COMMONWEALTH OF AUSTRALIA

Proof Committee Hansard

SENATE

SENATE SELECT COMMITTEE ON HEALTH

Health policy, administration and expenditure

(Public)

WEDNESDAY, 11 MARCH 2015

GOSFORD

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SENATE

SENATE SELECT COMMITTEE ON HEALTH

Wednesday, 11 March 2015

Members in attendance: Senators Cameron, Ketter, 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.

DE LYALL, Dr Stephen, General Practitioner, Hunter General Practitioners Association

PEARCE, Dr Colin, General Practitioner, Hunter General Practitioners Association

VAN LEEUWEN, Dr Fiona, General Practitioner and Clinical Director, Hunter Medicare Local, and ViceChair, Hunter General Practitioners Association

[14:57]

CHAIR: Welcome. It is good to see you. In terms of shifting the conversation along, it is good to have you return to give us further evidence and respond to some of the challenges we set when we last saw you. Would you like to make an opening statement?

Dr Pearce: First, we must apologise, because when we received the invitation to this it was for a round table discussion, so we have simply come to discuss— **CHAIR:** That is fine.

Dr Pearce: Our practice made two submissions to the last inquiry, and Hunter GPA, at a regional level, made two submission to the last inquiry, and we stand by those submissions. We would also like to thank the Senate, in its wisdom, because a lot of people have claimed the victory in having the $5 co-payment overturned, but I think in large part that goes back to the listing and consultation that has happened as a broader arena from discussions that have been had in the Senate. There still remains, though, nonindexation, which is a relentless thing that is still going to create significant forces on general practitioners to continue discounting consultation fees to accept a bulk-bill rate or adding in a co-payment. So, the reason we have come back, really, is to discuss the one remaining issue and any other things that we may be able to offer in terms of ways that money may be saved in health funding, which were all contained in our submissions.

CHAIR: Thank you for those opening remarks. Senator Cameron has been in the Senate a bit longer than I. I don't know how often you get thanked for doing the reporting and getting things on the record, but certainly the volume of engagement from the health profession, particularly GPs, around these issues has been informative in the debate. Getting those things on the record and the secretariat getting those reports is vital in informing the national debate about what has been happening and what could happen as we move forward.

I might go to page 77 of the January 2015 submission, which concludes:

> We urge against any further erosion of what is an essential part of the Australian health care system. We urge against proceeding with both the GP co-payment and the freeze on MBS rebates. Limit the damage, both with regards to financial and human currency. Instead, use our collective knowledge and experience to help begin to craft a health system that can improve the patient experience, improve the health of all Australians, and do this with a reduced per capita cost.

That is what we are really interested in doing. I think we have raised awareness of the risks. We are hoping that, despite the government's shift to a debt and deficit discourse again recently, they will not go any worse than they have already gone. We are really keen to hear from you about the policy settings that you think need to be implemented moving forward. Who would like to commence?

Dr De Lyall: I think that there are several guiding principles that we would always establish from a general practitioner's point of view. The first is that our aim and our total focus is putting our patients' needs first and foremost, to the extent that in the 30 years since Medicare was introduced general practitioners have effectively subsidised a large percentage of health care in this country by reducing or not accepting fees for a lot of the work they do. That is in the interests of making sure that our patients do not suffer and that particularly those who are most vulnerable and most at risk in the community are not denied access to health care and what we consider excellent health care.

The second thing is that we consider that general practice is first and foremost the prime point that starts to reduce costs in the health system because of our aim and our ability to prevent illness. We consider we are in the best position of all people in the health community to do that. The corollary of that is that, if you want to prevent costs rising, you need to adequately fund general practice—not to supplement doctors' incomes but to make sure that practices are viable so that they can continue to provide the services that they have been providing.

One of the reasons why the medical profession or the general practice profession was so galvanised about the recent proposals, apart from the fact that they came out of the blue, was that most practices immediately realised that implementation of those policies would have resulted in a massive, almost overnight change in how health care

was provided in this country at the primary level. There is a dichotomy here between the need to provide adequate care for patients and recognition of the fact that practices are small businesses and they actually have to run and pay staff. We are not just looking at doctors' incomes. We supplement or support a very large percentage of allied health professionals—our staff and our nurses, for instance.

Price signals or price problems such as were proposed would have resulted in fairly rapid, overnight changes in how practices were run—either practices closing or patients being asked to pay substantial co-payments or to stump up money up-front. That galvanised the profession in a way that I have not seen for a long time. This is general practice we are talking about here.

But the dichotomy is in making sure that, while those in need are adequately cared for, the people who care for them are in a position to provide that care by having a viable practice, by having a practice where you can make the money to pay for the practice to run as a small business. Our aim, within those basic parameters, would be to say: how can we improve the system as a whole, and as it applies to general practice, which is our particular sphere, and how can it be fitted in with the wider range of health care involving allied health professionals and specialists?

It is very easy to identify problems but, as you know from our previous submission, our focus is to try and look at solutions. We are not going to come up with solutions overnight. We have come up with initial ideas. But it is a complex problem, so working through solutions will take quite a while. If we do not have immediate detailed answers, it is because it requires time to come up with those answers.

CHAIR: One of the things that we have heard in the course of these inquiries is that there should be a moratorium on any further policy changes for a period of six months to allow at least some stabilising of the sector and some more considered conversations. We have heard various noises out of the government—'There will be a two-week consultation period and then it will be over,' or, 'No, it will be extended. It will go on.' Have you got any more certainty through your contacts within the sector about how long the consultation period is that the government might be undertaking?

Dr Pearce: We certainly have not been consulted, except at this venue, up until this point. We have certainly given feedback to the health minister. Fiona, as she may bring up later, has actually spoken with the health minister, but that was the only form of direct consultation that we have had with the government. We are not silly. We understand that the budget is in deficit. That is not a sustainable thing. It is something that needs to be addressed at a government level. But, equally, essential services like health, education and infrastructure all need to be provided.

If we take health aside and get back to your previous question, which Stephen answered, we can look at health and ask: what have we tried in order to improve the efficiency of health? I have divided those into three levels. The first is the provision of a more efficient way that does not increase costs in the long run. One of the things we talked about in a previous submission was getting doctors and all staff to work at the top of their game. Having people work at the top of their game means paying them effectively. It means educating them effectively. It means empowering them. Anyone involved in any business will know that.

People feel that they are downtrodden, like the aged-care nurse who just spoke—we see that all the time. The funding is poor. The number of staff on the ground is poor. They are meant to tick all these bureaucratic boxes and it all detracts from patient care and they become despondent in their jobs. It is similar with us. We are there, beavering away, doing general practice and doing what we thought was quite a good job in general practice, as the rest of health care in Australia does, and the indirect feedback we get from cuts that are put in place is, 'Yes, you may be doing a good job, but you need to work harder.' That does not engage the workforce.

So one of the key reforms we would suggest is about how we get people to work at the top of their game, at the top level. If a general practitioner manages something effectively, it is so much cheaper than sending someone to hospital or sending someone to a specialist. To give you an example, I do a reasonable amount of skin cancer medicine. If I take a basal cell cancer off someone's face, I do that in 15 minutes and the rebate from Medicare is about $160, plus the consultation. If I were to send that person to a plastic surgeon, they would not do any of that in their rooms. They would admit the person to a private hospital. The fee to stay in a private hospital—and these numbers are off the top of my head—would be about $1,000, I would imagine. There will be an anaesthetist's fee of around $500 to $1,000 and a surgeon's fee of about $500 to $1,000. That patient is well and truly out of pocket.

Admittedly, there are cases where that would need to happen—if it were a complicated lesion on the tip of the nose that required grafting, absolutely. But GPs have skin cancer cases coming out of our ears, our noses and everywhere else because in this country we are all exposed to the sun. If all GPs were taught to practise at the top of their game, doing a simple ellipse and a simple closure, costing the government $140, that would manage a huge amount of skin cancer. There are many people within my practice who just will not do it because they do not have

the confidence or they feel that they are not efficient enough to do it or well enough remunerated to do it, and so they refer it on.

This ongoing referral of things just creates more and more cost. That is point 1 and I have probably said enough. You may have some other questions, but we can work through those three areas: how to make our health system more efficient, finding fair ways to fund it—which is I think where the government really comes into it— and also deciding what sort of health system we want.

The population at the moment demand a health system which goes from before birth until death. From every sector they demand the highest quality, and that costs money. It is true that the people need to be aware of that, but if we want to downgrade that to something like the Americans have got, which is a two-tiered health system, that has got to come from the public. If the voting public are demanding a high-quality health service, they are also going to have to look at ways—the government will need to look at ways—to fund that service appropriately, because people will not do it for nothing. They are the three points, and I have covered part of the first one.

CHAIR: I call Dr Van Leeuwen, and then I am going to go to Senator Cameron.

Dr Van Leeuwen: I guess you were asking at the end there about—what did you say?—the political strategy or policy direction you would suggest— **CHAIR:** Yes.

Dr Van Leeuwen: we might be able to discuss. I would really like to implore our political leaders to shift the focus. I think that we need to provide patient care by acting as one whole system in support of the patient journey. We have the technology. We have the clinical leadership. I am asking: do our political leaders have the determination and will to build this system which can focus on quality care and efficiency underpinned by sustainable workforce and education strategies, which really then supports whole-of-system change, looking at cross-sector integrated care, using improvement systems, being outcomes focused, being data informed, underpinned by a sensible e-health strategy that unites us? I was talking about us having the resources. We already have so many resources which are able to facilitate this kind of thing. I tend to think that we can reorganise these things. I do not know that we need an enormous other injection of funds. I think we can gain efficiencies from the systems that we have.

The Improvement Foundation is a brilliant organisation which, on the ground in general practice, assists, encourages and educates GPs on using plan-do-study-act improvement cycles via its Australian Primary Care Collaboratives Program. We have HealthPathways now across the country. Interestingly, HealthPathways has been one of the underpinning guiding, success, integration and health information management referral tools used in the Canterbury district of New Zealand. They now—I was just at a talk the other day—have actually evened out that bump of increased hospital admissions in the winter that the nursing sister was discussing prior to us. If you can iron out your bump because you manage them so well in the community—and they have shown that that is possible and have actually revitalised their health system in the very short period of seven years—can we not take some encouragement, hope and guidance from those international leading concepts? We also, of course, have the ACI, the Agency for Clinical Innovation. We have the International Center for Clinical Excellence. We have clinical resources like Dr Tracey Tay, who has travelled the world looking for information about what systems people have tried elsewhere and how they work.

I would like to again implore our political leaders to shift the focus to consider sharing the care, sharing the cost and the responsibilities, across primary and tertiary health, because ultimately isn't that what we are about? Isn't it really about supporting the patient journey, providing the right care in the right time at the right place? Isn't that what is going to make us most efficient? And then ultimately, I guess, it is about hoping to share the outcomes, which should be improved.

Senator CAMERON: But isn't the federal government's position not about sharing the costs but about costshifting back to the states? It is because they have this philosophy of a small government at the Commonwealth level and that the states should carry the burden, and the states do not have the money, and on and on we go. The theory is fine. Everybody understands that GPs are the key to providing up-front health care that is cost-effective and delivers a lower cost in the hospital system. Almost all the submissions we have had go down that path. The only people that do not seem to understand it are the Commonwealth government, and I just do not understand why they have got to that position.

You are asking the question: can we get to a position where everybody works together? My view would be: no, we cannot, unless there is a fundamental shift in the Commonwealth government's economic ideology and politics. It is just not going to happen. So we have to fight through this. Where we are at the moment is that the government is slowly getting pushed back by actions like you guys coming here. This is the second time you have appeared

before the committee. You are obviously talking about these issues in your local community. You are making a contribution to the debate. It has forced the government onto the back foot. The $7 has gone, but now we have still got the indexation freeze. The indexation freeze is still there. What the AMA said in their submission to us earlier is that, rather than this fundamental change to how GPs operate, this is going to be death by a thousand cuts. Do you agree with that proposition that this is still a significant problem?

Dr De Lyall: I think so. The two immediate problems that have gone by the board, the change in the descriptor numbers and the co-payment, particularly the change in descriptor numbers—that was the initial thing that galvanised us—would probably have resulted in a fairly rapid change in how general practice was delivered in this country. The phrase 'death by a thousand cuts' used by the AMA is, I think, quite appropriate because over time you would find incrementally that separate practices would just reach a point where they could say, 'We can no longer provide the service we are providing.' And bear in mind that we are running as small businesses. We rely on funding from different sources. So incrementally you would find that practices would start to introduce various forms of co-payments. I know of quite a few practices that are not doing it but are already starting the thought processes of: 'Okay, I don't do this now, but I can see that in one or two years time I may have to do this because the income I'm getting is not matching my costs, which go up, and I need to pay staff and so on.'

Where you go with that depends on, I guess, how much the government is prepared to pay to fund general practice. We would argue that, given that there is a finite pool of resources combined between state and federal, the total amount may not need to go up, except per head as the population increases, but that the money needs to be better redistributed and that redistributing to general practice by way of things such as changing or getting rid of the indexation—or actually indexing it—will result in less money being needed by states because it comes to us.

The problem, I guess, is fundamental. It is that general practice, apart from contributions from patients themselves—the people who can afford to pay who are paying now—is primarily, as I understand it, funded by the federal government via Medicare. The state health system funds the hospital system. We are unsure as to where any changes we can suggest will affect that, because that involves federal-state relations.

Senator CAMERON: The easiest change for GPs to make is to stop bulk-billing, and that is what this is designed to do. It is designed to force that GP business model, which is already facing significant pressure, to buckle to the pressure. Get rid of bulk-billing and Medicare is fundamentally gone. And that is an ideological position for the Commonwealth government. That is where they are going. I do not see that that is in the interests of GPs. I do not think it is in the interests of the community. But that is what this is about. I think people need to understand that that is what is going on, because, if they destroy your business model, they destroy Medicare.

We are in a sort of forum. You do not have to answer. I am just engaging, I think. The other issue that has been raised that I would not mind your comments on is the lack of young doctors coming into the profession. It has been put to us that high-achieving students look at being a GP and say, 'I end up with a $100,000 to $150,000 debt before I even start.' So, if you are going into being a GP, that is $150,000 that you have got as a lead weight in the business model to start with. Why would you do that? That question has been put to us. Why wouldn't you just go into specialisation and earn four times the amount? That is a big problem for me. Is the business model of the GP sustainable with $150,000 or $100,000 degrees and a lack of indexation in the long run?

Dr Van Leeuwen: It is even harder than that really, because it comes down also to GP registrar training in practices. It comes down to the sustainability of workforce. I think there has been a lot of discussion about patients and who is disadvantaged in attending and those sorts of things. I think one of the biggest things to address is a sustainability of the workforce. I think a part of this whole-of-system change is the notion of people having clinical responsibility—because actually, all we are trained in is being clinicians—and trying to do the best job you can for what you are trained in. As Colin mentioned, working at the top of your scope in your area is the answer to workforce. If you have a really interesting job, you are going to come to work. If you are well supported to have in general practice some reflection time to put in place models that work and are efficient and successful, then that makes the career choice much more appealing.

Senator CAMERON: On that point, it struck me earlier today that, if they are going to be a GP, most highachieving students do that because they want to do something for society. They want to get in and help people—
Dr Pearce: Typically, they want to care for people.

Senator CAMERON: They want to care for people.

Dr De Lyall: Very few people get into medicine because they see it as a high-paying job where they can earn a lot of money. We do not do that.

Senator CAMERON: That is right. That is the point I am making. But then comes the crunch—that the system we have makes them immediately small-business people— **Dr De Lyall:** Yes.

Senator CAMERON: and I am not sure what training is given to a GP to actually look at a set of books and look at how you run a GP business. Everybody tells me it is a business, and to some extent the concept of being in a business grates a little bit with providing health care, but that is the system that we have got; it is the evolved system. I am not arguing that you can change it overnight or that we should change it, but if the business model is flawed then it puts further pressure on individuals who want to go into that area. If people are not being trained how to run a small business, no wonder they want to get their specialisation right away. Running a small business and being a good GP is not an easy task, is it?

Dr De Lyall: The alternative is that a lot of GPs join corporates, where all of that is taken care of for them and they just turn up for a fee, and that suits a lot of younger people. When I started in general practice, that did not exist. You basically joined a practice, paid your money and learnt on the job, and you learnt how to run a practice from the business side. But it was far less complex. We did not have computerisation, for instance. We did not have any of the regulations or reporting or the need to do what we do now. Thirty years ago, I would have seen twice as many patients per day as I see now. Partly it is because of how the system works and medico-legal reasons, and partly it is because of the demographic time bomb and the increasing complexity of the patients that we see. I think a lot of younger doctors look at older GPs, like me, who basically seem miserable all the time because we are working 60 hours week and are not particularly happy in what we are doing— **CHAIR:** I thought you looked rather young and happy when you walked in, Doctor!

Dr Pearce: For a Wednesday afternoon!

Dr De Lyall: First Wednesday off for years! No, the days of taking Wednesday afternoon off to play golf are long gone, if they ever existed. But thank you, Senator.

CHAIR: It might be a reflection of my age too!

Dr De Lyall: I think younger doctors look at that and say, 'I don't want to be part of that.' Partly it is also influenced by the gender of GPs. More than 50 per cent of doctors coming through are female, and there are issues with time off for having babies and running families and so on, which are naturally part of being women and cannot be avoided. It results in a fragmentation where you get a baseload of GPs like Colin and I, particularly older male GPs, doing a fair amount of the work. As you hear, we are all eventually at some stage going to pull up stumps and say we have had enough of this. The theory is that there will be this cohort of GPs retiring, and who is going to take their place?

Senator CAMERON: This has set a line that is really interesting in the whole debate that we are having. The discussion we had yesterday started to talk about managed care and the role that health funds would play into the future in terms of managed care. There are huge problems in the US with managed care. That seems to be something that is starting now to some extent in aged care with health funds putting salaried doctors into aged care. The point I have been making all through this for the last few weeks is that aged care is one of the most underserviced areas in health in the country. If we cannot look after our elderly, what are we about? We cannot look after the elderly with the system that we have at the moment. Some doctors were talking about a different system. They were talking about a capitation system like the UK with a pay for outcome in addition and a small fee for service. That is the model that some are looking at. Others are saying you are going to have to have more and more salaried GPs, because GPs are not going to be there. If you could get a decent salary and not have to run a business, why would you run a business for the sake of running a business? I do not know. These are huge issues I think.

Dr Pearce: In terms of the cost-shifting that goes on—and it has been going on a lot—we are asked for referrals to hospital-paid doctors to follow-up in-patients. That is meant to be covered by the state and as part of the admission, but they cost-shift and get some federal money. I think the only way forward and to provide our health system in a more efficient way is to think about federalising the health system. Why have this huge layer of bureaucracy and cost-shifting there? But to do that you actually need to pool those resources and have a health system at a government level that works.

I have the utmost respect for the health minister. She is a very well-qualified woman and has done a lot of things—we both had a listen to an interesting interview—but she is not trained in health. She has been thrown into a job where after a month's consultation she is trying to come up with a system that is going to move the country's health forward. It is just not going to work. We as grassroots GPs think that we know the answers. We know the way of starting a process to go forward, and we have provided those in a submission. We are quite willing to have open discussions about that. But you need to have people running a health system who understand health in order

to understand what happens between hospitals and general practice and to understand what happens in aged care. I am sure as all of you would be upskilling very quickly when you are put onto a committee such as this—you learn lots about what is going on in the world—that the health minister is doing the same thing. But the best way to learn something is to share it with somebody who has already been through it.

The consultation time that you talked about before is completely inadequate. I do not think six months is enough. You really need to think about ongoing consultation with peak bodies such as the RCGP, the AMA and local organisations like Hunter General Practitioners Association. Honestly, we can tell you how to do it. It is then a matter of crunching the numbers, funding it appropriately, trying to come out with something that is affordable—because that is important for the country—and that delivers what the country wants in terms of health care. Both those things are failing at the moment. It is not funded well enough, and we are really struggling. I think we are still meeting expectations on delivery of health care, but we are really struggling.

You are right. Non-indexation across the board is going to create further struggle with that—and it is going to create more and more barriers with that as each year goes on. We have already talked about how we are going to stage the progressive introduction of gap payments to our patients, starting with middle income earners, who I very much have a soft spot for. I think these people struggle very much. Without a health care card, middle income earners will be the first people who start to give a co-payment to, saying: 'This is the up-front fee; we can no longer afford to bulk bill you.'

CHAIR: Roughly, how much do you think that will be?

Dr Pearce: There has been a lot of talk around this and, as we have said, a lot of GPs really want to provide care, but it has got to be in a sustainable way for our practices. Our discounted fee for those people now is $60, and we probably will not index that. But rather than bulk-billing, probably 20 per cent to 50 per cent of those consultations—and there are about 12 doctors in our practice, so there is somewhere in that mark—so take it that 35 per cent of those consultations now will be bulk-billed, they will be charged about $60. When it gets to the point of bulk-billing health care card holders, they will have to be charged the same amount, because (1) you are going to deal with bad debts—people who just cannot pay; and (2) when you do not bulk-bill a health care card holder you no longer get the bulk-bill incentive, which is about $9 or $10. There is no point in going from 35 to 45, so you are going to have to then say: 'what percentage of bad debts or what are the cashflow implications going to be?' For health care card holders it will be at least $50, probably $60, non-indexed for the first while.

I am particularly a soft touch with this—I see people's needs for it. We are at probably the lower end of privately billing levels in Newcastle, so we would probably leave our private fee at $70. But once that ethos has developed in the practice, then people who really cannot afford to pay that either find other care in bulk-billing centres or at hospital emergency departments or in after-hours clinics, all of which in the long run will cost the government more. Or they will not seek care at all and they will die or have very adverse outcomes or will present to hospital with strokes et cetera. I have several examples written down of people who cannot afford medications who are trading off medications one for another, or of having to give people samples of medications to get started on treatment. There are a lot of people out there suffering in Australia, and I do not know there is a full perception of that at a government level.

Progressively those fees will be brought in, and the talk in our own organisation is that we just cannot afford not to. But nonindexation is going to create a billing ethos where people will pay a fee to see a doctor eventually. For some people it might be 1 July, it might be from now, but it will creep in and by the end of the next 12 months to two years I do not think there will be many bulk-billing practices left in Newcastle. That may be a little different from Sydney, because there is a supply and demand curve there, but I think that that is where Newcastle is going to be at soon.

Senator CAMERON: So bulk-billing could be dead in Newcastle?

Dr De Lyall: Yes, or substantially reduced, Senator. I think GPs generally are a pretty soft touch, and there will always be a core group there—20 per cent or 30 per cent—of people who, no matter how relatively poorly remunerated we are, we will still bulk-bill them because we know that if we do not they will suffer very adverse consequences. And also not directly to them, but it will cost the taxpayer far more down the track if we do not treat them. I go back long enough to have been working in the pre-Medicare days, and in those days—were you around then, Senator? I am not sure.

Senator CAMERON: I came here in '73, and I think there was no bulk-billing then.

Dr De Lyall: It was in '83 that we started. Bill Hayden's scheme went, and then for seven or eight years we had no Medicare. We would basically treat those people for nothing, and they were subsidised by the rest of the people.

So I used to have maybe 10 per cent of the people I saw who did not pay me anything—they were treated gratis. So in a sense, Medicare has been a bonus in that sense, because at least with those people I get something back.

Dr Van Leeuwen: But isn't it the same? Is the system not actually the same? Because the people who now can afford to pay are subsidising those in our practice who do not pay. It is just that you have some Medicare rebate. So in some ways it is not outrageously different, although at least we can attend.

CHAIR: Except for the cost to the families that have to pay in the middle.

Dr Van Leeuwen: Yes, that is right. Of course.

CHAIR: There is an issue that we have not discussed. You talked about having a heart for middle-income families, which might be mum and dad on pretty ordinary wages. They are holding it together. They have got two or three children, and one of those children develops a chronic illness. There is no conversation anywhere on the public record about how you deal with chronic illness for somebody who does not fit. If they are 16-plus, where do they go then? They are not Aboriginal—and not all Aboriginal people are caught up in the exemptions that we are hearing about. So there are so many layers of disadvantage built into this. As you would probably well and truly see, clusters of chronic illness can occur in families. People could be earning an awful lot of money and still not have enough money to deal with a chronic illness.

Dr Pearce: The other day a 47-year-old woman came and saw me in a drop-in clinic. She is not normally my patient. She is on treatment for antihypertensives. She ran a bakery with her husband. They did not have a health care card. They have two young children. This was a clinic designed for people as a last-minute thing—they have run out of blood pressure tablets or whatever. We put an hour side each day for one doctor to do that sort of stuff for people who are acutely unwell or who just need a quick review. She was on half a blood pressure tablet a day, because that way she only had to pay $30 every two months instead of every month. She said to me that she resented having to take the time off to come and see me—not 'resented' but it was a struggle for her to take the time off to come and see me to get a prescription. I said: 'Well, this isn't really just about getting your script though, is it? Let's make sure that you've actually had your other risk factors managed. Let's check your blood pressure.'

Once every 12 months she needs to come and get a script. Responsibly, you have to review the person's medical condition at least that often. But I noticed at the same time that she was overdue for a repeat mammogram. She had had a breast lump and needed a mammogram and a biopsy 12 months before. I said: 'I note that you have not had this done yet. You've been given the form. What's happened that you have not had it done?' She said: 'I'm not having that done. The last time I had my breast lump biopsied it cost me $1,000 out of my purse and I ended up getting $400 of that back from the government.' She was $600 out of pocket. So, if you want an example of a price point where middle-income earners suffer, there is one. And now she is not having another test done because she knows that she is going to be $300 or $400 out of pocket. It will not be a two-procedure thing unless there is another thing that needs a biopsy. It will just be the mammogram and ultrasound. She also went on to say that she takes her children to after-hours services or calls Doctor to Your Door, which is a service where, instead of a rebate of $35 from the government and something out of pocket for her, it costs the government I think $140 a visit. It is a more expensive mode of care to the public in general but it is 'free' to her.

Middle-income earners absolutely suffer. I ended up talking to her for 20 minutes because I was coming to this hearing. This is unbelievable. It is happening now. It is going to get progressively worse. Non-indexation is across the board. It is specialists. There is already a huge gap to see a specialist. What it means for general practice is that we are already discounting people 40 per cent to bulk-bill them on a health care card, and about 50 per cent or a bit more if they do not have a health care card. If we want to provide care, it is going to get back to what Stephen was saying—we are virtually going to be doing it for nothing with non-indexation.

CHAIR: Not for long, because people will stop practising. People who are thinking of retiring will retire and the doctors which we have funded and developed to this point—but taken away the PGPPP—will not go into the system, so we will have a massive hole—

Dr Pearce: An absolute health crisis, like they have in the UK at the moment, where they are trying to recruit their own doctors back, because it all got so bad over there they all left.

CHAIR: So, if you were a government that wanted to kill off Medicare, is the recipe pretty good?

Dr Pearce: I think at the moment the recipe is good. I think it was under-thought and under-modelled and under-consulted before it was presented to us just before Christmas, when there was very little time to organise some form of response.

Dr De Lyall: Doctors are cynical like most people. The other thing that we fear is that, if and when price point markings are introduced or if patients start having to pay for things they are not used to paying for, we are concerned that we will cop the opprobrium for that, whereas it is something that has been forced on us by the government. This could be a government of either persuasion, bearing in mind one of the previous Labor governments wanted to introduce a co-payment as well. But we fear that we will be copping the abuse from the public for doing that, and we are not happy with the thought of that either, but we will have to wear that and we will have to wear the fact that, for a lot of practices, there will be a marked drop in income initially, purely and simply because of the introduction of these price points. We are not happy with that, but we probably will not have any ability to do anything about that. We will be blamed for this.

CHAIR: Dr Van Leeuwen, and then I think Senator Ketter has got some questions.

Dr Van Leeuwen: It just seems that these recent things that have been occurring primarily focus on trying to gain extra money to improve the budget from primary care and general practice and the sharing of the cost savings. As to the savings, I would argue—and I do not have figures on that, of course; it is not what I know about—that the savings to be made in other areas of health, including the state-paid-for local health district systems, I would imagine would, quite possibly, exceed the minor savings we are talking about introducing in general practice.

CHAIR: And that point has been well made to us. There certainly are efficiencies out there; they have been identified by a number of participants. And if you wanted to target the most efficient part and do it damage, you would enact the policy that the government has been attempting to enact. That they are going after the wrong bit of the health sector is essentially what we have been told; that Medicare is absolutely sustainable; that GPs and primary healthcare is the most efficient and most effective part of our health system; and that the government have wilfully targeted the wrong part of the system, if they were genuine about making savings and efficiencies.

Dr Van Leeuwen: I am wondering: will there ever be political appetite to recognise that people's lives last longer than a very short political cycle, and clinicians' lives, working lives, last much longer than that as well? But the essential care that we need to deliver remains reasonably definable; we know that part. Senator Cameron, I am a bit flummoxed when you say, 'That is never going to happen,' because this is the state of play with the federal and state governments with health.

Senator CAMERON: No, with the commonwealth government.

Dr Van Leeuwen: Sorry—the commonwealth government and the state governments.

Senator CAMERON: So if we can get some common sense in the commonwealth government, and if we can get away from the ideology that drives the commonwealth government, then there is a chance?

Dr Van Leeuwen: Yes.

Senator CAMERON: But—given the political make-up of the commonwealth government, which is about small government, which is about cost-shifting health back to the states, with the states with very little capacity to pay—I am despondent about getting that fixed.

Dr Van Leeuwen: Yes.

Dr De Lyall: Can I shift it back to the states, though? How does that involve general practice? In what sense? As I was saying earlier, our primary source of funding is commonwealth rather than state. There are obviously, we would think, quite major efficiencies that can be made in state health delivery. We are all aware of numerous stories of layers and layers and layers of bureaucracy in the hospital system that seem to do nothing. Is it up to the commonwealth government to prod the states by way of bribery or threats of reduced payments to improve their efficiencies? How is that—

Senator CAMERON: I am not convinced that there is layer upon layer upon layer of bureaucracy that does nothing. I am a cynic about that. I think it is part of the right-wing approach that is taken by the commonwealth government to blame bureaucracy for everything and blame big government for everything; that is how they think. I am not convinced that that is the biggest problem. How does it affect GPs? Well, without Medicare—if Medicare collapses—then your model is gone completely. That is how it affects GPs.

Dr Pearce: And the cost-shifting comes because what would normally be looked after under general practice and federally goes to hospitals, and then that is zoned under the states.

Senator CAMERON: And what we will end up with goes back to when I came, in 1973; I was told: 'When you get to Australia, you have got to be a member of a health fund because that is how you get looked after.' So you will see massive increases in terms of private health, and that is the problem.

Dr Pearce: I have one thing to put on the record around health funds. One of our secretaries at work could not afford to be in a health fund four or five years ago. You are going to need to be in a health fund soon to actually get any decent care, if things keep happening. If she joins a health fund now, she has to pay 100 per cent more. So, guess what? She is never, ever going to join a health fund. What is my 21-year-old son going to do if he cannot afford to join a health fund until he is 30? How much is it going to cost him then?

That whole policy—and this is very separate to the issue that we are discussing, but it was brought up with me by a secretary—of preventing people from joining health funds in the future is going to mean that we end up with something very much like the States, where you have those that can actually pay and be in a health fund, and those that just get no care. That is tragic. That needs to be revisited. It is separate to this, though.

CHAIR: It is integrated, and that is the thing. We have a complex system at the moment. Just before you came we were talking about the threat—or what I perceive as a threat; the government might have a different view—of the white paper about federal-state relations. Given the speeches that I have heard in the parliament and the articulation of the vision about state-federal relations that has been put on the record in the parliament, they look like they are ready to build a very big fence between the federal government and the states—to actually make federal government much, much smaller and push things back onto the states. It is taking us back to Federation, if we think about Australians and health care. But this is about New South Wales and health care, and the federal government taking itself away from the responsibility for this. I am frightened that the walls are going up, not coming down, because that will save the federal government money and also they will not be responsible politically when things go wrong in health. I think that might be part of that as well.

Senator KETTER: I will just come back to that cost-shifting issue and the perverse outcomes that occur when there is an attempt to put a price signal at the GP level. Dr Pearce, you were just saying before that that forces people back to the emergency department of the hospital. I noted in Dr Fong's submission that GPs are extremely cost efficient in comparison with emergency department costs. I think there is an estimate of between one-eighth and one-twelfth of the cost—that comes from something called the BEACH program. Are you able to share a bit more about that?

Dr Pearce: I do not understand the BEACH study completely, but it is a collection of data, mainly from registrars and experienced doctors, where you just document what each consultation was about, how long it took and what the outcomes were, effectively. All that data is then collated, and they somehow look at the cost of that in a general practice setting versus what it would cost in a hospital setting.

The example I gave to the Senate in the last hearing was a child with an ear infection. The numbers were all wrong, because I was doing that off the top of my head. But if I see a child who is quite sick with an ear infection and a very high temperature, it is something that we can easily sort out in 10 minutes. The cost to the government is $35. In that example, we were demonstrating the cost to the parent, but should that parent then go to an emergency department, from the RACGP's submission, I believe it was either $400 or $500. I think $400 was the cost of an encounter in the emergency department. If there is an inexperienced intern on in the emergency department who is not used to assessing that type of child and they admit them overnight for observation because they are quite worried about them, then the cost of an avoidable admission in the hospital system is about $4,000 or $5,000. It is huge. You are looking at $35 as opposed to $4,000 or $5,000.

Dr De Lyall: And that does not take into account the time involved on the part of the parents. Most people who come and see me or other GPs are not going to wait that long. Patients rarely wait more than 10 minutes to see me. A lot of doctors are very efficient. If you go to an ED, you might wait five or six hours. That is an enormous amount of disruption to family life and an enormous amount of loss of productivity to this country. I do not think that has ever been measured, but it obviously has to be a factor.

Senator KETTER: It is almost a wanton act of fiscal vandalism on the part of the federal government to put that price signal in place at the GP level, to then push that cost onto the state and to put those extra pressures in the hospital system as well as creating a highly inefficient outcome.

Dr Pearce: I do not know that that was their primary objective. At first I thought that they were playing a great game of euchre where they led with a $7 co-payment and they were trying to get everyone's agenda out and see what obstacles there were. Then, when they got everyone's agenda out, they said, 'Okay, we'll revise it and do this.' Then they have trumped it with a non-indexed payment. I do not think that they were that clever about it, actually. I think that what happened was that they were just desperate. They had this budget, they had said that they were going to make a hell of a lot of cost savings, their initial policy was obviously not going to be accepted, and they came up with a secondary policy at the last minute—and who knows what the dynamic around forming that policy

was; we heard a lot in the news about the dynamic of how that policy was formed. But that policy was then presented to us, and it got an even bigger backlash. Now they have gone, 'Maybe we need to actually sit down and talk about this.' So I do not think that they were very smart about it at all, and I do not know that they were trying to cost-shift to the states. I think they were just trying to say: 'Health expenditure is blowing out. We need to either stop people going to the doctors, increase the funding or do something. Let's try this.' **Dr De Lyall:** And pick the easiest target.

CHAIR: So it is worse than being a policy-free zone; they were absolutely ignorant, in your view, of the outcomes?

Dr Pearce: I believe that they were. Listening to the afternoon session of the last Senate inquiry when Senator Cameron was talking to the department about the modelling that went into the Medicare changes, it was quite clear that they did not know. They are the ones coming up with the policy, and they did not know.

CHAIR: The Department of Health?

Dr Pearce: Yes, it was the Department of Health that afternoon.

CHAIR: We saw that the doctors' magazine covered that somewhat.

Dr Pearce: Yes.

CHAIR: They did not do modelling. I remember them telling us that they did not do modelling; then at Senate estimates we had the head of the department saying that they do modelling. It was confusing for us as well.

Senator KETTER: Moving to another area of inquiry, I think it was you, Dr Van Leeuwen, who talked about the HealthPathways system in New Zealand. There seems to have been a significant improvement over there in a relatively short period of time. Are you able to tell us a little bit more about that?

Dr Van Leeuwen: Sure. I guess this is not the whole of New Zealand, but in the Canterbury health district there was something called the Canterbury Initiative, which kicked off a whole bunch of health reform ideas. It was led by a woman who worked in the primary health sector initially and then moved across to be the planner and funder for the district health board in the Canterbury district. Because she had a primary health background, and then could come across to the tertiary system, and then became responsible for both, she had a very clear vision of how things can be. She was quite adequately and well informed by local league clinicians and would encourage them to speak with her about the best way of providing health—providing care for a fracture or clinical things—and then she would have a look at how that would be funded within their sector. They receive all the funding for their region, so in lots of ways it cuts out all the layers; they are all funded by the same thing. They get their block of money and have to fund their community of X number of people with this amount of money. So every time they realise savings, they can redeploy the savings elsewhere.

The HealthPathways is very much an integration kind of system. It is an information management and referral system. Their referral for pathology and imaging is quite different there; they have other guidelines about how you can order pathology, CT scans et cetera. But essentially they bring clinicians together—primary health clinicians, GPs and hospital specialists—to discuss a topic or a diagnosis, work out clinically the best way of a patient flowing through the system, and have a look at the roadblocks that exist in the system to prevent that from occurring efficiently—as in, most cheaply and most safely—with the best outcomes. Then that is supported by people all being on the same page with HealthPathways. So it is an integrated system which is web-based and has been brought across to Australia. It started in the local health district for us, the Hunter New England Area Health Service, a few years ago, and now is being more widely spread across the country.

Senator KETTER: How is it going in the Hunter?

Dr Van Leeuwen: In the Hunter it is going really well. It has been very well received by clinicians. If you ask people to advise and to perform at their peak in their area of specialty and training, it works really well. That is what you do with HealthPathways. You ask the heart cardiologist how you look after heart failure. You bring in the GP and then you talk about the patient. Then you have all of the other people—you might have community people, community nurses, the discharge planner. So it is an integrated approach to designing the way that patients flow.

Even though there are these arbitrary funding walls—and, Senator, I know you are you worried about there being more walls—between us and the hospitals that we refer patients to, in the urban setting I am not the one looking after my patient in the hospital. In the rural area, it is the same doctor who just opens the door in the wall and goes through. The funding is kind of mixed. Even though those walls exist, in the actual patient flow we need to negotiate them. The GP, I suppose, is kind of the biggest and best patient advocate. We are the patient's home. Very quickly, after a few minutes, and now more than ever in the last five years, I need to ask somebody if they are privately

insured. That is because it will inform me as to whether I will send them to a specialist orthopaedic surgeon in their rooms or put them on the waiting list that is probably going to take 18 months, because the waiting lists are extraordinarily difficult and out of hand.

Having said that, in the same area in New Zealand, please go and have a look at the Canterbury district's data. It is amazing. They are now doing elective surgery in their public hospital waiting lists. Fancy getting rid of your winter bump of omissions and then getting then rid of your wait lists. It is a remarkable thing. There have been multilayered approaches to collaboration, but the notion has been of one system working together to support the patient journey.

Senator CAMERON: Are there any references you can point us to for that information?

Dr Van Leeuwen: Yes. Could I sense some information through? Would that be okay?

Senator CAMERON: Yes, you could send it through to the secretariat.

Senator KETTER: It sounds like they have less constitutional impediments than what we do in Australia.

Dr De Lyall: Of course. That is the big problem. They have one system of government and one chamber of parliament. I would imagine it is a lot easier to get things through if there is a will there. I would be interested to hear from senators how the impasse between state and federal cost-shifting is ever going to be possibly resolved, because it has been going on for as long as I have been a doctor. Is it a resolvable problem—short of a crisis developing where it is forced on the entire community?

Senator CAMERON: I am not the shadow minister for health, but the shadow minister must obviously be looking at some of this. We have to come up with policy. We are working on policy. This is part of our policy development—sitting down and listening to you guys, and finding out what the issues are. How you do it is still a moot point. Kevin Rudd said if we could not fix the hospital system we would take it over. And that did not happen. This is a big call. We have had decades—or longer than decades, really—based on this private practice division between state and federal in health policy. It is not going to be easy to change. This has certainly opened my eyes to some of the issues.

Dr De Lyall: My fear is it might take a catastrophe to lead to that.

Senator CAMERON: The destruction in Medicare would be a catastrophe. That is a deliberate policy by the coalition.

Dr De Lyall: I think that was close to happening with the proposals that were put forward a couple months ago which have been negated now.

Dr Van Leeuwen: Which means we are hanging on the edge, actually. We are clinging to the edge. In New Zealand, they did have a catastrophe in actual fact. They had an earthquake in Christchurch—the area where this system was enacted. Fortunately, it had been partly enacted prior to the earthquake. Even though a whole bunch of GP surgeries fell to the ground, and they lost about a third to a quarter of their hospital beds in the day, they could activate and mobilise their medical forces to supply all the patients with all their routine stuff that they needed to care—medications management—as well as manage the acute emergency stuff.

Senator CAMERON: One of the propositions that has been put to us is that we should adopt a national DVA—

CHAIR: Like the gold card.

Dr Pearce: The gold card.

Senator CAMERON: The gold card. That has been put as a proposition, because that cuts through all the bureaucracy and problems. It would be very expensive.

Dr Pearce: If you are looking at a system like that, it is something that exists in Norway. Norway is probably a country that had a lot better policy in terms of government when they were selling off their oil and other reserves. There was a sinking fund that happened, and they have got trillions of dollars in the sinking fund. They pay huge tax, but education is supplied to everyone for free—not for free; they have paid tax for it. Education is available whether you are the daughter of a doctor, a garbage collector or a pensioner. It does not matter. It is free—or provided. It is the same with health. They do not pay out of pocket there. To go to that gold card, we are going to have to look at No. 2 on the list, which is: how do you fund this in a fair way? We have sold a lot of coal. We are now leasing off harbours. We are about to sell power in New South Wales. We are going to have nothing left. I think the government need to have a long, hard think about it.

Dr Van Leeuwen: We are not politicians, but we are clinicians and we can see that the funds that you would save in all these areas we have flagged, if you put that into sensible application of health models, including general practice—I do not think you have to sell off anything else.

Senator CAMERON: I would agree with you.

Dr Pearce: One thing that is about to happen, and it is not being well publicised, is that the government are about to sign another agreement with multinational drug companies in the United States that affects us paying—what is it?—10 times as much as, or a large multiple more than, New Zealand for the cost of our medications. How can a government trying to save $1 billion out of booting general practice, which only gets $5.1 billion out of $62 billion in health funds each year, justify signing an agreement that is going to cost billions, I am sure? I do not know the figures on it—you may be able to enlighten me—but that is about to happen now. It has happened in the past, which is why we are paying a lot more for all medications.

CHAIR: Senator Cameron asked some questions yesterday about the TPP and the implications and what that is going to mean. I guess one of the things we are finding in all of our inquiries around health is the difficulty of accessing information and getting details about those trade deals and what is actually going on in them. This government is refusing to make those available and transparent in every sector. I tried to table research into disability allocations and the organisation of disability funding in the education sector the other day, because the advocates cannot get the information. The government used its numbers to shut it down. So there is a lot of silence and a lot of privacy. We saw how that turned out, in terms of last May's last budget, for health. That is why coming and putting your thoughts on the record and the submissions that you have made here—the issues about blended payment, the incentivisation of pushing people onto specialisation rather than dealing with it at GP level—are important. We are noting all of these things in your submissions and they will inform our report, which will emerge usually in a half-year. We do value what you have to say here on the public record, because it means that there is an external scrutiny in the field of health, while private conversations are going on. I know they are important too, but I think coming and putting things in the public record is a very, very important thing for health right now. So thank you for your efforts.

Dr Pearce: Thank you for listening to us.

CHAIR: I thank all the witnesses who have appeared before us today for their valuable testimony. Thank you to Hansard, broadcasting and the secretariat. That concludes today's public hearing.

Committee adjourned at 16:04