operating in the long term.

Senator CAMERON: Have you had any discussions with Mr Barnaby Joyce about this?

Dr Kamerman: No. I must admit I have been that busy trying to organise my practice, I have not got around to organising an appointment with him. It is just as much my fault for not getting together with him. My staff are organising an appointment to meet with him and go through—

Senator CAMERON: So you are trying to organise a meeting with Barnaby Joyce. As a cabinet minister, he is going to be very influential in how this operates. Have any of the doctors had any feedback that any of the coalition MPs that you have engaged with have any understanding about this relationship between running a business and providing health care?

Dr Kamerman: Actually, I think Barnaby Joyce would be a good example. One of my colleagues had him visit their practice at length, and my discussion with them was that, yes, he took note of what was happening and the decision was made to go from the $7 to the $5 and protect the disadvantaged after that meeting. The message—

Senator CAMERON: Barnaby saved the patients, did he?

Dr Kamerman: I am not sure about that at all but that was certainly the message the practice was sending to him. Cabinet did meet after that, and my understanding was that, yes, from the profession's point of view—and this practice's point of view—it was very strongly put that the disadvantaged need to be looked after with a form of protection as far as continuing to get the full rebate rather than a co-payment.

Senator CAMERON: That is interesting.

CHAIR: But Dr Kamerman, you have said—just to be clear—that when we hear $5 rebate, a concessional holder as of July 1 should actually hear a $100 fee.

Dr Kamerman: I do not know that I would be charging $100 to a concession card holder.

CHAIR: What would you be charging, Dr Kamerman?

Dr Kamerman: I would probably be charging in the vicinity of $60 or $65.

CHAIR: So when they hear $5, they need to really hear $60, because that is what it really means.

Dr Kamerman: Correct.

CHAIR: Thank you.

Senator CAMERON: Tamworth is not the poorest place in regional Australia but it is certainly not the richest, is it?

Dr Kamerman: That is correct. There are a whole lot of disadvantaged people and disadvantaged areas. I am a methadone prescriber in town. I am going to have to make the decision whether I stop bulk-billing those people. If there is a reduction to access to opiate substitution therapy in town, because I am the only private prescriber—

Senator DI NATALE: You are the only private prescriber of methadone in Tamworth?

Dr Kamerman: I have a registrar who does it as well, so there are two of us who do it.

CHAIR: Within the one practice?

Dr Kamerman: In one practice.

Senator DI NATALE: A methadone patient is not going to pay 60 bucks to get their methadone.

Dr Kamerman: A lot of them will not.

Senator DI NATALE: Sorry—you are right. Many will not; most, I would suggest. I was a methadone prescriber as well. So what does that mean?

Dr Kamerman: It means crime rates will go up in Tamworth and around Australia, I presume, or the public system will be overwhelmed. Waiting time for methadone in Tamworth in the public system is about four to six months.

Senator CAMERON: We have engaged on this issue, about the social implications of these changes to Medicare in that it will create these social problems, where drug dependency cannot be dealt with effectively and that means more violence, more break-ins and more criminality. Do you agree with that proposition?

Dr Kamerman: Absolutely.

Senator CAMERON: And that is as a direct link to people not being able to access medical care—is that right?

Dr Kamerman: Correct.

Senator CAMERON: In the New England-Tamworth area, the last time I was up there I went to one of the suburbs in Tamworth that had a nurse practitioner operation.

Dr Kamerman: Coledale.

Senator CAMERON: It looked to me to be in one of the lower socioeconomic areas in Tamworth. Many people were telling me that this was the only way they could access health care, because at the moment they could not pay the fee to see a doctor. Do you think we will see more reliance on these types of operations if the $5 comes in?

Dr Kamerman: I totally agree. I think you are going to get a whole lot of diversion into alternative means of accessing care. Some of that might well be through NGOs picking up some of the costs. Organisations in our area, such as Centrecare and the Richmond Fellowship, bring patients along and pay fees on their behalf.

Senator CAMERON: Charity. So we move from a Medicare system to a charity system, do we?

Dr Kamerman: Yes.

Senator CAMERON: So we go back 100 years in this country.

Dr Kamerman: At the moment, if you think about it, what I am doing in practice and what most GPs do is provide a form of charity. We reduce our rates for people who are doing it tough. The trouble is that, in the economy at the moment, there are a lot of people doing it tough.

Senator CAMERON: But what I think you are arguing is that there is a limit to your capacity to make a 'charitable donation' to patients. It will now fall back to the charity groups, the non-government organisations.

Dr Kamerman: From memory, wasn't one of the principles of Medicare such that doctors were not having to provide charitable and honorary care for patients?

Senator CAMERON: Yes. What is the message we should take in the Senate? What should we do in the Senate in terms of all these changes? Some people are asking for a six-month moratorium to have discussions; we should not pass any legislation; we should look at whatever means we can to stop the $5 co-payment, even though that may be difficult?

CHAIR: I think Dr Alexander wants to answer that question.

Dr Alexander: I think the message that needs to go back to parliament is that, in order to sell an ideological policy, you first set up a few myths. The first myth is that there is a blow-out in the cost of Medicare. The second myth is that there is somehow a blow-out in patients accessing their GP. There is a simple message here. There has been no blow-out in patients accessing GPs or the costs in a decade, during which we have delivered better health outcomes. For every dollar of a co-payment, states and federal governments will have to find $3.35 to fund their public hospitals. There are no unnecessary or very rarely unnecessary visits to GPs. There are rarely, if any, millionaires being bulk-billed. When we use the word 'bulk-billed' it gets a bit distorted. The term 'bulk-bill' is often interpreted as meaning: are doctors charging their patients? When doctors bulk-bill, what we are actually doing is accepting half the cost of the fee. That is what we are really doing.

Senator Cameron is right. There will be a vastly inferior health system for the poor and the disadvantaged whether they access clinics or get their health care through the pharmacy. There is an interesting thing happening at the moment: as general practice comes under attack—and I point out to you that one of the few areas of general practice that will survive is the large corporate-run clinic, and people should be asking the question why. The huge void that this will fill as general practices' doors close—and that is what we are talking about; we are talking about the viability of general practice, because general practices are going to the wall as we sit here now and they are going to go to the wall with this new health policy. But we have pharmacists and the powerful pharmacy guild talking about how they want to do ear infections. It is an embarrassing grab for money. It is not about health care; it is about people grabbing little bits and cherry picking the bits that they want—even the nurse practitioner example.

The patient that we are dealing with in 2015 in Australia is complex, elderly and with multiple medical problems. As soon as we fragment that patient, it is costly to the taxpayer and hugely detrimental to that patient's health. GPs give patients a better quality of life and save the taxpayer billions. That is the message.

I understand it is difficult for committees such as this and politicians because GPs are such a diverse group of people. We have to be. We are in rural and regional Australia, in cities and in large corporates. It is interesting to know that the corporates have not been anti some of these changes. Why? Because patients accessing their GP are a very, very small part of their income. They make income from the areas that are blowing out in Medicare such as investigations, pathology and specialists. But the majority of rural and regional Australia relies often on privately run clinics such as many of those you have been talking about today. The large corporates will churn up the taxpayer dollars and survive this onslaught on general practice, but it is the smaller, privately run clinics that are going to struggle, and patients are going to suffer.

Senator CAMERON: Thanks for that, Dr Alexander. Dr Kamerman, I want to clarify the issue of the $100 payment. When would it be required for you to implement that payment to survive?

Dr Kamerman: I would imagine it would come in probably over the course of the next 12 months.

Senator CAMERON: So in 12 months in New England, in Tamworth, it will be $100 to see the doctor.

CHAIR: If you are a non-concessional claimant—

Dr Kamerman: If you are a non-concession holder, for an average consultation.

CHAIR: And, if you are a concessional holder, $60 or thereabout.

Dr Kamerman: Thereabout.

Senator CAMERON: When you indicated that Mr Joyce had taken this to cabinet and had this victory to cabinet, is this anecdotal evidence or did he tell you this?

Dr Kamerman: No, I certainly have not had any feedback from him. It was that the feedback I had from colleagues was that the message was put to him very clearly that those that were disadvantaged had to be protected in some way. I am well aware the government has made those changes to particular groups. I did notice that Indigenous people were not included in that unless they happen to have a concession card.

Senator CAMERON: So, if the price signal comes in, Mr Joyce has a lot more work to do in cabinet.

Dr Kamerman: Along with a whole lot of other politicians, I would imagine.

CHAIR: I have a final question in relation to what you said. I am almost frightened to ask this question, because it made me think that perhaps part of this ploy is to push the costs to the state governments in a very cynical way. You said that the best way for you to survive would be to pull up stumps in your practice and shift to the local hospital, delivering your service there—in a more expensive way, I understand—with the budget implication for the state government and not the federal government. Did I understand you correctly?

Dr Kamerman: That is correct. If I were working in a one- or two-doctor town with access to a hospital, the tipping point about running a practice is hitting us now. Why would I want to continue investing in a practice and maintaining all the obligations of looking after staff, the OH&S issues and the taxation accounting issues when I could close all that, walk down to the hospital and get quite a significant income with no overheads, living a much simpler life?

CHAIR: So this is not just a policy change that is going to drive patients to the local hospital; it will ultimately drive the GP practices to the local hospital as well.

Dr Kamerman: It could.

CHAIR: That is very concerning.

Finally, Dr Van Leeuwen, how do you make the decision? How do you do a financial audit of somebody when they are there to let you look in their ear? How do you make this decision about who you charge and who you do not charge? I do not know how to tell people do and do not have money by looking at them.

Dr Van Leeuwen: Of course the dilemma is that we do not really ether. The current system does not support us to identify the appropriate people and have their health subsidised.

Senator DI NATALE: You can look at whether they drive cars!

CHAIR: Yeah, check out the car park!

Dr Van Leeuwen: One other thing: I have been in general practice for 15 years now and I have never before had to sit down after each 15-minute consultation and so carefully determine in my mind how I am going to earn a reasonable income to pay my practice costs and my own wage and ensure that I am not charging the patient too much money.

CHAIR: That must be a very difficult experience for you every day.

Dr Van Leeuwen: I desperately want to focus on my clinical abilities, because that is what I am trained for.

CHAIR: But you are being forced to be a tax collector for the government.

Dr Van Leeuwen: I need to be thinking about money much more frequently than I would like to.

Dr Terry: In a smaller practice, having looked after generations within the same practice, we know their economic status very well. We know who is under financial strain because we get them in stressed about the fact that they cannot meet their obligations or there have been marriage break-ups. There have been a number of occasions where I have actually paid for the patients' medications or the girls have gone over to the chemist, got the medication, put it on our bill and come back because we know the patient is not going to actually have the money to buy it.

CHAIR: So we are at a critical point. You have certainly made that very clear.

The committee intends throughout the course of this year to continue to take evidence from real doctors like yourselves who are interacting with real patients, because there seems to be a big gap in consultation from the government and, as you pointed out, Dr Kamerman, from the health department's engagement with patients and the sector itself. Thank you very much for kicking off our consultation with doctors in such a professional, informed and generous way.

BOXALL, Dr Anne-marie, Senior Policy Adviser, National Rural Health Alliance

GREGORY, Mr Gordon, Chief Executive Officer, National Rural Health Alliance

MOORE, Professor Michael, Chief Executive Officer, Public Health Association of Australia

ROOT, Ms Josephine, Policy Manager, Consumers Health Forum of Australia

STANKEVICIUS, Mr Adam, Chief Executive Officer, Consumers Health Forum of Australia

[12:20]

CHAIR: Welcome. Thank you very much for agreeing to appear together. That will really assist us in the timing of the day. Is there anything any of you wish to add about the capacity in which you appear today?

Prof. Moore: I am an adjunct professor at the University of Canberra.

CHAIR: The committee would like to invite you to make opening statements. We will start with Mr Stankevicius.

Mr Stankevicius: The Consumers Health Forum of Australia believes we as a community and with the government need to go back to the drawing board on health reform. Unfortunately, what we have seen over the past 18 months in particular is a debate very much focused on health financing and not a debate focused on health outcomes. I think the evidence that you saw before us today by other witnesses is a great example of that. Even individual practitioners now are very focused on financially managing their small and medium businesses and not able to focus on the health outcomes they can deliver for their communities, and that is really disappointing.

What we have seen is a lack of evidence from the government about why the changes need to be made. We have also seen a lack of evidence to support the solutions they propose to the problems they are identifying. We have also at the same time seen an avalanche of data and reports, particularly over the past 12 months, that would indicate that, counter to the government's view, the health system is not unsustainable. We already know from that data that Australian health consumers are paying much more out of their own pockets than health consumers in places like France and the UK. It is an increasing amount. With every report that comes out we again see the message reinforced and the data updated. You can look at *Australia's health 2014*. You can look at the report on government services from two days ago. You can look at the health expenditure bulletin from a few months ago. All tell us the same story. All tell us of the billions of dollars Australian health consumers are paying out of their own pockets.

We have also, though, seen a universal health system in Australia over the past 40 years that has delivered some of the best life expectancy outcomes in the world. So it is not as though the current system that we have is actually delivering us health problems; it is actually delivering us very good life expectancy.

Australia is a wealthy country. We all need to recognise that. As a result, it is reasonable that we spend a higher amount on health than perhaps some of our OECD partners. But our focus needs to be on primary health care. Our focus needs to be on how it is we can improve primary health care and how it is we can avoid the high-cost hospital admissions. Again, the panel before us was talking to you about the fact that the growth in cost has been in those hospital admissions; it has not been in primary health care. We would certainly support stronger efforts to improve primary health care rather than focusing on putting that price barrier between consumers and access to primary health care. We need stronger investment in this area, not price barriers that are going to push consumers away.

We also know—and, again, the previous hearing appearances would have told you—that health monitoring and maintenance is so important for health consumers. It is so important for them to reduce the likelihood that they will end up in hospital but also to manage effectively their health conditions so they do end up actually going to their GP less. Regular visits mean fewer emergency visits in the future. What we have seen by way of a response from the government to what they claim to be an issue of unsustainability is a range of models that do put in place barriers to accessing primary health care and that do increase the costs on the providers of primary health care to the point where they may need to make decisions about putting in place those financial barriers, if the government does not. That means we are going to end up having a serious impact on life expectancy in this country and a serious cost impact on hospitals.

While we do not agree with most of the health recommendations that were in the Commission of Audit report—if we want to go back that far—one of those we did agree with was that the health minister take 12 months to consult with stakeholders and develop a long-term plan for health reform in this country. What we are really disappointed about is that path was not taken—that that recommendation was not picked up. To think that we can do serious health reform by making a few policy changes in the financial space and expect that to deliver

us a robust, effective, efficient and delivering health system is a fallacy. Serious discussions have to be had and serious decisions have to be made. We all need to be part of that discussion—not just providers, but people at this table and all the organisations that we work with and represent all have to be part of that discussion. We all know hard decisions will need to be made and we are all willing to have those discussions, but at this point we certainly have not been engaged in that process.

CHAIR: Thank you very much. Professor Mike Moore.

Prof. Moore: Thank you, Chair, and we appreciate the opportunity to be here. The fact that we can sit together at this table is no surprise to us, as we are part of a broadly coordinated coalition of health groups who have seen an approach that will undermine our universal healthcare system. We are working together with a wide range of groups and trying to see to what extent we can get a single voice to make it easier for government to understand what our thinking is about. It is part of the reason I asked the Rural Health Alliance, and Gordon Gregory will speak later. One of the other reasons for having Dr Boxall here is that she is the author of *Making Medicare*, which was published a couple of years ago. She has rather extensive knowledge in the area and has been a fantastic resource for a very wide range of groups which are interested in a universal healthcare system.

I have just one other side comment on the universal system. I was recently elected as the president-elect of the World Federation of Public Health Associations.

CHAIR: Congratulations.

Prof. Moore: Our approach is to encourage universal healthcare systems around the world, and how frustrating is that for me when my own government is busily undermining it. That is what we see happening here: an undermining of the universal healthcare system with suggestions that people should be paying what they can afford. We would argue that they do; that is why we have a progressive taxation system. Money is raised through the taxation system with the wealthier paying more in tax. Therefore when you have a universal healthcare system people can access that system without reference to the amount they can pay at any given time.

Of course, our system is not perfect—nobody is suggesting it is perfect. All the organisations that I am aware of are quite comfortable about looking at healthcare reform, but the most important thing about it as far as we are concerned is that it does not happen in a way that is cherry-picking. What we have seen here in looking at Medicare with a cherry-picking approach is that you look at just one part of the system and start playing with that. All that happens when you cherry pick is that another part of the system blows out. In this case the most obvious is the shift from cost to the federal budget to the cost of the state and territory budgets. It is not just cost-shifting to the states and territories—that game has been going on for many, many years—but with cost-shifting you go to much more expensive systems. As our hospitals pick up more, and I am reiterating what Adam has said, the important thing is that we have a comprehensive reform package that does not suddenly mean that state and territory budgets blow out. The bottom line looks like it is going very well because that will be completely unsustainable. Of course, there are those who believe that it is just a system of trying to pressure the states and territories to increase the GST. In fact, many of us are going to a discussion today around the federation white paper on health, which actually raises these issues as well.

What we are interested in is sustainability; we are interested in the sustainability of the whole system. We do not think that it is broken. We do believe that it is already sustainable, we do believe that improvements can be made and we are quite comfortable at working with the government—we would like to be a critical friend—on how we reform our whole health system.

CHAIR: Is there anyone else seeking to make an opening statement? Mr Gordon?

Mr Gregory: I would encourage the committee not to be misled by this sign in front of me: I am actually Mr Gregory!

CHAIR: Oh, okay! Mr Gregory, thank you very much for correcting the record; we will do our best to keep it honest for the rest of the time!

Senator CAMERON: It's pretty good no matter what we do!

Mr Gregory: The NRHA welcomes this opportunity to speak about some of the rural and remote issues relating to Australia's healthcare system and we thank our friends at the PHAA and at CHF for inviting us to share the table with them.

We are very impressed by what we heard from the previous panel, particularly from Ian Kamerman, who gave you to understand some of the local realities of rural and remote health. What you will get from us—from the Rural Health Alliance—is, if you like, a high-level national picture, so permit me to read some of this into the record for the committee.

CHAIR: Thank you.

Mr Gregory: When the facts are added together step-by-step, the only conclusion is that federal, state and territory governments must do more to improve health outcomes and health services in remote and rural areas. Life expectancy at birth falls as one moves from capital cities to remote areas. Compared with major cities, the burden of disease and injury is 10 per cent higher in regional areas and 26 per cent higher in remote areas. The rate of potentially avoidable hospitalisations is up to three times higher than in cities and hospital stays are also typically longer.

Access to health professionals, including GPs, falls with increasing remoteness. A greater proportion of rural people postpone or put off seeing a health practitioner due to cost; diagnosis therefore tends to be later, and more specialised care is very rarely available locally. Rates of survival after a diagnosis of cancer fall progressively with the patient's distance from the capital city.

There is a healthcare deficit for people in rural and remote areas of $2.1 billion every year. This figure allows for the fact that rural and remote people use public hospitals at a higher rate than city people. A universal health insurance system, paid for progressively through the income tax system, is a great and important principle, but for a small proportion it is not a reality: no doctor, no Medicare.

Health risk factors are also worse in rural areas: there are higher rates of smoking, of dangerous levels of drinking, of sedentary lifestyles and of obesity, and the rural population is older and has a higher proportion of people living with a disability. On average, incomes outside the capital cities are 15 per cent lower than in capital cities and the rate of private health insurance is lower.

For all of these reasons and more, the alliance strongly opposes any additional barriers that might be erected between primary care and the people of rural and remote Australia. All of the recently proposed changes to Medicare would pose extra costs either to the doctor or to the patient. Rural doctors are proud of the care they give to members of their community and there are particular reasons why they would find it hard to pass on higher costs to their patients—and you heard about some of these in some detail from Dr Kamerman. The viability of rural medical practices may be reduced, with further consequences for access to health services.

Out-of-pocket costs are already higher in rural areas. On top of that, any given level of out-of-pocket cost is harder for rural and remote people to meet, given, as I said, their lower average incomes. In aggregate, families in rural and remote areas have 10 to 20 per cent lower incomes and pay higher prices for most goods and services, including those related directly to health and wellbeing. Out-of-pocket costs for rural and remote people include those for transport and accommodation away from home. The state and territory patient travel and accommodation schemes are poorly understood and promoted, and not sufficient to cover the real costs involved in travelling to and staying in major cities.

To improve the outcomes of Australia's health system for people in rural and remote areas, there are five essential areas on which to focus. Firstly, we need improved access to integrated primary care, especially for infants and children, and including better access to medications. Access to primary care is the reason why Medicare and health workforce issues are so important. Secondly, we need more effective consideration of healthy ageing and aged care, including a focus on the social determinants of health for rural people and special attention to the growing burden of dementia in rural and remote areas. Thirdly, we need sufficient resources and strong political leadership for action on the national Aboriginal and Torres Strait Islander health plan. This should include strong support for the community controlled health sector and comprehension of the importance of attracting and retaining more Indigenous people to health professions. Fourthly, we need practical integration of disability, aged and acute care perhaps starting with a regional model in which funds are cashed out. Fifthly, we need investment in regional universities through a number of federal agencies, including for broadband, undergraduate training places and research activity.

The alliance, like our colleagues, accepts the need to strengthen the integrity of Australia's structural budget position. We are concerned, however, that too much weight is being attached to cuts in Commonwealth government services and in special purpose payments to other governments. The structural budget deficit can be fixed through an appropriate balance between savings and revenue measures. Cuts to essential services impact most heavily on people who are already vulnerable whereas progressive taxation does not.

For the convenience of this committee and its staff, attached to this opening address is a set of summary statements related to Medicare in rural and remote areas. Thank you.

CHAIR: I thank you for your opening statements and for the submission of documentation to support it. It is very helpful for us. I wonder whether you were here this morning when we heard from the Royal Australian College of General Practitioners? They sense that there is a restriction to this newfound willingness from the new

minister to engage in 'consultation', that it may only be a two-week period of further consultation. Can I ask for your reactions to that?

Prof. Moore: The former Minister for Health and his staff I heard people say he was very hard to reach and so forth. That was not my experience. We do not need to speak to the minister every time. We were able to speak to his appropriate staff and so on, and at the appropriate times speak to the minister. Just this morning, I had a meeting with the new chief of staff of the health minister. I do not see that in quite the same way. I have not heard whether they have put in place yet the way they are going to consult. The reality though is that a consultation process on reform of the health system cannot just be about Medicare. It has to be about the whole system. It is little about pushing down in one spot and things popping up in another.

Just looking at Medicare is going to create problems right across the system. It is actually going to take an effort, a comprehensive effort. Even if your only focus was about trying to improve the budget or decrease expenditure on health, trying to do it just on one element of the system simply will not achieve the goal. There is a huge amount of evidence there. What we really need to be looking at more than anything is how we can improve the primary health care system. Of course there are systems that can be improved and evidence around that. With regard specifically to the minister and the consultation process, the Public Health Association, and I imagine others, would like to be seen as a critical friend. We want to work with government to get better health outcomes for our people.

CHAIR: If you are going to seek those improvements and consultation based on evidence though, the first thing that needs to be acknowledged is the overwhelming evidence that putting a price signal on access to primary health has to be taken off the table. That has to be the first action of a government that is going to have any sort of evidence based discussion in the health space. Do you agree with that?

Prof. Moore: That is in our recommendations. We believe the co-payment in Medicare ought to be taken off the table. That should be the first step.

CHAIR: In your consultations with the chief of staff of the health minister this morning, what is your sense of the removal of that price signal?

Prof. Moore: When I have discussions with the chief of staff it is not for broadcasting. My comment there was simply that, yes, we do have access to the minister's office. That is the important thing. I put the perspective of the Public Health Association, and she listened.

CHAIR: We have had evidence this morning from the Rural Doctors Association of Australia that they also have had access to consultation, but none of that access to consultation resulted in policy decisions that were amenable to the outcomes of people in rural Australia. So consultation, as an exercise in friendly encounter, as opposed to evidence based, well-informed policy making, is a bit of a problem for this government, isn't it?

Prof. Moore: We would expect that to come through the Department of Health, largely to guide that, as well as the minister and the minister's office, of course.

CHAIR: Can I ask you then to characterise the level of consultation that you have had with the Department of Health?

Prof. Moore: We have had a series of meetings this year alone. We have a new secretary of the Department of Health. The Public Health Association, and, I think, Consumers Health Forum, and others, together have met with the new secretary. I have met with him twice. I have met with the department in the last two or three weeks—at least three or four times. And we are raising different issues. This is not the only issue we focus on, of course. What we believe is appropriate is a formal consultation process. In fact, this committee plays a role in the consultation process around Medicare. That is why we respond to the committee and we want to be involved in the process.

CHAIR: We appreciate your coming along. Do you have a forward schedule of ongoing consultation? Is there any sense that here is a six-month moratorium in sight for a fulsome conversation that is evidence based? Or do you have no schedule moving forward, except for a bit of goodwill and hope?

Prof. Moore: We have a new minister.

Mr Gregory: Let me speak on behalf of the National Rural Health Alliance, if I may. We agree with Michael's concept of the broad consultations that are necessarily across the board in relation to health, but if it were to be the case that something was done about a Medicare co-payment in the next two weeks, without consultation with us, we would be appalled.

I am agreeing that we wanted an ongoing way to be involved as a critical friend of the department and the minister about health reform. But we would like to be assured that there is nothing to be done about a Medicare

co-payment ever, without consultation with us, never mind within two weeks, because we have a view and we have evidence and we have positions. So we want to be consulted. From our point of view in the National Rural Health Alliance, we have a good relationship with Fiona Nash's office. One of the things we are interested in is the extent to which the consultation promised by the government might take place through her office as distinct from through Susan Ley's office. We do not know. We have been contacted by Fiona Nash's office but we have been given no indication of their intention or the senior minister's intention to consult with the National Rural Health Alliance. We represent 37 national organisations with a strong interest in rural and remote health, so we want to be consulted, please.

CHAIR: We hear of some efforts at consultation being made, but they are a bit patchy from what we can figure out so far. Did you want to comment on that?

Mr Stankevicius: I think it is the lack of clarity. Going back to my comments, they have not yet characterised what the problem is. The first kind of 'problem' was the unsustainability of the health budget. I think we have all realised that that is stalking horse number 1.

CHAIR: I think it has been described as a myth and a lie and a couple of other things.

Mr Stankevicius: I think there are probably more charitable views I have heard. The next is the price signal, because apparently there is this army of people who are going to the GP unnecessarily.

CHAIR: Also characterised as a myth and a lie on a number of occasions.

Mr Stankevicius: Exactly. We also know that there are whole classes of people who do not go to the GP as often as they should in order to get the health care they need. Still, what is the problem here? The previous proposal was going to the Medical Research Future Fund, so we know that the issue also was not about saving the budget bottom line. Again, outline for us what the problem is and then we are all willing to come to the table and work out how to solve this problem. In April last year we brought together 15 health experts across the country, including Senator Di Natale, to discuss their ways and how we can get better bang for our buck in the health area. It is looking at things like getting rid of those 150 low-value procedures. It is about better international price comparison, not only for drugs but also for prosthesis and a whole range of other areas where Australia seems to be paying extraordinary amounts compared to the UK and the US.

CHAIR: Without an accurate characterisation of the problem, what we really have is damage control rather than consultation, because the problem has not been honestly articulated at this point. Is that a fair representation of where we find ourselves right now?

Mr Stankevicius: Yes, and it has been focused on the finances.

CHAIR: Mr Gregory?

Mr Gregory: Yes, it is.

Mr Stankevicius: It has been focused on the finances rather than focused on how we can build a health system that actually delivers further increases in life expectancy. Michael and I were talking very publicly a few weeks ago about the avalanche of obesity that is happening in this country. How is that we can actually arm primary care to respond better to the challenges that obesity is going to bring to our health system. They are the ones that are going to be clogging up our hospitals if we do not actually do something now about it.

CHAIR: They will not be paying $100 to go to the doctor, or $60 if they are a concessional patient—

Prof. Moore: Which is also part of the reform process. The fee-for-service process has actually been about episodic treatment, which has actually worked very well. But as we see a huge increase in chronic diseases particularly associated with obesity, but also tobacco and alcohol, we need to question if our system is working appropriately for that style of treatment. Most observers are saying, 'No, it is not.'

Senator McLUCAS: Thank you to all your organisations for your evidence. Professor Moore, you talked about universality. It is not a word that has been part of the dialog around these changes as proposed by the government. But it was a big part of the debate originally. You make the comment, and I made it myself earlier, that you are the head of the global public health organisation—

Prof. Moore: To be. I am the vice president at the moment, but president to be of the World Federation of Public Health Associations.

Senator McLUCAS: I made the comment earlier that we are looking at America, which is trying really hard to cobble together a Medicare type health system in their country at the same time that we are essentially pulling ours apart. Can you tell the committee why universality is such an important and integral part of Medicare? Also, do you think that the introduction of a co-payment in fact removes universality?

Prof. Moore: I think that what we in public health associations see worldwide is that access to good health care is a human right, and, as such, we should be doing everything we can to ensure that there is equity of access. In our submission we distinguish between equality and equity. I think that is a very important issue. We have actually taken that distinction from the report to the World Health Organisation on the social determinants of health, which, of course, a Senate committee has also reported on. What we are interested in is a system whereby, independent of what you have paid, you have reasonable access to high-quality health care. That is not to say that everybody has to be able to get the best heart surgeon every time. It has to be reasonable access to somebody who has an appropriate standard of qualification. We are not arguing that we do not have a private system operating next to it. In fact, in our submission we raised the issue of the $7 billion that might be saved through the private health insurance rebate. But if we suggest you play with that, we too are cherry-picking. That is why it has to be comprehensive. I wonder if Dr Boxall would like to add something to that discussion?

Dr Boxall: The universality aspect of the debate has been lost. In my view it is one of the critical aspects of it. We have been talking a lot about the impact on patients of the potential changes, which is right, but the potential changes also have a big impact on our health system if they are implemented. One of those is that threat to universality. High bulk-billing rates have been pursued by both sides of government for a long time, and there is a reason for that. It is because it essentially functions as a safety net. Whilst some people may be able to afford to pay more, and they do, through the taxation system, bulk-billing is seen as a universal benefit. So if we are undermining a system and scaling back bulk-billing and making it a targeted system, we then need to be very sure that the safety nets we have in place are effective, and that is something that we are not entirely sure about at the moment, and we have evidence that people are falling through the safety nets.

The other side of the universality debate is that it is one of the main reasons people support Medicare. People feel that they are making a universal contribution through the tax system, and they feel that they need a universal benefit—

Senator McLUCAS: There is an ownership.

Dr Boxall: and bulk-billing is that benefit. It is not the MBS rebate that they feel is the benefit; it is bulk-billing rates. So people feel that high bulk-billing rates are an essential part of the system—a symbolic aspect of the system. Making bulk-billing targeted will actually, over time, I believe, undermine public support for Medicare.

Mr Stankevicius: And we all know, and we have seen, ever since I have been hanging around this space, for 25 years now, survey after survey, poll after poll, some public but most very private, right across the spectrum, saying that people overwhelmingly support increases in Medicare levies or increases in taxes if they can be assured that they will be directed to health care. So if governments of any colour go to the public and say, 'We're going to charge you a bit more for your Medicare surcharge but we can guarantee that it will go to health care,' there is overwhelming support. NDIS funding was a good example of that—

Senator McLUCAS: Exactly.

Mr Stankevicius: and I think that that reflects part of that social contract that Anne-marie is talking about, that says, 'We're willing to stump up a bit more because we see the social value in maintaining or building this kind of system.'

Senator McLUCAS: If the government was going to do that, they would have to make a case that the system was somehow broken, and I do not know that they have made that case yet.

Mr Stankevicius: I think, though, as Michael kind of alluded to, that if we are talking about a health financing debate, then everything is on the table, and at the moment all we are doing is talking about whacking users of the system or putting a price barrier between consumers and service providers, whereas the much more progressive way to do it is to actually have a robust discussion about the way in which the Medicare surcharge or levies are done.

Senator McLUCAS: We had really interesting evidence from one of our doctors just a moment ago who made the point that she does not feel skilled enough to ascertain what your income is. She can diagnose your health problem, but she does not know what your income is.

CHAIR: I had rather she got the training to diagnose my health problems than my financial capacity to pay!

Mr Stankevicius: Again, much like we have said about many conditions over the decades, diseases are not income-targeting. Just because you are poor does not mean you will have a chronic illness, but just because you are rich also does not mean that you will not have a chronic illness. So concession card holders are one group that absolutely needs to be protected because they have a whole range of other economic impacts on their lives, but we are saying that there is a whole class of people out there with chronic illness who are not concession card holders

who are regular users of health services who need to be regular users of health services to monitor and maintain their health conditions—

CHAIR: And so that they can continue to work and continue to live a full life.

Mr Stankevicius: exactly: so that they can continue to be productive members of society—who will be impacted on by these proposals.

CHAIR: Mr Gregory, do you want to make a comment there?

Mr Gregory: I wonder if it might be useful to make explicit the notion that we are actually talking about universality not as a black or white thing but as a black, white and grey thing—that is, that there are degrees of universality. I think what we are all saying, as forcefully as we possibly can, is: we do not want access to primary care to be any less universal than it currently is. That way of coining it actually suits the rural health alliance because we make the case that there are some people who do not have access at all to a doctor. We have half a million people in remote and very remote areas, and many of them do not have access to a doctor at all. So we are trying to keep our finger in the dike, but there are already some leaks in relation to people in quite remote areas.

Prof. Moore: The other element about the price signal of the people that miss out is this: I think one good example is self-funded retirees, many of whom are not on the pension—they are looking after themselves and have worked very hard to do so—who have a chronic disease, and the large costs associated with a chronic disease can be really debilitating to arrangements that they have made over many years.

Dr Boxall: We know from research that has been done at Sydney university in the past that having a concession card does not protect people, in some circumstances, with chronic disease from high out-of-pocket costs or from it being a real burden on access to care. We do have evidence that a concession card does not solve the problem by itself.

CHAIR: The hearing today has clarified for us that when the government says it is a $5 co-payment the doctors are saying, 'No; even with a concession card, it will be a $60 co-payment.' For chronically ill people, that will be a devastating impact on their access to health care.

Mr Stankevicius: Absolutely. Michael and I heard, in a forum just earlier this week, from some researchers who are working very closely in the mental health field, that life expectancy for people with chronic mental illness is actually worse than for our Indigenous population. Those people will, again, not necessarily be on a concession card, but will need very regular contact with primary healthcare providers in order to manage their conditions.

CHAIR: We did hear evidence at the Townsville hearing to that effect—about the need for ongoing monitoring, particularly for people who are managing mental illness with excellent medication but who need it regularly attended to.

Mr Stankevicius: The thing we saw coming out of our research early last year was the increasing number of people who are now accessing their life savings and accessing their superannuation in order to pay for significant ongoing health conditions, particularly chronic health conditions. In a *New York Times* article I read this week, medical debt was the largest reason for people to go into bankruptcy in America. If this is the health system we are aspiring to have, we are heading for a great big train wreck.

CHAIR: I think Professor Duckett gave us evidence about pre-Medicare garnisheeing of wages for people who sought health care. Australians today, who have had 40 years of Medicare, cannot believe there is such a world, but that is exactly where this government seems to be steering us.

Senator DI NATALE: I suppose I am tempted to go over old ground and get you to restate why you think this is the wrong direction to be heading, but perhaps, in the spirit of trying to be a little more constructive—let us assume we have a new Prime Minister next week who wants to invite you along to a forum on healthcare reform—what are the two or three key things you think need to occur in this space?

Mr Gregory: There needs to be an understanding of the need for different types of services—sometimes nuanced, sometimes quite distinct—in rural and remote areas. We know that one model does not fit all. Let me be like yourself and acknowledge credit where credit is due. There are already special programs, as you well know, for rural and remote health. We acknowledge them. There is money for the RFDS. There are special programs like MSOAP and so forth, but what we are saying to the government is that it is not enough. We know far more about the service models that will work in more remote areas, and we need to identify them, have confidence in them and fund them in an ongoing way. The keys are things like flexibility and ensuring that in rural and remote areas we do not deal with health, disability and aged care as if they were separate empires, because they are not. It is the same busy, active, wonderful clinicians who are working in all three of those areas, as you well know. So

we need to get much more serious about integrating health care with acute care, with aged care and with disability care. Of course, this is ultimately a challenge to governments to do something that we have been talking about for donkey's years—that is, a so-called joined-up government approach to health services. There is nowhere where it is more critical, or indeed where it would be more productive, than in rural areas, because it is the natural way of rural communities. Everything is related to everything else with the small numbers in rural areas. We have to allow for that in the health services, the aged care services and the NDIS.

Dr Boxall: There are lots of options for savings in the health system. Most of them are not politically easy, but I think the time for low-hanging fruit has well and truly passed. There is no shortage of options to find ways to make the system more effective and more efficient. One of the ones that already exists is identifying things on the MBS which are less effective or not effective. There is a process in train. The government is already doing that, but a lot more investment in that process will make a huge difference.

Senator DI NATALE: We are talking about the MSAC process for reviewing the MBS. That is only scratching the surface though, isn't it?

Dr Boxall: It is—and there is a lot more that could be done. To me, that is a very obvious way. It is already using an existing process; it should be ramped up.

Senator DI NATALE: Yes.

Dr Boxall: Another option is a campaign that has begun, called Choosing Wisely, and that is educating healthcare professionals and patients about making sure that only the most necessary tests are ordered and we do not do a battery of tests every time someone walks in the door with a cold.

Senator DI NATALE: Just on that, specifically, that is effectively voluntary and it is trying to engage the medical profession in a conversation that is important. But my concern there—and I still think it is a worthwhile initiative—is you are still going to get doctors and a subset of health professionals who will continue to order tests for which there is no basis and which add no value, except that they cost a hell of a lot of money. How do we overcome that barrier?

Dr Boxall: That is a supplement to anything else, I agree; that is all going to happen. It is a process of education, so it is something starting as people are in medical education now or in education as health professionals. It also needs a public awareness campaign. If people are ill, they are in a position of uncertainty and they want to know they have had every test under the sun so they feel safe and confident. So people need to be educated that having a vitamin D test, for example, when there is very little risk of you having a vitamin D deficiency, is not actually going to help you. So public awareness and health professional awareness are an important part of that campaign.

The other aspect of it is much more rigorous testing of new technologies that we introduce. We can do lots of whiz-bang things but we need to weigh up whether there is a benefit in doing lots of whiz-bang, high-cost things for a very small proportion of the population or whether we should invest more in primary care, where we are going to get much better outcomes for the population. That is a value judgement that governments need to make.

One more thing is changing the scope of practice for health professionals. It is very contentious, but there are ways of getting people with lesser training to do things—perfectly competent people who can provide services at a high quality but at a lower cost.

Senator DI NATALE: Do you have anything to say about private health insurance?

Dr Boxall: Probably not here, because it is a very lengthy debate. But I will say one thing about private health insurance in relation to Medicare. It has been a longstanding problem for Australia to manage a universal healthcare system that is funded through taxation as well as a private health insurance system on top of that that is partially funded by government. It is a problem that no government has successfully managed to solve since the introduction of Medibank. There has been tinkering around the edges, but it is well overdue for a thorough reconsideration.

Senator DI NATALE: Thank you.

Mr Gregory: Can I add that the balance between preventive health measures and others is quite wrong in Australia. We need to spend more of our time, energy and resources on preventive health. One very clear example is smoking. We have not succeeded in reducing the rate of smoking in rural areas as we have in city areas. We need to know why this is, we need to know better, because there is probably no single initiative more important than stopping people smoking—and they are still doing it in rural areas in high numbers.

Prof. Moore: And of course in Indigenous communities, although the government has been working quite seriously on prevention of smoking in Indigenous communities. To take your question, Senator Di Natale, 'What

would you say to a new prime minister,' I would say, 'First of all, Prime Minister, the health system is not in crisis. I know you think the budget system is in crisis, and that is a separate debate. But the health system is not in crisis.'

Senator CAMERON: You have all said the same. Your answers are exactly the same.

Prof. Moore: And we accept that co-payment 2 was actually a little bit better than co-payment 1. It did at least recognise the problems around pathology. It did at least recognise the importance of a co-payment with regard to the full range of social service card holders; we accept that. However, if we really want to proceed and go forward, No. 1, the co-payment must come off the table. No. 2, looking at reform should be done at arm's length and it should be comprehensive. No. 3, it should take into account the social determinants of health in a way that is consistent with the report of the Senate community affairs committee; and, to be a comprehensive, independent, systematic assessment of the whole health system, it must include representatives of vulnerable populations, such as Aboriginal and Torres Strait Islanders and others. Of course, whatever we do must also include the states and territories. That is actually what the challenge is.

CHAIR: Thank you.

Mr Stankevicius: I want to say that all of my answers have been stolen! Following up on Michael's last point, though, I think the people who use the system and the people who pay for the system as taxpayers are the ones who so far have not been comprehensively involved in the consultations on changes. That is the first thing I would say. Health consumers are the ones who know why they go to the doctor. The doctor might think something very different when they get there, but the consumers are the ones who have the reason in their head as to why they choose a hospital over an after-hours service and over waiting until the next day to try to get in to see a GP. There is a whole range of factors that are behavioural in the way in which people use health services which I do not think health policy planners understand enough of in order to make the right choices for planning the future of our health system. That would be my No. 1.

The Productivity Commission said about a year ago that there are 700,000 admissions to hospital we could avoid every year by better community intervention three weeks before the hospitalisation.

Prof. Moore: That would save a lot of money.

Mr Stankevicius: At an average of $5,000 per hospital visit, we are talking billions of dollars. So further investigating how we can do that is, I would say, one of the number one challenges. We know that keeping people out of hospital is actually keeping them healthier as well. But, again, it goes back to Michael's critical point about that state and territory divide with the Commonwealth. These things are not always going to hit the Commonwealth's budget bottom line first; they would probably hit the states and territories first. Therefore, the incentive for the Commonwealth to kind of get involved in that kind of savings activity is not as strong as it should be, to be quite honest.

The point I would make is what Anne-marie mentioned, which is actually doing the low-value, no value procedures. There is also the other one I mentioned, which is international comparisons. We have done it with drugs. Adam Elshaug, from the University of Sydney, has done some analysis of the top 10 prosthesis used in both the public and private sectors and has come up with $250 million to $400 million a year in savings if we did better international price comparisons with the US and the UK.

So there are a number of areas we could tackle and make significant cuts—not just shaving the top off—in health expenditure without putting that price barrier between providers and consumers and without having a serious impact on our health outcomes—which, after all, is what this debate should be about.

CHAIR: Noting the time, I think we need to move on now. I hope Ms Root has been reasonably covered there.

Ms Root: The only one I would add is the issue of futile care. We have talked about low value and no value but we also need to have a conversation in this country about when care is futile. There is a growing interest in the medical profession and in the community broadly around not always doing everything we can possibly do. There is a balance between quality of life and interventions, and we do not necessarily need to do everything to everybody. Not everybody needs to go to an ICU. If we know they are going to die, we need to have a process that helps that happen in a much more civilised way, I suppose is what I would say. So I would just add futile care to the discussion.

Senator CAMERON: That is an interesting point, because that brings in the palliative care versus euthanasia argument. When you boil that down to economic issues and moral issues, I do not think the committee is going to engage in that, to be honest. It is an issue that politicians have to engage in. There is of course the issue of prolonging life unnecessarily.

Mr Stankevicius: Absolutely. The data is increasingly showing that ordinary high amounts of expenditure—

Senator CAMERON: It is interesting that you are the only ones who have raised that as an issue. I know how controversial—

Prof. Moore: I do not think that we are suggesting something like voluntary active euthanasia; we are talking about good palliative care that does not have additional unnecessary treatment. I think we would all be on the same wavelength on that.

Senator CAMERON: I am obviously on a different wavelength. I support euthanasia if that is a person's choice.

Ms Root: What I am saying is that there is a view that people say, 'I want everything done,' and I think it requires consumers as well as health professionals to understand when that is not actually going to do any good. So this is not about voluntary euthanasia and it is not about making an economic argument. But it is about consumers having a better understanding and health professionals being equipped to have the conversation with them.

Senator CAMERON: Yes, I understand that. I do not think I want to go down that path.

Ms Root: So I just wanted to clarify that my comment—

Senator CAMERON: Yes, I understand, but there would be lots of different arguments and views. Has anyone actually had any discussions with government where we have clarified whether the budget papers are still the driver of the cuts in health—that is, the establishment of a medical research fund—or is it a budget emergency? Is it sustainability? Does anyone know what this is about yet?

Mr Stankevicius: I have not had any discussions personally with the department or ministers that would say that, but from what you see in the media I think it depends on which perspective you are looking at it from. It would appear that the former health minister has different reasoning, I suppose, from the Treasurer, who appears to have different reasoning from the Prime Minister, depending on which angle and, I think, which audience it is. That is again what I was saying at the beginning, and the senator clarified it: we have not properly characterised the problem yet, so how do we know what the solution is?

Senator CAMERON: The problem, from what I hear from lots of people, is that it is ideology. It is about cost cutting. It is about austerity. It is about more privatisation of aspects of medicine, because the budget papers are clear: all the savings from health are going into this research fund. Has anyone disavowed that position to you?

Prof. Moore: No, remembering that this is a medical fund, not a medical and health fund. On budget night, I actually put that very question to the then Secretary of the Department of Health, who said it was a government decision that it be a medical fund, not a health and medical fund, which we also find extraordinarily narrow in its concept.

From what we can work out, the fund will only feed into medical research as interest—so just the interest will be paid. My shallow understanding of budgets is that therefore the $2 billion will actually sit on the government's bottom line and, insofar as that is true, will assist in not having them go into the red, addressing their great fear that they might have some kind of deficit despite their AAA credit rating.

Senator CAMERON: It is interesting just to go back to the budget every now and again and have a look at the headline issues, such as getting rid of the Australian National Preventive Health Agency. I would have thought that would cost the community in the longer term, rather than save money.

Mr Stankevicius: I think the last time we were in front of you we were talking about exactly that bill. Actually, no, it might have been the community affairs committee. Sorry, it was at the table. When we were last at this table, we were talking about that and the Health Workforce Australia (Abolition) Bill.

Prof. Moore: I put a huge amount of work and effort into getting that bill up and supporting the agency. It actually reflects a lack of understanding of the long term. Mr Gregory raised the issue about prevention, and governments pay lip service, basically to prevention, but governments of whatever colour have basically stayed around two per cent of expenditure being on prevention—I am using Institute of Health and Welfare figures. It went up a little bit under the previous government and actually when Tony Abbott was health minister. That was almost entirely around HPV immunisation, which was a very good prevention measure. But, apart from that spike, by and large prevention has been around 1.8 per cent, and we would like to see governments seriously think about it. There is a variation in states and territories. Some states are spending quite a bit more than that, but the average is still in a similar area.

Senator CAMERON: There have been submissions to the inquiry that indicate that, as a percentage of GDP, our health spending is just under the OECD average, so sustainability is not the issue. We will have Treasury here

this afternoon. Have any of you looked at the budget papers? I cannot find how Treasury can argue unsustainability. There are assertions made about unsustainability, but I have seen no evidence. Have any of you seen any evidence on unsustainability?

Prof. Moore: Looking at your program, you are talking to Dr Duckett later today. He is actually the person with the best understanding on this; a better understanding than any of us. We would basically rely on his figures. As you are speaking to him, it would be really worthwhile asking him about the evidence.

Mr Stankevicius: I would also point you to the most recent *Health expenditure bulletin,* for 2012-13 I think it was. That showed for the first time since the institute has been collecting the data that the rate of Commonwealth contribution had dropped. That is the Australian Institute of Health and Welfare *Health expenditure bulletin* for 2012-13. The Treasury has been predicting a particular trajectory for expenditure. This showed that perhaps there is a blip in that and we do not know whether it is a one-year blip or a longer term blip, but it certainly showed the Commonwealth's trajectory had dropped, state and territory contributions had increased and of course individual health consumers out-of-pocket costs had increased.

Senator CAMERON: The other argument I have seen is that in world comparative terms Australians actually do pay a significant part of their health as a co-payment.

Senator MOORE: We have in our submission a graph that shows the proportion that Australians spend compared to other countries. People in the United States spend a lot more, but Australia is right down that end of the scale of OECD countries. That is on page 12 of our submission.

Senator CAMERON: Mr Stankevicius, your submission goes to an area that I have responsibility for—that is, the Department of Human Services—the potential privatisation of Medicare payments. Can you outline to me what you see the concerns there are?

Mr Stankevicius: I think there is a range of protections that we would want to be putting in place to ensure that personal information is being protected and that the point of contact with whatever service provider and the privacy of those kinds of relationships are being protected. One of the things that we have been most concerned about is that a few providers that have been raised as ones that have a large number of shopfronts across the country and therefore might be able to basically replace the service provision model are not necessarily set up to meet the needs of everyone in the population. If you think about Australia Post, for example, none of the post offices I have ever been to have a counter that is low enough for people in wheelchairs or for people with walking sticks so they can actually rest there to have their conversations. We all know that, particularly with the changing nature of rebates that we are seeing and that we have been talking about today, some people need to have those longer conversations with people at the counter. 'I have had this done. I am not sure how much I can claim.' 'How much I will get back? Will it go into my bank account?' 'Actually, you need to refill in this form again.' 'Sorry you cannot hear me.' 'You'll need to speak a bit louder.' Or if it is an Australia Post shopfront, the person next to you could be getting their currency exchanged and someone else could be picking up a parcel, and all of a sudden they are hearing very private conversations about a hysterectomy, about how many times someone has to see their gynaecologist and the fact that they filled out the form incorrectly. There is a whole range of concerns about the way in which that outsourcing model might apply. It is not just a transactional service when it comes to Medicare.

Senator CAMERON: In terms of evidence based policy, no-one has come here and argued that there is any evidence for this policy framework that the federal government is putting forward. Have you seen any evidence based policy or analysis that would justify what the government is doing?

Mr Stankevicius: If the objective is to improve health outcomes, we have not seen any evidence that would suggest that the proposals in relation to rebates or co-payments would improve health outcomes—none whatsoever; in fact the opposite.

Dr Boxall: Essentially it is all about constraining health expenditure, and there are a range of different mechanisms for doing that. Imposing co-payments or cost sharing on individuals is one of many, but it is one of the least effective mechanisms in the long run. It does actually reduce expenditure, obviously, because it imposes a financial barrier to people accessing care, but its long-term impact does not make good economic sense.

Senator CAMERON: Is it the same for rural areas?

Mr Gregory: We are not aware of any such argument as you asked for.

Mr Stankevicius: It compounds one of the examples that we gave from one of our consumer consultation forums last time. We were talking to a woman who has a mental health issue. She has to go and see her psychologist regularly in Melbourne. She is from rural Victoria. The cost that she hands over to see her psychologist is $200 per visit. The cost of her actually accessing that health service ends up costing her over $600, because to travel each way from where she lives to where she can get that service that she so desperately

needs, to maintain her health, is more than $200 each way in addition to the actual cost of the service. That is the exacerbation we are going to see.

Senator CAMERON: That goes to this whole issue that Australians are making a significant contribution, outside of the Medicare levy, to their health anyway.

Mr Stankevicius: I think the last time I saw some stats or reporting on the patient transport schemes, they are still expecting people who are going from rural New South Wales, for example, into Sydney for an operation to be able to find accommodation for $40 a night. I think that was the last I saw. You cannot even get a YHA bed for $40 a night in Sydney.

CHAIR: You would probably need hospitalisation after you had stayed in something that cost you $40 a night!

Mr Stankevicius: So there is a level of unreality, I think, in what it is we are expecting consumers, particularly rural and regional consumers, to put up with to access mainstream health services.

Senator CAMERON: What message should we give the Treasury boffins this afternoon, because they will come in with all their economic and fiscal arguments on this?

Prof. Moore: Compare the out-of-pocket expenses for Australians on that graph. It shows that, compared to New Zealand, compared to Germany—Germany is not exactly the poorest-performing economy on earth—Australians are spending much more out-of-pocket expenditure on health.

Senator McLUCAS: We have asked this question of the department previously, and the department has pointed out to us to at one point we were comparing apples and oranges because, between the countries, they are saying, the grocery list of the list of things that are included in the out-of-pockets are different, country by country. The other point that they have made—and I am interested in any comment you might have—is that Australians use complementary medicines at a higher rate than other nations. That is their argument to respond to your table, Professor. Do you want to comment on that?

Prof. Moore: It is challenging research, but the table comes from the Institute of Health and Welfare and we specifically choose to take things from evidence based along those lines. I am sure they spend as much time as they can to try and deal with those sorts of confounding factors. But comparisons between countries are always challenging, of course.

Senator McLUCAS: Of course.

Mr Gregory: Let me give just one simple example relating to the person from country Victoria who has to pay so much money to go to Melbourne to see a psychologist. The Rural Health Alliance, for which we work, currently has a package, which we are promoting, to make rural mental health services better. One element of that package is that currently, under ATAPS, telehealth with a psychologist is not eligible. If Medicare were to be changed so that it were, then the savings would be enormous. That is one small element of how you can redesign a service to fit the needs of both the Treasury and the gentleman or the lady from northern Victoria.

Senator McLUCAS: And in the knowledge that telehealth in that circumstance is quite efficacious.

Mr Gregory: Yes.

Mr Stankevicius: I cannot remember the exact list in my head—I have got it somewhere—of those comparisons about out-of-pocket costs. I know in the top three are PBS medication—so people paying out of their own pocket for PBS medication—

Senator McLUCAS: The co-payment.

Mr Stankevicius: and aids and appliances, which neither level of government actually currently subsidises. If you need to buy a wheelchair in this country, and you talk to some of our millionaires who are in wheelchairs, even they are astonished about the tens of thousands of dollars they have to pay for a reasonable standard wheelchair, and no government is subsidising that anywhere in a lot of cases.

CHAIR: If you want to provide us with that information, I am sure the secretary would be happy to receive it.

Mr Gregory: Out-of-pocket costs as calculated do not include the costs of transport and accommodation, so this 19 per cent, which makes Australia already higher, does not include the extra costs of rural people having to take transport and stay somewhere down in the city or the regional centre. It is not included.

Mr Stankevicius: Or private health insurance rebates. Those figures do not—

CHAIR: We have people paying their Medicare, they are paying their BUPA or some associated—they are out-of-pocket, and now they have to pay at the gate as well.

Prof. Moore: Can I just clarify please: the graph I have is actually from Stephen Duckett, it is not from the Institute of Health and Welfare. I thought I had better clarify that.

CHAIR: Thank you. We will clarify it with Dr Duckett after the break. Thank you very much for your submissions to us and for your evidence here today. We look forward to continuing to hear from you, especially if some of the consultations dry up in two weeks.

Proceedings suspended from 13:25 to 13:47

JUDKINS, Dr Simon, Councillor, Australasian College for Emergency Medicine

KILLEN, Mrs Alana, Chief Executive Officer, Australasian College for Emergency Medicine

CHAIR: I welcome representatives of the Australasian College for Emergency Medicine. Thank you for joining us once again. I invite you to make a brief opening statement.

Dr Judkins: Good afternoon. Thank you for the opportunity to speak today and discuss the concerns that we, the Australasian College for Emergency Medicine, have in relation to the proposed changes put forth regarding funding changes for health care in Australia. ACEM is a not-for-profit organisation responsible for the training and ongoing education of emergency physicians and for the advancement of professional standards in emergency medicine in Australia and New Zealand. As the peak professional organisation for emergency medicine in Australasia, ACEM has a vital interest in ensuring that the highest standards of emergency medical care are maintained for all patients across Australia.

ACEM remains significantly concerned that the introduction of any new co-payment mechanism for medical care will only further exacerbate the health access problems and ultimately lead to greater long-term financial and health costs for the Australian community. Australian consumers have already reported experiencing difficulty with costs, impacting on their ability to access the health care they need. ACEM contends that targeting primary health care for cost savings or revenue raising will be ineffective, as research has actually showing that the increase in rates of GP visits is more cost-effective than if these services were to be provided in others areas of the healthcare system. In particular those costs are for those patients with chronic illnesses who rely upon affordable access to primary health care much more than the rest of the population. They will likely be disproportionately impacted by an increase in out-of-pocket expenses. With an ageing population and subsequent increasing rates of chronic disease the need for effective community management of such illnesses will only grow further.

Many emergency departments across the country, as you would all be aware, consistently suffer from overcrowding and access block—that is, the inability for the ED to move patients to in-patient areas or theatre. It is a two-door hospital system which operates at maximum capacity most of the time. Any change which will lead to an exacerbation of this ongoing dire state raises grave concerns in the emergency medicine community. Emergency departments are designed for, and emergency staff are trained to, care for patients with acute illnesses and injury. Emergency departments not places for patients with chronic conditions who need ongoing care or for patients who can and should have the ability to be treated elsewhere in the health system. Compounding these proposed changes to the GP funding arrangements is the dismantling of the national partnership agreement, along with the National Emergency Access Target. We are concerned that the impact of this double whammy will see a significant deterioration in an already fragile state for many of our EDs and public hospitals. A robust and well-resourced GP community is one of the vital cogs in the healthcare machine and clearly has an impact on this ongoing problem.

ACEM contends that there are solutions within the health system to see a sustainable future. We acknowledge that the future challenges will necessarily involve balancing attempts to maintain or improve standards, without increasing per capita costs. ACEM considers appropriate resource stewardship needs to become a cornerstone of health system operations if sustainability is to be achieved. For example, as noted in a recent report by Russell and Doggett, there has been relatively little work done in identifying practices such as ordering tests, prescribing and procedures which are inappropriate and/or unnecessary. ACEM strongly believes that there are also significant gains to be made not only from a savings perspective but also with regard to quality of patient care and considering the value of various healthcare interventions. Choosing Wisely Australia, for example, is an initiative aimed at improving the quality of health care by addressing these very issues—that is, by identifying tests and treatment procedures where evidence shows that they have no benefit or, in some cases, cause harm. As a participant of Choosing Wisely Australia, ACEM is currently in the process of identifying such low value items for both patients and doctors to consider during their consultations.

ACEM and it fellows, the emergency physicians providing care in Australian and New Zealand emergency departments, understand the need for reform. We are strong advocates for reform that will see our health system robust, sustainable, effective and efficient. However, we also believe in a system that is just and socially equitable and a system that has a focus on prevention and maintaining health. We would strongly reject any change that would potentially see patients having to seek their care in an already overcrowded and stretched public hospital system, through lack of resourcing, access and care in other sectors. Thank you.

CHAIR: Thank you, Dr Judkins. Mrs Killen, do you want to add anything?

Mrs Killen: No. I think Dr Judkins has covered the points very nicely. Thank you.

CHAIR: Thank you for your submission and for your participation today. You have heard some of the evidence that has been given here this afternoon.

Dr Judkins: Yes.

CHAIR: One of the things that we consistently hear is that there is a myth that continues to be perpetrated about the sustainability of Medicare. On the back of that myth, if it continues and there is a co-payment, the articulation of our experts so far is that patients will end up in your field, in the emergency rooms across this country. Have you seen any shifts towards that already? Have you seen increasing anxiety about it? Could you speak to the concerns that you think are imminent, if a co-payment is required?

Dr Judkins: There is always concern and there has been concern for many years. We know about the issues of overcrowding and the stretching of emergency department resources. There is no doubt that there is a certain cohort of patients—there are a couple of different cohorts of patients—who do present to emergency departments when they could receive their health care in another place and there are those people who have been termed 'GP type patients', for want of a better term. But there are also those patients who, unfortunately, end up in our emergency departments because they have not been able to access appropriate care in another place, whether that is by a GP, whether it is by an aged care physician or whether it is by getting access to a surgeon or surgical outpatients. Whatever their chronic problem is, it becomes an acute problem, and they suffer a health crisis and end up in our emergency departments. It happens across a spectrum of specialties. It is not only GP patients; it is also surgical patients, oncology patients and, as we heard before, mental health patients. There is a big concern that we are seeing a growing number of mental health patients, a growing number of drug-affected and alcohol-affected patients. It is the combination of all these factors that I think makes most emergency physicians and emergency staff become gravely concerned when we hear there might be measures put in place that will exacerbate the problems that we already have.

Mrs Killen: Just with reference to your query about whether we would anticipate a co-payment impact on appearances or attendances, there is some anecdotal evidence that, following the announcements of the budget last year, there was a spike in emergency departments, because people assumed that it had already taken place. This is anecdotal. It was reported back to us that some emergency departments reported that patients were presenting there because they thought that they were going to have to pay already, so we know that there will be an impact. We have evidence that that is going to happen.

CHAIR: So you have had a trial run, almost.

Mrs Killen: Almost, yes. In the week or two following the announcement, we had reports saying that the people had actually been presenting at the EDs under the impression that the co-payment had already been implemented, and they could not afford to pay it and they were not going to pay it.

Dr Judkins: Looking at it from the opposite end, we certainly have not seen any comforting information to say that it is actually going to reduce presentations to emergency departments, so I think that we can only work on the information that we have. We read all the same material and listen to the same material that you have access to, and everything seems to suggest that if measures like this come into play then we will see a spike and a surge in patients attending their emergency departments.

CHAIR: How do your staff normally deal with patients who come to emergency departments who you think should see a GP? How do you manage that currently?

Dr Judkins: Currently we see them. People come to us for care, and we are not going to refuse anybody care, so we see them. There are a couple of different issues. The biggest problem we still have in emergency departments is the issue about overcrowded and full hospital system beds. Patients who need admission getting into the healthcare system provide us with a lot more anxiety than patients with minor problems who could be dealt with elsewhere, but they certainly do take a cohort of our staff and resources. But most of the time we will see them, because it is often quicker for us just to see them and sort them rather than spending a lot of effort and trying to say, 'Well, it's fine that you've come here now, but it's not an emergency department problem; you could do this, this and this.' We do not necessarily want to deny people access to health care.

CHAIR: You soak up a bit of the emergency overflow at the moment, but if this became an increasing trend then how would it impact on the work that you do and your capacity to care for people who genuinely have an emergency?

Dr Judkins: There are multiple, multiple studies, not only in Australia but overseas, that show that, if patients turn up to an emergency department with a crowded waiting room, with physicians and nursing staff who are under stress, patients have poor outcomes. If you are the fourth, fifth or 20th person in line when you walk into an emergency department and you actually have chest pain which is a cardiac problem, any delay that is put in place

for you to see the person who is going to make the decision on your treatment will worsen your outcome. So there is no doubt that turning up to an overcrowded and stressed emergency department increases patient morbidity and decreases the level of care that we can provide.

If the staff are overwhelmed, it is a bit like a needle in a haystack: you see so many patients that trying to pick out the patient who was actually the sick one becomes a lot more challenging. You are getting multiple inputs about multiple patients. To try to care for the person who is actually sick and identify the person who is actually the sick person among the increasing number of patients we are seeing does become more challenging.

CHAIR: You made reference in your opening comment to the National Emergency Access Target. Could you give us an update on where that is and any concerns you have about it.

Dr Judkins: For all the negative publicity and concerns about that, one of the positives for us is that it really focused not just individual jurisdictions but the whole health system of Australia on the fact that we need to reform the way we run our public hospitals. If you look at various jurisdictions around Australia, certainly there have been shining lights in Queensland, and Western Australia had their moment in the sun, but they are now struggling a bit. It did actually focus efforts on saying that emergency departments are for emergency patients and we need to unclog our emergency departments. We are concerned that, with the current lack of national focus on emergency department access and overcrowding, that will start to trend back to the bad old days where we had patients lying in beds for 24 hours. There is no incentive to get patients out of emergency departments who obviously need in-patient beds.

CHAIR: Let's just be clear: people who are not in the sector and who thought that there was a set of targets that were in hospitals may still think they are there. Can you explain what has happened, at what date you were advised and what the changes are based on.

Dr Judkins: We are coming to the end of the term of what we call the national emergency access target. That was the four-hour time line that we would look at trying to get all patients admitted or discharged out of emergency departments. It has taken quite a long time to get ahead of steam but we are starting to see significant gains across lots of different jurisdictions. Unfortunately, that national partnership agreement has been dissolved and that five-year period of health reform finishes this year and there is nothing really to replace it. So every state is now grappling with what their target may be and what the drivers are going to be to get patients out of emergency departments and through the hospital system. There is benefit to having a coordinated approach, because everybody learns from each other and everybody looks at examples. If we dissolve that down to individual jurisdictions or individual health services, we feel that the lack of focus will certainly see a decrease in the emphasis on getting patients through our health system.

CHAIR: The decision to stop that target and cut that funding was a decision of the Abbott government.

Mrs Killen: Yes.

CHAIR: To your knowledge, was it based on any evidence, or is it another ideological decision based on dollars only?

Mrs Killen: I think at the time of the announcement the wording in the budget was that there was little evidence to support the fact that the NEA targets had been effective. Our college produced some evidence to suggest that they were in fact gaining momentum and had in fact been successful in some states. So we found that rationalisation somewhat interesting at the time and would argue that there was actually some momentum occurring with regard to NEA targets. In fact, after the announcement, some of the state premiers came out and said that they intend to continue with the targets because they had been successful. There has been silence on that since that time and we have not really heard a lot of information. The feeling amongst the fraternity seems to be that the target is dead in the water, which we think is a shame because there were certainly some gains occurring.

CHAIR: Probably a lot of the consumers of health would be a little disappointed. They are probably still harbouring the impressing that they are going to get in and get out in four hours and that that is a goal. So that is no longer the situation?

Mrs Killen: No. As Dr Judkins intimated, the really good thing about it was that it was a whole-of-system approach. The hospitals had to take responsibility. The entire hospital was responsible for the throughput of patients and the patient journey. We were starting to see some really models of care being introduced in certain areas that were being very effective in moving the patients through. Of course, with the cessation of this target and the end of the partnership, there is no incentive for hospitals anymore. It is a shame, because there has been so much good work done and not an insignificant amount of money put into implementing these targets. Like everything else, the frustration is that you just start to get something working and then they take it away. It is disappointing.

Dr Judkins: And the evidence for these sorts of things does take time to appear. In fact, some good evidence has just come out of Queensland around the improvements they had within their hospital system with the national access targets, which showed that it was improving patient morbidity and patient mortality. So we were starting to get to the point where we were identifying success when the targets were being dissolved. Certainly there are lots of arguments about what the right target is et cetera, but there is certainly evidence to show that if you can focus a whole system on getting patients moving through the system in cutting inefficiencies, cutting waste and focusing on the right thing for the patient, you will see better healthcare outcomes.

Senator McLUCAS: Thanks very much for appearing before us again. I want to go to your point, Mrs Killen, about the anecdotal evidence around increased presentations. You were talking about the two weeks post budget—after the budget last May. I know it is anecdotal—and that is fine—but what did you hear?

Mrs Killen: What I heard were reports from various hospitals. We had contact in the college just to let us know for our interest, I suppose, that there were patients appearing in their emergency departments who were under the impressing that the co-payment had already been implemented and they had chosen to come to the ED because of that; that they would normally go to the GP but, because of the GP co-payment, they were coming to us. When I say 'anecdotal', it was definitely anecdotal. I can quote a number of calls that I got about this, but I do not have any—

Senator McLUCAS: Was it two or five?

Mrs Killen: Probably four or five phone calls about it. If I had done some emailing around and asked, perhaps I could have got more significant evidence but at the time it was just somebody ringing me up and saying, 'You might be interested in this.' I do not have anything other than some phone calls and anecdotal—

Senator McLUCAS: It ties in with evidence we heard this morning from a group of GPs, one of whom reported a decrease in attendance at her surgery in the fortnight post the budget and other GPs said there was not a decrease—these are GP services in areas where you have a 2½ week wait to get into surgery. So it is not as if there were a depletion in numbers; it was just a reduction in the time you had to wait to see a GP. So those people who did not go to the GP turned up at your place.

Mrs Killen: Yes. There are a lot of major concerns around that. Anything that disincentivises someone from attending their GP for us is a major concern not just for the overcrowding issue for our EDs but for the patient themselves who may put off coming. A preventable issue might become something chronic or worse and that leads to much worse outcomes and costs a lot more money in the long term.

Senator McLUCAS: There is no way we could put some more evidence around that anecdotal material, is there?

Mrs Killen: We could do surveys but they would be retrospective and I am not sure how my much validity they would be given.

Senator McLUCAS: It is a long time ago now.

Dr Judkins: Certainly we could look at data like tendencies at emergency departments to see whether there was a trend. Obviously we would have to get a lot of that information from health departments.

Mrs Killen: And there could be some confounding factors because it was winter. People say that that is because there was an outbreak of colds or something.

Senator McLUCAS: What you are telling us does stand to reason. It is probably accurate.

Mrs Killen: Yes.

Senator DI NATALE: Are you aware of the Productivity Commission report which came out yesterday on government services? Did you see any of that?

Dr Judkins: I saw a little bit of it last night. Certainly I seem to recall there was comment about the access to GP services and the extra costs of not seeing GPs.

Senator DI NATALE: There is also some stuff in there about emergency departments. It said that:

Nationally, 23.6 per cent of people who went to a hospital emergency department for their own health in 2012-13 thought at the time that care could have been provided at a general practice.

In other words, one in four people ended up in an emergency department when they thought they could just as easily have gone to a GP.

Dr Judkins: Yes. It is already an issue. From our point of view there are a number of different issues that affect emergency departments. The GP type of patient, again, is something we do not necessarily like to overstate because we have bigger fish to fry as far as access is concerned, just getting patients out of EDs who need to get

into the hospital system. Certainly, there are already comments that one in four patients are turning up. If that increases—as I said, we do not need anything to encourage patients to come to us to access care because we do not provide good GP type of care for patients. We see them once and send them on their way. We are not there for continuity of care. We are not there to treat chronic conditions. We are therefore for accidents and emergencies.

Senator DI NATALE: Fair enough. Hence the name, I suppose. Can I ask you about the Choosing Wisely initiative you are involved with. That is run by the NPS or auspiced through than National Prescribing Service—is that right?

Dr Judkins: Yes, that is right.

Senator DI NATALE: And I do not know whether it has been officially launched yet.

Dr Judkins: The launch is on 26 April or something like that.

Senator DI NATALE: I have a few questions about how that is going. I agree absolutely with the analysis that we do a lot of things in medicine. There are other areas we should be targeting that would improve the system—better value for money, a lot of low-value items. You are involved in this along with the other medical colleges?

Dr Judkins: We are involved with the colleges of physicians, radiologists, general practice and—I cannot remember the other college off the top of my head, but there is a core—

Senator DI NATALE: Are the AMA involved as well?

Dr Judkins: The AMA are not necessarily involved because they are not at college. It is really trying to get the learned colleges in to try to use evidence to say what is best practice. They wanted to really start off with a core group of engaged colleges and then try to expand out to involve all specialists.

Senator DI NATALE: What is the process?

Dr Judkins: The process has been that each college goes to its members and identifies procedures, processes, tests, medications and treatments that actually do not have any evidence.

Senator DI NATALE: How do they do it? Do they just write to their members?

Dr Judkins: It is evidence based. We look at the studies. I will give you an example. A bit of low-hanging fruit would be doing back X-rays for back pain. There is no evidence to suggest that that is a useful investigation, yet thousands of X-rays are performed all across Australia for back pain and they do not change management. So there are a lot of things that we do throughout the whole health system that are not evidence based. They are based on what we used to do. They are not based on any evidence at all, and they are based on patient expectation. Patients want something done.

Mrs Killen: There is consultation across the college around what our members feel are the top priorities. We are looking at the moment for maybe the top five.

Senator DI NATALE: So how have you done that? You put a call out to all your members saying, 'We are engaged in this process. Tell us your top five'? Or are you engaging people to do a literature review?

Mrs Killen: We are just in the early stages.

Dr Judkins: We have basically done a literature review and we have a committee. We have basically cut it down to 10 investigations or procedures and then we are putting that out to our members. If we asked them, we could come up with a list of 100. We want to get the big-ticket items that everybody knows and then start to work on those and really try and get that culture change throughout—

Senator DI NATALE: That is my next question. There are different ways of doing this. One is that you remove the item number, or whatever it might be if it is in private practice. I suppose that is a blunt way of doing it. The other way is to try and engage the profession. How do you see that translating into, 'We are no longer doing X-rays for back pain'? That is the step I do not quite get yet.

Mrs Killen: We have discussed this quite extensively and of course this is not a quick fix. This is not something that is going to save money in the next two or three years. This is a long-term cultural change involving education of the medical profession and the consumer. I think consumers come to emergency departments and expect to get a raft of tests and, if they do not, they feel they have not received the proper service. We need to educate the community and change the expectation of the consumer around the risks of radiation, overprescribing and inappropriate interventions, rather than have people coming in saying, 'I want a CAT scan,' 'I want an MRI,' 'I want a chest X-ray,' 'I want drugs' and, 'Why didn't you give me antibiotics?' It is a long-term process of education and cultural change—and that is part of the problem, because it is not a quick fix. It is not just taking out the MBS number and saying, 'That is no longer covered.'

Dr Judkins: The difference here is that this is a national campaign that says it is okay not to do these things, whereas when it is a one-on-one doctor-patient relationship and the patient says, 'I want this test done,' it is very hard to deny it, to say to a patient that you do not want to do it. There is an expectation from the community that these things need to be done, but I think having that overarching authority to say, 'This is okay because we don't support this investigation anymore,' will actually see that culture change. Most doctors, at least the people in my college, want to practise the best evidence based medicine, but occasionally you do need the support of the college and other organisations to say, 'That's fine,' and, 'If you don't do it, that's okay.'

Senator CAMERON: Dr Judkins, what can an X-ray of the back show in someone who presents to an emergency facility with severe back pain? Can it identify issues?

Dr Judkins: I suppose it can identify issues but, depending on the mechanism, it is rare. At the moment I have a bad back and I know that I have a bad back, but I am not going to go and get an X-ray because it is not going to change the management. I am pretty sure that I know what it is going to show. It might show a little bit of arthritis. It might show nothing—

Senator CAMERON: I think you are in a different position from most other people.

Dr Judkins: but the point is the evidence shows that doing a plain X-ray on a patient with your common, run-of-the-mill pain—'I've had a bit of an ache for a few weeks and it's not getting any better'—is not going to show anything. There are red flags, of course, so there are guidelines to say there are a group of patients you should X-ray. We have what we call red flags, so if you have a fever, if you have a funny feeling in your toes, et cetera et cetera, then it is time to start doing investigations. But routine screening of everybody who has back pain is not really going to change back pain management.

It comes down to the question of doing the most good for the whole population. We cannot afford to do a back X-ray on everybody. It might pick up one abnormality in 1,000 patients, but doing X-rays for everybody is not really benefiting society overall.

Senator CAMERON: Are you concerned about some of the submissions we have had that basically say primary health care is the biggest cost saver for government in terms of getting early intervention? I think you would agree with that.

Dr Judkins: Yes, absolutely.

Senator CAMERON: But are you concerned that that could result in cost cutting in the hospital and emergency sector if it is seen that the hospitals are too expensive?

Dr Judkins: If the end result was that the primary care community was providing such good service that we did not need people to turn up to hospital, I would be quite happy. I think that would be a great result.

Senator CAMERON: You would go to primary care.

Dr Judkins: I think it would be a great result. If we had enough resources in the community that people could get good preventative care and good care of their chronic problems and we could decrease the need for people to go to hospitals, that is a good outcome for everybody. If I did not have to do my job, if my job was not necessary, the world would be a great place.

Senator CAMERON: That is right. Has your college had any further discussions or any discussions with ministers on these proposals?

Dr Judkins: No.

Senator CAMERON: Have you sought to have discussions?

Dr Judkins: Yes, we have. We have sought to have a number of different conversations on a number of different topics, but we have not been able to engage.

Senator CAMERON: Do you know exactly how many times you have sought to engage?

Mrs Killen: No. We write occasionally, but to date we have not met with the minister.

Senator CAMERON: Have you had any response?

Mrs Killen: Yes, we get acknowledgement of our letters.

Senator CAMERON: You get a standard acknowledgement of your letter.

Mrs Killen: Yes.

Dr Judkins: We seem to get more engagement at the state health minister level. We have reasonably good relationships at that level, but certainly we do struggle at the national level to get the level of engagement that we would want.

Senator CAMERON: What types of issues would you like to be raising with the minister?

Dr Judkins: Things like the national access targets and the ongoing issues around how we make a public hospital system that is effective, efficient and safe. I think that is something we would like to continue our engagement on. We would certainly like our concerns heard around the issues of the GP co-payments. As I said, we are not health economists. We do not know the ins and outs of the budgetary issues, but we do know that all the evidence shows that, if something like this is implemented, it will make our life harder and make it more difficult for our patients who need emergency care.

Senator CAMERON: You are not building the car; you drive it.

Dr Judkins: That is right.

Senator CAMERON: You are dealing with the practical outcomes. Maybe someone from the minister's office is listening in. They may want to talk to you, hopefully.

Dr Judkins: We hope so.

CHAIR: Thank you very much. We would be keen to continue to receive any information from you and hopefully you will be able to advise us that you have been consulted. That would be a bit of a change. I have one final question. We have had a call for a six-month moratorium on any further policy change in the health sector, but we have also had an indication to the Royal Australian College of GPs that there may only be two more weeks of consultation. Would you support a moratorium for six months with regard to health policy change?

Mrs Killen: I think that would give us all a bit of breathing space.

Dr Judkins: Yes. We are pretty busy over the next two weeks, so having six months to organise something would be most beneficial.

CHAIR: Thank you very much.

McGOWAN, Mr Russell, Secretary, Australian Health Care Reform Alliance

ROSENBERG, Mr Sebastian, Member, Executive Board, Australian Health Care Reform Alliance

[14:18]

CHAIR: I now welcome representatives of the Australian Health Care Reform Alliance. Thank you for joining us. I invite you to make a brief opening statement and then the committee will have some questions.

Mr McGowan: Co-payments already comprise the third largest source of health funding in Australia, after federal and state and territory governments. They contribute over $24 million a year and comprise 17 per cent of healthcare funding. So what we are talking about today is tweaking that rather than introducing something that is brand new.

Australians pay for a higher proportion of their care through co-payments than people in most OECD countries. In fact, only people in the USA and Switzerland generally pay more out-of-pocket costs than people do in Australia. Over 17 per cent of Australians and 36 per cent of those with a chronic condition already report experiencing cost barriers to primary health care. Measures such as lengthening the time limit on level A consultations and failing to index rebates over extended periods put pressure on GPs to consider charging co-payments where they have not before or increasing them where they do charge them now. In some places, a large proportion of GP consultations attract significant co-payments at the moment.

Evidence that co-payments reduce healthcare costs is questionable. The limited available evidence suggests that health costs are just delayed or deferred and can translate to far more expensive care down the track. There is widespread evidence from both Australian and international sources that co-payments adversely impact on certain population groups already experiencing difficulties accessing care. These groups include the elderly, people on low incomes and those with chronic illnesses, especially mental illness, which my colleague Mr Rosenberg will address in more detail shortly. It is important also to remember that co-payments for health goods and services are only one component of the overall economic impact of illness and disability on consumers, their carers and families, and the community as a whole. I will hand over to Mr Rosenberg to talk about the mental health impact in particular.

Mr Rosenberg: My other hat is as a senior lecturer in the Brain and Mind Research Institute at the University of Sydney. I want to present the situation with regard to co-payments as they relate to mental health. What I see here, as someone who attempts to build up some expertise around policy, is a conflict between a couple of different policies.

I can understand that the issue of co-payments is really about driving down federal expenditure in health care. There was a concern about health being a runaway cost. I think the Institute of Health and Welfare's recent report about the fact that the health budget is growing slower than it ever has is an issue. However, I want to contrast that policy with the situation in mental health. I know that some of you have been particularly involved with the Senate's longstanding interest in mental health. Of course, the rate of access to care in mental health is low—it is lower than comparative chronic illnesses and so on, such as asthma and diabetes—so the majority of people who had a mental illness in the past year did not get any help for that mental illness. The reasons for that are not too clear, but what is clear from a policy perspective, as far as I can see, is the need to be encouraging as many people as possible to come forward, to discuss their mental health and to seek treatment.

There have only been two surveys of mental health and wellbeing in Australia to date. In 1997 it was shown that, of people who had a mental illness in the preceding 12 months, 38 per cent got care. Ten years later, when the survey was repeated, that number was 35 per cent. So you could say that Australia failed to lift the rate of access to care for mental health in that decade. According to Harvey Whiteford and others, there has been a change to that over recent years with regard to, again, the considerable Commonwealth investment, principally in the Better Access program, which has seen the figure tick up to around 40 per cent or so. Again, if we want to talk about expenditure—and, really, that is what co-payments are about—we are talking about spending $12 million per week on the Better Access program alone in order to start to foster some of that change in the rate of access to care.

So I want to contrast the mental health situation with the other situations which you are familiar with or have been discussing at more length. To my mind, at least, the goal in mental health is to encourage people into care and not to work out smarter, more rational ways of discouraging people from coming to care. It is also worth mentioning that raising the rate of access to care has been an element of successive national mental health policies and, indeed, state mental health policies for the last 20 years or so. I will leave my introductory statement at that, just to contrast the mental health situation with that of general health.

Senator McLUCAS: I am really pleased you have focused on the issues around mental health. Our committee is going to look more in depth around mental health issues after we deal with the co-payment problems, which are perennial, it seems.

Mr Rosenberg: If I can assist you with that, I would be delighted.

Senator McLUCAS: Thank you, Mr Rosenberg. I will ask one little question around those numbers. Do you attribute the increase in people accessing mental health services to better access alone, or does that data add in PHaMs and PIR?

Mr Rosenberg: No. It does not go to that level of data.

Senator McLUCAS: No. It is MBS data?

Mr Rosenberg: I would love to be able to explain it to you in some detail but I cannot. It has only fairly recently been published, and I have to say the methodology with which Professor Whiteford and others have calculated this positive impact on the rate of access to care is difficult to understand. So it bears further investigation. But it certainly does not get down to the contributary impact of individual programs—and, even if it did, the Better Access program is the gorilla in the room. The others are titchy by comparison in terms of expenditure.

Senator McLUCAS: I am very pleased that the document you have provided to us uses the word 'universal'. It is my view that the conversations we have had over the last 12 months to do with the 'crisis in health care', the problem that we have got to fix, has not been couched in a conversation around universality. So I invite you to talk to the committee about that fundamental principle of Medicare and make some comments about what the introduction of a co-payment to a GP visit would do to universality.

Mr McGowan: The Health Care Reform Alliance is an amalgam of a number of points of view from clinicians, consumers, policy people and others who got together more than a decade ago to look at what needed to be reform in health care. It came together with some values, among which was the need to continue to support universality of health care. To the extent that we have universality in Australia, Medicare and the medical benefits system is an important part of that. It provides fairly good access across the board in health care—although, of course, practitioners are able to charge co-payments of their own volition. The way it has evolved is that bulk-billing has become the norm in many places—although there are exceptions to that. The worry is that the mere addition of a small co-payment as a mandatory co-payment might open the door to a much larger co-payment which will impact on the affordability of health care to a much larger range of people than just the pensioners and concession card holders who will be exempt from the co-payment according to the proposals as we currently understand them.

You need look no further than dental services to see people who are disenfranchised, who perhaps cannot afford or do not have private health insurance that might meet some of their healthcare costs in dental services, as opposed to those who are covered by public dental services because they are on concession cards and the like. We would not like to see our medical services go down the same track that current oral services are on. That is something we have advocated strongly for over the last decade as well. It is an area of health reform we would like to see advanced rather than the rest of health care regress to the lowest common denominator.

There are also similarities in health care services in other jurisdictions, in other nations, which have those sorts of anomalies where those who can afford to pay high-end premiums for privately insured health care get coverage but there is a huge range of people who are neither publicly covered nor really able to afford significant co-payments. So the notion of universal care which provides equitable access for all is a fundamental value within the Health Care Reform Alliance.

Mr Rosenberg: Universality, in terms of making the rules fair and consistent in terms of payment, is one aspect. But, as Russell said, equity of access is another issue and, I would suggest, is one of the key reforms facing health care generally. Of course, universality in that respect has not been the case for some time, particularly for example with regard to the rate of care for people who live in non-urban regions. That has got to do with what is often called 'the tyranny of Medicare', which is the distribution of the workforce. I think those kinds of problems are fundamental to ensuring the ongoing equity of access and universality of Medicare, and really should lie at the heart of reforms.

Senator McLUCAS: That fits absolutely with Mr Gordon Gregory's evidence earlier today when he talked about the shades of grey when it comes to universality and Medicare. What do you say then to some of our colleagues who say it is only $5, it is only a cup of coffee?

Mr McGowan: There are already people who cannot afford medicines where the fixed payment is of that order—$5 or $6—and either delay or do not fill prescriptions because they cannot afford that at a particular time.

But the bigger concern is that $5 could very easily turn into much more because there is no constraint on GPs or, in fact, specialist. And if one were to look at specialists, one would see that the co-payments they charge are much, much greater than what the GPs who charge co-payments charge. And once GPs have started collecting a co-payment, there is no reason why they would necessarily restrict it to just the $5. I believe there may be some economic analysis of this that suggests that if all of the concession card holders and others are exempt from having to pay that co-payment, then practices, to make up the shortfall in the rebate that the patients will attract as a result of the changes, may have to charge more than $5 anyway—maybe as much is $30.

Senator McLUCAS: We certainly heard evidence to that effect this morning. We had a number of GPs sitting before us. One gentleman was talking about how he would have to charge a total of about $60 for a concessional patient, and the cost for a non-concessional payment would be in the vicinity of $100. Even for a non-concessional payment, there comes a point where that is a barrier for a person who is actually reasonably wealthy.

Mr Rosenberg: And that, of course, tallies with Professor Duckett's article from *The Conversation* today, which, no doubt, you would have seen.

Senator McLUCAS: It does indeed.

Mr Rosenberg: If I may just dip back into my mental health realm, I think it should be noted that access rates, as I talked about before, are at their lowest for young people—for young men in particular. Of the young men who last year said they had a mental illness that needed assistance, only 13 per cent got any help at all. That is quite a frightening figure when you think that 87 per cent of young men who had a mental illness last year got no treatment for that illness. And yet, 75 per cent of all mental illnesses manifest before the age of 25—which is a classic Pat McGorry type statement. I just want to impress on you that the mental health system is at its weakest precisely where it needs to be at its strongest. So teenagers and young adults are more likely to need bulk-billing and less likely to be able to afford co-payments. If you want to start talking about the impact, I think you need to be tailoring the issue of what $5 means to particular cohorts and to particular cohorts at risk—and, when you are talking about mental health, you are talking about young people.

CHAIR: Especially if that $5 is actually $60—even if you are on a concession.

Mr Rosenberg: Absolutely.

Senator DI NATALE: AHCRA has been in the health reform space for a number of years now. Have you been invited to meet with the minister to discuss your views on health reform at all?

Mr McGowan: Not with the previous minister—and I guess it is still early days with the new minister.

Senator DI NATALE: You have not been invited as yet?

Mr McGowan: No. Normally we would make an approach.

Senator DI NATALE: Have you done that yet?

Mr McGowan: I think we have written, but we have not yet had a response.

Senator DI NATALE: It is interesting to get that on the record. I am tempted again to go over why this is such a bad idea, but I feel like we have been there a few times and I suspect we might get the same sort of answer we have had from pretty much everybody who sat where you are sitting right now. So let's look at some of the things you have put in your submission that look at some areas where we could be doing better. You have mentioned fee for service. You have called it clumsy and you have suggested that there are opportunities to look at things such as capitation funds. Tell me a little more about that, and what you would like to see.

Mr McGowan: In some countries, and I am thinking particularly of some provinces in Canada, they have enrolled populations of consumers within general practice. The funding flows to the practices on the basis of those enrolled populations and not on the basis of particular services that are provided on a day-to-day basis.

Senator DI NATALE: Enrolment means I have a GP who might be the GP closest to where I live, and I register with that practice. Does that mean that I cannot see any other GP?

Mr McGowan: No, not at all. In those systems it is certainly possible to enrol with a different practice, as I understand it. The NHS in Britain essentially has an enrolled population for GP services. The Canadian one is probably closer to ours than the NHS is. So it would be possible to move towards that sort of system where more of the funds that a GP got came from a capitation—a payment on the basis of the people he was servicing as a population rather than from specific services that were provided to individuals.

Senator DI NATALE: How does it flow that we are going to get better health care as a result of having GPs who have a number of enrolled patients on their books?

Mr McGowan: The big thing here is people with chronic conditions that require ongoing monitoring. It is a bit like the bull and the frog—they never know quite when their condition is severe enough to actually warrant an intervention. But if they are part of an enrolled population, where the general practice is taking interest in their ongoing care, they will recall the patients for maintenance—for checking on how their health indicators are—and will then be able to offer intervention before a crisis develops. So, rather than having a person making their own decisions about when they think they are sick enough to seek a doctor's advice, the practice takes a more interventionist approach to maintaining the person's health.

Senator DI NATALE: Why is the incentive there for the practice to be more active in the care of that patient? Where does that incentive come from?

Mr McGowan: That is one of the tricks that needs to be worked through in this process. We have over the years developed enhanced primary health care plans, which have supposedly helped to share the load. But, yes, at the moment there are perverse incentives. Fee for service means that more often—

Senator DI NATALE: I want to tease out how a patient enrolment or capitation system provides an incentive for a GP to be more actively involved with a patient's care, particularly if they have chronic disease. They are paid not just to be enrolled with the practice, but what are they also paid to deliver?

Mr McGowan: They are paid on outcomes. For example, if there were cholesterol levels that were ideal from people to have to forestall against development of heart disease, then being able to demonstrate that their population actually had an average cholesterol level at the required amount could attract a bonus payment. That is the sort of thing.

Senator DI NATALE: I want to get this on the record. So it is an alternative model, or even a complementary model to fee for service—it does not have to be either/or. Perhaps under a blended model we might end up with a GP who has an enrolment of a few thousand patients in a particular district, and providing the GP can maintain cholesterol levels and blood sugar levels and so on within a particular range, controlling for the demographics of that community, then they are actually rewarded for that. Whereas under the current system that is not really taken into consideration.

Mr McGowan: No. That is only a proxy for the way they should do it. Essentially, they should be rewarded for maintaining good health amongst the population rather than for servicing illness. It is a tricky thing to get to. I agree that you probably need to go through a blended payment system that recognises some throughput payments as well as maintenance of health outcomes.

Senator DI NATALE: Do you think that is where we should be going?

Mr McGowan: Certainly.

Senator DI NATALE: Where is the resistance going to come from. I have heard a lot of people in the reform space say it, but I think it is worth trying to tease that out a little more.

Mr McGowan: There is certainly some inertia there within the clinical workforce, who are used to doing things in a certain way and being rewarded on a fee-for-service basis. Changes that may threaten their incomes are obviously not things they are going to immediately support. But then other threats to their incomes, such as—

Senator DI NATALE: They are being threatened at the moment.

Mr McGowan: Yes, there are other threats to their incomes that they are equally concerned about.

Mr Rosenberg: I wanted to mention more broadly that, as you would appreciate acutely, there is quite a lot of evidence to indicate that coordinated care provides the best care. That applies in primary care, as it does anywhere else. Going back to better access, there is discussion about it providing access, but for whom? There is debate about this, but is better access hitting young people? Is better access helping Aboriginal people? Is it helping people from a non-English-speaking background? There may be key groups who are missing out.

But my point really is that, when you look at the type of arrangements that Russell was outlining, you actually find a great deal of interest on the part of many GPs in expanding the nature of what they can do and making the most of their time. You only have to look at the popularity of something like the nurse incentive program and other programs, which are tiny. These are tiny programs and yet I think they hold the seeds of major reform, which is actually about expanding the nature of primary care.

In the mental health sphere, again, as you would appreciate, Senator, you start talking about bringing to bear, on the experience of care for people with mental illness, more than just the GP, who really importantly can in fact monitor the cholesterol of a person with mental illness, because people are dying of heart disease and other things and not of their mental illness. They need their cholesterol monitored, particularly given the impact of certain drugs and so on. But you also start talking about looking at a practice nurse, a social worker, an occupational

therapist, and an employment support consultant. There is a broad list of the types of ancillary allied health things that could augment what a GP does for a person with mental illness, all aimed at obviating the requirement for what is now commonly a traumatic and, nearly always, expensive visit to a hospital. At the moment there are very few structures like that. But where they are in place, even without any obvious financial incentive and other things, GPs can see the sound practice sense in reorganising the way they do things, to take advantage of small programs and look to bring together a more coordinated approach to the provision of care. I would suggest that that would apply across a range of chronic illnesses and not just mental illness.

Senator CAMERON: It seems to me that the issue of mental health is not as well understood as some of the general challenges in health. Part of it is because a lot of the mental health issues are under the carpet. People do not want to talk about it as much as other general health issues. When you talk to someone about mental health they know someone with mental health problems or there is someone in the family with them. Have we got a tip of the iceberg issue here, where there are much more in mental health than is generally understood?

Mr Rosenberg: How long have we got! I have been working in this area for only 10 years. I have not found anybody whose family or others have not been directly affected one way or another by mental illness. So, you are right, it is common. However, I would go as far as to say that I hotly dispute the issue that we do not know about the problem. What I think we have is a massive disconnect between a policy response to a known problem. I cannot remember now, but it was something like 32 separate statutory inquiries into mental health across this nation, since 2005. It is something that, frankly, you guys investigate every year, or every other year—some aspect of mental health. And if it is not you, then it will be your colleagues in other parliaments, in other places, or it will be a human rights commissioner. There is no shortage of an understanding of the profound nature and depth of the mental illness area and of the gap that exists between our understanding of the nature of the problems and the resources we have to address those problems. I am here representing AHCRA, but I do see, in terms of tip of iceberg, that potentially the population of people with mental illness could be particularly affected by the sorts of changes proposed by a copayment. So, I think to that extent you are right.

Senator CAMERON: You have made your position pretty clear, and it is consistent with that of all the professionals who have come here, and that is that the copayment is counterproductive. The coalition senators, in our interim report—I am not sure if you have read it—basically go to the fundamental issue that the commission of audit that was established said that healthcare spending was the single-largest long-term budget challenge and that it was unsustainable. Have you seen any evidence about the unsustainability of our health system?

Mr McGowan: No, quite the contrary. And Mr Rosenberg commented in his opening remarks on the fact that it is patchy, and if one chooses to focus on areas of overexpenditure or of waste, one can make savings that will in fact prevent the unmitigated growth. I think there is often a misunderstanding that outlays in health equate to outlays in the Medicare Benefits Schedule. And we have talked about ways of ameliorating that. It is not just about that. But there are all sorts of other ways in which you can tackle problems that lead to a lessening of pressure on fee-for-service payments through the Medicare benefits system.

Senator CAMERON: So, the system is not unsustainable; on the contrary, you think it is sustainable. That is your view. Have you had any discussions with any coalition politician at any level in which they understand this argument?

Mr McGowan: Yes. Every six months or so we offer to meet with people within the parliament to brief them on our concerns, and we get to sit with both opposition and coalition members and explain our concerns. And we certainly have raised these concerns and raised this understanding of the sustainability of the healthcare system and the need for continuing reform. For example, we were disappointed: we came into existence before the Rudd government came into being and established the Health and Hospitals Reform Commission, and we were disappointed that after much of the effort that we put into submissions to that commission and into the formulating of its outcomes it was not entirely enacted. So, we have had to discuss those principles that we have held for the whole time of our existence with both sides of politics, and we do get occasional hearings—normally at a more junior level than the minister, though. In recent times we have not had direct access to the minister with these views.

Mr Rosenberg: Perhaps I could just add to that. It is also worth noting, without wishing to be too distracting, that the commission of audit was largely silent about mental health, in abeyance for the work of the National Mental Health Commission's review, the results of which we are unsure about at the moment. But I would suggest further that one of the greater pressures on the Australian budgetary situation would probably be to do with a lack of productivity across our economy. And I would suggest that a lack of productivity could easily be sheeted home in a significant part to the fact that people with mental illness are generally not provided with the sort of assistance they need in order to become fulfilled members of our community. In fact, they are too often left

parked on pensions and other things without proper support and help to find employment and other things. And, again, the commission of audit was largely silent about all of those matters. You asked about sustainability. And I suppose in terms of mental health the system may well be sustainable, but it is not desirable.

Senator CAMERON: This morning the evidence we had from the AMA and a number of the colleges was if the $5 co-payment goes ahead you could end up with doctors charging $100 within 12 months to visit a doctor in a rural area—and Tamworth was the area the doctor was from. He argued that, if this comes in, to have sustainability in his practice they would have to charge $100 for non-concession card holders and $65 for concession card holders. That would destroy Medicare, wouldn't it?

Mr Rosenberg: As I said, those are the sorts of figures that Professor Duckett was talking about in his article today. I guess from my point of view and what I think Senator Di Natale was talking about is there are many ways which are already reasonably well understood that could be invested in that would be much more impactful on making a change to the way health is provided and delivering health reform, including more efficiently. This is, as our submission suggests, a very clumsy way of proceeding. As I said, particularly with the group I am most familiar with, which is people with mental illness, it could be grossly unfair and indeed very deleterious to their choice about whether to access mental health care or not. That access is already marginal and insufficient.

Senator CAMERON: I am not sure you guys are the right people to ask. Maybe when Professor Duckett comes to the table he will be able to deal with this. Lots of people have said that politicians would grasp the nettle and deal with the real issue—that is the lack of funding in the system. I am sure there are coalition politicians who are sitting down with Treasury and Finance officials now and being told maybe that the whole system is unsustainable. We may hear from them later. That is one of the arguments. Has there been any thought to an engagement from the health industry with some of the health bureaucrats on understanding some of the fundamentals—that if you put a co-payment in it is counterproductive, it will keep people from health and it will drive costs up? This seems to be a given and yet we must have either Finance bureaucrats or Treasury bureaucrats convincing politicians that that is not the case.

Mr McGowan: I think we have to be careful here to distinguish between sustainability of health outlays by the Commonwealth and sustainability of health services overall. What is envisaged here is in fact a cost-shifting from Commonwealth government outlays for primary healthcare services to the private pocket, to consumers. I already outlined in my opening statement the fact that as consumers we are paying greater out-of-pocket costs than virtually any other country at the moment on an OECD comparison basis and this is going to contribute further to that and that will include the extra co-payments we pay where GPs do not just charge $5 extra but a bigger co-payment. Their concern is about the sustainability of their practices if they have to sustain a $5 concession in rebate and how they will recover that. That again puts further pressure on shifting costs towards out-of-pocket costs paid by consumers. We need to be careful that we are talking about the same thing here.

No, I do not think it will destroy Medicare. Medicare is not unsustainable. The amount of GDP that is devoted to healthcare expenditure in this country is on the low to middle rung of the OECD comparison table not towards the top. We are not in fact marching—and again health economists can give you better figures on this—towards an unsustainable higher proportion of GDP spent on health care. It is in keeping with growth of the economy as a whole.

Mr Rosenberg: The other aspect of cost-shifting here, too, is, of course, you really risk many chronic illnesses not being picked up in general practice which then manifest in state hospitals. This is already the case in mental health where we have the classic macabre ambulance at the bottom of the cliff simply picking up people and taking them back to A&E where they are treated and traumatised and it is expensive and so on. You find ridiculous vistas of ambulances queuing up outside hospital A&Es. This is a ridiculous way to organise things. I think in some respects this is a microcosm of a broader discussion in relation to mental health in particular whereby, on closure of the asylums, there was never really an investment made in the type of community support needed to keep people living well and employed, functioning as citizens and happy in the community. On that basis that has left people at real risk. I guess further tinkering to what should be a large central role for general practice and primary care in that scenario would add further to that dilemma and that risk and that would be very unwelcome.

CHAIR: I would like to ask some questions but we are going to suspend for a short period. I want to note your media release of 14 December in which you speak very clearly about the threat of two tiers being established for a health system with the engagement of private health insurance to cover GP fees. We will definitely make some effort to put this evidence into our report. Thank you very much for your contribution today and for your ongoing work in the sector and for the 35 national and state organisations you represent.

Proceedings suspended from 14:57 to 15:07

DUCKETT, Dr Stephen, Director, Health Program, Grattan Institute

CHAIR: Welcome. Dr Duckett, do you have an opening statement for us today?

Dr Duckett: Yes. I would just like to make two points. The first is about sustainability. Healthcare expenditure is going up faster than gross domestic product, but only marginally so. If we think about it, we are not about to be overwhelmed by a silver tsunami; it is more like a grey glazier—slow change is what is happening. Sure, we have to do something about adjusting the health system to meet these changed demands, but the required changes are much more sophisticated than simply a cost-shift onto consumers. We need to be stepping back to look at what really needs to be done, planning for it and introducing it carefully.

The second point I want to make is about the freezes—the rebate reductions. There are two rebate reductions taking place. The first is a $5 reduction in the rebate, which applies to the patients of general practitioners and, in particular, those who are not under 15 or who do not hold a concession card. The second and more significant rebate reduction is the real reduction resulting from the freeze in rebates that apply for all medical practitioners. The cumulative effect of those two freezes is quite significant. Although people talk about a $5 increase in the co-payment, in my view the increase in the co-payment that the ordinary person is going to have to pay is more likely to be between $30 and $40 than $5.

CHAIR: Can I ask you to respond to comments that we heard earlier today, which are along the same lines as what you have just been putting before us, and that is that the Medicare rebate could cost patients between $30 and $40. We heard evidence this morning from GPs practising in the New England area that within the next 12 months the cost for concessional patients could go as high as $60 and for non-concessional patients up to $100 per consultation. This clearly is of great concern to the doctors who are at the patient impact point in the patient consultation. What are your views about the likely impact of the government continuing on its path with this price signal?

Dr Duckett: The government's objective is actually to reduce bulk-billing, so we should not be surprised if bulk-billing reduces. That is what the policy is trying to do and, in my view, it will achieve that: it will reduce bulk-billing. How each individual practice responds is going to be a matter of the exact economics of that practice. Think about it this way. Our analysis, as we have talked about in the submission, says the cumulative impact of the freeze between now and 2018, and the $5 rebate, is going to be about 10 per cent on general practice. You cannot expect a general practice to absorb a 10 per cent reduction without doing something. And our estimates are conservative—that is, we have assumed inflation will be running at about two per cent. The most recent figures are a bit less than that, but over the last four or five years inflation has been running closer to 2½ per cent or a bit higher. So there is going to be a significant impact on general practice revenues.

Once they decide to move away from bulk-billing, they lose the bulk-billing incentive, which is between $6 and $9. They have to increase their staffing. I think the Australian Medical Association referred to the $7 dollar co-payment as a red-tape nightmare. Well, the same description can probably apply to this change. They have to increase staffing to process the red tape—to process the credit cards. They have to pay the credit card transaction fees or they have to introduce cash handling. So the costs of actually implementing this are quite substantial.

That is why I think there will be a significant shift away from bulk-billing and a significant increase in the out-of-pocket costs that patients face. If you think about the $100 figure, the current rebate for a level B is around $35 to $37 and the typical out-of-pocket cost is about $31, so already we have a base of about $68 or $70 that people are paying if they are paying an out-of-pocket cost. I think $100 is a bit rich, I have to say. I think that would be hard to justify, especially if they are not going to bulk-bill any of their patients. But I can understand why there will be a significant increase in out-of-pocket costs.

Senator CAMERON: Just on that, doctors at a surgery in Tamworth where they have 15 GPs were arguing that they will still need to exercise some bulk-billing; and, if they are going to do that for the most needy, then others will have to pick up the slack. They have said they have worked it through, and within 12 months $100 is the figure. They have had their accountants working on it.

Dr Duckett: Yes. In The Conversation piece, which I think has been distributed, and in my submission, we said that they have a number of options—either making everybody else pay more and keeping bulk-billing, or increasing it. If you think about it, this is so unfair. Why is it that the patients of a particular practice in Tamworth are the ones that have to cross-subsidise within the practice? The whole point of Medicare is that it is a universal system where the cross-subsidy occurs across the whole country, not within a small practice in Tamworth.

CHAIR: That was an important point to clarify. That is, indeed, the question. Could you give us an indication, Dr Duckett, of what the current national rate of bulk-billing is?

Dr Duckett: The national rate is around 84 per cent for general practice items.

CHAIR: Has it fluctuated over some period of time?

Dr Duckett: Yes, it has gone up and down. It went down, I think, certainly to below 80 and into the mid-70s when Minister Abbott, the Prime Minister, was actually the health minister. His job as health minister was to restore the rates of bulk-billing and he did that quite successfully. So there was a dip in the rate of bulk-billing just before he became health minister and he introduced changes which increased the rate of bulk-billing.

CHAIR: And in the period of the last government, of the Labor government, there was a steady increase?

Dr Duckett: Yes. It continued a steady increase.

CHAIR: What is the highest point that we have been at?

Dr Duckett: I am not sure, but I think it is around now. Bulk billing started off very low when Medicare was reintroduced and has steadily increased, except for that dip in the nineties.

CHAIR: Are there studies that show the correlation between improved health outcomes and higher levels of bulk billing—nationally and internationally?

Dr Duckett: Certainly we know that, if you have out-of-pocket costs, people defer visits to doctors. We also know that, if you have out-of-pocket costs and people defer a visit to a doctor, the patient cannot make a judgement about what is necessary care and what is unnecessary care; so they end up missing out on necessary care as well. And there have. been a number of overseas studies which have shown that. There has been a major study which has assessed the impact of co-payments; we cited that in a submission we made to another committee—the Senate Standing Committee on Community Affairs inquiry into out-of-pocket costs. Generally, the overseas policy direction is not to have financial barriers in general practice. The whole international direction of health policy is to try to strengthen general practice, to try to strengthen primary care because this is the most efficient level of the health system. I am not saying that general practice or primary care is perfectly organised in Australia at the moment and, indeed, I do not believe it is. I think there need to be changes, but the changes you need to make are not forcing the consumer to drive all the change in primary care when they are people who just do not know what is necessary care and what is not necessary care.

CHAIR: Senator McLucas had some questions this morning with regard to claims about out-of-pocket and responses from the health department around the figures that were cited. I wondered if you wanted to go—

Senator McLUCAS: We canvassed this last year, Chair. The college referenced your graph, Dr Duckett, that looked at out-of-pocket costs and we had a conversation with them. The department has said that that data, and it is OECD data—no, I am not sure where the data originates from. The department has said in the past that it is not apples and apples, and secondly, because Australians use complementary medicines at a higher rate than other consumers internationally, it is hard to extrapolate from that data that Australia is paying such a high level of out-of-pocket costs at the moment. I think we have had this conversation in the committee previously.

Dr Duckett: I have heard that. I contacted the OECD in response to that to get their response and I think I provided a commentary on that in a supplementary submission to one of the previous inquiries. Certainly, it may be the case, but the reality is that on the best available evidence we have, Australians are spending more out-of-pocket than most other countries.

CHAIR: Could I just ask you if the institute or if you has a view about the potential for bulk billing to be means tested?

Dr Duckett: Of course, Medicare was introduced to replace means tested arrangements. I am old enough to remember what life was like before Medibank was introduced. Before Medibank was introduced a number of programs were introduced to try to target and introduce special programs for poor people. The reality was, even with special programs for poor people, there were other people who could not afford health care because they fell outside the restricted definitions and restricted mean tests. So the debate about Medibank and Medicare was: is it more efficient and more equitable to introduce a universal scheme so no-one falls through the cracks or should we have schemes were it is possible for people to fall through the cracks? The Australian people have made the decision time and time again that the right way to do it, and in my view demonstrably the efficient way to do it, is a universal scheme.

CHAIR: Can I ask of the degree of consultation the institute has had with the previous minister or with the new minster.

Dr Duckett: The Grattan Institute?

CHAIR: Yes.

Dr Duckett: I have met with the previous minister a couple of times when he was minister and also when he was shadow minister.

CHAIR: Do you believe the information you provided fed in in a consultative way to the decision making we have seen?

Dr Duckett: We were not consulted on the issue of a co-payment.

Senator CAMERON: I wonder why.

CHAIR: Can I take you to the current 'consultation' and I use the term loosely. We have heard from the Royal Australian College of GPs this morning the suggestion that this consultation phase may conclude in two weeks. They are calling for a six-month moratorium before any more botched health policy is announced. How would you characterise the current engagement of the new minister with the sector, particularly in terms of your experience?

Dr Duckett: We had the unusual situation which I do not think I have seen in health policy in this country of three health policies in less than a month, which suggests that policy is being made on the run. As I said earlier, we do need to look at primary care in general practice and we do need to think about whether the current arrangements are right for the future. That is not something that can be done in a two-week period.

CHAIR: Do you have any dates in your diary in the next two weeks to engage in conversations with the minister?

Dr Duckett: I would love to have a conversation with the minister on this topic.

CHAIR: Thank you very much.

Senator McLUCAS: Thank you again, Dr Duckett, for your contribution to this committee's work. I am going to ask you to comment on a point you made just a moment ago that, when the current Prime Minister was the health minister, the task he was given was to increase the bulk-billing rates. That was in mid-2000s. Then in your paper in *The conversation* today you say:

The result is likely to be a move away from bulk billing. This is indeed the objective of the government's policy.

It seems to be a huge shift. Eight or 10 years ago we thought it was a really good thing to lift bulk-billing rates and in fact then Minister Abbott did increase bulk-billing rates using a number of methods. Why do you say that the government's intended policy is now to reduce bulk-billing rates?

Dr Duckett: I cannot speculate on the reasons. The minister and the Prime Minister have both said this is what they are trying to do. The current minister, the previous minister and the Prime Minister have all said that this is what the object of policy is. I can only speculate on why they might want to go down that path. The evidence is overwhelming that, if you do increase co-payments, utilisation will go down, particularly among poor people, and if you do increase introduced co-payments, people will not make judgements about whether it is necessary care or unnecessary care. The government may only be focusing on the first of those effects—that is, utilisation will go down there will be short-run savings to the budget bottom line. Whether there are long-run savings to capital health expenditure is, in my view, a very moot point because I suspect there will not be.

Senator McLUCAS: You suspect there might—

Dr Duckett: There will not be savings to total health expenditure.

Senator McLUCAS: In the long run.

Dr Duckett: In the long run.

Senator McLUCAS: How long will it take until we could see that occurring?

Dr Duckett: I think we would see a reduction in bulk-billing in the quarterly statistics, so you will see that fairly quickly. Then, depending on the reaction of GPs in terms of co-payments, you might see that in the next annual results.

Senator McLUCAS: Thank you also for your evidence about what is sustainable. In your submission, you comment that people make priority choices—you use that language. As a wealthy country, should we be making decisions and prioritising the health of our nation? Is that a reasonable and sensible thing to do?

Dr Duckett: There are a couple of components to that question. The first is that the total health expenditure in the country is not only the result of decisions by governments; it is also the result of decisions by individual consumers about whether they will go to McDonald's or somewhere else for an outing or go to a particular movie, or whether they are going to buy football boots or whatever. People make choices all the time about how they are going to spend their money. What we do know is that people will prioritise health care when they need to—and it is not just a luxury good; people value health care. It is, therefore, not surprising that, collectively across all people, as countries gets wealthier they tend to spend more on health care. It is a priority. They say, 'If we are wealthier—if we can afford to spend more on something—we will prioritise health care over something else.'

There are only so many cars you can fit in your garage, for example. It is a choice that people make and, across the world, we see wealthier countries spending more on health care.

The other point is that Australia is a relatively wealthy country, but we spend less than the OECD average, taking into account our wealth and the size of our gross domestic product. So it is not as if we are a spendthrift nation; we actually have a good health system which is quite efficient and we are spending below the OECD average. In my view, this is not a question of sustainability. Sustainability is an eye-of-the-beholder question, but, even if you take, 'Are we going to bankrupt ourselves on health care?' we are spending less than the OECD average and a moderate amount of gross domestic product.

Senator McLUCAS: Is it your view that we have a reasonably efficient system in a relative sense internationally?

Dr Duckett: If you look at the OECD figures, we are below the OECD average on health as a share of GDP. I think we are below the OECD average on health per capita. We are above the OECD average in life expectancy. We have a good health system. That is not to say it cannot be improved. We have a good health system and we should treat it as a good health system and not try and dramatically change the underpinnings.

Senator McLUCAS: Thanks very much again for your evidence.

Senator DI NATALE: You spoke about Medicare and its introduction. You are a little older than me, so you are probably more familiar with the rationale for its introduction. You said it was introduced as a universal system. People who defend this measure say, 'Oh, well, it's a modest, $5 co-payment. It's not a big deal. People who are wealthy should be able to afford it.' Others would say, 'By undermining the principle that everybody gets the same level of health care at the point of access, you are undermining Medicare.' Do you think it is undermining the very principle that Medicare was founded on?

Dr Duckett: It absolutely undermines the principles. Medicare was founded as a universal scheme that everybody would have the same access to. You would not carve off particular people to have certain entitlements. That was the very type of system it replaced. Bulk-billing was supposed to be universally available. Whether every doctor picked it up or not was another matter, but Medicare was designed to be a universal system.

Senator DI NATALE: The government has said—and I note in your submission that you challenge it—'Well, we've increased spending by over 100 per cent over the last decade.' It likes quoting those sorts of raw numbers. So there has been a 100 per cent increase in spending on health over the last decade. It sounds like a lot. It sounds like things are spiralling out of control. Can you give some context to that figure?

Dr Duckett: I was surprised when that statement was repeated in Minister Ley's press release. I can understand a minister making a mistake once, but for that to be repeated really surprised me. The reason it surprised me is that it is the raw numbers. It is unadjusted for inflation. Everything has increased significantly in price over the last decade. If you are taking an economic perspective, if you are taking a policy perspective, you have to first of all adjust for inflation, at the least. Then, preferably, you should say, 'We probably also ought to adjust for the size of the population.' Sure, you ought to spend more when there are more people covered. Neither of those things were done in those media releases.

The second thing you might decide to do is adjust for how the economy grew at the same time. So instead of being this massive seven or eight per cent per annum increase, you end up with three or four per cent, which is closer to GDP growth. I am not saying that you should not be concerned about any growth. You should be concerned and you should be looking at policies. But in order to look at policies rationally, to have sensible public policy, you have to understand the problem you are trying to solve. If you do not adjust for inflation, if you do not adjust for population, you are not actually going to be looking at the right problem.

Senator DI NATALE: Let me go to the nub of your piece in The Conversation today and your submission, which is this idea that a drop in the rebate by $5 amounts to a $5 cost to the patient. You are saying that actually that is not how it works, and that when you take into account things like the freezing of Medicare rebates, that $5 cost that people assume they may have to pay actually means something more like $30 to $40. Can you explain that?

Dr Duckett: There are two changes that are taking place. There is a rebate reduction that only applies to GPs' patients and only applies to patients who do not have a concession card and are over 15. That is $5. That is the first change. The second change is the freeze in rebates through to July 2018. That is a bigger change in its cumulative effect. If you assume a two per cent increase or so inflation per annum, it is a six or so per cent impact in reduction in revenues to GPs, versus a four or so percentage impact from the $5. So it is a 10 per cent impact we are talking about altogether. Let us say that there is a $5 reduction in the rebate and, as the government wants me to do as a GP, I decide to stop bulk-billing that patient. I lose the bulk-billing incentive, which is between $6

and $9, depending on where I am and who they are. So instead of $5, we have got to $11 or $14 just by doing that. Then, if I am a bulk-billing practice, I have to start introducing red tape—the extra staff to actually process it, the card charges, cash handling charges, and so on and so forth.

Senator DI NATALE: Bad debts.

Dr Duckett: All of that adds up on the cost side. So there is a revenue drop and there is a cost increase. So, when you look at it, you say, 'What happens now?' If a person is not bulk-billed, the average out-of-pocket today is $31. So you would say, why would a practice not do what they are already doing—that is, an average of $31? So you immediately have an average of $31 as a likelihood; and then, on top of that, there is a $5 rebate reduction. So you are up to $36. My estimate was somewhere between $30 and $40, and the more I think about it, the more it is likely to be at that $40 end, not at the $30 end.

Senator DI NATALE: If a GP makes a decision about not bulk-billing non-concessional cardholders, what is to stop them making a decision, as we heard from the GP in Tamworth, that it is simply no longer possible for them to continue to bulk-bill concessional patients, if they want to keep their fees for non-concessional patients at a reasonable level?

Dr Duckett: The University of Sydney data suggests that concessional patients and patients under 15 account for about 57 per cent of all consultations, so it is a significant number. Then we thought there were some things that were not recorded in that University of Sydney data, so we conservatively said that about two-thirds of all consultations would be GP work that would be covered by the concessionals. That is a significant proportion of the GP's work and, if you are going to make the one-third that is left bear all the burden of all the increased costs, it might be too much. So they might have to reduce their bulk-billing for the concession card holders. I can see that as a possibility.

We estimated that if the government achieves what it wants to achieve, bulk-billing would probably drop from about 84 per cent to 67 per cent if everybody who is not a concession card holder is no longer bulk-billed. It might go below that, so it might drop into the mid- to low 60s.

Senator DI NATALE: One would assume that would be lower for practices, say, in regional and rural—

Dr Duckett: Bulk-billing rates are already lower in rural and regional Australia, so it is going to be even worse.

Senator CAMERON: I am really not sure where to start, because it is such an issue. It is not a complex issue. I want to raise this issue that I raised with the previous witness. If everyone who comes here clearly understands and can articulate the problems with increasing the cost to see a doctor, why can't the department understand this? Why can't Treasury understand it? Why can't the politicians understand it? Why can't the government understand it?

Dr Duckett: I have no idea whether the department supported this change, so it is really a case of why can't the politicians understand it. I do not know why the politicians cannot understand it.

Senator CAMERON: It just seems pretty clear after all the evidence you and every professional body have given saying this is counterproductive and it will cost more in the long run.

Dr Duckett: It is about cost shifting. The costs of the impact on the hospitals will fall on the states. The costs on patients will fall on patients. So the Commonwealth government, in a very narrow sense, might have a reduction in its outlays by shifting them onto everybody else. In my view, that is very lazy policy. Good policy is trying to address the total health system, not individual constituents.

Senator CAMERON: Could it be ideological—the Hayek approach, that government gets out of work whatever it can?

Dr Duckett: That is speculation.

Senator CAMERON: I think it is pretty reasonable speculation, given that you get senators making speeches about Hayek.

Dr Duckett: The Grattan Institute is independent.

Senator CAMERON: I want to come back to this $100. You said earlier that you thought it was a bit rich but, given what I outlined and the analysis that these doctors have done—you said that every surgery is different, every small business is different—they reckon they have done the analysis and that is what they will need to do to keep their business afloat.

Dr Duckett: I have not seen the numbers. I still think that making someone pay $100 to see a GP out of pocket—admittedly, they get a $37 rebate for it or a $32 rebate for it—is not the Australia that Australians think they are living in.

Senator CAMERON: That may be the case, but that is what the doctors were saying this morning.

Dr Duckett: I think it is poor policy if it leads to that. But, as I said, I have not seen those practice numbers, so I do not want to justify them.

Senator CAMERON: You say it is about cost shifting. Have you any estimate of the overall cost that is being shifted from the Commonwealth government, No. 1 to the state and No. 2 back to the community?

Dr Duckett: It is at least $10 billion over the forward estimates period. By the time you add the cost-shifting to the states, which I think has, on the public record, been estimated at $8 billion, and the $2 billion or so that is left in these current rebate changes, that comes to more than $10 billion.

Senator CAMERON: One of the issues that has come up is that people are still not sure whether this is about sustainability or whether it is about creating the research fund. Are you any clearer? Do you have any understanding as to why this policy is being undertaken?

Dr Duckett: Most of the money that goes into the research fund does not come from the rebate changes. The cost-shift to the states, for example, also goes into the research fund. If the rebate reductions and the rebate freeze do not go ahead, it does not alter the size of the research fund; it just changes how long it would take to get there. As I said, most of the money does not come from these changes; most of the money comes from the state changes, PBS changes and other changes.

Senator CAMERON: So the money is coming from the federal government cost-shifting back to the states?

Dr Duckett: Yes. The 2014-15 budget announced a number of changes in the health portfolio—not only the then policy about the $7 rebate change. When you add them all up, most of the money that flows into the research fund does not come from the rebate change. I think the research fund issue is a side issue. There is another issue about whether or not it is a good idea. So I think that is a distraction. What was the first part of your question?

Senator CAMERON: I was asking whether you could divvy up the amount of the cost shift to the states and the cost shift to the individual.

Dr Duckett: I think the previous secretary said that it was $8 billion in her testimony to the estimates committee.

Senator CAMERON: So that is $8 billion in total?

Dr Duckett: Yes, in total over the forward estimates.

Senator CAMERON: Given that we are a country where individuals pay internationally comparatively a very high fee now for health, this will make it worse, will it?

Dr Duckett: Again, there are a couple of issues in that. Obviously, as you say, we are one of the countries that spend a high proportion of total spending on out-of-pocket costs. This will certainly make it worse. This will certainly make it harder for people to see doctors when they need to, and it will have a long-term adverse impact on consumers, on patients. Secondly, to the extent that it shifts costs to hospital emergency departments and public hospital in-patient activity, it is bad for both the patients and the total health spending in state budgets. It is bad all around.

Senator CAMERON: So when the announcement was made—as part of the reboot strategy of the government—that the $7 co-payment would go, the issue is still there with the $5, isn't it?

Dr Duckett: Exactly.

Senator CAMERON: So the $5 plus the lack of indexation is every bit as much a problem?

Dr Duckett: The government did announce that the three strategies they would pursue at the time were going to achieve the same amount of dollars as the $7 change. So it was just a matter of how it was packaged and where the costs were going to fall. That was all that was happening.

Senator CAMERON: I wonder if they will run a public advertising campaign to let people know they are going to pay more money.

Dr Duckett: No comment.

Senator CAMERON: Seriously, if government is going to make such a decision that is going to have such an impact on the individuals, as you are outlining, surely there is a responsibility for the public to understand what is happening to their health costs.

Dr Duckett: As a general principle—

Senator CAMERON: I am joking on the advertising, but I am just saying—

Dr Duckett: As a general principle, I do not think government should advertise things that are not approved by the parliament. I think you have to be very—

CHAIR: We have seen a bit of that recently!

Dr Duckett: You have to be very careful about pre-empting parliamentary decisions. Obviously, once the decision has passed I think there is an obligation to explain the implications. I think it is important that the public understands what their entitlements are.

Senator CAMERON: But this is not a decision that will need to be passed, as I understand it. This will be a regulation.

Dr Duckett: The freeze?

Senator CAMERON: Is that your understanding?

Dr Duckett: As I understand it, the freeze does not have to go to the Senate because there is no change in the rebate, by definition. The five-dollar reduction in the rebate—I believe—certainly is at least a regulation. I am not sufficiently familiar with the legislation, but it may require a legislative change if it is making distinctions between various classes of people. But that may be able to be done by regulation. Anyway, it is a disallowable instrument.

Senator CAMERON: Okay.

Dr Duckett: Which presumably must have been made—the instrument must have been made. I suppose it is not coming into effect until 1 July?

Senator DI NATALE: It is 1 July.

CHAIR: Thank you very much, Dr Duckett, for your evidence this afternoon and for the clarity, as usual, in your explanation of what the outcome is of these policy changes that are mooted. We hope to continue the conversation—hopefully, more happily—in the future.

Dr Duckett: Thank you very much.

COSTA, Dr Con, President, Doctors Reform Society

WOODRUFF, Dr Tim, Vice President, Doctors Reform Society

[15:47]

CHAIR: I now welcome representatives of the Doctors Reform Society. Good afternoon and thank you for joining us, Dr Costa and Dr Woodruff. I invite you to make a brief opening statement.

Dr Costa: I am the national president of the Doctors Reform Society. I am a GP of about 30 years from Sydney.

Dr Woodruff: I am the vice president, and I am a rheumatologist. I do not practice general practice—I gave that up many years ago!

Dr Costa: I would like to start off by saying just briefly that my experience in general practice is one of underservicing rather than the arguments of overservicing. I particularly draw your attention to the 150,000 or 200,000 people in nursing homes around Australia. Currently, many GPs do not do house calls, much less visit nursing homes. It is hard work: you are taking care of very old people. Many of them are very high care; they are on six or seven different tablets, and quite toxic medication—particularly in combination. They have poor kidney function, they suffer from very bad heart disease, diabetes and dementia, and yet it seems to be considered okay that they get visited once a month for the doctor just to write up their prescriptions. Clearly, that is grossly inadequate and it is a huge problem in Australia. When we talk about a co-payment we really should think how that would impact on such an underservicing situation.

On top of that, we should mention the people who are dying—the terminally ill. It has been shown that in Sydney a sizeable minority of these do not even have a GP. I do not personally know of any GPs—I am sure some do—who participate in palliative care in the home, much less do house calls. So we can see that there is a problem. We are not denying there is a problem; we are just saying that bringing in a co-payment is going to make it worse for these people, as well as worse for Medicare and the Australian population as a whole.

The five dollar cut and freeze on the Medicare rebate is just more cost-cutting on primary health care. To us, it is designed to destroy universal bulk-billing; it will lead to an explosion in primary health costs and then public pressure to allow private health insurance funds to cover the gap. This was actually the health policy of the Liberal Party in 1993 under Hewson, where it was quite clear that they wanted private health insurance to cover the gap. This would effectively be a US two-tier system: expensive costs, reduced primary care—we will go on to that later on—and people going without. I would draw your attention to the measles epidemic in United States at the moment as an example of what happens when you do not cover the whole population. We are all at risk. It will end up being an unsustainable system with health costs around 16 per cent of GDP.

Can I briefly remind the committee of the benefits of Medicare when it came in: it spread doctors out to the outer suburban areas, poorer rural areas, smaller towns and created expanded GP care whereby Australians had a GP, not just the rich in the lower North Shore or the Eastern Suburbs and where the working people were cut out from having a family GP. Many working women, not just rich women, now have personal health checks and a family doctor for their children. So if we lose universal bulk-billing, we lose all of that and we go back to the pre-Medicare days where you only get that if you are wealthy.

The second thing is that Medicare is cheap, cheap, cheap. It costs $37 to see the GP versus $70 to $75 for the AMA, and the only reason that is held back at $70 to $75 is because of competition from Medicare bulk-billing. This thriftiness goes across all items and all disciplines, including pathology and radiology. Before Medicare and bulk-billing, the most common reason for going bankrupt and going to jail in South Australia was failure to pay your medical bills.

The other thing you should not forget is that universal bulk-billing is the biggest controller of health costs in primary health care: you lose universal bulk-billing and you get an upward explosion of health costs. It will not stay at $75, the AMA rate; it will be much higher.

If we are clear on all those things, we get a picture of why it is important to maintain the universality. To us, the co-payment is really a Trojan Horse for the private health insurance funds. It does not really matter whether it is $7. It does not matter if it is $5. It does not matter if it is the $6.15 of the AMA. It does not matter if you are charging it to everybody or just to the wealthier people. It is a Trojan Horse. To us Medicare, despite no support now for about 30 years by successive governments, which has allowed it to languish, remains incredibly popular. Sure, we need some more public policy initiatives—we need to get better care for people in nursing homes and the dying, and doctors to do house calls and get supported by nurses and provide a much more holistic GP service

and keep people out of hospital—but still it has remained remarkably robust and remarkably popular. So having failed to wear down the walls of the Medicare stockade, we feel that a co-payment is a Trojan Horse.

Let us be quite clear: the private health insurance funds are very, very keen to get into primary care—some would say it has already started. We have heard stories of the private funds paying fees or some sort of payments to practices in Queensland, and all that is lagging behind is the public policy or the government policy to allow it to happen more openly. This is a great concern for us.

A co-payment for seeing the GP is not about sustainability of the health system; it is about making bulk-billing unsustainable and reducing care to the needy, including the nursing homes and the dying, unless they have got private health insurance. The co-payment is the Trojan Horse: a way of getting into the castle, into the stockade, to take over.

The AMA co-payment is equally unacceptable: it is still a co-payment. It will still encourage doctors to move away from bulk-billing. The practicalities of collecting $6.15 would not make it worth it and already, in actual fact, when you think about it the AMA fee is $70 to $75—I am not sure exactly what it is—which in effect is already $36 co-payment. So the hypocrisy of the AMA talking about introducing a $6.15 co-payment, when their members are already charging a $36 co-payment, is a bit difficult to accept.

Dr Woodruff: I was just going to talk a little bit about what we can do, because there is plenty to do. I am not an expert on efficiency—you have just had an expert on efficiency, Dr Duckett, talking and you have read his submission—but there are things there that we can do both outside the MBS and within the MBS that can achieve the savings that we need to fund any good reforms of the system, and they are being totally ignored by the government. We need to act on them. We need to pressure the government to consider that there are genuine ways to save Medicare, save money and save patients. We do not need to destroy Medicare.

We believe that the reason this is not happening is purely ideological. Dr Costa talked about the issue of private health insurance as the Trojan horse in this whole story of it coming into two-tier primary healthcare access. We have to look at the history. When the coalition was in government under Prime Minister Howard, the government took two steps forward and one step back in their attempt to destroy Medicare as public health insurance and replace it with a two-tiered system. They won very convincingly on the first, and that is that we have two-tiered access to elective surgery. It has been combined with a huge growth in elective surgery because hospitals can do it in private and do it reasonably safely, but they have won that battle very convincingly. People wait three years, as you know, if they cannot afford private health insurance for a lot of elective surgery which would get them back as working, productive people. It is economically stupid, the way we are running the system at the moment, but that is how it is.

They tried to let bulk-billing go away and let the bulk-billing rate down to 68 per cent, as you know. Then Mr Abbott at the time did a huge backflip and effectively gave GPs a $40,000 pay rise for a full-time GP. That worked, and the bulk-billing rate has gone up. They only did that because of pressure from the community scaring them, worrying them about even losing the 2004 election. So the history is very clearly there that this is the agenda, and this is why the economic arguments that are put forward for efficiencies are being ignored and policies that simply do not make sense, either economically or morally, are being pursued. We have a battle on our hands to address that.

CHAIR: Can I go to the commentary that you have put on the table this afternoon with regard to private health insurance. In your submission you made some very clear claims about that, but I would like your reaction to statements from the media release from the Australian Health Care Reform Alliance which I think articulated similar issues. My question is: is this what you mean and is this what you are concerned about? They say:

The changes merely cut GPs' incomes in a variety of ways, inevitably forcing them to pass on the costs to consumers, including those with Concession Cards. This will pave the way for private health insurance to cover GP fees, signalling the death knell of universal health care. Once GP fees are insurable, it will inevitably mean fees will go up even further and soon a two-tier system will emerge. This may mean more readily available care for those with insurance (as in the Medibank Private trial in Queensland and elsewhere this year) but consequently slower and poorer care for those without, typically those on lower incomes, other vulnerable groups and Aboriginal and Torres Strait Islander people …

We need to look no further than Australia's dental system for clear-cut evidence of what a two-tier system looks like: it is mostly private, mostly expensive, and its public element is under-funded and has long waiting periods for limited care.

Dr Woodruff: Absolutely. This is exactly what we are talking about. This is the situation with that Medibank trial in Queensland, which the Senate has checked out under the legislation proposal previously. They are guaranteeing early access as well as waiving the co-payment—the 'we need a price signal' idea that the government is misleading the population about. They are going to abolish the price signal with the government's blessing. How hypocritical can that be? Price signals are not relevant to this government.; Price signals are only

for the disadvantaged and the poor; rich people do not appear to need price signals. Anyway, price signals when you have co-payments are a crazy idea because we have a price signal for somebody on $30,000, which is exactly the same as the price signal for politicians on $200,000 and for millionaires. How can that be a valid price signal? It just does not make sense.

And so one of our concerns and one of the things that we would like to pursue is that we should abolish these so-called price signals and we should look at even the Pharmaceutical Benefits Scheme where we have price signals—$35 or $36 a prescription, which is an enormous price signal for someone on $30,000 a year, especially if they are on three drugs a month. They will eventually, perhaps, get to the safety net—it is quite a big safety net—and people will be denying themselves prescriptions and the evidence is there from the Commonwealth fund on people postponing prescriptions, filling out prescriptions, in the first half of the year. Before they get to a safety net, they will be saying, 'Look, the fridge has broken down. What do I do?' It may be different for a tablet or medication that they desperately feel they need, but a lot of the medication we use is not something that you get a benefit from like that. For example, the statins which we pay ridiculous prices for—the cholesterol-lowering agents—nobody feels any benefit from them. It is a long-term plan.

Dr Costa: What we are saying is: once you stop universal bulk-billing and there are price rises, there will be tremendous pressure from the public, especially from those with private insurance, to have their private insurance cover the gap. That is how we see the Trojan horse working. It is a bit funny that we have a co-payment on the PBS and yet we continue to pay for a generic statin $42 a script when the same statin in New Zealand is only around $3 and in Great Britain around $2. There seems to be a thing where we need parsimony amongst the users and savings amongst the public, whereas we are quite happy to hand over billions of dollars unnecessarily to drug companies. There is a mismatch here that we do not understand.

CHAIR: We keep hearing about the need for a much more integrated, cohesive and comprehensive review of the system rather than these three announcements, which Dr Duckett indicated was a pretty radical pace of announcements and which we have had without any significant consultation with key people. What degree of consultation has your organisation had with either the former minister or the new minister?

Dr Woodruff: None.

CHAIR: None?

Dr Costa: We have not been contacted.

CHAIR: How many doctors do you represent?

Dr Costa: We are not a large organisation. We are fewer than a thousand doctors nationwide. However, we believe we have very strong support around Australia and we are often thought of as an alternative voice to other sections of the medical profession. I would say that our opinion should be sought.

Senator DI NATALE: How often do you and the AMA agree on policy issues? It does sound as though you agree on this one.

Dr Woodruff: We agree on their concern about co-payments, but we do not agree with the AMA's proposal which is about having co-payments.

Senator DI NATALE: You are both critical of the current proposal put by the government.

Dr Woodruff: Absolutely, but we do not see anything right about the suggestion to have an alternative co-payment that is restricted to some group, because it will have the same effect.

CHAIR: I very much like the critique of the sustainability argument. I think you said Medicare is 'cheap, cheap, cheap', not 'unsustainable, unsustainable, unsustainable', which is what we are hearing from the government.

Dr Costa: That is exactly right.

Senator CAMERON: Thank you, Dr Costa and Dr Woodruff, for what you constantly do on these issues. What we have heard today is that this is not really just about bulk-billing; it is about cost-shifting. You have argued that the cost-shift argument would then be taken up by people in the health funds and that that cost-shift should be taken up through the payment of the private health funds, and so you have the two-tiered system in place. If you can afford to be in a health fund, you do not pay the co-payment—

Dr Costa: That's right.

Senator CAMERON: whether that is $7 or $35 or whatever it is. If it comes about, that is Medicare gone, finished, isn't it?

Dr Costa: Yes.

Senator CAMERON: The universality is gone.

Dr Costa: Absolutely. Let us be quite clear about what we will lose. We will lose all those gains that we outlined before. There were very few doctors in the western suburbs. Working people never had a family doctor, and the only women who had pap smears were the women in the inner city. This would come back. People would leave the poorer country towns, for example. There are no hospitals around the poorer country towns, and so where they will go, I do not know. There will be a cost explosion for sure. I am certain there will be a cost explosion, which will need to be covered by the private health funds. And you will lose that control of costs where Medicare bulk-billing is holding back on the whole system.

Senator CAMERON: What we heard from the AMA and the rural doctors—some good people have presented today—is that they are in a small business and that they have to maintain sufficient income to keep the business viable. What we heard from one of the doctors who is part of a 15-doctor practice in Tamworth is that the estimates they have done with the $5 and the freeze is that for them to maintain their income and maintain the viability of their surgeries is that they would have to increase the payment to $100 to see a doctor. Is that unreasonable? I am not saying, 'Is that reasonable that they do that?' but is that something you could see?

Dr Woodruff: I think over time that might be what happens, but whether it is just about the viability of income that would take it to that level, I do not know, because competition plays its part in keeping the costs of health care down in general practice, in small businesses. Doctors are different in how they think, obviously. We are all human. Some people believe that they should have a lot of money for all the hard work they do; other people are happy to work in a community health centre for a quarter or a third their wage, and they are doctors. So what you have suggested or what they have suggested is conceivable. It is not necessarily just what is necessary to make a small run. We are both small businesspeople as well, doing exactly the same thing. It depends upon how much you think you deserve to some extent for all the hard you do. So that is going to vary, but it is going to be substantial. The cost control is lost.

Dr Costa: I think once you lose cost control, once you lose the pull back that bulk-billing holds on the private charging doctors, plus the combination of the insurer covering the gap, $100 is a very gettable amount. Doctors are not going charge less than what they can get.

Dr Woodruff: Not all of them. That is what I am saying: some doctors are going to do that and other doctors will say: 'I don't need that much. I can get by.' It is going to vary.

Senator CAMERON: Yes. You have raised the issue of this policy making no economic sense—

Dr Woodruff: Absolutely.

Senator CAMERON: and I think that has been reinforced time and time again. The AMA is on the same argument with you on that—the economics of this are crazy. You have raised the morality of it as well. But I suppose the morality is about people having access to health care.

Dr Woodruff: Yes.

Senator CAMERON: Have you got any idea what this policy of the $5 plus the freeze will mean in terms of people being able to access?

Dr Costa: It is mean-spirited. It makes no economic sense. It is mean-spirited. It is bad public policy. It is not going to save money, that is for sure; I am certain. It is going to drive up health costs. More importantly, as I started my presentation about, the hidden community cost has reached tragic dimensions for me as a doctor going to that nursing home. I have to tell you that I ended up stopping going to the nursing home because the people were so sick and needy. I was responsible and trying to fit them in at the end of a long day. I felt I was not really giving them the care they needed. It was a terrible, heart-wrenching decision because you are undersupported in the nursing home. The specialists will not come out there. It is very hard to get the patient to go to the specialist. There could have a chest pain in the middle of the day and you are in the middle of the clinic. You might be able to get there in two or three days. Sometimes that stretches to a week. By then they have gone to hospital. So in the end in good faith all I could do was stop going to the nursing home, which meant that the other doctor who was seeing the other 30 patients had to take my 30 patients on top of his workload.

So there are these hidden community costs, which are of tragic dimensions to me at the moment. These are people who fought for this country and who paid taxes all their life. They are in effect being siphoned off into these nursing homes—we are talking about a couple of hundred thousand people. I am not saying that doctors are not doing a good job for them; I am just saying that with the way the system works it is very hard for a doctor to take care of these people. Yet we are talking about a co-payment which is just going to make it so much worse. It is going to isolate these people even more from care unless they have private health insurance and unless the country is paying a lot of money for health care.

Senator CAMERON: You indicated the palliative care and aged-care health issues. Are there any examples internationally where it is done better?

Dr Costa: I am sure it is done better in other countries that have a more holistic system. We are under a private fee-for-service system with perverse incentives here. That is not Medicare. That was there before Medicare and Medicare is underfunding that. You have to have your doctors based around those people in the community who need the care—the really sick people—not sitting in medical centres treating the walk-ins and cut off from the really sick ones, who then depend on the hospital care, which is so much more expensive. We need to move away from fee for service and bring in some capitation. We need to enrol the really sick people with the GP and make the GPs responsible. Stop worrying about how much we are paying the GP and cutting their wages; give them more responsibility. Make it pay for us. Put the savings to the hospitals back into primary care. Do not leave the money in the hospitals when we are saving them money so they can just keep spending it.

There are lots of savings to be made here. There needs to be an inquiry into what is happening in these nursing homes and the palliative care. There is no public policy coming out. There are no initiatives. There it is just cost-cutting and cost-cutting, as if that is some sort of public health policy initiative. It just seems crazy.

Senator CAMERON: It is called reform. The last time I looked at the dictionary 'reform' meant to make things better.

Dr Costa: That is it.

Senator CAMERON: I shake my head.

CHAIR: Yes, making things worse and a lot more expensive. I know Senator Di Natale was seeking in his former questioning some responses on exactly the matters you have raised there—the whole notion of blended models of care and funding. Over to Senator Di Natale.

Senator DI NATALE: If you were speaking to the new Prime Minister next week, what would be the three key areas you would list to change in health?

Dr Costa: The three things?

Senator DI NATALE: Yes, if you had to pick three things that you think would make a big difference to healthcare delivery and potentially to savings.

Senator CAMERON: So is that for the Prime Minister or getting in early!

Senator DI NATALE: No, no. Honestly, you never know. You might have an audience with a new Prime Minister next week who is very interested in health reform. If you had to pick three areas that you think we should be focusing on right now—you have made your views clear on co-payments and the MBS—what would they be?

Dr Woodruff: I think the first priority is to improve primary health care. To improve that, we need to have it integrated and appropriately funded. It will pay for itself in terms of reduced hospital admissions, for example. It will pay for itself in terms of—

Senator DI NATALE: But what would you do? What would you recommend needs to be done in primary care?

Dr Woodruff: One of the things, which is about integration and making people not have to traverse the many different aspects of primary care to get proper care, would be to take the Labor Party initiative of Medicare Locals—which have fortunately not been completely chucked out and still are primary healthcare networks—and help them to evolve to be a strong, coordinating force to integrate the health system so there is much less duplication at the primary care level at least and it is much easier for patients, so that patients get much better access. I think that that would be a huge direction to take.

Senator DI NATALE: Is there anything in the area about the way primary care is funded at the moment?

Dr Woodruff: We are on record as saying that we think we should move away from totally fee-for-service, definitely. That is because it is a barrier to the teamwork that we need for that coordination of care and it has got all the perverse incentives that we were talking about: every little item has to be checked and filled. It just creates this crazy situation that we have now. We could move much more to block funding, enrolment and cavitation; all of those need to be considered. If there was more blended care at least, which already exists to a small extent, then we would have a lot better primary health care. It would allow, if you throw in all of those things, general practitioners to get into nursing homes and to help the aged in their nursing homes and at home. But it has to change, because this fee-for-service model just does not work for them.

Dr Costa: Can I give you one example to simplify this? Bupa, which has quickly become the second largest organisation, together with Medibank Private now control almost 70 per cent of the market. They have made an

excellent suggestion. That is, to put salaried doctors in nursing homes. That is an excellent suggestion. Why aren't we doing it? Why isn't Medicare doing that? That is because if Bupa did it, who would they treat? They would only treat privately insured people.

Senator DI NATALE: They are doing it because it would save them money.

Dr Costa: It would save them money in their private hospitals.

Senator DI NATALE: They point of them doing it is that they are a business and they recognise that these people are costing them a lot of money.

Dr Costa: What I would say to the Prime Minister is: 'Why aren't we doing that? You have got nursing homes with 200 people in them.'

Senator DI NATALE: And they are going in and out of hospitals.

Dr Costa: Most of their care is in EDs and hospitals. But that is not just for GPs, why not for the specialists? Before, those old people all lived somewhere else. Their old specialist is now in Woop Woop. Why aren't you allowing people to have a specialist go there and let people opt in with the specialist who visits? Just on that level, there is so much that could be done.

Senator DI NATALE: You mentioned Bupa as an example of doing something that perhaps the government should be doing, which should be universal. Would there be anything you would say about the funding or the subsidies that are provided to the private health insurance industry? Do you think that is money well spent?

Dr Woodruff: No. We are on record as saying that the private health insurance rebate should be removed. To do that, we would also need to have adequate hospital funding to make up for the downside of that. I am not suggesting that suddenly be removed like that, because that might cause chaos; but it certainly should be pared back. We welcome the fact that it is not going up now according to however much they want it to, which is because of legislation. But it is still going up. We think that the private health insurance rebate is a complete waste of money.

Senator DI NATALE: But doesn't it take the pressure off hospitals? Isn't that the argument that is used?

Dr Woodruff: It is the argument that is used, and it has been found time and again to be false by almost every bit of evidence that comes out. The fact is the load on public hospitals is, if anything, greater—we have longer waiting lists, we have patients waiting more time. The biggest threat to private health insurance and its industry, and the private health sector, is having a good public hospital system, a good public system. That is what they are worried about. And that is precisely why, carefully organised, the Howard government let its contribution to hospital funding decay down to 38 per cent over the time that they were in government. It puts pressure on people to have private health insurance. And it worked. The rebate did not do it. The rebate is just a complete waste of money funnelled through an expensive intermediary—the private health insurance companies—and we could get a so much bigger bang for our dollar if we were spending that directly on hospital care.

Senator DI NATALE: So you are suggesting that, rather than spending—I do not know what it is at now, but six or seven billion—

Dr Woodruff: Seven billion.

Senator DI NATALE: Rather than subsidising people to take out private health insurance, that money should be invested directly in purchasing services, whether they be in public or private hospitals?

Dr Woodruff: That needs to be worked out, and I am not quite sure whether it should be one or the other or a mixture of both, but yes. That is the direction we should be moving in.

Dr Costa: I would invest it in primary care and keep people out of hospital.

Senator DI NATALE: Yes, point taken.

Dr Woodruff: We need to do that, but we also need—

Senator DI NATALE: People will still need hospitals, won't they?

Dr Woodruff: We still need hospitals, we still need the ambulances at the bottom of the cliff. So we do have to be careful about that.

Senator CAMERON: We have just got to stop people falling over.

Dr Woodruff: We want them to stop falling over! Let us work on that, too.

CHAIR: I think we would like to keep a few of those ambulances off the ramps as well. That is another big problem. Can I thank you, Dr Woodruff and Dr Costa, for your contribution to the hearings today. We have heard with some concern that the consultation phase with the new minister may be as short as two weeks before they

make any further commentary. We invite you to put further submissions to us to put in the public place—ideas that you would like to see advanced in terms of policy, just so the whole thing does not go underground or disappear completely.

Dr Woodruff: It will not.

CHAIR: We look forward to further contributions. Thank you very much.

Dr Woodruff: Thank you very much.

Dr Costa: Thank you.

CAHILL, Ms Fifine, Assistant Secretary, Primary Care and Pathology Branch, Medical Benefits Division, Department of Health

CROKE, Ms Leesa, General Manager, Department of the Treasury

FAICHNEY, Ms Kirsty, Acting First Assistant Secretary, Medical Benefits Division, Department of Health

HOBBS, Dr Anthony, Acting Deputy Secretary, Department of Health

HUNT, Mr Nicholas, Assistant Secretary, Department of Finance

MONTEFIORE-GARDNER, Mr Robert, Senior Adviser, Department of the Treasury

STUART, Mr Andrew, Acting Secretary, Department of Health

THOMANN, Mr Mark, Acting Deputy Secretary, Department of Finance

[16:23]

CHAIR: I now welcome representatives from the departments of Health, Treasury and Finance. I remind committee members and officers that the Senate has resolved that an officer of a department of the Commonwealth or of a state shall not be asked to give opinions on matters of policy and shall be given reasonable opportunity to refer questions asked of the officer to superior officers or to a minister. This resolution prohibits only questions asking for opinions on matters of policy and does not preclude questions asking for explanations of policies or factual questions about when and how policies were adopted. Is there anything any of you would like to add about the capacity in which you appear today?

Dr Hobbs: I have responsibility for the Medicare division, the pharmaceutical division and sport.

Ms Croke: I am in the social policy division in the Treasury.

Mr Montefiore-Gardner: I am also in the social policy division in the Treasury.

Mr Thomann: I am Acting Secretary of Budget Group in Finance.

Mr Hunt: I am Assistant Secretary of Budget Group in Finance.

CHAIR: Thank you. I think we have until five o'clock. I will go straight to Senator Cameron for some questions.

Senator CAMERON: Where do we start? Department of Health, I think: who does your research in terms of health economics?

Mr Stuart: If that is a general kind of question, we have a small strategic policy unit in the department. We also have within each divisional area a certain amount of knowledge and understanding and a capability of reading research, and of course we have the National Health and Medical Research Council which pays for medical research in Australia. We have relationships with academic groups. And we fund specific research or buy specific research from time to time.

Senator CAMERON: I am not asking what advice you have given, but have you given advice to the previous minister and this minister upon the specific issue of co-payment?

Ms Faichney: We provide a significant amount of advice to ministers for guidance on what the issue is; if they ask us for advice, we provide it. I believe that at previous hearings it has been discussed that, yes, we will provide advice around co-payments.

Senator CAMERON: You have provided advice on co-payment?

Ms Faichney: Yes.

Senator CAMERON: What research have you done within your department on the economic effects of co-payment?

Mr Stuart: We have read the research which is nationally and internationally available, as I believe we have outlined at previous hearings.

Senator CAMERON: So you have read the research. Have you conducted any of your own research?

Mr Stuart: Not specifically.

Senator CAMERON: So, on one of the biggest changes to the health system, you provide advice to the minister; you have not done any specific research or analysis on co-payments—is that correct?

Ms Faichney: We provide analysis on co-payments. We have, obviously, significant Medicare data held within the department, and we are aware of historical data. There are co-payments now in the system, as has been

discussed previously at this hearing; there is already a co-payment process as part of Medicare. So we provide advice based on the data that we hold in the department.

Senator CAMERON: But what research have you done on the specific impact of increased co-payments on health outcomes?

Mr Stuart: I think you would need to acknowledge the difficulty of doing such research as part of the budget cycle. The nature of the research—

Senator CAMERON: So everything you do is about the budget cycle, is it?

Mr Stuart: No, of course not.

Senator CAMERON: Why would that be an issue related to the budget cycle?

Mr Stuart: There are significant methodological difficulties and significant time is required to do any kind of meaningful research on the impact of co-payments, which is why most of the commentators reflect and the literature reflects on research which has in fact been done internationally and is now getting quite old and involved randomised allocation of patients to different levels of co-payment or no co-payment, in the RAND study; that research is now getting quite old. It is very difficult to do. The logistics and perhaps the ethics of randomised allocation of patients to different levels of payment within a health system is very difficult. So I think what you are asking would be a very large national or international piece of work.

Senator CAMERON: You have got to provide advice to the minister on these issues, haven't you?

Mr Stuart: Yes, and, as I say, we read the available research and we reflect on the data available to the department.

Senator CAMERON: And what does the available research tell you about increasing the costs to get primary health care?

Mr Stuart: The international evidence and research is very equivocal and not directly related to the current Australian situation.

Senator CAMERON: It is not related to the current Australian situation. So you are reading international research and providing advice based on international research that is not based on the current Australian situation. What way is that to give a minister advice? Can you explain?

Mr Stuart: I have been explaining.

Senator CAMERON: Not very well. I am lost. You are saying that you rely on international evidence and international research, and then when I ask you whether you have done any yourself you say no, and then when I ask you what the international evidence is you say it is equivocal and you have to take into account the specific circumstances in Australia. Who has been looking at the specific circumstances in Australia?

Mr Stuart: I am unaware of any authoritative research in Australia specifically about the impact of something like Medicare co-payments or a reduction in the rebate.

Senator CAMERON: So all the evidence—

Senator DI NATALE: There must be some assumptions, though, about what impact it is going to have on demand for GP services, for example. How else do you cost the saving? You must have done some work on that.

Ms Faichney: Yes, there has been work done on it as part of the advice that we provide to government. Just for clarity, the co-payment measure, as you will be aware, is only for non-concessional Australians, so a very large part of Australia's population is excluded from that.

Senator DI NATALE: No, that is not true. This is important: does your modelling include the fact that some practices—we heard today from one in Tamworth—will make a decision not to continue bulk-billing their concessional patients?

Ms Faichney: I do not know why they would make that decision. There is no change for concessional patients and no changes to the incentive.

Senator DI NATALE: It is pretty straightforward. Again, it is pretty basic. If you have coupled a freeze in the indexation with a reduction in the rebate for non-concessional patients, there are only two ways that GPs can make up that income: they slug their non-concessional patients a lot more to make up for the freeze in indexation for their concessional patients, or they charge their concessional patients more. Some clinics have decided that they are going to target both groups and that their non-concessional patients and their concessional patients will both be slugged. In your research, have you factored into any of the modelling or work that you have done the fact that there will be a decline in the number of concessional patients that are bulk-billed?

Ms Faichney: It is very difficult, as you are well aware. In Australia—I know some of the witnesses have said it—a general practice is a small business. How they respond and how they change their billing practices will be a decision for them.

Senator DI NATALE: Yes, but you have to make some assumptions about what is going to happen in this space.

Senator CAMERON: Of course.

Senator DI NATALE: You do not provide the advice to the minister. You cannot just say, 'They're going to react in different ways.' So what sort of work have you done? I am sure that you have to make a range of assumptions, but what work have you done to determine what impact this is going to have on concessional patients and non-concessional patients?

Mr Stuart: We have made the assumption in the work that we have done that there will not be an impact on concessional patients, for two reasons.

Senator DI NATALE: Okay, so this is your first mistake. We had some evidence earlier on. We heard from a 15-doctor practice in Tamworth who said unequivocally that they will now be ceasing bulk-billing of their concessional patients.

Mr Stuart: I would ask them.

Senator DI NATALE: In your assumption—in your work—you are saying that you do not think it is going to have any impact on concessional patients. How do you square those two things?

Mr Stuart: We would have to choose a size of effect if we were going to make such an assumption.

Senator DI NATALE: Correct. It clearly has an effect, because we have heard that today.

Mr Stuart: I would invite those particular doctors to have a fresh look, because I cannot understand—

CHAIR: A fresh look at their own business?

Mr Stuart: I cannot understand how a $5 rebate reduction for non-concessional patients—

Senator DI NATALE: No, hang on, it is—

Mr Stuart: let me finish—and the continuation of a bulk-billing incentive for concessional patients adds up to—

Senator DI NATALE: And freezing of the Medicare rebate till 2018. You keep forgetting that.

Mr Stuart: That adds up to perhaps another $2 to $3 over the three years.

Senator DI NATALE: We heard from a former secretary of the department that he believes—and we have heard it from the AMA and a number of other practices—that that will have a bigger effect, in the order of six per cent compared to four per cent, than the reduction in the rebate, and you have ignored it.

Mr Stuart: I get to $5 in terms of the rebate reduction. On the back of an envelope, I get to two per cent per annum to 2018—to perhaps another $2.20 to $2.50—from the pause in indexation.

Senator CAMERON: So these doctors have got it completely wrong, have they?

Senator DI NATALE: Have you read Dr Duckett's piece in *The Conversation* today?

Mr Stuart: I have not had the opportunity to read his piece.

Senator DI NATALE: Have you looked at his submission to this inquiry?

Senator CAMERON: Has anyone read Dr Duckett's piece this morning? You were coming here and it goes to very issue you were coming here for. He is a renowned health economist. He has put a public position this morning. Have any of you read it? Has anyone from the Department of Health read that paper?

Mr Stuart: I think the answer to that question is no.

Senator CAMERON: No?

Mr Stuart: We have been monitoring the hearings. I was here to listen to Dr Duckett this afternoon, but I have not had the opportunity to read the paper produced today.

Senator CAMERON: So you cannot allocate a competent health economist within the whole of the Department of Health to give you an analysis of Dr Duckett's paper? Is that what you are saying? You were monitoring this and the Department of Health cannot make an analysis? Is that correct?

Mr Stuart: I have just become aware of Dr Duckett's paper, and the department would be very happy to look at Dr Duckett's paper when we have the time to do so.

Senator CAMERON: So there will be no domestic analysis done of this effect? You are doing back-of-the-envelope assessments. That is fine. What about Treasury and what about Finance? What have you guys and women been doing on this issue? Have you done any analysis in Treasury as to the impact on health costs of this increase in the co-payment and the freeze on the indexation?

Ms Croke: Not that I am aware of. I could take that on notice, but I am not aware that we have done anything in particular.

Senator CAMERON: So that is Treasury. What about Finance?

Mr Thomann: We have done no work on those broader impacts.

Senator CAMERON: Can I ask you and Treasury why you have not done this—because it has financial implications?

Mr Thomann: Because our role is to provide assurance on the costings provided by Health in terms of the impact on the budget bottom line. That is the limit of our costing role, really.

Senator CAMERON: So what is the budget bottom line, Treasury or Finance, of these changes? Have they changed since the budget in May?

Mr Thomann: Yes, they have. There have been some adjustments. I will ask my colleague—who is quicker on the folder than I—to read out the numbers.

Mr Hunt: The original budget measure delivered a save of around $3.5 billion.

Senator CAMERON: $3.5 billion?

Mr Hunt: Yes, $3.5 billion.

Senator CAMERON: Is that over the forward estimates?

Mr Hunt: Yes, that is right. The measure that was published at MYEFO delivered a net additional saving of $103 million.

Mr Thomann: Just to clarify, those are the figures published at MYEFO. But the new Minister for Health has announced that one element of that measure is no longer to be implemented.

Senator CAMERON: The $7?

Mr Thomann: It is consultation A and B. So these numbers will need to be revised in the 2015-16 budget on the basis of the revised government policy.

Senator CAMERON: Have you got a back-of-the-envelope assessment as to the difference?

Mr Thomann: The reversal of the consult A and B element of this is about a billion dollars.

Senator CAMERON: Finance, you say you are only interested in making sure that the figures in the budget are correct—that that is your job.

Mr Thomann: That is our core role.

Senator CAMERON: Treasury, what is your position? Ms Croke, what is your title?

Ms Croke: General Manager, Social Policy Division.

Senator CAMERON: Social Policy Division? So you are doing social policy?

Ms Croke: Yes.

Senator CAMERON: What we are hearing is that this is a terrible social policy—these budget decisions—with a huge, ongoing impact on the budget bottom line and on health. Has Treasury done any analysis on the social impacts of these budget decisions, given that you are the social analysis area?

Ms Croke: During the course of the budget there was advice provided to government. There is work done in another area of the department that looks at the taxation, the transfer system and distributional impacts. However, it does not take into account the health system. That is outside of the transfer system. I would have to take on notice if we did any additional work outside of that regular distributional analysis work that we have done.

Senator CAMERON: The health department has done no analysis. The finance department has done no analysis. But Treasury cannot tell me whether it has done any analysis. Is that where we are at?

Mr Stuart: No, it is not. You asked me questions about research, and I pointed out the difficulties of doing randomised controlled experiments with people's entitlements in a legislated environment. We did say that we had done significant analysis and provided significant advice to ministers and government.

Senator CAMERON: Did you do the analysis in terms of the effect of people not presenting early with symptoms, and the financial impact or health impact that would have?

Mr Stuart: I can tell you that we provided significant advice to the ministers and government in the context of the budget.

Senator CAMERON: I am not asking for what advice you have given. As a senator, I am asking you what analysis you have done in relation to the impact of increasing the cost of people going to see the doctor. I am not asking for advice to government; I am asking what you have done in relation to that.

Mr Stuart: We have read the available evidence.

Senator CAMERON: What evidence have you looked at?

Ms Cahill: As I responded to in relation to similar questions at Senate estimates, there is a range of international evidence. Mr Stuart referred to the RAND study, which is probably the best known piece of evidence. There are also a range of other international approaches on how health systems and health services are funded, and the mix of payments between insurance—which is, I guess, what Medicare comes under—and patient contributions. Some of the evidence earlier today was about the differences between fee-for-service versus having some kind of bundled payments—having doctors on salaries. There was a range of research. Obviously, those are things that we keep an eye on as the health department all the time.

Senator CAMERON: What conclusions have you come to in relation to the cost transfer—the transfer of cost from government to individuals? Have you done that analysis?

Ms Cahill: I am not sure exactly which cost transfer you would be referring to. Obviously, the proposal for a $5 co-payment does involve an element of transfer.

Senator CAMERON: You could not to do anything else today because you were listening to the evidence. You heard the evidence that there was a transfer of costs from the Commonwealth government to the states, and from the Commonwealth government to the individual. You heard that evidence, did you?

Ms Cahill: Personally, I did not.

Senator CAMERON: Who did? Who was listening? You could not do anything else, because you were listening to the evidence. Who heard the key part of the evidence? Nobody?

Mr Stuart: I am sorry. Who was giving this particular evidence?

Senator CAMERON: This was given on a number of occasions today by not just by one witness but several witnesses. I thought you were monitoring this all day.

Mr Stuart: I did not hear it in quite that form, Senator, but could you just ask the question that you are—

Senator CAMERON: What form did you hear it in?

Mr Stuart: I am uncertain what you are referring to, Senator. That is the problem. If you would be willing to ask us a question, we will see what we can do with it.

CHAIR: Mr Stuart, I think it is reasonably clear. The senator has just said that we have heard from multiple witnesses today that there is a cost transfer with this implementation of policy to the states and to people. We have heard it on a number of occasions. It is pretty clear. Did you hear that today or not?

Mr Stuart: Well, the idea that there is a cost transfer to individuals is actually the policy, so—

CHAIR: So you agree with that? That is the policy, and you did hear it today in the evidence?

Mr Stuart: Absolutely.

CHAIR: Okay, thank you.

Senator CAMERON: So it is government policy to transfer costs from government—and that is a collective cost—to the individual? That is what you are saying?

Mr Stuart: The government is arguing in favour of a price signal and seeking to reduce the rebate by $5 and leaving it to the clinicians as to how and when and whether they wish to pass that on. But in general the aim for the policy is a price signal to the user of health services.

Senator CAMERON: I thought that in the budget papers the aim of the policy was to establish a medical research fund. That is what the budget papers say.

Mr Stuart: That is another objective of the policy.

Senator CAMERON: No, that is what the budget papers say, that all the savings—Treasury, is that correct?

Ms Croke: The budget documentation does talk about 'the savings from the health measures will be directed to a Medical Research Future Fund'.

Senator CAMERON: All of the savings?

Ms Croke: All of the savings—

Senator CAMERON: All of the savings, so the health department—

Ms Croke: up to $20 billion.

Senator CAMERON: Up to $20 billion, yes. So is that your understanding, now that it has been clarified by Treasury that it is—

Ms Croke: But that is where the money is directed. There is another objective around the price signal.

Senator CAMERON: There is a cost-shift, and the argument was that the money that was saved—some of the money—would then go into a medical research fund. Is that right? Is that your understanding?

Mr Stuart: Yes, the money that is saved will go towards a medical research fund.

Senator CAMERON: Right. So the international research that you depend on you say is equivocal. Can you provide us details of where that research indicates, consistent with what we have heard here, that there is not only a cost impact to the individual but a health impact, and by that health impact then you are being passed through to hospitals? You know the arguments, don't you?

Mr Stuart: Yes.

Senator CAMERON: Mr Stuart, you know the arguments?

Mr Stuart: Yes, of course.

Senator CAMERON: Are those arguments right or wrong?

Mr Stuart: The evidence is very weak, so perhaps what I could try to do is simply paraphrase what I understand of the evidence, and then I will ask my colleagues, if they would, to help and paint that in a little more. The RAND study randomly assigned groups of individuals to different levels of insurance co-contribution: zero, 25, 50 and 75 per cent of their health costs. The RAND study found that, among the poorest in the community, the higher levels of co-contribution tended to reduce the accessing of health care. The RAND study also found that there was no evidence over a five-year time frame of any change in the health status of those individuals compared to those that were assigned into the no-cost group. So there was an apparent impact on access but no findable impact on health outcomes, and that is at a level of contribution, at even the smallest level, which is greater than the level of contribution represented by a $5 rebate reduction. Have I put that reasonably clearly?

Senator CAMERON: I have never heard this being argued by the health department at any time in the last decade.

Mr Stuart: No, I believe that I saw this evidence in terms of a transcript from Dr Bartlett from an earlier hearing.

Senator CAMERON: Yes, but I am talking about in the years past. In years gone by, this has never been used as an argument. You are saying there is equivocation. What are the counterarguments to that that you have looked at?

Ms Faichney: This is again back to the issue that all health systems are complex and individual to their country.

Senator CAMERON: I meant Mr Stuart. I am going to Mr Stuart. He is leading the charge on this.

Mr Stuart: I am sorry; I have said to you that we have been reading the evidence. We alluded to the RAND study. I have outlined, in fairly simply terms, my understanding of the RAND study. The department has also reviewed other literature. It does not lead you to very specific conclusions in relation to the government's proposal.

Senator CAMERON: Can you provide details to the committee of all the literature that you have looked at in relation to this conclusion that you are putting to us.

Mr Stuart: I am happy to take that on notice.

Senator CAMERON: Did you do a literature search?

Mr Stuart: Yes, the department undertook a literature search.

Senator CAMERON: Can you tell me the methodology of that literature search.

Ms Cahill: We can take that on notice.

Senator CAMERON: Treasury, do you come to the same conclusions—that by increasing the costs for someone to see a doctor and they delay access to getting health care that there are no health implications? Is that Treasury area's analysis as well? Do you agree with what you have just heard?

Ms Croke: We have not undertaken that analysis, and I am not familiar with those studies. I am sorry.

Senator CAMERON: Who does health in Treasury?

Ms Croke: We, in a way, shadow the Department of Health, but the Department of Health would undertake a significant amount of that research. I have not looked—and I do not know that we have looked—

Senator CAMERON: You have not done any research? Health have done a literature search and they have come to some conclusions base on—I am not sure how many—studies. How many studies was it that you looked at, Health department?

Ms Faichney: We have taken that on notice; we will have to let you know.

Senator CAMERON: Was it one; was it tens or was it scores?

Mr Stuart: We are happy to take that on notice, Senator.

Senator CAMERON: You will give me the details of what you have done, then. How many people were involved in the literature search?

Ms Faichney: I am sorry. As you know, a couple of us here are fairly new to the positions. We will have to take on notice the detail of the information that was done prior to that.

Senator CAMERON: So you cannot help me at all on this, can you?

Mr Stuart: I believe we are, Senator.

Senator CAMERON: Do you, Mr Stuart? You believe you are helping us, do you? Even though you have taken every question on notice, you do not know what literature search you have done, you cannot tell us how many documents you have looked at, and you are relying on one piece of evidence to say that there is equivocation. When we ask you to give us the counter position you cannot tell us. Yet you come here with one piece of evidence, you hang onto that and you say there is equivocation but you cannot tell us. So you are not being very helpful, but that is okay.

Senator DI NATALE: I just want to return to the line of questioning we were going down earlier. Just to be clear about this, in the advice you have provided to government and indeed in the impact on the budget you are assuming that the rate of bulk billing for concession card holders will not change.

Mr Stuart: That is the assumption.

Senator DI NATALE: It is the working assumption at the moment: there will be no change in the rate of bulk billing for people with a health care card.

Mr Stuart: We have no basis for any other assumption, given the incentives and the design of the government's package.

Senator DI NATALE: Perhaps I will put a different view to you, and you may be able to tell me why I am wrong with my line of thinking on that. You are assuming there is no change in the rate of bulk billing for concession card holders and you are assuming that the impact on non-concession card holders is, essentially, $5. Those are the two things. There is a $5 impact in terms of an out-of-pocket costs.

Mr Stuart: No, there a $5 impact and then there is the impact of the freezing of indexation of the rebates.

Senator DI NATALE: Let's talk about non-concessional patients. The GP is paid $5 less for an ordinary level-B consultation. What proportion of doctors do you assume will charge that to the patient? Have you made some assumptions about that? Surely you must have done that.

Ms Cahill: Yes, we have done that. I do not have the number in front of me but we have certainly assumed that in the vast majority of cases the doctor would pass on the $5.

Senator DI NATALE: What is the vast majority—99 per cent, 99.9 per cent? Is it that sort of quantum?

Ms Cahill: I would expect so.

Senator DI NATALE: You would expect that it would be over 99 per cent of GPs.

Ms Cahill: We expect that there will be the odd circumstance where a GP will be of the view that a non-concession card holder has a legitimate reason so that they would not seek that, but we would expect that in the vast majority of cases that that would be passed on. We also expect that there is some likelihood that a larger number of non-concession patients than currently occurs would be charged a co-payment higher than the $5.

Senator DI NATALE: This is what I am interested in getting to. Are you able to provide us with those numbers?

Ms Cahill: We could take something on notice.

Senator DI NATALE: It is pretty straight forward. It is: what percentage of patients will be charged that $5 out-of-pocket cost? The minister keeps saying that it is a choice of the doctor but let's just call a spade a spade. How many doctors do you think are not going to exercise a choice of taking a $5 reduction in a level-B consultation when the thing has been frozen for ever? It would be nice to have some confirmation from the department about what sort of number you expect. I would assume that it would have to be that over 99 per cent of doctors will choose to pass that cost on to patients.

Ms Cahill: We can certainly take that question on notice. We do our analysis at the service level; so we will not have looked at what percentage of doctors. We will have looked at what percentage of—

Senator DI NATALE: The percentage of services. Yes; fine.

Ms Cahill: The percentage of GP services in the items affected which we would expect to have changed.

Senator DI NATALE: Why does the minister persist in saying that it is a choice for the doctor, when the modelling clearly indicates that doctors are not going to do anything other than pass the cost onto patients?

Mr Stuart: No; it is not modelling; it is an assumption.

Senator DI NATALE: Okay it is not 'modelling'. I have used that word a few times and been pulled up. I know it has a very specific meaning here.

Mr Stuart: It is an assumption in our estimates.

Senator DI NATALE: Given that the advice you have provided is that we expect almost every service where a level B is charged and where there is a $5 reduction because a patient does not have a concession card, the doctor will pass that cost onto the patient. Why does the minister persist in saying this is a choice for the doctor to make when you are clearly telling him that it is going to happen in almost every case?

Ms Cahill: There are two aspects to that. The first is that many doctors will say that, at the moment, when they choose to bulk bill a patient they are foregoing considerable income. So there is a range of factors that go into doctors making those decisions. I think the other aspect of this goes to one of the important changes between the policy around co-payments that was announced in December compared to the policy that was originally announced at the time of the budget. I am sure senators will recall that one of the significant criticisms of the original co-payment model was that it applied to concessional patients and also that for those concessional patients the current bulk-billing incentive was to be turned into a low-gap incentive so that where a doctor did not choose to charge the patient the $7 there would be what many doctors viewed as a significant disincentive for not collecting that.

Senator DI NATALE: We are not talking about that now.

Ms Cahill: That was particularly significant for rural areas. So I think that is the aspect of the policy change that ministers have been seeking to emphasise in explaining the difference between the policy announced in December as opposed to the policy previously.

Senator DI NATALE: I do not expect you to answer for why the minister is making particular statements, so I accept that. You also indicated that you have done some work which suggests that some services will increase by more than the $5. Is that correct?

Ms Cahill: Yes. We would expect that, where there is a possibility that some doctors may choose to absorb that for individual patients, which is always likely, that they would usually recover that by either charging the non-concessional patients they currently charge a little bit more or potentially by changing their billing policy so that a few more patients will be charged a higher level of co-payment.

Senator DI NATALE: So you are expecting that there will be a number of other services—and we are not talking about level B services here.

Ms Cahill: These are estimations that we have done just in relation to the services that are affected by the patient contribution.

Senator DI NATALE: In your work—I will not say 'modelling'—you are assuming that there will be an increase in the charge to the patient over and above the $5. Is that what you are suggesting?

Ms Cahill: For a small number of services. Compared to the current rate of bulk billing of those services for nonconcessional patients, there may be a bit of a move to have more of those services than currently occurs being fully patient billed in the sense of charging that patient a co-payment of more than $5.

Senator DI NATALE: What sort of numbers are we talking about?

Ms Cahill: I do not have a number—I have a percentage of a percentage. We could certainly provide that to you.

Senator DI NATALE: That is what I am asking—what percentage of services are we talking about? You will provide that on notice?

Ms Cahill: We can look at that on notice.

Senator DI NATALE: We have, effectively, a $5 cut and if you look out to 2018 that reflects—it is basic maths but it is a table that comes from Dr Duckett's paper—about a four per cent reduction in GP incomes and then when you factor in indexation the value is on a level B consult. We assume inflation at about two per cent on this, as well. If you look at the freezing of the rebate for a level B consult, that is worth about six per cent. You have a reduction of 10 per cent in the income of a GP.

Ms Cahill: At the start of our questioning I think we were agreeing that in the vast majority of cases doctors would pass the $5 rebate reduction on to their nonconcessional patients.

Senator CAMERON: The evidence from the others is that it will be more than $5.

Ms Cahill: Yes but it is not a reduction to the GP's income; it is that some of that income is coming from a different source.

Senator DI NATALE: It is a reduction in the money that the government gets through Medicare. So it is a 10 per cent reduction for providing exactly the same service—GPs will now get 10 per cent less than they were getting previously, when you factor in both the indexation freeze and you factor in the reduction in the rebate for level B. You are talking about a 10 per cent reduction in the income a GP would otherwise receive from Medicare.

Mr Stuart: Across the practice or for a specific patient?

Ms Cahill: We would have to look at those calculations—

Senator DI NATALE: Across the practice.

Ms Cahill: The reduction only applies to a small number of items. There are many other items that a GP practice would be providing—

Senator DI NATALE: Level B consults are their bread and butter. What do you mean 'a small number'? It is what a GP does. It is the vast bulk of what they do.

Ms Cahill: It is the vast bulk of items but the other items such as chronic disease management—

Senator DI NATALE: Of course I might take out someone's toenail every now and then and charge that—

Ms Cahill: It is more the chronic disease management and health assessment. But they are not insignificant.

Senator DI NATALE: Sure. But a GP's income is dependent on level B consults.

Mr Stuart: Unless this gets extremely tedious we are not going to be able to have this discussion at the level of dollars for a practice. Sixty per cent of consultations are for concessional patients, who continue to be able to be bulk billed, and bulk billing incentives remain in place. We are talking about a $5 rebate reduction and an indexation freeze for consultations for up to 40 per cent of the practice's patients.

Senator DI NATALE: Are you saying the rebate is not frozen for concessional patients?

Mr Stuart: No, that is true, of course.

Senator DI NATALE: Of course it is true. It applies to every single person in that practice. There is a six per cent reduction in the level—regardless of whether they are concession card holders or they are not concession card holders, the freezing of indexation means there is a six per cent reduction for everybody.

Mr Stuart: Yes; I was not implying otherwise.

Senator DI NATALE: The point is, if you are going to reduce—

Mr Stuart: After three years.

Senator DI NATALE: a GP's increase by 10 per cent, that is a big change to the business model of that practice. What surprises me is that you have not done any sort of detailed work to look at what impact that is going to have on the billing practices of general practices across the country. What is even more concerning is that you are providing advice to the minister to suggest that there should be no change to the level of bulk-billing for concession card holders, when we had somebody today from a practice—a 15-doctor practice in Tamworth—who said, 'This year we will cease bulk-billing our concessional card patients. We're going to stop it. We can't absorb this decrease—a combination of indexation and a reduction in the level-B consult—

Senator CAMERON: Plus additional costs.

Senator DI NATALE: Yes, plus all the other things that are going on in general practice: indemnity, all the infrastructure costs, a whole lot of issues.

Mr Stuart: Let's just be clear about what we are and what we are not saying. The department is not saying that it has advised government that there will be no impact. The department has said that in its estimates it has assumed, for the purpose of the estimates, that there is not a behavioural impact.

Senator DI NATALE: Do you mean that GPs will not change their billing practices—is that what you mean by that?

Mr Stuart: In terms of estimates, we need to choose an assumption for those estimates.

Senator DI NATALE: But the assumption is wrong.

Mr Stuart: We have no basis for any other—

Senator DI NATALE: You have just reduced incomes by 10 per cent, you have practices already making decisions that they are going to stop bulk-billing concession card holders. What more basis do you need?

Mr Stuart: I am trying to point out the difference between assumptions in a costing and advice to a government. They are quite different things.

Senator DI NATALE: You are pointing out the difference between fiction and reality. That is the difference that we have here. You are presenting a fictional scenario, and then we have the reality, which is: 'We're going to have to stop bulk-billing our concession card holders.'

Mr Stuart: I am saying there is no evidence basis for picking any other assumption in this estimate.

CHAIR: We beg to differ, Mr Stuart.

Senator DI NATALE: You have reduced incomes by 10 per cent. If I am a GP, I have two options. One is that I increase the out-of-pocket costs for my non-concessional patients to make up for that 10 per cent shortfall—the freezing indexation. I have to charge my non-concessional patients more to cross-subsidise the fact that I am getting less for people with a health care card. I am getting less because we are freezing the rebate until 2018. Or, I charge them both an out-of-pocket cost. It is not brain surgery.

Ms Faichney: I think it is the concessional and non-concessional issue we need to clarify. Regardless of what the doctor from Tamworth might say around his billing, Mr Stuart is absolutely right in the assumption that with no rebate change for concessionals and with no bulk-billing incentive change for concessionals—

Senator DI NATALE: But freezing the rebate.

Ms Faichney: there is no reason to assume that there would be a major change in the bulk-billing practice for that.

Senator DI NATALE: I am not suggesting it is major.

Ms Faichney: Then we go to the non-concessional side. At the moment, over 70 per cent of non-concessionals are bulk-billed. So this goes to what Ms Cahill was saying that you would expect a practice to look at its billing practices; it would look at those individuals who have the ability to pay and may choose—of those they are already charging—to charge more. With those they are not charging, they may seek to recoup some of the loss from the $5.

Senator DI NATALE: So you are saying they will charge them more than $5?

Ms Faichney: They may for some; they may for others. It will depend on the structure of their practice.

Senator DI NATALE: And we are going to get some numbers on the proportions of what numbers we expect to be charged above the $5?

Ms Cahill: Just to be clear, those are assumptions that we have—

Senator DI NATALE: I accept that. They are all assumptions. I suppose what I am challenging is the assumption that there is going to be no change to the billing of concessional patients. Because it is impossible to conceive of a situation where every practice is going to say, 'You know what? All I'm going to do is charge my non-concessional patients a hell of a lot more to compensate for the fact that I'm going to continue bulk-billing people on health care cards.' There will be a lot of practices that will go, 'Well, you know what? I've never really been a big supporter of bulk-billing anyway.'

Doctors are different, and some doctors will choose to stop bulk-billing their concessional card patients. We heard that, loudly and clearly, earlier today. What surprises me is that your assumptions include no changes to the level of bulk-billing for doctors who are currently bulk-billing concessional patients. I do not know how you arrived at that conclusion.

Senator CAMERON: That is a point I would like to get some clarity on.

Mr Stuart: I can repeat, if I may, that there are at least three incentives on doctors to continue to bulk-bill concessional patients.

Senator DI NATALE: And the rebate is frozen.

Mr Stuart: There is a concessional payment, there is an exemption from the $5 rebate reduction and there is the capacity to direct bill at the point of care to Medicare for that patient. I will just make those points.

Senator CAMERON: You keep talking about assumptions. Could you provide us with details of the assumptions that you made and the methodology that you have used to come up with the arguments that you have put forward today? Is that possible?

Mr Stuart: That is a very broad question and I am not sure what the question really is there.

Senator CAMERON: You keep saying you have made assumptions, right?

Mr Stuart: We have been answering some specific questions.

Senator CAMERON: No. You said you have made assumptions. You have made assumptions to determine the impact that these changes will have on doctors and their profitability and on patients. Is that correct?

Mr Stuart: No, it is not. We have made some assumptions for the purpose of estimating the size of the saving for the government from its policy. That is what we have done.

Senator CAMERON: So, you have made assumptions on the size of the saving but there have been no assumptions done on the practical impact on either patients or doctors. Is that correct?

Mr Stuart: I would just point out again that that is not an area where we make assumptions. It would be nice if very good research was available in that area. There is not and so the behavioural impacts on the choices that individual doctors make, whether they work in Tamworth or elsewhere, is not something that the department can model. There is not the data, there is not the research nationally or internationally. So, as I have said to you before, we have done the best that we can in advising the government based on the available evidence.

Senator CAMERON: I put the question to you again. You should provide us with details of what assumptions you have made when you are making a determination in these issues. What assumptions have you made? Have you made any of the assumptions like the doctors have told us that there are additional costs other than the $5: extra staff to go on, a whole range of issues. Have you looked at any of that?

Mr Stuart: I believe we have taken that question on notice.

Senator CAMERON: Have you made any analysis or made any assumptions on what the bulk-billing percentage will be as a result of these changes over the forward estimates?

Ms Cahill: We would not usually make forward estimates of the bulk-billing rate per se. We have made some estimates of how different services might be affected by changes.

Senator CAMERON: Can you provide us details of that?

Ms Cahill: We can certainly take that on notice.

Senator CAMERON: Has Treasury made any analysis of the level of bulk-billing as a result of these changes?

Ms Croke: No, we have not.

Senator CAMERON: So Social Policy in Treasury have got no idea what is going to happen. The Department of Health said that they do not understand what is going to happen. How can this be evidence based policy? Where is the evidence for this policy? Does anyone know? That is the longest silence I have ever had from three, six, seven, eight very experienced bureaucrats in the public service.

Mr Stuart: I am a bit nonplussed, because we have been describing the available evidence and the level of available evidence nationally and internationally and its uncertainty, and in the absence of uncertainty governments make decisions. They always have and they always will. From both sides of politics.

CHAIR: I have got a few questions that I would like to conclude with. Firstly, my understanding of the Department of Health, given its title, is that it focuses on the health of the Australian nation. We have talked here a lot about money. What implications, what studies, what research, what anticipation do you have about the health outcomes of the decisions that we have seen forthcoming from this government?

What are the health outcomes? What have you modelled there? What have you found out? What have you anticipated? What are the expected health outcomes of putting an additional $5 in terms of people getting to the doctor?

Ms Faichney: I think this has probably been discussed at previous hearings as well. Health outcomes are a very difficult thing, because there are so many elements that impact it.

CHAIR: That is why we have a Department of Health.

Ms Faichney: That is exactly right, but we cannot say one thing versus another thing will affect health outcomes. There are a lot of things, including a person's individual decisions, as to what will happen with health. So it is very difficult to ever have a broad comment as to what the health outcomes are, and we do not tend to, as a result, make comment as to what we anticipate a health outcome will be. We anticipate what we are looking for, which is improved health through whatever the policy might be covering at the time.

CHAIR: And did the health department give advice to the minister that they saw improved health outcomes for Australia, improved health for Australians, by increasing the cost for them to go to their doctor? Is there any evidence to support that that you put before the ministers?

Ms Faichney: That is not the kind of advice that we would give—to say that we would expect a $5 co-payment to change health outcomes. What we expect people and doctors to do is to take into account their practices, to take into account the individuals, and people will make decisions as they always have, and as doctors always have, about what is in their interest and how to look after it.

CHAIR: So it is the doctors' fault—

Ms Faichney: No. I did not say that.

CHAIR: and we have not got adequate research in the health area.

Mr Stuart: That is not Ms Faichney said.

Ms Faichney: I did not say that.

CHAIR: Sorry; that is what I am hearing. I have got a series of factual questions. Hopefully we might be able to get some very quick answers to these. What is the most up-to-date national bulk-billing rate?

Ms Cahill: Did you want it for all services or for GP services?

CHAIR: For GP services.

Ms Faichney: Eighty-four per cent, as of September 2014.

CHAIR: Is that the highest that it has been?

Ms Cahill: I believe so.

Ms Faichney: Yes.

Mr Stuart: It is the highest that it has been in recent years.

CHAIR: Why has there been a policy drive, from various governments, to get to that level? What are the benefits of having bulk-billing? As the Department of Health, you should have a position on this. Why have we, as a nation, pushed to increase our bulk-billing rates?

Mr Stuart: I think that is a question for governments of the day, not a question for the health department.

CHAIR: Can you see if there have been any outcomes that have improved because of access to doctors that is provided by bulk-billing? Does the department have any evidence to prove that?

Ms Cahill: No direct evidence of links between bulk-billing rates and health outcomes.

CHAIR: So we have just been doing it for no good reason? It just felt like a good idea at the time? What policy formed the view that made that occur? What advice did you provide? 'Is bulk-billing good or bad?' is the core question.

Ms Faichney: It is not up to us, I think, to say whether bulk-billing is good or bad. As Mr Stuart has said, it is the government policy of the day and depending on that policy has changed what bulk-billing rates may be.

Mr Stuart: Senator, I think you are moving towards asking the officials for their opinions and also about what advice we have given governments in the past.

CHAIR: Let me keep sailing close to the wind and I might get some good information. Does the Department of Human Services provide bulk-billing data to the Department of Health?

Ms Cahill: Yes. Well, the Department of Human Services provides details of all the Medicare services that it has processed to the Department of Health, and, from that data, the Department of Health—or the Department of Human Services—can calculate a bulk-billing rate for different service types.

CHAIR: Can you provide the committee with an updated breakdown of bulk-billing rates by electorate?

Ms Cahill: We could take that on notice.

CHAIR: Thank you. How does the department define a concessional patient?

Ms Cahill: For the purposes of this policy, a concessional patient is defined as someone who has a Commonwealth concession card or a child who is under 16.

CHAIR: There was an email released under freedom of information in August, an advice from someone in the medical benefits division of the Department of Health to a colleague in Treasury which said that the figures provided include Commonwealth concession card holders and children under 16 as a concessional patient. That is what you have just said. Is that continuing to be the description of what a concessional patient is?

Ms Cahill: Yes. It is consistent with the current definition for the GP bulk-billing incentives.

CHAIR: And you would normally include children under 16 in your definition of concessional patients?

Ms Cahill: For the purposes of these policies, yes.

CHAIR: Is the department aware of any analysis of how many children under 16 are bulk-billed?

Ms Cahill: We could take that on notice for you. Again, it would be helpful if you could specify whether you want it across all of Medicare or for GP services.

CHAIR: GP services and across Medicare. Does the Department of Human Services hold that data? Or do you hold that data?

Ms Cahill: Both, depending on the time period.

CHAIR: So, between the two of you, hopefully, you might be able to get us that. Is the department aware of any analysis of how many concessional patients account for the overall number of bulk-billed consultations?

Ms Faichney: In 2013-14 it was 93.1 per cent of GP services—I cannot do it for all; I have the figure here for GP services—provided to concessional patients that were bulk-billed.

Senator CAMERON: Can you provide us on notice the basis of that answer—where you got the information?

Ms Faichney: It would be from the data that comes through from DHS and our own. It is Medicare data.

CHAIR: So, you can provide us with the raw data. Do you do any analysis of that data?

Ms Cahill: Yes.

CHAIR: And can you provide us with analysis of that data?

Ms Faichney: That is very broad. What analysis are you after?

CHAIR: How many concessional patients account for the overall number of bulk-billed consultations.

Ms Cahill: Are you wanting to know how many patients, as opposed to how many services? Or are you wanting to know—

CHAIR: When you get the data and you analyse it, what do you analyse it for?

Ms Cahill: We analyse it for a whole range of things all the time. So, we look at many different variables. I am just trying to understand what your question is so we can give you the correct answer.

CHAIR: Well, you have the data and I do not, so I would like to know what the analysis is that you do with that data, and I would like as much information about it as possible.

Ms Cahill: That is a very broad question.

Ms Faichney: It is extremely broad. We do analysis based on the question, if that makes sense. Usually you analyse data for a reason; there is a question asked, and you analyse for that purpose. And I do apologise, but that is what we are struggling with; we are trying to understand what the question is around what the analysis is that is being asked.

Ms Cahill: The routine analysis that we do is generally the analysis that you will find regularly published in quarterly reports on the department's website, indicating things like bulk-billing rates, average out-of-pocket costs and those sorts of questions. And then we do other analysis according to the issue of the day that we think the analysis would illuminate.

CHAIR: So, you have a range of concessional patients. Can I ask you to provide me with details about the different numbers of concessional patients, according to the different concessional structures that they are within? So, break it down for me—if I am a child who is getting a concession or if I am a pensioner or if I am a person with a disability pension. Can you break it down?

Ms Cahill: Yes, we can break it down to a point. There are some groups of concession cards that are costed in the way the data comes from the Department of Social Services to the Department of Human Services. But we can certainly break it down to a fair degree that I think would meet what you have asked for.

Mr Stuart: Perhaps I could just make sure I understand, Senator. Are you looking for information about who is currently being bulk-billed and who is not currently being bulk-billed? Is that the nature of the question?

CHAIR: Yes, which concessional patients—the percentages across the different ranges of who is actually a concessional patient, which ones, which categories of concessional patients are being bulk-billed.

Ms Faichney: So, of the 93.1 per cent.

CHAIR: Yes; break it down for me.

Ms Faichney: Okay. We can see how far—how granular—that data goes.

CHAIR: And on 29 January the minister said that at the moment 72 per cent of all bulk-billed consultations are to non-concessional patients.

Ms Faichney: At the moment, 72½ per cent of the services provided to non-concessional patients are bulk-billed, and that is a comment I made before.

CHAIR: What is the source of that statement?

Ms Faichney: Again, it is the analysis of the data we have, which would indicate—

CHAIR: From yourself and the Department of Human Services?

Ms Faichney: Yes—how the billing works in Medicare.

CHAIR: With regard to consultations, what degree of consultation was conducted prior to the announcement on 9 December with the change to the short GP consultation times and the $5 copayment?

Ms Faichney: It is not standard practice to consult more broadly, a comment that has been made previously in these hearings regarding budget measures.

CHAIR: We have heard on a number of occasions that there was no consultation with key players in the sector.

Ms Faichney: And, as I have just said, it is not standard practice to consult on budget proposals.

CHAIR: Is it not standard practice for this government? Or is it generally not standard practice to consult any experts in the field?

Ms Faichney: Between the May announcement and the December announcement there was significant consultation—again, as has been said in these hearings—with a whole range, and we have a significant number of people we consulted with. Those consultations raised a number of issues and concerns with that proposal from the May budget and raised a number of areas that they had particular concerns with. We did not consult specifically on the actual budget measures that were then announced in December, but we were informed by those consultations.

CHAIR: Could you provide us with a list of which groups were consulted?

Ms Faichney: Absolutely. In fact, we can probably read that out, if you want us to. We have a list here.

CHAIR: We appreciate that. How long was allowed for that consultation?

Ms Faichney: The consultation went from the minute the budget was announced—

CHAIR: The announcement on 9 December?

Ms Faichney: It is ongoing.

CHAIR: So, there was a period of consultation between the budget and 9 December, when the government delivered its policy. It has changed. We have seen a backflip since then. Was there further consultation after 9 December?

Ms Faichney: I think it would be fair to say that there has been a significant amount of information provided to the government and to the department regarding the 9 December changes. The government will have taken that information into account, and that may have informed the decision that was then announced on 15 January. But you would have to ask government.

CHAIR: Were the people who were consulted after 9 December different from the people who were consulted before 9 December?

Ms Faichney: I did not say people were consulted; I said there was a range of information provided, as you well know, including what we all get all the time, whether it is through media or correspondence to the department or direct contact to us or to the minister's office. A significant amount of the information gets provided in those ways, and that gets taken into account. You would have to ask the government how they then took that into account in making the decision on 15 January.

CHAIR: Did material come to the department that was used to provide advice to government that was significant in the enormous change that we saw between 9 December and the government's backflip early in the new year?

Ms Faichney: I would simply say that we had a lot of people raise concerns. I do not recall whether it was in writing or anything like that, but I do recall that we have had phone calls and we have certainly had correspondence come through. And, as you heard today from the peak bodies, they have had conversations as well where they have raised significant concerns. The minister met with the AMA on 23 December, and I assume at that stage again, as was mentioned by Dr Owler, raised all those concerns at the same time.

CHAIR: Was any modelling work done regarding the implementation of the short GP consultation times?

Ms Faichney: Sorry—modelling work?

CHAIR: Did you do any modelling around—

Ms Faichney: It is not 'modelling'; I think we have had this conversation before as well. We are aware of how consultations fall in from data across time series. It is not modelled, if that makes sense. I am sorry; I am not being very clear. But we were aware of where current consultation timings fell, if that makes sense.

CHAIR: And you advised the minister about changes and how much saving there would be to the government if you changed those parameters of consultation?

Ms Faichney: We provide a range of advice and, as previously said, in the budget context.

CHAIR: And what was the saving that you said?

Mr Thomann: Around a billion dollars over the forward estimates.

CHAIR: In addition to what was already mooted in the budget in May?

Mr Thomann: Compared with the bottom line in the 2014-15 budget, yes.

CHAIR: So, the budget already had a pretty good go at getting some money back, and this was to get more?

Mr Stuart: No. We might just outline the relationship between the $7 estimate and then the three parts that made up the subsequent package.

Senator CAMERON: Before we go to that, perhaps I could just indicate that I have a flight and I need to catch it, and I would like to indicate formally on the record that I am very disappointed about the lack of analysis that has taken place in relation to a major change. When we get the answers to the questions on notice I think we will need another session—maybe even half a day—with these public servants, to go through the responses to the questions on notice, because I am very worried that this policy has been made without any evidence base. And we will have to wait and see what the responses are. It is very disappointing.

CHAIR: Thank you, Senator Cameron.

Senator CAMERON: And it is not unexpected.

Mr Thomann: Perhaps I could just make clear my answer. In response to Senator Cameron's answer earlier, where we read out some different figures, there are some on's and off's in relation to the 2014-15 budget measure. The 2014-15 budget measure, over the four years, is worth $3½ billion, as we have already indicated. But that was reversed by this measure, by $2.6 billion. So, it is quite a significant change in policy. But there are other measures, including redefining level A and B GP consultations, which then added around $1 billion over the forward estimates. So, you have on's and off's, compared with the 2014-15 budget measure—

CHAIR: I might ask you to put that—simply—in writing for us.

Mr Thomann: We could take that on notice and provide that to you.

CHAIR: Thank you very much. With regard to the short GP times, in your planning around that, in terms of communication with the GPs, what was your plan in terms of assisting GPs with implementing the change and communicating that to the GPs?

Ms Faichney: In the department we use something called MBS Online, and there are practices and individual GPs. A number of people subscribe to it, because it is the most effective way to provide to practices information on changes on the MBS. And on the day of the announcement the former minister contacted the peak bodies regarding the changes, and then the department contacted them following that, offering to further discuss the detail. But equally, MBS Online is how you get the actual change out.

CHAIR: Could you say that in the consultation phase any of the peak bodies that were contacted by the minister on that day had recommended this sort of a change?

Ms Faichney: I could not tell you what had been recommended to the minister by those peak bodies, I am sorry.

CHAIR: But do you have consultations with those peak bodies, as the department, to provide advice to the minister?

Ms Faichney: As I mentioned earlier, we had spoken at length with these organisations between the May budget and that announcement, and those discussions were where their concerns would be raised. I do not recall anything specific around timing and consultations.

CHAIR: So, the policy outcome of the government is to reduce the number of people who go to the doctor because they consider that there is over-servicing. Is that their policy goal?

Ms Faichney: I am not aware of that as a policy goal. You would have to ask the government.

CHAIR: If they are seeking to reduce the money they spend on people going to the doctor, and they are saying that there is over-servicing of doctors, surely their policy goal is to reduce the number of times people access the doctor. We have had the minister say it several times.

Mr Stuart: I have heard the minister say that the goal is still to introduce a price signal.

CHAIR: A price signal determined to do what?

Mr Stuart: I am paraphrasing the minister and the government about introducing a price signal. I am unaware of a more elaborate statement about objectives than that. I am willing to take on notice whether there has been one.

CHAIR: I am sure you will find a few comments by the ministers. I will look forward to your becoming aware of them. They consider that there is over-servicing and that we need to reduce the number of people who access the doctor. It has been said on quite a number of occasions. Were there any consumer health advocates or any peak groups who put a claim to you as the department that there is over-servicing of the Australian public? Has any peak body put to you that there is a problem in Australia with over-servicing?

Ms Faichney: I think it is understood that there is waste in the system. And I know that has been said here today. Whether that is over-servicing or whether it is something else is, again, a complex area. But there is certainly an understanding, including by the GP groups, that there is a degree of waste in the system.

CHAIR: Waste in the system, as a health system, I can understand. But we have heard over and over and over that access to a GP is critical, that GPs at every single level can only see negative health outcomes by putting a barrier between people who need to seek their health care and a GP, that there is nothing good to come of it. We have not heard one peak body advocate for a price signal. The only body that seems to be advocating for a price signal is the minister and the current government. There is no-one else. Has anybody else ever put to the health department at any point in time that a price signal needs to be implemented because there is chronic overservicing of Medicare?

Mr Stuart: I think that is a question that is not easy to answer without taking it on notice. If we did take it on notice, there would be a very substantial search. But I am aware of public commentators in Australia making that case—

CHAIR: They have not made it to this committee.

Mr Stuart: and publishing such articles in the newspaper. Whether they have sent such information to the department, as I say, I would have to take on notice. But it would be a very diligent and detailed file search.

CHAIR: I asked you a little bit about consultation prior to 9 December. We do have a new minister and I understand that there has been a change in consultation, although today we heard that the consultation period might be as short as two weeks. Can the department provide us with any indication of the consultations planned or that have been undertaken and what the forward program is?

Ms Faichney: As we mentioned, the minister is undertaking consultation. I understand her office has provided advice, and we sought it as well when we heard the comment regarding the time limit. We are not aware of any time limit with regard to the consultations. The minister met with the AMA in December. She has continued to meet and will continue to meet with them over the long term and short term. It is clear in the press release that she is going to do consultations around this. There is no indication of a time limit.

CHAIR: Do we have any idea about the number of consultations, where they are going to occur and what form they will take?

Ms Faichney: The framework of it? At the moment there are consultations happening. A framework for—

CHAIR: In what form?

Ms Faichney: At the moment the minister is meeting directly with GPs. She is meeting directly with the peak bodies, literally one-on-one or in groups. She is doing forums, she is visiting clinics and she is going to hospitals. I am trying to think of other ones that have been happening.

Mr Stuart: Consumers.

Ms Faichney: Consumers, yes. So a range of these are happening at the moment. Regarding forward ones, it will be a decision of the minister as to how that consultation continues to roll out.

CHAIR: Is it a different process from what led up to the announcement on 9 December?

Ms Faichney: I think it is very clear that the minister said when she came in that she would be consulting widely on it. She was not minister prior to 9 December.

CHAIR: Does this mean there is a change in what you have said, that there is no policy consultation prior to announcements? That is what you said—you do not do consultation prior to announcements. But now there has been a change?

Ms Faichney: We do not consult on specific budget measures. I said that between the two budgets, yes, there was wide consultation, but it is not normal policy to consult specifically on budget measures. That is what I hoped I had been reasonably clear on. Consultation in itself to inform budget measures is perfectly normal and is wide ranging at the best of times and it comes in a range of ways, whether it is through correspondence, forums or more formalised things like this. But budget measures themselves do not tend to be consulted on closely.

CHAIR: Could you provide us with the areas of primary health care that are being consulted on, specifically with regard to general practice and matters that relate to general practice? Could you also provide us with a schedule of consultations that are anticipated and ones that have already occurred and the groups that are to be invited or have been invited?

Ms Faichney: We can ask the minister's office.

Mr Stuart: We can ask the minister and the minister's office if they are willing to provide it. We will take that on notice.

CHAIR: Are you aware of requests made today at this hearing for a moratorium on any further health announcements, or ones that may have budgetary implications, for a period of at least six months to allow adequate time for consultation? Did you hear those comments and calls today?

Ms Faichney: I do not think it is just today. I think that is a common call. People ask for these things. I think that is why the minister has said she will go out and consult widely and for a while on these things.

CHAIR: How will the information that you get from these consultations be used to inform changes to existing policies?

Ms Faichney: That will be a decision for the government.

CHAIR: The last few questions regard costings. I think we did some of this, but I want to make sure I have covered it off. The announcement on 9 December included the short consultation times, the $5 co-payment and the extended indexation freeze. What were the combined projected savings? Was it $3.5 billion over four years?

Mr Thomann: No, Senator. I will ask my colleague to go through it in detail. The $3.5 billion was the projected savings for the measure that was published in the 2014-15 budget.

CHAIR: Right.

Mr Thomann: So that number had to be backed out as that was reversed, and we had to replace it with new numbers in relation to those three alternative elements of the policy announced in MYEFO.

Senator DI NATALE: You would have to revise it again—is that right? Because you have dropped; you have got no more level A and B. There should be a third revision.

Mr Thomann: Such is the nature of our job in Finance that we will continue to—

Senator DI NATALE: Are you expecting any more?

Mr Thomann: We will continue to account for decisions as they are made.

Senator DI NATALE: Can I stop and interrupt—we are up to mark 3, I think. Have you got any figures on mark 3?

Mr Thomann: Sorry?

Senator DI NATALE: You said $3½ billion is what you expect for version 3.

Mr Thomann: No, that was the—

CHAIR: That was version 1.

Senator DI NATALE: Version 1, sorry.

Mr Thomann: That was the value of the numbers you published in the forward—

Senator DI NATALE: And what are we looking at with version 3?

Mr Thomann: We do not have any policy detail for version 3.

Senator DI NATALE: You have not got any policy detail?

Mr Thomann: That will be decided in the 2015-16 budget process.

Senator DI NATALE: Hang on. What do you mean you have not got any policy detail?

Mr Thomann: The MYEFO measure was published and now the minister is in the process of consultation, and there will be a process of consideration.

Senator DI NATALE: I thought there was already a commitment to a $5.00 reduction and a freezing of indexation. Those two measures have not changed.

Mr Thomann: But they are already in the estimates published in MYEFO.

Senator DI NATALE: For version 1?

Mr Hunt: They went into the estimates at MYEFO.

Mr Thomann: At MYEFO.

Mr Hunt: They are part of the current budget bottom line.

Senator DI NATALE: So there was that, along with the level A and B? I should say I have not looked at these.

Mr Hunt: That is right.

CHAIR: So level A and B have gone.

Senator DI NATALE: Level A and B are gone.

Mr Thomann: The minister has made an announcement about that, and that would have to be accounted for in the 2015-16 budget process.

Senator DI NATALE: What are we looking at now, given that they were already in MYEFO—take away the level A and B changes? What savings are we talking about now? What is the number?

Mr Thomann: If you take away the level A and B GP consultations, based against the MYEFO baseline published, we are now down around $1 billion, which is the estimated saving for the level A and B GP consultation element of the measure.

Senator DI NATALE: No, that level A and B has gone.

Mr Thomann: That is right, and so—

CHAIR: How much has gone with that? What is the amount?

Mr Hunt: Around $1 billion.

Mr Thomann: Around $1 billion.

Senator DI NATALE: A billion off what number?

Mr Thomann: Off the number published at MYEFO.

Senator DI NATALE: Which is? I have not got it.

CHAIR: Which is what?

Mr Hunt: Which was broadly 3.6, so it was published—

Senator DI NATALE: So if 3.5 was the original figure—

Mr Hunt: That is right.

Senator DI NATALE: It went up to 3.6 with version 2—

Mr Hunt: That is right. At MYEFO, you will see the measure has a net value of $100 million, which is because the measure included the reversal of the $3.5 billion and then a package of savings with broadly the same profile of expenditure. So the difference was about $100 million.

Senator DI NATALE: $100 million.

Mr Hunt: It was a very similar quantum of savings to the forward estimates.

Senator DI NATALE: I see—that is where the $100 million was, okay.

Mr Hunt: And one component—

Senator DI NATALE: So it is an additional $100 million on the 3.5, and now we have lost another billion from that?

Mr Hunt: Around a billion of that, that is correct.

Senator DI NATALE: Have you got something like a chart to—

CHAIR: Show us this?

Senator DI NATALE: A diagram to show how it—

Mr Thomann: We have agreed to provide you on notice a chart which sets out the accounting.

CHAIR: Okay.

Senator DI NATALE: The long one?

Mr Thomann: No.

Senator DI NATALE: Have you got a few blank pages behind it, to keep filling it out?

CHAIR: The $5 co-payment—how much is that worth? Is it $800 million?

Mr Thomann: The $5 rebate reduction in and of itself, taken in isolation from everything else, is worth about $870 million over the four-year period.

CHAIR: And the other savings—are you going to provide us with a breakdown of those?

Mr Thomann: Yes. We will provide you with a table setting that out.

CHAIR: Wonderful. What are the projected savings after the announcement of 15 January that the short GP—oh, we have got that. How have the estimated savings for the $5 co-payment been calculated?

Mr Thomann: I am sorry, Senator—would you mind repeating the question?

CHAIR: How have you estimated the savings for the $5 co-payment? How have they been calculated? What are the assumptions that you have built in there?

Mr Hunt: I think we discussed this in broad detail. Finance agreed those costs with the Department of Health.

CHAIR: So they basically have said that they believe nearly every single doctor is going to pass on this cost so that you will get the five dollars at every consultation—is that correct?

Mr Hunt: I do not have the assumptions here that we agreed in that costing process.

CHAIR: Could you provide those for us?

Mr Thomann: The major part of the costing is based on a five-dollar reduction for non-concessional patients. The bulk of the costing is based on that assumption.

CHAIR: Okay. And going back to our conversation earlier about concessional patients: have you done any numbers around any impact on them?

Mr Thomann: Concessional patients are not affected by the five-dollar reduction in the rebate.

CHAIR: That is your claim, but the doctors say something quite different.

Mr Thomann: But in terms of the costing, the data is based on how many nonconcessional patients are estimated to be billed—how many will receive that rebate over the next four years. We have taken that number and reduced it by five dollars per service against those MBS consultation items.

CHAIR: Okay. Can I just ask the Department of Health: will the co-payment require legislation or a legislative amendment?

Ms Cahill: Both.

CHAIR: And what advice are you providing around that for the government?

Ms Faichney: The rebate reduction can be done by regulation—it can be done by legislation as well, but it can be done either way. The policy decision to enable the doctor to get the direct rebate while still charging the five-dollar co-payment—at the moment, bulk-billing is literally that; there is no co-payment—that requires a legislative change because that enables the doctor to get the benefit of that direct rebate to them still while only charging the five dollars. It changes the definition of what bulk-billing—for want of a better term—means.

Senator DI NATALE: I did not realise that change was being implemented—I should have. So there will be specific legislation to say that you can just charge five dollars?

Ms Faichney: Yes, to support nonconcessionals who would now be charged because, obviously, of the change to the concessionals—regardless of all that. That is a legislative change, which is to enable doctors to prevent people having to pay the whole bit up-front, and just to—

Senator DI NATALE: The full amount, yes.

CHAIR: How advanced is the work on that piece of legislation?

Ms Faichney: We have T-status or A-status—sorry, you would know more than me, Fifine. It is underway. Of course, there are consultations happening and things. There are OPC-drafting challenges at all times but, yes, it is underway in anticipation of each needing to be introduced and passed by 1 July.

CHAIR: And so the timing, then, on the introduction?

Mr Stuart: Subject to government decision.

CHAIR: Okay—a day when they think they might have the numbers somewhere! What work is being undertaken by the department to assist GPs in implementing this co-payment in their practices? And what consultations are you having with them to hear their concerns?

Ms Faichney: The minister is out consulting extensively at the moment on a range of things, as well as the department talking—

Ms Cahill: We are also working very closely with the Department of Human Services. They will provide a whole range of support to GPs, including explanations of how things work. And there are also flow-ons to IT systems that GP practices interact with through the Department of Human Services to make various things, like checking whether someone has a concession card, easier for GP practices to do.

CHAIR: Are you aware of the claims by GPs that the administrative costs and the administrative burden of this will be very significant? That it is not just the five dollars they are going to forego, or pass on as the case may be, but that there will be administrative costs in collecting that money and changing their current billing practices?

Ms Faichney: The majority of GPs already have a percentage of their patients that they patient bill. A lot of the concerns that we heard previously around the administrative burden were actually to do with the seven-dollar co-payment and the fact that it had some very specific elements to it, such as the 10 services and elements like that. I have not heard more recently—and that does not mean it has not happened—that the level of the administrative burden with the five dollars, which is a rebate reduction—

Ms Cahill: And which also applies to a very small proportion of services compared to the seven-dollar—

CHAIR: For surgeries that are cashless, concerns have been raised in surgeries that I have visited, particularly in low-socioeconomic areas or where there might be a high degree of drug and alcohol abuse, about the safety of people in those cashless surgeries. Have you had any representations made to you? Is there any plan to deal with that?

Ms Faichney: We have certainly heard those concerns previously—yes, absolutely. It is part of the process of implementation. I am sure we will work things through on that. But my concern with some of the comments is that I think 100 per cent of GP practices already have the ability to patient-bill.

CHAIR: I would hope the fact that they do not, based on a whole range of socioeconomic and social concerns, would be of some interest to you. They have a reasonable degree of expertise in their own environment, and that needs to continue.

Senator DI NATALE: I did not realise there was going to be legislation to allow people to charge the co-pay and the doctor to claim the rebate back. Does that mean that practices that might currently be charging $70 might reduce their charge to $35 and claim the rest back? Is there a capacity to do that?

Ms Cahill: That is not the current proposal. The proposal as announced in December was—

Senator DI NATALE: But how do you do it legislatively? How do you allow some practices to charge that $5 and claim the rebate back and—

Ms Cahill: That would allow all practices to charge an amount of up to $5 and then directly—

Senator DI NATALE: It is just up to $5?

Ms Faichney: Yes.

Senator DI NATALE: There will be a ceiling of $5?

Ms Cahill: Yes.

Senator DI NATALE: I have a second question, quickly: have you done any work on looking at alternative proposals—specifically means-testing access to Medicare? I am referring to an interview that the Treasurer did where he would not rule out means-testing Medicare.

Mr Stuart: Sorry, I do not think we can answer that question.

Senator DI NATALE: You can answer the question about whether you have done any specific work looking at other models that target means-testing of Medicare.

Mr Stuart: I am afraid that the question would be: have we ever, ever done any work on that? I do not think I could answer that question.

Senator DI NATALE: No, that is not the question I am asking; that is your question. My question is: are you doing any work around means-testing of Medicare? Have you done any within the past one year.

Mr Stuart: I think we might be getting into a bit of trouble about what advice we may be offering government.

Senator DI NATALE: No, that is not the question.

CHAIR: That sounds like yes.

Senator DI NATALE: We might be here for another half an hour, because—

Ms Faichney: I am not aware of a request for us to look into means-testing of Medicare. I have not been in the job for a year. I would have to take that on notice.

Senator DI NATALE: You have not been in for a year but, Mr Stuart, you have been in the job for longer than that.

Mr Stuart: No, I have been involved in this area since December. But we do not want to be in the 'admit or deny' game. I am unaware.

Senator DI NATALE: You are unaware of any work being done in that area? All I am looking at is: is there any work being done on an alternative proposal that would look at other ways of means-testing Medicare?

Ms Faichney: Not that I am aware of.

Senator DI NATALE: Mr Stuart?

Mr Stuart: Not that I am aware of.

Senator DI NATALE: This is the last question I have. We keep hearing that the indexation freeze does not require any legislative or regulatory change. I am assuming that is correct.

Ms Faichney: That is correct, yes. There is no change you are making.

Senator DI NATALE: Just status quo—all right. Thank you.

CHAIR: Can I just ask a final question about assumptions: what assumptions has the department made about the impact of the $5 co-pay on accident and emergency departments and hospital admissions? There has been an awful lot of commentary around that.

Ms Faichney: I think that might have been a question on notice previously that we may have answered.

CHAIR: We should get a fulsome answer, then!

Ms Faichney: No, I am just trying to think. I do not believe that we will have. I think we have been in this space already today: because the policy excludes non-concessionals and is a $5 rebate reduction on a smaller number, I do not think we would have modelled a particular change on behaviour to EDs. Equally, that data is very difficult to try to model, if we even could.

CHAIR: The state governments are doing it, though, because they are very mindful that the flow-on costs to them are quite significant. At every hearing we have had, it has been raised with us that there is an expected flow-on of people going to their emergency department as soon as a co-pay is introduced at their GP.

Ms Faichney: I have heard those concerns raised with regard to the original $7 co-payment.

CHAIR: They are continuing to be raised—do not worry. I am still hearing them. Are you doing anything about modelling the impact on accident and emergency of implementing a price signal co-payment for the Australian people, between them and their doctor?

Mr Stuart: I am aware that we had heard about a couple of states having done some work. I am aware that we asked them for that work. I am unaware of having received it. I do not think we have received anything from those states.

Senator DI NATALE: Could you double-check that?

Mr Stuart: I will take that on notice.

CHAIR: Also, the articulations of negative impacts of a co-payment, of a price signal, on the aged and infirm, on people in aged-care settings, on people with mental illness and on the Indigenous community. There have been numerous and ongoing concerns about the social outcomes of declining health because of declining access for each of those groups. Have you factored into any of your modelling, or any of your decision making or recommendations, any of that data?

Ms Faichney: Residents of aged-care homes are excluded from this. With regard to the Indigenous, a large number are under 16 or concessional.

CHAIR: What about the ones who are not?

Ms Faichney: For those who are not, it will be exactly the same as other non-concessional. I cannot remember what the other ones were, but either way it will be in *Hansard* and we can take that on notice. The current policy excludes people such as residents. The mental health plans are excluded. These are a small number of GP consultations—they do not include the mental health plans or the chronic disease management plans.

CHAIR: We heard today that mental health is already underserviced. It was 38 per cent down to 36 per cent of people, and then more recently up to 42 per cent, accessing care in a year. Mental health is an indicator of chronic illness and there are many working Australians who are not concession holders who have chronic illnesses and attend the doctor far more often than those of us who might be fortunate enough not to face a chronic illness. What modelling have you done around chronic illness and for people who are experiencing that and their access to the health system?

Ms Faichney: They are excluded from this policy. So the $5—

CHAIR: If I have MS, for example—

Ms Faichney: Sorry, they are not excluded; the items are excluded from this. We would not model something that there is no impact on, so the mental health assessments are excluded. The chronic disease management items are excluded. So you go to a doctor and there is no change for you; there is no rebate reduction.

CHAIR: If I have MS and I present at my doctor more frequently than others, and I do not have a concession card, are you going to say there is no impact of this $5 dollar co-payment?

Ms Faichney: I could not say how a doctor is going to treat you. Sorry, I cannot provide that kind of intel.

Senator DI NATALE: You can say that you have some work that shows that in the vast majority of services the costs will be passed onto the patient.

Ms Cahill: That is our assumption.

Senator DI NATALE: Yes. The assumption is that you will be charged $5 for every visit as a minimum, and in some cases over and above the $5, based on the work you have done.

Ms Cahill: That is our assumption based on our experience rather than—

Dr Hobbs: Could I just clarify that. If you do have a chronic illness, then each and every Australian with a Medicare card is entitled to a chronic disease management plan which is an extensive assessment of their chronic illness—and many people have comorbidities. There is a review process as well, so that may be three in a calendar year, for instance, and also the ability to refer on to allied health. That will not be captured by the $5 co-payment. I think that is what my colleague Ms Faichney was talking about. If you presented, and you were a non-concessional person, for a standard consultation level B, then it would be up to the particular practice to decide whether or not they were going to charge a co-payment.

CHAIR: The doctors who presented to us today indicated that they already exercise a fair degree of charity and incredible discernment to figure out who can pay and who cannot pay. What you are asking, it seems, or what the government is asking you to implement is policy that will lead to significant increased challenges for those who are most ill in our community, and particularly chronically ill people.

Mr Stuart: That sounded to me like a statement.

CHAIR: Yes, I think it is a statement. I think I will stand by it too. We may have a few other questions on notice, and I can indicate that we will have a pretty short time line in terms of these questions and we will require responses promptly, because this is a matter of considerable public interest and we would like to report promptly to the community. As Senator Cameron indicated, there is every chance that in the near future we will be calling you back for further discussions to try and keep this conversation in the public place. Thank you.

I want to thank all the witnesses who have appeared before the committee for giving their time today. Thank you also to Hansard, broadcasting and the hardworking secretariat. That concludes today's public hearing.

Committee adjourned at 18:00