Doctors Reform Society

Submission to House of Representatives Standing Committee on Health, Aged Care and Disability into access to and affordability of medical non-GP specialists in Australia.

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Thank you for the opportunity to contribute to the debate about this crucially important issue.

We note the very broad Terms of Reference and will comment briefly on some of these but wish to concentrate predominantly on the affordability of non-GP specialist services and the geographical distribution of such services.

However, we would like to suggest firstly that the current discussion from the minister and others in the media has generally been about the non-GP specialist co-payments limiting access to care, as well as the geographical problems for rural and remote communities. We suggest that that emphasis is incorrect and that the discussion should be framed around providing adequate public inpatient and outpatient services so that there is no need for any patient to seek private care unless they can afford it and wish to have private care.

a) *Examine current access to medical non-GP specialists in cities, regional and rural communities, with consideration of workforce distribution, shortages, waiting times and barriers to recruitment, retention and training.*

Others with access to much larger resources than us will undoubtably provide evidence indicating current access to medical non-GP specialists and to in hospital services is clearly limited by both cost and distribution of services and will indicate various contributing factors to these limitations including the ones listed above.

The very fact that there are years long waiting times to access public hospital outpatient services is a clear indicator that patients either can' t afford the private copayment or, even if they can, they know that there are likely to be further copayments for investigations which they will struggle to afford.

Public hospitals triage patients on waiting lists. They stratify them according to immediacy of need. However, as well as straightforward waiting times, there are the waiting times to be triaged which is often months. Then, if need changes, a further referral may well be acted on appropriately, but that change will also take months. Whilst similar types of delays also occur in the private system, they are almost always much shorter.

It is very clear to us that a wind-surfing chef who develops an overuse syndrome of a tendon at his wrist which is more attributable to his windsurfing than his occupation but then has to wait without work for 2 years for the necessary operation, is discriminated against by the system. His retired neighbour develops an identical problem which prevents him playing golf but only for 2 months because his private health insurance enables him to access care almost immediately.

The inequalities of the system are also very clear to us when we have patients who need an elective joint replacement forced to wait 18 months, limping in pain around the house on a walking frame,

dealing with narcotic side effects, unable to participate properly in family life, often being a burden on family members who are willing to support them but shouldn't have to. The neighbour's joint replacement gets done through the private system within months of the need being identified.

b) *Examine the effectiveness, transparency and equity of referral pathways from the perspective of patients, primary health care practitioners and medical non-GP specialists across the public and private health sectors, with consideration of factors affecting referral patterns and any systemic, regulatory or administrative barriers to the appropriate utilisation of these pathways.*

There are widespread differences in referral pathways to non-GP specialist outpatients in public hospitals. In some cases, non-medically trained staff judge the referral as appropriate and reject if they view it as not e.g. a referral to an osteoporosis clinic rejected because no menopausal history was included: the patient's name was John. In other cases, the referral can be sorted by the triaging non-GP specialist with a letter to the GP suggesting investigations prior to attendance. Standard referral templates at public hospitals often require completely unnecessary tests when non-medical staff make the initial assessment of the referral. The public system can, however, be much more efficient than the private system (but not as remunerative for the private non-GP specialist as they might like). Thus, if a non-GP specialist triages the patient, they can decide if the referral is indeed necessary and if the standard required tests are indeed useful. They may be able to inform the GP that the referral isn't necessary, or that extra tests can be done beforehand, and override requests for unnecessary tests. This can be done via a letter or other communication. As a salaried non-GP specialist that is efficient and the non-GP specialist is paid for their time. This already happens in a very limited way in some hospitals with innovative non-GP specialists. A private non-GP specialist probably won't do that because time is money and there is no rebate for such a service.

c) *Examine the affordability of non-GP specialist services, including out of pocket costs for consultations, diagnostics, procedures, and patient access to non-GP specialists through public health services, as well as factors influencing fee setting by non-GP specialists in the public and private health sectors.*

You will be aware that in the community the cost of non-GP specialist services, including simply the first consultation and relatively simple diagnostics and procedures that only take an hour or so, is indeed unaffordable to many of our patients. Such patients therefore go on waiting lists at public hospitals firstly to get an appointment and then, if a procedure is needed, to wait for that on another waiting list. Many of the non-GP specialists who see these patients on the waiting list also have private practices where they charge co-payments, which forces patients to see them publicly. After a long wait they do that with the full knowledge that the co-payments they charge will mean that such patients will wait whilst the patients who can afford their services in private will not have to wait.

<u>Reasons for copayments</u>

We suggest that this is for three main reasons. The first is the sense of entitlement of non-GP specialists who feel that the income generated by the co-payments is necessary for them to live the lifestyle which they deserve. Many of them work extremely hard, long hours, and have little time for family. They benefit from these long hours by a sense of achievement, a reward that comes from the kind of work they do. But they also benefit financially and this financial benefit enables them to have the luxuries of life but also means that they have access to affordable and timely healthcare at a standard often much higher than the patients they see in public hospitals. It also means their children's educational opportunities are much higher than their average public hospital patient.

The second main reason for these co-payments being sufficient to prevent access to many in the community is more subtle. Non-GP specialists look around their colleagues and notice what they are

charging. Some would feel that the charges of other non-GP specialists are excessive and they definitely charge significantly lower copayments than some of their colleagues, so they feel they are being much fairer and less greedy than their colleagues. However, the co-payments they charge are still sufficient to prevent patients accessing their care and being forced to go on to waiting lists to see them at the public hospital.

The third main reason for these co-payments is the grossly inadequate competition in the community and at public hospitals for access to non-GP specialist community services, whether they be consultations or simple diagnostic procedures. This is directly the fault of the public hospitals choosing not to employ sufficient non-GP specialists and trying to remain within budget, and avoiding even longer waiting times for surgery, but it is also a fault of the state governments, which don't give them sufficient funds to employ enough non-GP specialists to staff outpatients.

A recent example of this comes from a major Melbourne teaching hospital which advertised for a 0.5 Head of Department position in a medical specialty and a specialist applied, was told they were successful, and then told that the position would only be 0.2. When this was queried, the applicant was told that they had no interest in expanding this particular specialty and no more sessions would be made available. Waiting times for appointments can be over 6 months.

However, the Federal Government is responsible for somewhat less than half the cost of running public hospitals. It too is directly at fault because:

1. It doesn't fund public hospitals with sufficient amounts to provide adequate outpatient services.
2. It doesn't attempt to direct the funds it provides into adequate outpatient services.

It is worth noting here just how disorganised and inconsistent the funding of public hospital out-patients is. In Victoria state governments provide public hospitals with a budget and they employ non-GP specialists. However, some public hospitals in Victoria partly fund outpatient services through the federal government rebate and take the bulk billing rebate and then top it up with their own funds to make up the salary of the non-GP specialist and to pay on-costs. But some public hospitals in Victoria do it all by themselves and just rely on the federal government to give the usual percentage that happens with all public hospitals. We do not know how widespread this gaming of Medicare is across Australia.

However, it is a saving for the public hospitals but almost certainly is more expensive for the health system overall in that there are administrative requirements required to bulk bill patients and do the accounting associated with these payments. In addition, potentially it is requiring non-GP specialists to see every patient, which may be quite unnecessary and inefficient on quite a lot of occasions when the senior registrar is reviewing a patient whose condition is stable.

d) Examine the impact on patient outcomes by delays due to cost, distance and waiting times, and broader system impacts on primary care, emergency departments, public hospitals, chronic disease management, as well as impacts on people due to deferred or missed care,

The impact of delayed care essentially means that patients and their families relying on the public system suffer and die more than those who can access the private system. Others may document the numbers and specifics but the above is the reality.

e) Assess innovative and emerging models of care that may improve access to medical non-GP specialists

The first two reasons for excessive co-payments are not easily amenable to change. It has been suggested that the Medicare rebate be not paid to those who charge extremely high co-payments. Whilst this would address the very tip of the excessive co-payment iceberg, it would also be a

complicated change, possibly requiring a High Court challenge, and would take quite some time to implement.

We suggest something considerably simpler. What is required is adequate publicly funded non-GP specialist services to the point where patients who wish to go private do so because they want to go private, not because they don't want to wait the inordinately long times to get public care. This would mean that those who are paying such co-payments are choosing to because they wish to have private care and they can afford it. But non-GP specialists who currently rely on the many patients who really stretch their finances to get private care because of the waits for the public system, may then find that lowering their copayments will maintain their market share.

Options

We suggest the federal government consider two options. Firstly, it could provide a hypothecated amount of funding for public hospital outpatients. Whilst this could be done as an addition to the current outpatient services, the risk would be that public hospitals would diminish what they are doing currently and have no overall increase in our patient services.

The more complex second option which would avoid states reducing their input to public outpatients as in the first option, would be for the Federal government to take over outpatient services in their entirety. They could determine how much less they would contribute to state government budgets so that inpatient services continue but still provide sufficient funds to establish competition from public outpatients to private consultations and services.

This service could include hospital outpatients but also community clinics where non-GP specialists would be seen away from the hospital so that the geographical barriers to access might also be improved.

It would be necessary however, that each clinic of this type was directly linked to a public hospital. States differ in the way they run hospital networks, and it would have to be linked in through the hospital network, whatever the arrangement that state has.

The Federal Government has opened multiple urgent care clinics to provide general practice consultations in the community. It is willing to pay the general practitioners a significant salary for working in these clinics. If they were to set up and run public hospital outpatients with community non-GP specialist clinics, the non-GP specialist would be paid a salary similar to that already paid in a public hospital.

One argument against this might be that non-GP specialists won't want to give up their private practice to work in the public system. There are plenty of non-GP specialists who already work in the public system, part-time or full-time. Recently graduated non-GP specialists might be very keen to have an immediate well-funded position as a non-GP specialist without taking on the complexities of private practice or indeed easing themselves very gradually into private practice.

Such clinics could be staffed by not only non-GP specialists but training registrars, permanently employed assistants (medical officers or otherwise) and general practitioners. One consultant can manage a much larger number of patients with appropriate support. With the increasing complexity of management of many chronic conditions some long-term follow-up is often needed in non-GP specialist clinics. Properly supported ancillary staff can take much of the workload with the consultant immediately available.

Additional Improvements

Access for GPs to non-GP specialist advice

Non-GP specialist advice should be immediately available to GPs, either by phone or e-mail. This could be done centrally with 'call centres'. Locally available services would allow proper referral when urgent as opposed to adding another layer to the process.

Outreach/Telehealth

Outreach services are becoming more common but could be better integrated between the larger centre and regional areas. Telehealth is a great advance but having some personal contact at some point is also invaluable. Formalising sub-specialty services in regional areas with properly resourced fly –in/fly out staff who provide the tertiary services when needed would be one away around the problem of attracting non-GP specialists to regional areas.

Non-GP training in 'office' subspecialities

A further option to increase availability of non-GP specialists would be to negotiate with the non-GP specialist colleges to redefine training programs to better meet the needs of the population.

In Britain there exists the specialty of office urology. Such urologists perform cystoscopies in offices or day facilities and consult but do no other surgery. Training time is less. There are numerous opportunities to 'fast-track' non-GP specialists by limiting their breadth of practice (and therefore duration of training. Do all cardiologists need to learn to do angiography, could there be a specialty of ophthalmology limited to cataract surgery? Do all endoscopists need to be fully trained gastroenterologists? There is a place to limit training in endocrinology to only diabetes or neurology to only stroke medicine. Office ear nose and throat medicine is probably an option.

Public hospitals

Importantly, for outpatient services to provide timely affordable care to those who need it and can't afford private care, there also needs to be an improvement in timely access to the inpatient care which may result from such outpatient consultations. This is also a mixed state/federal responsibility. Public hospitals have inadequate funds. Governments do claim record funding but that is almost inevitable for most government programs as the population grows. With this population growth, the aging of the population, and increased capacity to treat illnesses better, there is an inevitably increase in demand. What is needed is funding to meet that demand, not record funding. No innovation is required. Instead, a simple commitment the states to adequately fund increased demand would lead to an increase in federal funding to fit with its National Health Reform Agreement commitment to 42.5% of total funding of public hospitals by 2030 under the National Health Reform Agreement. The federal government has, however, maintained a cap on the increase per year it will fund. If states exceed that cap of 8%, it will not be matched by the federal government, even if it is to address increased demand.

However, there is an extra twist. Over 10% of patients in public hospitals are waiting either for aged care placements or what used to be called aged care packages to enable them to stay at home. These are completely the responsibility of the federal government. Once again, it will claim record funding, but it will not be able to claim funding that is adequate for demand.

Increased forced distribution of non-GP specialists

Lastly the Australian Health Practitioners Agency has been innovative in attempting to get non-GP specialists into regional and remote areas of need and documented non-GP specialist shortages through it's the Expedited Specialist Pathway. The scheme fast-tracks approval of non-GP specialist qualifications for non-GP specialists in a limited number of areas who have qualifications from the UK, Ireland, Canada, and New Zealand. They need to have a 6-month period of supervision, which is usually in an urban setting, and then must commit to working in areas of documented need for 10 years.

A recent report on the scheme showed that only 11% are practicing in regional and remote areas but 88% are practicing in defined areas of workforce shortage, which does include some metropolitan areas. The low number to date of those in rural areas might reflect that the scheme is only 2 years old and many might still be in the supervisory 6-month phase. Hopefully this is a way of improving regional and remote access to care, but it is currently limited to only a small number of specialties.

Fee transparency

Whilst an online record of fees would help some GPs in their choice of non-GP specialist and may help some patients, the complexity of the multiple item numbers is such that it would really only be useful for relatively simple attendances. Even then, however, it has quite reasonably been suggested that such a site may lead to some specialists realizing that they could be charging a lot more like their colleagues do and actually increasing their fees.

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