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24th June 2005

Ken Whelan
District Manager
The Townsville Health Service District

Dear Ken

RE Appointment of Dr Donald Myers

I write to detail my concerns about the appointment of Dr Donald Myers, to the position of Senior Medical Offer in Neurosurgery.

You will recall earlier this year, medical appointments at Staff Specialist level were handed over to the control of the Clinical Institutes, and my involvement was reduced from managing the recruitment, selection, appointment and credentialing process, to involvement only by request in the process up to Credentialing which I continue to manage.

In the case of Dr Myers, I was not involved at all until after the offer of full time Senior Specialist had been made and then again after he was offered a locum SMO position. I was asked to support the appointment after the recruitment process had been completed and without having the opportunity to meet the practitioner.

I expressed reservations after reviewing the CV of Donald Myers regarding the recency and continuity of practice and addressed these concerns to you, Shaun and Reno. Dr Myers had been working for the last two years in the Virgin Islands and prior to that had work hiatus of over two and a half years. I asked Reno specifically about the breadth of practice that Dr Myers experienced in the Virgin Islands and about his competence to deal with emergent care requirements in the Townsville Health Service. Reno reassured me that Dr Myers was current in general neurosurgery, specifically in clipping cerebral aneurysms and in current technologies supporting neurosurgical care. I requested that Reno provide advice in writing about the award of Clinical Privileges. This advice (attached) recommends privileges across the breadth of neurosurgery, excluding paediatrics.

When the final Area of Need paperwork was to be submitted; it transpired that the previously discussed appointment at specialist level, which would have entailed a review by the Royal Australian College of Surgeons, had been recast as a Senior Medical Officer locum with no College review. The Chief Health Officer contacted me to discuss the concerns held by the MBQ regarding the provision of supervision. Reno had listed himself as supervisor, yet he was to be overseas for the first three weeks of Dr Myers appointment.

As you know I then went to considerable lengths in an effort to develop a workable plan allowing adequate supervision and support in Reno's absence to ensure service continuity. These plans were then reviewed given public statements by the Royal Australian College of Surgeons on the day of Dr Myers arrival and I met with Dr Myers for the first time to discuss the decision to offer him leave until Reno's return.

In my discussions with Dr Myers it became clear that he was not current in the breadth of neurosurgery. Indeed he stated he had not had access to modern neurosurgical materials and interventions throughout his appointment in the Virgin Islands, since 2002. He stated that he had not had access to equipment to clip aneurysms over that time, therefore he was not current with this procedure and would need to be familiarised with equipment.

I am deeply concerned that advice from Reno was inaccurate and would certainly not have offered my support had I been provided with a more realistic representation of the facts.

This morning I have learned that this matter is common knowledge "around the town" and I feel that it is likely that this will excite media attention in the near future.

I request that you discuss this matter with Reno as I am not satisfied with his performance in this process. I believe that he did not accurately represent this practitioners skills and created the very real potential for him to be operating independently and inappropriately so.

Further I would appreciate your assurance that you will act protect my reputation in the public, within Queensland Health and the medical community regarding this matter. This matter has not been handled well and I have not been given the opportunity for timely input and intervention.

Yours sincerely,

Dr Andrew Johnson
Executive Director of Medical Services
Townsville Health Service District

AJJ-11

Medicare Reform – Consultation Draft

A private view from the north

Disclaimer:

Whilst this paper is written by senior hospital medical superintendents working within the Queensland Health system in North Queensland, it has not been submitted to, nor endorsed by Queensland Health.

The views in this paper represent the personal and private views of Dr Andrew Johnson and Dr Craig Margetts, and are expressed by way of a genuine and private contribution to the debate over Medicare reform. The proposals have been discussed and debated with a broad range of health practitioners and administrators, and the authors gratefully acknowledge these contributions.

Any correspondence regarding these views should be directed to the individuals in his private capacities.

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Dr Craig Margetts craigandkerri@paradiseblue.com.au

November 2004

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1 Executive Summary

1.1 Problem

- Medicare as a vehicle to deliver universal-access health care is not delivering equitably to all Australians.
- Many areas of Australia, particularly rural, regional, remote and outer metropolitan areas remain less able to access healthcare, particularly specialist care.
- Financial incentives drive specialists to work in major metropolitan centres.
- Specialists are financially disadvantaged by working in the public hospital sector, yet specialists in purely private practice are still extensively funded by the taxpayer through Medicare. That is, "private practice" is in fact a misnomer in Australia.
- Aboriginal and Torres Strait Islander health status remains a national challenge, with access to basic health services still unresolved in many areas.

1.2 Proposal

- Change Medicare to reward specialists providing service to public hospitals, universities and communities in need and those specialists who "bulk-bill" for their services.
- Reset the baseline for Medicare rebates from 75% and 85% of the CMBS (Commonwealth Medical Benefits Schedule) fee for inpatients and outpatients respectively, to 50% and add in a "shopping basket" of bonus schemes to reward level of commitment to:
  - Public hospital on-call service (10-20% bonus)
  - Public Hospital and tertiary education sessional work (4-20% bonus)
  - Work in areas of need (6-50% bonus)
  - Bulk-billing (6-60% bonus)

1.3 Effect

- Market forces in "private sector" will be skewed to advantage those who make a contribution to the national health objective of universal access to care.

- Metro-centric health lobby groups will likely argue that this will result in increased costs to patients and private health insurers.

    - This will only be so in cases where the patient elects to be seen by specialists in the private sector who have no public sector or university sessional commitment, do not "bulk-bill" and are not available for public on-call. Where the patient elects to see doctors in the private sector, who also provide service to public hospitals or universities, or who "bulk-bill" a proportion of their patients, they can expect to pay less.

- Specialists will "follow the dollars" and provide service to public hospitals and universities, and in areas of relative medical need.

- Sharing a scarce specialist resource across public and private sectors will ease some of the trend towards polarisation seen in recent years.

1.4 Cost

- Adjustment of bonus percentages allows system to be cost-neutral.[1]

- Increased payments to practitioners contributing toward national healthcare objectives are offset by reduced payments to practitioners who work solely in private practice.

[1] Figures used in this document should be considered to be indicative only. The author does not have access to formal economic modelling.

2 Aims

This paper aims to open debate on a combination of simple yet practical steps to address some key problem areas in health today.

Specifically the paper proposes the use of differential Medicare payments to promote national healthcare objectives in specialist practice, such as:

- Improved access to specialist care in areas of relative need;
- Improved access to specialist care in regional, rural and remote Australia;
- Increased provision of bulk-billing services by specialists;
- Encouragement for private specialists to provide service in public hospital and tertiary education sectors; and
- Augmentation and strengthening of the symbiotic relationship between Australia's public and private sectors.

By use of differential payments, these objectives may be met with little or no increase in net expenditure on Medicare[2].

[2] This paper does not address similar issues in general practice, yet the concepts discussed herein could have broader application across this area, especially the incentives for practice in areas of relative need and procedural general practice.

3 Scope

This paper should be considered as an exploration of a concept, not as a fully costed and modelled solution. The authors have no access to Health insurance Commission (HIC) or other data to be able to effectively perform economic modelling. The intent is to elucidate some innovative concepts, the details of which would need rigorous modelling by health economists. The figures used in this paper should be considered to be indicative only.

4 Background

In common with metropolitan areas, regional Australia has many issues of concern with the current state of the healthcare system. The impact of these issues, however, tends to be more acutely apparent in rural, regional and remote areas of the country.

Central to these are the increasing polarisation of the specialist Medical Workforce toward either fully public or fully private practices; as well as the increasing difficulties in providing for ongoing medical education, and the availability of practitioners to fill public and tertiary education sector specialist vacancies.

4.1 Polarisation of the Medical Workforce

In regional centres, most would agree that the most viable way to provide specialist services is with an integration of public and private practice. Under such a model all specialists share both the challenge of duties to the public sector and also the benefits of private practice. Unfortunately, there are perverse financial incentives pushing practitioners away from this model to a more polarised environment.

These financial issues are compounded by the fact that public hospital on-call duties tend to be more onerous and complicated than private on-call (public hospitals manage the majority of trauma and emergency work, regardless of insurance status). This means that the financial outcome of the polarisation is skewed in favour of specialists opting for purely private work.

Three significant factors have impacted upon the traditional relationships between public and private sectors. These are:

- the effects of fixed private practice costs (including the current "medical indemnity crisis") ;
- an increasing reliance upon Overseas Qualified Doctors; and
- the differential in earning potential between public sector and private sectors.

These are explored in more detail below.

4.1.1 Fixed Costs of Private Practice

Indemnity and private practice overhead costs are largely fixed.

Most private practices carry extensive background practice costs which change little when the practitioner is working in public hospitals. This situation has been further compounded as medical indemnity payments have increased in recent years. The practitioner receives little, if any, discount on their indemnity payments for time spent in public hospitals; time which, in many jurisdictions, is indemnified by the State.

The more a specialist contributes to the public or tertiary sector, the greater is the relative burden of these fixed costs and this phenomenon acts as a financial disincentive to engagement with public hospitals and universities.

On the other hand, indemnity payments for practitioners who do not earn any private income[3] are heavily discounted in comparison to those with significant private income. Further, accepting a full-time staff position in a Public Hospital effectively dispenses with staffing and practice overhead concerns.

In this way, the same issues that (for the majority of specialists) increase the drive to move to exclusive *private* practice paradoxically push a few specialists into exclusive *public* practice thereby increasing the polarisation effect.

That is, due to perverse incentives inherent in our system, public practice has in many centres become an "all or nothing" concept. Practitioners either opt-out of public sector practice altogether in an effort to spread their private sector background practice costs across a wider base, or reduce their cost base by becoming a full time public sector employee.

This can be illustrated by the recent example of one particular surgical discipline in a major centre in North Queensland. Three new specialists have set up purely in private practice, with no public commitment and no private on-call availability. Another specialist in the same discipline has moved from a public/private role to purely public commitment.

This has resulted in a situation where the private market is adequately serviced, effectively discouraging new entrants, while the public hospital struggles to maintain a reasonable on call load for the remaining specialists in that discipline who provide a commitment to the public sector. When these practitioners inevitably "burn out" from the unenviable hours and on-call, they will be extremely difficult to replace, especially with Australian recognised specialists. Indeed the full-time specialist recruited to fill gaps left by departing visiting practitioners, is overseas trained.

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[3] NB: Private revenue earned within State government Rights of Private Practice (ROPP) arrangements are not included, as practice costs and indemnity are covered by the employer.

4.1.2 Increasing Reliance upon Overseas Qualified Doctors in the Public Sector

National shortages of Australian trained medical staff, in particular specialists, impact on rural and remote areas to a greater extent than in the major metropolitan centres. Notwithstanding the recruitment of a few private specialists into full-time Public employment, the only realistic option available to the public system has been to recruit specialist medical staff from overseas to fill the majority of positions.

Many of these overseas-trained specialists are unable to gain specialist recognition in Australia and practice under "Area-of-Need" registration, which precludes them from private practice, therefore often the only option available is full-time public sector service.

That is, the trend, particularly in regional areas is to have Australian trained practitioners working in the private sector and overseas-trained specialists working in the public sector. In some regional centres the proportion of overseas-trained specialist staff in the public sector approaches 100%.

4.1.3 Disparity Between Public Sector and Private Sector Earning Capacity

Visiting medical officers (VMOs) in the public sector receive what would appear on face value to be handsome hourly rates. However, the reality is that these rates may represent as little as 5% - 50% of the practitioners earning potential had they spent that time in the private sector, dependant upon the nature of the specialty and the level of demand for their specialty in the private sector. Economists and accountants refer to the difference in remuneration as an "opportunity cost" paid by the specialist. Therefore, as a result of this opportunity cost many specialists can accurately say that they "pay" to work in the public hospitals.

For this reason many practitioners maintain that they must "give up" their public work to fund their growing indemnity and private practice overhead costs through increased private sector billings.

Addressing this disparity can be approached in a number of ways, using the "carrot and stick" analogy these can be characterised as:

- increasing sessional payments to Visiting Medical Officers (VMOs) to reflect their background practice costs (direct "carrot");
- regulating maximum earnings in the private sector ("stick");
- decreasing public subsidy of earnings in the private sector ("stick");

- rewarding public sector commitment by increased earning potential in private sector (indirect "carrot"); or
- a combination of the above

In short, the current financial arrangements provide incentives for both ends of the public - private spectrum, whereas the longer-term sustainability of the healthcare system is best served by a mutually interdependent approach.

4.2 Commitment to Health Education

At the same time as public hospitals struggle to attract applicants for staff and visiting positions, universities report significant difficulties in recruitment. This is evidenced by the vacancies in university chair positions, and the trend to overseas trained practitioners in university posts.

The paradox is apparent. The medium-term solution to the relative shortage of doctors in rural and regional Australia must include an increase in university graduate numbers, particularly from rurally-based Universities. However, the ability to achieve this, is limited by the shortage of those very specialists who are the teachers of tomorrow's workforce.

4.3 Aboriginal and Torres Strait Islander Health

The 1998 report, *Expenditure on Health Services for Aboriginal and Torres Strait Islander People*[4], identified that

> *"The health of Aboriginal and Torres Strait Islander people is much worse than any other demographic group in Australia. On average, Aboriginal and Torres Strait Islander people die at three times the rate of other Australians...*
>
> *Life expectancy for Aboriginal and Torres Strait Islander men is about 17 years less than for other Australian males and the difference is slightly more for women."*

[4] Deeble J. et al, *Expenditure on Health Services for Aboriginal and Torres Strait Islander People,* 1998, Australian Institute of Health and Welfare.

The report goes on to consider the expenditure on healthcare for the Aboriginal and Torres Strait Islander population, as being around 8% greater per capita than for other Australians. A significant part of this increased expenditure can be attributed to the additional costs incurred in providing services in rural and remote settings.

That is, it could be said that the Aboriginal and Torres Strait Islander population is three times sicker than other Australians are. Yet in a system aiming at universality of access, based on services provided to address clinical need, only 8% more is spent on this group. This can hardly be represented as service delivered equitably on the basis of demonstrated need.

5 The Concept – Medicare Reform

To address these trends, which simultaneously undermine the viability of quality service provision in education, public and private sectors; the issue of perverse financial incentives needs to be addressed at a legislative and regulatory level.

This proposal puts forward a way to encourage joint public/private sector practice and educational commitment, with radical yet simple adjustment to the Medicare system.

In essence, the proposal builds into Medicare, incentives for specialist practitioners to:

- contribute to the public hospital system and universities;
- practice in areas of need and rural, regional and remote areas; and
- increase their levels of bulk-billing

This would be accomplished by having Medicare rebates (currently set at 75% and 85% of Commonwealth Medical Benefits Scheme fees for inpatients and outpatients respectively), adjusted to allow differential benefits to practitioners. Where the practitioner contributes to the public healthcare system, health education, bulk-billing, and care provision in areas of relatively poor access to care, they will receive bonus payments not available to practitioners who make no direct contribution to these areas of practice.

This could be achieved without increasing net expenditure on Medicare, by a system of loadings to reward behaviours that support the above ideals, offset by a lower baseline payment.

Alternatively, the baseline payment levels may be left unchanged, and bonus payments introduced. This would require significant additional investment and would be significantly less effective, as it would offer a "carrot", but no "stick".

For the purposes of this discussion, we will explore the cost-neutral, yet politically more difficult approach.

Whilst the exact details of the loadings would need to be subjected to considerable modelling and economic analysis, an indicative approach is outlined below.

5.1 Baseline Adjustment

The baseline for Medicare payments is reset to (say) 50% of the CMBS fee for all specialist practices.

To compensate, this payment can be supplemented by a range of bonus loadings that recognise and encourage:

- Public Hospital On-Call commitment
- Public Hospital sessional commitment
- University sessional Commitment
- Bulk-billing
- Practice in areas of relative need

This is facilitated through a "shopping basket" approach, whereby practitioners can cumulatively earn "reward points" for participation in different activities.

Involvement with public hospitals and universities, would reward the practitioner with a bonus percentage for payments across all provider numbers they hold.

Practice in rural, regional and remote areas, practice in areas of relative need and the percentage of work bulk-billed, would gain a geographically specific increase in payment for services provided accessing the relevant provider numbers specific to those locations of practice.

In the sections that follow, each component is described, along with a table representing indicative bonus percentages to be added to a practitioner's Medicare payment.

5.2 Public Hospital / University Commitment Bonuses

One of the most difficult problems in public hospitals is maintaining a viable on-call roster, particularly in specialty areas. As such, contribution to the on-call roster achieves a significant increment, with additional bonuses for sessional commitment.

The reality is, there is significant scope for public hospitals to take on additional specialists onto on-call rosters as this does not increase costs significantly. However the scope to increase day-time sessional commitment beyond current levels is more limited in some areas, due to availability of resources: support staff; clinic space; theatre time; and funding. This comes as a result of the polarisation discussed before, where there is an increasing trend away from visiting practitioners, to a smaller number of full-time staff specialists, who absorb a greater proportion of the available daytime duties.

The level of commitment would be certified by the hospital or university in an annual statement of ordinary hours[5] worked. This may require public hospital and university payrolls and/or attendance registers (in the case of honorary appointments) to be linked to provider numbers.

These incentives would increase competition for public hospital and university positions and would tend to enhance the prospects of attracting appropriately trained and qualified practitioners to these posts.

Contribution to Public Sector On-Call Roster	Bonus "Points"
No Relationship	0%
Available for on-call	10%
On call: 1:10 or less	12%
On call: 1:5 or less	16%
On call: 1:3 or 1:4	18%
On call: 1:2	19%
On call: 1:1	20%

In the above model, a doctor contributing to a Public Hospital on-call roster of 1:3 would receive:

Component	Payment as % CMBS fee
Baseline	50
1:3 on-call	18
Total	**68%**

This provides a clear financial reward to that doctor, over and above a doctor who chooses to provide less cover. Modelling would be required to demonstrate whether this financial reward would translate into sufficiently significant incentive for the specialist to accept the detriment to lifestyle that on-call service brings.

To maintain a viable roster, a target of 1:3 commitment or less is ideal. 1:1 and 1:2 rosters are generally not sustainable particularly for practitioners to enjoy any quality of life. It is a source of major frustration for practitioners to be forced to maintain a 1:2 roster in the public system, when colleagues work in the private sector and make no contribution to on-call commitments.

[5] "Ordinary hours" refers to time worked during normal working hours and excludes overtime and call-back. VMOs will normally be contracted to perform a specified number of sessions, and will be paid an hourly sum.

Public hospital sessional work and Tertiary sector sessions would be rewarded in a similar manner.[6] Most Visiting Medical Officers with public hospital appointments work between 2 and 5 sessions per week in the public system. This translates into between 6 and 15 hours per week. Allowing for periods of leave and other confounding factors, this bonus would be best paid on the basis of actual ordinary hours worked per annum.

Public/Tertiary Education Contribution	Bonus "Points"
No Relationship	0%
Between 36 hours and 149 hours per annum	4%
Between 150 and 299 hours per annum	8%
Between 300 and 449 hours per annum	12%
Between 450 and 599 hours per annum	16%
Between 600 and 749 hours per annum	18%
750 hours per annum or greater	20%

As these rewards are cumulative, a doctor providing a 1:3 on-call service, in addition to 6 hours per week or 300 hours per annum, in either the University or Public Hospital sector would receive a payment of 80% of the CMBS fee.

Component	Payment as % CMBS fee
Baseline	50
1:3 on-call	18
300 hours sessional commitment	12
Total	**80%**

5.3 Bulk- Billing Bonus

This incentive is aimed at addressing the issue of affordable access to service for those most in need. The rebate applicable would be paid on all consultations for a particular provider number, bulk-billed or not, thus providing a very substantial incentive for the specialist to bulk-bill at least a significant proportion of their occasions of service.

The "break-even" point for Medicare in relation to current outlay would be if around 40% of occasions of service were bulk-billed. A substantial funding injection would be required if bulk-billing rates went higher than this mark. Conversely, the Maximum Points Available, or the baseline payment percentage could be adjusted to maintain equilibrium.

[6] For the purposes of this paper, a session is defined in its common usage as a three-hour continuous period of work.

Bulk-Billing by Doctor	Bonus "Points"
No Bulk-Billing	0%
15% of Services	6%
30% of Services	12%
45% of Services	27%
60% of Services	36%
75% of Services	42%
90% of Services	48%
100% of Services	60%

To take the previous scenario one step further, if our specialist provided 30% of his or her services as bulk billing, then an additional 12 percentage points would be added, bringing their total bonus to 42% (on top of the baseline 50% = 92%). This may only require the specialist to bulk-bill a particular segment of their clientele, eg health care card holders and pensioners.

Component	Payment as % of CMBS fee
Baseline	50
1:3 on-call	18
300 hours sessional commitment	12
30% bulk-billing	**12**
Total	**92%**

5.4 Area of Need and Regional / Rural and Remote Practice Bonuses

Indices of rurality, regionality and remoteness currently in use, eg RRMA and ARIA scoring, may be less than ideal measures for application in healthcare, but are readily available and are well understood[7]. Such an index could be used to provide bonuses to practice in centres remote from major cities.

Using the RRMA index as an example, this may result in a bonus table as follows:

Rural and Regional Loading	Bonus "Points"
RRMA M1	0%
RRMA M2	6%
RRMA R1	12%
RRMA R2	16%
RRMA R3, Rem 1 & Rem 2	20%

[7] The map of RRMA allocations can be found at:
http://gisca02.gisca.adelaide.edu.au/aria/asgc/asgc.html

Once again, if our example specialist worked in an area of RRMA R1 (eg Mackay city), their rebate would increase a further 12 percentage points, to be a total bonus of 54% (or 104% payment in total once the baseline 50% is added).

Component	Payment as % CMBS fee
Baseline	50
1:3 on-call	18
300 hours sessional commitment	12
30% bulk-billing	**12**
RRMA R1	**12**
Total	**104%**

A similar loading can provide incentives to practice in areas of relative under-servicing, based on the level of access to MBS in the locality that the service is provided.[8]

Access Loading	Bonus "Points"
10% or more above Av. Nat. Billings	-6%
>Average National Billings	0%
Up to 10% below Av. Nat. Billings	6%
10%-20% below Av Nat. Billings	15%
20% or more below Av Nat. Billings	30%

Again, if our specialist was working in an area where there was a relative shortage of billings, say up to 10% - an additional 6 percentage points would be added to bring their final bonus to 60% or a total rebate of 110% of MBS.

Component	Payment as % CMBS fee
Baseline	50
1:3 on-call	18
300 hours sessional commitment	12
30% bulk-billing	**12**
RRMA R1	**12**
10% below national average billings	**6**
Total	**110%**

[8] This may be calculated by Statistical Local Area (SLA) expressing extent of billings (HIC data) against population (census data).

Both the rurality and access incentives would apply only to the locality of service provision. The access loadings would need to be reviewed annually for each SLA, as, if the scheme is effective, there will be a trend for districts to move to the average as practitioners move from relatively over-serviced areas to areas of relative need.

To illustrate this concept, a practitioner in Brisbane with no public sector commitment would be eligible for Medicare payment of only 44%.

Component	Payment as % CMBS fee
Baseline	50
Billings 10% greater than nat. average	**-6**
Total	**44%**

A practitioner in Townsville with a 5 session public commitment, plus on call 1 in 3, and a 30% bulk billing rate, would be eligible for a payment of 96% of the CMBS item number.

Component	Payment as % CMBS fee
Baseline	50
1:3 on-call	18
750+ hours sessional commitment	20
30% bulk-billing	**12**
10% below national average billings	**6**
Total	**96%**

If the same practitioner saw the patient on an outreach clinic to Mt Isa, and bulk-billed all patients seen there, the payment eligibility would be 190% of the CMBS fee.

Component	Payment as % CMBS fee
Baseline	50
1:3 on-call	18
300 hours sessional commitment	12
100% bulk-billing	**60**
RRMA Rem 2	**20**
20% below nat. average billings	**30**
Total	**190%**

5.5 Aboriginal and Torres Strait Islander Practice Incentives

The poor access to health services for Aboriginal and Torres Strait Islander populations, will be addressed in significant measure by the bonuses for regional, rural and remoteness, and service in areas of relative need.

That said, specific additional incentives may be required to assist in attracting doctors to provide Aboriginal and Torres Strait Islander health services, particularly in remote settlements. Particular specialty groups would be of relevance in these areas, notably nephrology, endocrinology, ophthalmology and cardiology. This may be addressed by well remunerated item numbers, specific to targeted specialty screening and intervention in remote Aboriginal and Torres Strait Islander communities, and for telehealth services provided to these areas.

5.6 Summary

As can be seen from the attached "bonus calculator", by application of these incentive programs, doctors are rewarded for being associated with public hospitals, even if only on an on-call capacity, rewarded for being associated with universities and are provided ongoing financial incentive to work in rural and remote areas and areas of relative medical need. The "bonus calculator" is best viewed in electronic form, which allows the parameters for each of the bonus categories to be changed, with a "live-read" of the resultant payment bonus.

6 Challenges to Implementation

6.1 Challenges For the Health Insurance Funds

Health funds will be concerned about the impact on their claims, of variation on the rebate for inpatient medical fees. Health funds have strived in recent years to offer "gap-free" products to their customers, and this proposal does inject significant variation into the size of the "gap".

In reality, the funds would be called upon to pay out significantly more for patients of some practitioners, and significantly less, or nothing, to patients of other practitioners. To compensate for this uncertainty, the government may need to introduce some "risk-sharing" models, whereby they would monitor the impact and provide partial compensation if required, on the proviso that funds had taken steps to mitigate their risk.

6.2 Challenges From Medical Lobby Groups

In circulating discussion drafts of this document, there have been indications of extremes of support or derision from medical lobby groups. It is likely that the rural medical lobby will support the central principles, if not the detail. However, speculation from specialists, administrators and lobbyists has focussed on potential for very significant opposition from mainstream medical lobby groups, and some learned Colleges.

The reason suggested for such predicted response, centres around preservation of position, power, high incomes and quality of life. This is a normal and expected response when positions of privilege and power are challenged, as they would be by this proposal.

7 Projected Benefits of Implementation

It is anticipated that several benefits would ensue from the approach described:

7.1 Benefits For the Patient

- Given the higher payments on offer, practitioners would be more likely to move toward bulk-billing for services as it became a more financially viable alternative. This improves access to specialist care for those least able to afford it.
- GPs would refer preferentially to those practitioners with a public sector commitment, university commitment, and/or bulk billing practices to limit costs to their patients.
- Patients in areas of relative under-servicing and in rural, regional and remote areas could expect to see a significant improvement in the availability of specialist level care.

7.2 Benefits for the Doctors

- Those specialists, and there are a great many, who contribute to national healthcare objectives as outlined above, stand to gain significant to substantial financial reward in their private practice.
- The specialists who provide on-call support for public hospitals, can expect to work much less onerous rosters as other practitioners, currently not contributing to the on-call service, join in to maintain their financial rewards in private practice.

7.3 Benefits For the Public Sector and Tertiary Education Sectors

- Competition for public sector and tertiary education sector posts would increase as the positions became desirable to enhance private referrals and payments.
- Practitioners would be likely to seek out appointments in rural, regional and remote settings, and areas of relative medical need, in order to access the greater financial rewards available.
- The relationship with visiting specialist staff will become one closer to mutual interdependence, rather than the current situation, where the specialist labour force is a "seller's market, often demanding and receiving unaffordable terms and conditions for their service.

7.4 Benefits For the Commonwealth

- Specialists would be more likely to provide services to remote Aboriginal and Torres Strait Islander communities, to address identified health priority areas.
- By prudential management of levels of baseline payments and bonus payment percentages, this proposal provides a cost–neutral mechanism to utilise market forces to support healthcare objectives.
- None of the mechanisms proposed would require major investment in infrastructure, nor would they be particularly difficult to administer. Other schemes which aim to address similar objectives (eg MSOAP – the Medical Specialist Outreach Assistance Program) could be terminated. All of the measures suggested rely on data already collected and technology and systems already in place.

8 Conclusion

It would be folly to suggest that such radical change to Medicare could be achieved without significant political risk. However, the proposal offers significant potential improvement in access to care, particularly in areas of relative need.

The author contends that implementation of this proposal would specifically benefit large groups of people in outer metropolitan, rural, regional and remote Australia. This benefit would be largely at the expense of that part of the medical profession that does not contribute directly to public health provision. This distribution of benefit and cost may make this a marketable change for a government committed to delivering on the central tenet of Medicare – Universality of Access.

9 Glossary of Terms and Abbreviations

Bulk-billing	The process by which accounts for medical services are submitted direct to the HIC, for the agreed fee, with no out – of - pocket expenses for the patient
CMBS	Commonwealth Medical Benefits Schedule
HIC	Health Insurance Commission
session	A session is normally considered to be a continuous period of work, of up to one half day per week. The session is defined in Queensland as three hours.
VMO	Visiting Medical Officer, a practitioner, usually a specialist who maintains a private practice, and performs a sessional commitment to a public hospital.
Staff Specialist	A specialist who is employed by a public hospital or health service
"Area-of-Need"	A geographic area or health service which has a demonstrated need for a practitioner with specific skills, yet is unable to recruit appropriately qualified, Australian registered practitioners.